

**“No control and no way out” – an exploration of birth trauma and its effects**

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## Abstract

Childbirth in Ireland has become a medical process over the course of the last century, in order to lower maternal and infant mortality rates, and great success has been enjoyed in this objective. However, within this era of safety, little consideration has been given to the mental health, inclusive of the emotional processes of the woman giving birth. This research is an Interpretative Phenomenological Analysis of three semi-structured interviews with women who have had a traumatic birth experience. The work seeks to identify patterns in these stories which allow for an understanding of factors which may contribute to birth trauma. The work also seeks to understand the process by which women are impacted, both shortly after the event and in the long term, by a negative birth experience. It seeks to understand the extent to which this can be classified within conventional trauma understandings. The work presumes a psychodynamic psychotherapeutic context to birth trauma, as well as to understanding the processes personal to a victim of the phenomenon. In this context, work on anxiety and trauma by psychodynamic psychotherapists provides a foundation for understanding the systems at play. In addition, a look at studies which deal with women who have experienced birth trauma allows for this research to incorporate with the current work in existence within the space. This research concludes that there are factors which determine a birth experience as traumatic. Further, there exist means for women to overcome this experience with relatively benign after-effect. However, this after-effect, though not immediately as impactful as Post Traumatic Stress Disorder (PTSD), does create a feeling of loss within a woman. Thus, there is a conclusion that birth trauma and PTSD, though closely linked in symptomology, often do not share common successful treatments and are not, therefore, as enmeshed as they are currently perceived to be. This research concludes that further exploration of the area of birth trauma, its processing and its treatments, would be welcomed.

## Chapter One – Introduction

Birth trauma is a somewhat hidden subset of a number of birth-related psychological conditions. Defining a birth trauma requires a boundary which separates women whose experience of labour is difficult but is integrated into her motherhood easily, from those women whose difficult birth experience has an impact on them that supersedes any hormonal fluctuation which may be considered likely for all women in a post natal period. There are a number of factors which influence whether or not a birth is likely to be traumatic. Current figures (Economic and Social Research Institute, 2012) say 99.3% of births in Ireland are within a hospital setting. Women enter into the hospital system with the presumption that their needs will be met, their bodies will be respected and their children will be delivered of them safely, securely and in as stress-free a manner as possible. That birth trauma is present in our society is counter-intuitive, given that birth has become a medical experience in order to make it a safer process. Birth trauma, as a phenomenon, holds many characteristics common with Post Traumatic Stress Disorder (PTSD). PTSD is an ailment that used to fall into the category of 'anxiety disorder' but has, since the most recent publication of *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) become classified as a 'trauma- or stress-related disorder'. It is more commonly associated with soldiers, anyone involved in a warfare or terrorist situation, or those who have experienced or witnessed violent attack. The DSM-5 lays out specific criteria for the diagnosis of PTSD. These include that the person was exposed to or threatened with death, serious injury or sexual violence, and subsequent to this, they persistently re-experience the event in memory, nightmare, flashback or negate it via a disassociated state. Furthermore, they will avoid certain thoughts or external reminders, will experience blame (of self or others) as a consequence of the event and will display certain behaviours which highlight their condition. Finally, DSM-5 criteria require that they experience these symptoms for more than one month and that they cause social or occupational disturbance to the sufferer. These symptoms are mostly consistent with those being reported by women who identify themselves, or are diagnosed as having experienced birth trauma. Consequently, much of the documented evidence on birth trauma operates within a framework of PTSD. However, there are some factors which are significant for birth trauma victims, which work to create a niche for the ailment outside of PTSD and other trauma disorders. First of all, the period after a labour is an intense one, with a number of hormones coming to the fore to bring the woman's body into her new motherhood. Secondly, the physical recovery from a labour can be equally intense, with muscles, tissues and organs all reeling from the impact of the birth experience. Finally, the emotional upheaval of going from the pregnant state into motherhood, even for women who are not first time mothers, generates a cycle of responsibility, bonding and protective

vulnerability that can overwhelm. Coupling this with a likely lack of sleep and responsibility for an utterly dependent new life, working with a woman who has encountered birth trauma requires not only a knowledge of PTSD but also a knowledge of the specific constraints and challenges of the labour experience and the post natal period.

This research is a piece of work around a woman's entitlement, not only to a healthy and safe delivery, but also to have her voice heard, her body respected and her emotional wellbeing being held as a factor in the overall 'success' of the experience. The negation of impact because a healthy child results from the experience can be seen to cause, in some women, an undermining within themselves that has consequences that they were not expecting from their birth experience. It is within this space that this research seeks to identify birth trauma.

Theorists who have worked within the space of trauma, birth or otherwise, tend to veer towards psychotherapy's more empathetic and compassionate side. Freud's (1900) hypothesis that birth and anxiety went hand in hand and Fairburn's idea (Gomez, 1997) of the 'shockingly intolerable' early abandonment mean that it is the traumatised child that remains the focus for much of the theory on the topic of birth trauma. However, it is Rogers' (1967) acknowledgement of and reflection on a person's experience, as well as the healing power of Gestalt (Hatcher, Himmelstein & Aronson, 1976) in the work of trauma that form the toolbox for a psychodynamic psychotherapist who is working with women who have experienced birth trauma. Further, there exists a variety of voluntary organisations such as AIMS (the Association for Improvements to the Maternity Services – Ireland), Nurture, The Birth Trauma Association or Solace for Mothers. These bodies work with women after a traumatic birth experience, in both psychotherapeutic and other manners.

Klein's work with infants explains a great deal in terms of the child's perspective on the trauma of birth and the subsequent projection of this trauma onto the primary identification object (mother). Symington (1986) writes of her theory that 'Klein thought that the early ego was called into existence at birth in order to deal with anxiety and that this was its prime role. This early ego is rudimentary and lacks coherence, its strength or weakness due to a constitutional factor, i.e. something inherited' (p. 264). This serves to emphasise the vital nature of early bonding for a baby. If the child is immediately traumatised by the impact of the birthing experience, it needs a stable figure to maintain order for it within the perceived chaos of the world outside the womb. Bowlby contributed hugely to this field of thought. His theory around separation anxiety and its significance for a child holds a tenet that it (as cited in van der Horst, 2011) 'may mirror birth trauma and is the counterpart to the craving of the infant in the "return-to-the-womb" theory' (p. 177). From this we can see the vital importance of a mother's capabilities in the realm of providing comfort to her baby

within the chaos of the new world. However, what are the implications if the woman herself is traumatised and unable, at that point, to provide what the child needs? At what point does the woman's ability to care become hindered by her own experience?

The hypothesis within this research on birth trauma is that no woman expects her labour to be anything other than a natural and life-enhancing, though intense experience. There are certain situations within childbirth when something goes wrong and the life of the mother, the child, or both are endangered. However, there is a further set of women whose lives, and those of their babies, were not endangered. These women's labours went into a space which they did not expect and did this so so dramatically that they left the encounter shocked and traumatised. It seems that there is a section of birthing women in Ireland who are not only not getting the births that they envisaged, but are encountering experiences that leave them walking away from maternity care with a baby and a negative after-effect. This is the trauma which is entering the delivery room and mothers are dealing with frequently. This study aims to look at how this trauma occurs as well as the effects of this trauma on mothers. It aims to look at the birth experience's influence on a woman's relationship with herself, both in the moment and after the event. How does a woman feel about her physicality, her emotional state, her cognitive being, when each has suffered an upheaval of the most primal nature?

#### **Aims and objectives:**

This research aims to gain some understanding of the trauma that some mothers feel after childbirth. This understanding would be primarily psychotherapeutic, but would also allow it to have a manifestation within general society's understanding of the care of women before and after giving birth.

The specific objective of the work is to identify patterns within a small number of birth stories, which establish the birth experience within a traumatic spectrum, and to highlight the specifics of the experience or experiences which led to the birth being a traumatic event. Further, an exploration should unfold around the manifestation of traumatic symptoms as well as their impact on each woman.

## Chapter Two – Literature Review

This chapter will look at literature that is currently relevant to the issue of birth trauma. Taking the issue from a psychoanalytic point of view, we can see that birth can be deemed to be innately traumatic but this view is taken from the point of view of the infant, and little onus is placed on the experience of the mother within the birthing process. Looking at how childbirth is approached in Ireland, the focus is primarily on the medical model that is currently in place. This allows for little emphasis to be placed on the woman's overall experience within the process. There is an impact on a woman's psyche from a difficult childbirth experience. Indeed, it can be viewed as deeply impactful on a woman's sense of self, particularly in the initial period after the birth. Though it can be difficult to frame the impact of a birth trauma within the context of a time in a woman's life where she is experiencing massive change already (in terms of having a new child), there are several studies which are relevant to this piece which add greatly to overall understanding. Finally, it seems relevant to look at factors which influence a birth experience in terms of level of trauma as well as attempting to get a full understanding of how a woman is impacted by a traumatic experience of this nature.

Birth, as an experience from a psychotherapeutic point of view, is innately traumatic for the baby. The baby, ejected dramatically into the world, has what Freud (as cited in Heller, 2005) calls 'the first experience of anxiety'. Bion (Grotstein, 2007) acknowledged that the baby, born into trauma, had feelings of chaos and confusion which marked the earliest human experience for every individual. In this state, it is primarily the mother's responsibility to ensure that the baby is attached enough to control, organise and manage these feelings of anxiety, chaos and confusion. The earliest experience can mark a child (and, later, their therapist's) work with matters for analysis in order to allow for relational coherence to manifest within a person.

Klein's (1975) work with children and infants furthered understanding and acceptance of the trauma of the infant. She allowed that the experience of birth and the subsequent response to this from both mother and infant was the beginning of the paranoid-schizoid state and the positive or negative processing of same. Within all of these spaces and theories, the mother's role is one of comforter. It is she who is responsible for making the baby's transition into the world as comfortable, secure and easy as possible. Though later thinking allows that any primary care giver can fulfil this role (Bowlby's widely accepted writings (Gomez, 1997) on attachment theory allow that any person, male or female, related or unrelated to the baby, can fulfil the role of primary care giver), it conventionally falls to the mother to make this transition into the world as seamless as possible for the newborn. Further, the flood of nurturing and loving hormones caused by the

release of a substantial quantity of oxytocin and adrenaline at the birthing process allows this piece to be fulfilled organically.

