

## Subsequent Childbirth After a Previous Traumatic Birth

Cheryl Tatano Beck ▼ Sue Watson

- ▶ **Background:** Nine percent of new mothers in the United States who participated in the Listening to Mothers II Postpartum Survey screened positive for meeting the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria for posttraumatic stress disorder after childbirth. Women who have had a traumatic birth experience report fewer subsequent children and a longer length of time before their second baby. Childbirth-related posttraumatic stress disorder impacts couples' physical relationship, communication, conflict, emotions, and bonding with their children.
- ▶ **Objective:** The purpose of this study was to describe the meaning of women's experiences of a subsequent childbirth after a previous traumatic birth.
- ▶ **Methods:** Phenomenology was the research design used. An international sample of 35 women participated in this Internet study. Women were asked, "Please describe in as much detail as you can remember your subsequent pregnancy, labor, and delivery following your previous traumatic birth." Colaizzi's phenomenological data analysis approach was used to analyze the stories of the 35 women.
- ▶ **Results:** Data analysis yielded four themes: (a) riding the turbulent wave of panic during pregnancy; (b) strategizing: attempts to reclaim their body and complete the journey to motherhood; (c) bringing reverence to the birthing process and empowering women; and (d) still elusive: the longed-for healing birth experience.
- ▶ **Discussion:** Subsequent childbirth after a previous birth trauma has the potential to either heal or retraumatize women. During pregnancy, women need permission and encouragement to grieve their prior traumatic births to help remove the burden of their invisible pain.
- ▶ **Key Words:** phenomenology • posttraumatic stress disorder (PTSD) • subsequent childbirth • traumatic childbirth

A large percentage of women giving birth in the United States experienced hospital care that did not reflect the best evidence for practice nor for women's preferences. The Institute of Medicine (2003) identified childbirth as a national healthcare priority for quality improvement. A maternity care quality chasm still exists (Sakala & Corry, 2007).

Researchers and healthcare professionals at an international meeting on current issues regarding PTSD after childbirth recommended the need for research focusing on women's subjective birth experiences (Ayers, Joseph, McKenzie-McHarg, Slade, & Wijma, 2008). Olde, van der Hart, Kleber, and van Son (2006) called for examining the chronic nature of childbirth-related posttraumatic stress lasting longer than 6 months after birth.

The purpose of the current study was to help fill the knowledge gap of one aspect of the chronicity of birth trauma: women's subjective experiences of the subsequent pregnancy, labor, and delivery after a traumatic childbirth.

### Review of Literature

Traumatic childbirth is defined as "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" (Beck, 2004a, p. 28). For some women, a traumatic birth also involves perceiving their birthing experience as dehumanizing and stripping them of their dignity (Beck, 2004a, 2004b, 2006). After a traumatic childbirth, 2% to 21% of women meet the diagnostic criteria for PTSD (Ayers, 2004; Ayers, Harris, Sawyer, Parfitt, & Ford, 2009), involving the development of three characteristic symptoms stemming from the exposure to the trauma: persistent reexperiencing of the traumatic event, persistent avoiding of reminders of the trauma and a numbing of general responsiveness, and persistent increased arousal (American Psychiatric Association, 2000).

### Risk Factors

Risk factors contributing to women perceiving their childbirth as traumatic can be divided into three categories: prenatal factors, nature and circumstances of the delivery,

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and subjective factors during childbirth (van Son, Verkerk, van der Hart, Komproe, & Pop, 2005). Under the prenatal category are factors such as histories of previous traumatic births, prenatal PTSD (Onoye, Goebert, Morland, Matsu, & Wright, 2009), child sexual abuse, and psychiatric counseling. Factors included in the category of nature and circumstances of the delivery include a high level of medical intervention, extremely painful labor and delivery, and delivery type (Ayers et al., 2009). Subjective risk factors during childbirth can include feelings of powerlessness, lack of caring and support from labor and delivery staff, and fear of dying (Thomson & Downe, 2008).

