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Women's Experiences of Birth Trauma and Postpartum Mental Health

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Women's Experiences of Birth Trauma and Postpartum Mental Health

By

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MSW Clinical Research Paper

Presented to the Faculty of the School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota in Partial Fulfillment of the Requirements for
the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Approximately a third of childbearing women report their birth experience as traumatic (Ford, Ayers, & Bradley, 2010). This experience is subjective and what qualifies as trauma varies among the women who report it. Research surrounding birth trauma is primarily quantitative in nature and does not fully address the personal and emotional experience of birth trauma. The goal of this study was to examine the thoughts and emotional experiences among women who self-identified as having a traumatic birth. Qualitative interviews were conducted with nine women who reported the birth of at least one child as traumatic. Interviews focused on participants' birth stories, thoughts and feelings in labor, and experiences postpartum. Several themes were identified, such as: physical events in labor, control, thoughts and feelings during labor, relationship and interaction with medical staff, and postpartum experiences. The study suggests that the interactions between women and medical staff as well as the type of follow up care received has an impact on both perception of and recovery from trauma. While this research study is exploratory in nature, it holds implications for social work practice and identifies areas for future birth trauma research.

Keywords: birth trauma, thoughts, emotions, postpartum, qualitative

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Background

Childbirth is a normal physiological event that many women experience during their lifetime. Up until the 17th century, birth was not viewed as a medical emergency and it generally took place in out of hospital settings, attended by women. By the 19th century interventions such as the C-section and anesthesia had become more common and hospitals became the standard place to birth (Johansen, Newburn, & MacFarlane, 2002). The continuing medicalization of childbirth has led to many women and medical professionals approaching childbirth as something that needs to be managed and controlled. American women in particular typically birth within highly medical settings and have a great deal of interventions applied, which are often unnecessary and sometimes harmful. Intervention rates vary throughout regions of the United States but nationwide, C-section rates are over 31% and induction rates are over 43% (Ehrenthal, Jiang & Strobino, 2010). The quality of both medical and emotional treatment of birthing women has an impact on how they view the experience of childbirth as well as their postpartum mental health.

Problem

Childbirth is generally recognized as a joyous and life changing event for women but despite cultural expectations, not all women have a positive experience. Over a third of women experience their birth as frightening or traumatic (Ford, Ayers, & Bradley, 2010). Following a childbirth that did not meet expectations, women can be left with feelings of guilt, anger, and uncertainty. Mental health support in the time after a traumatic birth can be very beneficial to new mothers, but birth trauma related resources

have not been available for long and are limited in availability. Prior to the implementation of the Diagnostic and Statistical Manual of Mental Disorders Four (DSM IV), the concept of childbirth as traumatic was not accepted amongst the mental health community.

Birth trauma is inherently unique from other types of trauma as it tied to an event that generally has some positive outcome, such as the birth of child. It also carries great societal pressure for the women who have experienced it to express happiness about their birth and to embrace the concept that a healthy child nullifies the negative effects of the birth. While most practitioners have an understanding of trauma and how to treat people following trauma, few providers understand the epidemiology and treatment of birth trauma. Not all practitioners recognize that trauma following birth cannot always be addressed in the same manner as other types of trauma. This knowledge gap among mental health professionals is troubling because women suffering from birth trauma may be missed in diagnostic assessments and may not receive the type of treatment that would be most beneficial for healing afterward.

Research Question

Research into the area of childbirth-related trauma is growing, however little is available specially studying the thoughts and emotions of women during the childbirth process. An exploratory qualitative study was conducted with women who self-identify their birth as traumatic. The goal of the study was to examine women's experiences in more depth than questionnaires or other quantitative research methods have previously addressed. In person interviews were conducted with nine women who have experienced birth trauma. The interviews focused not just on the events of labor but also the thoughts

and emotions tied to those events. This research will benefit social workers and other mental health professionals who work with women; due to the rate of birth trauma, it is extremely likely that they will work with multiple women who have endured it. The research question for this study was: in what ways do women experience birth as traumatic and how does that experience impact their postpartum mental health?

Review of the Literature

Definition and Prevalence of Birth Trauma

Historically, the concept of birth trauma has been debated among clinicians. Changes to the diagnostic criteria for post-traumatic stress in the DSM-IV, which included childbirth as a traumatic event, brought more acceptance that birth trauma is a reality for many women. Reid (2011) defines traumatic birth as any birth that the mother identifies as distressing to the point of considering it a trauma and includes trepidation surrounding future births. Other definitions of traumatic birth are less broad than Reid's. Beck (2008) defines birth trauma as "an event that occurs during any phase of the childbearing process that involves actual or threatened serious injury or death to the mother or her infant" (p. 229). Ryding, Wijma, and Wijma (2000) define birth trauma as any delivery that includes strong fear of maternal or fetal death or injury or terrifying dissociation during childbirth.

Approximately a third of childbearing women report their birth experience as traumatic (Ford, Ayers, & Bradley, 2010; Wenzel, 2011). Creedy, Shochet, and Horsfall (2000) had similar findings. They conducted a longitudinal study of 499 women using phone interviews and found that 33% of women indicated that their birth was traumatic and had at least three symptoms of post-traumatic stress. Ford and Ayers (2011) reported

a wider range of findings present in the literature, speculating that rates of birth trauma are between 20 to 48%. Beck (2006) also adds an important note that other authors do not discuss; childbirth related trauma can be caused by treatment by others or interventions that occur during postpartum care in addition to labor care.

Distress following birth trauma can be especially troubling for women because the experience of childbirth is expected to be joyful; conflicting emotions can arise when the experience was not as positive as expected. Birth trauma has distinctions that differentiate it from other types of trauma that are not interspersed with positive factors such as the arrival of a newborn child (Beck, 2004). Ayers, Harris, Sawyer, Parfitt, and Ford (2009) emphasize how childbirth related trauma differs from other types of trauma: most often women choose to become pregnant and birth their child, childbirth is something that the bulk of women experience, it comes with bodily changes, and is predominately seen as a happy occasion.

Risk Factors for Experiencing Traumatic Birth

Many of the studies in the literature focused on birth trauma discussed a history of mental health concerns as a major risk factor for both viewing birth as traumatic and developing postpartum mental health issues such as depression and post-traumatic stress disorder (Maggioni, Margola, & Fillipi, 2006). Cohen, Ansara, Schei, Stuckless, and Stewart (2004) found that women who had depression before or during pregnancy, panic attacks during pregnancy, or a history of two or more previous traumatic life events had a higher association with birth trauma and symptoms of postpartum PTSD. Wenzel (2011) also found that women who had antepartum fears of childbirth had an increased risk of experiencing birth as traumatic.

Allen (1998) also discusses prior trauma as a risk factor, stating that labor can sometimes resemble past experiences of trauma and can prompt the birth experience to also feel traumatic to the mother. Out of the prior mental health risk factors identified in the literature, many of the authors found that having depression prenatally was the greatest risk factor for developing signs of posttraumatic stress after birth (Beck, 2006; Cohen et al., 2004; Maggioni, Margola, & Fillipi, 2006). Ford, Ayers, and Bradley (2010) supported this notion; their research also found that having a history of psychiatric concerns or past trauma greatly increased a woman's risk for postpartum mental health problems.

Prior trauma of sexual abuse greatly increases the likelihood of experiencing birth as traumatic and having mental health concerns in the postpartum period. According to Soet, Brack, and Dilorio (2003) women with a sexual abuse history were 12 times more likely describe their birth as a trauma. Ford and Ayers (2011) support this, indicating that feelings of violation and lack of control can lead to re-experiencing prior trauma symptoms. Wenzel (2011) also discusses the risk of trauma with sexual abuse survivors, stating that the labor pains may trigger memories of the pain associated with the abuse or feelings of helplessness.

Events in Labor that May Lead to Identification of Trauma

Researchers have identified several medical events that can occur during birth which seem to be connected with greater rates of women reporting as traumatic and an elevated risk for postpartum mental health problems. These events include both medical interventions and the type of care received by medical staff.

Medical interventions. According to Creedy et al., (2000) a high level of medical procedures during labor and discontent with the medical care received correlates with symptoms of acute trauma postpartum. Events that women may find traumatic include but are not limited to surgical birth, hemorrhaging at any point during labor or postpartum, threat to the baby's health, insufficient pain control, and severe perineal tearing (Reid, 2011). Beck (2004) conducted a qualitative study of 40 mothers using descriptive phenomenology to identify themes among women who experienced traumatic birth. She found that medical events most commonly associated with perception of trauma are: emergency C-section, fetal risk, inadequate care from medical staff, fear of getting an epidural, insufficient pain relief, postpartum hemorrhage, instrumental delivery, long and painful labor, and fast birth. Creedy et al. (2000) supported the association between instrumental delivery and trauma, indicating that some women find forceps-assisted delivery as traumatic as other considered emergency C-sections.

Surgical birth is discussed by many authors studying birth trauma. Cohen, Ansara, Schei, Stuckless, and Stewart (2004) conducted telephone interviews with 200 new mothers 8 – 10 weeks postpartum and found that cesarean birth was also associated with higher rates of trauma and postpartum PTSD. Creedy et al. (2000) supported this finding stating that the occurrence of an emergency C-section led to greater perception of trauma and may have repercussions on postpartum mental health and emotional wellbeing. In later research Beck (2011) found that the variables that lead to the highest amount of distress following birth were coercion to induce labor or receive an epidural, and planned C-section. These findings contradict the findings of other authors who found the planned surgical birth led to lower levels of trauma than unplanned C-sections. Beck

(2011) speculates that women who chose a planned surgical birth may have deep fears of childbirth and antepartum beliefs that it would be traumatic.

In one study, Ryding, Wijma, and Wijma (2000) interviewed 25 women who had emergency C-sections and found that 74% of the women classified the experience as traumatic and 33% had severe posttraumatic stress reactions in the first two months postpartum. Creedy et al., (2000) also indicate that research has shown mothers have increased rates of depression and lower levels of self-esteem following emergency surgical birth.

Inadequate care from medical staff. Childbirth is an extremely vulnerable time for women and lack of support can lead to feelings of abandonment and fear. Ford and Ayers (2011) conducted a longitudinal study of 138 mothers in the United Kingdom exploring provider support and women's sense of control in birth and the relationship to postpartum posttraumatic stress symptoms. Questionnaires were given once in pregnancy and twice postpartum. The researchers found that negative experiences with medical staff, inadequate support from staff, lack of communication from staff, and feeling unimportant to staff were associated with greater perception of trauma. According to Beck (2004), women who identified their birth as traumatic indicated that they often felt ignored by medical staff and that their options were not clearly communicated to them. Some women reflected that staff often talked about them as if they were not present, which contributed to their feelings of disconnection and lack of ownership of their birth. Soet, Brack, and Dilorio (2003) had similar findings. The authors conducted observational research that included a survey in late pregnancy and a telephonic interview at four weeks postpartum. Findings suggested that aggressive and unsympathetic

treatment from medical staff, lack of information, and failure to obtain consent for interventions during labor are probable indicators of developing signs of posttraumatic stress following birth.

Research suggests that positive care from staff and clear communication may provide somewhat of a protective factor to women who experience medical interventions that others more frequently report as traumatic. Ryding, Wijma, and Wijma (2000) found that women who identified less negative feelings following an emergency C-section stated that they felt in control throughout labor and felt involved in the decision to go to surgery. Wenzel (2011) supports this notion, speculating that insufficient care and information from medical staff lead women to feel abandoned and more likely to feel the experience was traumatic.

Thoughts and Emotional Experiences among Women who View Birth as Traumatic

Because trauma is a largely subjective experience, birth trauma research must consider more than just the physical events of labor. The researcher needs to gain an understanding of the thoughts and emotions of women who classify their birth as traumatic in order to better identify causes and preventative factors. Women can have medically normal births but still feel psychologically traumatized by fear that their baby will not survive, feeling violated by medical procedures or bodily exposure, or feeling that those around them are uncaring or hurtful (Ford & Ayers, 2011; Wenzel 2011). White, Matthey, Boyd, and Barnett (2006) support this notion, suggesting that it is not the clinical procedures in childbirth that women tend to view as traumatic but rather their interpretations of said events, level of autonomy, and treatment received from others during the birthing process. Ayers (2007) also stresses that individual perceptions of

their labor are pivotal in whether or not they view it as traumatic. Two women may have extremely similar events occur in labor but it may be that only one would describe the experience as traumatic. However, limited research has explored the key role of thoughts and emotions regarding birth and how they impact the development of posttraumatic stress.

Among the research available examining the emotional experience of birth trauma, similar themes have emerged. Ayers (2007) found that some of the most common themes described by women who viewed their birth as traumatic were: difficulty managing labor, feeling overwhelmed mentally, desire to for labor to be over at any cost, and a lack of understanding regarding what was happening. Beck (2004) identified four themes in her qualitative research: feeling uncared for, lack of communication, violation of trust, and thoughts that delivering a healthy baby negated any adverse events during labor.

Expectations of labor. The mindset that women enter labor with can have a significant impact on how they view childbirth. Unmet expectations in regards to a variety of factors in birth can influence perception of trauma. Ryding, Wijma, and Wijma (2000) found that unmet expectations were most often associated with women who had developed posttraumatic stress. In addition to positive expectations not being met, going into the birth experience with fear or negative beliefs make it more likely that the mother will consider the experience traumatic. For example, Soet, Brack, and Dilorio (2003) found that women who expected childbirth to be excruciatingly painful were more likely to report it as a trauma.

Feeling unsafe during labor and delivery. The qualitative research available on birth trauma tends to consistently demonstrate the theme of the mother's perception of safety during labor and delivery. Beck (2004) states that women place trust in their care providers that they will protect them and their babies in any circumstance. According to Beck (2004) when situations arise in birth where women feel unsafe, they experience a sense of terror about both their own wellbeing and the safety of their unborn child. Gamble et al. (2005) supported this concept, stating that an overwhelming sense of fear or anxiety in birth is a precipitator for postpartum PTSD in some women. Allen (1998) conducted a two stage study with women who identified their birth as traumatic. The study included a questionnaire and semi-structured interview which was analyzed using grounded theory. The author found that many women who developed signs of postpartum PTSD experienced fear for the life or safety of the baby and underwent emergency medical procedures due to fetal distress.

