

THE IMPACT OF A DIFFICULT BIRTH ON MOTHERING OVER TIME

by

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Abstract

Existing literature about childbirth does not clearly address the relationship between women's experiences of "difficult birth" and the meanings women create from those events. This research focuses on women who identified they experienced a difficult birth, as opposed to a traumatic birth a topic that has received some attention. The experiences of 12 women and how a difficult birth affects the mother and how she creates meaning about it over time were explored. I focus on the women's perceptions about their ability to mother and on the relationship between the infant and the family. The women's stories are analyzed through ethnographic-informed methods with a feminist perspective. The absence of information about women's experience of difficult birthing and their subsequent mothering is due to the silencing of their voice and a lack of investigation into their concerns during childbirth.

This research identifies six themes common to the women's stories: health care professionals who have the dominant or authorial voice; hospital staff, who share little or no information with the women about their care; women, who are made to feel inadequate by HCPs; women, who experience an absence or a lack of care or assessment; significant others who abandon the women; and, women who experience ethical situations concerning their own care and that of their infant. I conclude that mothering over time is deeply affected by the experience of difficult birth, despite the varied and diverse situations and the contexts of difficult births.

Preface

This dissertation is original, unpublished, independent work by the author, Lynn Rollison.

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To my mother, who showed me how to mother in her everyday actions as she mothered her own children and for loving mine.

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Dedication

This work is dedicated to my Mother and Father who exemplify love, kindness, and understanding.

Chapter 1 Introduction

Giving birth shapes a woman's experience of mothering. The act of childbirth is formative and transformative for the woman. Yet, how the birth occurs and what happens during this process is unpredictable and unique for each woman and for each pregnancy she experiences. Despite preparations women may experience birth as a difficult event. I have often heard women describe their births as "difficult" highlighting an under recognized and perhaps traumatic event. Women have identified that being listened to, respected and feeling cared for by family and professionals empowers them and makes their experience positive and rewarding (Hodnett 2002; Howarth et al. 2011; Lavender et al. 1999; Michels et al. 2013). Negative birth experiences have also been studied (Nystedt et al. 2008; Razurel et al. 2011) finding that women who experience traumatic births can develop postpartum depression (PPD) (Beck et al. 2011a; Kinsella and Monk 2009) and posttraumatic stress disorder (PTSD) (Ayers 2007; Beck et al. 2011b; Menage 1993) due to medical interventions (Gamble and Creedy 2004) and the fear of death for herself or her child (Elmir et al. 2012; Souza et al. 2009; Wilde and Murray 2009).

Simkin (1991, 1992b) explored the impact that birthing has on a woman's life for decades and that women recalled memories of their birth experience with accuracy; indeed many were "strikingly vivid" (1992b:64). For women who expressed overall dissatisfaction with their births, memories of pain, not being listened to and being disregarded all played an important role many years after the event (Waldenstrom et al. 2004a). Forssen (2012) completed a study of older women's experiences of childbearing and birthing and the significance of those experiences for women's well-being over their lifetime. Forssen found that during prenatal and maternity care women's treatment through encounters with health care professionals "are experienced as violations of dignity and abuse, and pose lifelong threats to their health and well-

being” (1543). However, despite these studies, there is little research on the impact of a “difficult birth” on women over the long term, the meanings women make of their experiences (Mollard 2014) and the long term effects of the experience on their mothering. Little statistical data is available on the concept of a difficult birth and when it is investigated these studies usually refer to birth “trauma” (Ayers et al. 2006). Birth trauma has been defined as the experience of post traumatic stress disorder that occurs after child birth (The Birth Trauma Association 2015). This research addresses a large gap in the literature in which a difficult birth—when this term is used by women to describe their births—helps to form a particular landscape in women’s experience of childrearing. Furthermore, this issue of difficult births and it’s outcomes for women has concerned me for many years in my practice as an obstetrical nurse.

Informed by feminist and ethnographic methods, my analysis of the narratives of twelve women’s experiences of a difficult birth look more closely at the meaning this event had on their mothering over their life. The significance of this study lies in what is illuminated from the women’s experiences and how their stories of difficult birth and perceptions of their mothering over time have affected them. While I acknowledge circumstances when medical interventions can save the lives of women and their children, my theoretical perspective necessarily requires a critique of the actions and practices of medical practitioners as they impact on women during childbearing.

It is my intention that this research and analysis will have implications for practice, education and policy development in maternal health. Furthermore, this study may also facilitate women’s access to information about possible choices and courses of action in order to avoid the complications of a difficult birth and provide support for women and their families in instances when a difficult birth occurs. Finally the participating women’s experiences and the impact of

their difficult births can inform midwives, doulas, doctors or other health care professionals (HCPs) who work with mothers, children and families (Brand and Brennan 2009; Edoka et al. 2011). The study contributes to understandings of women's experiences during childbirth and how their lives are shaped by this event.

Personal Perspective as a Nurse

As a maternity nurse, educator and a mother, I have been amazed by the women who have shared their birth stories with me. Many talked with me about the disappointment they experienced around the process of giving birth. Whether their own expectations are grounded in the cultural construction of pregnancy and birthing or from the fairy tales women are often told about birth, their preconceptions were not met, setting them up for disappointment. My personal experiences and their stories piqued my interest and led me to investigate difficult birthing and the impact it has on mothering. I was particularly curious about how women understand and make meaning from difficult birth experiences over time (Callister 2004). The medical and scholarly term for a "difficult" birth may in fact be a "traumatic" birth but women do not tend to use this term (Ayers 2004, 2007; Beck et al. 2011a; Beck et al. 2011b; Gamble et al. 2005; Modarres et al. 2012). However, in conversations women often referred to these births as "difficult," perhaps to minimize the effect this might have on the child, to create some distance from the experience, to down play the event or to deny the experience to minimize the trauma. Indeed births defined as traumatic have been recognized and studied in the literature by health professionals and the women experiencing those births were treated in the postpartum period for depression or other conditions. In my nursing practice, time and time again, I heard women use the term "difficult" when describing their birth experience which left me wondering about the aftermath of that event. For this study, it is the women who described their birth as difficult that

are of interest. In particular, I wanted to understand how the experience of a difficult birth affects a woman and her mothering and what judgements about mothering and motherhood the women make about their experience of birth. Throughout this study, motherhood and mothering are described by participating women themselves.

My own difficult birthing experience, as a mother, an obstetric nurse and researcher in this study, situates me within the research and provides the impetus for this work.

Positioning the Self

I became pregnant during my nursing education. In anticipation of the birth, I attended Lamaze preparation classes in addition to prenatal education. I felt well prepared to give birth. Three weeks prior to my due date, my membranes ruptured spontaneously; yet, labour did not commence. I was admitted to the hospital in the early morning to be assessed for evidence of a prolapsed umbilical cord. Later that morning my contractions began and I experienced back labour, a dysfunctional labour pattern that is often protracted. I received analgesia and some nursing support and was left alone for times during labour. After twenty-two hours, I was fully dilated. The foetus remained posterior, which is uncommon, as the head usually rotates during labour to a vertex presentation. After several hours of pushing and with a decreasing fetal heartbeat, the doctor decided that I should have a pudendal block (see Appendix A: Glossary of medical terms). My feet were placed in stirrups, medical attendants applied forceps and I was given an episiotomy to deliver the baby. I experienced a postpartum hemorrhage and a third-degree tear into the anal sphincter requiring an extensive repair of my perineum. I was unable to breastfeed due to sore nipples, which I felt as a devastating loss. I became anxious and depressed; a condition that was neither diagnosed nor treated. It was not until after many years of nursing experience and probing into existing maternity care practice—during which the issue of

difficult birthing experiences continually surfaced—that I reflected on my own difficult birth and from there to health care practices and women’s birthing experiences generally.

Personal experience thus ignited my curiosity to explore the culture of birth and to question why and how things can go so very wrong. I became interested in the problems and aberrations of pregnancy, labour and birth and how they might be addressed. My focus extended to issues of loss and grief associated with childbirth and I investigated technological initiatives as they developed to see if they might improve outcomes for positive birth experiences for women. I also pursued further education, all of which culminated in my current focus on birthing and women’s experiences. Looking back, I thought about my own birthing and if other women’s experiences were similar. Questions tumbled over each other: What does it mean to a woman whose birth process becomes something she did not expect? What happens when clinical decisions are not shared or when the care she receives has the effect of disembodiment? How do women feel when their pain and the medical techniques used to deliver the baby seemed more like torture than help, when the risk of injury and death are real?

Unfolding the Narratives

Here I outline how resolving those questions informed my research and provide an outline of the research and analysis that follows. Chapter one introduces the literature on difficult and traumatic births. Chapter two features the epistemic and methodological considerations that explicate the importance of a feminist approach in this study on women and childbearing. I outline the central tenets of feminism to allow an appreciation of why feminist epistemology is critical when grappling with women’s experiences. I discuss the research approach, including my own position as the researcher in ethnography and the methods used for data gathering. I also explain data management, methods of analysis, rigour and the limitations of the study. Chapter

three introduces each research participant. In their own words, the women provide insights into their birth experience and how their difficult birth affected their mothering over the long-term. In chapter four I examine antenatal education and the care the women who participated in the research took of their pregnant bodies, antenatal medical care and the public pregnant body. I also include here the experiences of four women who experienced preterm deliveries and became mothers earlier than they planned. In chapter five, I highlight the stories of four other women; two women who gave birth without attending prenatal education classes and two who experienced an interventionist childbirth. In chapter six, I present the stories of three women who experienced medically managed births at term and of one woman who experienced post-term birth. Chapter seven unfolds the experiences of women who were left alone while in labour. In chapter eight the women participants share their feelings of guilt, love for their child, their sense of vulnerability during birth and how their experiences of difficult births stayed with them as they have matured. I describe the conceptual dimensions that arose from the research in chapter nine followed in chapter ten with a discussion of the concepts of reflection and reflexivity as documented throughout the work. This final chapter also provides my own conclusions and a discussion of the recommendations for change through themes of enforced silence; bullying, including being ignored or made to feel stupid; neglect; isolation; projected stigma; and, ethical issues identified by the women.

Significance of the Study

There is currently a gap in our knowledge about how women's lives are affected longitudinally following a difficult birth. My study intends to contribute information to childbearing women and families, nurses, doctors, midwives and other HCPs about women's experiences of a difficult birth and how that birth affects them over their lives. The study

provides insights to current health care practices to shed light on personal experiences of birth with recommendations for improvement. Situated from a birthing woman's perspective this work draws attention to the long-term impact of a difficult birth on the mother, the infant and the family.

Contributions to Knowledge

My research provides substantive contributions to understanding the untold stories of women's difficult childbearing and resultant mothering and mothering behavior (Forssen 2012). In addition to women sharing their stories—defined in their own terms how the births were difficult—the research probed the resultant connections women make with their children over time; a process about which little is known.

This research also contributes to understanding the treatment of women in health care settings and the actions of HCPs that can adversely affect women's birthing experiences and the meaning they make of that birthing process (Creedy et al. 2000; Dahlke 2009; Davis-Floyd 2001). In surfacing this awareness raising these issues can raise the awareness of HCPs, who might reflect on their own actions in order to ameliorate or discontinue practices that are detrimental for women (Gamble and Creedy 2004; Gamble et al. 2005; Gavin et al. 2005). Awareness of taken-for-granted actions that can stimulate postpartum depression and post-traumatic stress may help HCPs, public health and hospital institutions to change previously held beliefs or practices to minimize trauma through changes in policy and trauma-informed care (Forssen 2012; Goodwin-Smith 2012; Seng et al. 2009; Seng et al. 2013; Soet et al. 2003). Furthermore, the recognition of difficult births and its sequelae by family members and community may help to prepare women and families for the changes that might follow upon a

woman's experience of a difficult birth (Deave et al. 2008; Edeka et al. 2011; Elmir et al. 2012; Emmanuel et al. 2011; Field 1998).

Chapter 2 Positioning the Study

This chapter explores pregnancy, becoming a mother, the qualities of a “satisfactory birth experience” (Hodnett 2002:160) as well as an unsatisfactory birth experience. The main purpose of this literature review is to provide an overview of current thoughts about childbirth, expose gaps in knowledge about difficult birthing experiences and illustrate where my work fits in.

There is a disconnection between what has been written and the actual experience of motherhood (Arendell 2000). Numerous writers have explored topics related to the physical and psychological aspects of childbearing (Ayers and Pickering 2005; Beck 1995, 1996, 1998; Bewley and Cockburn 2002; Hodnett 2002; O’Brien 1989). Many professionals espouse support for women-centred care during labour, birth and childrearing (notably Kitzinger 1987a, 1987b; Oakley 1980; O’Brien 1981; Rothman 1984; Simkin 2004) and women have written about their lives as women and as mothers (see Atherton 2007; Bergum 1989; Chodorow 1978; Heilbrun 1988; Owens 2008; Rich 1979). Mothers have handed down knowledge, from generation to generation, through oral history in stories and fables (Carpenter 1985; Dworkin 1974; Gluck and Patai 1991). However, while many of these stories reflect an ideological position, few pose the question of what the impact of a difficult birth might have on a woman. Despite the disinclination of HCPs to discuss and include prevention strategies for a difficult birth experience during education and prenatal care, women imagine and idealize their birthing experience.

By “difficult” birth I am referring to births that may occur from unavoidable events such as a prolapsed cord, fetal distress, maternal conditions and other complications. In addition, difficult births may also be a consequence of the initiation of questionable interventions and the knowledge that once interventions are implemented often lead to more intervening activities

(Lothian 2006a; Romano and Lothian 2008). Both unavoidable and avoidable interventions will be described as part of the women's difficult birth experiences.

Pregnancy and Becoming a Mother: A Socio-Cultural Perspective

As women, we share expectations of ourselves in order to fulfill the socio-cultural ways of being both women and mothers in the Western world. As mothers, women are expected to care for their children to adulthood. Yet little education, if any, is provided for the woman in order to be a "good mother" in our culture (Choi et al. 2005). Sitcom television mothers, including icons such as June Cleaver, Carol Brady, Kitty Forman and Marge Simpsonⁱ have shaped Western images of what a mother is supposed to look like. She is a woman who is coiffed and dressed immaculately; who cooks, cleans and bandages cuts; smiles and takes care not only of her children but all the members of her family. The heart of the message is that a good mother-wife performs all these duties to support her home and family. Mother is house proud and "sexy" and women, children and men watching these media images internalize the messages.

Currently, reality television offers images and stories that dramatize intimate details of women's experiences of birthing. The popularity and ubiquity of these narratives give the impression that surgical approaches to birth are typical and risk free. The choices women are making about their bodies have been standardized by the everyday acceptance of interventionist obstetrical care seen in tabloids and newspapers. There is normalization and a familiarity with the surgical process that allows women to select these approaches for themselves.

Looking at more drastic approaches to childbearing, in 2009, a 60-year-old Indo-Canadian woman gave birth to twins she conceived through *in vitro* fertilization done in India. She delivered her children by caesarean section seven weeks preterm in Alberta (CTV News 2009). One month prior to the births in Alberta, a woman in California gave birth to octuplets

after receiving fertility treatments. These babies were born via cesarean section nine weeks premature. The mother now has 14 children and her fertility treatments have led to an international debate about a woman's "right" to bear children. These examples are extreme and contest the boundaries of societal acceptance and medical technology.

Yet, after a woman has borne a child she is viewed as the "primary and uttermost source of that child's good and evil, its survival, health, sanity and selfhood" (Rich 1979:264). According to Rich (1979), society penalizes some children because they do not fit into an idealized mould resulting in a sense of worthlessness. Society lays blame for the *waste* of a child on the "bad" mother who has failed as a superwoman and failed to rear her child as well-adjusted, obedient, achieving and non-alienating (Rich 1979). The backlash of blame is evident in the words and accusations leveled at mothers as well as their children (Jackson and Mannix 2004). Often women are blamed for their own difficult or traumatic births— also informed by myriad messages, images and representations from oral histories and storytelling usually not from the woman who lived these experiences. Child rearing practices, child play, expectations and assumptions that are supported on an intergenerational basis are presentations of "rightness." The meanings of failure are also insidious messages that are shared as women's lore and reflected as "horror" stories of pregnancy and birth with little association to actual women's experiences.

Becoming a mother is a life altering experience (Dahlke 2009) marked by physicality and a deeply personal way of knowing (Carpenter 1985). During pregnancy women invariably try to live up to perceived social expectations, assessing the availability of emotional and financial help, the burden of household tasks and infant care before her (Green 2003). In addition, women are under an extraordinary amount of scrutiny from their partners, family, friends and even

strangers (Bowman 2006; Callister 2001). This scrutiny involves monitoring weight gain, how the woman is carrying the foetus, whether she is eating right and other physical changes. The woman imagines her ideal birth experience and how she sees herself as a “good” mother (Mercer 2004, 2006; Sandelowski et al. 1994).

Today, women look to the health system for information and care during pregnancy and birth. In Canada, pregnant women have been enculturated to seek primary antenatal care from a general practitioner, obstetrician or more recently the midwife (Bourgeault and Fynes 1997). The medicalized system of childbirth has only been in existence for the past several centuries.

Historical records depict the slow and gradual take-over of childbirth from early midwives, to barber surgeons then later to obstetricians and with these changes birthing moved from the home to the hospital (Brodsky 2008; Ehrenreich and English 1973; Donegan 1978; Donnison 1988; Wertz and Wertz 1989). This was a political move that took many decades to achieve through the elimination or outlawing of midwifery and through denial of midwives to formal education (Donegan 1978). Birth was seen through the lens of the patriarchal medical system as a pathological state that needed to be cured and thus the take-over of child birthing was achieved (Brodsky 2008).

Throughout time, women have helped each other during birthing (Ross Leitenberger 1998; National Aboriginal Health Organization 2008). During the early history of Western colonization in Canada, midwifery was formally recognized and regulated for many years and throughout various provinces. In 1912 the Medical Council of Canada was formed, which unfortunately eliminated the practice of midwifery in most locations. It was not until 1993 that Ontario legalized the registration of midwives. In 1995 British Columbia permitted the registration of midwives through legislation and regulation to care for childbearing women

(College of Midwives of British Columbia nd). Up until this time, Canada was one of a few developed countries that did not recognize midwifery.

Many similarities exist in education for doctors, nurses and midwives with the goals of working with women who are giving birth yet a hierarchy within the various roles of care providers still exists (Brodsky 2008; Kalisch and Kalisch 1977; Salvage and Smith 2000; Zelek and Phillips 2003). In the past, nurses were seen as being the handmaidens to physicians with nurses lesser knowledge, gender and unequal power as the basis for these differences (Ehrenreich and English 1973; Kalisch and Kalisch 1977; Wertz and Wertz 1989). Today with nursing degrees as entry to practice the differences of unequal power should be decreasing and the narrowing of the educational gap has not had a significant effect on the development of mutual respect (Davies 2000; Kalisch and Kalisch 1977). With the most recent inclusion of midwives into the Canadian health care setting their role is also under question and collaboration is inconsistent (Homer et al. 2009; Larsson et al. 2009). Midwives have been seen by physicians as competing for clients and working effectively together “is limited both by tensions over role boundaries and power and by incivility that is intensified by increasing workloads and a fragmented labour force” (Reiger and Lane 2009). Conversely, physicians in most Western countries today enjoy the income, prestige and authority which “reflects their omnipotence amongst health care professionals and their power within our society” (Zelek and Phillips 2003:1). Veiled conversations and suggestions are seen in journals alluding to the disharmony between HCPs suggesting that HCPs should “work together” rather than “working alongside” one another for patient safety and the best outcome for mothers and newborn (Davies 2000).

