

## **Just another ordinary bad birth?**

### **A narrative analysis of first time mothers' traumatic birth experiences**

#### Abstract

A difficult birth experience can have long lasting psychological effects on both mother and baby and this study details 4 in-depth accounts of first time mothers who described their birth experience as traumatizing. Narrative analysis was used to record discrepancies between the ideal and the real and produced narrative accounts that highlighted how these mothers felt invisible and dismissed in a medical culture of engineering obstetrics. Participants also detailed how their birth experience could be improved and this is set in context alongside current recommendations in maternal health care and the complexities of delivering such care in UK health settings.

## Introduction

For many women, childbirth is a major life event that brings celebration, life satisfaction and reward (Nelson, 2003) but some birth experiences bring difficulties in adjusting to new life circumstances and can trigger distress and trauma for the mother (Beck, 2009). While post-natal depression is now widely acknowledged amongst the clinical health professions, trauma during the birth stage can lead to a diagnosis of Post-Traumatic Stress Disorder (PTSD)<sup>1</sup> (Ford & Ayers, 2011). Between 1% and 6% of women are diagnosed with PTSD within one year after the birth of their child (Ayers, McKenzie-McHarg & Slade, 2015; Ayers & Pickering, 2001; Czarnocka & Slade, 2000). A much higher percentage of women (20% to 48%) describe childbirth as traumatic (Ayers, Harris, Sawyer, Parfitt, & Ford, 2009; Soet, Brack, & Dilorio, 2003).

Childbirth can produce debilitating traumatic stress as a result of threat to physical integrity, injury, and/or death to the mother and baby (Ayers, 2004). Giving birth may trigger a traumatic stress response and women may experience anger, anxiety, disassociation, apathy and/or disconnection in the weeks following birth as a reaction to such an overwhelming event (Nilsson, Bondas & Lundgren, 2010). Some women do recover within the first three months and will not go on to develop PTSD but Beck, Gable, Sakala, & Declercq (2011) found that 9% of the mothers met the full criteria for a PTSD diagnosis following their birth, with a further 18% experiencing post-traumatic symptoms. Kendall-Tackett (2013) note that this PTSD incidence in birth mothers was higher compared to individuals exposed to a terrorist attack (see Galea et al, 2003).

PTSD inevitably impacts on the mother's ability to cope and successfully care for her child in the postnatal period (Borg-Cunnen, McNeill & Murray, 2014). A traumatic birth experience can also affect the mother-baby bond, the parent-baby bond and the (sexual) relationship with her partner (Iles, Slade & Spilby, 2011; Nicholls and Ayers, 2007; Parfitt & Ayers, 2009). Decisions to have another child and the ability to engage with healthcare systems and professionals in the future can also be impacted by a traumatic birth (Ayers, Eagle & Waring, 2006; Hofberg and Brockington, 2000). Furthermore, birth trauma can produce symptoms of

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<sup>1</sup> The Diagnostic and Statistical Manual of Mental Disorders V (American Psychiatric Association, 2013) now classes Post-traumatic Stress Disorder as a 'Trauma and Stress Related Disorder' linked to an external event, rather than an anxiety disorder.

hyperarousal recorded up to 36 months later in women who had traumatic births (Ayers et al., 2015).

### **Risk factors in developing trauma for pregnant women**

In a meta-ethnographic study, Elmir, Schmied, Wilkes, & Jackson (2010) found that women who had traumatic birth experiences felt 'invisible and out of control', described the birth as a 'nightmare' and classified the birth itself as having significant personal impact on their lives. This is set against the finding that women report that they are reluctant to disclose their emotional responses to/during the birth in clinical settings where medical language predominates and there is an absence of emotive language (Beck, 1998). So what kinds of birth are more likely to produce trauma in women giving birth? Here, we identify 4 aspects of the birthing process that may result in birth trauma. These are birth pain, mismatches in expectations of childbirth, the impact of previous trauma and death of the neonate.

#### **Birth pain**

Quine, Rutter and Gowan's (1993) study suggested that women who expected more pain and had a more negative birth experience were more likely to perceive the birth as traumatic. Waldenström, Hildingsson, Rubertson and Radestad (2004) noted that mothers who request an epidural for pain relief are already more anxious, usually receive more pain relief and experience a more negative birth than others. Some qualitative studies have found that assisted delivery and emergency caesarean sections are related to the symptoms of post-traumatic stress (Ayers et al., 2009; Creedy, Shochet, & Horsfall, 2000; Söderquist, Wijma, & Wijma, 2002). Ryding, Wijma & Wijma (1998) found that mothers who had either an emergency caesarean section or instrumental delivery experienced significantly more symptoms of PTSD than those who had an elective caesarean or normal vaginal birth. Intrauterine death, stillbirth, major complications and invasive medical procedures involving inadequate pain relief. These types of birth increase the likelihood of trauma being experienced by women (Soet et al., 2003).