Feeling powerless or a lack of control. Many authors discussed the role of power and control in a woman's perception of her birth and how that perception may influence the development of postpartum PTSD. Allen (1998) stated that feeling out of control during the birth led to a greater risk of posttraumatic stress following the birth. Allen (1998) speculated that the lack of control felt by women "was maintained by failed attempts to elicit practical and emotional support from staff and partners" (p. 107). Beck (2004) had similar findings; stating that women would attempt to regain control of the birth by seeking reassurance from providers and their support system. Failure to provide that reassurance and a sense of control may lead to greater instances of trauma. Wenzel (2011) states that this lack of reassurance for mothers leads to validated feelings of

powerlessness. Ayers (2007) found that many women who experienced birth trauma held a defeatist attitude about their birth; indicating that what happened was due to bad luck and they had no control over what happened to them.

Loss of control was one of four main themes in birth trauma that Beck (2004) identified. Beck (2004) quoted one of the study participants who stated "I strongly believe that my PTSD was caused by feeling powerless and loss of control over what people did to my body" (p. 33). Maggioni, Margola, and Fillipi (2006) conducted a two-wave longitudinal study using questionnaires at 38-42 weeks pregnant and again 3-6 months postpartum. Their findings support other research indicating perception of control as an influencing factor in the development of postpartum mental health problems. The authors acknowledged that the meaning of control in birth can vary widely among women and include control over others as well as control over themselves and their bodies (Maggioni, Margola, & Fillipi, 2006). The authors also found that lack of input or control in the decision process during labor was also a precipitator of developing postpartum mental health concerns.

Feeling degraded. Feeling degraded during the labor and birth process can lead to viewing the experience as traumatic. Beck (2004) stated that many women who experienced birth trauma viewed their labor as a fight which took away their self-respect and independence. The author also discussed how that feeling of degradation can be a significant violation for some mothers. She found that some women felt the experience of their birth was akin to a rape or other violent crime (Beck, 2004). Often the feeling of degradation comes from how birthing mothers are treated by care providers. Reid (2011)

ascertains that abusive treatment, such as verbal devaluation, from birth providers can lead to a view of birth as traumatic.

Elmir, Schmied, Wilkes, and Jackson (2010) conducted a meta-ethnographic review of birth trauma related findings. One of the themes they identified was inhumane treatment of birthing mothers. The authors found that an area that women found particularly distressing was having people, such as medical students, witnessing the birth without the permission from the laboring woman. Both Beck (2004) and Elmir et al. (2010) discuss the concept of mothers being treated as if they were not a person; they were we talked about in regard to medical events but not talked to.

Social support. Social support plays a role in the development of trauma. Perceptions of adequate social support seem to provide somewhat of a buffer to negative physical or psychological events where as conversely, lack of social support appears to add to perceptions of birth as traumatic. Illes, Slade, and Spiby (2011) examined the role of perceived support from partners in regard to postpartum depression and PTSD symptoms. The authors found a significant correlation between perceived support level from partners and postpartum PTSD symptoms and depression; women who felt satisfied with the support they received were less symptomatic than those dissatisfied with their partners. Ford and Ayers (2011) supported those findings stating that women without adequate social support had the highest likelihood of developing symptoms of PTSD following birth. The authors emphasize that good social support is particularly important for women with a history of trauma to help avoid additional traumatization Wenzel (2011) concurred; indicating that women who birthed alone had much higher levels of posttraumatic stress than women whose partners played an active role in the birth.

Fear of death. Fear of maternal or fetal death was a common thought reported by women who viewed their birth as traumatic. According to Wenzel (2011), of the women who experienced birth as traumatic, 10 to 15% of them felt that they would not survive the birth or that their child would die. Ayers (2007) found that women who developed signs of posttraumatic stress had higher levels of fear that they or their baby would die during labor than women who did not have symptoms following birth. That fear can increase when events in labor lead women to begin to doubt that their provider has their best interests in mind. Beck (2004) ascertains that women place their full trust in their care providers to protect their lives and the lives of their unborn children, and when that trust is broken it can lead women to feel strong fear for their safety and the welfare of their children.

Postpartum Concerns Following Birth Trauma

Motherhood. Mothers often do not get much acknowledgement of and attention to the trauma, as many births that women perceive as traumatic are seen as routine by care providers (Beck, 2004). Mothers also often have their feeling about the birth dismissed and receive pressure from others that having a healthy baby is the only thing that matters (Beck, 2004). Soet, Brack, and Dilorio (2003) conducted surveys with 103 pregnant women and follow up interviews at 4 weeks postpartum. They found that women have trouble even discussing their difficult or distressing birth experience and tended to follow any negative comment with a comment about having a healthy child and how grateful they were. The authors discuss the societal coercion that women need to be satisfied with their birth experience and their needs and wellbeing are less important now that they are mothers (Soet, Brack, & Dilorio, 2003).

This lack of acknowledgement and permission to be unhappy with their birth experience can lead to guilt and shame in new mothers as well as questioning their ability to parent. Ayers (2007) found that following traumatic birth women had increased levels of anger and guilt about the birth. Reid (2011) examined the effect of birth trauma and maternal-child relationships. She found that many women speak of themselves as failures following a traumatic birth and have anxiety that their emotional well-being following the event will negatively affect their capacity to parent the new child. The sense of doubt can leave mothers feeling like they need to prove their worth as a parent. According to Beck (2008) many women who experienced birth trauma have a strong desire to demonstrate their value as mothers to compensate for their feelings of failure surrounding their births. Elmir et al. (2010) supported Beck's findings; stating that some women make a significant amount of effort to connect with their babies in an attempt to counteract their feelings of failure in regard to the birth.

The transition to motherhood marks a significant shift in identity for most women, especially first time mothers. Because birth is an essential part of that transition, it is important to examine the role of the birth itself in identity development. Briddon, Slade, Isaac, and Wrench (2011) support this notion, stating that there is a relationship between birth and identity. The authors speculate that birth of a child and the mother's perspective of herself within the context of her birth influences her identity as a mother.

Attachment difficulties. Trauma associated with the birth of their child can lead to attachment difficulties in some women. According to Reid (2011) women may have difficulty separating the negative experience of childbirth from the positivity of having a newborn, which negatively impacts attachment between mother and child. Wenzel

(2011) reports that women who experienced birth trauma often reported that their infants were difficult to deal with. Birth trauma can also hinder breastfeeding efforts, which can mean missed bonding time between mother and child. Beck (2008) found that some women who had a traumatic birth were psychologically unable to breastfeed because they considered it an additional intrusion upon their bodies, they had been unable to attach to their babies, or endured painful flashbacks of the birth while breastfeeding.

Elmir et al. (2010) found it was common for women who experienced birth trauma to experience detachment from or negative feelings toward their infants; this could be short term or last beyond infancy. Wenzel (2011) states that women with birth trauma may avoid things that prompt them to re-experience their birth, such as their own child. Wenzel (2011) continues to state “that these women are at a high risk of impairment in their relationship with their infants, which in turn could foster an insecure attachment style in the baby” (p. 116).

Mental health. The majority of the research regarding birth trauma indicates a significant relationship between perceptions of trauma during birth and postpartum mental health problems (Creedy et al., 2000; Elmir et al., 2010, Ford et al., 2010) Depression, anxiety, and PTSD are common mental health concerns that women can experience following a traumatic birth.

Depression. White et al., (2006) found that a significant number of women who experience traumatic childbirth met diagnostic criteria for depression in the postpartum period. Research has shown mothers have increased rates of depression and lower levels of self-esteem following emergency surgical birth in particular (Creedy et al., 2000; Ford et al.; Elmir,). Wenzel (2011) states that women who experience birth trauma have

increased rates of depression in the year following their birth. Spies-Sorenson and Tschetter (2010) state that development of postpartum depression is linked to women's views of their birth, which supports the notion that traumatic birth is often a precipitator to postpartum depression. Tracey (2000) speculates that depression in mothers following trauma may present differently postpartum than depression in mothers without birth trauma; that the mothers who experienced birth trauma have a "flatness" or lack of emotions (p. 185).

Posttraumatic Stress Disorder. PTSD is another mental health complication that can follow traumatic birth. According to White et al. (2006) 2 to 7% of women develop PTSD following childbirth. The authors conducted a longitudinal study of new mothers and found that 2% of their sample met criteria for PTSD following birth trauma. However, they acknowledge 10.5% of their sample did not meet diagnostic criteria for PTSD but did experience substantial symptoms of post-traumatic stress. Ford et al. (2010) had similar findings, stating that 1- 6% women develop postpartum PTSD after birth trauma. Briddon et al. (2011) studied memory processes in relation to PTSD symptoms after childbirth using formal assessment tools and narrative accounts. Their findings support previous research, indicating that the rates of PTSD following childbirth are 2.8 to 5.6%; however it is important to note that they found that 24 to 34% of women have trauma symptoms, but not enough to merit a formal diagnosis of PTSD. The authors emphasize that even though women might not meet diagnostic criteria, their posttraumatic stress symptoms can still cause serious functional impairment (Briddon et al., 2011).

Anxiety. Women who do not meet the criteria for PTSD following a traumatic birth can still have high levels of anxiety in the postpartum period. Ayers (2007) conducted a qualitative study of 50 postpartum women, 25 experiencing posttraumatic stress symptoms and 25 that were not symptomatic. She conducted interviews at three months postpartum and compared findings among the two groups. She found that following a traumatic birth, many women had constant painful and invasive thoughts and memories of the birth. Lemola, Stadlmayr, and Grob (2007) examined PTSD and depression symptoms in 374 mothers, 6 weeks after they had given birth. They found that 22.5% of the sample reported moderate to frequent symptoms of hyperarousal. Creed et al., (2000) also suggest that birth trauma can lead to mothers having hypervigilance regarding their infants, including constant concern for the welfare of the child. Elmir et al. (2010) supported this finding, stating that in some cases the hypervigilance was acute enough that the mothers would not allow anyone else to care for their child.

Implications for Mental Health Providers

There is limited research available focusing on recovery from traumatic birth. Due to the previously discussed uniqueness of birth trauma, it cannot be assumed that providers can treat birth trauma in the same manner as they would treat others experiencing symptoms of posttraumatic stress after non-birth related trauma. Beck (2004) stresses the importance for clinicians to not only discuss the result of a woman's birth but also the expectations that were not met during the birthing process. This step may be vitally important in identifying women who are having postpartum mental health problems. White et al. (2006) suggest that it is likely that women experiencing functional

impairment following birth trauma are being overlooked by providers who rely solely on standardized tools to recognize mental health problems in the postpartum period. They suggest that in addition to the standardized tools and scales used to help identify postpartum mental health concerns, providers should be asking postpartum women about their births and inquire further if symptoms of trauma are present (White et al., 2006).

Beck (2011) speculates that all providers should screen for signs of postpartum traumatic stress in addition to screening for postpartum depression. Ayers (2007), supports this notion, suggesting that providing postpartum mental health services to women who have experienced birth trauma may help to mitigate symptoms of posttraumatic stress. Ford and Ayers (2011) stress that providers must look at not just the obstetrical interventions to make a determination of traumatic stress, but rather investigate women's unique interpretations of those events.

Limitations of Current Research

Much of the research on birth trauma focuses primarily on the physical events of labor and the risk factors of women developing postpartum PTSD. There is limited research available studying the thoughts and emotions of women during and following traumatic birth. This poses a problem for the researcher, as the experience of trauma is a subjective one. Research focusing mainly on the events of birth may not be able to fully delve into why some women will experience a set of circumstances as traumatic, while others experience the same circumstances but do not report them as a traumatic. While birth trauma research is growing, there is a gap in the research in regards to treatment. Very few studies address what best practice should look like when working with women

following birth trauma. Future research should focus on prevention measures prenatally, emotional state in labor, and therapeutic interventions in the postpartum period.

Conclusion

This literature review discussed the contributing factors to the development of birth trauma, postpartum complications, and implications for providers who work with postpartum women. As previously discussed, there is a gap in the research in regard to the thoughts and emotional state of women in labor. The purpose of this research was to explore that gap area by investigating the thoughts and emotions of women in labor, how those feelings may have contributed to the development of birth trauma, and its influence on postpartum wellness. The research question for this study was: in what ways do women experience birth as traumatic and how does that experience impact their postpartum mental health?

Conceptual Framework

The conceptual framework used for this study is the conflict perspective. The perspective addresses areas of conflict, dominance, and oppression within a social context. While the term oppression may seem extreme in relation to childbirth, the literature indicates that disempowerment; much like oppression is what many women felt in labor. Power relationships are emphasized within the conflict perspective, and as discussed in the literature review, is also a theme in birth trauma research findings (Hutchinson, 2003). Conflict theorists note that oppression from those in power, such as abusive or degrading birth providers, leads to a sense of alienation in the non-dominant group, such as birthing mothers (Hutchinson, 2003).

Hutchinson (2003) states “concepts from the conflict perspective have great value for understanding power dimensions” (p. 58). The perspective can be used to examine the provider-patient relationship more closely within the context of birth trauma. Beck (2004) discusses women’s discontent with their care providers in birth treating them as less than human and discussing them as if they were not present, which supports that sense of alienation described within the conflict perspective.

The conflict perspective also explores power dynamics within the context of social class. Pregnant women, in America particularly, tend to experience some form of disempowerment during their pregnancy (Beck, 2004). Cultural norms tend to take ownership of women’s bodies away from them and make them public domain. Pregnant women are frequently touched without their permission and are given unsolicited direction on how to care for their unborn child and how to handle birth (Gauldin, 2006). This disenfranchisement can be particularly poignant in regard to medical decisions in labor. A theme discovered in studies reviewed was feeling out of control or lack of consent in decisions; women felt like medical interventions were used on them without informed consent and sometimes without any discussion at all. In my work as a birth professional, I have witnessed women having medical interventions performed on them without consent such as episiotomies, artificial rupture of membranes, and blood draws. Actions like this have contributed to feelings of demoralization and violation among mothers, which contributes the perception of trauma.

