Birth Trauma

In the Eye of the Beholder

Cheryl Tatano Beck

- ***Background:*** The reported prevalence of posttraumatic stress disorder after childbirth ranges from 1.5% to 6%.
- ***Objective:*** To describe the meaning of women's birth trauma experiences.
- ***Methods:*** Descriptive phenomenology was the qualitative research design used to investigate mothers' experiences of traumatic births. Women were recruited through the Internet, primarily through Trauma and Birth Stress (TABS), a charitable trust located in New Zealand. The purposive sample consisted of 40 mothers: 23 in New Zealand, 8 in the United States, 6 in Australia, and 3 in the United Kingdom. Each woman was asked to describe the experience of her traumatic birth and to send it over the Internet to the researcher. Colaizzi's method was used to analyze the 40 mothers' stories.
- ***Results:*** Four themes emerged that described the essence of women's experiences of birth trauma: To care for me: Was that too much too ask? To communicate with me: Why was this neglected? To provide safe care: You betrayed my trust and I felt powerless, and The end justifies the means: At whose expense? At what price?
- ***Conclusions:*** Birth trauma lies in the eye of the beholder. Mothers perceived that their traumatic births often were viewed as routine by clinicians.

- ***Key Words:*** birth trauma · phenomenology · PTSD · qualitative research

In her 1878 novel *Molly Bawn*, Margaret Wolfe Hungerford, an Irish-born 19th century romance novelist, first penned the phrase "beauty is in the eye of the beholder." Beauty is not the only quality or phenomenon that lies in the eye of the beholder; birth trauma also does. What a mother perceives as birth trauma may be seen quite differently through the eyes of obstetric care providers, who may view it as a routine delivery and just another day at the hospital. The reported prevalence of posttraumatic stress disorder (PTSD) after childbirth ranges from 1.5% (Ayers & Pickering, 2001) to 5.6% (Creedy, Shochet, & Horsfall, 2000). Although there is a reported prevalence of PTSD after childbirth, little research has aimed at an understanding of this phenomenon from the women's experience. This phenomenologic study investigated the meaning of women's birth trauma experiences.

Literature Review

A review of the literature on birth trauma showed limited research on the trauma itself rather than its aftermath, PTSD. This literature review focused on the studies that investigated traumatic births and their risk factors as well as research on the components of physical-emotional-mental birth trauma that can lead to the development of PTSD. Birth trauma is an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror.

Three studies were found that discussed elements of birth trauma, although their main focus was on identifying the prevalence of diagnosed PTSD resulting from childbirth.

In the United Kingdom, women ($N = 500$) volunteered to participate in research on psychological stress related to obstetric or gynecologic procedures. Advertisement in newspapers and magazines was the method of recruitment. A small number of women ($n = 102$) in this sample described their experiences of obstetric or gynecologic procedures as "terrifying" and "still affecting them now" (Menage, 1993). These women completed the PTSD Interview questionnaire (Watson, Juba, Manifold, Kucala, & Anderson, 1991). Of the 102 women, 30 met the *Diagnostic and Statistical Manual* (DSM-III-R) criteria for a diagnosis of PTSD. These women with a diagnosis of

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PTSD resulting from birth trauma reported that during the procedures, they felt powerless, lacked information about the procedures, experienced physical pain, perceived unsympathetic attitudes of the healthcare providers, and lacked a clearly understood consent on their part for the procedures. As compared with the nontrauma group, the women with trauma had experienced significantly more infant death and a higher number of invasive procedures.

Beauty is not the only quality or phenomenon that lies in the eye of the beholder; birth trauma also does

In a cross-sectional study of all the women who had given birth over a 1-year period in an obstetric department in Sweden, Wijma, Soderquist, and Wijma (1997) reported that 28 of 1,640 women (1.7%) met the criteria for PTSD. Factors related to the women's experience of PTSD after childbirth included a history of psychiatric counseling, a negative cognitive appraisal of the past delivery, nulliparity, and a negative contact with the delivery staff.