### Long-Term Impact of Traumatic Childbirth

Researchers are uncovering an unsettling gamut of long-term detrimental effects of traumatic childbirth not only on the mothers themselves but also on their relationships with infants and other family members. Mothers' breastfeeding experiences and the yearly anniversary of their birth trauma can also be negatively impacted.

Impaired mother-infant relationships after traumatic childbirth are being confirmed in the literature. For example, in the study of Ayers, Wright, and Wells (2007) of mothers who experienced birth trauma in the United Kingdom, women described themselves as feeling detached and having feelings of rejection toward their infants. Nicholls and Ayers (2007) reported two different types of mother-infant bonding in couples who shared that PTSD after childbirth affected their relationships with their children; they became anxious/overprotective or avoidant/rejecting. Childbirth-related PTSD also impacted their relationships with their partners, including their physical relationship, communication, conflict, emotions, support, and coping.

Long-term detrimental effects of traumatic childbirth can extend also into women's breastfeeding experiences. In their Internet study, Beck and Watson (2008) explored the impact of birth trauma on the breastfeeding experiences of 52 mothers. For some mothers, their traumatic childbirth led to distressing impediments that curtailed their breastfeeding attempts, such as feeling that their breasts were just one more thing to be violated.

Another aspect of the chronic effect of birth trauma was identified in Beck's (2006) Internet study of the anniversary of traumatic childbirth, an invisible phenomenon that mothers struggled with. Thirty-seven women comprised this international sample of mothers from the United States, New Zealand, Australia, United Kingdom, and Canada. Beck concluded that a failure to rescue occurred for women as the anniversary approached, and all others focused on the celebration of the children's birthdays. This failure to rescue led to unnecessary emotional or physical suffering or both.

Catherall (1998) warned of secondary trauma in families living with trauma survivors. The entire family is vulnerable to becoming secondarily traumatized. The long-term impact of trauma does not result necessarily in PTSD symp-

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not be underestimated.

toms in family members. Catherall stated that it can have a more insidious effect of a disturbing milieu in the family. The members of the family may be close physically, but their ability to express emotions is limited. True closeness in the family is missing, and their problem solving is impaired. Abrams (1999) identified one of the central clinical characteristics of intergenerational transmission of trauma is the silence that happens in families regarding traumatic experiences. Abrams pleaded that the multi-generational impact of trauma should

### Posttraumatic Growth

Researchers are reporting that traumatic experiences can have positive benefits in a person's life. Posttraumatic growth has been documented in a wide range of people who faced traumatic experiences such as bereaved parents (Engelkemeyer & Marwit, 2008), human immunodeficiency virus caregivers (Cadell, 2007), and homeless women with histories of traumatic experiences (Stump & Smith, 2008). "Posttraumatic growth describes the experience of individuals whose development, at least in some areas, has surpassed what was present before the struggle with the crisis occurred. The individual has not only survived, but has experienced changes that are viewed as important, and that go beyond what was the previous status quo" (Tedeschi & Calhoun, 2004, p. 4). It is not the actual trauma that is responsible for posttraumatic growth but what happens after the trauma. Tedeschi and Calhoun (2004, p. 6) proposed five domains of posttraumatic growth: "greater appreciation of life and changed sense of priorities; warmer, more intimate relationships with others; a greater sense of personal strength; recognition of new possibilities or paths for one's life; and spiritual development."

Childbirth can have an enormous potential to help change how a woman feels about herself and can impact her transition to motherhood (Levy, 2006). Attias and Goodwin (1999, p. 299) noted that a woman who survives a traumatic experience may be able to rebuild her wounded inner self "by having a child, transforming her body from a container of ashes to a container for a new human life." A positive childbirth has the potential to empower a traumatized woman and help her reclaim her life.

One study was located that touched on the positive growth of women after a previous negative birthing experience. In Cheyney's (2008) qualitative study of women in the United States who chose home births after experiencing a negative birth, three integrated conceptual themes emerged from their home birth narratives: knowledge, power, and intimacy. The power of their home births helped heal scars of their past hospital births. Positive growth after birth trauma has yet to be investigated systematically by researchers.