The relationship between HCPs, the woman and her family is a critical factor that can affect the level of “satisfaction” a woman feels about her birthing experience (Hodnett 2002).

However, HCPs often hold different perspectives and philosophies about birthing that can create a disconnection between mother and care providers (Chalmers et al. 2001). Statements such as “If the baby is born alive and the mother is healthy; what more can the parents ask for?” are commonly heard coming from HCPs (Carlton et al. 2005:149). However, for a woman these aspirations of a live baby and mother may not be consistent with her own vision for her birthing experience (Dagan et al. 1999; Hodnett 2002).

Women construct an ideal for their birth experience imagining a care provider of her choice, a supportive and loving partner by her side, family members who offer additional care and nurturing, as well as safe delivery of her unborn child. Prenatal education class videos depict the birth as, ideally, a positive and empowering experience for women, the mothers expect that their choice and wishes in their birth plan, which were discussed during pregnancy care, will be recalled and respected by those providing care (Kitzinger 1978; Simkin 1991). For some women these images of their ideal birthing experience and motherhood dreams are not fulfilled leaving women feeling they have failed (Pincus 2000).

Qualities of a Satisfactory Birth Experience

Hodnett (2002) describes four factors that define women’s satisfaction with the experience of childbirth. However, “satisfaction” is not a term I have ever heard used by women to describe their birth experience. Satisfaction, according to Hodnett (2002), is the fulfillment of personal expectations; the amount of support received from caregivers; the quality of the caregiver-patient relationship; and, involvement in decision making during birthing. Having a voice and participating in decision making appear to be so important that they override “the influences of age, socioeconomic status, ethnicity, childbirth preparation, the physical birth environment, pain, immobility, medical intervention, and continuity of care, when women

evaluate their childbirth experiences” (Hodnett 2002:160). A synthesized review of research on psychosocial factors that influence the outcome of labour and childbirth, by Howarth et al. (2010) found that women who had continuous one-to-one support, they experienced lower pain, fear and anxiety, as well as greater satisfaction with the labour and birth. When women consistently saw the same care provider throughout their pregnancies and births, they were more satisfied than women who saw a number of different professionals (van Teijlingen et al. 2003). In a study in Ireland, Cronin (2003) used in-depth interviews and focus groups to examine experiences of giving birth, and identified the importance of support from lay networks, health care professionals and other services such as public health as significant issues. Cronin also identified support for breastfeeding, the mother and child relationship, coping and psychological strategies for depression, frustration and loneliness as central for the women.

One of the issues identified in the literature about women’s lack of satisfaction during their birth experiences is how a mother works through her birth experience over time and how dissatisfaction affects her mothering. Consistent with other work on birth satisfaction, Hodnett (2002) reports interviews with new mothers are often conducted while the woman is still in hospital. Women may not be at their best during the early postpartum period and the full impact of the experience may not have fully registered with them yet. However, Hodnett (2002) did find that participating in decision making and having a voice are leading determinants in defining satisfaction with one’s birth process. Thus, a major source of childbirth dissatisfaction, that is, not being informed and not having a say or choice in how their births progressed is not being heard. Women’s points of view are marginalized and the omissions of choice and voice are read as dismissive and oppressive thus rendering women silent. When women’s voices are silenced by care givers avoiding negotiation and spending time sharing information and decision making,

this allows the medical system, as an institution, to run smoothly. The literature suggests that women's subjectivity is minimized at best and absent at worst (Brodsky 2008; Davis-Floyd 2001). Women's bodies, whether pregnant or not, have been the object of male fascination and obsession (Goodwin-Smith 2012) and pregnancy has been described as a social construction of illness that has been pathologized and treated and administered as "otherness via the professional representations of the modern expert" (527).

How a woman sees herself becoming or being a mother often reflects how she was mothered (Carpenter 1985; Rubin 1967a, 1967b). Thus, the understanding and knowledge a woman brings to motherhood are influenced through the interplay of factors over her life span (Logsdon and Gennaro 2005; Misra et al. 2003). A woman's attitudes towards mothering develop as a result of the interaction between biological and environmental variables in her life (Evans and Stoddard 1990), including the cultural beliefs and images depicted in the media. For instance, many girls play with dolls mirroring maternal roles and modelling what lies ahead. These dolls assure enculturation of girl children into our gendered cultural roles that see a mother not only as having a child but also as a person who socializes and nurtures (Chodorow 1978). Socialization into motherhood includes the role of primary parent or caretaker and mothering is also central to the sexual division of labour (Baines et al. 1991; Chodorow 1978). Although some men in contemporary society also provide childcare, there are important role differences. In heterosexual relationships men often have more choice about the caring work they undertake. Moreover, the concept of "maternal bonding," is a key concept that has fuelled the ideology of motherhood (Baines, et al. 1991; Mercer 2004; Rubin 1967a, 1967b).

Attachment Theory

Early work by Bowlby and others describe the deep feeling parents have for their children (Ainsworth 1964; Bowlby 1997; Vaillant 1985) and the damage that occurs when a child experiences loss or a lack of attachment. It is believed that the attachment that is formed in infancy will help to shape the attachment relationships people have as adults. Meeting an infant's first basic needs, a prerequisite for optimal development, is the basis for secure attachment to a primary caregiver (Steinhauer 1998). Attachment is the bond of caring that ties child and caregiver to each other and once formed the attachment persists despite temporary absences of the primary caregiver. Harris (1998) disputes Bowlby's claims of kind, honest people will have kind, honest children and those disreputable parents who are rude and liars will have children that are the same way. Harris (1998) maintaining that this may not be the case and proposes that parents do not entirely shape their child's personality or character and that peers have more influence on them than their parents. For example, take children whose parents are immigrants where the child continues to speak the native language at home, but can also learn their new language and speak it without an accent, while the parents' accent remains. Children learn skills from their peers because they want to fit in (Harris 1998). Field also argues against attachment model stating that mothers are not the only individuals that infants and children are attached. Children may well exhibit crying and attachment when a sibling or peer get ready to leave them and may become just as fussy or unable to sleep (Field 1996). In addition, another limitation to the attachment model is that the mother is viewed as the primary attachment figure, when in fact; a partner or other family member can have the same type of attachment with the infant at the same time (Field 1996).

The development of attachment occurs for mothers and other family members with accompanying deep feelings and craving for the child that is often referred to as love. Maslow's (1943) hierarchy of needs outlines the necessary requirements for human development of which love and a sense of belonging are foundational for each individual.

After giving birth, mothers often describe an intense, immediate love for their child and I have often amazed how women fall in love with their child at first sight. Hormonal influences of oxytocin aid and stimulate these feelings of early love or attachment reinforced by cultural expectations and societal norms in shaping a woman's expectations of herself to love her child. For some women and men these feelings of love begin prior to birth and grow with time (Condon 2012; Deutsch 1944; Winnicot 1958). Early dependence and the helplessness of a newborn add to a parent's sense of caring and devotion. Rich (1979) describes her feelings toward her first child and critiques the lack of information about the psychic crisis and the feelings of being taken over by love. She notes that the "new physical and psychic potentialities ... [and] heightened sensibility ... can be exhilarating, bewildering and exhausting" (17). Further she points out that, no one "mentions the strangeness of attraction—which can be as single-minded and overwhelming as the early days of a love affair—to a being so tiny, so dependent, so folded-in to itself—who is, and yet is not part of oneself" (17). Unfortunately, with advancing technology, the structure of health care experiences and the processes of hospital practice have changed birthing processes and some women's experiences of birthing.

I now turn to the structure of health care experiences and the processes of current Canadian hospital practices to gain a sense of how birthing has changed with science and advancing technology.

Medical Control of Childbearing: Caesarean Births

Health care today in Canada is experiencing cultural, social and technological changes that have further influenced birthing practices. Hospital procedures and processes are privileged and oppressive: privileged in that they support the workings of the institution rather than the woman receiving care and oppressive due to their lack of a women-centred approach (Farmer 2004; Goodwin-Smith 2012).

There is an increasing rate of caesarean births (Lowe 2013). The argument for caesarean sections is framed as permitting women to schedule the most convenient date for the birth. More often obstetricians prefer cesarean sections as they are more convenient as they can be done in day-light hours and more suited for scheduling their office hours. For doctors, scheduling a birth, rather than being called in the middle of the night is one consideration, but financial incentives are a big factor, since caesarean sections are lucrative for physicians and private hospitals because a greater number of births can be performed during one work shift. Also avoidance of malpractice suits is important to doctors because the birthing time is considerably shortened and there is a perceived decreased risk of complications; thus, litigation is avoided (Davis-Floyd 1993; Munro et al. 2009). Caesarean births also increase health care costs exponentially.

Women in North America have been enculturated to view surgical birth as an easier way to have a child, avoiding the pain and “messiness” of birth (Bryant et al. 2007). Women are choosing caesarean sections (Klein 2004) in the belief that caesarean are safest for the baby (Munro et al. 2009; Ryding et al. 1998). However, caesarean birth is major surgery, an invasive procedure that holds considerable risk (Declercq et al. 2005; Ecker and Frigoletto 2007; Liu et al. 2007; Liu et al. 2002). Today, caesarean rates in Canada and the United States are approximately 30 per cent (Liu et al. 2007).

The World Health Organization suggests that caesarean section rates higher than 15 percent cannot be medically justified (Gibbons et al. 2010). Countries whose caesarean section rates exceed fifteen per cent include the United States with 30.3 per cent, Australia with 30.3 per cent, United Kingdom at 22 per cent and Canada at 26.3 per cent (Gibbons et al. 2010). The escalating caesarean rate in the developed world contrasts sharply with estimates of around one to two per cent in very poor countries (such as sub-Saharan Africa, see Gibbons et al. 2010) where access to medical technology is limited (Dumont et al. 2001). Yet the proportion of women in developing countries needing a caesarean section is theoretically higher due to poor prenatal care and greater obstetric risk (Dumont et al. 2001). Women in Canada have access to publically supported prenatal health care through a system of universal medical coverage. Early health care during the prenatal period assists in the detection and prevention of problems in later pregnancy and delivery (Hudelist et al. 2008; Kalyanadrishnan and Scheid 2006; Richards 2009). In Canada today, we should be seeing *fewer* operative births; yet, the opposite is true. While rising rates may be due to women electing to have caesarean births or women being coerced into believing it is the best and easiest way give birth.

Investigations in Canada show recent and unexplained increases in frequency and severity of postpartum hemorrhages (Joseph et al. 2007) that suggest childbirth practices may be causing such complications. Women in developed countries and in some developing countries are undergoing and demanding caesarean sections to avoid the perceived risks of vaginal childbirth (Fenwick et al. 2010; Hopkins 2000; Hsu et al. 2008; Karlstrom et al. 2010; Kelly et al. 2013; Lee et al. 2001).

Increasing rates of caesarean births have been explained in term of biological deviances, or individual desire by both women and obstetricians. This complex phenomenon is reduced to

explanations that originate from beliefs held by each individual and deny the influence of social contexts. Caesarean births have become medical phenomena and are produced, at least partially, through social belief systems (Bryant et al. 2007). These social contexts include the recognition that caesarean birth is structured by broader gendered power relations with the obstetrician having greater decision-making for when and how these surgeries are performed (LoCicero 1993). In other instances women who are employing new medical technologies for pregnancy and surgical births can be seen as a marker of choice, conferring a sense of empowerment and social status (Behague 2002). However the rising surgical birth rate and the impetus to contain health care costs may drive the need for research aimed at promoting vaginal delivery (Johnson and Wiencek 2005), albeit from a different ideological perspective. Women's bodies, seen as objects through operative births, take away women's participation as well as their subjectivity.

In my own practice, women have reported to me that they "don't feel like a woman" following a forceps birth or an emergency caesarean birth. After surgical interventions, women question themselves, their bodies and their ability to have a vaginal birth. These comments translate as a loss of self-esteem and a lost opportunity for an empowering female experience (Callister 2004, 2006; Page 2004).

Operative Births in British Columbia (B.C.)

The Canadian Institute for Health Information (2013) reported an increase in the number and rate of births by caesarean across the country. By 2010 caesarean birth rates in Canada have "increased to 26.9% from 17.6% in 1995" (Kelly et al. 2013:207). This means that, on average, one in four Canadian women will have a caesarean delivery (British Columbia Perinatal Database Registry 2011). Among the provinces, Newfoundland and Labrador and B.C. continue to have the highest primary caesarean rates (21.1% and 22.4% respectively), while Manitoba and

Quebec had the lowest rates 14.2% and 15.3% respectively (Canadian Institute for Health Information 2013).

The British Columbia Perinatal Data Registry summarized their findings over the ten years from 1995-1996 to 2005-2006:

Over this time there has been an average of 40,000 births per year. During this time the rate of spontaneous vaginal delivery decreased from 64.2 to 60.1%; the rate of assisted vaginal delivery, including vacuum and forceps intervention, decreased from 12.2 to 10.4%. The provincial Caesarean section rate rose from 23.6 to 29.5% (BC Perinatal Health Programs, Executive Summary, Caesarean Birth Task Force Report 2008:5).

Clearly, there is a continual increase in unexplained high risk caesarean deliveries in the province of B.C. where numbers have increased steadily and significantly from 27.1 per cent in 2001/2002, to 31.0 per cent in 2010/2011 (Perinatal Services of British Columbia 2011). This means that in 2009/2010, the B.C. rate of 30.3 per cent was 13 per cent higher than the Canadian rate of 26.8 per cent.

Caesarean births are performed for a variety of reasons, such as a foetus too large for the pelvic opening, fetal distress, or following a failed induction (British Columbia Perinatal Health Report, Caesarean Task Force, 2008). Other complications—separation of the placenta from the uterus prior to the birth of the infant, a cervix that does not dilate, a foetus that does not descend within the pelvis—increase the risk of surgical birth (Davidson et al. 2012). Other indications include breech presentation (Kotaska 2004; Kotaska et al. 2009), twins, previous caesarean birth (Behague 2002; Hildingsson 2008) and obesity (Davidson et al. 2012); although for these conditions the research suggests that vaginal birth would be a reasonable choice for some of these women (Lothian 2006b). Some obstetric situations are emergencies (such as abruptio

placenta and placenta previa) and, in these situations, caesarean birth often saves the lives of both mother and child. While other complications are infrequent; however, women are unwilling to take risks and therefore request a caesarean birth for the health of their unborn baby and care providers respond. Birth moves from a normal physiological process to an orchestrated process of high risk surgery, thereby changing the dynamics of the birthing experience. As more women request a caesarean birth prior to the onset of labour—termed “caesarean on demand” (Lothian 2006b)—high risk surgical birth becomes a legitimate norm. The move from a vaginal birth to surgical intervention affects the outcomes of labour and birth and ultimately reduces a woman’s level of wellness after birth (Davidson et al. 2012).

Unsatisfactory Birth Experiences

Despite modern medical technology and increasing surgical interventions, women experience births that are less than optimal. Indeed, health professionals are seeing an increase in the number of women who experience great dissatisfaction following childbirth (Beck 1995, 1996, 2001; Kitzinger 2006; Romano 2006). Women who have experienced difficult birthing may display a sense of bewilderment, express feelings of unresolved loss, weep and manifest other symptoms of deep emotional trauma (Beck 2001; Beck et al. 2011a, 2011b; Figueiredo and Conde 2011). There is a growing link between women’s experience of an unsatisfactory birth and the instances of postpartum depression (PPD) and posttraumatic stress disorder (PTSD) (Creedy et al. 2000). An increasing number of women are taking antidepressant medications prior to birth. These medications may be prescribed for myriad reasons including reasons due to PPD triggered by a previous birth (Logsdon et al. 2006), or after a difficult birth (Goodman et al. 2004; Misri 2005; Soet et al. 2003).

Birth has been studied and described as a negative event (Waldenstrom et al. 2004). Their experiences of negativity have been associated with excessive pain (Lowe 2002) or fear of childbirth (Fenwick et al. 2009; Nilsson and Lundgren 2009). The meaning of women's experience of childbirth fear, according to Nilsson and Lundgren (2009), is "to lose oneself as a woman into loneliness" accompanied by feelings of danger and pain that threatens the loss of self-identity (4). Other negative birth experiences include sudden birth complications (Wilde and Murray 2009) such as an emergency caesarean section or instrument birth when accompanied by dissatisfaction with intrapartum care have shown to result in increasing rates of PPD and PTSD after childbirth (Creedy et al. 2000). Women who experience a preterm births (Bick 2012; Wood and Quenby 2011) or other life threatening complication for themselves or their newborn also experience higher rates of PPD and PTSD (Elmir et al. 2012; Hunter et al. 2008; Oyelese and Smulian 2006; Williams et al. 2005).

A traumatic response can occur immediately following birth or be delayed to surface at some later time. With negative birth experiences feelings of pessimism, however, do not diminish (Howarth et al. 2010; Simkin 1991, 1996). Following a difficult birth, women survivors of sexual abuse, incest, PTSD and other mental health concerns may suffer from depression or re-traumatization (see Ayers 2007; Beck 2008a; Gamble and Creedy 2004; Klaus 2010; Kulkarni 2014; Leach et al. 2014; Leeners et al. 2006; MacKay and Rutherford 2012; Misri 1995; Mollard 2014; Onoye et al. 2009; Parfitt and Ayers 2009; Parratt 1994; Rose 1992; Rouhe et al. 2011; Seng et al. 2009, 2014; Simkin 1992a). Research in clinical psychology has indicated that understanding predictors and triggers to PTSD following traumatic birth through a process of describing and evaluating counseling for women for its efficacy is in order (McKenzie-McHarg 2004). Other areas for further investigation is the elaboration of other predictors, such as

psychosocial and cognitive factors in addition to a complete understanding of the best methods and timing of measurements of PTSD also requires further investigation (McKenzie-McHarg 2004). Researchers are just beginning to identify strategies to assist women in the antepartum and postpartum periods to identify strategies to assist or prevent these occurrences in women's lives and in the lives of their families (Ayers et al. 2006; Clatworthy 2012; Figueiredo and Conde 2011; Letourneau et al. 2012). There is preliminary evidence indicating that interventions delivered in pregnancy can be effective in preventing PPD when based on psychological therapies and treatments are better conceptualized early in pregnancy rather than preventive interventions (Clatworthy 2012). In addition, treating the entire family has also been strongly recommended in the identification and treatment of PPD (Letourneau et al. 2012; Zauderer 2014).

The polarities of satisfactory and traumatic births have been studied, as well as the broad middle ground of investigations on various aspects of pregnancy, prenatal care and education, labour and birth. However, few studies have looked at what the meaning of difficult birth is for women and when "difficulty" is mentioned the topic usually refers to traumatic births.

One-third of Euro-American women evaluate their experience of childbirth as traumatic, giving examples of having been dismissed, treated without dignity and ignored (Ayers et al. 2006; Forssen 2012). An estimated 19 per cent of women will suffer with PPD during the first year after birth (Gavin et al. 2005) making this "the most common complication of childbirth" (Beck 2008a:122). The idea of childbirth complication frames the event as medicalized and does not consider the social context in which a woman experiences PPD. Medicalization moves the experience of PPD into an arena as something other than a normalized childbirth (Graham and Oakley 2005). The challenging role transition for the new mother is exacerbated by the

experience of PPD and there are serious psychosocial consequences for a woman and child (Deave et al. 2008; Field 1998).