Creedy, Shochet, and Horsfall (2000) conducted a prospective, longitudinal study in Australia. Recruited into the study during their third trimester, the women completed various questionnaires including the State Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1983) Eligibility criteria for inclusion in the sample required that participants be older than 18 years, in the third trimester of pregnancy, at low risk for obstetric complications, and able to understand English. Telephone interviews with the women (n = 499) 4 to 6 weeks postpartum explored their perceptions of the labor and delivery care and the presence of trauma symptoms. The DSM-IV diagnostic criteria for acute posttraumatic stress disorder were met by 28 mothers (5.6%). These stressful birth events included extreme pain, fear of the mother for her life or that of her infant, and a perception of a real or actual lack of obstetric care. Two variables were associated significantly ($p < .0001$) with acute trauma symptoms: a high degree of obstetric intervention and dissatisfaction with the care received during labor and delivery.

The following three studies focused on traumatic births and posttraumatic stress symptoms. No formal diagnosis of PTSD was included as part of the research.

In Sweden, Ryding, Wijma, and Wijma (1998) interviewed women (N = 53) approximately 2 days after emergency cesarean delivery to determine whether this trauma met the stressor criterion of PTSD. Other sample criteria besides the experience of an emergency cesarean included use of the Swedish language and delivery of a live infant who had not been transferred to another hospital for special care. In this study, 29 mothers (55%) reported experiencing intense fear of death or injury to themselves or to their baby during the delivery process, which fulfilled the stressor criterion of DSM-IV. The most common fear was related to concerns that the baby would die or be injured. The mothers who feared for their own lives had experienced a painful labor. The findings showed that 8% of the women were angry because they felt that the delivery staff had treated them very badly. These mothers felt violated and helpless during the care provided by the delivery staff.

Czarnocka and Slade (2000) assessed the prevalence and potential predictors of posttraumatic stress symptoms with a sample of women (N = 264) in the United Kingdom. Eligibility criteria specified women who were older than 18 years, had delivered a healthy infant, (c) spoke English, and (d) had no immediate plans of moving out of the area. At 6 weeks postpartum, the mothers completed the Post-Traumatic Stress Disorder Questionnaire (PTSD-Q) and Interview (Watson et al., 1991). In this assessment, 3% of the sample (n = 8) reported symptoms on the PTSD-Q indicating clinically significant levels of the three posttraumatic stress dimensions: intrusions, avoidance, and hyperarousal. Regression analysis showed the following significant predictors of posttraumatic stress symptoms related to childbirth: low levels of perceived support from labor and delivery staff and partner and low perceived control during labor.

One study conducted in the United States investigated the prevalence and predictors of psychological trauma experienced by women during childbirth (Soet, Brack, & Dilorio, 2003). Women were recruited from childbirth education classes. In late pregnancy, the women (N = 103) completed questionnaires measuring such concepts as locus of control and social support. Approximately 4 weeks after delivery, a follow-up interview was conducted by telephone. The mother's experience of birth trauma was measured using the Traumatic Event Scale (TES) (Wijma et al., 1997). In these interviews, 35 women (34%) reported traumatic births. Significant predictors of birth trauma included cesarean delivery, medical intervention, long painful labor, feelings of powerlessness, inadequate information, negative interaction with medical personnel, and differences between expectations and the actual event of childbirth.

The literature review found only one qualitative study that had investigated traumatic births. Women who perceived having traumatic deliveries were recruited by health visitors when they brought their infant for the 8-month well baby checkup. Allen (1998) interviewed women (N = 20) in the United Kingdom 10 months after their delivery who perceived that they had experienced distressing labor. Grounded theory analysis showed that the core category related to a traumatic birth experience was the mothers' feelings of not being in control of events or of their own behavior. Causal factors leading to the perception of a traumatic birth were the belief that the baby would be harmed, past experiences in labor, and pain during labor. The mothers tried to gain control by seeking reassurance and knowledge provided by staff and partners.

Seng (2002) acknowledged the complexities of conducting research on PTSD and childbearing. A conceptual framework for research was developed to study the effects of past and current abuse and posttraumatic stress on

childbearing women. Seng's framework emphasized PTSD as a potential mediator in the relation between trauma and adverse childbearing outcomes. By both behavioral and neuroendocrine pathways PTSD can be a possible mechanism for adverse maternal and infant outcomes using Seng's conceptual framework, studies can be designed where treatment for PTSD and decreasing high life event stress can potentially decrease association between PTSD and negative childbearing outcomes.

The literature review found a limited number of studies on birth trauma. These quantitative studies focused on identifying predictors of PTSD that related to childbirth. None of the studies investigated the long-term effects of birth trauma for women. Current PTSD knowledge does not address the meaning of a traumatic birth for women. The purpose of the current phenomenologic study was to investigate the following research question: What is the essential structure of women's experiences of birth trauma?