However, within this framework, there is little room for the psychological process of the new mother. Even a woman giving birth for the second, third or fourth time becomes a mother anew with each birth and the experience each time, no matter how frequent, is undeniably significant for a woman. And so, where does understanding for the woman come within the experience of birth trauma? Is the acceptance of labour as an ordeal and the associated physical recovery time a sufficient concession to the impact of a birth experience on a woman? When, more to the point, does a birth become a traumatic event for a woman, even outside of significant health or wellbeing concerns for either her or the baby? Montrelay, operating under Lacanian psychoanalysis, offers a piece around the loss of pregnancy (at the moment of fulfilling its potential at childbirth, as distinct from a pregnancy that is lost without a childbirth experience) for the woman, and how the process of giving birth opens a woman to (Schneiderman, 1993) 'a limitless pain, falling, panic, a black hole. An unheard-of tearing of being. A rapture of anguish, dizziness, states of being in flux' (p. 86). The joy of meeting their child, she hypothesizes, is accompanied by what must be an inevitable loss of a valuable and valued state of being. The unconscious, which she imagines was 'sleeping' for the duration of the woman's pregnancy, is now, once again, open for business and she must leave the state of joyous limbo that holding another life inside her body allowed her. The trauma that is innate in this piece manifests in different manners with different experiences and is, thus, largely overlooked within the maelstrom of the birthing experience. True to this experience is that of a client of Lemoine-Luccioni, a Paris-based psychoanalyst (Schneiderman, 1993), whom she referred to as 'Ann-Marie' and who, whilst pregnant during her analysis, dreamt and spoke of experiencing her upcoming birth as a 'hemorrhage' (sic). She worried about the emptying that would occur with childbirth as well as the void that would subsequently follow. She, at one point during their sessions, refers to the 'tidal wave of blood' that childbirth will be. The loss of blood as a state of trauma is linked not only within psychoanalytic thought but much more widely within medical fields and, most pertinently, within the collective unconscious view of medical emergency as a trauma. Thus, for women who have not encountered much in the realm of medical intervention within their daily lives, the idea of childbirth can morph into a traumatic event in imagination long before it is so in their experience. However, if this is so, then which are the factors that determine whether a woman will process her experience as a natural and necessary one, or will veer into tokophobia (the fear of labour)?

The idea that the process of childbirth would be difficult for a woman, or that the after-effect, when a healthy child is alive in the world, would be anything other than positive, is difficult for both new mothers and their wider social sphere to comprehend. Within a medical model, the focus is retained on the physical health of mother and baby. Choice within the decision-making process, respect for the woman's desires and the maintenance of her dignity are not factors in a medical model's process and yet this is something that is not apparent to women before they give birth for the first time. Ireland's maternity healthcare system offered the world a somewhat revolutionary system of infant delivery with the Active Management of Labour system in 1968, which was implemented nationwide and worldwide in the 1980s. Its founders and proponents, O'Driscoll, Meagher and Boylan, all Dublin-based obstetricians, redefined labour (1980) in terms of the 'number of hours a woman spends in the delivery room, from the time of admission until the time the baby is born' (p. 8). Prior to this, a woman's labour was more loosely defined, based on her and the baby's comfort and the hospital's discretion. The AML system gave structure to what had previously been a much more organic process and allowed midwives, obstetricians and all other hospital personnel to operate from the same handbook. Other cultures and countries who do not adhere to this system find other difficulties come into play for the women in labour. The Iranian experience, as exemplified in a recent study by Taghizadeh et al (2014) highlights a system whereby women labour almost entirely alone, with only other labouring women for company and intermittent care from a midwifery team. The psychological difficulties experienced by women within this study were found to be varied, and the proliferation of these difficulties was found in up to 46.5% of live births. Two Australian studies (Creedy et al, 2000 and Alcorn et al, 2010) found that between 33% and 45.5% of women were reporting the experience of a traumatic birth. Within the former of these studies, 5.6% of women reached the criteria within the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM – IV - TR*; American Psychiatric Association, 2000) for acute Post Traumatic Stress Disorder. Notably, it was also found within this study that the women who developed symptoms of trauma were those who experienced the most significant medical interventions in their labour experience and who reported the most dissatisfaction with their care throughout the experience. In the U.S. (Soet et al, 2003), a narrower study of 103 women found that 32% of the sample reported a perception of their birth experience as a traumatic event. Of these women, though only 1.9% developed all of the symptoms of PTSD, the other 30.1% were partially symptomatic. Alcorn et al's (2010) study was more concerned with the predicting factors associated with PTSD in post-partum women and found that approximately 33% of women who did experience trauma as a result of their birth experience had previous contributing factors which may have affected this internal process (for example, previous anxiety or depression, or a previous

exposure to trauma). Though the statistics and diagnoses for more general post-natal trauma are varied, it seems widely accepted that up to 2% of birthing women, within the western medical sphere, will be diagnosed with PTSD. A study by Lapp et al (2010) concerned itself with how women who presented with the disorder following child birth were treated. As this study notes, 'PTSD after childbirth is thought to consist mostly of the same symptoms as PTSD after other kinds of traumatic events, which may include feelings of helplessness, extreme panic, dissociation and lack or loss of control during the delivery process' (p. 114). This 'loss of control', though counter-intuitive when broadly considering the concept of childbirth (being a controlled experience is not within the realm of most women's imaginings before the event), is a piece that recurs within studies of post-natal PTSD. Olde et al (2006) cite this loss of control as being a mitigating factor within the development of the disorder post childbirth, though they gave equal credence to factors such as partner support, staff-mother contact and the routine procedures of the hospital. Likewise, the issue of control recurred within Joseph and Baliham's study (2004), which looked at what could be done to help diagnose PTSD within women following labour, and how they could be best treated post diagnosis. This piece around control is more pertinent in post-natal PTSD than it might be in other forms of the disorder, as the event is one which a woman may choose to enter into again. Thus, her control over her symptom, and her response to the event, can have wide-reaching after-effects in terms of her sexual behaviour and desire to further procreate, as well as her response to the baby, in terms of both initial attachment and her parenting style. Most women, when they imagine trauma, are less likely to willingly enter into the 'danger zone' of reoccurrence than a woman who wishes to expand her family. Ford & Ayers (2011), as part of their study, looked at the influence of support from healthcare professionals within the labour experience as well as after the event, in the severity and duration of post-traumatic stress symptoms. They found that there was a correlation between the level of support received and a woman's ability to recover from the experience, but only when the woman had a prior experience of trauma. When this event was a woman's first experience of trauma, the impact of support on her recovery process was negligible. This remained true at both three weeks and three months after the birth. Thus, they concluded that personal control during the birth experience (as well as the woman's perception of this) was more important in the prevention of post-traumatic stress for women with no prior trauma experience. However, for women with prior trauma experience, the key component in the avoidance of post-traumatic stress symptoms was support from the healthcare professional. Thus, the idea that a woman is more likely to need additional support during birth subsequent to a previously traumatic birth experience ties in with thinking around the recovery from any level of post-traumatic stress experience.

From a psychotherapeutic point of view, trauma, which in the wider medical community is considered to be an event which causes structural damage to the body, can be viewed as similar. Structural damage to the psyche, irrevocable change or, as defined by Rycroft (1968) 'any totally unexpected experience which the subject is unable to assimilate' (p. 187) allows that a person who suffers such an unanticipated event will be left altered, in a manner more negative than positive, from having undergone this experience. The two pieces that thus define 'trauma', from the viewpoint of a person's mental well-being, are that the event in question was unexpected and that their capacity to recover from it is limited. In the case of childbirth, both of these pieces are immediately called into question. The experience of labour, and even potential complications, is expected, imagined and prepared for at great length by the majority of pregnant women but precisely how this will unfold can only be known at the time of labour. Secondly, a woman's capacity to recover from a labour, whether it is traumatic or not, is limited significantly by the new baby whom she is now largely responsible for the care of. The body's response to childbirth and its subsequent bleeding, milk production, hormonal fluctuation and internal cramping are manifestations of the magnitude of the change that has just occurred within the woman's body and in her life. Thus, there is a certain context to looking at the after-effects of birth trauma on a woman. Her psychological process within the integration of this piece is coloured not only by her physical and hormonal state, but also by the new life that has been thrust into hers, allowing Lacan's imagined newly-reawakened unconscious precious little time, energy or capacity. The processing of a traumatic birth experience for a woman is, as previously mentioned, hugely coloured by the way she adapts to life with her new baby. Factors such as time, energy, sleep deprivation and the challenge of caring for an utterly dependent new life are influential factors in the woman's ability to process her traumatic experience. Ayers (2007) looked at how women processed their traumatic birth experience as it occurred, as well as how they dealt with it afterwards. She found that women, in the retrospective appraisal of their birth experience, adopted a widely fatalistic view (thus reiterating the lack of control as a factor in the development of an experience as traumatic). They also focused on the inevitability of the experience as well as their lack of personal choice. Many of the women interviewed also focused on 'getting on with it' as a coping mechanism. Nearly all of the women in the study found it difficult to recall certain elements of their labour experience and nearly all women spoke of their choice to repress memories when they did reoccur. Finally, a piece of this study that ties in with previous studies/theories on the ability of a woman to imagine entering into childbearing again, was that in which the author found that women discussed the parity (or rank) of their birth, particularly if it was a first birth, as being a significant factor in the traumatic elements of it. One woman within the study said: 'They say your first tends to be the worst'. Stamrood et

al's study (2011) found that, contrary to this, 'no associations were observed between parity and PTSD, especially after other variables had been taken into account, such as mode of delivery' (p. 89).