#### **Mismatches in expectations of childbirth and intra-partum care**

Expectations of childbirth can determine a women's response to her experience (Beaton & Gupton, 1990; Bramadat and Driedger, 1993), and a natural delivery can be conceptualised as traumatic if the woman is dissatisfied with aspects of the birth itself, leading to guilt and depression (Maggioni, Margola & Fillipi, 2006). Waldenström (1999) looked at the

experiences of labour and birth in 1,111 mothers and found that women who had a positive expectation of labour in early pregnancy, went on to have a positive birth experience. Green, Coupland and Kitzinger (1990) recorded expectations, experiences and psychological outcomes of childbirth in 825 women. Low expectations, (later actualized) were reported alongside lower levels of satisfaction. Social and clinical support that is dismissive, hostile or negative as a result of giving birth impacts the birth experience negatively (Beck & Watson, 2010; Lyons, 1998). Difficulties in communication and poor personal relationships with midwives resulted in dissatisfaction (Kakabian-Khasholian, Campbell, Shediach-Rizkallah & Ghorayeb, 2000; Sadler, Davison & McCowen, 2001). Indeed, in a meta-analysis of risk factors for PTSD, lack of support was the strongest predictor for onset of symptoms following a traumatic event (Brewin, Andrews & Valentine, 2000). Ford and Ayers (2011) found that loss of control and intrusive medical interventions for the mother were more likely to result in acute post-traumatic symptoms in the post-natal period.

In contrast, continuous one-to-one intrapartum care for mothers and babies produces better clinical outcomes for both mother and baby. Mothers report that they require less pain medication, have shorter labours, and are more satisfied with the birth experience (Hodnett, Gates, Hofmeyr, & Sakala, 2013). Studies have found that perceptions of control may be determined by the support received from caregivers. Green and Baston (2003) found that professionals who considered the mothers feelings and whose behaviour was supportive was related to the women's sense of feeling in control in labour. Increases in perception of control is related to the amount of support perceived from the professionals (Lundgren, 2005; Nystedt, Högberg & Lundman, 2006). Conversely, low perceived control has been linked with lower satisfaction of childbirth, postnatal depression (Slade, MacPherson, Hume & Maresh, 1993), and perceiving the birth as traumatic. Post-traumatic stress symptoms are more likely to be experienced under these conditions (Soet et al., 2003, Czarnocka & Slade, 2000).

### **The impact of previous trauma on giving birth**

There is evidence to suggest that some mothers may be particularly vulnerable to developing PTSD due to a previous trauma or pre-existing psychological problems (Ayers et al., 2015; Ballard, Stanley & Brockington, 1995; Rhodes and Hutchinson, 1994). Wijma, Soderquist and Wijma (1997) reported that women with a history of psychological and psychiatric intervention, who had never given birth before and who appraised the delivery and contact with staff negatively were particularly vulnerable in developing PTSD. Ford and

Ayers (2011) noted that women who had a history of trauma and also received low care and support from health professionals were more likely to experience symptoms of trauma in the post-natal period. Creedy et al., (2000) interviewed women at four to six weeks postpartum to explore the care and management received during birth from the health professionals and to identify signs of any trauma symptoms. Women who were both dissatisfied with their care and received a high level of medical intervention were more likely to develop trauma symptoms meeting the DSM-IV criteria than if they had experienced either dissatisfaction or medical intervention.

### **Death of the neonate<sup>2</sup>**

A significant prevalence of PTSD has been identified following the experiences of perinatal loss, stillbirth and premature births (Turton, Hughes, Evans & Fainman, 2001; Engelhard, Van Den Hout, & Schouten, 2006). Engelhard, Van Den Hout, & Arntz (2001) found that prevalence rates of PTSD in mothers after the loss of a pregnancy in the first trimester were 25% one month after the event, reducing to 7% after four months. Lefkowitz, Baxt and Evans (2010) found a slightly higher incidence rate with 35% of respondents in a sample of 127 meeting the diagnostic criteria for Acute Stress Disorder 3-5 days after their baby was admitted to a neonatal unit. Thirty days later, 15% of the sample met the criteria for a PTSD diagnosis. Holditch-Davis, Bartlett, Blickman and Miles (2003) found in a small sample of mothers who gave birth prematurely, that all of them had at least one symptom of PTSD, whereas more than 50% suffered with re-experiencing the traumatic event, avoidance and numbing, and increased arousal at six months *after* their baby's expected due date of delivery.

### **Aims and rationale**

The majority of studies into childbirth related trauma are often quantitative and underestimate or under-report the impact of women's subjective experiences of childbirth (Kendall-Tackett, 2013). Indeed, Garthus-Niegal, van Soest, Vollrath, & Eberhard-Gran (2013) note that the woman's subjective (*vis-à-vis* objective) birth experience has a major effect on post-partum symptoms of PTSD and mediates obstetric factors in the birth process itself. Our aim here is to focus on the events during and after the birth while also setting the births in their medical context - providing an account of medical issues during the pregnancy, medical interventions during labour and recording any medical issues with the neonate as well as the instance of post-natal depression and/or other psychological sequelae for the

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<sup>2</sup> Although none of our research participants experienced death of the neonate, we document this literature as of significance in understanding associated trauma and/or the emergence of PTSD

woman. This will provide in-depth, focussed and subjective narrative accounts of self-defined traumatic births, acknowledging multidimensional and medically complex aspects of the birth experience. We will also ask for recommendations for future peri- and post-natal care from this participant sample group. We can then address specific needs to reduce suffering and distress experienced by future new mothers in the birthing period.