Methods

Research Design

Descriptive phenomenology was the qualitative research design chosen for the study of mothers' experiences of traumatic births. Husserl's (1970) descriptive (eidetic) phenomenology was the philosophical underpinning for this study. In phenomenology, the nature of a phenomenon (i.e., what makes something what it is without which it could not be what it is) is investigated (Husserl, 1962). Phenomena as they are experienced consciously are described without theories about causes and as free as possible from unexamined preconceptions and presuppositions (Spiegelberg, 1975). One assumption of descriptive phenomenology is that for any human experience there are distinct essential structures that make up that phenomenon regardless of the particular person who experiences it. These essential structures are discovered by studying the particulars encountered in the lived experience.

An understanding of these essential structures requires phenomenologic reduction (Husserl, 1960), in which researchers attempt to put aside temporarily any presuppositions they may hold about the phenomena they are studying, allowing phenomena to come directly into view without distortion by the researchers' preconceptions. "Bracketing" is the term used by Husserl (1960) to describe this process of peeling away the layers of interpretation so the phenomena can be seen as they are. Bracketing does not eliminate perspective, but brings the experience into clearer focus.

Procedure

After approval had been obtained from the university's institutional review board, women were recruited via the Internet primarily through Trauma and Birth Stress (TABS), a charitable trust located in New Zealand. Trauma and Birth Stress was founded by five mothers who had experienced birth trauma. This self-help organization supports women who have experienced birth trauma and educates about birth trauma and the resulting PTSD.

Members of TABS were informed of the study by a packet sent to each of them by regular postal mail from the chairperson of TABS. Two letters were included in the packet. The first letter was written by the chairperson as an introduction to the study. The researcher wrote the second letter, explaining her role and describing the research program. An announcement recruiting women also was placed in the TABS newsletter. Women interested in participating had two options: e-mail or regular postal mail. In addition to recruitment through TABS, a few mothers learned of the study from the researcher's university Web site. Finally, two women from Australia joined the study after hearing a joint presentation on PTSD after childbirth by the chairperson of TABS, a psychiatrist, and the researcher.

A purposive sample was used to gain perspectives from the participants who had experienced the phenomenon investigated in the study. The sample criteria required that the mother had experienced birth trauma, was willing to articulate her experience, and could read and write English. Ability to use the Internet was not a sample criterion. The mothers who chose the Internet as the means of participation e-mailed the researcher concerning their interest. The researcher then sent the interested women two attachments: an informed consent form and directions for participating in the study. After reading both documents, the women had the opportunity of e-mailing the researcher with any further questions about the study. They electronically signed the informed consent form and returned it to the researcher by attachment. The mothers who chose to participate in the study by regular postal mail contacted the chairperson of TABS, who then sent them the informed consent form. Each mother was asked to describe her experience of traumatic birth in as much detail as she could remember and wished to share.

Of the 40 mothers, 38 participated in the study through the Internet. They sent their birth trauma stories as attachments to the researcher. The remaining two women wrote their experiences of birth trauma and sent them by regular postal mail to the researcher. After the researcher read each mother's birth trauma story, she e-mailed the woman if she had any questions or needed clarification concerning what had been written. Two participants also sent the researcher boxes of journals they had written chronicling their traumatic birth experiences and the PTSD that followed. Data collection extended over an 18-month period.

Data Analysis

The study used Colaizzi's (1978) method of data analysis, which consists of the following seven steps:

1. Read all the participants' descriptions of the phenomenon under study.
2. Extract significant statements that pertain directly to the phenomenon.
3. Formulate meanings for these significant statements.
4. Categorize the formulated meanings into clusters of themes.
5. Integrate the findings into an exhaustive description of the phenomenon being studied.
6. Validate the exhaustive description by returning to some of the participants to ask them how it compares with their experiences.

7. Incorporate any changes offered by the participants into the final description of the essence of the phenomenon.

A portion of the audit trail for the data analysis can be found in Table 1, which includes selected examples of significant statements and corresponding formulated meanings. With regard to the clustering of the formulated meanings around the four themes, the largest number of formulated meanings clustered around themes 1 and 2, followed by themes 3 and 4.

Colaizzi's (1978) process for thematic analysis was used. Once the formulated meanings were organized into clusters of themes, these clusters were referred back to the women's original birth trauma stories for their validation. At this stage of thematic analysis, the researcher must not be tempted to ignore data or themes that do not fit (Colaizzi).