The conflict perspective explores how these types of actions and power issues impact human behavior (Hutchinson, 2003). This is relevant to birth trauma research because of the subjectivity of the trauma experience. It is important to explore how

pressure and influence from birth providers impacts mothers' decision-making abilities and overall perception of the experience of labor. Many of the themes in qualitative birth trauma research are associated with feelings of exclusion or violation, which would suggest that conflict plays a significant role in the development of trauma and it is important to examine findings within that context. In the subsequent section, methodology will be discussed.

Methods

Research Design

The purpose of this study was to explore women's experiences of birth trauma. The research was qualitative and exploratory in nature. Qualitative research methodology was chosen because open ended questions allow the participants to more fully share their perceptions and allows the researcher to gain a better understanding of the unique thoughts and emotions that individual women have during traumatic birth. The researcher conducted semi-structured interviews focused on birth stories, identified areas of hardship, and postpartum experience. The participants were given the opportunity to review the interview guide (see Appendix A) before the interviews were conducted. The participants signed the consent form (see Appendix B) and were given the opportunity to ask questions about the research process prior to beginning the interview. The interviews were expected to last approximately one to two hours and were audio recorded.

Sample

Snowball sampling was used to recruit eight mothers who self-identified their birth experience as traumatic. The researcher used three methods of recruitment to obtain

study participants. First a message was sent out to members of a Minnesota collective of birth professionals. This message was posted on the internal members only online forum and included an information sheet detailing the study (see Appendix C). The researcher requested that doulas in particular send the information sheet to former clients that had a previous traumatic birth. A doula is a woman trained in childbirth who provides prenatal and postpartum support to mothers as well as continuous emotional and physical support during labor. Because of the role doulas have during childbirth and the relationships they develop with their clients, they were expected to be an asset in identifying and recruiting possible participants for the study.

The second method of recruitment was through a cesarean awareness organization that provides cesarean awareness and recovery resources as well as support for women choosing vaginal birth after cesarean. The organization has monthly in-person support meetings and an online message board. Messages submitted are emailed to all people subscribed to the message board. The information sheet (Appendix C) was submitted electronically on the message board with a request for anyone interested in participating to contact the researcher.

The third method of recruitment was through email contact with mental health professionals who work with women in the perinatal period. The mental health professionals that were contacted were selected because they are in the researcher's professional network and are familiar with the researcher's study. The email message (see Appendix D) briefly introduced the study and requested for the professionals to provide the information sheet to clients who have identified a history of birth trauma. The information sheet listed both email and phone contact information for the researcher.

The researcher used a script for both phone and email inquiries about the study (see Appendix E) that reiterated the aims of the study and offered the opportunity for respondents to ask questions about the study. When a potential participant agreed to take part in the study, the researcher discussed the scheduling and location of the in-person interview.

Protection of Human Subjects

Several steps were taken for the protection of participants. In order to ensure participants entered into the study with informed consent, they reviewed and signed the consent form outlining the risks, benefits, and details of the study and had the opportunity to ask questions before the interview commenced (see Appendix B). The researcher confirmed understanding of consent with participants by asking questions about the consent form. Both the information sheet and the consent form indicated that if a potential participant was less than 6 months postpartum, had not previously processed their birth experience, or was currently experiencing severe symptoms of posttraumatic stress, the risks outweighed the benefits, and participation was not encouraged. Interviews were conducted in a private space to protect confidentiality and increase comfort in discussing extremely personal experiences without concern of being overheard. The private locations varied and were determined collaboratively between the researcher and participants. Locations included were library study rooms and participants' homes. Participants were informed that the nature of the study was entirely voluntary and they were free to terminate participation in the study at any time. Due to the sensitive nature of the study, all participants were given community resources to contact if they experienced any distress following the interview. The resources were

listed and highlighted on the consent form (see Appendix B) and participants left the interview with a copy of the consent form to reference. All data collected was kept confidential on the researcher's password protected personal computer. Participants' identifying information was not included in the findings and only the researcher, a research assistant, and the research chair had access to the interview transcripts.

Data Collection

Data was collected using semi-structured, in person, interviews. The interviews consisted of seven questions with the possibility of additional follow up questions based on participant responses (see Appendix A). Topics the questions addressed were: birth story, support received, and postpartum experience. The interviews were audio recorded and the recordings were transcribed by the researcher.

Data Analysis

Content analysis was used to identify codes and themes in the interview. Content analysis is a systematic qualitative data analysis method that involves carefully examining and interpreting data to identify themes and other patterns in human communication (Berg, 2009). The researcher reviewed the interview transcripts several times using open coding. After open coding was completed, grounded theory was used to group similar concepts identified in the open coding into themes. Any code that appeared three or more times in multiple transcripts was considered a theme and a list of themes was developed. The researcher reviewed the identified themes with a research assistant and the research chair as a reliability check for identified themes.

Strengths and Limitations of the Study

This study explored an aspect of birth trauma that is underrepresented in the literature. The research has shown that certain medical events are linked to higher rates of trauma reported, but those events alone do not seem to be the catalyst in developing posttraumatic stress symptoms. It appears that it is not the events in labor that have the strongest correlation to birth trauma, but rather the women's perceptions of the events in labor and the emotional experience that have a greater influence. Exploratory qualitative research focusing on the thoughts and emotions of women during the birthing process gives greater insight into the development of birth related trauma. This study makes a positive contribution to birth trauma research and provides topics of interest for future research.

There are some limitations to the study. First is the sample size; due to the time-restricted nature of this research, the researcher had to limit the sample size in order to be able to analyze the data in a period of a few months. The research may also have limited generalizability due to the small sample size. The purpose of this study was not to make broad conclusions, but rather identify preliminary themes and areas for continued research on the subjectivity of birth trauma.

It is also important to note the potential for researcher bias when working with the topic of birth trauma. I developed a clinical interest in the topic of birth trauma after the birth of my first child. I experienced several events throughout my labor that I perceived as traumatic and caused a significant amount of impairment in my life postpartum. When I initially sought help, I found there were limited birth trauma focused resources available. This lack of resources prompted me to take a personal and professional interest in birth trauma. I acknowledge that I have the potential for

transference of my own experience to the interpretation of my research, however I will take steps to ensure that transference does not occur. I reviewed interview questions (see Appendix A) with my committee members and I also reviewed my coding with my research chair.

Findings

The researcher had twenty women contact her and indicate that they were interested in the study. However due to scheduling conflicts or lack of response to the researcher's request to schedule an interview, not all interested parties participated in the study. Nine interviews were conducted ranging in length from 12 minutes to 55 minutes. The majority of interviews lasted between 20 and 45 minutes. Six of the interviews were conducted in person and three of the interviews took place via webcam, using Skype.

Several themes with three or more codes were identified during the content analysis process. Due to the large number of themes identified, initial themes with similar coding were categorized into like groups. The broad themes identified were physical events in labor, control, thoughts and feelings during labor, relationship and interaction with medical staff, and postpartum experiences.

Participant Information

Among the women who participated in the study, eight of the women indicated that the trauma occurred during the birth of their first child and one indicated that the trauma occurred during the birth of her third child. Participants were not asked to indicate race, age, or marital status, so that demographic information is not included in the study.

Some participants indicated that they had an unremarkable pregnancy or did not discuss their pregnancies at all, however four of the nine participants indicated that they were diagnosed with hyperemesis gravidarum (HG) during their pregnancy. Hyperemesis gravidarum is severe nausea and vomiting during pregnancy. It generally includes a loss of over 5% of pre-pregnancy body weight, dehydration, and nutritional deficiencies. It often requires costly medical treatment, and severely limits a pregnant woman's ability to function. According to Fejzo, Ingles, and Goodwin (2008) the rate of occurrence for HG is about 0.5% of pregnancies. This is important to note because although HG occurs in less than 1% of the general pregnant population, 44% of study participants indicated having HG during pregnancy.

All of the births occurred in a hospital setting, although one participant indicated that she had originally planned a home birth but had to switch to hospital care due to gestational diabetes. Six out the nine participants indicated that their labor was either induced or augmented using Pitocin, which is a synthetic version of the body's own hormone, oxytocin. Seven out of nine participants indicated that they had a c-section, all of those c-sections were unplanned. Of those seven participants, five indicated that their labor had been either induced or augmented with Pitocin. In addition, five of the nine participants indicated that their baby spent time in the NICU or special care nursery following birth.

The following sections will examine the common themes discovered among the study participants' individual experiences. In order to distinguish the different experiences among the women interviewed, study participants will be referred as

participants A – I when quotations from the interviews are used. These labels were given based on the order of interview and hold no special meaning or rank.

Physical Events in Labor

Participants identified several events, experiences, or medical interventions in their labor that contributed to their experience of trauma. These include physical pain and exhaustion, induction, and c-section.

Pain and Exhaustion. Several of the participants discussed the physical pain they experienced during labor and delivery. Participant A discussed the pain in her birth at length, particularly in regard to her Pitocin induced contractions, stating “it was really hard to stay calm when I was just feeling them so intensely.” Despite her wishes to avoid getting an epidural, she eventually chose to get one but did not find relief for long. She stated “at about 6 in the morning the epidural started to wear off.” She had another epidural placed but was unable to find relief from that either. She reflected, “I just was so exhausted and in pain because the second epidural that they hooked up ended up not working.” She recalled the lack of adequate pain relief during pushing, stating “his shoulders got stuck so the last bit of his birth was lots of, like the cutting of the episiotomy and him kinda tearing him out of me and I had no pain relief.” When reflecting on her birth as a whole she indicated “It was just so much more physically painful than I ever thought it would be; emotionally, and spiritually, all of it.”

Other participants also reflected on their level of pain during labor. Participant B, who was also induced stated “Pitocin contractions are very painful.” Participant I, who was induced as well, discussed her contractions while on Pitocin. She stated “It was awful. It just caused really bad contractions but they weren't productive.” Participant E

also reflected on the pain stating “after a while the pain got really bad and I asked for the epidural and they gave me the epidural and I remember just lying there crying because I was in so much pain.” Participant F was a first time mom who had a water break early and progressed quickly afterward. She discussed how her labor although her labor was quick, it was also powerful: “They filled the tub for me but I was in such intense labor that I couldn’t make it across the hall.”

With pain also came discussion of exhaustion during labor. Participant A described her feelings of exhaustion while pushing:

I could just feel myself like, I just felt like I was [pause] not effective and not productive. I had these fantasies of having the mirror and seeing my son’s head crown and everything and they brought it over one time and I could see this much of his head [indicates around the size of a quarter with fingers] and I said ‘get it out if here, if I can’t even, if I don’t, I cannot go on’.

Participant I also spoke about exhaustion in labor. She discussed her feelings on the initial attempts to induce her labor that were unsuccessful, stating “nothing was still happening and by that time I was exhausted and fed up and asked to go home.” Although she did go home initially, she was unable to get much rest during a several day induction process. She stated “I was just so exhausted and I had been having a ton of back labor.” Many of the participants who discussed the pain they experienced also had their labor induced or augmented with Pitocin.

Induction. Six out of the nine participants indicated that their labor had been induced or augmented using Pitocin. Participant A was a first time mom who expressed a strong desire not to be induced. She stated “my obgyn wanted to induce me at 41 weeks

and I really begged her to let me wait because I really felt like my body and my baby know how to do this and don't feel like we need to rush anything." She was able to go to past 41 weeks but not to 42 weeks:

She [the doctor] said she was willing to wait a little bit but she didn't want me to go one day over 42. I turned 42 weeks on a Sunday and they don't induce on Sunday so she backed it up to Friday.

Participant B was also a first time mom and although she did not want to induce she was told that she would not be allowed to have her pregnancy go to her due date: "I am a type 2 diabetic so the clinic I went through told me that I couldn't go to 40 weeks gestation because there is a risk of stillbirth." Participant D was also a first time mom who was told "if I didn't go by my due date [my doctor] was going to induce me the day after." However she thought her water had broken a few days before her due date and she went to the hospital. Once at the hospital, she was told that her baby was having decelerations on the heart monitor and the decision was made to induce. She stated "they started me on Pitocin to get contractions and labor started and of course they said that was going to take hours." Participant E was a first time mom who had her labor augmented with Pitocin. She stated that she felt she was in labor for several days, despite medical staff's disagreeing. She was having problems with kidney stones and what she felt strongly was labor, the medical staff believed was just pain from her body trying to pass kidney stones. Once her labor was acknowledged, the staff felt that her labor was not progressing fast enough. She stated "they talked me into using some Pitocin to speed things up to get her out." Participant G was also a first time mom who was told by her doctor that she had to be induced before her due date because she had a negative blood type: "She wanted to

induce my on my due date because of the rh factor. She didn't want to have to give me a second shot of the rhogam". After her child was born she learned that there are no medical risks to giving a second injection of rhogam and waiting for labor to occur on its own. Participant I was a first time mom who also discussed induction for a reason that was not a medical necessity: "I was seeing a family physician and she suggested that I was measuring big and probably having a big baby and wanted to induce me for a big baby and my body wasn't ready at all yet." The majority of the participants who had their labor induced or augmented also ended up having a c-section.

C-Section. Seven of the nine participants reported having a surgical birth after laboring for different durations of time. Participant G had fully dilated and spent time pushing with no progress before a c-section was decided upon. She discussed her experience:

They went in and did the c-section and they had to push her back up. Like they had one doctor or nurse pushing her up and another pulling her out and they were not, they were having a hard time getting her out at that point. She had gotten herself jammed down there and it kind of became an emergency all of a sudden.

Participant H was the only mother who was not a first time mom. She had two previous vaginal deliveries that she did not report any trauma from. With her third child, she had her water break and went into labor six weeks before her due date. Her baby was breech at the time and she could not find a doctor who would allow her to vaginally birth a breech baby. She stated "I was pretty much kicking and screaming. I did not want to have a C-section and I was trying to do everything I could to not make it happen." Participant B developed an infection before she was fully dilated and consented to a c-section despite

her strong desire to not have one. She discussing being brought into the operating room: “They brought me into the c-section room or the operating room or whatever and strapped my arms down. That really freaked me out..”