## Method

### *Participants and procedure*

The participants for this study were women who gave birth in a National Health Service (NHS) hospital in the South East of England and who perceived their first birth experience as traumatic. The second author had worked as Perinatal Counsellor in an NHS maternity department and recruited the primiparous participant sample using her professional network of client contacts. Participants were initially asked if they believed that they had experienced a traumatic birth. Using a purposive sampling technique, the inclusion criteria stated that the first child's range was set at 3 to 8 years of age to allow for a significant time period from the perceived traumatic birth and to avoid unnecessary re-traumatisation as a result of the research interview. Mothers were excluded if their child was over 8 years old or if the trauma was not with their first child.

Of thirteen participants invited to take part in the research study, 5 participants agreed to take part and were interviewed<sup>3</sup> (see Appendix 1 for the research interview schedule used) and the second author carried out the research interviews. One participant later withdrew her consent for material to be used citing personal reasons. Pseudonyms were allocated to the remaining four research participants – Sonja, Mel, Sarah and Georgia. Ages of the participants ranged from 30 to 42 years of age and all participants described themselves as White British. Three of the women had given birth to a second child and the first-born children were aged either 5 or 6 at the time of the research interview (see Table 1).

Two of the research interviews took place in the second author's consulting room, two in a mutually agreed public place that allowed for some privacy, and the remaining research interview took place at the participant's home. The aim was to provide a safe environment for the women to disclose their most intimate thoughts and experiences and at points during the research interview. At the close of the research interview, participants were debriefed and any questions or concerns were addressed with the researcher. This included supplying the participant with contact details of the researcher should any further concerns be identified. A list of qualified therapists was also given to each participant for help and support at the close of the research interview. Research interviews lasted between 30-90 minutes and were recorded and then transcribed to produce a verbatim account of the mother's narrative.

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<sup>3</sup> We note the number of participants invited and the number unwilling to be interviewed on this topic

### *Study design and the narrative analysis*

The semi-structured research interview was designed to elicit information in relation to the participant's experience of their traumatic birth. This is in line with a narrative analytic framework that elicited each woman's story as a meaningful experience, exploring the social and psychological functions of the storytelling by research participants (Murray, 2003; Ricour, 1984). This analytic strategy then encompassed the thoughts, feelings, expectations and lived experience of labour; the mother's subjective experience of the birth stage; and the needs of the mother in antenatal and peri-natal stages. The research interview adopted a sequential approach to the pregnancy and began by exploring how the women felt when they first found out they were pregnant and then explored the trauma experienced at the birth stage, and then ended by asking about the impact of the traumatic birth and how healthcare could be improved. The narrative approach adopted was one which concentrates on discrepancies between the ideal and the real (Bruner, 1990), using this to promote change and thereby improving outcomes for women who have experienced trauma during the birth process (for example, see The Centre for Narrative Research, 2016 and Kaufert, 1998).

### *Producing themes and developing a coding framework for the woman's medical journey*

The research interviews were analysed for content and tone, temporal stages in the narrative as well as documenting the specific events that made the birth traumatic. This produced a set of themes for the narrative analysis which were 'experiencing birth trauma', 'being invisible', 'just get on with it', and 'making things better'. The transcripts were also analysed to produce data on the medical experience of pregnancy each woman had encountered and we developed a coding frame for the data that drew out particular information from the transcripts, giving us a baseline overview of the pregnancy and birth for each woman participant. The coding framework for the women's medical journey documented 'medical issues during pregnancy', 'medical interventions during labour', 'type of delivery', 'medical issues with the neonate', and the presence/absence of 'post-natal depression and/or other elements of psychological distress' for each participant. This helped



to account for medical experiences alongside narrative themes and the journey each woman participant experienced (see Table 2).

### *Ethical considerations*

The University of XXX ethics committee approved the research study. The research second author (the research interviewer) was an accredited Counsellor and EMDR (Eye Movement Desensitization and Reprocessing) therapist. Both authors were conscious that the research interview could trigger a re-experiencing of the traumatic birth. In the event that a participant experienced an undue level of distress as a result of the research interview, they were to be referred to their GP and/or Health Visitor. This did not occur for any of the 5 participants who were interviewed.

## Results

All participants had medical interventions during labour which they described as 'traumatic'. Three of the women (Sonja, Mel and Sarah) had emergency caesarean sections and one (Georgia) had a Ventouse assisted delivery. One woman (Mel) received a PTSD diagnosis in the post-natal period and Sarah was diagnosed with PTSD prior to pregnancy due to a previous sexual assault. Both participants were diagnosed by psychiatrists. All of the women's partners were in attendance during the birthing stage. Analysing the accounts of the women participants produced 4 narrative themes. These were 'experiencing birth trauma', 'being invisible', 'just get on with it', and 'making things better'.

### Experiencing birth trauma

Women's experiences of trauma began during the build up to the birth during medical procedures for birth preparation and when they were in labour. Sarah, who had been previously sexually assaulted and diagnosed with PTSD, details a particularly distressing incident when the nurse attempted an internal examination:

The woman wanted to do an inspection to check my cervix. I was screaming because I was in so much pain and she's trying to check the cervix and I'm like it's hurting too much, you need to give me something, you can't just go down there. She literally was holding her hand inside me trying to get further up so she could feel it and I'm screaming at her, "This is hurting, you need to give me something." It took for one of the doctors to walk past and hear all the cries and screams to come in and say to the nurse, "You can clearly see this woman is in labour, why is she in here? She needs to be on the other ward, she needs to go on the delivery suite." And it was that bad that when she was trying to check my cervix, there was blood everywhere.