The four themes were validated by nine mothers who had participated in the study. This group of mothers, who met with the researcher while she was in New Zealand, felt that none of the results needed to be changed. In addition, four mothers who had participated in the study and one father reviewed this article before it was submitted for publication. All agreed that the results captured the essence of their birth trauma experiences. The rationale for not including all the participants for validation of the results was that once some of the women had written their story, they did not want to revisit it again.

Results

Sample

The purposive sample consisted of 40 mothers who perceived that they had experienced birth trauma. The length of time since their traumatic deliveries ranged from 5 weeks to 14 years. The mothers lived in New Zealand (n = 23), the United States (n = 8), Australia (n = 6), and the United Kingdom (n = 3). According to the diagnoses, 32 of the women (80%) had PTSD attributable to birth trauma, whereas 8 women (20%) had experienced PTSD symptoms, but had not yet gone for mental healthcare after delivery. The mean age of the sample at the time the women participated in the study was 34 years (range, 25-44 years). Of the 40 women, 34 were married, 3 were divorced, and 3 were single. Of the 15 women who shared their education level, 1 had graduated from medical school, 4 had completed graduate school, 8 had graduated from college, 1 had a partial college education, and 1 had graduated from high school. Sixteen of the women were primiparas, whereas 24 were multiparas. Eighteen of the

TABLE 1. Selected Examples of Significant Statements and Their Formulated Meanings for Two Themes

Theme No.	Significant Statements	Formulated Meanings
1 To care for me: Was that too much to ask?	When you returned to my labor room and I was vomiting and shaking and no longer handling the contractions, you never reassured me or explained what was happening.	The woman felt uninformed and lacked reassurance about her labor process.
	Lying indecently and asking why the curtain behind me was open and could they close it. I felt exposed to the outside world!	The mother felt stripped of her dignity as her privacy was not respected.
2 To communicate with me: Why was this neglected?	While waiting for a scan for retained placenta fragments, I read my chart and learned for the first time my congenitally deformed baby was born alive. I thought he had been born dead and that they had brought him back to life. I went into a real inner panic and made me think, "what else don't I know or haven't they told me."	The mother panicked and became distrustful of her health care providers once she learned that information about her baby had been withheld from her.
	The midwife never told me or my support people where she was going, what she was doing, how long she would be, or what to do if I needed help.	During labor the woman felt abandoned by her primary clinician.

women (45%) had undergone cesarean deliveries, whereas 22 (55%) had delivered vaginally. Almost an equal number of birth traumas in this sample had occurred during cesarean and vaginal deliveries. Labor had been induced for 17 of the mothers. Two mothers delivered twins and one mother had triplets. Three mothers in the sample were bipolar, and one had experienced prenatal depression with this most recent pregnancy.

Themes

The study results clearly show that birth trauma is in the eye of the beholder. The birth traumas identified by the women in the sample are presented in Table 2. The concept of birth trauma involves traumatic experiences that may occur during any phase of childbearing. During any phase, the trauma may be classified as a negative outcome including a stillbirth, an obstetric complication (e.g., an emergency cesarean), or psychological distress (fear of an epidural).

Theme 1. To Care for Me: Was That Too Much to Ask?

> I am amazed that 3½ hours in the labor and delivery room could cause such utter destruction in my life. It truly was like being the victim of a violent crime or rape.

What could have happened to this woman and others to turn the delivery process into a rape scene? Perceived lack of a caring approach during such a vulnerable time was one of the core components in this scenario for a traumatic birth. The mothers reported that feeling abandoned and alone, stripped of their dignity, lack of interest in them as unique persons, and lack of support and reassurance all contributed to their birth trauma. One mother said she "felt betrayed by a system that is supposedly there to care for me."

TABLE 2. List of Birth Traumas

- Stillbirth/infant death
- Emergency cesarean delivery/fetal distress
- Cardiac arrest
- Inadequate medical care
- Fear of epidural
- Congenital anomalies
- Inadequate pain relief
- Postpartum hemorrhage/manual removal of placenta
- Forceps/vacuum extraction/skull fracture
- Severe toxemia
- Premature birth
- Separation from infant in NICU
- Prolonged, painful labor
- Rapid delivery
- Degrading experience

The women who participated in this study reported that their expectations for their labor and delivery care were shattered. One mother painfully stated:

> The labor care has hurt deep in my soul and I have no words to describe the hurt. I was treated like a nothing, just someone to get data from. The nurse took my pulse, temperature, blood pressure, and weight without talking to me as a person. She then asked about teeth, colds and smoking without acknowledging me as a person. She left me, tears rolling down my face.