Simkin (1991) conducted a retrospective study of women and their perceptions and recollections of their birth process. Simkin taught childbirth classes during the late 1960s and early 1970s to the women participating in the study and interviewed the women 20 years later to access their recollections of birth over time. The results from the study showed the women held vivid and detailed memories of their birthing. Simkin claims that childbirth has a powerful effect on women and has “the potential for permanent or long-term positive or negative impact” (210) on the lives of women and how they see themselves. As a woman recollects her caregiver forever, “the question that should be kept in the caregivers mind at all times is ‘how will she remember this?’” (Simkin 1991:210). Furthermore, caregivers need to remember that they represent authority figures during this vulnerable time in a woman’s life and their actions can “contribute directly to her long-term satisfaction and indirectly to her self-esteem” (210).

Birth trauma and its sequelae can extend beyond the postpartum period into an unknown future. These experiences of birth and how a woman mothers following a difficult birth have been portrayed through the diagnosis of PPD and PTSD.

Women’s Birthing Experience: Trauma and Post-traumatic Stress Disorder

Trauma and traumatic memory have been a focus of psychiatry, cognitive science and neuroscience for approximately the past 100 years or so (van der Kolk 1987; van der Kolk et al. 2001). The awareness or retrieval of lost memories has also extended knowledge about the relationship among stress, memory and traumatic events.

In 1980, posttraumatic stress disorder (PTSD) was first included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (American Psychiatric Association [APA],

1980), thus legitimizing experiences of trauma on an individual's life. The DSM-IV provided a broadened view of what constituted an extreme traumatic stressor, including "direct personal experience of an event that involves actual or threatened death or serious injury, or a threat to the physical integrity of the self or others" (DSM 1994:424). This broad range of qualifying traumatic events, with the added criterion of a specific emotional response, deemphasizes the objective features of the stressors and highlights the clinical principle that people may perceive and respond *differently* to similar events. This criterion established a category for trauma and its consequences following a difficult birth.

Researchers have studied traumatic aspects of the birthing process, including risk for postnatal emotional distress (Callahan and Hynan 2002), prevalence and prediction of posttraumatic stress symptoms following childbirth (Czarnocka and Slade 2000), PTSD in women who have undergone obstetric or gynecological procedures (Menage 1993) and, PTSD after childbirth (Beck et al. 2011b; Marrs 2013; Modarres et al. 2012; Thurgood et al. 2009). To date, no information or research has been found on the impact of a difficult birth on mothering over time.

As noted previously, in Canada an increasing number of women are experiencing instrumental or caesarean births. Similarly, an increasing number of women are taking antidepressants prior to and following giving birth. Evidence suggests that fewer women are having a positive, empowering birth experience and an increasing number (more than 19.2%) of women are suffering from depression following birth and some having traumatic birth experiences (Beck 2004a, 2004b, 2006).

Even though birthing emergencies resulting in surgical intervention are becoming more common, they are, in themselves a source of trauma (Creedy et al. 2000). Trauma during or

following birth has been described and studied by nurse researcher Beck (1995, 1996, 1998, 2001, 2006), who has helped to identify and extend understanding women's experiences following a difficult birth in both the United States and Australia. Birth trauma involves experiences that "may occur during any phase of childbearing ... the trauma may be classified as a negative outcome, including a stillbirth, an obstetric complication (e.g., an emergency caesarean) or psychological distress (fear of an epidural)" (Beck 2004a:212). A more extensive list of birth traumas include infant death, emergency caesarean delivery and/or fetal distress, cardiac arrest, inadequate medical care, congenital anomalies, inadequate pain management, manual removal of placenta, forceps, vacuum extraction and/or fetal skull fracture, separation from infant in the neonatal intensive care unit, prolonged painful labour, rapid delivery and degrading experiences (Beck 2004a). With all these bodily changes and adaptations in pregnancy I wish to ask, how does a traumatic memory impact one's sense of motherhood?

Structural Violence

Difficult births may be framed as "structural violence," that is, the absence or lack of care and attention by social agencies that are intended to serve others (Galtung 1990). Farmer (2004) describes structural violence as a social arrangement that places individuals in harm's way. The arrangements "are structural because they are embedded in the political and economic organization of our social world and ... violence because they cause injury to people" (Farmer et al. 2006:1686). Furthermore, structural violence is often brought to bear on those people whose social status lacks empowerment.

The organization of the health care system has been constructed on the basis of scientific and social progress privileging biological investigations over human experiences of suffering (Farmer 2004). Included within the structure is an acceptance of care meted to those seen as

needing care as well as justification for those disadvantaged from receiving care. In most hospital systems unequal distribution of power (Ho 2007) is a consequence of direct or indirect human agency (Farmer 2006) and the inequities that exist are the underlying problems for particular groups. The idea of structural violence is linked very closely to social injustice and the social machinery of oppression (Farmer 2004; McPherson 2012). McPherson (2012) has studied violence and finds that violence is about “power differences and power inequities are a necessary and sufficient condition for violence” to be perpetrated on another (37).

For birthing women structural violence may be seen as the increasing use of surgical births without adequate evidence that these types of birthing procedures are needed, in not informing women about treatment, or by treating women in a less than humane manner. More will be said on structural violence later in the paper.

Baby as Product

The experience of pregnancy for the woman is a life transition. A woman becomes pregnant, experiences nine months or so, of changes in mind and body, labours and gives birth from her body. When described this way we see the woman as object, a separation of the mother’s birthing (process) from the baby (product) and the baby as object.

New ways of “seeing” the body produce new ways of experiencing the body. Technology allows us to penetrate that once secret enclosure of the uterus to expose the image of the foetus to public gaze, eclipsing the pregnant woman in the public mind (Duden 1993). Anxious, perhaps, about the health of the global environment, medical science and technology has focused on protecting life in the maternal ecosystem, which can pit foetus against mother such as restrictions placed on women in regards to their activity, their work environments and what they eat, as well as women with addictions to alcohol or drugs or any activities that are seen as harmful (Roth

2000). This adversarial relationship occurs not just within the female body but outside of the body, through dialogue by others who wish to control women and their reproduction (Moore et al. 2010). The church, legal system and societal ideologies have supported the ownership of women's bodies, first by the father and later by the husband. The mystery of childbirth and its powerful function in society have always been a frightening concept for men (Keen 1992). The control of women through laws and church reinforced the dogma of male control.

The history of "ideological gynecology has now led us to the epoch of fetal dominance" (Duden 1993:99). The visible image and appearance of the foetus has colonized discourse, vision and even the experience of the potentially or actually pregnant woman. The foetus threatened by extinction is used as a signifier, an instance, a news-hook, or an emblem of a much more general statement about endangered life (Duden 1993).

Women, Mothering and Being Female

Women have been associated with "nature" and an essentialized biology, an affiliation that has persisted "through culture, language and history" (Merchant 1983:xix). As most of the people taking up the work of mothering have "had female bodies, mothers, taken as a class, have experienced the vulnerabilities and exploitation as well as the pleasures of being female in the ways of their culture" (Merchant 1983:41). However, an expectation of many cultures is that many more women than men who have not actually become mothers "are still expected to engage in maternal work or identify with those who do" (Merchant 1983:43). "Maternal" is associated with women and many "men will not identify with it even though they may be behaving in ways that have traditionally been seen as feminine" (hooks 1984:138-139).

Mothering is inseparable from the condition of being female.

Surveillance: Medical Gaze of the Female Body

Margaret Atwood raises a series of questions that speak to the body under gaze and the terminology or naming that is assigned to describe birth:

Who gives (birth)? And to whom is it given? Certainly it doesn't feel like giving, which implies a flow, a gentle handing over, no coercion ... Maybe the phrase was made by someone viewing the results only ... Yet one more thing that needs to be renamed.

(Atwood 2001:311)

The idea of “view” or “gaze” in Atwood’s writing provides the onlooker with a different and distinct notion of birth compared to the woman experiencing birth. To gain a true understanding of childbearing it is essential to speak to a woman about her birth experience. However, the notion of a woman’s perceptions or experiences of birth and hospitalization is rarely covered in textbooks. Much of the information about the person is from the perspective of the trained observer or helper and can be termed as surveillance. Surveillance is defined as the information and perspective gained from watching another. The term “medical gaze” was coined by French philosopher and critic Michel Foucault in *The Birth of the Clinic* (2003), to denote the dehumanizing medical separation of the patient’s body from the patient’s person or identity through surveillance. When seen through the medical gaze, “women’s problems” (read reproductive health) are described as pathological (Theriot 1993) and hysterical (Birnbaum 1997; Freud 1962). The concept of surveillance is addressed throughout the work.

Today’s sense of privacy and decorum in Western society looks very different. Music videos and films offer a wide-range of visual imagery and states of undress where women are scrutinized and watched by others. Women’s bodies are depicted, not as a whole but in parts. Women then are understood as not being complete and being less than fully human and women

experience an uneasy citizenship (Boston Women's Health Book Collective 2005; Canadian Women's Health Network 2014). Influenced by fictionalized images, women have their own negative sense of their bodies (Bordo 2003). Societal and media images are juxtaposed against my own experience of women's sense of privacy. When caring for mothers during childbirth, I have frequently heard women describe intense shyness and great fear that their genitals may be unnecessarily exposed. This sense of vulnerability requires that extra effort must be taken to respect a woman's wishes and to preserve her dignity.

The arrival of the doctor, at the bedside, brings with it the medical gaze. The medicalized view is a stance much different from the woman's perspective. The medical gaze or surveillance involves seeing the woman as something to cure, to minister to and maneuver. Seeing the woman and her foetus as "patients," objectifies them through the scientific lens that defines reproduction as a biological defect (LeMoncheck 1996). Modern medicine is almost entirely preoccupied with diseases and treatments and very little is focused on health (Connors 1980). The seizure and medicalization of pregnancy and childbirth by men "are rooted in the patriarchal model that has been centuries in the making" (Cahill 2001:334). Childbirth is seen as pathological with women's bodies as inherently defective and these beliefs continue to shape women's position in society and are monitored through acts of surveillance.

The image of the female body when viewed at delivery shifts when the physician enters the delivery room. All attention is now moved from the labouring woman to the doctor. The physician needs to prepare, to scrub and glove and may don a sterile gown (with the nurse's assistance) and ready the equipment used for the delivery. He or she asks for topical anaesthetic agents, their preferred suture materials and inquire which paediatrician is on call. It is almost as if the work is now legitimate: the doctor is here and the real work can begin.

When the physician enters s/he disrupts the individuals and family who are attending the woman. At this moment the physician identifies the woman's need for assistance and for interventions facilitating the birth that keep the gaze focused on the woman's genitals. The hours of interaction and caring (Meleis 1997) for the woman and her wishes such as birth plan requests, family supports and needs have been provided by others. Medical surveillance—like science—is relieved of personal knowledge and emotion, is clinical and objective. After the woman has given birth, she often profusely thanks the physician for “delivering” her infant. In fact, she delivered her own newborn (Hunter 2006) through tremendous efforts of her body and mind and with the continuous help and support of the nurses and family who have been with her since her first contractions. If the doctor had not arrived for the delivery, the nurse would have helped the woman give birth, a situation referred to as BBA or “born before arrival” of the physician; yet the physician is still paid for the delivery. The work and travail that has occurred throughout the labouring process is measured in terms of the doctor's participation through validation of his or her surveillance.

Rothman (1984) describes the terms *to be delivered* or *to give birth*. When the mother is seen as “giving birth,” an attendant is assisting, aiding and literally being present for the woman. But when the doctor is present then the mother is in the passive position of *being delivered* (Hunter 2006). The doctor is in complete control and holds the power within the institution (Rothman 1984).

The social structure of the relationships between HCP and the woman may be very different depending on each individual. The approach taken and language used can be interpreted in a variety of ways and language is seen as reflecting the social relationship being built between

HCPs and the labouring women and this language is consistent with societal expectations and pressures (Hunter 2006).

When childbearing women receive care, this care is based on recommendations according to specific guidelines that direct care to a generalized population rather than a more individualized approach. When looking at socially mediated text, what is actually seen is women's corporeality as a commodity and where their wishes and preferences for supportive birthing practices have been marginalized (Cahill 2001; Goodwin-Smith 2012). Along with marginalization come fear of childbearing and insecurity and these fears influence women to choose surgical birthing methods. Something is dreadfully wrong with the images and messages women are receiving. The physical reality of the birthing experience has become lost. Consequently birth has become a confusion of events resulting from a failure to understand the process of birth or failure to appreciate the meaning of birth that leads to mystification of the process. As the experience of non-medicalized birth moves farther from view, women do not believe in themselves or their bodies and the potential for the "rite of passage" in women's development is lost (Neiterman 2012).

The medicalized picture of birthing and pregnancy follows the empirico-analytic position in science (Davis-Floyd 2001). The material realities indicate to women that the medical system is going to take care of her, with the woman having little to say about it (Howarth et al. 2012). So a woman's voice becomes lost and she loses her ability to choose. The justification for the medicalization of childbirth, in part, lies with the belief that the female body is flawed (Martin 1987). The Enlightenment period reinforced the notion of the flawed body with the promotion of the mind and body separation, with the body becoming the object of dissection and examination (Walsh 2010). This social construction of the female pregnant body is seen to be acted on by

external forces that impinge on behaviour and experience (Walsh 2010). Consequently, childbirth became reductionistic and women's bodies analogous to a machine (Davis-Floyd 2001).

The medicalized body is viewed and outcomes are predicted and are separate from process. There is no room for bias in this tradition. The empirico-analytic approach (positivism) considers singular truth claims and facts derived only from cause and effect relationships (Carr and Kemmis 1986; Denzin and Lincoln 2011; Emden 1991; Lloyd 1979). Thinking with and through the pregnant body, women come to understand their agency as embodying the foetus and subsequently all actions and thoughts are inclusive and encompass the unborn child. Today, and becoming more evident with time, the foetus is granted greater value and rights than the pregnant woman (Duden 1993). Women have been ordered by governments in both Canada and the United States to have caesarean births, fetal surgery, blood transfusions and other procedures that favour the foetus over the rights of the woman as a person (Binion 1995; Epstein 1995; Minkoff and Paltrow 2006).

Davis and Walker (2010) describe the image of women's bodies that have emerged from medicine and modernity. An essentialist, biological approach views the body as "disconnected from the mind, spirit, and social and cultural contexts in order to be understood as an isolated object" (Davis and Walker 2010:457). The metaphor of the body as machine with parts that can fail is envisioned to explain a cause and effect functioning. Yet, from my maternal child nursing in Canada and international experiences, it is the whole woman who brings the child into the world, not merely flesh and bones (Kitzinger 1987a).

A Woman's Desire for Birth

Desire may be constructed not as attachment to an object/subject (Kant 1790/1914) but, rather, as the notion of possibility. In the work of Lacan (1998) desire has a very distinct meaning which is associated with absence, loss and lack. If there is a lack or an absence then there suggests space, an emptiness; desire is only possible with the speaking or articulation of that desired. Possibility hints at a potential for change combined with the notions of absence, loss or lack that allow for a feminist reading that yields a searching for a different experience and the possibility for change. Desire originates from within. Women envision what they desire for their births and wish for birthing that is fulfilling and safe, conscious and connected to family, loving and supportive. Women hope for an idyllic, pain free birth. A woman who delivers a healthy, normal child of the desired sex and, who breastfeeds well, she hopes she will love the baby and her recovery is quick and without incident.

In today's Western culture where there is a pill for every ailment, pregnant women are requesting and "demanding" (Lippman 2004; Ryding et al. 1998) surgical intervention and they want an epidural on admission to hospital. The desire to feel no pain has rendered childbirth a frightening event (Gallagher et al. 2012; Melender and Lauri 1999). Further, the purpose of birth under this fear means that a rite of passage for women is lost and with it the loss of the sensory experience (Davis-Floyd 2001).

Choice

Choice is a hallmark of feminist thought and women, as feminists, choose to make a stand against sexism, racism, classism, sexist exploitation and oppression in order to end patriarchy (hooks 2000). Furthermore, choice is about what women want for themselves whether to be heard, to gain an education, a better life for themselves and their children, or to participate

in political and legal imperatives that positively work for women. However, the system works to silence women in order to keep women participating in ways that support the taken-for-granted aspects of patriarchy. In order to exercise choice women must be able to identify what they want, find their voice and have the courage to speak in order to gain change (Belenky et al. 1986). Choice for women may be witnessed in their decision to bear a child, choose an abortion or to not have children at all. For childbearing women they may now choose their care providers, depending on the availability and access to midwives and obstetricians and choice may be exercised when there is little or minimal risk. However, once in the throes of labour and particularly when the situation becomes more tenuous then choice and decision-making may be seen, by the experts, as expendable and choice may be eliminated; and actions by others, with their knowledge, power and authority, take over relieving women of their agency.

Corporeality

Corporeality is the materiality and the reality of the body. Our bodies are sensory and the individual body is felt and interpreted and is on display to those who see us. It is through our bodies that we interact with and play a part in our everyday world. Nothing, “after all, is more personal than the life of the body” (Bordo 2003:17). Women’s bodies are associated with life centred on the body, which may be seen both in the beautification of one’s own body, the reproductive body and care and maintenance of the bodies of others. Bordo (2003) characterizes “culture as having a grip on the body that is constant and is an intimate fact of everyday life” (17). For the pregnant woman her body is associated and largely confined to a life centred on and concern for her body and the foetus she houses.

Conversely Bordo (2003) tells us that the body may operate as a metaphor for culture. The body is not only a text of culture, it is also, as anthropologist Bourdieu and philosopher

Foucault has claimed, “a practical, direct locus of social control” (Bordo 2003:165). Taught through banal activities such as table manners and toilet habits, through ritual and trivial routines, rules and practices; culture is “*made body*” (Bordo 2003:165). Bourdieu (1977) argues that these rituals are automatically converted into habitual activity and thus are beyond our conscious grasp through voluntary deliberate transformation. In effect, our bodies and minds are representations of our specific cultural expectations, values and desires. Each sex is directed towards a ritualized program taught to each group and when experienced through the personal lens, becomes naturalized, enacted, rationalized and agentive.

Rothman (1994) claims that in every pregnant woman, we have living proof that individuals “do not enter the world as autonomous, atomistic, isolated beings, but begin socially, begin connected” (146). Every pregnant woman we see is a walking contradiction to the segmentation of our lives; pregnancy does not permit it.

There are gaps in the literature as to how women’s experience of birthing impacts their self understanding—particularly evident in the lack of research five years post-birth. Researchers have also noted that if the mother experiences PPD, other members of the family may also experience depression (Burke 2003; Cummings and Davies 1994; Goodman et al. 2004; Letourneau et al. 2012; Miller 2002). What isn’t clear in the literature is how the experience of difficult birth affects the mother and how she creates meaning of that experience over her life. This research will explore the meaning of giving birth and create a fuller picture of women’s experiences of a difficult birth and mothering over time.