The internal examination was abandoned only on the intervention of a more senior health professional which, while validating Sarah's objections and resistance, displayed the lack of control that Sarah had over her own body and the sense of powerlessness and fear Sarah felt.

The degree of pain experienced in labour shocked Georgia in the delivery room:

I do remember distinctly in my mind everybody shouting at me saying, "Get this baby out," and I remember thinking and feeling like my body was about to split in half... Unbearable pain, I felt my body was going to be split in two. I felt like I was going to die.

Georgia felt that she had reached her pain tolerance limit and there was no space in this narrative for acknowledgment of such frightening thoughts as the team worked to deliver the neonate. Indeed, Georgia's use of the phrase 'shouting at' displays the disconnect and,

perhaps panic, between the clinical team and herself as the patient/new mother-to-be. Inside Georgia was going through a fairly deep existential threat to her sense of self-integrity. Mel describes the impact of an emergency Caesarean when the neonate was threatened by meconium aspiration:

Then something happened and I think the baby pooped or something. Next minute, that was an emergency, straight into theatre... I just went into shock. I was shaking on the table. I felt so physically cold and the doctor was shouting at the nurses, "You've got to cover her up, she's freezing." My partner was in shock, I was in shock and you're just there on this table.

Again, the narrative points to passivity and powerlessness of the experience for Mel with the clinical team dealing with both medical issues with the neonate and Mel. In this particular instance, the staff (rather than the patient) were being 'shouted at'. The situation becomes more critical with Mel and the clinical team then intervene with psychological support. Mel continues:

Because of the epidural you're paralysed, I was physically shaking and so cold and they put this great big blanket over me. In the end, it got to the stage where [they] had to talk me down and imagine something and take me out of the scenario I was in to calm me down

Mel needed both physical and psychological comfort and reiterates her state of paralysis to the point where the clinical team actually realise that they needed to intervene with psychological support and labour had gone beyond medical intervention. Georgia too feels lost in the middle of the medical process of labour:

The process of the baby coming out with the Ventouse and the events that followed from that, being stitched up with no anaesthetic then having placenta taken out (which my understanding is that this should not have happened in that order). Everybody was just shouting at me and saying to me this is what we're going to do. It felt like everybody else around me was not calm and they were panicking, which in turn made me panic (99-107).

The urgency in the clinical team is perceived as confusion and disorder by Georgia and again, we have another participant who feels that she has been 'shouted at' during the birth process. Medical urgency, the sense of heightened emotion in the delivery suite and the experience of being shouted at by medical staff was detrimental to the women participants' birth experience and would not ameliorate a perceived traumatic birthing process.

### **Being invisible**

In this narrative theme, the participants describe how they feel they disembodied from staff-patient interactions despite the fact that they and their unborn child are very present and

are approaching a meaningful life event for the first time. Feeling invisible to hospital staff began immediately for Mel:

As soon as I opened the door to the hospital, I didn't feel they were really bothered about me. I know that sounds quite strange but this is the first time being a Mum, it was like they didn't even look at your face, it was like they were oblivious, the women behind the desks (103-107).

Mel notes the absence of engagement between staff and patient with frontline staff giving the impression they are disinterested to the point of uncaring in a health focussed environment. This appears to have quite a profound effect on Mel even before the medical interventions of labour begin - as we follow Mel's narrative we note that Mel discharged herself from hospital after the birth. We previously introduced Sarah's distress over an internal examination. Sarah comments on how her reactions were ignored by one of the medical staff:

[The nurse] was not listening to me one little bit. I was crying my eyes out, literally screaming... The doctor even came and apologised to me for the nurse's behaviour (96-124)

In her account, Sarah fails to understand why a nurse continues with a procedure despite Sarah's protests and was then relieved to find an ally in another member of the clinical team whom Sarah felt acknowledged her state of being and the manner in which she had been treated. Sarah had not felt heard in relation to an intrusive medical procedure. In a similar manner Georgia feels left out of the series of interactions between the clinical team members:

One of my main negative feelings about that was I didn't feel anybody was actually talking to me directly. It was like I wasn't in the room, everyone was talking about me or about the situation rather than talking to me saying this is what's happening and this is what we're going to do.

Georgia's comments suggest that she was far removed from the medical conversations perhaps to the point of invisibility and there is a sense of disembodiment in her narrative. Georgia's narrative also suggests lack of consultation and distancing between herself and the medical team over Georgia being able to contribute or make decisions about the birth process. The lack of communication from medical staff was evident in Sonja and Sarah's accounts in the post-natal period:

Sonja: There was a bit of discussion going on. Then [the Doctor] saying, "We need to take this baby." They took him... No, I didn't know why. I actually had never really been told what the deal was... He'd obviously been taken round to neonatal. Again, that wasn't explained, I didn't really understand why.

Sarah: They didn't explain anything to me, they were just taking her to neonatal to get her checked out and that was about one o'clock in the morning. I woke up at seven and she still wasn't there and I was panicking, where's my baby... But that whole time, I kept waking up in the night thinking where is she? And I wasn't being told anything.