A multipara who had an induced labor said:

> I felt like just a vessel into which you poured hormones hoping for the quick release of another baby.

The adjectives used by the mothers in this study to describe the care they had received during the delivery process included "mechanical," "arrogant," "cold," "technical," and "lack of empathy." For example, within 24 hours of giving birth, one mother had to say goodbye forever to her beloved newborn daughter. As her baby was dying in the neonatal intensive care unit (NICU), her husband took lots of photos until the film ran out. She and her husband asked for more film and ignored the disapproving looks of the staff members. They wondered:

> Was this too much to ask for—for us it was our only opportunity to do this before our daughter died.

The mothers reported that being stripped of their dignity also played a part in birth trauma. As one young Puerto Rican mother recounted:

> They had me in all kinds of positions (including all fours) to hear the heartbeat with a stethoscope, and about 20 students came in the room without my permission. All I heard them saying was that I was now 7½ dilated. By the way, while I was on all fours, I was trying to cover my bottom by holding the gown, and a nurse took my hands from the gown. So, I felt raped, and my dignity was taken from me.

During the delivery process, some women were shaken to the core by feeling abandoned and alone, as illustrated by the following quote:

> I had a major bleed and started shaking involuntarily all over. Even my jaw shook and I couldn't stop. I heard the specialist say he was having trouble stopping the bleeding. I was very frightened, and then it hit me. I might not make it! I can still recall the sick dread of real fear. I needed urgent reassurance, but none was offered.

Theme 2: To Communicate With Me: Why Was This Neglected?

At times, the mothers perceived that the labor and delivery staff failed to communicate with their patients. During a traumatic birth, women often felt invisible. Clinicians spoke to each other as if the woman were not present. One woman who was having her first baby recalled:

> After an hour trying to deliver the baby with a vacuum extractor, the obstetrician said it was too late for an

> emergency cesarean. The baby was truly stuck. By now the doctors are acting like I'm not there. The attending physician was saying, "We may have lost this bloody baby." The hospital staff discussed my baby's possible death in front of me and argued in front of me just as if I weren't there.

The following segment of a mother's story dramatically illustrates how someone merely communicating with her and explaining what was happening could have prevented her birth trauma:

> The doctor turned on this machine that sounded like a swimming pool pump. He proceeded and hurriedly showed me the piece that was to be inserted into me. It was chrome metal and extremely large in circumference. Next thing he begins to pull on this hose, which was the extension of the suction. He gritted his teeth and pulled. I felt sick. On the end of this machine was our baby's head. He used every ounce of his male strength to pull the baby out. I was horrified. I started to imagine, and any minute now a head will come out, ripped off of its body. I was really in shock. He had his foot up on the bed, using it as leverage to pull. All of a sudden, the loud sucking machine made an even louder noise, and it broke suction. The doctor fell back and nearly landed on his bum. Blood came spurting out of me, all over him. That was it for me. I thought he'd ripped the head off. He then swore and said hurriedly, "Get the forceps." I can still remember the feeling of him ripping the baby out of me. It was the most awful unnatural devastating feeling ever. Well, finally out came this baby. I was, by this stage, still stuck in my own private horror movie, visualizing my baby being born dead with half of its head missing. The pediatrician was standing beside the doctor, and I assumed that he would take the dead baby away. But, much to my horror and surprise, the doctor pulled out this blood red baby and threw it onto my tummy. I screamed, "Get him off of me!" I cried my eyes out!

Clinicians also at times failed to communicate among themselves, which influenced the women's perceptions of their deliveries as traumatic. For example, labor was induced for one woman who had experienced a previous serious vasovagal reaction before pregnancy and it came time for her to receive an epidural. She was terrified because the midwife did not tell the anesthetist about her history. As this mother shared,

> I remember my husband trying to tell the anesthetist that I was fearful of a vasovagal attack. The midwife should have been doing that. My husband kept saying, "My wife, my wife." He could not remember what to say. I was terrified for my life. My soul was in agony because the medical people did not know the situation. I was terrified to the core of my being. I called out, "I'm scared, I'm scared." Not scared of the needle, scared for my life.