The issue of personal control over the labour experience is recurrent in the research that is currently available on the issue of birth trauma. One piece which directly addresses this is Christiaens et al (2010) wherein the study took a cross-cultural look at how Belgian and Dutch women cope with labour pain. The factor which they particularly address was whether or not they had personal control of pain relief during labour. They specified this as 'women's active role in the decision to have or refrain from having pain relief during labour' (p.2). In line with their hypothesis, they found that the use of pain medication within labour, and the perception of labour as painful, was lowest when women experienced a high personal control over the use of analgesia. Thus, the experience of pain within labour as a subjective and personal experience comes to the fore. The choice over something such as analgesia means that a woman can determine her own pain level as well as controlling her response to it. This piece seems highly significant, particularly within the Irish context, as the Active Management of Labour systems is one which does not allow a woman's personal control to be an influencing factor over analgesia or her rate of progression within the labouring process. Her 'progression' is determined by physiological factors (the rate of widening of her cervix being the most commonly used) and thus, her pain management is secondary to her labour's time limit. This then means that control over labour pain becomes a non-subjective experience for the woman, instead being a by-product of the necessity for her to continue to move towards her labour's conclusion, rather than a factor in determining how her labour is progressing and, most crucially, how she is faring within the experience.

The impact of birth trauma can affect a woman's sense of herself. How does she now feel about her body, her capacity for pain, her ability to be in control, her relationship with her partner, her relationship with health care professionals? One study, which narrowed the birth trauma to that of severe perineal trauma (a woman's perineum is the stretch of tissue between her vagina and her anus and is the area routinely torn or cut during childbirth as part of the labour process) is that of Priddis et al (2014) who looked specifically at how women sought to make meaning of this physical trauma for themselves. The study 'explores the disconnect between the expectations and reality of the birth experience and immediate postpartum period for women, and how this reality impacts on their ability to mother their baby and the sexual relationship with their partner' (p.7). Women reported anxiety about their bodies following the physical trauma, which often led to faecal and urinary incontinence. This, in turn, impacted most of the women in terms of their sexual relationships, with the majority (more than half of the 12 women interviewed) speaking of a lack of

desire for a sexual relationship owing to a fear of the physical pain involved. For the majority of women, the experience of processing both the reconciliation of ideal versus reality and the acceptance of their new 'normal' body was epitomised by resignation. Finally, the women who emerged with the most positive feelings around their bodies and their relationships were those that were 'able to access a supportive group, meeting women with similar experiences' which, it seems, allowed women a 'way to comprehend' (p. 13). Though this piece was mired in the physicality of the experience of childbirth trauma, the physicality of the experience has to be at least part of every trauma, as the experience itself is mainly physical in nature. The labour experience holds certain characteristics that are specific only to it, which leads to the hypothesis that there could be an effective method of dealing with the phenomenon. One study which looked at precisely this, by Gamble et al (2005), found that of women who experienced a difficult birth, a midwife-led counselling session within 72 hours of the experience, accompanied by a telephone-based follow-up four to six weeks post-partum allowed a marked improvement in rates of recovery from trauma, compared to a control group who were offered no such support. Interestingly, the support offered 'did not require sophisticated psychotherapeutic skills' (p. 13), though the midwives who offered the service did receive close supervision and were trained in a counselling approach. Also relevant is that this level of intervention is inconsistent with best practice in the treatment of wider PTSD symptoms. In fact, Mayou et al (2000) conducted a study on debriefing interventions for car crash survivors and found that contrary to the findings above, survivors were equally or more likely to develop and sustain PTSD symptoms in the three-year period after the event, should they receive debriefing therapy 2 – 10 days after the event. Therefore, there is a hypothesis that there is something within specific birth-related trauma which causes it to differ from PTSD, even though the two share many characteristics. One potential differentiating factor is that of the woman's desire to talk about her experience, particularly with the healthcare professionals who were involved in her care during the experience. This is highlighted by Cooke and Stacy (2003), who found that 90% of first time mothers and 79% of multiparas (women who were having a child subsequent to their first) expressed a strong interest in speaking with their midwife about their experience. This point highlights the difficulty that some women can feel in processing their experience, in that this is an option rarely available to a woman after labour. Significantly, Creedy (2000) found that women experienced the emotional level of care provided by the staff present at their birth to be low and 'unsatisfactory' (p. 106). Likewise, Singh (2001) reported that 25% of women surveyed did not feel they received any emotional support during their birthing process. It is this piece, the 'emotional support' (p. 24) that is most significantly absent within the medical approach to childbirth and this neglect during what is a hugely emotive experience can be expected to have consequences.

Recovery from trauma is a complicated process. Women who experience birth trauma are unlikely to walk away from the experience unscathed. However, there are factors which can heavily influence the impact that the trauma will likely have on a majority of women, which could, therefore, influence the recovery treatments offered.

The idea of mental preparation for labour is widespread in Ireland. Ante-natal classes are provided by all the maternity hospitals in Ireland and routinely attended by expectant parents, particularly nulliparous (or first time) ones. UK figures from a survey of 1400 expectant mothers (Royal College of Midwives, 2001) show that there is a disparity amongst social groups, with only 52% of lower-income families attending ante-natal classes, compared with 91% of families on an income of over £40,000 (approx. €50,000). Birth preparation, though done by the majority, is also, thus, a socio-economic issue. Another study by Miquelutti et al (2013) looked at how ante-natal education prepared a woman, in reality, for the experience of labour. Findings were positive and the women (all from lower income families, based in Brazil) who participated in the Birth Preparation Programme, overall, experienced more self-control during labour and 'used non-pharmacological techniques to control pain and facilitate labour and expressed satisfaction with the birthing experience' (p. 1). However, looking again at the Priddis et al study (2014) and the effect of a negative experience on a woman who has done preparation for her labour, we can see that there is a disparity for women between what they expect, at times, and what they receive. In this study, Priddis says: 'The women in this study described feeling surprised and upset when the reality of childbirth and the post-natal period did not match their expectations' (p. 16). Therefore, there is a hypothesis to be ascertained that, though birth preparation seems well advised and likely forms a better psychological place for a woman to begin her childbirth process than an uneducated space, there is an element within the expectation process which may give women a false sense of what the labour ward and the process of childbirth will actually encompass, physically and psychologically. This is discussed by Reiger and Dempsey (2006) in their essay on the social and cultural issues at play within childbirth. Their point that 'in sexual behaviour, which of course includes birth and breastfeeding then, the locus of subjectivity cannot remain in the head, although this is its usual location in western culture. It appears that many women in late modern societies increasingly find this displacement difficult to attain and some struggle to integrate mind/ body processes' (p. 365). This is a vital point when it comes to the issue of the birth preparation process. Women prepare their minds and intellects as best they can for what is a physical process. Rarely is there a physical element to ante-natal classes and even the most physically influential of birth preparation programmes (hypno-birthing or pre-natal yoga, for example) seek to improve a process that is already in place for a woman, rather than work to have her take ownership of the physical aspects of

the upcoming process. Likewise, though classes intellectualise the physical concepts of childbirth, they do not deal with the psychological impacts which are inevitable. Women often have no experience of dealing with an absolute lack of control over bodily function, and though often encouraged to 'let go' or, as Reiger & Dempsey put it, 'let your inner monkey do it' (p. 370). Equally, they note that, within this piece, childbirth becomes a process of 'actively surrendering' (p. 371). For a woman whose intellect, emotion, opinion and psychological well-being have been at play at all times in her adult life, the idea of this level of surrender to her physical side can be a very difficult one. A very basic look at how a woman feels about her physicality post childbirth should surely highlight, then, that this very primal, entirely physical process gives a woman something that no other life experience can. Most women in western society do not live primarily through their physicality. Moraitou et al in their study (2011) which aimed to look at a woman's experience of positive emotions in the post-natal period, with a specific onus on post-natal depression, found that an overwhelming majority of the women they interviewed reported positive feelings after childbirth. The feelings most acutely felt by women were joyfulness, pride and interest. Though joyfulness is easily associated with a new offspring, as are pride and interest, the fact that the women surveyed were only one week post-delivery allows room for the hypothesis that some of the pride in question was personally centred. Women, even those who along the line went on to experience post-natal depression, can allow pride to manifest only a week after giving birth. Interestingly, the authors also found a correlation between the education level of the women and the variety of positive emotions which they experienced. From this, we can see that a woman's ability to process her traumatic birth experience is quite a subjective experience and has a number of mitigating factors. Moreover, there are extensive political, social, cultural and personal factors which will influence how a woman ultimately feels about herself after a traumatic birth experience. Though it is true that not everything that she takes from the experience will be negative, it is this aspect of change, outside of change to lifestyle and circumstance that will naturally occur with the birth of a baby, which holds the greatest impact for a woman.

Within this review of the literature, there has been consideration given to several modalities of thought in terms of framing birth trauma for a woman. Most crucially, the impact of this type of an experience on a woman, far from being enmeshed within the chaos of having a new baby, can be seen as a distinct process and one that may require support, care and work for the new mother.

## **Chapter 3 - Methodology**

### **3.1 - Research Design**

#### **3.1.1 - Semi-structured Interview**

Semi-structured qualitative interviews were chosen as the primary tool for this research study as they were deemed most likely to give a full understanding of the nuance and intricacies of the subject matter. The reason for choosing a qualitative study was that it was felt to be the most accurate means of understanding the fullness of the subject matter, with a strong hold on the psychodynamic psychotherapeutic phenomena at play. A desire to describe, analyse in terms of patterns or themes and then to interpret the issue of the processing of birth trauma in relation to its wider significance for women and for the offerings of psychotherapy (McLeod, 2001) motivated this decision. Doing an in-depth interview offered the greatest likelihood for the subjects involved to give a full and frank account of their experience, in a manner which would then feed or quash the hypothesis that the research question was founded on. As Darlington and Scott (2002) say, 'the in-depth interview takes seriously the notion that people are experts on their own experience and so best able to report how they experienced a particular event or phenomenon' (p. 48). The subjectivity of the idea of trauma was given much consideration when deciding on the tools for the research. Overcoming this element of personal input into the understanding of the experience necessitated a rapport with the interviewer and an ownership of her process for each woman involved. Semi-structured interviews were deemed the most appropriate for reaching the smaller details of an experience which would allow the research to build a theme of understanding from the women's collective account.

### **3.2 - Participants**

#### **3.2.1 - Participant Selection**

The criterion for inclusion within the research was that a woman had had a birth experience which she deemed to be traumatic. The participants were selected via a process of personal referrals, commonly known as snowballing.