This chapter has exposed a disconnection between what has been written about women during pregnancy and birth and what women think and feel about their own embodiment. There is an increase in mechanization of birthing, such as caesarean sections, which are the highest in

B.C. and on the rise in Canada. Women are influenced by cultural and societal messages telling them that surgical intervention is safer than vaginal birth and that caesarean births are to be preferred. Women believe what they are told by experts and current medical practices support interventions that have become normalized through their frequency of use. However, as I will show, these interventions and medical processes work to disempower women by removing choice and dehumanizing their experiences of birthing. Following instrumental birth women are often bereft wondering what they did wrong and how things could go so badly. A side effect of these interventions, experienced by the women in this study, might be disappointment, regret, shame and trauma following their birthing experiences. For some of these women, the trauma of a difficult birthing manifested as PPD and PTSD. This research investigates the contexts that constitute a difficult birth and why women felt their births were difficult or traumatic. The next chapter explores the methodological underpinnings of the research and how the research has been shaped by feminism through the use of critical ethnography.

Chapter 3 Theory and Methods

This chapter explores the theoretical choices and methods that provide structure and give philosophical meaning to the research. Approaching my work with the women participants, I chose feminist informed-ethnography and critical ethnographic methods which attends to the reflexive significance of gender as a basic feature of all social life (Reinharz 1992) and reveals the realities of “women as actors” (DiIorio 1982; Jacobsen 2009a). Using a feminist lens to explore women’s perspectives and their concerns, I bring to the surface and unpack many assumptions that constituted some of the everyday worlds of the women participants.

Feminism and feminist thought require the exploration of women’s lives from their point of view. Using feminist research strategies one is able to access women’s subjective understandings by engaging in a respectful process that enables women to uncover or surface knowledge about their lives (Belenky et al. 1986). This process involves listening closely to women’s voices, respecting their ways of being in the world and valuing their understandings of their life and its meanings. Belenky et al. emphasize the importance of women’s experience as a form of knowledge and stress the significance of subjectivities as a way of knowing (Cook and Fonow 1986; Henderson et al. 1992; hooks 1984; MacKinnon 1989; O’Shaughnessy and Krogman 2012; Stanley and Wise 1983).

Feminist epistemology and methods support data collection through the development of the life histories of childbearing women. This research aims to open up discourses about childbearing today, to make recommendations for changes that women identify as positive and supportive. In addition, this work unravels the institutional processes of modern health care to expose the reified and hegemonic medical approaches that women experience during childbirth.

The epistemic and research methods implemented provide a strong framework to guide and direct this feminist work and the methods are well-suited to eliciting the data I was seeking.

Feminist Epistemology

Feminist epistemology evolved over many decades of women who expressed feelings of exclusion from knowledge construction, seeing their own experiences, sense of self-worth and personal lives diminished and invalidated by the hegemonies in their various cultures (Hesse-Biber 2011). Feminist epistemology is both constructive and critical (Longino 1997). Critical dimensions include the “demonstration of forms of masculine bias at the heart of philosophical analyses of such topics as objectivity, reason, knowledge, and rationality” (Longino 1997:20). These biases work to diminish women’s input hindering the advance of philosophy and science (Jiang 2005). For example, due to devaluing femininity, the knowledge that mothers have of children is not greatly appreciated (Anderson 1995:50). In general, the more a “kind of knowledge is associated with femininity, the less value it will be assigned by traditional Western epistemology” (Jiang 2005: 57). In this research I valued women’s input and their knowledge about mothering behaviours as well as their stories of birthing. Conversely, constructive dimensions include creating a legitimate place and “space for feminist ways of inquiry and identifying or defending epistemic guidelines of feminist inquiry” (Longino 1997:20). Utilizing feminist ways of inquiry through attention to women’s voices of childbearing and respecting and sharing their experiences embrace constructive dimensions. Thus, feminism provides an epistemological lens to explore childbearing and to unearth the experiences of women who have had a difficult birth and the meanings they made from that birth on their mothering.

Feminist epistemology guided each aspect of the work to explore women's understandings and experiences to create new meanings about difficult births. Throughout the work I examined the gendered ways that women received care during birthing and how this impacted their mothering over time. Ethical principles were maintained through adherence to the methods and through the reflexive nature of the work.

Feminist Research

Feminist research begins with women's own experiences and perspectives (Presser 2005) and draws upon those insights and struggles to recognize women's lived realities, thus "unearthing subjugated knowledge" (Hesse-Biber 2011:3). Feminist researchers seek to minimize cultural hierarchies of knowledge by challenging traditional epistemic constructions while disclosing the multiple, historically significant positions women hold in relation to both the development of questions and how we go about research (Presser 2005). Feminist perspectives embrace an intentionality of transformation and empowerment of women's legitimate voice and ethical positioning.

Feminist research embraces a sense of openness between people and of being aware of issues of vulnerability, reciprocity and mutuality (Reinharz 1992). Openness is about being present and calls for the researcher to adopt an "open discovering way of being" and to develop a "capacity to be surprised and sensitive to the unpredicted and unexpected" (Dahlberg et al. 2008:98). Being open with women is the "mark of a true willingness to listen, see, and understand. It involves respect, and certain humility toward the phenomenon, as well as sensitivity and reflexivity" (98). Openness is gently giving purpose and being involved in an authentic, non-judgmental way with others (Finlay and Evans 2009). Reciprocity is essential for

the establishment of a firm working alliance and requires that there is a minimization of hierarchy between researcher and participant (Oakley 1981), the participant “is not ‘objectified’ nor placed in a passive role, but plays an active part in the research process” (Letherby 2003:83). Mutual interactions in which the researcher is open and “gives something of herself by talking about herself, answers questions when asked and perhaps feeding back some findings to respondent when writing up” (83) are also essential aspects of feminist approaches in research. During my interactions with participants I engaged in mutuality that reflected an open, respectful and attentive approach with participants.

Throughout the research I thought deeply about the women, what they said and the meanings that emerged. Reflexivity involves a process of critical reflection describing how the researcher constructed knowledge at each step of the research process (Guillemin and Gillam, 2004). This includes influences on the researcher’s production of knowledge and how these have guided and shaped the planning, conduct and also writing up the research. A reflexive researcher is one who is able to take a step back and critically evaluate her role in the research to recognize the limitations of the knowledge that is produced, leading to more rigorous research (Guillemin and Gillam 2004).

Engaging with the research and the nature of the topic I realized that my story of birth and mothering played a role in the conceptualization of the research. I was the researcher, but my experience was also part of the work. Reed-Danahay (1997) defines autoethnography as research connecting the personal to the cultural and thereby placing the self within a social context. As a maternal child educator, nurse and mother, writing about my own experiences alongside the participating women’s stories I reflected and thought about the women’s birthing experiences as well as my own also makes this work autoethnographic . As a nurse I possess “insider”

knowledge of the clinical setting that guides the care of birthing women as well as the acceptable and less acceptable actions of HCPs (Zaman 2008). This knowledge enhanced my understanding of the stories that women told allowing me to further delve into the women's interpretation that added to the analysis of the data. In addition, my own understandings of the maternal child field gave me "insider" knowledge of perspective and perceptions that HCPs might consider as part of their everyday worlds and were included as part of the analysis within the narratives. Ellis et al. (2010) describe a form of reflexive/narrative autoethnography where the ethnographer studies their own experience "alongside cultural member's lives" (5). Autoethnography is an approach that acknowledges and accommodates subjectivity, emotionality and the researchers influence on the research, rather than hiding from these matters (Adams et al. 2008). This "layering" of understandings helps to elicit political, socially-just and socially conscious acts of awareness about child birthing (Ellis et al. 2010).

Key Hallmarks of Feminist Methodology

Current feminist thinking includes a diversified approach to inquiry. Amid the multiple and complex ways to conduct research, Olesen (2011) has emphasized that voice, ethics, reflexivity and transformation are key to feminist methods and I consider them briefly below.

Voice

The emphasis on voice in research is grounded in feminist methodology (Millman and Kanter 1979). Voice reflects the meanings inscribed in experience, as interests and focus are revealed in what a woman says. Historically, women's voices have been silenced and not taken seriously (Gilligan 1982; Lloyd 1979). Problematizing women's embodied realities is an act of consciousness-raising. Once they have developed their own understanding of their position(s) in the world, women's voices arise from the practical, experiential and pragmatic everyday

experiences that reflect a gendered lens through which to view their cultural positions (Bordo 2003). By giving voice to their experience women engage in sharing meaning. Women who articulate their own experiences of birth offer an opportunity to uncover and interrogate birthing and mothering experiences through “story telling.” In narrating their stories, women speak with their own voice and from their own situation; their subjectivities and societal positioning shape their understandings and knowledges about the world in which they live. As women’s contexts differ, so too will their subjectivities and their experiences, to reveal different knowledges and meanings imbued with alternate understandings. Women’s knowledge of their subjectivities and experiences may be shared through speaking aloud through their voice and the notion of voice is inherently political. Knowledge is understood as power and those individuals with knowledge have socio-economic and political power to change things if they choose. Cultural practices, language discourses and social relationships reveal privileged often hegemonic perspectives, including issues of social justice (Bordo 2003; Chodorow 1978; Harding 1991; Ho 2007; Spender 1987).

Rather than seeing ourselves in retreat or defeat, Batliwala (2007) encourages women to recognize that we are witnessing a historical and dialectic process, where our voices and claims have been ritualized as a means of neutralizing or pushing back the changes in power that were sought along both gender and social hierarchies. There are three tasks of reclaiming, reframing and resistance required to bring a new clarity of voice, vision and to invigorate strategies on the part of feminists (Batliwala 2007). Feminist research is a means of addressing those tasks. My conversations with women have helped to unpick their understanding of their difficult births and mothering, to reconceptualise their experiences by allowing for emerging empowerment and transformation in thinking about the birthing event and the impact over each participant woman’s

life. The interviews and conversations opened up a space for women to look at, reconfigure, reframe and voice their own experiences in order to help other childbearing women prepare for birthing with the stories, knowledge and wisdom of experienced mothers. Sharing birthing stories with an active and interested listener women can work to empower themselves through validation of their experiences.

Ethics

Human agency is guided by an individual's ethical position (Rallis and Rossman 2010). In this section I briefly discuss traditional health care views on ethics, including non-maleficence, respect for human dignity, veracity and fidelity in relation to client care as outlined by professional and legal parameters of health care professionals in Canada (British Columbia Medical Association 1995; British Columbia Midwifery Association 2004; Canadian Nursing Association 2008).

The time-honoured ethical principle of non-maleficence or “do no harm” is considered the highest duty of professional care providers. A basic consideration in care giving and in virtually all professional codes of conduct is *first, do no harm* (CNA 2008). This raises the question of how one knows that their actions are causing harm, without knowing the lived experience of that person. To bear witness, or not, (Levinas 1979) constitutes a “rhythmical interchange,” a way that health care provider can co-participate in the lives of the person they are serving (Milton and Cody 2001:290). To refuse to bear witness through a person's time of profound vulnerability and pain is to choose a stance likely experienced by those persons as injury and insult (Milton and Cody 2001).

The respect for human dignity by professional governing bodies forbids any restriction on care giving related to the characteristics of clients, their socioeconomic status, health problems,

or environment. All HCPs must respect human dignity, the uniqueness of the client and their situation. The principle of veracity is another foundational ethic of health professionals. Care providers are bound to provide honesty and truth to the client, unless doing so will cause harm to the client. Withholding veracity is a form of “paternalism, which holds that one should decide what is best for the client and whether truthfulness will serve that end” (Milton and Cody 2001:290). There is an implicit assumption that care providers, with their scientific knowledge, somehow have a closer understanding of truth than the person receiving care. However, when care providers focus on the individual’s experience, there can be little pretense that they know better than the client. Being faithful to the client’s desires, hopes and dreams from their perspective and by honouring human dignity, brings a sense of fidelity, which must be central to the integrity of professional philosophy, actions and outcomes, for a client-centred approach to health care delivery (291),

The development of rapport by establishing respect and trust between people facilitates a relational ethical stance (Gadow 1985, 1999). Such an approach in feminist research thus addresses issues of relationship, social justice, disparities in power, and the legitimacy of the experience of the other. Feminist ethics also addresses how research methods are constructed, including valuing difference, acknowledging emotions and subjectivities, as well as addressing confidentiality, privacy and avoiding harm (Preissle 2007). Finally, feminist ethics assumes a “caring reflexivity” (Rallis and Rossman 2010), that is, intentionality for social change that has practical implications for the improvement of women’s lives (Harding and Norberg 2005).

Reflexivity and Transformation

Over the past few decades, reflective inquiry has been used as a method for investigating and resolving problems enabling HCPs to direct their observations and thought to improving

practice (Dewey 1933). Reflexive methods is a means whereby the process undertaken in research are made transparent and used as part of the data (Bulpitt and Martin 2010). Opting for a reflexive approach in the research requires understandings of how a researcher's social background, status, personal assumptions and ways of being in the world affect and influences the researcher and the research project (Hesse-Biber 2011; Rice and Ezzy 1999). Enacting a reflexive approach to research encourages feminist researchers to examine the temporalities and connections of everyday experiences and places these experiences at the centre of enquiry enables exploration of "whose knowledges are dominant, where and how was the knowledge obtained, by whom, from whom, and for what purposes" (Olesen 2011:129).

Carolan (2003) argues that reflexivity is an inter-subjective experience of connection, a dialectical process between self and other therefore, the role of researcher is subject to the same critical analysis and scrutiny as the research itself. Reflexivity is not a single event but a process that assists in dealing with the ethical aspects of research, as well as guiding the research and researcher. In particular, the researcher's personal experiences, characterized by self-critique and self-appraisal, are integral to the actual research (Koch and Harrington 1998; Reinharz 1992). By paying attention to the specific ways in which personal agendas affect the research at all points in the research process—from the identification of the research problem, to the theoretical approach and methods chosen to access the data, to how the research findings are analyzed and interpreted. Hertz (1997) notes that the reflexive researcher does not merely report the facts of the research but also actively constructs interpretations, such as, "what do I know?" At the same time the researcher questions their own interpretations by asking themselves, "how do I know what I know?" (Hertz 1997). MacKinnon (1989) advocates the use of consciousness-raising by asking questions of agency through problematizing one's social reality and that it is possible to see

things differently. Through this hegemonic process transformation of new understandings can lead to emancipation.

Feminist research strategies are designed to be respectful and ethical to both participant and researcher. Built into the methods used in this project is a sense of reflexivity, which means that the investigator is both the instrument of research and the researcher, and therefore, part of the research design. Feminist research offers the opportunity to engage respectfully in an exploration of women's intimate worlds without exploitation. In this research project, I and my respondents engaged in consciousness-raising designed to support empowerment of the interiorized embodiment of women and mothering. Feminist epistemology and methods are thus well-suited for an exploration of the meaning women make of their childbearing experiences and of their mothering after a difficult birth. Moreover, a critical perspective ensured the empowerment and emancipatory elements for change underpinned the study.

By engaging in reflexivity, multiple perspectives are brought to bear to better understand the impact over time of a difficult birth on mothering. Gender as a category serves to unravel the many social and structural texts that have bearing on creating a birthing experience. Exploring women's subjectivity politicizes personal experience and, in doing so, facilitates greater awareness and understanding of the cultural conditions in which the women participants gave birth and mothered their child. It is in these moments that the transformative intent of feminist research becomes apparent through the potential for bettering women's lives. Hence, women's experience as knowledge can be theorized. I searched my own understandings to identify where I came to specific theories in action (Argyris and Schon 1978; Argyris 1993; Mezirow 1990), how I knew and how these knowledges influenced my practice and the research process.

Experience is constituted in language and language is an assortment of ways of interpreting diverse versions of experience, women's ambiguities, authenticities and subjectivities can be expressed, in part, through words. Language acts to position women in their realities in particular ways that in turn are conveyed through story as meaning.

Delving into issues women face through storytelling, which has the effect of sharing their embodied knowledges, has the power to expose new awareness and the potential for creating change (Gluck and Patai 1991; Grosz 1994). However, cultural and societal pressures impinge on women in other ways, shaping expectations placed on them in their everyday lives. For many women, enculturated expectations have served as an oppressive regime of truth, actively working against them to subjugate their understandings and valorize ideologies that undermine their realities. Feminist methods help inform participants' embodied worlds that aim to interrogate the ways in which oppressed groups can be transformed and empowered, particularly by grappling with the power of resistance to dominant ideologies and to the colonizing gaze and agency of dominant groups. Engaging in a form of feminist praxis problematizes and explores the taken for granted beliefs and practices imbued with power and authority with the intention to transform understandings and create meanings.

Meaning Making

Making meaning, according to Durkheim, is about organizing and constructing experiences we have as humans and assigning merit and learning based on our social world (Dobbin 2009). The organization of information is a fundamental way to make meaning (Dobbin 2009) and making meaning is necessary for humans and constitutes a powerful motivation for living (Frankl 1973).

Meaning making has implications for childbearing women and becomes an important element to understand how, from their experiences of birth, women make meaning from the events that occur (Wickramasinghe 2010). The most significant new relationship for the women is the one with the child and has the power to change women's priorities in life (Prinds et al. 2014). Becoming a mother is a momentous life experience and within this transition to motherhood existential consideration regarding the meaning of life are reinvigorated (Prinds et al. 2014). The relationship to the child is a fearful confrontation of the potential loss of the child and a heightened awareness of the potential for aloneness and failure. While motherhood is constructed as a joyful event, in reality, this view diminishes the process of the birth experience and negates the confrontation with human fragility (Choi et al. 2005; Prinds et al. 2014).

Mezirow and associates (1990) have identified how people structure meaning. First, there are "meaning schemes" or sets of related and customary expectations or relationship categories often referred to as cause and effect. For example, we anticipate that walking will get us further to our destination or turning the key will open the door. Meaning schemes are seen, in this way, as rules for interpreting our lives. The second, "meaning perspectives," are made up of higher order beliefs and orientations. Examples of teacher-student, mother-child and other familiar role relationships establish meaning perspectives involving customary expectations familiar to everyone. Further, meaning perspectives refer to the "structures of assumption within which new experience is assimilated and transformed by one's past experience during the process of interpretation" (2). This process of incorporating new experiences involves the application of habits of expectations to objects or events to form an interpretation and then take action. Usually acquired through enculturation, meaning perspectives involve "ways of understanding and using knowledge and ways of dealing with feelings about oneself" (3). Often the context of an

emotional event will become reinforced and embedded in our memory and perspectives. Ideas of ourselves and our sense of identity are tied up in previous experiences and the meanings we made those past experiences. Over time, experience strengthens our structures of “meaning by reinforcing our expectation of how things are supposed to be” (Mezirow 1990:4), thereby making meaning from an event.

Wickramasinghe (2010) speaks of meaning making as a compounded metaphor that can be applied in various ways to research methods but can also be applied to meaning making at an individual level. Wickramasinghe’s considerations of meaning making theory is useful to appreciate women’s processes for understanding the experience of difficult birth and the meanings they make of that experience. Meaning making involves reading the multiple connotations of an event, including the interpretation of realities and making personal sense of “experiences and of assimilation at an individual psychological level” (8). For the women in this study, the meaning they make from their birth experience shapes their understandings and how they take these experiences into their lives. In this way, women make sense of their birthing experiences through an interpretation of their material realities.

Ethnography

Ethnographic research is a way of studying and describing a people to discover and investigate social and cultural patterns and meanings (Angrosino 2007; Street 2014; Van Maanen 2011; Wolcott 2005). Ethnographic methods are ways to “uncover meanings in everyday practice in such a way that they [meanings] are not destroyed, distorted, decontextualized, trivialized or sentimentalized” (Benner 1985:6). Best known as an anthropological method, ethnography is also successfully used by nurse researchers in contemporary research (Aamodt 1982; Baillie 1995; Cruz and Higginbottom 2013; Leininger 1985; Manias and Street 2001).