Theme 3: To Provide Safe Care: You Betrayed My Trust and I Felt Powerless

Women began their labors confident that the delivery staff would provide safe care. The women entrusted their lives and that of their unborn baby into the hands of these clinicians. At times, women perceived that they received unsafe care, which ignited terror in them as they feared for their own safety and that of their infants, but felt powerless to rectify the dangerous situation. As one mother vehemently recounted:

> I remember believing that the labor and delivery team would know what was right and would be there should things go wrong. That was my first mistake. They didn't and they weren't! I strongly believe my PTSD was caused by feelings of powerlessness and loss of control of what people did to my body.

One brief scenario vividly illustrates this third theme. Shortly before becoming pregnant the second time, one mother had surgery to repair a hiatal hernia. During this pregnancy, gestational diabetes developed, and at 28 weeks a scan detected a mass in the brain of her fetus. Her desired birth plan was to have a cesarean delivery to save her baby the distress of a vaginal birth. The doctor "pressured" her into a trial of labor because her first delivery had been so straightforward and rapid. The doctor assured her that if she got into any difficulties she could "easily convert to cesarean." As this mother explained,

> I went into the delivery room assured that my baby and I would be in safe hands. I got into difficulties at 9 p.m. with severe abdominal pain and felt something was terribly wrong. I was in what I describe as "white pain," a terrible ripping pain. I told the staff something was wrong and I begged for a cesarean. I was refused without an examination. An epidural was administered without an examination. I was pushing for hours to no avail, flat on my back, numb from the waist down and feeling that my vague pushes were killing my unborn daughter. I started to die inside. The whole of my genital area was swollen to resemble a baboon. My daughter was posterior, brow presenting, and I continued in second stage labor actively pushing for over 6 hours. My daughter was distressed and her heartbeat kept disappearing. An episiotomy was cut without so much as eye contact with me. My daughter was born flat, resuscitated with Apgars of 2 and 6, and taken to the NICU. After being stitched up, I went to see my baby, and I didn't recognize her, felt no bond, nothing. She wasn't my baby; my baby had died. In my mind, my efforts to give birth had killed her. After delivery I was incontinent. The familiar stomach pain returned. My hiatus hernia repair had now failed. I later had repair surgery to reattach a part of my labia majora. I had an anal sphincter repair and my pelvic floor was refashioned at the same time. I'm waiting for a repeat hiatus hernia repair, and I am still going to physiotherapy to improve the incontinence. During labor, I had expected pain, and I had expected a powerful experience. I expected that, if necessary, medical staff would intervene to keep us safe. Why didn't anyone use their professional judgment? That was what I expected from them. I have posttraumatic stress disorder.

Theme 4: The End Justifies the Means: At Whose Expense? At What Price?

Mothers believed that the bottom line in considering a delivery a successful and fulfilling experience was the outcome of the baby. If the baby was born alive with good Apgar scores, that was what mattered to the labor and delivery staff and even to the mother's family and friends. The safe arrival of a live, healthy infant symbolized the achievement of clinical efficiency and of professional and fiscal goals. Mothers perceived that their traumatic deliveries were glossed over and pushed into the background as the healthy newborn took center stage. Why put a damper on this celebration by focusing on the mother's traumatic experience giving birth!

One woman had been hospitalized with chronic sciatica 20 years earlier when she was 18 years old. She received an epidural steroid injection for treatment. As the woman recalled,

> The needle hit a nerve in my back and created a frightful situation where I could not move and had such a horrible sensation I vowed on the spot never ever to have another epidural.

Submitting to her most dreaded epidural and saying goodbye to her dreams of a vaginal delivery, this woman experienced an out-of-body experience as she lay on the delivery table hemorrhaging. She wrote,

> I would have done *anything* to have this baby and did *everything*, even stuff I didn't want to. All I get told when dealing with the residual emotional effects is, "You should be happy with the outcome."

After an hour of pushing, one primipara was offered forceps. The epidural was topped up, but not given enough time to work properly, nor was it checked. The mother felt the cut, the forceps going in, and her body tearing as the doctor pulled the baby out. She screamed loud and long. She shared that she

> was congratulated for how "quickly and easily" the baby came out and that he scored a perfect 10! The worst thing was that nobody acknowledged that I had a bad time. Everyone was so pleased it had gone so well! I felt as if I had been raped!