### **3.3 - Procedure**

#### **3.3.1 Ethical Considerations**

A research proposal was submitted to the Ethics Committee of the School of Counselling & Psychotherapy at Dublin Business School. Approval was granted and any suggested changes were implemented.

#### **3.3.2 Pilot Interviews**

Two pilot interviews were undertaken prior to the questions for the interviews being finalised. Both of these interviewees answered all questions that were asked of them and also of the questions' impact on them in terms of their process and with consideration for the emotive nature of the subject matter. They also assessed their capacity, within the constraints of these questions, to give a full and frank account of their experience. No changes were suggested by the pilot interviewees and no changes were made to the questions or style of interview following the pilot interviews.

#### **3.3.3 Interview Process**

All interviewees were initially contacted via email to be given a detailed information sheet (Appendix A) on the research. This information sheet gave details on the nature of the research, the educational award being sought by the researcher and the confidentiality terms that pertained to being involved with the research. It was outlined to the interviewees that the interview would take approximately an hour. Following this contact, each interviewee was contacted again to verify that they wished to proceed and arrangements were made to conduct the interview at a time and location of their choosing. Two of the women involved chose to have the interviewer come to her own home. This is also true of the two women who took part in the pilot interviews. One woman chose to have the interview conducted at a private office space within her workplace. At the time of interview, the interviewees were given a full consent form (Appendix B), as well as another copy of the information sheet. After the interview was completed, they were given a copy of a debriefing document (Appendix C), which contained details of the purpose of the study, further details on the confidentiality of their input and contact details for IACP and IAHP, should they have felt that they needed to make contact with a therapist.

The interviewees were informed of how the interviews were to be recorded, which was on two separate recording devices, which were both tested for operational accuracy within each setting. The interviewees were also informed that the interviews would be transcribed in full and the

recordings would be destroyed subsequent to the research being completed. This information was also contained on the debriefing document.

The anonymity of the interviewees was discussed and its paramount importance was stressed. It was verified that the interviewees' correct names, as well as those of their partners and children, would not be used within the research.

Two of the three interviews were a little more than an hour in duration, as time was allowed for breaks when the interviewee requested them. The interviewer also suggested taking a break at certain points in the interview, when it was felt that the subject matter had reached an emotive point for the interviewee. The third interview took just under an hour as the interviewee declined breaks when suggested and did not propose any herself. Owing to the emotive nature of the subject material, the interviewer conducted the interviews with a focus on empathy and sensitivity.

The interviews followed a format of thirteen finalised questions (Appendix D). There was also an allowance for further interjection and clarification questions from the interviewer. The interviewees did not see or receive the finalised question sheet, which was used only by the interviewer.

### **3.3.4 Interpretative Phenomenological Analysis**

The interviews were transcribed verbatim, with the inclusion of pauses, breaks and changes in intonation. The interviewer also made notes immediately after each interview which supplemented the transcripts in terms of counter-transferential phenomena. Interpretative Phenomenological Analysis was used to analyse the content. In line with Smith et al (2009), the research interviews sought to work with 'the close, line-by-line analysis of experiential claims, concerns and understandings of each research participant' (p. 79). Further, the subjectivity and the individuality of each woman's experience within her birth trauma lent itself to the use of IPA in that, as per McLeod (2011), this analysis is 'particularly sensitive in describing and exploring differences in experience across informants' (p. 148).

When the transcriptions were completed, they were analysed individually with emerging codes written into the left hand margin. Once this process had been completed several times on each transcript, themes were written into the right hand margin of each transcript. Following this, the themes were formulated as broad, independent subjects and the codes were again inspected for suitability for inclusion within each theme. A table of themes (Appendix E) was drawn up to ensure that each theme was represented by data within the transcript from each interview. It was also inspected in relation to each individual interview, to ensure that no individual phenomenon from an isolated incident or interview was overlooked or under-represented.

### **3.3.5 Reliability and Validation of data**

In order to counteract the entirely subjective nature of both the subject matter and the process of gathering each woman's narrative in terms of her experience, issues of credibility, transferability, dependability and confirmability were kept in line with the researcher's understanding of the writings of Guba & Lincoln (1981). Credibility, from this point of view, allows that the interviewee has a full belief in the truth of her own narrative. Transferability allows that the researcher can broaden the results of each interview to include other contexts. Dependability allows that the researcher remains open to the organic nature of the research and documents any changes that occur in the context of the narrative or the findings. Confirmability allows that the researcher continues a process of verification throughout the research process. Following these guidelines, the research has been conducted in as reliable and valid a manner as is possible.

## Chapter 4 – Analysis

### Demographic information for interviewees

<b>Name:</b>	<b>Age:</b>	<b>Number of Children:</b>	<b>Year of traumatic birth experience</b>	<b>Births since traumatic experience:</b>
<b>Elizabeth</b>	<b>37</b>	<b>2</b>	<b>2011</b>	<b>1</b>
<b>Anna</b>	<b>37</b>	<b>2</b>	<b>2009</b>	<b>1 (<i>also experienced as traumatic</i>)</b>
<b>Rosie</b>	<b>33</b>	<b>1</b>	<b>2012</b>	<b>0</b>

## **Theme 1 – Factors influencing the perception of a birth experience as traumatic:**

The themes of control and disempowerment were prominent within all of the interviews conducted. As a prelude and major contributing factor to the trauma encountered, these two themes characterised the difference between each interviewee's expectations and her experience. Each woman spoke about her inability to have her voice heard, both in overt and covert ways. Elizabeth talked about her realisation that her expectations for labour were not going to be met:

*'It was made very clear to me that this was not going to be the way that it was going to work'. Elizabeth.*

Even after labour was over, Rosie, whose child was separated from her and placed in intensive care, experienced her voice as being unheard, and her emotional state being ignored by the people around her. She became emotional as she described:

*'They just put me in this room on my own, when I'd just had a baby. And I'd like, no baby. So I was . . . they came in and they were like, "are you not going to sleep? You must be exhausted". And I was kind of like, well, "no"'. Rosie.*

Further, there was a significant difference between this sense of disempowerment and how women tend to view themselves and their bodies. Anna said:

*'Your body suddenly becomes this piece of meat. Like a carcass. And you're just lying there experiencing it like, oh sweet fuck'. Anna.*

Likewise, two of the women interviewed expressed a very similar sentiment, in terms of the disparity between how they perceive they are in the world and how their views were adhered to within their birth experience.

*'I've done loads of different jobs... And I can do all that stuff... I've done everything I wanted to do... (but) you can't achieve with your new baby... your baby decides your birth plan'. Anna.*

and

*'I kept trying to make my point, but I couldn't.... I couldn't get my point across and this would be quite unusual for me.... I've been successful in my career, you know? I'm a strong confident woman at times... But I couldn't understand just how I couldn't make myself understood'. Elizabeth.*

In addition to not being listened to by those around them, each woman experienced a lack of control within their labour experience that brought them great distress. Anna's panic, fear and distress at even the memory of her point of least control within the experience are evidenced by:

*'I had no control and no way out and I was completely trapped in this experience like I ... that, for me... the birth, that, for me, was really frightening... that I couldn't get out of this. I couldn't back out. There was no going home. You fucking end this and this is going to keep*

*going until this baby comes out and there's nothing you can do about it and there's this higher energy that's taken your body over and you have to suck it up and go along with it and you just have to go along with it. And I didn't want to. I didn't want to. I didn't want to do it.... That panic of, oh, I can't get out of this. I'm stuck. I'm stuck. You know? That was the hardest bit for me'. Anna.*

This piece, which was the point at which Anna can identify herself as traumatised, was a highly emotive recount for her. When Anna had recounted this, there was a pause in the interview, and this was also how Anna was impacted by the trauma: after the raw fact of it hit home with her, her life paused.

Rosie talked about a 'threat' which she experienced within the room, which made the entire experience 'different', she perceived, from that which she understood labour to be. Though she chose to leave the detail of this threat unnamed, and could not be pressed upon it, her desire to repress the memory of the event allows weight to the magnitude of the danger she felt she was in. The chronology of events and the experience of time were distorted for all the women interviewed. Each imagined time as being slower or faster than it actually was. For each woman, this gave them a sense of feeling distorted in their reality and out of control, in terms of their capacity to rationalise what was happening to them. Each felt a sense of not knowing and therefore not being able to influence what was coming.

Further, there was also a recurring sense of the women experiencing a lack of support from those around them within their labours. This was particularly manifest in relation to the medical staff present. Rosie talked about the staff's treatment of her, even after her labour was over, whilst she was felt vulnerable:

*'You're taking her away when I'm asleep to put her on the antibiotics and then keeping her because you think that you're being, like, nice to me, is not actually being that, like, nice to me. Like, just bring her back'. Rosie.*

Within the labour experience, the reaction of staff to each woman's difficulty seriously marked the impact of the trauma on each woman. Elizabeth was beginning to feel more isolated and had this compounded for her, which meant that the experience heightened in terms of the difficulty it held for her.

*'She (a midwife) got very angry with me. I felt like she was nearly going to slap me, basically telling me that I was panicking and to cop on and calm down. And I felt like, well, f off'. Elizabeth.*

Further, Elizabeth experienced relational distance from her husband at a time when her vulnerability was heightened:

*'I thought I was going to puke and I remember just as I was in the middle of another contraction saying, 'Just keep away from me. Oh my God, you've been smoking. That's so disgusting'. And he got annoyed, cos he was so embarrassed'. Elizabeth.*

These factors which influenced the transition of each woman's labour experience into a traumatic event seem subtle. The nuance of treatment and how treatment is perceived can be a gentle matter. However, within this realm, the repetition of these factors and the gravity of their impact give them more weight than anecdotal evidence of their power would suggest.