Ethnographers uncover what people do and why, before assigning meaning to people's agency. Geertz (1973) claims the ethnographer "inscribes social discourse" (19) by writing it down and the ethnographer encounters "a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular and inexplicit and which he [sic] must contrive somehow first to grasp, then to render" (10) understandable to the reader. This interwoven configuration of concepts and societal structures is, particularly during the transformation of woman to mother, through a complex array of experiences that require investigation.

There are four important hallmarks that guide ethnography and the generation of theory. Ethnography is conducted locally and resultant data is copious, dense and detailed (Geertz 1973). The data provide a new understanding that is holistic, discloses the complexity of human experience and uncovers meaning behind actions.

Geertz (1973:7) uses the term "thick description" to describe the type of rich, complex data collected while doing ethnographic research. Doing ethnography "is like trying to read (in the sense of construct a reading of) a manuscript—foreign, faded, full of ellipses, incoherencies, suspicious emendations, and tendentious commentaries, but written not in conventionalized graphs of sound but in transient examples of shaped behaviour" (10). Thick description is a means of bringing to the surface the complexities, contexts, and situatedness of women's lives, and taking notice of the nuances of human nature and personality, to respectfully expose dimensions of meaning grounded in the everyday realities. Ethnographic data collection that enables thick description, through investigation into another person's world and feminist research methods are well suited to a study of women's birth experiences.

Feminist research revolves around the need to know and understand the nature of the oppression women sustain as women. Using ethnography allows a holistic approach to the study of women and to value their storytelling and meaning made from childbirth. Ethnography, particularly critical ethnography, allows for the exploration of women's experiences from positions variously reflecting women's perspectives (Harding 1986).

Critical Ethnography

Hammersley (1992:96) describe critical ethnography as “an ‘appropriation’ and ‘reconstruction’ of conventional ethnography so as to transform it into a project concerned with bringing about human emancipation.” To that end it values the history of the research setting, recognizes the political dimensions of the collaborative researcher–participant undertaking (Hammersley 1992) and offers the potential to both investigate and affect the social and political aspects of the research participants (Foley and Valenzuela 2005) who are central to the process of doing collaborative research. Critical ethnographic research provides a forum for consciousness-raising from which nurses and clients can work together to understand and restructure clinical practices (Foley and Valenzuela 2005). For a woman who experienced a difficult birth, consciousness-raising helps to identify those factors that were within her control and outside her control. What makes this research project a critical feminist ethnography is that it brings a critical perspective to the position of the researcher and the participants. In particular, critical ethnography asks “in whose interests does the research serve?” and problematizes economic, cultural and social worlds and their taken-for-granted aspects, to see what is at stake and for whom. Moreover, a critical perspective problematizes discourses, practices, and social relationships in ways that illuminate hegemonies and how they become reified in the everyday

world. A critical feminist ethnography thus helps to unravel the social aspects of our world, but it also investigates the nature of oppression and our subjectivities.

Methods

Throughout the interviews I used a cyclical approach to the development of my inquiry. I formulated questions, asked a participant to share her story and then checked to see if I had covered all my questions. I also reflected on my own assumptions throughout the research. I reflected on my own personal and professional understandings and knowledge of birthing and its processes in the hospital setting. I examined my thoughts and questions about the stories and I analyzed the process by which my interpretation was made throughout the research and how the course of description was achieved (Fox 1993). Such reflexivity is an extension of communication into the deeper domains of human experience (Freshwater and Rolfe 2001) shedding light on my respondent women and the performativity of motherhood (Butler 1988). Moreover, I engaged each woman with a commitment to reciprocity through mutual sharing of understandings with sincerity and honesty. Where possible, I engaged in mutuality and authenticity through joint decision-making, such as how conversations should proceed and by being flexible with schedules, family and commitments.

To access women's stories, I used elements of ethnographic methods to capture life history through narrative and to uncover memories and meaning in artifacts (such as photographs) which the women shared with me. My ethnographic method included the feminist epistemological hallmarks of reflexivity, voice, ethics and transformation. In addition to paying attention to ethical concerns, the participating women were informed of all aspects of this study—from recruitment procedures, ethical considerations, addressing data collection and data analysis to the drawing of conclusions.

In my method, I adopted Wolcott's (2005) trilogy of research methods: *experiencing*, *enquiring* and *examining*. Instead of experiencing the women's lives through researcher observation (Wolcott 2005) I *experienced* their lives through their stories (Lyotard 1984). *Enquiring* or, asking questions during the interview (Wolcott 2005), was an active part of the research as I enquired of participants what was going on and probed to discover their experiences of birthing. The last aspect involves *examining* artifacts and mementos, such as photographs, toys and memorabilia, which served to trigger memories about their mothering over time. These steps, along with keeping field notes and journaling, formed the basis of data collection for my study.

Reflexivity influences a researcher's production of knowledge and guides and shapes the planning, conduct, analysis and writing of the research. A reflexive researcher takes a step back to critically evaluate her own role in the research. In addition, a reflexive stance also recognizes the limitations of the knowledge that is produced (Guillemin and Gilliam 2004). Given the nature of the research question, the feminist perspective taken, the position of the researcher and of the participating women, this questioning became an important consideration given the fluidity of power relationships built into research (Stanley and Wise 1983). I remained aware of reciprocity, mutuality and issues of vulnerability (Reinharz 1992) and reflected on the authenticity of human issues I encountered, thus legitimizing and grounding the work and ensuring research rigour (Meleis 1996).

Aims of the Research

This research is designed to investigate the impact of a difficult birth on a woman and on her perception of her own mothering. I wanted to investigate difficult birth experiences to determine if over time, this experience affected how women made meaning of their experience,

and their relationships with children and family members. Over the course of my research, I conducted three interviews with each of the 12 women (see Appendix - C for a list of starter questions).

The open-ended interview approach enabled the women to share with me their individual stories, from which I was able to identify common threads and, using a reflexive approach, dig deeper and develop subsequent questions to further probe their difficult births. Synthesizing the data resulted in the establishment of six analytic categories: enforced silence; bullying (including being ignored or made to feel stupid); neglect; isolation; ‘projected stigma;’ and ethical issues implicated in biomedical birthing practice.

Artifacts

Images and objects help to shape memories. Photographs, for example, freeze moments in time and provide a means of reflecting on the past. Images sharpen memories from exact moments, bringing forth recollections such as who was in the room and what one’s private thoughts were. Thus, I asked women to share pictures of their baby, baby books and other mementos as part of their interaction with me (see Appendix B – Consent Form for Artifacts). These artifacts provided a rich and fuller picture of the women’s birthing experience and to learn how the women related to the mementos linking the past to the present in their creation of meaning.

The sharing of personal artifacts encouraged further discussion thus incorporating these discussions and mementos into the interview process and the research itself. A baby’s teddy bear, blanket, photograph or toys are reminder of that childhood time in a family’s life and helped establish context for the women’s stories.

Ethnography: Life History through Stories or Narratives

Life history is a method used within ethnography to indicate a narrative study, either oral or written, (Connelly and Clandinin 1990; Holloway and Freshwater 2007; Polkinghorne 1995) of an extensive autobiography or biography (Chase 2005). According to Chase, life history may be presented as a short topic story or a narrative of one's entire life, from birth to the present or as an extended story about "a significant aspect of one's life such as schooling, work, marriage, divorce, childbirth, an illness, a trauma" (652). A life history may revolve around an epiphanal event (Denzin 1989) or a turning point in one's life (McAdams et al. 2001). Birth particularly one that is difficult, can be said to be an epiphanal moment and is a turning point for substantive changes in a woman's life. Collecting life history narratives supports my intent to interview women about their mothering starting from their childbirth experiences (Angrosino 2007).

A life history approach links experiences or actions and the theoretical with the personal (Mandelbaum 1973). Capturing a life history usually involves multiple interviews over an extended period of time (Hagemaster 1992; Haglund 2004). Based on starter questions in an interview format (see Appendix B), I used semi-structured in-depth interviews over three meetings to explore each woman's birthing story and history of mothering. Stories of relationships and context added to the richness of the conversation. I found myself in a virtual space, travelling with the women as they shared their path of lived experience through their births.

Life History: Hearing Women's Stories through Thick Description

Stories or narratives help people make sense of their experience (e.g. Bochner, Ellis and Tillmann-Healy 1997). With personal knowledge there is an opportunity to reclaim and reframe one's previously "inscriptive" exteriority (Grosz 1993) and to seek a more accurate, reflexive

and “true” rendition of one’s interiorized, intimate world. Thick description is a means of bringing to the surface the complexities, contexts and situatedness of women’s lives and taking notice of the nuances of human nature and personality to expose dimensions grounded in their everyday world (Geertz 1973). The potential for data collection that includes thick description and feminist research methods is well-suited to a study of women’s birth experiences. The research offers the opportunity to engage in a non-exploitive and respectful exploration of women’s intimate worlds. All participants engaged in consciousness-raising designed to support empowerment of the interiorized embodiment of women and mothering.

Recruitment and Working with Participants

Women were recruited to the study through advertisements (see Appendix D) posted in various communities, as well as through word of mouth or, the “snowball” technique (Babbie 2012). I provided a small package for each participant that included information describing the study (for a list of enclosures see Appendix G), a letter of introduction, consent forms (Baker, Lavender and Tincello 2005) and my contact information (see Appendix F for letter, Appendix E for consent form and Appendix I for contact information), as well as a list of counselling services in their geographic area (see Appendix K).

Initial Contact with Participating Women

After a woman connected with me, I set a time to meet with her in a setting of her choice such as in her home, a coffee shop, restaurant or my office. In our preliminary meeting, I described the study and my intention for three audio-taped interviews, other data collection methods and the time the study required. Subsequent interviews were held in a variety of settings that worked for them and the process. Coffee shops, outdoors and restaurants were problematic due to background noise, which impaired the audio component making it difficult to decipher,

and we avoided these locations for locations that were quieter. All the women who came forward elected to participate in the research after our initial discussion and each woman signed the consent to participate prior to the first interview.

Each time we met, I reviewed consent. I gave a list of starter questions to the women in advance to ensure they knew the types of questions I would ask, as well as the potential length of time involved (Forbat and Henderson 2005). In addition to the questions posed women shared other details about their lives (background and context). Most women shed a tear or wept at the first interview; yet, reminiscing did not bring up negative latent issues as I thought they might. Some tears surrounding birth, such as when love began and other heartfelt moments, also brought tears of recalled joy and happiness.

The participants were all English-speaking women over 19 years of age who had experienced a difficult birth at least two years ago as a minimum period in order to track the effects of a difficult birth over time. The woman herself defined her birth as difficult and that the birthing experience affected her mothering. Participants were not required to have a medical examination or confirmation as to any “medical diagnosis” of a difficult birth. There was no limit to the length of time since a difficult birth occurred, which allowed women over 19 years of age to participate. Women recently diagnosed or currently experiencing symptoms and/or being treated for posttraumatic stress disorder (PTSD) were excluded.

My goal was to understand the impact of a difficult birth and how women experienced mothering over time (Lindseth and Norberg 2004; Waldenstrom 2004). In order to investigate the question of the impact of a difficult birth on mothering, I conducted life history interviews with 12 women over a period of one year (Easton et al. 2000). Delving into the interiority of women’s experiences, I paid attention to the women’s meaning-making (Grosz 1993).

The Twelve Women

I interviewed women whose difficult births occurred from three to 33 years ago and who thus represented a broad range of ages, differing cultural times, health care practices and aspects of technical birth (See Table 1 for a list of demographics). Of the 12 women, ten said their first birth was difficult, one identified her second birth as difficult and another identified her third birth. All were English-speaking Canadians, representing many provinces, with the exception of the east coast of Canada. While most were Caucasian, one woman was of First Nations heritage. Three were nurse educators, one was a practicing maternal child nurse and one a newly graduated practical nurse. Three women stated their own mothers were registered nurses and one woman's father was a doctor. Eight of the women had post-secondary education at the time of their births. Culturally eight of the women can be assumed as privileged (Turcotte 2011) due to their educated level and assumed socio-economic status. Four women did not have higher education at the time they gave birth. Regardless of educational status, all the women in this study experienced what they describe as a difficult birth. Education offers little protection from the effects of birthing on mothering, although several of the women were not deemed as privileged and were regarded with disrespect.

Three of the participants were nurses when they gave birth. Their education and knowledge of hospital birthing and awareness of procedures may have helped to provide a deeper articulation of their experience and the difficulty they endured; however, their understandings did nothing to ameliorate their suffering. Two other participants became nurses after their difficult births and their reflections about their births were then read through nursing knowledge acquired after their births. One woman who related her naivité at the time of her birth and was shocked during her education on neonatal resuscitation with further realization of the

Table 3.1 Women's Birth Demographics

Name	Age	Year Since Birth	Pregnancy	Type of Birth	Medical Complications	Mental health and counselling
Amber	Early thirties	12	First	Suction and Forceps Epidural	C-Difficile Third degree tear	
Barbara	Late twenties	15	First	Forceps Epidural	Third degree tear	Depression and counselling
Carol	Late twenties	20	First	Cesarean Section	Preterm birth at 30 weeks Kink in ureter Hospitalized for several weeks prior to birth	
Diana	Late teen	12	First	Forceps Epidural	Post-partum hemorrhage To O.R. for repair of third degree tear and tear of cervix	
Eileen	Early thirties	13	First	Vaginal birth	Prolonged healing time	
Francis	Thirty	8	First	Attempted forceps, then Cesarean Section	Infected incision for a year	Depression and counselling
Gillian	Late teen	34	First	Cesarean Section General Anaesthetic	Pelvic infection (sepsis)	Depression and counselling
Hillary	Late twenties	14	First	Vaginal birth	Preterm birth at 30 weeks	Depression and counselling
Isabelle	Mid thirties	33	Third	Vaginal birth	Preterm birth at 31 weeks Ruptured appendix	PPD
Jennifer	Thirty	5	First	Cesarean Section Epidural	Breech presentation Brain tumor	PPD and counselling
Karen	Late twenties	17	Second	Vaginal birth	Induced birth at 38 weeks Kink in ureter	
Lyanne	Early thirties	13	First	Cesarean Section	Preterm birth at 30 weeks Intrauterine growth restriction and oligohydramnios	PPD, PTSD and counselling

danger she and her foetus were in at delivery. One of the women was lesbian and her hospital experience was affected by discrimination whilst her child was in the Special Care Nursery. The woman with First Nation's heritage stated she over-heard racial epithets about another woman whilst hospitalized.

Data Collection

All interviews were digitally-recorded, transcribed verbatim by myself or a transcriptionist, then checked against the tape for accuracy. Transcripts were then returned to each woman so she could verify and clarify her contribution prior to the next meeting.

On each subsequent interview, I clarified my process and asked the participants to share any thoughts that may have surfaced since our previous interview. Corrections and additions were then made to the description of her experiences. Participants validated, embellished or deepened previous conversations, adding to the validity of the research. If I forgot to ask specific questions I sent the women messages via email and received prompt responses. I gave open invitations for women to contact me through email or telephone with any additional thoughts and recollections and several used email to provide clarifying details they wanted me to know.

As a nurse I am skilled at observation and in noting moments of sadness, emotion and discomfort. I observed details of the participant's demeanour, affect and sense of agency as thick descriptions (Geertz 1973). This added context to the women's experience but I also noted my own feelings, questioned my reaction and explored my own difficult birth experience. These latter notations helped to develop my own reflexive voice within these complex layered dimensions of the women's realities.

Methods of Data Analysis

Data collection and analysis occurred simultaneously as well as through ongoing reflection (Glaser and Strauss 1967). I had initially planned to use N-Vivo[®] to organize my data but found that reading the text and the use of pen and paper as the research unfolded was a more effective way to work with the data as it grew in depth and breadth. To identify themes, I used ethnographic coding, categorizing and clustering of themes to analyze data as the stories unfolded (Morse and Field 1995). Reading and re-reading of transcripts for clarification, context and content was ongoing, until I could hear each participant's words and their voices in my mind. I worked with the data and wrote their stories as a narrative text (Connelly and Clandinin 1990; Holloway and Freshwater 2007; Smith and Watson 2010). To ensure their stories were accurate, I went back and forth between the transcripts and the narrative to confirm that I captured the woman's situation as she described it. I clustered the women's stories and narratives into a number of emerging themes. Organizing the work into themes took several attempts to uncover how best to present their stories in a respectful, compelling and thoughtful way.

After the initial analysis of individual stories, I tried to make sense of their experiences by mapping concepts, which helped to create another set of meanings that emerged from the interviews. I arranged each woman's interview data in such a way that I could then see how many experiences were similar or unique to gain an overall sense of the birth stories. I highlighted information such as years since birth occurred, birth complications, interventions and other factors to exemplify each story in relation to the other participants. I also grouped their narrative responses to the initial questions to gain an overview of experiences. This provided multiple contexts and gave both historical and a contemporary sense to the interpretation.

I used the knowledge and information gained from the two previous interviews to develop the final interview questions, which extended my understanding of their experience. In order to improve birthing experiences for other women, I asked participants for recommendations they would offer health care providers. I enquired how the participant's experience of a difficult birth affected their mothering over time and affected them as they have matured as women.

Rigour

Traditional approaches, such as the empirico-analytic tradition, are inappropriate to gauge the rigour of this research (Denzin and Lincoln 2011; Koch 2006; Koch and Harrington 1998; Lather 1991; Rolfe 2006; Van Maanen 2011). Instead, various approaches to exploring the rigour of qualitative research have been described notably by Beck (1993), Beck et al. (1994) and Sandelowski (1993). Thus, credibility in this study is created through the description of sequential steps that provided the map within the study, recording the process and the methods followed. "Truth" value is obtained from the discovery of human experiences as they are lived and perceived by participants and these realities are multiple. I value the women's knowledges as both legitimate and subjective and took seriously the women's contributions and validations of their meaning-making. Repeated interviews, observations and use of artifacts ensured that multiple methods of data collection allowed for questions to be explored and clarified and to determine the congruence of the results within the study (Morse and Field 1995).

Grappling with how to "measure" rigour within qualitative work is "a futile task" since all research is on a continuum and each study is individual and cannot be measured against prescribed frameworks and criteria (Rolfe 2006:303). However, Rolfe does say that all published research reports should include a reflexive research diary. For a study on women and their

experience of mothering following a difficult birth, a reflexive approach is a foundational feminist method. Lather's (1993) conceptualization of transgressive validity is "the most completely worked out feminist model" (Olesen 2011:136) offering a feminist emancipatory stance. Lather (1993) argues for four frameworks in examining validity: ironic, neo-pragmatic, rhizomatic and situated. I chose situated validity in particular, Lather's concepts of situated validity "to embody a situated, partial, positioned or explicit tentativeness" (686) of the work for others to read. Situatedness and partialities, as a measure of rigour, are also reflective of those aspects that women experience in their everyday lives. Situated validity also constructs authority through practices of engagement and reflexivity, which have been included in the design of each aspect of this research. Validity of this nature creates a questioning text that is simultaneously bounded and unbounded, closed and opened.

Thus, the women's stories are bound by their experiences and description but are unbound when others find resonance with the narratives of the women's realities. Situated validity also brings together the concepts of ethics and epistemology. Within this work, the strong ethical principles reflected in relational practice and knowledge construction are part of the feminist research foundation to transform the social position of women. The authenticity of the women's stories may be recognized by others who may have experienced or known of similar situations in their own lives or that of other women. This resonance with women's experiences acts to support validity (Lather 1991).