One of the knowledge gaps identified in this literature review focused on an aspect of the long-term effects of birth trauma: mothers' subsequent childbirth. This phenomenological study was designed to answer the research question:

What is the meaning of women's experiences of a subsequent childbirth following a previous traumatic birth?

## Methods

### Research Design

The term *phenomenology* is derived from the Greek word *phenomenon*, which means "to show itself." The goal of phenomenology is to describe human experiences as they are experienced consciously without theories about their cause and as free as possible from the researchers' unexamined presuppositions about the phenomenon under study. In phenomenology, researchers "borrow" other individuals' experiences to better understand the deeper meaning of the phenomenon (Van Manen, 1984).

The existential phenomenological method developed by Colaizzi (1973, 1978) was used in this Internet study. His method is designed to uncover the fundamental structure of a phenomenon, that is, the essence of an experience. An assumption of phenomenology is that for any phenomenon, there are essential structures that comprise that human experience. Only by examining specific experiences of the phenomenon being studied can their essential structures be uncovered.

Colaizzi's (1973, 1978) method includes features of Husserl's and Heidegger's philosophies. Colaizzi maintains that description is the key to discovering the essence and the meaning of a phenomenon and that phenomenology is presuppositionless (Husserl, 1954). Colaizzi, however, holds a Heideggerian view of reduction, the process of researchers bracketing presuppositions and their natural attitude about the phenomenon being studied. For Colaizzi (1978, p. 58), researchers identify their presuppositions regarding the phenomenon under study not to bracket them off to the side but instead to use them to "interrogate" one's "beliefs, hypotheses, attitudes, and hunches" about the phenomenon to help formulate research questions. Colaizzi agrees with Merleau-Ponty (1956, p. 64) that "the greatest lesson of reduction is the impossibility of a complete reduction." Individual phenomenological reflection about the phenomenon being studied is one approach Colaizzi (1973) offers for assisting researchers to decrease the coloring of their presuppositions and biases on their research activity.

Because the phenomenon of subsequent childbirth after a previous traumatic birth had not been examined systematically before this current study, description of the meaning of women's experiences was the focus of this study. Before the start of the study, the researchers undertook an individual phenomenological reflection. They questioned themselves regarding their presuppositions about the phenomenon of subsequent childbirth after a traumatic birth and how these might influence what and how they conducted their research.

### Sample

Thirty-five women participated in the study (Table 1). Saturation of data was achieved easily with this sample size. Their mean age was 33 years (range = 27 to 51 years). All the participants were Caucasian and had two to four children. The length of time since their previous birth trauma to the subsequent birth ranged from 1 to 13 years. Eight of the 35 women (23%) opted for a home birth for their

TABLE 1. Demographic and Obstetric Characteristics

	n	%
Country		
United States	15	43
United Kingdom	8	23
New Zealand	6	17
Australia	5	14
Canada	1	3
Marital status		
Married	34	98
Divorced	1	2
Single	0	0
Education		
High school	3	9
Some college	5	15
College degree	13	38
Graduate	7	19
Missing	7	19
Delivery		
Vaginal	25	72
Cesarean	10	29
Diagnosed PTSD		
Yes	14	40
No	19	55
Missing	2	5
Currently under care of therapist		
Yes	8	23
No	22	63
Missing	5	15

Note. PTSD = posttraumatic stress disorder.

subsequent births. Of these 8 mothers who gave birth at home, 4 lived in Australia, 3 in the United States, and 1 in the United Kingdom. Fourteen mothers (40%) had been diagnosed with PTSD after childbirth.

All the birth traumas were self-defined. Women were not asked if they had experienced other traumas before their birth traumas. Therefore, this was not an exclusionary criterion. The most frequently identified traumatic births focused on emergency cesarean deliveries, postpartum hemorrhage, severe preeclampsia, preterm labor, high level of medical interventions (i.e., forceps, vacuum extraction, induction), infant in the neonatal intensive care unit, feeling violated, lack or respectful treatment, unsympathetic, nonsupportive labor and delivery staff, and "emotional torture."