## Theme 2 – Processing the experience:

Examining the level to which each of the women's experiences fit the criteria for Post Traumatic Stress Disorder depends on each woman's processing of her experience. The interviewer found that whilst all the women, to varying degrees, fit the DSM-5 criteria, it was their response which heightened the level of impact on them. Further, the timeframe of one month's duration which the DSM-5 demands for a full PTSD diagnosis causes difficulty, in that each woman was dealing with life as a new mother and the demands of her new baby, which have come entirely to the fore. For example, Anna talks about:

*'Shock kind of kicked in a little bit. And I found myself reliving the birth as I tried to get to sleep... I think being on your own (immediately after labour) is really really really really hard'. Anna.*

And even later:

*'And then after this, I was actually shaking. I'm actually shaking now, thinking about it... I was actually, physically, afterwards, I was so... that scared me as well, being physically so unable and I had a baby to mind'. Anna.*

However, within a month of her birth experience, she had engaged in therapy, had done some work with a family member around reliving the experience as she would have wanted it to be, and her focus had moved to her issues with breastfeeding and sleep deprivation. Of the experience of therapy at this point, she says:

*'That was really good, and actually, made me realise that I wasn't crazy. And I wasn't depressed. I was just really fucking tired. And I didn't know that's how it was going to be. At that point, I thought, this is ridiculous, I never knew this'. Anna.*

Likewise, Elizabeth talked about her psychological process in the days and weeks after the birth, and in her recount of this, was openly downplaying the impact of her labour experience on her. Though she says:

*'I lost a huge amount of weight... which was just pure stress'. Elizabeth.*

she counters this with:

*'I spoke very openly... I spoke with my friends about it'. Elizabeth.*

The interviewer experienced Rosie as someone who was processing her experience through repression and denial. She was concordant with this piece and after recounting her birth experience, talked about her husband's perception of the events saying:

*'We just remember it differently. He's just like, it was way worse than that but you don't remember it. He remembers all, how it was like, panic . . . I'm completely fine with that. I definitely think it's like nature's way of like making you want to have another baby'. Rosie.*

The interviewer noted that Rosie moved from first person to second person pronoun when she spoke about her experience. Also, it is worth noting that of the interviewees, Rosie was the only one who had not yet had another child since her traumatic birth experience. Further, she was the only interviewee to be pregnant at the time of doing the interview. Rosie had engaged in some cognitive behavioural therapy subsequent to her birth experience, but not as a consequence of it. She did not discuss her birth experience with this therapist.

The research suggests that, though women can be traumatised and can experience PTSD, their processing of it is so heavily influenced by life after the experience (with a new baby, or working to expand their family) that they can be seen to move more quickly through the experience. Though they are changed by what they have gone through, they do not seem to retain their PTSD symptoms for an extended period. A major factor in their standard of processing seems to be their structure for processing difficulty beforehand. Anna spoke about her previous work with a therapist:

*'... a guy that I would have seen over the years, any time that I'm going through a change, work or partnership or relationship or something'... Anna.*

as well as her level of self-awareness within a process:

*'a lot of depression within my family and I think a lot of it is hormonal'. Anna.*

Likewise, Elizabeth, even at the most difficult point within her experience, talked about

*'I kind of half started to cry... and I remember thinking "well, you can't cry now, cos this is just happening, you just need to get through this"'. Elizabeth.*

This seems in line what the interviewer perceived to be Elizabeth's capacity within difficulty to draw on her internal strengths. She recounted her experience in great detail, remembering facial expressions, odours, the positioning of equipment in the room and a host of other small details that marked a piece about how she is within herself and within most experiences. When asked about whether or not her traumatic birth experience would mark how she felt about future labours, she said:

*'I went into Fiachra (her subsequent child)'s birth saying "I don't want that to happen again" and I was very vocal about how I didn't want that to happen again, but if it had happened again, I would have been able to just leave it at the door'. Elizabeth.*

Elizabeth was also able to exemplify the idea that the adjustment of living with a new baby was deeply merged with each woman's recovery from their birth experience.

*'I definitely feel like I was in a haze and didn't come out of that haze until Aoife was about six or seven months old'. Elizabeth.*

Equally, the experience of needing to enforce their own change within subsequent experiences was recurrent throughout the interviews. Elizabeth experienced this as a need to be more vocal.

*'(My friend) is pregnant at the moment and I said to her "you're not going to be in control of everything but just stand up for yourself and be vocal about what you want".'. Elizabeth.*

For Anna, in her subsequent birth, she opted for a community midwifery programme in a different hospital (she had had her first, difficult experience with a consultant-based programme).

*'I felt like midwives should be the one helping you to give birth, not the consultant. I felt that he swanned in and swanned out. Like he was grand, but the midwives were great...'. Anna.*

This piece is about how each woman recovered from her experience. The recovery is difficult to separate from the process that each woman experienced as a result of becoming a mother and having a new baby to mind. However, what was highlighted most clearly was the influence of each woman's previous style of recovery and attitude towards difficulty on her ability to integrate and process her traumatic experience.

### Theme 3 – Loss of self:

Within each of the interviews conducted, each woman expressed that they felt a sense of loss as a result of her birth experience. There was a loss of the sense of self, of what she knew about herself and her capacity to cope, which was altered after her birth experience. This was signified by a strategy of repressing the impact of the experience in all the women, but most significantly in Rosie, as was discussed in the previous theme. However, each of the women, to a degree, downplayed her experience as having been difficult, even immediately after recounting it, which was, for each interviewee, an emotive experience. Elizabeth talks about:

*'That's my story and it wasn't a great story but it's not... I don't feel like a massive victim'. Elizabeth.*

This recurs with each woman and though they acknowledge the loss, there is a sense that a new mother does not have enough time or space for the recovery process necessary for fully experiencing the loss and disappointment they felt from their labour. As Anna synthesises, the disappointment arises from the expectation that

*... 'we can all have this wonderful experience of childbirth and it doesn't have to be painful, which I think sets women up to be disappointed in the birth that they have, and feel like they haven't lived up to what people... think that you can do'. Anna.*

and again

*'you do not have an idea about childbirth... is going to be like....and it never is that.... We all have the rosy images of the mother and child sleeping together in bed. My ass. I mean, really? ... I just think the reality is very scary'. Anna.*

This sense is further highlighted by each woman's focus on her child's health and well-being in the days and weeks after the birth. Each woman spoke at length about her child's ability to sleep, feed and recover from what each baby had gone through. Interestingly, this response was most striking when each woman was asked about her own process after the birth, as though her process and her baby's progress had become merged. She was no longer herself, with her familiar map of the world at her disposal. Elizabeth hints at being aware that there was a loss when she had to

*'go from (my) own like, totally separate...'. Elizabeth.*

but cannot finish this thought. It opens an existential piece around life, birth and identity that a birth trauma can epitomise. A birth is not just about the baby, but also the birth of a woman as a mother. That this new chapter/experience could be marred by such an intense difficulty exemplifies the loss, not just of pregnancy, in all the gentle comfort of that state, but also of life as a separate, single entity.

However, each woman also experienced a passing feeling where she initially disassociated from her baby, in the moment after the labour was over. Each of the women interviewed took their child onto their chest after the labour was over but none of them recounts this as being a positive experience.

*'They brought her over to me to hold for like ten seconds or something and then they took her away'. Rosie.*

*'They said, "Do you want to look?", and I said, "I don't need to look". Just let him be there. I was so relieved to be the other side of it'. Anna.*

*'I was just thinking, "I'm in so much fucking pain. Take the fucking child away from me."' Elizabeth.*

This disassociation from her baby signifies a moment for the woman where she remained stuck in her own process and frozen by her own trauma, before she could pick up the pieces of her new life as a mother. This re-emergence from trauma occurred in the days after the labour, for each woman. As a further coping mechanism, each woman worked to focus on her conscious being in the days and weeks after the labour. There was a sense that focusing on the emotional content would be too risky for each woman. This loss of capacity to remain within her own emotional realm seemed dominated by fear, particularly with Rosie but also with the other women interviewed. Rosie acknowledges that:

*'I totally see how my conscious brain helps me through loads'. Rosie.*

The repression of fear centres around the removal of each woman from her emotional self, as though relying on anything other than her consciousness was unreliable, unsafe and contained the potential to move into a space which would make it difficult to care for her new child.

Rosie spoke of her fear when threatened with a caesarean section:

*'I was frightened... and then, so I was more frightened for my husband. Cos I know how squeamish he is about needles and blood and operations'. Rosie.*

She also spoke of her fear after the event, in terms of processing the fear that she had felt:

*'I think maybe it (putting her husband's fears ahead of her own) was just my way of not being frightened as well'. Rosie.*

Rosie removes herself from the fear, and from the experience of processing it. She projects her fear onto her husband. She openly acknowledges that this is a manner of disassociating from her own fear. Significantly, Rosie describes her experience of motherhood as one which is marked by a level of personal emotional removal from the experience.

*'I know some friends who were like completely different once they're a mum. And then some people who have this additional aspect of them that is that they are also a mum. And I think I fall into that second group'. Rosie.*

The coping mechanisms used are masking a subtle thought process for each woman. This experience of their birth as a loss is one which does not tie in with their conscious understanding of the experience. However, the 'huge shift' that Elizabeth describes in the days after the birth of her child is what Anna also calls:

*'this awareness... cos you don't know in your heart and soul that it's going to pass and you're going to get better'. Anna.*

These are experiences around what each woman lost in terms of expectation, assumption based on previous ability and knowledge of her own capabilities. Anna frames it in terms of blame:

*'I don't think that the trauma was in any way my fault. I think it's the reality of having babies and I probably wasn't prepared for it'. Anna.*

However, though there is no sense of self-blame within any of the interviewees, there is a sense of something more than disappointment that pervades their understanding of their experience. There could be a suggestion that loss occurs with every birth, not only those that are traumatic. However, there is another idea, within the experience of a traumatic birth, which magnifies this sense of loss into something which then pervades each woman's understanding of herself as a mother. Anna describes:

*'It was awful, because this was the birth of my child. I didn't want this to be such a negative experience'.*

This encapsulates the feeling that the expectation of this crux point in each woman's life not being met and not being fulfilled has become, for each, a sadness which, as a starting point to her new life as a mother, influenced each next step. The scramble she felt she had to do to get to a point of recovery meant that rather than beginning from a point of positivity, or at least neutrality, her new journey required struggle to get to equilibrium.