Both Sonja and Sarah highlight a process where the patient was neither informed nor consulted of the next stages in the medical decision making process. The lack of medical accountability led to confusion and anxiety on the part of Sonja and Sarah. Their roles as new mothers were subsumed by medical non-communication and they were left with no information or updates to help them understand their baby's health status. There was an absent baby and a present mother who had not been advised or consulted about her newborn's health.

### **"Just get on with it"**

Throughout the birthing experience, the woman participants received a clear message from the medical and clinical teams about how they were to handle their pregnancy and what was expected of them as a new and first time mother during and after labour. This began soon in the birthing process for Sonja when Sonja attended the hospital with early labour pains:

A consultant came in and she was very blunt and said, "Take some Paracetamol and go home." I was like, "Whoa, go home?" and she was like, "Yeah. Stay there for a little while but really there's no point in you being here". But they kept coming in and saying, "Are you ready to go now? Just take some Paracetamol, go home and have sex is the best thing".

While Sonja's early labour pains were a matter of routine for the clinical staff, this was not 'routine' for Sonja as a new mother-to-be, receiving mixed messages from the consultant and medical team. Sonja was effectively being dismissed as she took up physical space and staff resources in the hospital. Sarah was more directly told how she should be dealing with the birth:

At one point [the nurse] turned round and said to me, "You need to cope a lot better than this, you've got a lot more to come"... she was shouting at me.

Sarah's current state was clearly not acceptable for this particular member of nursing staff and dismisses Sarah's sense of distress during the birth. Mel too felt harshly treated by a member of the clinical team delivering post-natal care:

She was one of these ladies with the blue uniform on, a dark blue one, I don't know what it is and said, "What are you crying for?". Not an arm round me or anything... Because she said what are you crying for, I thought "Oh my God, should I not be crying then?".

These two interactions from nursing staff communicate strong messages about how women participants are expected to deal with the birth. The latent message from nursing staff in these instances is for woman participants to be in control of their emotions and accept the experience, no matter how testing this might be for them. There is a noticeable lack of communication, compassion and understanding in the responses to the women in labour from the nursing staff. Mel brings us back to understanding the impact of an emergency Caesarean:

For me, it was a shock and was taken up to the ward, I felt like I was dumped in this room with four other women, didn't know where I was really because you're so drugged up anyway and that was it! You've got your baby next to you, get on with it... Then there's the other side of you thinking I've just had my stomach cut open and no-one's really responding to me, so why should I not just get on and deal with it myself anyway?

Despite Mel's internal struggles to look after herself by stating her needs, the predominant ward culture that she experienced encourages her to accept her subsumed position and accept the level of care that is offered. On reflection, Sonja internalised shame when she was unable to challenge the midwives' insistence to breastfeed:

A different midwife walked back in, plonked him on me and said, "You decided to have this baby, you need to deal with him". I wasn't angry at her, I was ashamed at myself because I was dumb enough at that point to think that what she said was gospel and yeah, I'd decided to have my baby, he's my responsibility. I was crying my eyes out and she offered me nothing, no support whatsoever.

The practicalities of breast feeding the baby dominate the interaction and are priorities for the staff. Sonja is left to comfort herself as best she can in a situation where she feels powerless and isolated, feeling pushed to breastfeed. Women participants were expected to deal with their birthing experience in a particular manner by ignoring the psychological experience and psychological challenges. The message from clinical staff in these circumstances is to simply get on with the process of practical mothering without negative (and futile) emotions.

### **Making things better**

The women participants were very keen and involved in wanting to improve the maternity services that they had experienced and focussed on the beginning of the birthing experience itself rather than ante-natal care. Sonja and Mel wanted to improve the admissions process and to improve mothers-to-be's adjustment to the hospital setting:

Mel: Firstly, when you walk into the hospital, they've got to acknowledge you and say, 'This is your room, this is what's going to happen. We're going to leave you but we're going to monitor you. You're not on your own.' (429-432).

Sonja: They've got to remember every woman walking through that door is in a really vulnerable situation and offer that care and support as it feels it should be. It feels personal when they're with you, that they're attentive and have empathy with how you might be feeling.

Mel asks that her arrival is noted in a formal manner as well as clear messages and boundaries being set by the clinical team involved in the birth and communicated to the patient. Mel asks for reassurance for other mothers-to-be to help settle fears around isolation and uncertainty. Sonja reminds us of women's vulnerability in this situation and highlights the psychological wellbeing of the new mother-to-be beyond the medical care that is delivered. Georgia re-enforces this request:

I needed a professional to be calm and say to me don't worry, this is what we're going to do or this is what you need to do to help us to get this baby out. (137-140).

Georgia also points out the value of communication and reassurance between the medical team and herself/the patient which is in contrast to what many of the participants had experienced. The narrative accounts outlined in previous sections suggested that they felt invisible, left out and were 'shouted at' by professionals. Georgia perhaps views the process of giving birth as a joint decision making process and her 'helping' the medical team deliver the baby safely. Mel thinks that there needs to be someone who will follow up the birth experience during the recovery period from a traumatic birth:

Maybe the first night you should have somebody responsible for you, just looking after you, just being there. "You have a couple of hours, I'll keep an eye on her," and that sense of somebody's actually looking out for you and for that baby you've just had and taking responsibility off you where you've had such trauma (526-531).