### Procedure

Once institutional review board approval was obtained from the university, recruitment began. Data collection continued

for 2 years and 2 months. Women were recruited by means of a notice placed on the Web site of Trauma and Birth Stress (TABS; www.tabs.org.nz), a charitable trust located in New Zealand. The mission of TABS is to support women who have experienced traumatic childbirth and PTSD because of their birth trauma. The sample criteria required that the mother had experienced a traumatic childbirth with a previous labor and delivery, that she was willing to articulate her experience, and that she could read and write English. This international representation of participants was a strength of this recruitment method. A disadvantage, however, was that only women who had access to the Internet and who used TABS for support participated in this study.

Women who were interested in participating in this Internet study contacted the first author at her university e-mail address, which was listed on the recruitment notice. An information sheet and directions for the study were sent by attachment to interested mothers. After reading these two documents, women could e-mail the researcher if they had any questions concerning the study.

Women were asked, "Please describe in as much detail as you can remember your subsequent pregnancy, labor, and delivery following your previous traumatic birth." Women sent their descriptions of their experiences as e-mail attachments to the researcher. The sending of their story implied their informed consent. The length of time varied from when a mother first e-mailed about her interest in the study to when she sent her completed story to the researchers. The shortest turnaround time was 2 days whereas the longest was 9 months. If women did not respond within a certain period, the researchers did not recontact them. The women's wish not to follow

through on participation in the study was respected. Throughout this procedure, the first author kept a reflexive journal.

#### Data Analysis

Colaizzi's (1978) method of data analysis was used. The order of his steps is as follows: written protocols, significant statements, formulated meanings, clusters of themes, exhaustive description, and fundamental structure. It should be noted, however, that these steps do overlap. From each participant's description of the phenomenon, significant statements, which are phrases or sentences that directly describe the phenomenon, are extracted (Table 2). For each significant statement, the researcher formulates its meaning. Here, creative insight is called into play. Colaizzi cautioned that in this step of data analysis, the researcher must take a precarious leap from what the participants said to what they mean. Formulated meanings should never sever all connections from the original transcripts. It is in this step of formulating meanings that Colaizzi's connection to Heidegger can be seen. The next step entails organizing all the formulated meanings into clusters of themes. At this point, all the results to date are combined into an exhaustive description. This step is followed by revising the exhaustive description into a more condensed statement of the identification of the fundamental structure of the phenomenon being studied. The fundamental structure can be shared with the participants to validate how well it captured aspects of their experiences. If any participants share new data, they are integrated into the final description of the phenomenon. Member checking was done with one participant who reviewed the themes and

TABLE 2. Example of Extracting Significant Statements

No.	Significant statements
1	One thing that I'd noticed when I was a child was that when my parents got together with other adults, the talk eventually turned to two things: for my father (a Vietnam veteran) and the other men the talk turned to the war and interestingly, to me as a small child, for my mother and the other women the talk always turned to childbirth.
2	It was as if, from a young age, for me, the connections between the two were drawn. A man is tested through war, a woman is tested through childbirth.
3	My dad, as abusive as he was, was considered a "good man" because he'd been a good soldier and so, I reasoned forward with a child's intelligence, that all that really mattered for a woman was to be strong and capable in childbirth.
4	And I failed. In the past, with the previous two births (particularly with the one that resulted in PTSD)—that's what it felt like. I failed at being a woman.
5	I don't think that I am alone in feeling. I have a sneaking suspicion that this is pretty universal.
6	Just as a man who "talks" under torture in a POW situation feels as though he's failed, a woman who can't "handle" tortuous situations during childbirth feels like she's failed. It is not true. But it feels true.
7	My dad received two Purple Hearts and a Bronze Star during Vietnam. He, by most standards, would be considered a hero. Where are my Purple Hearts? My Bronze Star? I've fought a war, no less terrifying, no less destroying but there are no accolades. At least that's what it feels like.
8	I am viewed as flawed if not down right strange that I find L & D so terrifying.
9	The medical establishment thinks that I am "mental" and I have no common ground on which to discuss my childbirth experiences with "normal" women.
10	I know, I've tried. And that makes me feel isolated and inferior.