## **Chapter 5 – Discussion**

### **Introduction**

This chapter links the research done by this study with the work of the theorists discussed in chapter two. Understanding the factors that could bring women into a traumatic birth experience was primary in this research's aims. The understanding gained was always intended to link primarily with psychotherapeutic thought, but is also a social and cultural piece. However, equally important, psychotherapeutically, culturally and from the point of view of this research, was the exploration of the manifestation and impact of the traumatic symptoms. This research ties in with previous work in terms of understanding how birth trauma develops. Further, it fits with the psychotherapeutic traditions' understanding of what, precisely, birth trauma is. However, in processing the experience, this research has found a disjuncture between the symptoms of PTSD and those of birth trauma. Though the two contain significant crossover, there is an aside to birth trauma, in that the period after it is a massively new departure for its victim, which means that it holds a space somewhat apart from other traumatic symptoms. Finally, it is in looking at the most fundamental of texts on anxiety and trauma that this research found the most defined links between what was uncovered by this work and what was already in place in the psychotherapeutic world.

### **Theme 1: factors influencing the perception of the birth experience as traumatic**

Returning to Rycroft's definition (1968) of trauma, as being a 'totally unexpected event which the subject is unable to assimilate' (p. 187), there is evidence in the analysis that each woman has experienced trauma within her birth experience. Whether she works to assimilate it via therapy, the support of family and friends or by repressing the experience, each woman's trauma is manifest and abject. The studies which were examined within the literature review for this work looked at factors such as what Lapp (2010) describes as the 'helplessness, extreme panic, disassociation and lack or loss of control during the delivery process' (p. 114). These factors were present for each of the women interviewed. Each woman experienced her labour and birth as a process in which she was helpless. There were moments of extreme panic in two of the three cases. The lack or losses of control were prevalent throughout all of the interviews. The Ford and Ayers (2010) study allows that control for each woman becomes an experience around pain and around intervention, stating that 'pain and obstetric intervention is potentially . . . frightening for women and may, therefore, result in more feelings of helplessness or horror' (p. 1,560). This is consistent with the findings of the analysis in this research in that each woman, when she experienced a lack of control within the situation, whether by intervention of a medical nature or simply by the nature of the experience overwhelming her, identified her experience as traumatic. Language in the interviews came to play a part in understanding how each woman had identified her experience as traumatic. In terms of speaking about her child and her pregnancy, the women were measured in tone and language. However, when it came to the issue of control within the birth experience, each interviewee used a more volatile language and became more emotive. Thus, the subjectivity of the experience as traumatic is allowed, whilst maintaining integrity in alignment with the work already in place in the field.

In dealing with the issue of control, there is another element which is also relevant. Ayers' (2007) study, which looked at how women process their traumatic birth experience and concluded that a fatalistic viewpoint was often employed, is consistent with the findings of this research. The feeling that this is 'how it is' was a widely recurring theme in the interviews and, though this is enmeshed with the change in focus from mother to infant, which will be discussed in the second theme, there is an element of regaining control in this. The interviewees displayed a sense of allowing what had happened *to* them to be something that was just that. Though they had anticipated their birth experience as being one in which they retained some sense of personal physical autonomy, it being their child's birth and their baby's experience allowed each woman to allow the experience to be as outside of her control to the extent that it was.

However, the residue of anger which is left by an experience of disempowerment, though only a slight adjustment from the issue of control, cannot be disavowed. Each of the women interviewed was left with a feeling of great discontent at their treatment by the hospital staff. Creedy's piece (1999) around emotional support within the birthing experience opens our acknowledgment of the level of support which a woman expects to encounter within her labour. Thus the medicalization of the experience, as per the Active Management of Labour System, means that women encounter a hospital environment when they are anticipating a less clinical, more nurturing environment. Thus, their transition from a woman with emotional, cognitive and physical ability, into simply a physical being is, we see, being experienced as a form of disempowerment. Creedy's acknowledgment that women who 'perceive that they were not consulted or respected' were more likely to ultimately experience 'adverse psychological outcomes' (p. 110). What a woman thinks and feels about her physical experience opens an avenue of thought around the lack of acknowledgement of the vitality of the emotional and cognitive spectrums in relation to the outcome for a woman within the current system operating in a majority of birth experiences.

This ties in well with the Christiaens et al (2010) study around personal control of analgesia and the women's perception of her role in the labour as being either more active or passive. This study reiterated that a woman's perception of labour as painful was lowest when they experienced a high level of personal control over analgesia. The study says 'although pain acceptance is a personal attribute, the effectiveness of pain acceptance in the reduction of pain medication use depends on the care context' (p. 10). Thus, the researchers found that women who felt that their voice was being heard within the context of their pain management were more likely to accept the pain that they were in, over those who felt that they were being 'managed' themselves. In these latter cases, these women succumbed to a lack of control both over the pain and the analgesia. Again, we see that issues of control, disempowerment and personal advocacy affect the perception of a labour experience as successful for a woman, more so than the current system's acknowledgment of it as an auxiliary offering allows. It is Anna's piece around control that is most striking, in this context, from this research. Her assertion that she had 'no control and no way out', her panicked response to this and the representative quality that this piece had for each of the interviewees give the research coherence amongst existing literature.

The issue of support within the birthing experience, which was explored by the analysis of this research, lay in correlation with the studies in the work's literature review. Olde et al (2006) highlighted partner support as holding a correlation with the development of post-natal PTSD. Likewise, Joseph and Baliham (2004) highlighted the importance of partner and familial support in

the event of a birth being experienced as difficult. Looking at the experience of Iranian women again, as per the study by Taghizadeh et al (2014), we can see that an isolating experience (Iranian women tend to labour without a birth partner, in a hospital environment) provides a direct correlation with a perception of that experience as difficult. One woman within that study highlighted this isolation when she said: 'At this moment, you feel helpless. You feel you are not able to face it alone. Neither your knowledge nor your feelings can help you. You feel that you have reached a dead end' (p. 33). It should be recalled that 46.5% of women within this study experienced psychological difficulties as a result of the birth. Thus, having support is key to an ability to contain the emotional and cognitive manifestations of the physical experience, but, more than this, the level of support offered and the perception of this support are equally key. Most particularly, strong healthcare provider support for women with an expectation of difficulty when entering into the birth experience provides the best scenario for women to avoid a traumatic experience. This is held up by Ford and Ayers (2011) when they say 'in these women, support from health-practitioners may protect against the development of PTS symptoms or, conversely, a lack of support may contribute to PTS symptoms' (p. 1,555). This is consistent with the interviews conducted by this research and the perception of Elizabeth that her experience could have been made exponentially less difficult by the provision of more support from the midwife who was working with her throughout her experience. At one point, Elizabeth felt like the midwife in question was 'nearly going to slap me'. Likewise Rosie, whose language around this issue became quite childlike and simplistic, spoke about the midwives thinking 'that you're being . . . nice to me' while she experienced their support as 'not actually being that, like, nice to me'. Thus, through the perceived deterioration of the healthcare support within the situation, each woman found herself entering into a traumatic environment.

The dearth of full research into the influence of partner support on the avoidance of trauma within the birth experience means that there is a difficulty in fully assessing the role of the father (or other birth partner) beyond it being acknowledged (Olde et al, 2006, as well as Joseph and Baliham, 2004) as one of several factors with the potential for development of PTSD. Further, beyond generic 'support', it is difficult to identify the factors which influence the impact of the presence of a partner within a birthing environment. Within this research, two of the women gave a lot of credit to their partners for their role in the birth event, with Anna saying that her husband was an '*amazing birth partner.... Couldn't have been better. He was brilliant*'. Equally, Rosie experienced her husband as both fully supportive of her within her difficulty and as being a projection point for her fear, which allowed her to distance herself from it. Elizabeth did speak of a particular experience with her husband in which she experienced a personal alienation from his support. Interestingly, this was a

point during her experience when she felt most isolated and removed from all support (it was around this time that she felt that the midwife that was working with her was angry with her). She did not, after this particular event, or after the entire event, experience her husband as unsupportive on an ongoing basis. Equally, she never spoke of her husband as being a good source of support for her at any point during her experience.

Within both the positive and the negative experiences of partner support, however, there are no mitigating factors outlined to identify the perception of the other person as particularly supportive, or not. This could be due to this being such a subjective experience. It is also one which is likely to have much weight within the dynamic of the couple, outside of the birthing process.

## **Theme 2: processing the experience**

The idea that PTSD could be a product of the birthing process has great significance and relevance within the context of this study. It is also an area where there is a considerable amount of research and a wide acceptance of the statistic that close to 2% of all labours result in PTSD for the woman. In terms of meeting the criteria for PTSD, even within this study, it is easy to appoint seven of the eight strata of diagnosis (criteria A, B, C, D, E, G and H) on the women involved. However, it is the period after the birth, the DSM's criterion F of 'one month duration' that appears to muddy these lines. Each woman in this research entered into motherhood with efforts to overcome the difficulty of her birth experience and each began to focus on her child's wellbeing after she recovered from the initial shock of the birth experience. This transfer of onus from mother to child means that it becomes increasingly difficult to correctly assess whether the woman's difficulties can be categorized as PTSD. This is because the months following her birth were spent with a focus on the difficulties of her child and her motherhood experience with only subliminal conjecture for the impact of her birthing experience.

Stramrood et al's work (2011) on highlighting the instances of PTSD as a direct consequence of childbirth offers the conclusion that 'posttraumatic stress symptoms were related to obstetric complications and interventions, low sense of coherence, and appraising the delivery and labor (sic) pain as being "worse than expected".' (p. 96). This study maintained its focus within the realm of the birth and labour process and therefore has significance in the diagnosis of PTSD. However, it, like most other studies within the field, does not allow for the complicating factor of new motherhood in the subject's ability to integrate her experience. Like this, the findings of this research must allow for an ambiguity in the determining of PTSD as a consequence of childbirth, as the experience in which each of the participants found themselves newly in, opened for them a set of complications which muddied both their recovery process and their prognosis. Equally, Ford and Ayers (2011) noted that 'Three weeks after birth, one woman (0.8%) fulfilled DSM-IV criteria A-D (traumatic event plus symptoms) for PTSD related to birth, but at this time point the duration criterion could not be met' (p. 1,557). There must be a consensus, then, that there is a great difficulty in differentiating between what is stress, anxiety or trauma as a result of one particular sole experience and these symptoms because of a particular experience compounded by the sleep deprivation and physical discomfort of new motherhood. Indeed, Creedy (1999) accepts that 're-experiencing (or intrusive) symptoms may affect a woman's ability to adapt to the changing demands of motherhood' (p. 108) which, though the inverse of the hypothesis outlined here, actually accentuates it. A woman, knowing that the demands of motherhood are not going to

decrease, might employ any means of repression or denial necessary to avoid re-experiencing or intrusive symptoms. Within this research, Anna summed this up when she said *'consciously, I think I had moved on after a day.... The problems of breastfeeding not working and all of that. And then sometimes the echo still. There was still shock going on after... And there was the whole transition to motherhood. Which... just fucked with my head'*. Whilst each of the women who participated in this research undoubtedly experienced post-traumatic stress symptoms, it must ultimately be acknowledged that, for each of them, by the time one month had passed, they were mired in new difficulties and it had become impossible for them to spend time with the trauma of their birth experience in the face of these new challenges.