While Mel proposes a more informal 'baby buddy' approach, Sonja and Georgia would welcome a more formalised support system. Georgia wants a cleaner and more individualised response while Sonja adopts a longer term and more sustained service:

Georgia: If somebody professional had come along in the few hours after, maybe the next day after the birth, and said, "This is what's happened, I can see on your notes this is how the labour went. Are you ok, do you want to talk about what happened?" and, "Let's look at you and the baby knowing what has happened, is this baby now ok?" (157-163).

Sonja: There should be a lot more trained specialists, whether that be a midwife who's trained to deal with postnatal depression, traumatic births, talk them through, discuss that and a follow on program, support, whatever that needs to look like (842-852).

Georgia and Sonja suggest system improvements in natal care, specifically relating to incidences in the birth which could lead to trauma. The importance of personal attention, being cared for, being thought about, and being attended to by medical staff is highlighted by Mel:

[The trainee midwife] helped me totally. As soon as she turned up in the morning, she was holding my hand all the way through and I thought you're going to make a lovely midwife. Because she knew, she was so attentive, even to my partner. She read my birthing plan, she knew exactly what I wanted

Mel comments that the trainee midwife had spent some time preparing to meet and care for Mel. This was followed through with a strong, sustaining presence which involved physical touch that may re-enforce the psychological support that Mel experienced. Indeed, Sarah assesses her nurse as "fantastic" as that nurse stayed with Sarah throughout the birth. The women participants were interested in accessing medical care that made them feel safe in a situation where they had felt psychologically and physically vulnerable. Sonja summarises this in her encounter with one particular nursing staff member:

I remember her coming in and she might've sensed something in me and she said, "It's going to be all right, if I could take you home and look after you, I would," and she put an arm round me and gave me a hug and I cried the first time publicly in front of other people. I was desperate for her to come back and for me to see her again and I didn't see her again. She was like a comforting mother figure who offered something that felt warm and safe (1123-1133).

The significance of personal touch and the release of Sonja's emotions is central to this encounter with a nursing staff member and responds to a need in Sonja which she again later looks for during her birth experience.



## **Discussion**

As we have evidenced in the accounts provided from our women participants, psychological aspects of the birth process and a mother's experience may be significant in determining post-partum outcomes. We documented the physical and emotional impacts of birth trauma, the invisibility of being a woman in labour, and the dismissive attitudes of some clinical staff towards new mothers. Our participants became distressed as they and their birth experience became *more invisible* in the medical processes. Women participants experienced a loss of control, low levels of support, and, in some instances, a loss of dignity. As we have noted, psychological sequelae such as postnatal depression, anxiety and PTSD are linked to a negative or traumatic birth experience (Allen, 1998; Hodnett, 1989; Nicolson, 1998; Niven, 1992; RCM, 2000). Additionally, difficulties in maintaining and forming relationships with her partner and baby are also a result of negative and/or traumatic birth experiences in the longer term. Specifically, PTSD has been associated with a dysfunctional mother-baby attachment with hypervigilance and arousal, for example, leading to an over-protective attachment style (Ballard et al., 1995; Bailham & Joseph, 2003). In line with Oakley (1993), we agree that assessing the success of childbirth should include the 'experience of labour' and not only focus on physical indicators of birth success and that medicine and medical processes should not have exclusive control over childbirth.

### **Fear and 'ordinary bad births'**

Fears of childbirth were present in participants' accounts of their birth experience and current research suggests that fear of childbirth is routinely experienced by women whether anticipating birth or not (Stoll, Edmonds & Hall, 2015). Particular elements of birth fear centre on labour pain, anxiety about the birth, anxieties about the neonate's health and loneliness/isolation during the birth experience (Korukcu, Bulut & Kukulcu, 2016). The participants in this study reported that they were made to feel invisible, were dismissed, shouted at or told to simply accept the pain and fear of the birthing process itself. Wolf (2001) noted the lack of compassion in birth culture and labelled such experiences as 'ordinary bad births'. McCarthy & McMahon (2008) found that some women believed that being distressed during this period was a normal and expected experience associated with becoming mothers and in parallel, this appeared to be endorsed in some of the accounts of medical care reported by the research participants. In contrast, feeling and being safe and tolerating pain as well as having information to make appropriate decisions are important

factors for women's birthing preferences and impact upon the long term satisfaction of giving birth (Maznin & Creedy, 2012).

### **Making things better: the importance of staff-patient communication**

Difficulties in communication and poor personal relationships with midwives and clinical staff resulted in dissatisfaction for our research participants. Indeed, women giving birth generally rate the quality of communication with health professionals more significantly than the staff's clinical skills (Kersnick, 2000; Saeed, Mohammed, Magzoub et al., 2001). In parallel, fathers who were birth companions felt satisfied with health care professionals when new father needs were met (Hoga, Gopuveia, Higashi & Roth, 2013). Baker, Choi, Henshaw et al. (2005) found that women who reported poor communication with nursing staff and who were unable to influence decisions during the birthing process as a result of inadequate information experienced fear, anger, guilt, disappointment and distress.