Note. PTSD = posttraumatic stress disorder.

totally agreed with them. In addition, one mother who had not participated in the study but had experienced the phenomenon being studied reviewed the findings and also agreed with them.

## Results

The researchers reflected on the written descriptions provided by the 35 women to explicate the phenomenon of their experiences of subsequent childbirth after a previous traumatic birth. These reflections yielded 274 significant statements that were clustered into four themes and finally into the fundamental structure that identified the essence of this phenomenon (Table 3).

### Theme 1: Riding the Turbulent Wave of Panic During Pregnancy

Fear, terror, anxiety, panic, dread, and denial were the most frequent terms used to describe the world women lived in during their pregnancy after a previous traumatic birth.

I remember the exact moment I realized what was happening. I was on my lunch break at work, sitting under a large oak tree, watching cars go by my office, talking with my husband. I suddenly knew... I am pregnant again! I remember the exact angle of the sun, the shading of the objects around me. I remember looking into the sun, at that tree, at the windows to the office thinking, "NO! God PLEASE NO!" I felt my chest at once sink inward on me and take on the weight of a 1000 bricks. I was short of breath, my head seared. All I could think of was "NOOOOOOOOO!"

Another woman described in detail the day she took her pregnancy test.

I took the test and crumpled over the edge of our bed, sobbing and retching hysterically for hours. I was dizzy. I was nauseous. I was sick. I could not breathe. I thought my chest would implode. I had a terrible migraine. I could not move from the spot where I had crumpled. I could not talk to my husband or see our daughter. I felt torn to pieces, shredded as shards of glass. I spent the next 2 trimesters hanging on for my life with suicidal

thoughts but no real desire to carry them out through. I wanted to see my little girl. It was hell on earth.

Some women went into denial during the first trimester of their pregnancy to cope. Throughout her pregnancy, one woman revealed that she "felt numb to my baby." Some women described how they turned their denial of pregnancy into something positive. One multipara explained that after she was in denial for a few months, she then became determined to make things different this next time, and right at the end of her pregnancy she felt empowered by all that she had learned: "After 3 months of ignoring the fact that I was going to have to go through birth again, I decided I would treat my next labor and delivery as a healing and empowering experience."

Other mothers remained in a heightened state of anxiety throughout their pregnancy, and for some this anxiety escalated to panic and terror. Knowing she may have to go through the same "emotional torture" she endured with her previous traumatic birth, one woman shared, "My 9 months of pregnancy were an anxiety filled abyss which was completely marred as an experience due to the terror that was continually in my mind from my experience 8 years earlier." As the delivery date got closer, some mothers reported having panic attacks.

### Theme 2: Strategizing: Attempts to Reclaim Their Body and Complete the Journey to Motherhood

"Well, this time; I told myself *things would be different*. I actually started planning for this birth literally while they were stitching me up from the traumatic first birth." During pregnancy women described a number of different strategies they used to help them survive the 9 months of pregnancy while waiting for what they were dreading: labor and delivery (Table 4). Some women spent time nurturing themselves by swimming, walking, going to yoga classes, and spending time outdoors.

Keeping a journal throughout the pregnancy helped mothers because they had somewhere to write things down, especially if they felt that family and friends did not understand just how difficult this pregnancy, subsequent to their prior traumatic delivery, was. Inspirational quotes were placed around the house to read and motivate women.