Other participants also discussed having their arms strapped down during surgery combined with nausea and vomiting as particularly difficult. Participant C had a history of infertility and loss. At 18 weeks her cervix began to shorten. She had two cervical cerclages placed and both failed. At twenty weeks she was admitted to the hospital and placed in trendelenburg position, a position where the woman is placed flat on her back with her back with her bed at an angle so her feet are higher than her head, in order to attempt to stop her cervix from dilating any further. She was 22 weeks pregnant when her water fully ruptured. She was given the option to attempt a vaginal birth or have a c-section if the baby made it to 23 weeks. She was on medication to stop contractions; however at 23 weeks 5 days her body began to labor again and she chose to have a c-section. She discussed her experience during the surgery:

The poor anesthesiologist kept pushing drugs on me and nothing was working and you can't move, and you're strapped to the thing and I'm puking all over my husband who was scared to death that his wife was on the operating table and they were taking out his one pound baby you know and I was vomiting all over him and I was crying because I couldn't concentrate on anything else besides puking.

Participant E had a similar experience during her surgery

I started vomiting when they brought me to the operating room, I was vomiting and they had me laying on my back and they were trying to get me to stay on my back but I wanted to turn my head so I could puke. They ended up strapping me to

the table and I started puking and choking on my vomit and finally they were there with an aspirator to clean it out but it was really traumatic.

Participant D also discussed vomiting in relation to her c-section but she began vomiting immediately after her surgery as opposed to during. She stated “after having a c-section you already feel like, you’ve got an incision in your stomach area and here you are retching and it’s a very painful.”

Another concern that participant D discussed was fear that she would feel the doctors cutting into her during the surgery:

You can still move your toes and you can still move some of your body parts and it’s freaky to think that you can move that and they’re about to cut into you. So the doctors, they were kind of joking around with me and kept telling them, ‘I can feel my toes, I can feel my toes’, and they said ‘that’s fine you’ll be able to move some areas around’ and I was so frantic. ‘I am I going to feel when you’re cutting into me?’ And they said ‘I don’t know; what do you feel right now?’ And I said ‘nothing’ and they said ‘we’re already into the second layer’.

Two of the participants experienced complications with their epidurals during the surgery. Participant I described difficulties getting an effective epidural or spinal block placed:

The epidural didn’t really work at all on my left side. So they decided they were going to take that out and do a spinal instead. I remember being in operating room sitting on the edge of the bed having them take my epidural out and trying to put the spinal in and the couldn’t get that in right. They couldn’t get in into the right space so they tried it a few different times and the anesthesiologist finally

decided to use whatever medication was in the spinal and put it in the epidural space.

Once the medication took effect, the numbing of her body went too far up into her diaphragm resulting in difficulty breathing:

It went up to my throat and it paralyzed my vocal cords and I couldn't breathe. I remember my husband wasn't in the room with me yet and of course my hands were tied down. I couldn't breathe at all and I just remember trying to talk and tell them I couldn't breathe. I felt like I was drowning. And they tried putting an oxygen mask over me and I said no. I could feel the air going into my mouth but since everything was paralyzed from my neck down rather than just from the bottom of my breasts down. So I couldn't feel myself breathing and then they got this bag out and I could see the nurse squeeze it and every time she squeezed it I could try to talk myself into the fact that I was getting air.

Participant B had a similar experience:

All I could think of was I really feel like it was creeping up or something. I felt like I was suffocating I don't know if that was because I had this big sheet in my face and my arms tied down and all these people and all these things. I don't know if it was that or if I was in panic or but it really freaked me out.

Eventually participant I had her spinal block lessen in intensity so she felt like she could breathe again; however the epidural's effects lessened not just on her diaphragm, but her whole body:

My spinal completely wore off to the point, at this point they were stitching me up and on my left side again I could totally feel it and I mentioned it, I can feel

everything you're doing to me and it hurts and I know the anesthesiologist said we're almost done, do you want us to knock you out, and I said no just hurry up and get it over with.

In addition to the medical events in labor, participants discussed their feelings about the amount of control they had during those events.

Control

All nine participants discussed the concept of control during their labor and delivery. Their discussion of control centered around two topics: lack of control and unmet expectations around labor.

Lack of Control. Several participants discussed lack of control in decision making. Participant D spoke about how the hospital staff could not reach any of the doctors from her obstetrics practice but would not make any decisions about how to proceed with her care:

At the beginning it was really frustrating when they couldn't get ahold of any of the OB doctors from my office that I had gone to so it was frustrating having to wait around for the doctor to come in to check me.

She waited for over an hour while the staff attempted to contact her doctor. She stated:

Once they finally got ahold of my doctor, she was kind of like 'ok well I'm going to take my time coming in' and in that meantime, about 3 or 4 hours... the Pitocin started working...when I got my first real actual labor contraction his heart rate went down again.

The staff wanted her to have an immediate c-section but they stated that they needed to get her doctor's approval before prepping her for surgery. When asked about

what she found particularly traumatic or troubling about her birth, she discussed this experience further: "You know that part there is not up to you. You're like why can't I make that decision? Go ahead with the c-section. Why does my doctor have to come? So that part, not being able to have control." Participant C also discussed having to wait for answers: "I waited for an hour and no one would tell me anything." She also talked about having no control over when the NICU doctors would provide any assistance for her child. She had been told that there was nothing that they would do unless the baby was at least 24 weeks gestation. She stated "The NICU team came in and said that if I delivered by baby could live for 5 min or 5 hours but they would not intervene. There was nothing they could do and they were very cold about it."

Participant B also discussed feeling like she had no control over her birth from the beginning, stating "they told me that I had no choice but to be induced early." Throughout her labor she felt that medical staff would attempt to make decisions about her birth without discussing them with her first or respecting her wishes. She stated "it wasn't up to me, none of it was under my, you know what I mean, like I wasn't in charge of anything in this whole thing." This issue was particularly troubling to her when the doctor attempted to break her bag of waters without first discussing it:

Then she basically turned to the nurse and said can you hand me the hook so I can break her water And I was like whoa, whoa, whoa, WAIT, I'm in the room can we talk about this? Maybe I'm not ready or maybe I need like one second for this to soak in before you break my water cause all I could think in my head is that this giant clock is going to start hanging over me as soon as they break my water

and I'm open for infection as soon as they break my water and she's like it's no big deal as she's just reaching in there to go for it.

When discussing her overall birth experience, participant B stated: "I felt manipulated, I felt lied to, I felt like they were withholding information the entire time and I wasn't part of the plan, I wasn't part of the process."

Participant H discussed similar issues with lack of control over her body. She stated "stuff was happening to me and I couldn't do anything about it." She expressed frustration that she did not have a choice in getting a c-section. She stated "with the OB practice and the whole hospital. I couldn't find anyone who was comfortable doing a breech delivery and I talked to maybe five different doctors wouldn't even consider it or didn't feel comfortable doing it." She explained that her lack of choice may have been why her labor progressed slowly at first: "I felt out of control with that situation and almost like I was trying to hold him in." Participant G also discussed her lack of choices in the birthing process. Several times she made statements such as, "I was exhausted and didn't really know what other options there were"; "the worst part was... wishing we had been more informed on things as far as options and we just figured they would give us those options"; and "just wishing to have another option sometime because we just kept doing the same thing over and over again and I remember feeling very frustrated at that point."

Participant A indicated that due to the induction, she never felt in control of her labor. She stated "Because I was forced into labor, my endorphins and all that really didn't have a chance to catch up. I always felt like I was one or two contractions behind." She also expressed her feelings about not having the choice to eat or drink during labor:

I just felt like the whole process was more barbaric than it should be. You know not to let someone eat or drink just because I was hooked up to this. Like all my rights as to nourishing my body were gone.

Participant C described a similar experience of not being allowed to eat or drink. She stated:

I was so thirsty that I was hallucinating about water. At one point I turned to my husband and said take me home. I need a glass of water. I'll have this baby at home. I'm 23 weeks pregnant, there's no way I was going home but I was that thirsty.

Lack of control can be felt both physically and emotionally. Participant F discussed how she felt an internal lack of control over her body but also felt external pressure and control to not display any emotion during the birth of her daughter. When she described her birth she stated "it was so fast that I didn't feel like I had time to really experience it or sort of master all of the different stages of the birthing process but all of that was kind of hard to process in the moment." However, she stated the area that was more traumatic to her was her then husband's reaction to her emotional state upon delivering her daughter:

When I had my daughter and then they put her on my stomach that moment, that was the traumatic... When she was on my stomach and I looked at my husband to sort of share that moment with him he was completely absent. He just looked at me like, I started to cry, and he gave me a look like you better stop crying don't be emotional about this and so I felt like in that moment I had to turn away and I couldn't experience that first moment of her life and of course they like cut the

cord and let her sit there for a second and they took her away and I was feeling like I wanted to keep her with me but I was feeling shame from my husband so I just let them take her.

Participant E also discussed lack of mental control; stating "I was just delirious. I remember singing in my head camp songs just to get through the contractions." In addition to a lack of control, participants also discussed having their births not meet the expectations they held about the experience.

Unmet Expectations. Participants often described how the events and emotions and their labor were not what they had expected them to be prior to giving birth. For some women it was very difficult to deal with those expectations and desires for their birth nor being fulfilled. Participant A reflected her on her thoughts during the birth and stated "my dreams of an intervention free birth were not happening." Participant B expressed a similar sentiment about her birth: "The whole thing, this is not the plan. The birth plan that you are supposed to write out, this is not what I envisioned." Participant E expressed that she felt confident that she and her midwife were in agreement about what she needed and was best for her; however she stated "but then when I got to the hospital and gave birth, it seemed like everything that we ever talked about was gone. Like I was just a stranger there." She also had high expectations for her hospital in general that were not met: "I had heard great things about [my hospital] and their birthing experience and yea, it wasn't quite that. It was very traumatic."

In addition, participant E discussed how her expectations for her mental and emotional experience, particularly not wanting to be left alone, were not met:

They thought I was being overstimulated. In my birth plan I specifically said that I want to have stimulation because I want to take my mind off of this. I wanted to talk to people I want to be able to converse with people. For me, I didn't want serene. I wanted it to be alright I'm doing this without. I didn't want to focus on the birth as much. I wanted to enjoy [but] they kicked everyone out.

Participant F also discussed her mental and emotional expectations not being met:

I think it was that feeling incomplete and that I didn't get to experience the things, not even the things I was told I would experience, but the things that I just naturally wanted to experience for myself that I feel were sort of stopped or interrupted either by the situation being a fast birth or by my ex being there and sort of stopping those things and not being there for me in the way I thought he would be or in a way shaming the emotion out of it... Going back over my birth story that moment I had with or didn't have with my husband at the time sort of created this trauma around this sort of incompleteness of the experience.

Many of the participants who had c-sections spoke about how a surgical birth was not something that had prepared for or expected could happen. For participant H, this was particularly poignant because she had initially planned a home birth. She stated "It was unexpected [and] it was totally the opposite of what I was trying to do with a homebirth. I ended up having a c-section." Participant I expressed a similar sentiment: "It never even occurred to me that I could possibly have a c-section so we didn't plan for it or you know the recovery and what all it would entail. Even now it makes me mad." Participant D stated

No one in my family ever had one. My mother, mother in law, nobody that I really am close to has had a c-section before and I just thought there was no way that, or reason why I'd ever need one and here I am in the operating room and they're putting the epidural in my back and I was literally terrified.

In addition to discussion about the physical events in labor, participants spoke about their thoughts and feelings during their birth experiences.

Thoughts and Feelings During Labor

All nine of the study participants discussed their thoughts and emotions during their births in varying levels of depth. Some participants spoke in depth about that aspect of their experience while others made brief summary statements about their feelings. The types of thoughts and feeling discussed were: fear, feeling alone or abandoned, and feelings of anger, guilt, shame or failure.

Fear. Eight of the nine study participants discussed feelings of fear for their own wellbeing or the wellbeing of their unborn child and fear of particular interventions during the birth experience. Participant A expressed that she was particularly afraid of using Pitocin during her labor. She stated "Pitocin was like the big dirty word for me because I was so afraid." She ended up being given Pitocin when attempts to induce by breaking her water did not work. Because the Pitocin contractions were so intense for her, she had additional fear arise, which in turn made the experience harder for her: "worrying about like what's going on, you know, is this normal, made them even more intense." For participant H, having a c-section was one of her strongest fears in birth. She described a conversation she had with her husband while in labor: "I had this moment with my husband and we just cried and after I cried he said what are you most afraid of and I said

I'm afraid of having a c-section." Participant D also discussed how afraid she was about having a c-section, stating "I was crying. I was like literally hysterical, I was so afraid."

Participant B indicated similar feelings after the decision was made that she would have a c-section. She stated "The panic like literally set in and I held myself together until she left and then I just starting crying because I just felt, violated is the only way I can describe how I felt."

Some of the participants described fear that something was wrong during their labor. Participant E discussed having those feelings throughout her labor, stating "I actually saw the footprint and something in me was like this is not right. There is something not right." She continued to discuss her birth experience and came back to this same feeling when she was pushing:

Suddenly when I started pushing I could feel [my daughter] trying to move but she was pushing into my hip and I remember saying that I said she's pushing into my hip, I need a c-section, she's pushing into my hip. She's not moving right, she's not there.

Participant A had similar feelings toward the end of her labor. She stated "I was kind of in labor land but I started to feel like something wasn't quite right." In addition to feeling something was wrong, some participants experienced strong fear that they were going to die. Participant I discussed her experience of that fear when her spinal block went too high on her body causing paralysis up to her neck: "It was super awful. I thought I was dying and then my husband came in and he was terrified because he kept trying to talk to me and I would move my mouth but no words would come out so he didn't know what was going on." Participant E also talked about how she felt she was going to die during

her c-section. She stated "I remember thinking that I'm going to die. I remember honestly thinking I was going to die when I was throwing up and choking on my vomit when they had me strapped down."