The small number of participants represents individuals who have experienced a difficult birth; however, their stories provided rich data to explore the impact of difficult birth on the life of a woman. The applicability of findings rests with readers as they read and interpret the stories and acknowledge women's experiences. The narratives may resonate for the reader, adding to an

understanding of women's experiences and the applicability of the study. The intent is to offer the women's stories to shine light on the impact their difficult birth had on their mothering. It is my intention to illuminate the participants' understandings so the reader obtains glimpses of the women's experiences, thus raising awareness of the longer term impact of a difficult birth on mothering. By "creating the evocative, true-to-life and meaningful portraits, stories and landscapes of human experience ... [is to] constitute the best test of rigor in qualitative work" (Sandelowski 1993:1). Furthermore, the kinship between art and science and qualitative research "bridges these realms of meaning" (3). Rigour is achieved through the consistent application of the research approach, where we seek meaning in the human experience, in this instance, of mothers after a difficult birth (Meleis 1996).

This chapter has provided a brief overview of the theory and methods used in this research. The philosophical approach of ethnography, feminism/feminist research epistemologies and ethical concerns guide each aspect of the study. The next chapter will begin with the narratives of the participating women and how their lives have been changed by their experience of a difficult birth.

Chapter 4 Women's Stories of Childbirth

In this chapter I provide narratives of the birthing experience that led the women participants to define their births as difficult (Holloway and Freshwater 2007). What made the births difficult included not being believed, listened to or included in decision making, not being respected and treated with disdain and being left alone. Other women experienced urgent medical situations that involved themselves and their unborn child and the potential injury or loss of the newborn.

I then present the women's views on how they think their difficult birth affected their mothering over time. Women in this study talked at length about the difficulty they experienced with the births of their children, their relationships with them today and the lasting effects of these difficult birthing experiences on their mothering over time. In addition to physical, corporeal and emotional scars, several of the women had iatrogenic wounds that took many months to heal.

Each woman's narrative provides some background information to assist in developing an understanding of the differing contexts for the women giving birth and how their mothering was affected over time.

Of the 12 women in the study, three (e.g. Isabelle, Jennifer, Lyanne) were diagnosed by a physician with postpartum depression (PPD) and were treated with antidepressants. Isabelle had experienced PPD with her previous two births but she felt the third birth was the worst. Jennifer experienced PPD after she delivered her daughter, who died of a rare brain cancer at three months of age. She sought help and counselling for her grieving and loss, work that is on-going. Lyanne also suffered from what was labeled posttraumatic stress disorder (PTSD) and was hospitalized after the birth. Three other women sought counselling for depression following their

difficult birth experiences and during the years after (e.g. Francis, Gillian and Hillary). Most of these women have other children. For two women (e.g. Diana, Eileen), the difficult birth experiences resulted in that baby being their only child. Three women suffered prolonged recoveries and protracted healing times following their difficult birth experiences (e.g. Amber, Diana and Eileen).

The partners of Amber and Eileen provided support and care for several months during the postpartum period. Both women spoke of a deep connection to their children that developed over this period. This situation worked to draw the couples closer and both women were thankful for their partners' attention and care. Amber and Eileen spoke of the close relationship their husbands have with these children, from being so hands-on in the early days following birth.

Amber: Narrative of Difficult Birth

Amber, a nurse, in her early thirties, was pregnant in 2004 with her first child. She prepared for birth through reading and attending prenatal classes. At full term, Amber began labour at 6 a.m. She was excited about the imminent birth and at 9:30 a.m. she went to the hospital. Amber was dilated two to three centimeters. "I didn't have a birth plan. I thought, 'It is my first child, and we'll see how I am going to react to it.'" She tried going into the bathtub but as the pain intensified she decided to have an epidural. It was a Sunday and a quiet day in the labour unit.

By the afternoon the physician ruptured her membranes to progress the labour. "I think the doctor wanted to deliver the baby. We don't know for sure but we had a feeling she was going out and wanted to get the baby delivered." When it came time to push Amber couldn't feel anything because her sensation was entirely blocked from the epidural. "They decided it was

time for me to push and I wasn't feeling anything so I just went along with it." They had to turn the baby and since the baby wasn't descending the physician tried suction and then used forceps.

Amber relates that the baby's Apgar scores were OK and she was "cone-headed but fine." As usual with forceps deliveries, Amber had an episiotomy and she also suffered a tear into her anus (third-degree tear). Her voice shaky with emotion, Amber told me, "It wasn't until they got Avril out that I realized how difficult that was." It was at this point, Amber felt that the birth was difficult and that she suffered. Amber said that immediately following the repair of her perineum and tear, Amber was in a lot of pain. After several days she was discharged from the hospital but the pain in her perineum increased. On day five she went to the doctor who diagnosed an infection of the episiotomy and placed her on antibiotics. She then developed C-difficile, which causes severe diarrhea when normal gut bacteria are killed by antibiotics. Amber recalled she, "was very sick and breastfeeding." Amber's husband, Allan, took her to emergency where she was given intravenous fluids and more antibiotics, "The whole process went on for so long it took about 6 months for the stitches and the scarring to heal. I was surprised I had more children after that."

Impact of a Difficult Birth on Mothering

When Amber began to speak of her difficult birth she became emotional. She spoke about her life context and experience of becoming a mother. Amber described how her mothering affected the connection with her first child and her husband, making their relationships deeper because he was there to help her at a time when she was extremely vulnerable. The difficult birth brought her closer to her child because of the sense of risk involved at the birth and what they had gone through together the weeks following. I asked Amber how the difficult birth affected her mothering: "I think it's that change of control. Not

having control all the time; but the other piece of being supportive and an advocate for her.” Feeling as though she had little or no voice to speak up for herself and her child at the birth, Amber identified that today she is determined in her advocacy; “so when April [her second child was born] I didn’t let things happen as they did. Then I had more of a voice. You reflect and you learn.”

Barbara: Narrative of Difficult Birth

Barbara recalls the “actual delivery [of her first child] was about 29 hours, so for many reasons it was a difficult birth.” The medical aspects of her birth made it difficult but so, too, did the fragility of her relationship with her partner and family. She had married a man from South America, whom she described as very family-centred and wanted his family present for the birth. His mother and brother came to Canada and were staying with them in their small apartment. Barbara said that her “family, on the other hand, was very removed and distant. The delivery itself was a forceps birth but there was a lot of difficulty building up to that moment when I had my daughter.” Barbara had an argument with her husband and he left just as she commenced labour. She called her sister for help but she was not available. Barbara went to the hospital and later, her husband, Bartoli, came to visit but left her during the night to get some sleep. After a long night of back labour, Barbara agreed to an epidural and progressed to full dilation. Then, a doctor came into the room and said, “we have some medical doctors who would benefit from witnessing a birth.’ I felt very dependent and vulnerable and not in a place to say no.” Next, she recalls “looking up from my knees and seeing these white coats, a row of doctors, mostly men, looking at my crotch. It certainly didn’t help me relax and be open and create a sacred and beautiful, rich experience.” They used forceps to pull out the baby. Barbara remembers:

My immediate response was ‘Bring her to me right NOW!’ But they took her and measured her and this wolf in me coming out, I said, ‘Bring her to me NOW!’ This instinct emerged and I surprised myself. So there she was beside me and all the effort for the beautiful magical experience and she latched on.

Barbara’s expectations were eroded not only by the nature of the delivery but also in terms of her personal relationships with her husband and family. While she adjusted to early motherhood, Barbara’s mother-in-law was anxious to help but “there was this territorial thing in me that didn’t want anybody getting involved with my baby’s wellbeing.” Bartoli and Barbara had another argument, hurtful things were said and Bartoli, his mother and brother packed their bags and left the apartment. Barbara didn’t expect her husband to leave as well but eventually, Bartoli returned although things were very strained. They moved to South America, “so there were more changes and more upheaval for the next six months. I was very much alone during this whole experience.” Their relationship ended and Barbara moved back to Canada alone with her child. She speaks about her sense of isolation;

What is wrong with our society? We don’t have a clue how to support each other. Not a clue. Do it yourself. You made that choice—you live with that. ‘Yes, but there is a baby here’ and I become a single mother in all of that too. Again our society says you do it yourself and you go to work or you go on welfare and those are the options. And there wasn’t anything in between.

Impact of a Difficult Birth on Mothering

Barbara's difficult birth involved an acute "sense of abandonment, which has become a large part of my own healing journey." She described how she was very conscious of her experience and worried how her birthing experience might be felt by her daughter following her birth. Barbara's difficult birth affected her sense of mothering and the discord generated at that time resulted in her marital relationship ending in divorce and a crisis in her life.

I became a single parent. It totally impacted my mothering and how resourced I was and what I had to give. The stresses that were around me and the things I had to move through, it certainly made me a stronger person. It gave me a lot of purpose. It really brought to the surface what I value. In some ways it brought together my earlier experiences of abandonment to the surface for me to look at so it can be healed as well.

Carol: Narrative of Difficult Birth

In her late twenties, Carol married and moved to the southern United States to be with her new husband. In 1987 Carol became pregnant while she was working in a large hospital as a medical-surgical nurse. At a routine doctor's appointment, they discovered she was in preterm labour. "I literally went into full blown labour every night and it was back labour." Carol was seen by myriad of specialists trying to determine what was going on in order to stop the labour. She underwent ultrasounds, various tests, X-rays, dyes and medications. Carol said she was placed on tocolytics to stop the labour, analgesics for pain, antibiotics, as well as many other drugs. The goal was to keep the foetus in utero until its lungs were mature enough to survive outside the mother's body. This was a lonely time for Carol as her husband worked away.

One doctor finally diagnosed a kink in the ureter that was causing nightly labour pains. They inserted a stent and the labour stopped. Carol was given a course of antibiotics and sent home but her membranes ruptured and she returned to hospital where she underwent a caesarean section. The baby was born preterm at 30 weeks' gestation.

Following the birth, Carol suffered from intractable nausea for two weeks and remained hospitalized. A psychologist came in to see her, as well as a gastroenterologist, who asked "What do you think is making you so sick?" Carol said she felt it was all the drugs. So they discontinued all medications and she began to feel better. By the time she went home she weighed 97 pounds. "I think it was the iodine because I kept saying, 'I can taste the iodine.'" Carol managed to breastfeed her baby through this period with the support of her mother and father. She says her husband,

was just too young or something. He didn't get it. He couldn't cope.

Maybe he didn't understand the seriousness of it or any concept of what it is to suffer. So there was 'a disconnect' for me with my relationship with my husband.

Impact of a Difficult Birth on Mothering

The difficult birth affected Carol's mothering over time in that it reinforced the perception of herself as a good mother. She identifies herself as a source of strength and protection. She described having some hard years being a single working mother. She explained that the lesson she learned through the difficult birth experience was that "you must survive; you have to do whatever it takes to get that child into the world." Carol recalls her birth, postpartum recovery and questioning of her ability to continue with her profession.

Honestly, after [the birth] I didn't know if I could really be a nurse again. I thought this was a torture chamber. It was a torture chamber—and then there was [the baby] Carryn. Not being strong myself and then a C-section. I was lower than my pre-pregnant weight before I left the hospital. Even my legs had atrophied. There was nothing to me because I was throwing up.

Carol's marriage ended, which she feels was related to her husband's lack of empathy and understanding for their first child, who suffers from attention deficit disorder. She pondered the love she feels for her difficult birth child.

I guess I'm just more aware of the preciousness of life and how things can start out a certain way and then they can change unpredictably. Just honouring that and not to take things for granted.

Diana: Narrative of Difficult Birth

Diana became pregnant after dating Dennis for several months. She was 19 years old and lived with her mother and sister during the pregnancy. At term, Diana was induced for her first and only child. Prostaglandin gel was inserted in the cervix and then she was sent home to await the commencement of regular contractions. Later that evening, Diana felt the first contractions. She returned to the hospital and “they decided to use” the drug oxytocin intravenously to enhance labour and Diana experienced a spontaneous, small rupture of her membranes. Diana told me her mother, who was maintained on methadone, had delivered her own infant, Diana's brother, ten weeks earlier. Labour progressed and Diana began to vomit (a sign that labour is moving along). They gave her Demerol (pethidine), which allowed her to sleep between contractions but she awoke vomiting and contracting. Next they performed an artificial rupture

of membranes and there was meconium present. Then they gave her an epidural and she dilated to ten centimeters. She pushed for three hours and then her physician called in the obstetrician for assistance. Diana recalled “I was young, 19, and my first pregnancy. I also did not do prenatal classes. So they were concerned that things weren’t moving along because I didn’t know what I was doing.” Diana described the birth where forceps and “fundal pressure were used to pull her baby out. The umbilical cord was wrapped around the baby’s neck twice. Once the baby was born all Diana could think was “Oh, you’re there—neat!” Two hours later, “I’m on the gurney [going] into the operating room. I had passed out because I had lost two pints of blood in the delivery. I had a tear in my cervix and an episiotomy that also tore.” Diana recalled her first few months following birth: “I remember us going home, I remember Halloween and Christmas.”

Impact of a Difficult Birth on Mothering

Diana said this was an experience she would not want to do again. She recalled the baby’s head being pulled from her body. She stated that it was a disappointing time. Diana told me, “What made it the biggest challenge was the doctor not explaining things to me. Not really explaining necessarily what was going on.” Further she shared that the obstetrician didn’t “come to check on me, the three days I was in the hospital. To me, I thought, that’s funny. You’re the one that looked over the actual occurrence. You were the one in charge. That part was challenging to me because it was just such a cold bedside manner.”

She set the context of her birthing experience and spoke of her two most recent concerns: her son’s recent seizure and her husband’s serious illness. Speaking about her birthing Diana said it was a disappointing time but it was formative and increased her capacity to deal with family

crisis. She said she learned about elements of caretaking and being reflexive as preparing her for other challenging life circumstances.

Diana explained how the difficult birth affected her mothering. “I definitely have learned to pick my battles.” Diana’s son, born with the use of forceps, was now 12 years old and recently had a grand mal seizure.

There are certain things that are worth fighting over and things that aren’t.

Now with the seizure, I’m going ‘Okay. No, you still need to go to bed at a decent time. You get to stay up half an hour later on the weekends because you still need to recover.’

Diana spoke about a friend with twins, one of whom also had a grand mal seizure. She supported her friend emotionally and listened to her story of going to emergency and seeing the pediatrician. The friend, Diana related, “Knows how important it is to know; the more knowledge you have is power.” Diana spoke of a conversation with her husband about her friend’s child, during which “I felt my anxiety instantly almost go through the roof, to the point where I was literally shaking in my hands.” Worries of other women trigger Diana’s memories of fear for her own child and their outcomes today.

Eileen: Narrative of Difficult Birth

Eileen, in her early thirties, was at full term. She broke out in hives, was swollen and felt awful. The following day her water broke and later that night she went to the hospital. Eileen was prescribed intravenous antibiotics because she’d had rheumatic fever as a child.

At 10 o’clock, they said, ‘You’ve really gone into the hard labour now. It shouldn’t be long.’ Thirty hours later, she was finally born. So it was a very long process. For me, a lot of it is blanked out. I just remember being

tired and throwing up a lot. When the third set of nurses came in, one of the nurses looked at my chart and said ‘Why hasn’t she had anything to drink?’ ‘Well she throws it up.’ ‘Well why doesn’t she have ice?’ ‘She throws it up.’ I couldn’t even have the ice chips. And she said, ‘Well she’s really dehydrated put more liquids into the IV.’

Maternal dehydration causes ketosis and is toxic to the foetus. Eileen trusted her body to do the work of giving birth. She recalled,

The doctor was yelling at me because she wanted to do a C-section and we said ‘Give us a little more time to just see if it happens.’ She was angry with me for going through with the vaginal birth [and we said to the doctor] ‘It hasn’t been that long and you’re not seeing any distress from the baby.’

She did deliver her infant vaginally. Eileen was hospitalized for a week afterwards and was refused discharge due to the infant’s weight loss. The baby lost a pound following birth, although she “had been breastfeeding well.” Both suffered from thrush due to the antibiotics, which took months to clear up. Eileen eventually signed herself out against medical advice. It took Eileen “a couple of months before [the stitches] healed.”

Impact of a Difficult Birth on Mothering

Eileen recalled the difficult birth heralded a starting point of great significance for her and her family. When asked what made the labour difficult she replied, “The fact that I couldn’t move around very freely because of the IV. I just remember throwing up a lot. Nobody ever warned me that I’d throw up.” She told me what made the birth difficult was

the length, the exhaustion and then at the very end ... the ripping. I can't remember how many stitches it was but I've still got the scar from it. Then the recovery; how long it took and how exhausting it was.

Immediately following the birth, Eileen stated she breastfed her infant. Her husband, Evan, left work to care for her and the baby and did all of the household tasks until she recovered.

I didn't do very much mothering. Evan did all the mothering from the time we got home. I fed her and that was my job [laughing]. She was still feeding at night when she was two. I think that part of the difficult birth ... was very traumatic for her for it to take so long to be born.

Eileen ruminated about the connection with her child that stemmed from the vulnerability at birth.

Having the difficult experience makes you feel your child's more precious. It really gives you that feeling when something's a little more difficult to obtain, it becomes more important. It was a lot of work and it makes you realize how precious this person is and you take more caution or better care.

The difficult birth affected the bond between Eileen and her child.

Because it was difficult it increased the intensity of care; that desire to do things to the best of your ability to really be that effective caregiver. I think if it had been easy, I wouldn't have that same awareness.

Francis: Narrative of Difficult Birth

Francis says she chose a midwife for her pregnancy. She confided, "I was doing this later in life, so I waited a very long time" to have a baby. There was some confusion about her due

date and it was estimated that she was one week further along than she believed. At 42 weeks gestation, or 41 weeks by Francis' calculations, her midwife explained the potential of death for post-date infants. Francis said "All I heard was dead baby" and agreed to an induction. On Monday, after the non-stress test, an obstetrician inserted prostaglandin to induce labour and she was discharged to come back to hospital when labour was established. Returning later in the day, she recalled being admitted to a small windowless room. Francis said "I felt like I was stuck in a closet and that is not a great way to feel when you're having a baby." From the moment labour started Francis said it was relentless. Her midwife was busy with another delivery and she felt alone. Francis recalled, "I remember my left hip being out of joint. Later we realized that's where his head was. It was pushing sideways it wasn't pushing forward." When she was fully dilated, Francis pushed for four and one-half hours. "He was ready to come out but he couldn't." At this point "I started asking for help." Although the nurse attending Francis was told to go on a break, she "wouldn't leave me. I asked for help and she went to get the obstetrician and he came a few minutes later." Francis described "how time becomes irrelevant in these situations. You are just dealing with the moment and what's happening. You leave your body most of the time at this point." The obstetrician wanted to assess her pushing to ensure she was doing it right. Francis stated emphatically,

I went to acting school for crying out loud. I learned how to breathe down there. I'm breathing, I'm pushing, I'm doing all of this body work.

Thinking, thank God I went to acting school so I could birth this kid. But he's not coming out. So I'm in trouble.

Despite a trial of forceps under epidural anesthesia, the baby could not be delivered. Then Francis recalled "being wheeled into the OR not long after that." All of her plans and hopes for a

nonmedicated birth were dashed. The baby had passed meconium and the pediatrician was there for his care. Frank, Francis's husband, told her they had a boy; she was elated. But "I felt cheated, I felt like it had gotten away from me. I felt shame right away. You go back and you think, 'Where could I have done this differently?'" Francis recalled crying in the midwives' offices for six weeks. Her incision was infected and it would be a year before the wound stopped weeping pus.