**TABLE 3: Fundamental Structure of the Phenomenon**

Subsequent childbirth after a previous traumatic birth far exceeds the confines of the actual labor and delivery. During the 9 months of pregnancy, women ride turbulent waves of panic, terror, and fear that the looming birth could be a repeat of the emotional and/or physical torture they had endured with their previous labor and delivery. Women strategized during pregnancy how they could reclaim their bodies that had been violated and traumatized by their previous childbirth. Women vowed to themselves that things would be different and that this time they would complete their journey to motherhood. Mothers employed strategies to try to bring a reverence to the birthing process and rectify all that had gone so wrong with their prior childbirth. The array of various strategies entailed such actions as hiring doulas for support during labor and delivery, becoming avid readers of childbirth books, writing a detailed birth plan, learning birth hypnosis, interviewing obstetricians and midwives about their philosophy of birth, doing yoga, and drawing birthing art. All these well-designed strategies did not ensure that all women would experience the healing childbirth they desperately longed for. For the mothers whose subsequent childbirth was a healing experience, they reclaimed their bodies, had a strong sense of control, and their birth became an empowering experience. The role of caring supporters was crucial in their labor and delivery. Women were treated with respect, dignity, and compassion. Although their subsequent birth was positive and empowering, women were quick to note that it could never change the past. Still elusive for some women was their longed-for healing subsequent birth.

**TABLE 4: Strategies Used to Cope With Pregnancy and Looming Labor and Delivery**

- Writing a detailed birth plan
- Mentally preparing for birth
- Learning birth hypnosis
- Doing birth art
- Writing positive affirmations
- Preparing for birthing at home
- Hiring a doula for labor and delivery
- Celebrating upcoming birth
- Avoiding ultrasounds
- Trying not to think about upcoming birth
- Reading books on healthy pregnancy and birth
- Mapping out your pelvis
- Learning birthing positions to open up the pelvis
- Practicing hypnosis for labor
- Researching birth centers and scheduling tours
- Interviewing obstetricians and midwives
- Exercising to help baby get in the correct position
- Using Internet support group
- Hiring a life coach
- Painting previous birth experience
- Creating "what if" sheet with all possible concerns and then solutions for them
- Creating "Yes, if necessary No" sheet for labor of what the mother wanted to happen
- Determining role of supporters during birth
- Researching homeopathic remedies to prepare body for labor and birth
- Developing a tool kit to help cope in labor
- Developing trust with healthcare provider

Figure 1 is an illustration of one mother's poster that she put up in her home.

Women strategized how to ensure that their looming labor and delivery was not another traumatic one. As one multipara explained, "I need to bring a reverence to the process so I won't feel like a piece of meat lost in the system." Attempts were made to put into place a plan that would attempt to rectify all that had gone wrong with the previous childbirth. Some women turned to doulas in hopes of being supported during their subsequent labor and delivery. Hypnobirthing was a plan used by some women to keep the first traumatic birth from being repeated.

Women reported reading avidly to understand the birth process fully. The most frequently cited books were *Rebounding from Childbirth* (Madsen, 1994), *Birthing from Within* (England & Horowitz, 1998), and *Birth and Beyond* (Gordon, 2002). Mothers often engaged in birth art exercises.

Toward the end of pregnancy I did the birth art exercises out of the book *Birthing from Within*... I began to trust myself. That will stay with me forever. That is more than

just what I needed to birth the way I wanted to. That is what I needed to become a real woman.

Opening up to their healthcare providers about their previous traumatic births was helpful for some mothers. Once clinicians knew of their history, they would address the mothers' concerns during each prenatal visit. Also sharing with their partners their fears and insecurities around pregnancy and birth helped women's emotional preparedness.

### Theme 3: Bringing Reverence to the Birthing Process and Empowering Women

Three quarters of the women who participated in this Internet study reported that their subsequent labor and delivery was either a "healing experience" or at least "a lot better" than their previous traumatic birth. Women became more confident in themselves as women and as mothers in that they really did know what was best for their babies and themselves. The role of supporters throughout labor and delivery was crucial. What was it that made a subsequent birth a healing experience? In the mothers' own words:

I was treated with respect, my wishes and those of my husband were listened to. I wasn't made to feel like a piece of meat this time but instead like a woman experiencing one of nature's most wonderful events.