Other participants did not experience fear for their own lives, but expressed fear for the lives or safety of their babies. Participant D described the experience of when her son first started to show signs of distress on the fetal heart monitor:

She's kind of frantic about it when she plugged in the fetal heart monitor. It didn't sound like it was going. I just thought or assumed that it wasn't working. So she was really nervous and frantic and she was like turn on your side, no turn on your other side. She kept flopping me back and forth and she started to fumble for the air mask on the wall. It was one of those oxygen masks. So I turn around and I'm like what's going on? Is everything ok? So finally she got the heartbeat going and she said we're not waiting for your doctors anymore. We're going to admit you to the hospital now. And I'm like is everything ok? And she said well, it sounds like your baby is under distress.

Participant B indicated that there was meconium present when her water was broken and she did not know what that meant. She stated "they were like well you know, it's just, it's a sign the baby's distressed and I'm like oh, super. So now I'm sitting here worried myself." Participant E also experienced fear over signs of distress, stating "Finally it got to the point where she needs to come out. The heart rate was dropping." Participant D's son continued to have decelerations on the heart monitor. She discussed the conversations she had with the medical staff and her doctor:

We need to rush you in for a c-section because he's not handling the contractions well... She said there's no way he's going to be able to handle full out labor for however long it takes you to progress and after that, once you're at 10 centimeters and you're fully effaced, he's not going to be able to handle the pressures of going through the birth canal and whatever because there's obviously something going on.

Participant G expressed fear that her daughter would die because she got stuck in the birth canal prior to her c-section and the medical staff was having difficulty removing her:

They had one doctor or nurse pushing her up and another pulling her out and they were not, they were having a hard time getting her out at that point. She had gotten herself jammed down there and it kind of became an emergency all of a sudden then when that kinda started to happen. I started crying because I thought we were going to have a headless child.

Participant B's fears about the meconium were confirmed when the baby was delivered. She remembered thinking "something's wrong the baby's not crying, something's really wrong, the baby's not crying" and she stated "they just grabbed him and ran and they wouldn't let my husband [go with]. Participant C experienced that fear throughout the three weeks she was at the hospital. She stated "Being in bed for three weeks...and just knowing that I was going to deliver a baby that probably wasn't going to live... Every day they would make me a decision whether or not to terminate or deliver." Once she delivered at 24 weeks, there was a great deal of uncertainty if the baby would survive. She was able to see the baby briefly before she was brought to the NICU:

They dropped the side of the incubator and let me, she grabbed my hand, just like you see on tv, she grabbed my fingers and it was only for 30 seconds but you could tell by the looks on the nurses faces that they thought it might be the only time I got to see her.

In addition to feelings of fear, many participants indicated feeling alone or abandoned throughout the birthing process.

Feeling Alone or Abandoned. Seven of the nine participants discussed feeling alone or abandoned during their labor. Participant A spoke about feeling alone in the birthing process despite having what she classified as good support from her husband, doula, and medical staff:

I also felt really spiritually alone I felt just like, I almost felt like I, I'm sure a lot of women say this, but I almost felt like I was in hell or something.... I felt like I was in this in this desolate place and even though [my husband] was on this side and my doula was on this side and the nurse and the doctor were down here with me. They were all so supportive and saying such wonderful things and I just felt totally alone.

Participant B also indicated feeling alone, stating "I felt like I was screaming and nobody could hear it." While participants A and B described emotionally feeling alone, participant I spoke of actually being left alone. Her son required resuscitation upon birth and her husband accompanied the baby to the special care nursery while she was still having her C-section incision repaired. She stated "my husband went with him and I was all by myself." During this time when her husband was gone, her spinal block wore off, allowing her to feel everything that was happening to her body.

Some women felt abandoned by the medical staff that they had trusted to provide the best care for them and their child. Participant C discussed her experience with having an extremely premature baby:

So at 22 weeks, 6 days, I called the NICU and said ok, I'm in active labor and I want to talk to someone. So they came down and I said it's 4 hours till midnight. Are you telling me that if I deliver at 4 hours till midnight, you're not going to do anything? And they said we can't do anything until after midnight. And I just remember mindboggling like something magical was going to happen at midnight at 23 weeks.

Participant E also discussed feeling abandoned by medical staff. Over a period of a few weeks, she went to the hospital several times in severe pain and was told that she was not in labor and she should return home. She spoke about one of the times she went in after feeling dismissed several times before:

I remember I walked into the emergency room department and they asked me if I wanted a wheelchair and I said no I'm going to walk so you guys can see how much pain I'm in because it seemed like they were just ignoring me... I don't feel like they helped me enough there so I just feel like they neglected me.

She indicated that this feeling of neglect lasted her entire birth experience. She stated "My whole birth experience was discounted. Just scraped off to the side."

Unlike participants C and E, participant F did not indicate any feelings of abandonment from staff but rather it was feelings of abandonment from her husband that she found traumatic:

My husband was really kind of in shock so he wasn't really much help to me... he was just kind of absent. He just didn't know how to handle it. He just really didn't know how to prepare himself didn't know how to say he wasn't prepared I feel like maybe he wanted to help but just didn't, he was just so taken aback by the reality of it or something and he just kinda shut down and he didn't want to stay at the hospital with me he wanted to go home and sleep at home. Very strange. Sort of like he just wanted to sever himself from the whole thing.

In addition to feelings of abandonment, some participants discussed feelings of shame, failure, anger, or guilt.

Failure, Guilt, Anger, and Shame. Two of the participants specifically used the word failure when talking about their births. Participant B spoke about how she had failed herself throughout her birth story. She made statements such as "So that was kind of one of my oh crap I failed" and "I was like well, in my head, if I have a c-section, I failed. I didn't have a successful birth if I had a c-section cause to me c-section was failure." Participant C's discussion of failure was more focused on how her feelings of failure about going into preterm labor impacted her child. She stated "I felt like I had caused this. It was my body that dilated and failed her. She was a perfectly healthy baby but it was my body that failed her."

Participant A never used the word failure but spoke about feeling broken from her birth. She stated:

I just felt like I was just a crumple. I didn't feel strong, I didn't feel beautiful, I didn't feel like a warrior, you know all those goddessy kinds of images that we

think of when women give birth. I just felt broke, and injured, and bloody, and raw, and cut up and all of that.

Other participants expressed anger at feeling failed by their doctors. Participant B stated “The doctor left and I just there and cried and cried and cried cause this has been, all I could think of was all the mistakes I was so mad at my doctor.” Participant I expressed feeling like her doctor made bad choices for her and upon reflecting on her birth she stated “even now it makes me mad.” In addition to some participants expressing anger toward their medical provider, all of the participants spoke about their relationship and interactions with medical staff.

Relationship and Interaction with Medical Staff

All nine participants discussed their relationship with their provider or their interactions with medical staff. Many women spoke at length about it and it was the most commonly occurring theme found in the interviews. This theme included the topics of communication issues, disagreement with medical staff or failure to listen, treatment from medical staff, and lack of follow up or acknowledgement of their experience.

Communication Issues. Many of the participants discussed communication issues such as lack of information being provided by medical staff about options, risks, and what was happening with their child. Some participants spoke about having a lack of information given to them when they had to make choices in labor. Participant C was given a choice between attempting a vaginal birth or having a c-section, but was not offered any assistance in making that decision. She spoke about the impact that making that decision without information had on her:

The skin on the outside is horizontal but inside it's almost a j incision for access to the baby. I will deliver at 36 weeks [if I have another child]. They won't even let me go to 37 because of how they cut me. They didn't tell me that when they offered me the c-section versus vaginal delivery. I don't think I realized how much that was going to [pause] I [pause] yeah, now that I made that decision in that moment I kind of wish I wouldn't of but I still can't wrap my head around delivering a preemie vaginally. No one gave me any info. It was just on my gut.

There was no information that any one gave me. It was just on my gut.

Participant B also expressed thoughts of making different decisions if she had been better informed. From the beginning of her induction she felt there was a lack of information. Her doctor had ordered a prostaglandin gel to ripen her cervix the night before her induction but the nurse at the hospital did not think she should get the gel. Instead of following her doctor's orders, the nurse called the doctor who was on call from the practice and not the doctor that the participant had been seeing and who put in the order for the gel:

So she kind of mentioned when she was in there, I don't know if they're going to want to give you the gel because it might put you into labor too quickly. I said I wasn't worried about it going to quickly, I'm like 5 min down the road I'll get here, no big deal. So, she said let me call the clinic and see what the doctor on call wants to do. So she called the doctor's office and the person on call was brand new and just started doing this and they go I don't know what to do what do you want to do, they asked the nurse and the nurse says I don't think we should give

her the gel because I'm worried she'll go too quick. And me I'm like NOOOOO, that's what they decided.

When reflecting on her birth, she stated "I wish that the doctor's office would have been more forthcoming with me about what risks I was really.... I don't feel like I had all the pieces of the puzzle to make the correct decision."

Participant G also spoke to a large extent about not having enough information and her regrets surrounding the decisions she made with limited information. She expressed frustration that no one offered any other options during pushing when her baby was not descending into the birth canal, stating "It was the difficulty of the pushing and not understanding why she wasn't going any further and they weren't very helpful with that. They just said to keep pushing." She spoke about how she felt that her provider had her best interest at heart and would give her information needed, but she didn't feel that happened:

I think there's confusion on your part as first time parent and you really don't know what your other options are and you kind of expect the people there to be, to give you those options... I think we made some bad decisions but I think it was more just lack of information on our part.... I'm wishing that I would have had somebody or team or whoever who would say ok here's the pros and cons to each decision and going in a little more informed would have been huge for a lot of things... I never would have agreed to be induced had I known.

Participant I expressed similar feelings about her induction:

I was hoping for a natural birth and I trusted that my doctor had best interests in mind but now I know a lot more about inductions and reasons that are valid for

inducing and so I mean the whole induction process was traumatic... She definitely did not go over like these are the risks or anything like that.

Other participants discussed medical staff not providing them with answers or explanations of why they were experiencing certain things. Participant E spoke about medical staff not giving her sufficient information about why she was in so much pain if, as medical staff told her, she truly was not in labor. She stated "I just remember it just being really frustrating. Nobody had answers. No one had answers and it just seemed like there was nothing." Participant A had a somewhat similar experience: "I was asking for help. I didn't know, I mean I had never given birth before, so I didn't know why I was feeling so much pain."

Participant D spoke about how the medical staff had difficulty reaching her doctor to make decisions about how to proceed and also about not getting answers to her questions about what was happening. She stated "We waited around for about an hour waiting for them to contact what would have been my OB, the on call doctor, and his wife, because there was a husband and wife couple and there was also another alternate OB at the hospital. Four doctors and they could not contact a single one." She also stated "They don't always have the time to answer your questions so when you're freaked out, it's like what's going on and they're not answering you because they're needing to do their job. It's terrifying."

Other participants discussed a lack of communication about the wellbeing and care of their newborns. Participant C discussed her frustration understanding her daughter's care in the NICU. She stated "People would start to talk very medical. I'm a geriatrics nurse, not a NICU nurse, I would have to stop them and say hold on, what is,

what's going on." Participant B's son went to the NICU immediately after birth and she felt that no one really had answers for her as to why. When talking about her feelings at the time she stated:

I didn't really know why he was in NICU... I didn't really get it and didn't understand what was going on and why he was there and nobody really had a good answer for me... It was like how come nobody told me these things? I had to beg the information out of people.

In an effort to fully understand her birth and facilitating healing afterward, she requested copies of her medical records. Upon reviewing her medical records, she discovered that her son had required resuscitation at birth. She discussed her feelings about having to discover that information via medical records:

Why didn't anyone tell me that? I'm an adult. I had a baby. I think I can know that my child was, you know what I mean? That's kind of important. All they said was he had breathed in some meconium into his lungs and had a hard time breathing. They didn't tell me that they brought him back to life.

Although participant D did not have her child go to the NICU, she also expressed discontent about the lack of information that medical staff could give her about her son when she was separated from him following her c-section:

They brought me to the recovery area and for like an hour and a half I was asking the doctors do you guys know any, do you guys know any information about the baby like how much he weights and how long he is and they were like sorry we have no idea and that was a little frustrating for me.

In addition to feeling communication was inadequate at times, participants also discussed having medical staff disagree with them or feelings that staff were not listening to them.

Disagreements with or Being Ignored by Medical Staff. Several of the participants discussed feeling the medical staff did not listen to them or ignored their instincts about their bodies. Participant E talked about how both her feelings that she was in labor and her concerns for her daughter were dismissed:

I was in so much pain, and the whole time they're telling me I'm not in labor, I'm just passing kidney stones... I remember sitting on the table in the ultrasound room having contractions and the woman asking me, are you sure you're not in labor? I said no well they're telling me I'm not in labor.

She spoke about how she knew that her daughter was malpositioned when she was pushing. She asked for a c-section as soon as she realized that; however the medical staff urged her to keep pushing. Her birth eventually did end in a c-section due to malposition and she expressed concern that her daughter's lingering health problems were caused by being stuck in the birth canal. She stated "I just wonder what would have happened if they had just listened to me and done the c-section when I asked for it. Not that I wanted one. I didn't want the easy way out but I knew something was really wrong." She discussed feeling ignored as one of the most traumatic aspects of her birth experience. She stated "I think the biggest thing is that they didn't listen to me and they discounted me. It just seems like the nurses and the midwives didn't listen to my intuition and just wrote me off as being a first time mother."

Participant C was in the hospital with ruptured membranes for over two weeks. She talked about how she was concerned that the baby may not have had enough

amniotic fluid. She stated “I kept asking and asking them to give me an ultrasound to let me know how much amniotic fluid I’d lost to see because knowing that not having enough amniotic fluid can cause deformities and that kind of things, I just wanted to know where we were at and they kept refusing my ultrasound.” She also spoke about her concerns about her c-section incision before she was discharged from the hospital:

I remember telling them my stomach is really hard. Is it supposed to be this hard? Well you just had surgery, it’s gonna to be hard and I’m like but it’s really, really hard. I’m like I work with surgery patients, this is really hard. You’re fine [sternly] you just had surgery.... Yea, but I know my body and that wasn’t, I knew something was wrong ... I had been home less than 24 hours. I stood up and literally had gushed a puddle on the floor from a very small part of the incision that had dehiscid.