### **Making things better: continuity of care and feeling in control**

When transitioning into motherhood for the first time, women participants expected high levels of professional support in terms of meeting individual needs and facilitating partner participation in the birth process (Thorstensson, Andersson, Isrealsson, Ekstrom & Wahn, 2016). Experiencing a sense of control positively contributes to women's satisfaction during the birth stages while factors such as unsupportive care and lack of continuity of care undermine perceived control for the woman (Brown & Lumley, 1998; Waldenström, 1999). Furthermore, Ford and Ayers (2011) found that loss of control and intrusive medical interventions for the mother were more likely to result in acute post-traumatic symptoms in the post-natal period. Client centred communication is an important aspect of the midwife-patient relationship and women appreciated continuity of care that followed individualized pathways (Baas, Erwich, Wiegers, de Cock, & Hutton, 2015). Similar findings from a qualitative synthesis were recommended for those parents who had experienced intrauterine death and stillbirth (Lisy, Peters, Riitano Jordan, & Aromataris 2016; see also Kingdom, Givens & O'Donnell, 2015).

### **Making things better: do we pathologise or normalise the experience of giving birth?**

Critical perspectives on birth and medical culture suggest that the medicalization of pregnancy and labour turns the human experience into a form of 'engineering obstetrics'. Medical discourses construct birth as high risk, so legitimising the use of (intrusive) obstetric technologies that become customary, unquestioned, and well-rehearsed by clinical staff teams. Cahill (2001) comments that this may erode *real* maternal choices and entrenched systems in managing labour predominate (Zadoroznyj, 1999). Furthermore, McCallum (2005: 234) asserts that a hegemonic medical culture morphs into "an abstract conscious collective" that frames the processes of birth and consequently, the birth experience. Interestingly, Crossley (2007) comments that first time mothers are fed a promotional doctrine which suggests that giving birth is 'just a natural process' when the reality is that women enter a highly medicalized environment where they will be attended to by clinical staff who will avoid high risk births. Therefore, engaging with a 'natural discourse' of childbirth may create a set of expectations for women that are idealistic and at odds with the birth experience.

Hence, post-natal debriefing and psychological interventions (pre-term 'screen and treat') have been put forward as responses to ameliorating difficult and/or traumatic births for women (Ayers, 2014). Ayers, Jessop, Pike, Parfitt, & Ford (2014) suggest that mothers are screened in pregnancy for their attachment type and then a program of care set out to reduce the risk of developing PTSD and increase the likelihood of secure attachment with the neonate. Psychologically screening in or out women who may be prone to developing post-natal PTSD risks Type 1 (false positive) and Type 2 (false negative) errors. Moreover, to date, there is little to no evidence that midwife-led interventions are either effective or useful (Borg-Cunnen et al, 2014). Postnatal debriefing too has its limitations. Women clients comment on its value based on 'being heard' but this initiative has no clinical worth in terms of reducing rates of morbidity (Baxter, McCourt & Jarrett, 2014).

Psychological screening locates the site of the pathology with the mother-to-be when the picture may be more complex and risks pathologising normal reactions to a traumatic event (see McNally, 2009). Moreover, it was only when avoidant attachment styles *were coupled* with a birth that required a caesarean or an assisted vaginal delivery alongside poor support correlated with a postnatal diagnosis of PTSD (Ayers et al., 2014). Again, loss of control and intrusive medical interventions for the mother were more likely to result in acute post-traumatic symptoms in the post-natal period (Ford & Ayers, 2011). Adopting such a screening policy can easily dismiss the significant role clinical teams play in the birthing

experience and, irrespective of type of delivery experienced and/or the lack of care delivered by medical staff, firmly locates responsibility for psychological adjustment and attachment with the individual woman (for example, see Peñacoba-Puente, Marín-Morales, Carmona-Monge, & Velasco Furlong).

### **Making things better: understanding the challenges in improving women's experience of giving birth**

Despite recommendations from an impressive array of international and national, public health, professional health and charitable health bodies and organisations [for example, the Maternal Mental Health Alliance (2013), the National Society for the Prevention of Cruelty to Children (Hogg, 2013), the UK Royal College of Midwives (Boots Family Trust, 2013), the UK Department of Health (2013), and the World Health Organisation (2015; 2017)], it appears that little change and progress has been made in service delivery for some women who give birth, traumatic or otherwise. Along with findings from this paper and substantiated with comprehensive research from the past twenty years, some women continue to experience sub-standard health delivery during this particular life stage.

For example, 'Changing Childbirth' (Department of Health, 1993), a report produced by the UK Expert Midwives Group, suggested making the women the centre of the care during pregnancy, birth and the postnatal stage. This report highlighted the importance of keeping birth 'normal', providing choice, continuity and control, as well as focussing on the midwifery care. It was thought that this would improve psychological and physical outcomes as well as enhancing the women's experience and feelings of satisfaction with the birthing process. The Royal College of Midwives (RCM) voiced their frustration with the lack of progress on this initiative whilst also recently commenting on UK midwifery shortages, cuts to service and frozen pay scales for the profession (RCM, 2013; RCM, 2017).

However, we need to consider other contributing factors in the profession when seeking to understand exactly why policy recommendations are not implemented or do not come to fruition in clinical settings. Why are clinical teams, specifically midwives, not responding to basic psychological and emotional needs of patients? Staff burnout, work-related stress, compassion fatigue, exposure to maternal and neonatal deaths, vicarious traumatisation, depersonalisation, and/or clinical under-resourcing may contribute to a sustained

impairment in maternity care service delivery (Mollart, Skinner, Newing & Fourer, 2013; Pezaro, 2016; Muliira, Vito-Bosco Sendikadiwa & Lwasampijja, 2015; Wallbank & Robertson, 2013; Walpole, 2011). Pezaro, Clyne, Turner, Fulton & Gerada (2016) suggest that improved patient care may depend on sustained investment in the psychological health and wellbeing of midwives themselves from their incumbent employers.