Impact of a Difficult Birth on Mothering

When I asked about her birth experience and how it affected her mothering, Francis replied thoughtfully, "After you have a disappointing traumatic experience when you birth, the things that happened afterwards are so important because you can empower yourself later. That's all you can do." She told me that the difficult birth set in motion a type of "pushing and pulling" in the relationship between her and her child. She looked back and reflected on her experience that resulted in living and working through feelings of grief and shame with the loss of her ideal birth. She told me these feelings were less now, since his birth seven years ago.

Gillian: Narrative of Difficult Birth

In 1979, when she was 19 years old, Gillian married Gary and was soon pregnant with their first child. She had a very healthy pregnancy and, like Diana, did not attend prenatal classes. Gillian described herself as being "very naïve and in denial, perhaps." On Thanksgiving weekend she had worked through Saturday and on Sunday she cooked dinner and went bowling. On Monday Gillian was having contractions, although she thought she had eaten too much or perhaps needed to go to the bathroom; however, she was having contractions. She called a friend and then the hospital and was told to come in as her contractions were so close together. Getting to the hospital at 9 p.m. Gillian was fully dilated and ready to give birth. The doctor was called in

and they discovered the baby was in distress with a prolapsed cord. “Instantly,” Gillian said, “I’m having a C-section and the doctor shows up and it’s a big whirlwind. I’m in extreme labour now. I’m mad because I am having a C-section and they are all talking around me.” They rolled her onto her back from side-lying and she recalled, “My back was breaking in half from the excruciating pain.” Gillian was given a general anesthetic and when she woke she remarked, “I have a son.”

Gillian had little experience with babies and laughed saying, “I didn’t even know I had to burp a baby. He really never woke up except to feed and I don’t know if that was a result of the C-section or the birth?” Within a day or two, while still in hospital, Gillian became sick and so weak she couldn’t hold the baby, and a nurse accused her of rejecting the baby. Gillian replied, “I’m not rejecting it, I just can’t hold it.’ I was in so much pain. I ended up having a pelvic infection that went undiagnosed for a whole week.” She reiterates how the nurses were horrible to her, insisting that she get up and walk to the end of the hall and to the shower. “I had a fever, I had incredible pain and I didn’t know what was happening. Nobody was listening to me. I felt terrified.” She asked her husband to call her mother but he insisted that he didn’t need to phone her yet. The following Sunday night,

I remember a nurse sitting with me. It was dark and she sat in the corner. It was like she was an angel to me. I remember this soft light around her and she said, ‘I’m not supposed to tell you this dear, but you are very ill. You need to get another doctor. You are very sick. I can lose my job for saying this.’

The next morning, Gillian told her husband to get another doctor. The angel nurse had told her to call a specific obstetrician from a nearby town.

So he came in that morning; looked at me and the chart. He touched me and I just about hit the ceiling [with pain] and he made things happen ‘STAT.’ There was a flurry of nurses moving me to isolation, IV antibiotics; I had to be given blood. I was so grateful.

Gillian was in hospital for another week recovering from the pelvic infection. “All of a sudden I start to feel better when they [gave] me the blood. Wow, I feel human again.” Her mother came to stay for a one month stay while Gillian recovered.

Impact of a Difficult Birth on Mothering

Gillian spoke of the impact that the difficult birth had on her mothering over time, she said,

Right off the bat having a C-section made it difficult. Probably my ignorance made it difficult. If I really had wisdom, knowledge and an awareness and ownership of my body and was really actively participating in my pregnancy and owning the birth process ... but I just so wasn’t there. I didn’t have anyone encouraging me to do that. I didn’t have a natural inclination to do it, which was interesting. I don’t know why. Because you’d think as women ... doesn’t that just happen to us magically?

She went to describe how overwhelmed she was at that time. “I was just at the mercy of everything happening to me. And not having a husband who was really into it and on board either. Then all the other complications made it very difficult too.”

Within several years, Gillian goes onto have two other children, a boy and a girl; both these children have a rare form of microcephaly and require intensive daily care. She cares for

them herself with little support. “We had our own business, a bakery. I worked. I’d get them up in the night and take them into the bakery, put them back to sleep. Then they’d all wake up and I’d feed them. I was just stupid. I don’t know how I did it.” After several years she had a “nervous breakdown” and eventually both children were placed in care.

I carried a lot of guilt for years about my children. I struggled; especially when I let them go into care. It was brutal because I kept thinking I should have them. The Ministry [of Children and Family Development] should support me so that I could stay home and be with my children. I fought against that for years. I went through depressions and it was hard. Truly only in the last four years, I’ve kind of forgiven the Ministry. I’ve forgiven myself. I’ve just accepted that this is the way it is.

Hillary: Narrative of Difficult Birth

Hillary became pregnant in her early thirties and gave birth to her first child, a daughter, ten weeks prematurely. The delivery was spontaneous and happened within a two-hour period. In the middle of the night, Hillary had gone to the hospital thinking “something was wrong; that intuition, something is not right. I was told, ‘No, no, you’re imaging it. You’re being paranoid. Just go home.’” She was told that it might be indigestion. Hillary refused to leave the hospital until she saw her obstetrician at 6 a.m.

She described a need to bear down and recalled “I actually felt her head. My husband ran out in the hallway and started screaming. A nurse came running in and she believed me, she’s the one who delivered her. She was an amazing, amazing nurse.” Many preterm infants are not ready to breathe when born so early and Hillary felt lucky that morning as the head of the respiratory therapists for the province was in the hospital to give a talk and he was able to intubate the infant

(place a tube in her airway). “I was so lucky, it’s incredible really that those events came together but it was definitely shocking and very traumatic.” For several days nobody knew if the baby was going to make it. “The baby was without oxygen for some period of time, who knows how long. He intubated her quickly, within ten minutes, but the whole birthing process was probably going on for at least an hour, probably two, before that.” Hillary was fearful, and was not able to hold her daughter or feed her because of the all tubes the baby required to breathe, plus a nasogastric tube for feeding. “She was taken off the full machine that made her lungs pump, so after day five we could pick her up and hold her.” Hillary’s baby remained in hospital for five weeks.

Of her birthing experience Hillary said, “There was nothing positive about it. It was terrifying and scary. It was really beyond words. You don’t know if your child is brain damaged, whether she’s going to have lasting effects, whether she’s going to live.”

Impact of a Difficult Birth on Mothering

Hillary’s difficult birth affected her mothering due to the circumstances of prematurity and not being believed when in labour.

I was terrified because it was my first child. My mother passed away when I was five, so I had no one with me other than my husband, who was great, but he was hysterical too. I was just unsure about what was happening. I really felt that no one was listening to me. So that was the hardest part of that moment.

She described her feelings of utter fear for her child, feelings that instigated her need to advocate for her children and family members in a different, more intensive way. Her difficult birth “made me a different parent than I would have been, if she had been born full term or if she

had been born in a more thoughtful way.” Because of the drastic nature of the birthing experience, Hillary didn’t want her daughter to feel her fear and terror from the birth. For Hillary it was a dreadful time of worry. She recalled filling out the baby book about one year following the birth and pondering what she should write. Hillary said she decided that she couldn’t pretend her daughter wasn’t born prematurely. So, she wrote that her daughter decided to come into the world early and fought right through it all. Hillary was resolute to make the birth story about her daughter’s strength instead of “how horrible it was for us at that time.”

She recalled wanting another child and trying to find answers to why this had happened to her.

I actually did go through some therapy before I had my son. Because I thought I can never have another child, never; even though I wanted another child. Nobody could tell me why it happened. I felt very much like I was ignored in the moment and I thought I can’t do that again.

Isabelle: Narrative of Difficult Birth

Isabelle had two children prior to her difficult pregnancy and birth, one son with a disability aged two and another son aged five. She recalled that she was 31 weeks pregnant and noted this “last [birth] was the worst.” She developed terrible abdominal pain, which turned out to be a ruptured appendix necessitating emergency surgery and twelve hours post-operatively, she went into spontaneous labour. Isabelle reported her husband was with her and she was “so doped up with analgesics that I was a little bit out of it.” The baby was high in her uterus, so it took a long time to push him out. Then the cord was around his neck and he was in distress. Isabelle told me “the nurse turned off the [fetal monitor] audio because it was too stressful when the heart rate would go down, down, down.” When the baby was born he was “really blue ... and

then they took him away to the ICU (Intensive Care Unit).” Isabelle described the experience as being

surreal. I don’t even really remember the whole first year of the baby’s life because I was so exhausted from the birth and being sick. I also suffered from terrible postpartum depression as well. So, it was a pretty stressful time. You don’t realize how serious it is until the doctor says, ‘We’ll worry about you and then we’ll worry about the baby.’

Impact of a Difficult Birth on Mothering

Isabelle stated the difficult birth had affected her over time and that it was part of the legacy of the protectiveness she felt for her tiny child. She said she had always been protective, an advocate, fighting for her children’s rights, particularly for her child with a disability and for what disabled children need.

It made me overprotective at times and I’ve had to learn to let go of things. I still have a tendency to rescue [laughing]. When they were young, it was more emotional rescuing and trying to pull them back in and make sure they’re safe and happy; always providing and making sure they weren’t hurt.

Isabelle questions herself and tries to make up for the preterm birth by being a more ideal and perfect mother.

It also created high expectations of how to mother for me. I had to be a really super mum to make up for this traumatic birth and prematurity and [in addition to her] special needs, brain injured child. I had to be a super

mum to compensate for that sort of failure. You did feel like it was a failure. You'd failed them somehow.

Jennifer: Narrative of Difficult Birth

Jennifer was pregnant at 30 years old with her first child. When she got pregnant, she was working in silvaculture, which involved spraying pesticides. She remembered “moments of being stuck in the bush and just really taking huge whiffs [of pesticides] and thinking to myself ‘This isn’t good.’” The material safety data sheet (MSDS) on the specific pesticides she was spraying showed no teratogenic effects on an embryo/foetus. By the time she was at ten weeks gestation, she switched to office work for health concerns. Jennifer’s pregnancy was uneventful, but looking back now she says, “I see red flags.”

Jennifer’s membranes ruptured two days after her due date and labour commenced. She went to the hospital and was contracting every three minutes. After 12 hours a nurse noted something wasn’t right and with closer examination noticed the baby was in breech position and Jennifer underwent an emergency caesarean birth. Prior to discharge Jennifer was not given information on pain control. Being an independent person she asked for little help. Six weeks following the birth Jennifer experienced postpartum depression. She recalled that she had hematomas all along her incision line, which her doctor said was normal. However, her mother, who was a nurse, said there *was* something wrong with the incision.

Her energy depleted, all Jennifer could do was breastfeed the baby, then hand the baby off to her partner Jeffrey or her mother. For the first six weeks, baby Jade “didn’t really show too many signs of anything.” She was gaining weight but she was tiny. By eight weeks she started to develop nystagmus “then it got, obviously, worse.” Jennifer called the nurses’ hotline and they recommended she see a physician, who referred her to an ophthalmologist, then to a pediatric

ophthalmologist, who diagnosed congenital nystagmus. The pediatric ophthalmologist reassured Jennifer that surgery should fix the problem. However, in the “worst case scenario,” Jade could be legally blind. Jennifer was scheduled to fly to see her mother in eastern Canada. Jade had not gained weight in a month and Jennifer’s doctor admitted the baby to hospital for failure to thrive. The doctor told Jennifer if she wanted to fly, she could always go into the hospital there. Jennifer called her aunt, who was also a nurse, who advised her “No, you don’t get on the plane, you stay in the hospital.” So Jade was admitted to hospital and the nurses assessed Jennifer’s breastfeeding although Jennifer stated breastfeeding “was never an issue for us.” The pediatrician wanted to do an ultrasound of Jade’s brain before discharge. As Jennifer was packing to leave, the nurse asked them to stay as the doctor wanted to speak with them. After three hours, Jennifer and Jeffrey knew something was awry. The pediatrician announced “There’s a brain tumor,” referred Jade to a children’s hospital and Jennifer was discharged home with her baby. The next day Jade would not breastfeed so they returned to the hospital and were transferred to a large children’s hospital. Jennifer was allowed to travel with the baby when she was airlifted but Jeffrey had to drive. Once there, Jade was sedated and had an MRI and “that was the last time she was ever really awake.” Jennifer signed consent for a shunt to release the pressure on Jade’s brain. “The second they released the pressure she was in excruciating pain for 48 hours” before they could get the pain under control. “She screamed the entire time, then she started to seize constantly.” Jade was moved from the ICU to the neurology ward, and then, “because it was cancer,” to the pediatric oncology ward. Jennifer’s parents flew in to be with the family. Jennifer recalled the conversation with the physicians and palliative workers: “They started off with blah, blah, blah an anaplastic astrocytoma is this ... I just completely interrupted

them and said ‘How long do we have?’ And he said ‘At best three weeks.’” Fourteen days later Jade stopped breathing.

Impact of a Difficult Birth on Mothering

Jennifer spoke about her caesarean birth experience, how it affected her and the additional complication of postpartum depression.

Initially the birth experience with Jade, obviously, made it difficult to mother because of having a C-section, having a major surgery, being in pain. It made it difficult to complete all those tasks, all those everyday things. Yes, it did, definitely, one hundred per cent.

In addition, the loss of their child was devastating and life changing. Jennifer said that after a great deal of soul-searching she and her husband, Jeffery decided to have another child. She spoke about her birthing experience with this child.

Now, the second time, again difficult to complete those tasks, everything, but not having the PPD involved, definitely easier.

Jennifer said she would be interested to hear what other women say about their births.

To talk to somebody who had a ‘normal’ typical experience where it progressed and everybody was healthy and they went home after 48 hours.

I wonder what difficulties they had. They must have difficulties? It’s not like birthing a child is easy. It affects you physically. Everybody, right after birth, has hormones going on, that’s difficult to balance.

Jennifer reflected about the life transition for women and noted that all births have a deep impact on the mother for many reasons.

I think mothering is such a huge responsibility. As much as we take it on, we want it and we love it, when you have it, how could it not affect your mothering? Whether you have a good birth or a bad one, either way you have trauma to your body. You have a new one [baby] that's very unpredictable, unstable initially. You're balancing a lot.

Karen: Narrative of Difficult Birth

Karen recalled her first child was born by a caesarean section due to a prolapsed cord. She described it as “an intense but quick experience.” With her second pregnancy, Karen suffered kidney stones and required stents to be put in her ureters during pregnancy. “I was very uncomfortable and painful and sick during the pregnancy. So my doctor decided to induce me at 38 weeks. They were doing a study at the hospital and I was a study participant.” She stated, “no, I don't remember signing anything” about consent to be enrolled in the study. “They were doing a study on the placebo effect of prostaglandin. So they gave me some prostaglandin or not prostaglandin and sent me home.” For three days Karen went back and forth to the hospital until she was in active labour. “I felt absolutely horrible and exhausted. I hadn't been sleeping. All I can really remember in the labour room is people telling me that I needed to push.” Karen's mother and father were also present at the birth and Karen told me it was the only birth they had ever seen. “My doctor yelled at [my father] to open the door and yell SCN (Special Care Nursery). So he opened the door and said ‘SCN, whatever that means’” and the special care nurses came in.

Karen was in “massive pain from the kidney stones” and baby Kalen was “born flat, not breathing and not doing well.” They whisked him away and neither Karen nor her family was given any information. When Karen finally saw him,

His head was shaved and he had an IV in his hand, a lot of bruising on his head and I was crying. I never really knew what happened. What makes this whole experience so traumatic for me is that I didn't even realize how little I knew about my own birth experience until I was educated [as a RN] and until I did my NRP (Neonatal Resuscitation Program). I have since called them [the hospital] and asked if I could get my records from that birth. [They asked Karen] 'What particular part of that do you want?' 'I want it all!' [Karen replied] Again, the response was, 'Well, no, what part do you want?' Karen said, 17 years later "I don't even know what his Apgars were."

Impact of a Difficult Birth on Mothering

Recalling the birth of her son Kalen, Karen said, "He's the fragile one to me [laughing]. So, I've taken that with us." As a nurse she works with birthing women and talking about birth is part of her everyday experience. However, Karen said that she doesn't discuss her deliveries. She only says, "I had a C-section, a back labour and delivery and a vaginal birth." Karen stated she doesn't go back to that time and she doesn't bring up Kalen's birth experience. Further, she has not told her son about his birth. She wonders what she would say. "'When you were born, wow, what a gong show that was.' He probably doesn't even have any idea" [laughing].

Describing the effects of the difficult birth on her mothering and on her thoughts about her son, Karen said,

He is different. They're all three different but he's definitely. He's like the thinker. He doesn't just blurt out stuff. I don't know, I expect greatness from him, which is interesting, because I think it's why I get so

disappointed when he plays video games all the time. ‘Don’t you want to do more with your brain? I know you do. Come on’ [laughing]. He goes to the alternate school because [regular school] is not a good fit for him.

Karen still carries anger around about her son’s birth. She described her experience of being bullied and enrolled in a study on prostaglandin, which she sees as abusive. She feels her rights were ignored and the nature of the induced labour put her child at greater risk with no explanation for his suffering.

Lyanne: Narrative of Difficult Birth

Pregnant with her first and only child, Lyanne was in a relationship with her long-term partner Linda. Prior to the birth, Lyanne was hospitalized for several weeks for intrauterine growth restriction and she delivered her daughter ten weeks early. “She was just two pounds at birth and the first 72 hours, they told us it was touch and go.”

Lyanne experienced some “very unusual pains and went to emergency for an ultrasound. [They] discovered that [I] didn’t have any amniotic fluid, the placenta was not great and the baby was underweight.” Lyanne had placenta previa, which was not disclosed to her by her physician, and she was transferred to a larger hospital. The obstetrician decided that she didn’t need to be delivered that first night but after two weeks the fetal heart rate began to “dip quite a bit.” Dropping foetal heart rates without labour indicates that the child is in danger particularly with oligohydramnios or low amniotic fluid volume. The obstetrician was concerned, “he said, ‘What do you think we should do?’ I said, ‘I think she needs to be delivered.’ So they took me later that night.”

The caesarean section, Lyanne described, “was quite traumatic because they wouldn’t let Linda in until they had prepped me, I was already really scared. I couldn’t understand why they

couldn't let her in for the epidural and the prep." Even if I'd had a normal birthing experience it would have been difficult for me because of my sexual abuse history. I know that it made the whole C-section more difficult too, because of having my arms strapped down."

When Lara was born, "she was blue. They worked on her [because] she wasn't breathing. So, they got her breathing and they showed her to us and ran down the hall to the NICU (Neonatal Intensive Care Unit)." Lyanne's birthing experience was further complicated by the baby's inability to breastfeed. However, Lyanne pumped her breasts and gave Lara the expressed breast milk. Lyanne was hospitalized later for postpartum depression and hypothyroidism and eventually gave up pumping her breasts.

Impact of a Difficult Birth on Mothering

Speaking of how the difficult birth affected her mothering Lyanne describes her hospitalization whilst pregnant.

Well, number one was the emergency of it. That this has to happen and 'Oh my God, it's not time.' And 'what do you mean I have no amniotic fluid?' What did I do wrong? I started to blame myself. Waiting in the hospital for two weeks and not knowing what the heck was going to happen.