Pain relief was taken seriously. First time around I was ignored. I begged and pleaded for pain relief. Second time it was offered but because I was made to feel in control, I was able to decline.

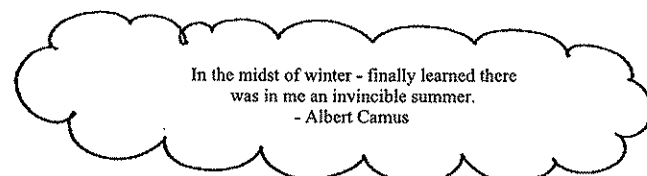
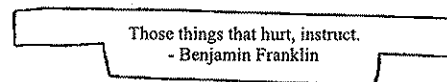
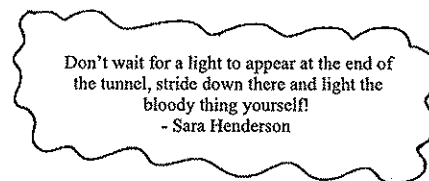
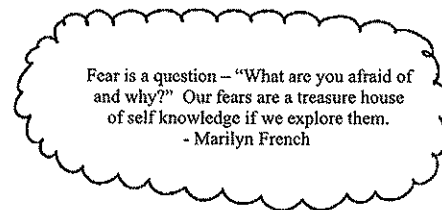


FIGURE 1. A poster of inspirational quotes by one mother.

I wasn't rushed! My baby was allowed to arrive when she was ready. When my first was born, I was told "5 minutes or I get the forceps" by the doctor on call. I pushed so hard that I tore badly.

Communication with labor and delivery staff was so much better the second time. The first time the emergency cord was pulled but no one told me why. I thought my baby was dead and no one would elaborate.

Women reclaimed their bodies, had a strong sense of control, and birth became an empowering experience. Only essential fetal monitoring and minimal medical intervention occurred. Women were allowed to start labor on their own and not be induced. Under gentle supervision of caring and supportive healthcare professionals, women were reassured to just do what their body felt like doing and to follow their body's lead. The number of vaginal examinations was kept at a minimum, and women were permitted to walk around and choose the position they felt best laboring in. One mother described her healing birth:

I pushed my baby into the world and I was shocked. I had never dared to dream for such a perfect delivery. They let me push spontaneously and my baby was delivered into my arms. My husband and I both cried with utter relief that I had given birth exactly how I wanted to and my trauma was healed.

For some women, the birth plan they had prepared during their pregnancy was honored by the labor and delivery staff, which helped them feel like they had some control and were a part of the birth and not just a witness.

Eight women opted for home births after their previous traumatic births, and for six of them, it did end in fulfilling their dream.

It was as healing and empowering as I had always hoped for. I did not want any high tech management. My home birth was the proudest day of my life and the victory was sweeter because I overcame so very much to come to it.

Another mother who had a successful home birth labored mostly in her bedroom under candlelight and music playing. She described it as very peaceful being at home surrounded by all her things. Her dog kept vigil by her side. She shared how it was such a gentle way for her baby to be born.

My baby cried for a minute or two as if telling me his birth story and crawled up my body and found my heart and left breast. My heart swelled with so many emotions—love, joy, happiness, pride, relief, and wonderment.

A couple of women explained that their subsequent birth was healing, but at the same time they mourned what they had missed out with their prior birth. The following quote illustrates this.

Even though it was an enormously healing experience, the expectations I had were unrealistic. What I went through during and after my first delivery cannot be erased from memory. If anything with this second birth being so wonderful, it makes dealing with my first birth harder. It makes it sadder and me angrier as before I had nothing to compare it to. I didn't know how different it could be or

how special those first few moments are. I didn't fully understand what I had missed out on. So now 3 years later I find myself grieving again for what we went through, how I was treated and what I missed out on.

Other mothers admitted that although their subsequent births were healing, they could never change the past.