Participant B also discussed her frustration with feeling like the medical staff did not listen to her from the start of her labor. When discussing the decision made by the nurse and the on-call doctor to not give her the prostaglandin gel that her doctor ordered, she said “They decided not to give it to me. Didn’t really listen to my input at all and I got just this gut feeling that this is not the plan that it was supposed to be and now you’re veering off track.” Later in her labor, the doctor wanted to give her a medication to speed up her labor that is not FDA approved for pregnant women and can have serious complications such as uterine rupture or maternal/fetal death:

One of my notes on my thing in capital letters, highlighted and circled a hundred times was do NOT take cytotec. So they we’re just going to put this pill in you and dadadada and it’s going to make you progress. And I was like wait, wait,

wait, is it cytotec? Because I'm not taking that and they got kind of mad at me and I was like I'm sorry but I'm not taking the chance of a uterine rupture just to try to progress this.

She also had her water broken despite her objections and concerns that having her water broken too early increased her risk of an infection, which she did develop several hours into her labor. She stated "The nurse was like oh you running a little temp and I was like see the clock's been ticking. I knew it, I knew it, I knew it. Here comes the infection because they broke my water too soon."

Her feelings of being dismissed continued through her c-section when she was having a reaction to the spinal block placement. She stated "I kept telling them you know I don't really think I can breathe and it's really hard and they'd just kind of blow me off." Participant I also expressed the impact of feeling ignored when she too had an adverse reaction to the spinal block:

I mean the whole induction process was traumatic but especially having a c-section and especially the whole issue with the anesthesia and feeling like I was drowning and feeling all alone. I guess not feeling like they were listening to me and doing something for me. They were just like oh sometimes this happens, it just gets screwed up but you'll be fine and I think that was probably the hardest part and of course not knowing if my baby was ok because I was so focused on watching that bag of air of whatever they were squeezing so I felt like I was still alive. And then not knowing if my baby was ok.

Participant G had originally been with a doctor she felt listened and respected her wishes but ended up with a new doctor midway through her pregnancy. She was

concerned about postpartum depression and she had her original doctor had discussed preemptive planning to help minimize the likelihood of depression occurring. However, the new doctor did not agree with that plan:

5 months pregnant [my doctor] went out on medical leave and we got placed with another doctor on his team. We didn't really want to leave his clinic because they had my entire medical history and got placed with another doctor who was quite a bit older and probably needed to not be a doctor anymore and she didn't really think it was an issue... we had talked about with the original doctor about starting a very low dose anti-depressant at the beginning of the third trimester and this doctor said oh pish posh. Those were her words. She said there's no such thing and we went oh, ok. And again you expect to kind of trust those people and she didn't see any need for it whatsoever.

Participant A discussed how her wishes for her birth did not align with what her medical provider had recommended in regard to her being overdue. She expressed a strong desire not to be induced: "I really begged her to let me wait because I really felt like my body and my baby know how to do this and don't feel like we need to rush anything." Participant E spoke about her experience with a nurse who did not agree with her that she was sufficiently feeding her newborn. She stated "That night a nurse came in and said I wasn't feeding the baby enough. She needs to drink one of the full Enfamil formulas and proceeded to feed my daughter that whole bottle and then my daughter threw up all over me immediately. I was really shaken about it." Along with feeling unheard by medical staff, some participants discussed the way they were treated by medical staff.

Treatment from Medical Staff. Participant E discussed feeling like the medical staff were irritated with her for returning to triage several times despite being in severe pain. She stated “When I got up there and the midwife came in and she just seemed really annoyed that I was even there again.” Participant G spoke about the way her doctor treated her when she was pushing:

The one thing I remember from her is her coming in after that one set of pushes after the first hour and she just screamed at me to push harder and I mean not mad screamed, I think she thought she was being a cheerleader where it was like scaring me. So then her coming back all chipper and saying ‘ready for a c-section?’.

When she spoke about the doctor she stated “I would have hoped to had a doctor that was a little more understanding, helpful.”

Participant D, who had been terrified to have a c-section discussed, a comment made by the operating room staff shortly after her son was born. She stated “It was pretty traumatic. I was crying pretty good and the baby was crying and they were laughing about how he’s a crybaby like me.” Participant B discussed a similar experience: “So I was at two maybe three and the guy comes in to do the epidural and he goes ‘what’s she dilated to?’ and they’re like ‘three’ and he was like ‘t’ah’ [laughter] and rolls his eyes.” She expressed feeling that she did not matter to the medical staff. She stated “I felt so much like I was herded through and I was a number and they didn’t really care.... I think that might have helped me if I felt like they gave a crap at all.” Other participants spoke about how their providers did not follow up with them or take time to acknowledge that they had a difficult experience.

No Follow up or Acknowledgment. Seven of the nine participants stated that there was not enough follow up medically or that their medical provider never acknowledged how hard their birth experience was for them. Participant D spoke about the lack of follow up in the initial week of her c-section:

8 weeks postpartum, she checked my incision area and said 'oh yea, everything looks great, you look like you're feeling well' and she said 'when you came in here a week after having the baby you know', and I said 'what? I didn't come into the doctor' and she said 'oh well you were supposed to have to come in like 5-7 days after your c-section so we could check to make sure everything was healing properly' and I was like 'ok well no one ever relayed that message to me'.

Participant H also expressed a similar experience with not knowing what to do after a c-section and unclear instructions for follow up:

I think I could have used more support in that way and also I had no idea what to expect after having a c-section. I felt like they sent me home with a general call if this happens, call if that happens, but there was so much more that I had no idea to expect. Should I be doing this, you know, should I be doing this and should I be. I don't know I felt like I wasn't completely prepared with what to expect.

Participant I talked about her doctor left before she had even gone into the recovery room following her c-section:

My doctor she didn't perform the surgery since she's just a family doctor, but she was in the room and I remember her just taking my son and being over at the counter or wherever they took him, the little warmer thing to suction him and stuff and after that she just came over to me and said you know, 'I'm going to go

home and get some sleep. I have a conference to be at' and then I never ever heard from her again. Not once to check in and see how I was doing or anything. I don't really feel like she was very supportive at all.

Participant C was struggling with postpartum depression and she contacted her doctor for help. Her doctor told her that she would get her information on support groups for NICU parents, however she stated "I called her 3 times. She never called me back with that information." She spoke about how she felt there was general lack of follow up with her experience. She stated "There was no follow through, no one followed through in the medical professions." Participant F did not specifically talk about an experience with medical staff but how in general there is a lack of support for women after they have a baby:

I think that something that I notice and I think a lot of people notice is that the care sort of comes all at once when you have a new baby or like at the end of your pregnancy and then it goes away. It just sort of dwindles. Everyone gets really excited when there's a new baby and then it kind of falls off.

Participant E talked about her experience with lack of follow up:

Nobody followed up with me afterward saying oh yea the fact that you went four days here and was laboring but nobody ever gave the validation that I actually ever was in labor...There was no follow up care. I think there needs to be more follow up care. I think that after someone gives birth, someone should come in and talk to them about the experience. How did it go? What are you feeling?

Participant B spoke about her desire to be able to tell the practice about her experience birthing with them. She stated:

I really wish I could call that clinic and tell the doctors what I really think of them and what my experience is but sadly nobody called and asked me my opinion, my satisfaction on my experience... I feel like the only thing that could have made things better for me, and even now, if they were to call. I think it would be helpful for me to sit down with them just for a minute. I'll pay for your time, just let me get this off my chest. Let me tell you why your clinic is terrible.

Participant I also spoke about how she would have liked some acknowledgement that her birth did not go as she'd planned, particularly her feelings that an unnecessary induction was responsible for her c-section. She discussed her desire to have a vaginal birth after c-section (VBAC) in subsequent pregnancies and her doctor said that would not be possible, although VBAC was indeed a possibility for her and she did go on to have VBACs with her other children. She stated "She just kind of stuck to her guns that the baby was too big and blah blah blah and my pelvis was too small. So I think actually getting correct information and would have been helpful and maybe just acknowledging that fact that my birth wasn't how I wanted it to go." These physical, emotional, and relational experiences that participants had during their birth and immediate postpartum impacted both their physical and emotional wellbeing postpartum.

Postpartum

All nine of the participants discussed the impact of their birth on them in the postpartum period. The topics that they discussed were: physical problems, feelings and

emotional needs, disconnection or bonding troubles, mental health concerns and medication, as well as what helped them heal from the experience.

Physical Problems with Mother or Baby. Participant A spoke about the physical problems she had in the more immediate postpartum period. She stated “I was in so much pain from pushing for so long I mean everything was so swollen that I couldn’t go to the bathroom so my bladder was really distended.” Participant H discussed her problems following her c-section: “I had a hard recovery from the c-section in general. I got a staph infection so I was in more pain than usual for a few weeks.” Participant I had similar problems following her surgery. She stated

The first several weeks were really difficult and I could barely move because I felt like every time I was going to stand up my stomach would just fall out of my incision and it was hard caring for an infant after a major surgery.

She also spoke about the impact of her birth experience on breastfeeding;

Being pumped full of fluids for so many days made it so hard to breastfeed because I was so swollen and the baby couldn’t really latch on. He was so swollen from being pumped with so many fluids too. So he lost more than 10% after so we had a really hard time with breastfeeding and I remember just sitting there just crying.

Other participants discussed the need for their baby to go to the NICU or the special care nursery. Participant H stated “because of the gestational diabetes he had to go to the NICU for a day and a half and we were separated and that was kind of the spiral just trying to heal from that.” Participant I also spoke of her baby needing care:

My baby was born and I guess he was unresponsive and he had to be taken and worked on right away and when they finally got him suctioned really deep and breathing and stuff he had to go to the special care nursery.

Participant C's child went to the NICU immediately upon birth and it was unclear if she would survive. She discussed being unprepared for seeing her child in the NICU:

Everyone left the room and it's me and my husband and this baby and these monitors and you know she had the umbilical lines, she had a ventilator um they had an IV in her head she was, no one prepared me for how, she was under a bilirubin light, how, she looked beat up.

In addition to physical issues, all of the participants discussed feelings and emotional needs postpartum.

Feelings and Emotional Needs. All nine participants discussed their feelings and emotions postpartum. Participant I described her feelings after her birth. She stated:

Physically it was tough but I'd say it was more so emotionally rough. That's the main thing I would think just trying to process that I didn't have the birth that I wanted and learning more and more about giving birth naturally and stuff and realizing that I totally got screwed over and probably didn't need to be induced for a big baby and I could have birthed him just fine if I had gone into labor on my own. So that part was really hard to come to terms with... I know immediately after his birth, I'd say within hours, I knew it was like the most horrible thing ever.

Participant H also discussed feeling like she didn't get the birth she wanted and the repercussions:

The biggest thing that made me sad was that I was denying that he was my son that I just had. So it was a lot of guilt and some confusion with that and then with the disappointment of having the c-section.

Participant D expressed similar feelings of missing out on what she felt her birth experience should have been:

I didn't have a vaginal birth and I feel like if I were to have had a vaginal birth, I would have been able to have that bonding time and I would have been able to see him come into the world and I feel like a part of that was taken and that part I'll never be able to get back... As soon as you have your baby the first things you want to do is be able to hold them and have them be close to you and I feel like a part of that had been taken from me.

Participant B also discussed feelings about how things should have been for her and her child postpartum:

The first time I got to see my son was on the screen of my husband's camera. That's really sad to meet, I mean to see him, on a camera. It made me feel really, really sad and it made me feel like I lost the experience. You're supposed to have your baby on your chest. I read all this stuff that says you're supposed to nurse right away if they want to and they're supposed to be with you. I didn't get any of that.

Participant C also expressed concern about whether or not she should have done things differently and the impact of prematurely delivering her daughter. She stated "I wish I would have had more options with that. Cause now that we're considering doing it again,

the concept that we won't have a vaginal birth because of the way." She also talked about how the experience with having her daughter in the NICU was difficult for her:

The whole situation is surreal because, to know that you are the mother of this baby but you have no control over anything. I had to *ask* to hold her I wasn't *able* to hold her for the first seven days of her life and then I had to *ask* the nurse permission to hold her. You have no control... unless you've been in the NICU, you don't understand that experience.

Some participants discussed difficulty hearing about or seeing anything birth related or a need to tell everyone about their own birth experience. Participant F stated:

Every time I would see a newborn or like a birth scene on TV show or something I would like just have this really intense reaction and bawl like I couldn't look at newborn babies or like see pregnant women and I was like what is the deal...

Whatever happened in the birth just kept kind of being there after the birth.

Participant A also had a hard time hearing about positive birth experiences. She stated "The one thing that was really hard was hearing about the other people who had great births." She expressed feeling a need to share her experience with others: "I felt like telling other people about my birth story... So having them kind of mourn with me was very healing to me." Participant B also discussed needing to share her experience. She stated "I told my story to everybody and nobody wants to hear it six times and that's what I wanted to do. I wanted to tell it six or sixty times to everybody who I came across and you just can't do that." She spoke about facing pressure to move on from the experience. She stated "Suck it up you're fine you have a baby everything's great, you have a newborn you should be happy, this is a happy, what's wrong with you?"

Other participants discussed guilt or embarrassment. When talking about her postpartum period, participant G stated:

It was hard to talk about things initially because I was terribly embarrassed, you know. You can't deal with your own kid.... knowing that there was a little girl, a little baby in midst of it that was kind of getting gypped on her first year with her mom. That part for me as for as guilt goes is up there for me.

Participant C also discussed initial guilt about choosing to have everything possible done to save the life of her baby born at 24 weeks after she saw all the medical interventions her daughter required. She stated "We went in there and we were looking at the baby and feeling really guilty. Really, really guilty that I did this to her." Participant C as well as many other participants also discussed feelings of disconnection or bonding troubles following their birth.