### **Limitations of the study**

We note 2 limitations of the study presented here. Firstly, the small number of participants who came forward for interview may impact of the generalisability of the findings. Despite this, we acknowledge that participant accounts reflected ongoing concerns in current research and policy literature about the nature of maternity services being delivered to women. While 'giving voice' to our women participants resonates and reflects such empirical findings, 'giving voice' is also an end in itself. We were also able to detail the more complex aspects of the birth experience and record the responses from clinical teams alongside evidenced impacts on women participants. Secondly, our population sample was specifically recruited to include women who self-defined their births as traumatic and we note that such accounts may sit in opposition to other women's less negative/more positive birth experiences. However, the accounts of women who experience traumatic births can help us re-set the baseline by ensuring a gold standard of maternal clinical care delivery provided to *all women who give birth*. Thus avoiding resources being allocated to pre-term 'screen and treat' services while medical staff concentrate on the delivery of more human centred medical therapy.

### **Conclusion**

A successful birthing experience brings together both the health and wellbeing of the mother and neonate and moves beyond a medical focus on maternal death and morbidity rates, and rates of live births per 100,000. Successful births include clinical staff welcoming and supporting the mother through the birth experience and into early motherhood. This involves integrating psychological care and psychological aspects of the birth experience in both peri- and post-natal stages. Briefing first time mothers about unexpected medical events, variations in birthing plans and potential trauma could become part of a more

realistic appreciation of childbirth that seeks to avoid idealisation of motherhood and the birth experience. In parallel, we can acknowledge that the clinical team will be psychologically processing the birth event as well whilst perhaps operating under strained working conditions as a result of financial underfunding and psychological underinvestment in staff care. The nature of childbirth is psychologically and medically complex even more so with restricted human and clinical resources and it may be timely to deal more compassionately with both mothers and midwifery staff. Furthermore, rather than implement psychological screening, maternity services should aim for delivering consistent and assured standards of quality care to women, irrespective of mental health status.

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## **Appendix 1**

### **Research Interview Schedule**

#### **Setting the scene, finding out about being pregnant, expectations and experiences.**

- How did you feel when you first found out you were pregnant?
- What was your pregnancy like?
- During pregnancy, what were your thoughts and expectations of labour and parenthood? Where did these come from? NCT, classes, leaflets, books?
- What professionals did you have contact with during this time?
- What did you think of their care?
- What care did you expect to receive from the professionals (for example, midwives and doctors) at this time?
- And during labour?

#### **Understanding the subjective birth experience**

- How did the birth start?
- What was it like during labour? And when your baby arrived?
- Tell me about being on the ward.
- What did you find traumatic?
- Can you tell me what happened?
- What effect did this have on you?
- What scared you the most?
- When did you realise something was wrong?
- What did you do?
- How did you feel?
- Who could you talk to?
- What did you need during this time?

#### **Reflecting on the birth experience**

- How did your experience impact on you and your baby?
- What do you think you needed at this time... and from who?
- How do you feel the care could be improved in the future?
- Is there anything you would do or want done differently?
- What do you think women need most during their stay in hospital?
- What positive feelings did you experience during the birth stage?
- Is there anything else you would like to add?

**Table 1: Participant pseudonyms, ages, ethnicities and details of participants' children**

<b>Name of participant</b>	<b>Age of participant</b>	<b>Ethnicity</b>	<b>Number of children; gender and ages at time of research interview</b>	<b>Age of first child at time of research interview</b>
Sonja Interview 1	38	White British	2; boy aged 6, girl aged 2	6
Mel Interview 2	42	White British	1; girl aged 6	6
Sarah Interview 3	30	White British	2; girl aged 5, boy aged 1	5
Georgia Interview 4	35	White British	2; boy aged 5, girl aged 2	5

**Table 2: Framing the medical experience of participants**

	Sonja	Mel	Sarah	Georgia
<b>Medical issues during pregnancy</b>	Some pregnancy sickness; Group B Streptococcus (GBS) infection; Tested for cystic fibrosis (absent)	Little pregnancy sickness	Pre-eclampsia; Pelvic girdle pain	Pregnancy sickness: Pelvic girdle pain requiring physiotherapy
<b>Medical therapy/interventions during labour</b>	Co-codamol (produced hallucinations); epidural	Membrane sweep; gas and air; Pethidine	Distressing and painful internal examination; gas and air; Pethidine; epidural	Gas and air; episiotomy (no anaesthetic)
<b>Type of delivery</b>	Emergency Caesarean	Emergency Caesarean; discharged herself from hospital but had to return later for post-natal care	Emergency Caesarean	Vacuum assisted vaginal delivery
<b>Medical issues with neonate</b>	Meconium at birth; temperature fluctuations and admitted to neonatal unit	Meconium aspiration in utero	Explored for respiratory problems	Fractured skull diagnosed at two months of age
<b>Post-natal depression</b>	Yes and attended PND Group	Yes and attended PND Group	Yes and under pre-natal care of a psychiatrist and counsellor for depression and PTSD	No