Leaving aside the issue of PTSD and looking at the overall process of a woman in recovering from birth trauma, this research found that women were utilising coping mechanisms that were mostly within their existing systems for working with disparity in their lives. The positive influence of therapy on the one participant (Anna) who chose to work with a psychotherapist for this particular issue highlights the role that the field has within this space. Likewise, looking at other studies, the Gamble et al (2005) work explicitly highlighted the influence of specific psychotherapeutic encounters in aiding a woman's recovery from birth trauma. This study highlighted that *'linking emotional responses with perceived causes of distress is one strategy to alleviate self-blame and promote resilience. It also enhances the sense of control and may prevent recurring distress in a subsequent pregnancy'* (p. 15). Interestingly, the study was based around a counselling model in which a number of midwives were trained in, and administered short term therapy. With this piece of work, there is an opening of the hypothesis that rectifying some of the loss of control that women experience as a result of the medicalization of the process of childbirth could be, in itself, a foundation for successful processing of a difficult event. This is reinforced by Cooke and Stacy (2003) who specifically noted that a large majority of women, with all kinds of birth experiences, wished to speak with the midwife who had worked with them, after the event. Thus, the feeling that the emotional side to childbirth is not being acknowledged by the staff that work with women in labour is once again brought to the fore. From this research, we see that all of the women involved worked on processing her experience by utilising what Cooke and Stacy (2003) noted was the desire within the majority of women to talk about their experience.

Equally, within this research, it was repeatedly seen how the women's cognitive or emotional sides were impacted by the reduction of themselves to a purely physical manifestation by the healthcare professionals present. Rosie noted, early in the difficulty of her experience, how the staff were *'letting just anyone have a butcher of me'*. Equally, Anna experienced how *'your body suddenly*

*becomes this piece of meat. Like a carcass*'. None of the women involved in this research was offered post-natal support relating to the emotional aspects of their experience. Anna very distinctly noted, when talking about accessing support after the event, that *'in the actual hospital, there wasn't anybody to ask*'. Each of the women involved in this research left the hospital with negative or neutral attitudes towards the staff that cared for them. Each of them was eager to leave the hospital environment. This suggests that there is a deficit in what is being currently offered to help a woman process an experience, particularly from an emotional perspective.

One of the participants in this research, Rosie, did very little overt work in recovering from her birth experience. However, similar to the findings of the Priddis et al study (2014), which found that *'women gave accounts of their pleasure of giving birth vaginally, the act that had resulted in... how they felt they were treated*' (p. 18), Rosie talked about her pride at how *'it's great that I . . . had a non-assisted vaginal birth*'. This piece, when explored by Priddis et al, (2014) seems to centre around a societal and cultural pride. One of the questions asked of a pregnant woman who has had previous labours is whether or not she had a 'normal' previous delivery, with the boundaries for 'normal' being that the baby was birthed vaginally, without instrumental assistance. The unconscious pride that results in such an 'achievement' is part of the process of recovery from any accompanying trauma. Priddis also noted that the women who accessed a 'supportive group' were best able to 'move towards a "new kind of normal"'. (p. 13). The interviewer noted, during this research, that Rosie was the woman with the least integration of her experience. It is interesting, therefore, that she was also the woman who accessed the least overt support after the event.

Again, an issue that comes to the fore from this study concerns women accessing the supports that they already have in place when it comes to the recovery from birth trauma. Whether it is as a consequence of not having the emotional space to explore new avenues, or a consequence of not being offered any additional supports by the systems which are currently in place, each of the participants worked within a familiar system when it came to processing their birth trauma.

### **Theme 3: loss of self**

Looking again at the Freudian view (as cited in Heller, 2005) of childbirth being a person's 'first experience of anxiety' (p. 21), as well as the work of Bion, Klein and Bowlby within the sphere of the baby and its ability to process the trauma of its entry into the world, we can see that there is an element of childbirth, which, for the baby, undoubtedly causes some traumatic experience. This links with this research in that each of the women interviewed moved her focus from her own situation to that of her child, and her child's needs, very soon after the birth was over. As previously noted, even recounting her experience, each woman responded to queries about her own process after the birth with pieces about her child's ability to sleep, feed and generally recover from what each had gone through. This raises a question about whether some of the child's initial 'anxiety', in the Freudian terms, or attachment need, to use Bowlby's language, is a projection of the mother's difficulty onto the baby. As Bowlby (as cited in Gomez, 1997) notes 'the mother and the young baby are powerfully motivated to remain close to each other physically and emotionally; both become anxious if separated for too long' (p. 156 – 157). The mother's anxiety, particularly as seen in this research, was baby-focused. When interviewed, Elizabeth spoke about her child's physical 'agony' for much longer than she allowed for her own physical pain within her experience. This ability to repress the impact of the difficulty of their experience allowed each woman to move into motherhood, with all the accompanying distortion of personal focus.

Ayers' (2007) study brought the idea of disassociation and mental defeat as being commonplace within a traumatic birth. Indeed, she highlighted their importance in honing a woman's ability to succumb to the inevitability of what was happening. In order to 'get through' it, women were removing themselves from their own experience. This removal and repression is seen throughout this research. The documented evidence of Rosie's repression means that it became possible for her to encounter what she did without becoming overwhelmed by it. The same can be said for her avoidance of fear. As a coping mechanism, the research found that the women were likely to avoid maintaining their personal emotional space, and moved from their feelings of panic, anger and fear to the more disassociated emotional states where their focus could be on their 'conscious brain' (Rosie) or their baby's wellbeing. The exception to this is the moment immediately after the child was taken from each woman. Before even the delivery of the placenta, each woman received her child onto her chest and the research found that whilst this experience ranged from absolute emotional disassociation to relief and/or discomfort, the participants were, for a moment of their trauma, frozen in a state of their own being. In the moment when her baby was external for the first time, each woman remained emotionally internal, stuck within her own experience and her own

physicality. This research did not aim to look at post-natal depression and did not find any evidence of it within the narrative of the participants. However, there was an issue for each woman about what precisely the moment of bringing her child into the world represented for her and it was for each woman interviewed, a piece around being stuck in a moment of personal trauma.

Long before this moment, however, like the work described in Lemoine-Luccioni's writings (1993), with the slant on Lacanian philosophy, overcoming the fear of the 'tidal wave of blood' (p. 64) that labour could possibly be, means that women have to enter the idea of childbirth with a repressed fear of potential trauma. When trauma is realised, the fear is not only of the situation that they are currently in, but also of what they imagined could possibly have been. Fear can overwhelm and is, therefore, too dangerous for a traumatised woman with a new baby to enter into. Anna spoke of 'relief' and wanting to cry at the idea of being 'the other side of it'. Rosie repeatedly mentioned 'what would have happened if it was way more'. There is an 'emptying' that comes with childbirth that is well described in Lemoine-Luccioni's work. This piece, whilst potentially having a physical connotation, is mired in the emotional realm. Being 'empty' is a defeat that cannot marry with the new mother's expectations of herself, her baby or her motherhood. The masks that her coping mechanisms use are necessary in order to overcome the 'huge shift' (Elizabeth) that she needs to make. Within the space of fear of childbirth and holding the idea that each woman has worked to prepare herself for the experience (all of the women who took part in this research, in common with the majority of first time mothers in Ireland, took part in ante-natal education), there is something within the space of Montrelay's work (1993) about the 'limitless pain' (p. 86) of labour which has been compounded by this research. That work has been done to prepare, and yet, again in the space of Reiger & Dempsey's (2006) focus on the struggle to integrate mind and body processes, this preparation has been deemed futile by the physicality of the process and the lack of control that each woman experienced. Far from the ability, as per Mongan (1992), to 'experience this wonderful event on a deeper level' (p. 88) that the work of popular hypnobirthing classes build expectation for, the women in this research highlighted that this was not what they had wanted, not what they had prepared for and not what they 'knew' about themselves as capable, competent women. This is difficult for a woman to integrate and the idea that she would have been in a situation where her body was functioning without the input of her emotional or cognitive self is a divorce from her integrated understanding of herself as a person. Further, she has just come from a space of being pregnant. In this space, she was full, able and prepared. She was, as Montrelay says (1993), 'a tree of life' (p. 86). And then, during labour she 'bleeds in expelling the placenta-time of pregnancy.... The one and the other lose some life'. The sadness that will inevitably accompany the end of a pregnancy is usually countered by the wave of positive hormonal and emotional being. However,

when there is a feeling of being stuck, of being, as Anna said, 'relieved to be on the other side of it', there is a freezing of this positivity. In this moment, the woman loses something significant, not only in expectation of her experience, but also in understanding of herself. Priddis (2014) looks at this with raw, poetic understanding and says, 'The transition from self to other – where other is an unknown and unfamiliar self – and...the distortion of body boundaries that occurred in pregnancy, reaches a pinnacle during the birth process. At the moment of birth a woman experiences a physical and emotional opening of the self to the other, and the loss of the boundary of what is internal and external occurs as the baby and placenta are born' (p. 19). The fact that the 'physical opening' has occurred without the space for the women involved in this research to bring themselves to terms with the physicality of their experience represents such a transition from expectation to realisation that this is their moment of trauma.