Disconnection and Trouble Bonding. Participant C had a child in the NICU and also had a severe infection following the birth of her child. She stated:

At one point I remember calling my husband and telling him that the nurses were trying to kill me and he needed to come down to my room cause he was in the NICU, cause the nurses were trying to kill me. I was delusional, my fever was so high.

Once her fever broke she expressed remaining feelings of disconnection. She stated "There are not babies that are born at 23 weeks. You feel completely disconnected." She also talked about the impact of the attitudes of the NICU nurses toward her baby:

The nurses used to refer to the babies as their babies. My babies, oh look how my baby girl is doing. This is my baby. This isn't your baby and when you're going

through the postpartum that was horrible. Like cause you're not feeling connected and you're having some woman who's saying 'her baby'.

Two of the participants discussed lack of memories about their experience. Participant I's lack of memory was limited to the initial time after her baby was born. She spoke of an initial lack of memory after the spinal block failed during her surgery. She stated "I don't have much recollection of anything after that part of it" and when she talked about what she struggled with postpartum she stated "Kind of just having such a foggy memory of his first day or two of life." Participant G had much longer issues of memory loss. She stated:

I have very few memories of the whole first year and I think that's where I struggle now... and I look back on pictures from her first year and it's just a picture. There's no memory associated with the picture except it's her at this age.

Many of the participants discussed feelings of disbelief that their baby was in fact their own. Participant E stated "It was just a really delirious time. I remember holding her and thinking is this really mine? I can't believe this." Participant H spoke about her experience and said "Not physically, but emotionally it was rough. Trying to bond." She continued on to state:

After he was born I didn't get to see him right away. Everybody saw him but me for like two hours and that was hard. I didn't even believe for a weeks that he was even my kid. I kept asking my husband like show me the pictures, show me the pictures the pictures you took in the room. This doesn't even look like him. So I was really struggling with that. I couldn't even believe he was mine.

Participant B spoke several times about feelings that her child was not hers and a lack of connection. She made statements such as “How am I going to know he’s mine?”, “It was like this didn’t really happen. None of this really happened.”, “I felt like I was just going through the motions”, “The hardest part of all that was I didn’t feel like I had that bond with him”, and “He’s mine, but who cares.” Participant F also talked about feeling like she could not connect with her husband or her child. She stated “Wanting to be very emotionally connected to both of them but feeling like I wasn’t allowed to be with either of them I think was my biggest struggle postpartum in the first like year.” In addition to bonding trouble, several participants discussed depression and anxiety as well thoughts around taking medication.

Depression, Anxiety, and Medication. Participant C spoke about how she suffered from severe postpartum depression. She stated “My mom came down two days after the baby was born and she stayed about a week but once she left, I quit life.” She spoke about her routine with her mother gone and her husband back at work: “So he would go to work at 9 in the morning, come home at 10, 11 [at night] get me dressed because I physically could not function.” Participant E recalled being alone with her daughter and feeling overwhelmed by depression. She stated “I sat with her in the rocking chair and cried and cried and I cried... There was nothing, it seemed like I’d never be happy again.” Participant B also discussed postpartum depression. She spoke about how she was not typically an emotional person so it was hard for her to deal with depression. She stated “I literally could not shut off tears which was embarrassing to me... I hid it from everyone else. No one else could know.” Participant H discussed that she felt she possibly had postpartum depression: “I think it could have been more than the

baby blues. I was weepy and I was angry and I'd go from being sad and weepy to angry at my husband and kind of picking fights."

Participant G discussed her experience of depression and anxiety at length:

The day they were discharging me I knew something was wrong with me. I was not handling things very well at all at that point. Came home and over the next five days thing went downhill very, very quickly for me and when she was 10 days old they took me back to the hospital and readmitted me for severe postpartum depression.

She continued:

What put me in the hospital the second time and I don't remember doing this, but I had taken all the pills and that's what put me back in the hospital the second time was taking, and again I have no recollection of that and I don't recall wanting to, I just remember I wanted to not feel like that, I don't think there was an intention to like kill myself, I think there was an intention to just not feel like that anymore or at least for a little while.

She also stated:

Things just getting worse and worse and it was just panic and anxiety and unable to function. I could hold her and that was about it...I was in [the hospital] 3 times over that year with an inability to cope with anything...It was a good year before things felt like they were starting to head back to, where I could have an emotion and not be terrified of it.

Most of the participants who discussed depression and anxiety also discussed medications. Participant C discussed medications with her doctor while she was still pregnant:

I'm afraid because I've had a history of depression that I'm going to be depressed when I deliver, thinking I was going to deliver at term. They gave me options but all had side effects that I wasn't willing to take.

Participant B stated:

I did actually end up going to my doctor and saying that I needed something and he did end up putting me on medication... and I wasn't on it long because I got scared later, like why am I, how selfish of me to be on medication when I'm nursing my son and now he's on medication.

Participant G discussed problems with the medications that she was placed on after being hospitalized the first time. She stated "[I] got a doctor that wasn't very good at things and got a very strange cocktail of medications and those made things worse. They had kind of an old set of medications they were giving me." When she was readmitted to the hospital, the doctors expressed concerns with medications she had been put on:

One set of medications they gave me, I would do things I didn't remember doing ... they looked at my medications and they were like why is she on this? Who put you on this? Because, they called it a toxic combination, they had all sorts of things in there. There was ambien and there was trazadone and there was like four of five heavy duty things in there that I guess they don't normally mix together.

Despite the range of problems they faced postpartum, most participants discussed what helped them heal from their experience.

What Helped. Participant A discussed both physical and emotional measures that helped with healing. She stated:

One other thing I wanted to say that I haven't told a lot of people, because some people, rightfully so might be freaked out about it, is that I did encapsulate my placenta and I took that really faithfully and every time I took it I felt like it gave me strength. I know it helped me emotionally too.

She also talked about how a conversation with her doula was very helpful for her:

Having her say to me that 'you were the toughest birth I did, you were the toughest birth I was at'. I hope this doesn't sound sick or anything but I felt good hearing that because I felt like it was really tough...I'll never forget this, she said 'it is ok to feel broken' and that was so important for me to hear because I usually have a pretty positive attitude about life and things and I think right away she recognized that I need someone to give me permission to feel just totally broken and I did for a long time.

She also took time to process her experience. She stated "I did a lot of writing afterward and I wrote a birth story in kind of a narrative form and that was very healing."

Participant D spoke about how she felt that finally having relief from hyperemesis seemed to provide somewhat of a protective factor against postpartum depression:

I never had any issues of postpartum depression or anything like that. For me after being sick for 9 months and finally being able to eat whatever I wanted and be able to just drink as many fluids as I could without feeling like I needed to be sick was the most amazing feeling.

She also spoke of how her mother had suffered from postpartum depression and made an effort to check in with her on how she was feeling postpartum:

She was real conscious about calling me and making sure that everything was ok and letting me that that it was ok. If you're up in the middle of the night bawling your eyes out, you need to call me and we'll talk because it's completely normal to have a newborn and be freaked out and not know what to do. I went through that too.

Other participants discussed how having someone to talk to or someone to help them was beneficial. Participant B saw a therapist after her birth experience. She stated "It was good to have somebody to talk to that wasn't going to tell me to shut up and stop talking about my birth story again. I think that's really what I needed." Participant F also saw a therapist who was able to help her work through the negative reactions she was to pregnant women and infants. She stated:

For me it was recognizing what was, being able to talk through it, pinpoint maybe that experience in that specific moment just being able to give sort of a reason for it really and then practicing just recognition when it came up in my life.

Participant G also found therapy to be helpful when she found a therapist who was a good fit for her. She stated:

Once I found a good one who helped me get to the core of things and help me see things a little bit differently and understand that this was nothing that I was doing by choice. It's a disease that you deal with and having them help my husband and the rest of my family understand that part of it too.

Participant H stated that therapy was helpful for her as well. She stated:

I think it helped to first of all just tell my story and say everything that I felt about it and also to know like ok this is the stuff you could control, this was the stuff that was out of your control so I could kind of be able to dissect it a little bit, to see it from a different perspective.

Other participants talked about how follow up from medical staff was helpful to them. Participant I discussed feeling abandoned by her doctor but she had another who performed her c-section that she found helpful. She stated "The doctor who performed the surgery was great. I called him a few times after I was home and he would call me back right away and answer questions and stuff." Participant E spoke about a nurse who helped her postpartum:

The one thing that did help was that through the county, we were on WIC, and I had a home nurse and she started seeing me in my seventh month of pregnancy and she honestly I think saved my life and my baby's life. Because one day she came over and I was just broken crying a lot. She just sat with me and helped me. She called me so much even on the weekend just to see how I was doing and I know that was one thing that really, really helped was the home nurse program because she helped me advocate for myself and my daughter's needs so that was one really good thing.

Discussion

The themes discovered in this study were similar many of the key themes present in birth trauma related literature such as medical interventions, control, thoughts and emotions, relationship with medical staff, and postpartum implications. However the data also showed some findings that were underrepresented in the current literature such as the

role induction may play in women finding birth traumatic as well as women's reports of what helped them that was not focused on therapeutic intervention. These findings have contributed to existing research and hold implications for both social work practice and policy. However as the study was primarily exploratory in nature, more research will need to be done on themes identified to support policy change.

Comparison to the Research

Physical Events and Medical Interventions. The theme of physical events in labor supported some aspects of the research. However, there were many aspects discussed in the literature that did not appear in the data and one theme discovered in the data that was not covered in the literature. The findings from this study seem to most strongly support Beck's (2004) findings. Events she identified as possibly traumatic were: emergency C-section, fetal risk, inadequate care from medical staff, fear of getting an epidural, insufficient pain relief, postpartum hemorrhage, instrumental delivery, long and painful labor, and fast birth. All of these events except postpartum hemorrhage, were discussed at least one interview but C-section, pain, fetal risk, and inadequate care from medical staff were found in several. Although Reed (2011) and Beck (2004) both discuss hemorrhaging as an event commonly associated with trauma, no participants reported hemorrhaging at any point in labor or postpartum.

The most strongly supported finding from the literature was the relationship between C-section and trauma. Seven out of the nine participants indicated having a C-section as a traumatic event which supports the findings Cohen, Ansara, Schei, Stuckless, and Stewart (2004) as well as Creedy et al. (2000) who found that surgical birth was associated with

greater perceptions of trauma and acute stress symptoms following birth. The majority of the C-sections were unplanned, which also supports the researchers' findings that emergency or unplanned surgical birth is more likely than planned surgical birth to result in emotional struggles postpartum.

The second most prevalent medical theme found in this study was not addressed in much of the literature reviewed. Six out of nine participants reported having an induction, but only one researcher in the literature reviewed for this study even touched on the subject. Beck's (2011) study identified coercion to induce as a possible traumatic factor but did not discuss the process of induction in itself as a traumatic event. Based on the findings of this study, it was surprising to find that induction was not a topic discussed thoroughly in birth trauma research. Although this generalizability of this study could be low due to the small sample size, it appears to the researcher that there is a correlation between induction and perceptions of trauma in birth. Three out of the nine participants also discussed epidurals or spinal blocks not working correctly, which was another topic not addressed in the existing research.

Control. The theme of lack of control was prevalent in both the literature and the findings in this study. All nine participants discussed lack of control or unmet expectations about their birth. This supported Allen's (1998) finding that feeling a lack of control in birth led to greater instance of posttraumatic stress postpartum. Much like the literature, what qualified as a lack of control varied among participants, however many of the participants' stories supported the findings of Maggioni, Margola, and Fillipi (2006), that lack on input in decisions was a strong indicator for developing a perception of trauma and acute stress following the birth. The concept of unmet expectations leading to

greater feelings of trauma as discussed by Ryding, Wijma, and Wijma (2000) was also strongly supported by this study.

Thoughts and Feelings During Labor. Much of the qualitative research on birth trauma discussed the importance of feeling safe and women's belief that their providers will always do what is best for them (Beck, 2004). This study supports those findings. Eight out of nine participants discussed fear for themselves or for their children. Some participants described fear to the point of terror during their birth experience. Gamble (2005) discussed that fear for self or child in labor leads to greater instances of PTSD. There was mixed support for that finding in this study. Two of the eight participants who discussed fear reported that they had little to no mental health problems following delivery; however the remaining six participants discussed problems ranging from depression to signs of PTSD. In addition one participant reported PTSD who did not discuss any fear during her birth experience. Some of the participants also discussed feelings of failure, guilt, anger, and shame, which was supported by Soet, Brack, and Dilorio (2003) and Ayers (2007).

The findings from this study regarding emotional experience most closely match the findings of Beck (2004) who discussed the themes of feeling uncared for, lack of communication, violation of trust, and thoughts that delivering a healthy baby negated any adverse events during labor. All of these themes were addressed by participants. Although the concept of feeling pressure that having a healthy baby is the only thing that matters was only discussed by one participant, the remaining themes identified by Beck were discussed by several participants. While Beck's findings are supported by this study, the study did not address many of the concepts discussed Ayers' (2007) qualitative

research. The researcher identified themes such as: difficulty managing labor, feeling overwhelmed mentally, desire to for labor to be over at any cost, and a lack of understanding regarding what was happening. This study supports the findings of difficulty managing labor and a lack of understanding as many participants discussed pain and also lack of communication about options and medical procedures. However, none of the other themes were discussed by study participants.

Relationship with Medical Staff. The topic of interactions with, relationships with, and care from medical staff was prevalent both in the research and in the findings from this study. The findings from this study were consistent with Ford and Ayers (2011) who found negative experiences with medical staff, inadequate support, lack of communication, and feeling unimportant were associated with higher rates of trauma. Beck (2004) identified feeling ignored or not having options communicated as a precipitator of trauma, which was an aspect of the birth experiences discussed by seven of the nine study participants. While there is support for this finding within the literature, the findings from this study suggest that this component of labor and birth may have a greater impact on perceptions of trauma than previously thought. The concept of lack of acknowledgement was also supported by the literature. Both Beck (2004) and Soet, Brack, and Dilorio (2003) discussed how lack of acknowledgement from medical providers about the difficulty of the birth could lead to increased mental health concerns postpartum.