Women who perceived that they had experienced traumatic births viewed the site of their labor and delivery as a battlefield. While engaged in battle, their protective layers were stripped away, leaving them exposed to the onslaught of birth trauma. Stripped from these women were their individuality, dignity, control, communication, caring, trust, and support and reassurance.

Discussion

The birth traumas experienced by the mothers in this study have been identified previously such as emergency cesarean deliveries (Ballard, Stanley, & Brockington, 1995; Soet et al., 2003), long, painful labors with inadequate pain relief (Ballard et al., 1995; Fones, 1996; Soet et al., 2003), epidurals (Ballard et al., 1995; Fones, 1996), forceps deliveries (Fones, 1996), fetal or newborn deaths (Ballard et al., 1995; Turton, Hughes, Evans, & Fainman, 2001), premature infants and infants in the NICU (DeMier, Hynan, Harris, & Manniello, 1996; Holditch-Davis, Bartlett, Blickman, & Miles, 2003), degrading experiences (Menage, 1993), and perceptions of unsafe care during childbirth (Creedy, et al., 2000). Creedy et al. (2000) reported that the perception of unsafe care had a significant additive effect on birth trauma symptoms for women who also had a high level of obstetric intervention during their labor and delivery.

Parts of the four themes that describe the essence of a traumatic birth have been reported in previous studies, but nowhere has the totality of the experience been reported. Aspects of theme 1 (To care for me: Was that too much to ask?) have been mentioned by Ballard et al. (1995), Menage (1993), and Wijma et al. (1997). Theme 2 (To communicate with me: Why was this neglected?) appears in the research of Ballard et al. (1995), Creedy et al. (2000), Menage (1993), and Soet et al. (2003). The mothers' feelings of powerlessness and loss of control (theme 3) have been echoed previously by Allen (1998), Czarnocka and Slade (2000), Menage (1993), and Soet et al. (2003). Maes, Delmeire, Mylle, and Altramura (2001) reported that loss of control is a significant component of the traumatic event for many mothers who experience PTSD. Theme 4 (The end justifies the means: At whose expense? At what price?) has not been specifically addressed in any previous research. Whereas some of the mothers in this study felt as if they had been raped, the clinicians appeared to the women as oblivious to their plight. The mothers perceived that the clinicians focused only on the successful outcomes of clinical efficiency and live healthy infants.

In reviewing this manuscript before it was submitted for publication, two mothers made a special point to emphasize the importance of this fourth theme. The one mother wrote:

> For me the most telling statement remains, "The end justifies the means: At whose expense? At what price?" For me, this sums up my situation and many others I know of.

The other mother said:

> This I believe is the actual contributing factor toward PTSD occurring. As no one is comfortable enough in themselves to be honest with the mother and the partner too I might add. So let's just breathe a sigh of relief and focus on the fact that the baby arrived.

Besides providing safe care, what is it that clinicians can do to help prevent traumatic births? At a woman's admission to labor and delivery, it is important that clinicians take a careful history from her regarding any particular fears she may have about giving birth, such as needle phobia. If a woman has had previous deliveries, this admission history should include questions on whether previous deliveries were perceived as traumatic. Identification of any possible contributing factors to birth trauma can alert clinicians so that special care can be taken regarding these factors.

During labor and delivery, clinicians should strive to enhance a woman's sense of control by offering her options

when possible. Many events during the delivery process are, however, out of the control of both the obstetric care providers and the mothers. Obstetric care providers need to discuss with the women the means of delivery, and not just the outcome. When hopes for the best laid birth plans are dashed, women's unmet expectations regarding their anticipated birth process need to be addressed by clinicians. Mothers' perceptions of birth trauma can be based not only on the event, but also on their unmet expectations regarding the event.

Church and Scanlan (2002) alert clinicians to have a proactive role in preventing PTSD after childbirth by vigilantly watching mothers during the postpartum period for recognition of early trauma-related symptoms: a dazed appearance, withdrawal, or temporary amnesia. Knowing that birth trauma lies in the eye of the beholder, they should treat every woman as though she were a survivor of a previous traumatic experience (Crompton, 2003).

Accepted for publication September 18, 2003.

The author thanks Sue Watson, the Chairperson of Trauma and Birth Stress (TABS), a charitable trust in New Zealand, for her unwavering support and enthusiastic assistance with this research project. Without her help, this research study would never have come to fruition. To all the courageous women who shared their most personal and powerful stories of birth trauma, the author is forever indebted.

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