The overall sense of loss is compounded by the fact that there is a loss to each woman in terms of her individuality. The social and cultural difficulty in the idea that this loss of separateness creates a void for a woman that is not absolutely filled by her child and her love for her child means that it cannot easily be expressed. This was the case within this research, though there remains enough evidence of it throughout the experience of these women to be manifest. When separation becomes an issue between mother and baby, the woman loses the ability to be fully alone. She is either with her child, or separate from him/ her. When her child is brought from her in a situation that is not as she wanted it to be, there is a widening of the void felt by this loss of individuation. Anna talked of her 'awareness' as a result of 'not knowing that it's going to pass' and this is the embodiment of this sentiment. There is an altering that has occurred, not only within the woman but within her life and the difficulty in allowing this change means that there is a pervading sense of emotional discomfort that needs to be integrated before the woman can move into her new space comfortably.

The sense of loss that results from a traumatic birth is not overt in a woman's understanding of her experience and is, therefore, even more subjective than any of the other themes that pervaded this research. However, its links with the previous research are strong and the women's understanding of their own impact allows it a distinct and accountable space within this work.

## Chapter 6 – Conclusion

*'It is significant that woman – like females of certain domesticated animals – requires help in performing the function assigned to her by nature.... At just the time when woman attains the realization of her feminine destiny, she is still dependent: proof again that in the human species nature and artifice are never wholly separated'.*

(de Beauvoir, 1997, p. 521)

In working on a piece about the processing of a traumatic birth experience, there is the opening of several different topics for consideration. Control, power, autonomy and dependence are all prevalent throughout any reading on this topic. Each manifests with subjective emotional residue. A woman entering into a birthing process has a presumption for her body, her mind and her emotional state that is based on her experience of life and society to this point. That she requires assistance in what is the most natural of bodily functions and that the new life contained within her, since conception felt to be hers and within her control, requires a shift in cognitive and emotional function that the constraints of a maternity hospital can rarely accommodate. However, this can be dealt with, should the support provided be in line with her understanding of her own autonomy within the situation. The influence of those she has around her has been testified to repeatedly within this work. Likewise, the impact of the confluence of her disposition is fundamental to her encountering the experience within a positive frame. Sometimes, as this work attests, the shift of focus from a woman's needs to those of the process around her, whether by function of the situation or the institution, impacts on her with such a sense of void that she is left harmed by the experience more than impacted by its significance.

This research was a piece of work done with a consistent focus on integrity and objectivity, in treatment of subject and subject matter. There were a number of restrictions to the work, namely that the limitations of the interview style employed meant that though there are certain universalities to the themes discussed, they are only a part of the myriad of themes entrenched within the wide spectrum of disturbances to the psyche that occur within the space of birth and, specifically, birth trauma. Likewise, though as comprehensive as possible an understanding has been laid out here in terms of the themes that were discussed, each could allow a much greater body of work to be performed in order to come to a conclusive piece.

Further research into each theme, particularly that of the woman's experience of loss after a traumatic birth event, would be welcomed by the researcher and the field in general.

In working with women who have encountered an experience of this nature, there is named evidence within this work that suggests that therapy, and certain forms of therapy, enjoys much success. This recommendation for both the maternity sector and for women in their post-natal period is significant and an area that is somewhat under-resourced in terms of social and cultural understanding of the potential for therapeutic support. It is a space in which therapy has a real offering and honing a specific service for women who have encountered this specific area of trauma is a field for growth within the spectrum of psychotherapy offerings.

Lastly, to conclude this piece of work, there is a space owed to the delicate nature of the psyche in terms of understanding how and why birth trauma occurs, as well as how to best overcome its damages.

A woman, in all her strength at the time of childbirth, retains still a psyche that is as formed as her life and experience has allowed it to be. There are no predictions for how any one woman will respond to the natural challenges of childbirth. However, as evidenced herein, there are predictors for how these challenges could remain subject to a boundary. There are also factors which could allow a woman greater sense of autonomy in terms of herself within a difficult space. These findings are important for understanding both the sector and the psyche. Maintaining ego within the space of physical impact cannot continue to be ignored within the field of maternity. The secondary nature of emotional and cognitive wellbeing in the labour ward attests to the danger zone that has become the potential for birth trauma.

If the objectives for a 'successful' labour are for a woman to walk away with not only a healthy baby, but also an intact sense of herself, then further emphases placed on the integration of body, mind and psychological processes need to be prioritised.

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**Appendix A:**



**INFORMATION FORM**

My name is Lorraine Hackett and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is concerned with processing a traumatic birth experience. I will be exploring the views of people like yourself who have experienced same.

**What is Involved?**

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being a woman who has experienced a traumatic birth. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

**Confidentiality**

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

**DECLARATION**

**I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.**

**I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.**

**Name of Participant (in block letters) \_\_\_\_\_**

**Signature \_\_\_\_\_**

**Date / /**

**Appendix B:**



## CONSENT FORM

**Protocol Title:**

**An exploration of the process of integrating a traumatic birth experience**

**Please tick the appropriate answer.**

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

Yes No

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.

Yes No

I understand that my identity will remain confidential at all times.

Yes No

I am aware of the potential risks of this research study.

Yes No

I am aware that audio recordings will be made of sessions

Yes No

I have been given a copy of the Information Leaflet and this Consent form for my records.

Yes No

Participant \_\_\_\_\_  
Signature and dated

\_\_\_\_\_  
Name in block capitals

**To be completed by the Principal Investigator or his nominee.**

I the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/her to ask questions on any aspect of the study that concerned them.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Name in Block Capitals**

\_\_\_\_\_  
**Date**

## **Appendix C:**

### **The experience of processing a traumatic birth**

**Research conducted by Lorraine Hackett, student of MA in Psychotherapy, Year 2, DBS.**

Thank you for agreeing to participate in this research. Your input is greatly valued.

#### **Purpose of the Study**

The hour-long interview which you have agreed to participate will form part of my MA in Psychotherapy thesis wherein I will investigate the psychotherapeutic impact of a traumatic birth experience. As previously discussed, your interview is entirely confidential. Your interview will be transcribed and once the transcription is complete, the original recording of the interview will be deleted. The transcript of your interview will be stored on a file-protected computer. Your identity will be shielded within the final research and within the final transcript. All other copies of the transcript will also be deleted.

If you would like to receive a report of this study (or a summary of the findings) when it is completed, please contact me on [lorrainehackett@gmail.com](mailto:lorrainehackett@gmail.com) or 087 1356 294.

#### **Concerns**

If you feel that you have been impacted by partaking in this study, and would like to avail of psychotherapy at this point, qualified therapists can be found via [www.iahip.org](http://www.iahip.org) or [www.iacp.ie](http://www.iacp.ie).

## **Appendix D:**

### The experience of processing a traumatic birth

1. Tell me a little about your pregnancy and the time leading up to the birth? What were you expecting, feeling etc?
2. What sort of birth plan if any, had you for the labour?
3. Tell me about your experience of your labour?
4. Who was with you during your experience and how do you feel they experienced it?
5. What was your sense of what happened immediately afterwards?
6. Were you offered counselling or any support afterwards?
  - a. If yes, what was offered and did you avail of it?
  - b. If no, did you seek out support yourself and what was this?
  - c. Did you feel that this support worked or didn't work for you?
7. Do you have a feeling on whether or not your sense of yourself changed as a result of this experience?
8. Do you feel that this experience influenced, in any way, your ability to interact with people?
9. How do you feel this experience impacted on you as a mother?
10. Did this experience impact, in any way, how you feel about future pregnancies?
11. Did this experience impact your relationship with your partner?
12. Did this experience impact how you feel about your body?
13. Is there anything else that you would like to add?

## **Appendix E:**

**Table of emergent themes from the transcripts of the interviews:**

Elizabeth	Anna	Rosie
Disempowerment - Disparity between expectation and reality – onus of fault on the preparation ‘not being realistic’	Disempowerment – Disparity between expectation and reality – onus of fault being on the preparation ‘not being realistic’	Control Feeling of not being prepared
Pride – proud of her body	Feeling out of control	Feeling out of control
Disempowerment - Not being listened to	Being physically disempowered	Disempowerment – physically
Disempowerment - Not being understood	Disempowerment and loss This is not how she understands herself	Control and loss Not being listened to
Disempowerment - This is not how she is usually treated/ how she usually understands herself	Control and disempowerment Time distortion	Control and loss Not feeling understood
Repression - Downplaying her experience	Disassociation from baby	Repression - Downplaying her experience
Repression of memory – unclear on details	Control Moments of panic	Loss Repression and distortion of memory
Repression - Time distortion	Processing Resignation – this is ‘how it is’	Time distortion
Disassociation from baby	Disassociation from staff – midwife not supportive; consultant ‘swanned in and out’;	Disassociation from baby
Control - Moments of panic	Physical pain of the experience	Loss Resignation – this is ‘how it is’
Control - Resignation – this is ‘how it is’	Disempowerment Feeling very isolated after the event	Processing Focus on the baby after the event
Disempowerment - Anger	Control Shock. The shock of labour Feeling like she was cracking. Shook and was cold at the thought of it. Repeated examples.	Repression – Fear. Repression of fear. Projection of fear onto husband. Acknowledgment of fear.
Disempowerment and control - Support – isolation from support. Disassociation from midwife; from obstetrician; from Shane; from staff at Holles St; hospital not as expected; hospital not listening to her; fears not being recognised; staff ‘not doing a good job’;	Processing of the experience, with her mother, her therapist, made her feel ‘normal’ again.	Control Disassociation from staff – unhappy with systems at Holles St.
Control Fear – felt a ‘flood of fear’. hers were not recognised/ she	Loss. Grief.	Feeling isolated – no baby, no support.

wasn't listened to re her fear of caesarean fear being used as a tool against her (15 mins to get this baby out, or she has to have a section)		
Processing Transfer of focus to baby – disassociation from trauma. In a haze for about 6 or 7 months	Proud of herself and her body	Disempowerment Lack of support with breastfeeding.
Processing the experience Change as a consequence of experience	Loss Need to 'offer up' her need for control	Disempowerment.
Loss – of knowledge of self Of understanding of medical systems Disappointment.	Loss Did not want more children	Pride at vaginal delivery
	Closeness with partner	Processing Disassociation from self as a mother
	Disempowerment Change of hospital for 2 <sup>nd</sup> birth – not great midwifery first time around	Processing Focus on consciousness.
	Loss - Fear and panic	
	Disassociation from baby	