All the positive, empowering births in the world won't ever change what happened with my first baby and me. Our relationship is forever built around his birth experience. The second birth was so wonderful I would go through it all again, but it can never change the past.

#### Theme 4: Still Elusive: The Longed-for Healing Birth Experience

Sadly, some mothers did not experience the healing subsequent birth they had hoped for. Two women chose to try a home birth after their previous traumatic birth but did not end up with the healing experience they longed for. One mother did deliver at home, but because of postpartum hemorrhage, she was transported by ambulance to the hospital, terrified she would not live to raise her baby. After laboring at home, another multipara who attempted a vaginal birth after cesarean needed to be transported by ambulance for a repeat cesarean birth after she failed to progress.

When the ambulance arrived I felt rescued. I have never been so grateful that hospitals exist. The blue light ambulance journey was terrifying and I was in excruciating pain. By this point I was trying to detach my head from my body, as I had done years earlier when I was being raped.

She went on to vividly describe that as she lay on the operating table:

...with my legs held in the air by 2 strangers while a third mopped the blood between my legs I felt raped all over again. I wanted to die. I had failed as a woman. My privacy had been invaded again. I felt sick.

One multipara shared that although this birth had been a better experience, she would not say it was healing in relation to her first birth that had been so traumatic. "The contrast in the way I was treated just emphasized how bad the first one was. I had no sense of healing until 30 years later when I received counseling for PTSD."

#### Discussion

Healthcare professionals' failure to rescue women during their previous traumatic childbirth can result in a troubling effect on mothers as they courageously face another pregnancy, labor, and delivery. Subsequent childbirth after a previous birth trauma provides clinicians with not only a golden opportunity but also a professional responsibility to help these traumatized women reclaim their bodies and complete their journey to motherhood.

To help women prepare for a subsequent childbirth after a previous traumatic birth, clinicians first need to identify who these women are. There are instruments available to screen women for posttraumatic stress symptoms due to birth trauma. An essential part of initial prenatal visits should

be taking time to discuss with women their previous births. Traumatized women need permission and encouragement to grieve their prior traumatic births to help remove the burden of their invisible pain. Pregnancy is a valuable time for health-care professionals to help women recognize and deal with unresolved, buried, or traumatic issues. Women should be asked about their hopes and fears for their impending labor and delivery and how they envision this birth. If a woman is exploring the possibility of a home birth, clinicians should question the mother about her previous births. Opting for a home birth may be an indication of a prior traumatic birth (Cheyney, 2008). If women need mental health follow-up during their pregnancy, cognitive behavior therapy and eye movement desensitization reprocessing treatment are two options for PTSD because of birth trauma. Treatment can be given in conjunction with a woman's family members to address secondary effects of PTSD.

Strategies can be employed to help mothers heal and increase their confidence before labor and delivery. Clinicians can share with mothers the Web site for TABS ([www.tabs.org.nz](http://www.tabs.org.nz)), a charitable trust in New Zealand that provides support for women who have suffered through a traumatic birth. Obstetric care providers can suggest to the women some of the numerous strategies that mothers in this study described using during their pregnancies. Women can be encouraged to write down their previous traumatic birth stories. Mothers can share their written stories with their current obstetric care providers so that they understand these women. Some women who participated in this study revealed that birthing artwork definitely helped them prepare for their subsequent labor and delivery after a traumatic childbirth.

Some women in this study touched on one of Tedeschi and Calhoun's (2004) domains of posttraumatic growth, a sense of personal growth. These women revealed feelings of empowerment and of reclaiming their bodies with their subsequent childbirths. Future research needs to be focused specifically on examining the five domains of posttraumatic growth in women who have experienced a subsequent childbirth after a previous birth trauma.

When women are traumatized during childbirth, this can leave a lasting imprint on their lives. If subsequent childbirth has the potential to either heal or retraumatize women, health-care professionals need to be carefully aware of the consequences their words and actions during labor and delivery can have (Levy, 2006). ▀

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