Postpartum. Although the research discussed motherhood and identity, the concept was not addressed strongly in this study. A few of the participants discussed feeling like a bad mother or feeling like failures, but it was not widely discussed among

study participants. However, the theme of disconnection and bonding difficulties was also addressed by researchers such as Elmir et al. (2010) and Reid (2011) and it was supported by many of the participants from this study. Seven of the nine participants discussed feelings of detachment or difficulty bonding that ranged from a day or two up to a year in duration.

Although the topics of depression and PTSD were covered heavily in the research, few participants used those terms to describe their experience. None of the participants discussed having a formal mental health diagnosis from a mental health professional, although many reported attending therapy postpartum, and one was hospitalized for mental health concerns on three occasions. Some participants used the terms depression and PTSD but many of the participants described their experience of terms of emotional difficulty rather than using clinical language. Although they may have met criteria for a mental health diagnosis at the time, the researcher cannot make speculations and only used the information directly given by participants to formulate themes.

An area of this study's findings that was not widely found in the literature is discussion of on what did, or would have, helped from the women's perspectives. There is limited research on recovery following birth trauma and the majority of the literature focuses on clinical interventions. There is a lack of qualitative research focused on what mothers indicate aided them in recovery or what they felt protected them from developing acute stress or depressive symptoms following a birth that they found traumatic. An aspect of recovery reported to be extremely beneficial by participants in their recovery or something they felt would have helped them recover was

acknowledgement from medical staff about the difficulty of their experience and follow up. This seemed to be as or more beneficial than therapy to some participants.

Implications for Social Work Practice

The findings of this study hold many implications for changes that medical staff could make prenatally, during labor, and in the immediate postpartum to help minimize women's perceptions of trauma and life disruption. However there are also many implications for social workers. Based on the findings of this study and some of the existing research on birth trauma, lack of acknowledgement seems to play a role in women developing acute stress or mental health concerns postpartum. Participants also discussed a lack of follow up as a contributor to their negative feelings about their birth experience. This is a service gap that could be addressed by hospital social workers. Hospital social workers could meet with women the day after they give birth to discuss their birth experience. This is an opportunity to identify women who experienced their birth as traumatic, provide acknowledgement and validation about their feelings regarding their birth, do initial debriefing with women who found their experience as acutely traumatic, and provide resources and referrals for women to take home with them. A barrier to seeking help reported by some women was not knowing who or what was available to them to help address what they were struggling with. This approach by social workers could greatly diminish or eliminate that barrier.

Another possibility for social work practice is to develop groups focused on birth trauma. The literature discussed social support as a protective factor following traumatic birth and participants discussed issues of feeling alone, guilt, and lack of understanding, which could be addressed in a group format. Social workers who work with women any

time in the first year postpartum, especially for issues of depression, stress, or anxiety, should include questions about their birth experience as part of their assessment. Both the research and this study indicate the psychological impact that traumatic birth can have on women, and if social workers are not exploring this possibility in their clinical practice with women, they have the potential to miss a contributing factor to the symptoms their clients are experiencing. It would be beneficial to ask all recent mothers about their birth experience, provide acknowledge and permission to have the feelings about it they do, and facilitate healing from the experience.

Implications for Policy

Many policy implications raised by this study are at a hospital and birth provider level. It seems that much of what participants reported as traumatic stemmed from choices made by their care providers or from hospital policy. More educational programs and information about birth are needed to reduce the instance of women reporting that if they had known the risks or full information about options provided to them, they would have made different choices. Affordable and accessible childbirth education could also help reduce the risk of this aspect of traumatic birth. This research supports a bill currently up for review in the Minnesota legislature. House File 1047 and Senate File 582 propose additional support and healthcare to help educate about, prevent, and treat postpartum depression in particular. The bill has the potential to help more mothers have increased attachment and less emotional difficulties following birth. The findings from this study indicating that lack of information and follow up contributed to postpartum difficulties demonstrates that the resources provided through this bill are needed.

Implications for Future Research

More qualitative research is needed about birth trauma in general. There is substantial research available about medical interventions linked with higher rates of birth trauma but limited research on how women experience those interventions. Qualitative research on trauma following C-sections and inductions in particular could help both medical and mental health providers identify the ways they can better support women prenatally, during birth, and postpartum to reduce overall instances of trauma and the likelihood of acute stress or other emotional problems following birth.

Another area that additional research is needed is regarding acknowledgement and follow up after birth. While this study suggests follow up and an acknowledgment are vital following birth trauma, more participants need to be interviewed on this topic to determine if that theme is more universal. Due to the small sample size and a population consisting of mostly women from the same metropolitan area, it is unknown if these results are generalizable to the larger United States population. Once additional data is received on this subject, it would be helpful to create

Strengths and Limitations of the Study

This study explored an aspect of birth trauma that is underrepresented in the literature. The research has shown that certain medical events are linked to higher rates of trauma reported, but those events alone do not seem to be the catalyst in developing posttraumatic stress symptoms. It appears that it is not the events in labor that have the strongest correlation to birth trauma, but rather the women's perceptions of the events in labor and the emotional experience that have a greater influence. Exploratory qualitative research focusing on the thoughts and emotions of women during the birthing process

will give greater insight into the development of birth related trauma. This study makes a positive contribution to birth trauma research and has provided topics of interest for future research.

There are some limitations to the study. First is the sample size; due to the time-restricted nature of this research, the researcher had to limit the sample size to nine in order to be able to analyze the data in a period of a few months. The research may also have limited generalizability due to the small sample size and also due to the fact that the majority of participants lived in the same metropolitan area. The purpose of this study was not to make broad conclusions, but rather identify preliminary themes and areas for continued research on the subjectivity of birth trauma.

It is also important to reiterate the potential for researcher bias when working with the topic of birth trauma. I developed a clinical interest in the topic of birth trauma after the birth of my first child. I experienced several events throughout my labor that I perceived as traumatic and caused a significant amount of impairment in my life postpartum. I acknowledge that I have the potential for transference of my own experience to the interpretation of my research, however I took steps to ensure that transference did not occur. I reviewed interview questions (see Appendix A) with my committee members and I reviewed my coding with my research chair and a research assistant. I also kept a field journal and processed my own reactions and potential for transference with another professional to ensure I was not placing my own interpretations onto the experiences of others.

Conclusion

Childbirth related trauma is a reality for up to a third of women and research is only beginning to touch on both the cause of it and recovery from it. More research and programming that addresses birth trauma is needed as there is a clear service gap for women who are struggling following birth trauma. Additional focus is needed not just on recovery but also prevention. This study contributed to the existing knowledge base regarding birth trauma and also identified areas of interest that have not been researched at length. Trauma is a subjective experience; however there are many emotional aspects of birth that seem to be common among birth trauma survivors. Those who work with birthing women must keep in mind several things: mothers need information support, communication, respect, acknowledgement, and validation. The transition to motherhood is a very vulnerable and identity changing to women and the interactions medical and mental health professionals have with them during the perinatal period does appear to play a role in the development of and recovery from childbirth related trauma.

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Appendix A: Interview Questions

1. Please tell me your birth story.
2. What aspects of your birth did you find particularly traumatic or troubling?
3. What were some of the thoughts you remember having during the experience?
4. How would you describe the support you received from your care team and loved ones during the birth?
5. Please tell me about your experience postpartum.
6. Did you seek out therapy services after your birth?
 - a. If yes,
 1. What was your experience like with the therapy provider?
7. In what ways do you think that your care providers and support system could have helped you more in the postpartum period?

Appendix B: Consent Form

BIRTH TRAUMA AND POSTPARTUM MENTAL HEALTH RESEARCH INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating how women experience birth as traumatic and what impact that experience has on postpartum mental health. This study is being conducted by Ashley Ashbacher, LSW, CD (DONA), Ashley is a licensed social worker, a certified doula, and a student in the Master of Social Work Program at the St. Catherine University and the University of St. Thomas. You were selected as a possible participant in this research because you responded to her request for women who identified their birth experience as traumatic. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:

The purpose of this study is to learn more about the emotions and thoughts women experience during a traumatic birth and how the experience impacts them in the postpartum period, particularly in regard to mental health. Approximately 8 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to participate in one approximately one to two hour long audio recorded interview in which the researcher will ask several questions about your birth and the postpartum period. The questions are available prior to the interview. The researcher will meet with you in a private location where you can talk freely without risk of being interrupted or overheard.

Risks and Benefits:

The study has a small amount of risk. It is possible that discussion of your birth trauma could bring up some symptoms of posttraumatic stress such as anxiety or re-experiencing. The interview may bring up painful memories and emotions. If you have given birth less than 6 months ago, still currently experiencing severe posttraumatic stress symptoms or feel that participating in this study would be distressing to you, it may be best to not participate in the study.

If you choose to participate and experience any distress afterward please contact your therapist (if applicable) or a crisis hotline. The Postpartum Support International crisis hotline number is **1-800-273-8255**. If you do not feel that you are in crisis but would still like to process the interview with a peer, you can call the Pregnancy and Postpartum Support MN helpline at **(612) 787-PPSM**. Within 24 hours, you will receive a call back from a Volunteer Facilitator who can answer questions, provide resources, and, if you like, pair you with a peer volunteer. PPSM can also be contacted via email: info@ppsupportmn.org.

There are no direct benefits to this research. However, for some women who experienced birth trauma, it can be healing to discuss your birth story.

Confidentiality:

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified but direct quotes from the interviews may be used. However these quotes will not include information that could identify you. I will keep the research results in a password protected computer in my personal office and only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 2013. I will then destroy all identifying information that can be linked back to you. Only I and my advisor will have access to the audio recording and it will be destroyed after the presentation of the research on May 20, 2013. The researcher will use an assistant. They will not have access to your name or contact information and will be required to sign an agreement to keep information confidential.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University or the University of St. Thomas in any way. If you decide to participate, and in any point in the interview you do not want to answer a question you are free to decline. You are also free to stop at any time without affecting these relationships, and no further data will be collected.

Contacts and questions:

If you have any questions, please feel free to contact me, Ashley Ashbacher at xxx-xxx-xxxx. You may ask questions now, or if you have any additional questions later, the faculty advisor, Catherine Marrs Fuchsel, PhD, LICSW at 651-690-6146 will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact John Schmitt, PhD, Chair St. Catherine University Institutional Review Board, at (651) 690-7739. You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

I consent to participate in the study and I agree to be audio taped.

Signature of Participant

Date

Signature of Researcher

Date

Appendix C: Information Sheet

INFORMATION SHEET FOR THE STUDY

My name is Ashley Ashbacher and I am a doula and a graduate student under Professor Catherine Marrs Fuchsel, PhD in the School of Social Work at St. Catherine University and the University of St. Thomas. I am conducting a research study to explore the experiences of women who felt that that childbirth was traumatic. I am interested in learning more about the emotional experience of mothers who experienced birth trauma and how that experienced affected them postpartum. I hope that what I learn will be valuable to social workers and other mental health professionals to help them better understand the impact birth trauma has on the lives of mothers. I would like to interview women who feel that they experienced an extremely difficult or traumatic birth.

I am looking for eight women to participate in the study. The interview will last approximately one to two hours and will take place in a private space at a time convenient to you. I will be audio taping the interview so I can review it afterward. If you agree to the interview, I will have you sign a consent form indicating you understand the study and are freely agreeing to participate. You will have the right to stop at any time during the interview.

In the interview I will ask you to tell me your birth story, the areas you felt were most difficult, and your postpartum experience. I will also ask you about your support system in birth and postpartum.

The study has minimal risk. It is possible that discussion of your birth trauma could bring up some symptoms of posttraumatic stress such as anxiety or re-experiencing. The interview may bring up painful memories and emotions. If you have given birth less than 6 months ago, have not previously discussed your birth experience with someone, are still currently experiencing severe posttraumatic stress symptoms or feel that participating in this study would be distressing to you, it may be best to not participate in the study. If you choose to participate and experience any distress afterward, I will provide you with community support resources. There may be direct benefits to you and community members for participating in this research. For some women who experienced birth trauma it can be healing to discuss your birth story and the research will help providers work to reduce the instance of traumatic birth and provide better care to women who have experienced birth as extremely difficult or traumatic..

The information obtained from the interview will be used to complete my graduate clinical research paper and will be presented at the University of St. Thomas in May 2013 and will also be discussed at the 2013 Postpartum Support International conference. Any identifying information will be removed from the written report and your personal information will be kept confidential. The interview recording and transcripts will be kept on my personal, password protected computer. Only Dr. Catherine Marrs Fuchsel, my research assistant, and I will have access to the recordings and your personal information.

Contact information if you are interested in participating:

Ashley Ashbacher

Phone: xxx-xxx-xxxx

Email: xxxxxxxx

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

Appendix D: Email Script for Professionals and Doulas

I am writing to you to request your assistance in recruiting participants for the study I am conducting as part of my Master's program in the School of Social Work at St. Catherine University and the University of St. Thomas. I am conducting a study regarding the emotional experience of women who experienced birth trauma. I am looking to speak with women who are at least 6 months postpartum, have previously processed their birth experience, and are not currently experiencing acute or severe post-traumatic stress symptoms. I have attached the information sheet for potential study participants to this email. If you have clients you feel would be appropriate for my study, please consider giving them the information sheet to review.

Thank you for your consideration and assistance in this process,
Ashley Ashbacher, BSW, LSW, CD(DONA)

Appendix E: Participant Email and Phone Script

Thank you for contacting me about my study. I have a couple questions for you to start. Did you give birth over 6 months ago? Also have you talked to anyone such as a family member, friend, or therapist, about your birth experience? Do you have any questions about the information sheet or anything else about the study? If you are still interested, the next step would be to set up an in person interview. The interview will last around 1 to 2 hours. In the interview I will ask you to tell me your birth story, the areas you felt were most difficult, and your postpartum experience. I will also ask you about your support system in birth and postpartum. You have the right to back out of the study at any time. Are there particular days and times that tend to work better for you? For confidentiality, the interview will need to take place in a private location. I would like to find a location that is convenient to both of us. Please let me know if there is a location you prefer, otherwise I will contact you again within two days with potential meeting locations and times.