Her difficult birth affected her mothering, in that,

It's made me more hyper-vigilant around her. That's something I have to work on daily. The first several years I was always worried, especially the first year. I think it just sort of triggered me; my nervous system was always on the edge of when an emergency was going to happen for her.

Caring for a preterm infant requires unending vigilance for the parents.

In the beginning when she was a baby, there was worry, more worry about things. Like she had some problems with her legs and on her first birthday she couldn't even sit up by herself. So everything was quite delayed; there was concern if she would walk. There was physiotherapy and I was always trying to make sure we were doing the right thing to enhance her development.

She speaks of her daughter's health today,

I feel that it was such a gift that she's healthy; it could have been very different. So, I just treasure her even more because of that. I can't imagine – not that I love my daughter more than any other mother loves their child, but there's just something ... like, we made it!

Lyanne reflected on how much she does for her daughter today and the pattern that was created.

I think sometimes I do too much for her that she could do herself. I think that's complicated because I see that as my job. I have to let go and let her be more independent. She can cook and make her own food but I like to make it for her. Linda's always at me about that; 'She can do it herself.' 'Yes, she can; but, I want to' [laughing].

It has all been difficult for Lyanne to work through; each of her daughter's birthdays was an anniversary of a trauma and that it wasn't a joyous event. As Lara has grown and matured, however, Lyanne continues to process her own trauma.

This chapter has introduced each of the women in this study and they have shared some thoughts on their difficult birth and the impact it had on their mothering. Their thoughts and further details of their birth will be shared throughout the remainder of this document. In the

following chapters I discuss prenatal surveillance and preterm birth (chapter four), birthing women's struggles and medicalized births (chapter five), unethical treatment (chapter six), being left alone (chapter seven), and vulnerability and mothering (chapter eight).

Chapter 5 Embodied Pregnancy and Preterm Births

Women experience pregnancy through many conscious and unconscious layers of awareness. Pregnancy is a physical and a psychic (read soul) experience that is embodied but is also experienced as a public display of bodily change. Mental changes and adjustments are necessary as the pregnancy progresses, requiring on-going negotiation and accommodation of self and with others. Embodiment of pregnancy is the woman's intimate lived interpretation of the experience.

Merleau-Ponty (1999) emphasizes it is through lived experience that one perceives their world. Grosz (1994) argues that Merleau-Ponty's sense of the body as interpreting one's world of experience aligns with the body-subject that supports feminist thinking. Merleau-Ponty's understanding of lived experience has three crucial insights. First, he feels that embedded in experience are social, political, historical and cultural forces which cannot provide an outside vantage point for judging individuals. The construction of experience is, at the same time, active and passive functioning; its role is both inscription and rebellion of sociopolitical values and speaks to the unspoken assumptions of women's experiences worthy of exploration (Merleau-Ponty 1999). Arguing that understanding experience is part of the production of knowledge, and thus legitimate, Merleau-Ponty argues the starting point of exploration of women's experience is through understanding a woman's lived reality.

Merleau-Ponty (1999) connects experience to consciousness, he also regards experience as always embodied, corporeally constituted, located in and as the subjects' manifestation. Thus, experience can only be understood between the mind and the body—or through them—in their lived conjunction. The pregnant woman, who knows herself through her highly attuned body, notices and interprets every nuance and change. A woman also knows her foetus and, with that

knowledge, the birth of her child brings about great changes to her understandings, known through her body. As pregnant women live and experience their world through their bodies, their pregnancy and childbirth are constituted through their embodiment. For a woman there is no other time in her life when she is more aware of her own embodiment than when she is pregnant (Bondas and Ericksson 2001).

Merleau-Ponty's (1999) insights of interpreting one's own world as legitimate provide validity to women's corporeal experiences by taking her embodiment seriously. The authority that a woman possesses of her own embodiment is often denied or rejected on admission to hospital. Honouring women's subjectivity recognizes the mind and body as valid; however, HCPs scrutinize every aspect of pregnancy and the pregnant body, thus appear to control and keep women as objects. Technological approaches override a woman's sense of self. When women follow medically regimented recommendations they are viewed as compliant but when they question procedures, women are seen as renegade and encounter repercussions.

This chapter examines the notion of embodied pregnancy and corporeality up to, during and following delivery, particularly as those women who experienced preterm birth share their stories and struggles. Also within the chapter, I expand on the concept of surveillance and themes of participants' experiences are extrapolated for further insight to their intimate, lived interpretations of the difficult birth experience.

Structured Surveillance

Surveillance is about assessing a woman's state of health in pregnancy and comparing her status to discourses of normalization information to define if she is "at risk" (Lupton 1999). All throughout pregnancy women are under a structured routine of surveillance from care providers who monitor all aspects of their health to ensure a healthy mother and foetus. Each

month, medical surveillance of the pregnancy is structured with routine tests, blood work, vital signs, urinary analysis and monitoring to ensure all is progressing within normal limits. Not only are physicians, midwives and health professionals capable of assessing a woman's health condition, but so too are family members, friends and even strangers who share pregnancy and health advice, often times unsolicited, for women to take up and comply.

The pregnant woman is no longer permitted to drink alcohol, restrictions that are normalized within North American culture. It is now common to see notices in restaurant washrooms and liquor stores warning of the dangers of alcohol consumption when pregnant (Bordo 2003). If a woman smokes cigarettes (Powers et al. 2013) or marijuana, uses traditional medicines or other non-traditional health care practices, the woman may be seen as uncaring, selfish and the public feel justified in their righteous expressions of her unfitness as a prospective mother. Pejorative opinions are not uncommon, potentially leading to disparities in care (Kerker et al. 2004).

The adjustments women make during pregnancy affect relationships, work and family. Pregnant women confront many emotions such as thoughts of giving birth, choices of care provider, dealing with fears and other concerns (Bondas and Eriksson 2001; Howarth 2010). Initially, many women face the prospect of medicalized care depending upon their health during pregnancy (Davis-Floyd 2001). Women and often their partners attend antenatal or prenatal classes in the final trimester to understand the bodily processes she is experiencing, to learn about hospital routines, fetal and infant development, labour, birth and breastfeeding (Morton 2009; Nichols 1995; Schott 2003).

Close monitoring is not uncommon, particularly when the woman's health is doubtful, where conditions involving the infant may place the mother or foetus at risk or, where pre-

existing conditions may require careful monitoring of the woman's diet, activities and environment (Cahill 2001; Chalmers et al. 2012; Cindoglu and Sayan-Cengiz 2010; Goodwin-Smith 2012).

Surveillance objectifies the woman by increasing the observation and control of women to ensure the health of the foetus (Duden 1993). Many of the women in this study complied with directives or recommendations issued by HCPs. As part of structured surveillance they kept appointments, attended clinics for check-ups, screening or education (Wetterberg 2004).

Structured Surveillance Through Antenatal Education

Women's prenatal education is typically focused on labour and birthing practices developed by HCPs and offered in the final weeks of pregnancy (Svensson et al. 2008). Over time, care prior to birth has moved from care facilitated by lay women and midwives to a more technological and scientific process controlled through physician or midwife visits (Mitchinson 2002; Wertz and Wertz 1989).

Today women look to television, computer sites (Stoopnikoff 2011) and print material to gain information about pregnancy, birth and childrearing (Morris and McInerney 2010; Morton and Hsu 2007). Pregnant women have their own cultural expectations of anticipated food cravings, morning sickness, enlarged breasts and other changes to their body (Davidson et al. 2012). In a study of women's thoughts about pregnancy, researchers found that all the participating women "consciously and some almost constantly thought about how their health habits would affect the baby's health" (Bondas and Eriksson 2001:828). Many women felt they should exercise but were uncertain about what they could do because they were afraid of harming the child (Bondas and Eriksson 2001).

Prenatal care, a form of surveillance, also involves the selection and development of a support team of family and health care providers (Province of British Columbia 2013) to “ensure” a healthy pregnancy. Surveillance is potentiated through much of the information health provider collect from pregnant women for health maintenance (Perinatal Services BC 2013). The ongoing scrutiny of structured surveillance treats all women as “patients” with illness expectations, turning every pregnancy into a potentially dangerous time (Goodwin-Smith 2012). Pregnancy is defined as pathological and life threatening, aligned with sickness, with physicians looking for symptoms and diagnosis (Davidson et al. 2012) and comparing a woman’s pregnant state with her normal non-pregnant state (Mitchinson 2002). Biomedicine is organized to determine statistically acceptable variation among pregnant women.

Prenatal classes are designed to prepare the woman, that is, to make her compliant with the hospital processes of labouring and birthing. Women are inculcated into the practices they may be offered, which are “normal” for the HCPs but are invasive and risky for the woman and her foetus (Lothian 2006a; Stoopnikoff 2011). Women are taught exercises to learn how to breathe (Dick-Read 2004), as if they did not know how to do this before.

Looking more closely, however, prenatal classes are designed to give a quick overview highlighting preparations for labour, warning signs, impending labour, surgical options, pain management, breastfeeding, community resources and other knowledge (Morton and Hsu 2007). They can build self-confidence so that women can “say no” to procedures and processes (Lothian 2008; Schott 200; Simkin 2010). Prenatal education serves as a practice to passively direct and educate women and families into prescribed technology-based hospital maternity care. The routines of medicalized childbirth (Davis-Floyd 2001; Lothian 2006b) are bland experiences, depicting birthing as a homogeneous experience devoid of many of the realities of birth and of

individual women's experiences (Cahill 2001; Davis 2003). There is, however, a great deal of information not covered or discussed in antenatal classes (Koehn 2008). For instance, Kitzinger (2010) argues that "ideally prenatal classes ought not to be just about physiology and exercises, but also education for a major life experience" (78). The point Kitzinger (2010) is emphasizing is the lack of pertinent knowledge of birthing and transition in prenatal education, something with which new mothers concur (Cliff 1997; Koehn 2008; Nichols 1995). Sbisa (1996) declares that although it is in women's interests to seek prenatal education, which is a form of external control and part of the system of surveillance; yet, it may and does, provoke resistance. Yoshino (2008) suggests that prenatal education has been made acceptable and even desirable for women as a means of enculturating them into the medical system. Attendance at prenatal classes supports a more covert level of surveillance by ensuring women's compliance through education, while the messages to women stress the importance of the medical system to having a live, healthy baby. In this sense, there are a variety of veiled threats. If a woman does not seek these services, specifically prenatal medical care, then social services are engaged to scrutinize the mother, particularly if she struggles with poverty (Lapierre 2008) and addiction (Smith 2006).

Women who comply with generalized recommendations for a healthy pregnancy attend the prescribed appointments and tests, prenatal classes, follow advice, avoid substances such as alcohol, tobacco and caffeine and fulfill prescribed healthful behaviours. But for some women who do not play by the established institutional rules or do not know the rules exist, their action or resistance puts them into a clinical category of risk with subsequent consequences.

Non-attendance at parenting classes disadvantage women putting them in a more vulnerable population, some having "a low level of education, being unemployed and smokers" (Fabian et al. 2004:234). Fabian et al. (2004) emphasize that prenatal education may not be adapted to these

parents' needs, particularly for women who need extra support during the transition to parenthood. Moreover, avoiding childbirth education classes may place the mother's and infant's health at risk if conditions, such as preeclampsia, are not noted (Davidson et al. 2012). Class formats and group discussion with other expectant couples who happen to be more vocal and have fewer problems, can also raise feelings of embarrassment and inadequacy for younger mothers-to-be (Nichols 1995; Nolan 1995; Stoopnikoff 2011).

As the literature suggests, prenatal education classes only deal with specific and limited content, omitting full participation of the woman or her family for birth and the motherhood experience (Kitzinger 2010). Online prenatal chat rooms provide a much more informative and sensitive environment in which women can openly discuss concerns and share questions about fears (Stoopnikoff 2011). What seems important to note is that, childbirth education "is a cultural phenomenon with deeply embedded values regarding the nature and importance of information, scientific evidence and consumer choice" (Morton and Hsu 2007:25). And, speaking to or of a notion of a homogeneous group of women, excludes those who fall outside the dominant picture of womanhood, pregnancy and birthing.

Non-Attendance and Attendance to Prenatal Education

Diana and Gillian were both pregnant at 19 and did not attend antenatal classes. During their interviews, Diana and Gillian could not understand why they were treated with disregard and disrespect. In fact, both expressed a sense of wonderment about their treatment. Diana described her experience of physical damage, hemorrhage, surgery and neglect. Discrimination by medical and nursing staff is not uncommon, and their lack of care from HCPs may originate from their non-attendance at antenatal classes, their age or socio-economic status (Fabian et al. 2004). Gillian spoke of being marginalized, neglected and treated appallingly with respect to

postpartum care, despite the fact she suffered with puerperal fever (sepsis) and could have died. It is not surprising that Diana and Gillian struggled in the postpartum period. They were subject to surveillance by the dominant interests, hegemonic and reified practices of the day.

Several of the women recalled their preparations for childbirth. Amber shared her experience of early pregnancy. “It was with my first child, my daughter. To give you a little history, before I had gone through all the [prenatal] classes, I knew that it wasn’t going to be painless or easy, right.” During her early pregnancy, Barbara did “the prenatal courses and, looking back, it was probably the best time in our whole marriage because of all the anticipation of this baby coming into our lives.” Barbara felt she prepared herself for birth with the usual doctors’ visits and attendance at prenatal classes and expressed her happiness at that time as a couple. Her readiness speaks to her personal, mental and social preparations for welcoming a child into their family (Koehn 2008). Francis also followed the norms and expectations of prenatal care. She had waited a “long time” to get pregnant. Francis stated that “Beforehand, I said I’m going to do everything right. So I did prenatal yoga, ate right and I quit my bad things. I had a bit of coffee but not too much and did a lot of walking.”

Four women reported they followed the prenatal directions, hence they had expectations that were consistent with the literature, which suggested women embrace the enculturated practices of pregnancy. Francis altered her diet and increased her physical activity, actions seen to promote health (Blincoe 2006; Garriguet 2009; Geisel 2003; Reifsnider and Gill 2000; Rosello-Soberon et al. 2005; Stang et al. 2005; Williamson 2006). She anticipated with enthusiasm the life changes that accompanied the birth. She had read a great deal about alternative birthing methods with a focus on processes that keep childbirth unmedicalized and woman-centred. Both Amber and Francis also chose exercise based on their activity preferences

and included this as part of their preparation. Most of the participating women wanted to do everything they could to prepare their bodies, to stay well and, thus have a healthy child (Bondas and Eriksson 2001).

Preparations for a healthy baby are also intended to connect and prepare women for the role of motherhood. Many theorists claim that every pregnancy implies ensuring safe passage, bonding with the unborn child and learning to give (Rubin 1976, 1984; Stainton et al.1992). Consistent with medical advice and through participation in prenatal classes, it is not uncommon for pregnant women to alter their patterns of everyday life and engage in self-monitoring their health (Bondas and Eriksson 2001; Grote and Bledsoe 2007).

In her late twenties during her first pregnancy Jennifer explained that her ongoing bodily changes were mentally unsettling throughout the pregnancy. She spoke of a renegotiation of self with the alterations from her pre-pregnant life.

To be somebody who's fit and goes to the gym five days a week and runs on the treadmill, lifts weights and hikes with our dog then, for nine months to start having restrictions and having to ... well ... I need to eat more of this. Really not even more or less of anything but to be conscious of it every single day. It's something that you don't even know. Yet, it just sort of grows and you can't wrap your mind around it. I think for those nine months that just losing my body, losing that control of my body. I didn't sleep well at all. I already had that ... not resentment, but, oh my god, this is a difficult road. I don't know if I was prepared for this.

Jennifer had a sense of her body seeping away, of losing control of her embodied self. Her recognition of loss of control signalled her awareness of being scrutinized but she accepted that it

was important as an intervention aspect of care to keep her and the baby safe. She felt she must restrict choices and think about the care of the embryo/foetus and this required relentless vigilance (Bondas and Eriksson 2001).

Another aspect of embodiment is how women experience their own bodies, their corporeal self, throughout pregnancy. They come to know themselves *through* their body, especially the space they occupy. Pregnant women are granted more spatiality; they are permitted to take up more room (Young 1984, 1990). As the pregnancy extends and the woman gains weight and her shape enlarges, her embodied self becomes something she does not recognize, particularly if she has struggled with her weight in the past (Mehta et al. 2011).

The image of the ideal self must be renegotiated to include the developing foetus and a body open to scrutiny. The pregnant woman is now situated in public spaces where others touch, comment and speak their thoughts about her health. The lack of personal space, privacy of one's exteriority signals a productive body. Technical representations, scans, visualizations of the baby, making the interiority public as well, all provide information about the status of the foetus. The foetus is seen by some groups as a person before birth, shifting the focus from being pregnant, to the metaphor of mother as container (Betterton 2002; Duden 1993; Raphael-Leff 1991; Winnicott 1953). With the social and medical gaze on the foetus, the woman is rendered less important, depoliticizing her body to an object (Duden 1993) moving the spotlight from the mother as object to the foetus as second patient prior to birth (Cahill 2001; Doyal 1995).

Haraway (1988) speaks of "learning in our bodies to see and attach the objective to our theoretical and political scanners in order to name where we are and are not, in dimensions of mental and physical space we hardly know how to name" (582). There is a powerful tie created between meaning and bodies (Haraway 1988). The social construction of pregnancy does not

match that of the material reality of the woman. Pregnant women experience themselves very differently and the social messages are mixed and inconsistent. For instance, Karen spoke about becoming pregnant again after a difficult birth and going to the doctor for a check-up.

So I went in for a kidney ultrasound, Kalen was five months old. And she said ‘When was your last period?’ I said ‘I haven’t had a period. Do you see the baby? I’m breastfeeding. What period?’ ‘I’ll just do an internal just to see.’ She obviously must have seen something. She comes back, ‘You’re five weeks pregnant.’ I just came unglued. The worst thing I’d ever heard in my life. What, are you crazy? [laughing] And it was like denial, I’m denying this.

Public Pregnant Bodies and the Lived Experience of Preterm Birth

Many women share or recount their personal experience and what they think is right and appropriate for the pregnant woman (Carpenter 1985). Women may feel pressure to live up to ideals of the perfect mother-to-be balancing family life and a successful career. Bordo (1993) claims that “the overwhelming majority [of women] will suffer considerable personal inconvenience, pain, risk and curtailment of their freedom to do what their doctors advise is in the best interests of their foetuses” (83). Notably, it is the foetus that has captured society’s attention, surpassing the corporeality of the woman and her human rights (Duden 1993).

Hillary’s understanding of her own body, her corporeality, is illuminated in her story of preterm birth. At 30 weeks gestation and experiencing contractions Hillary and her husband arrived at the hospital in the middle of the night after a 30 minute drive from home. She was placed on an external fetal monitor (EFM) and left alone. She recalled that no one touched her uterus to confirm if she was indeed having contractions. The nurses did not compare her

contractions to the monitor strip, typically one of the practices to determine labour. At times Hillary got up to the bathroom and removed the monitor. Recalling the events Hillary said,

I woke up at three in the morning and I felt wet. I knew it wasn't urine. I knew that I had cramping. When I went to the hospital they did a swab and it came back negative for amniotic fluid. They hooked me up to a monitor and I kept taking it off because I kept going to the bathroom. I know now that was part of the process of getting ready. That's part of labour. I was vomiting and had diarrhea.

Cardinal signs of active labour include diarrhea and vomiting (Fraser and Cooper 2009).

Hillary said she was aware that she was in labour, although the medical tests indicated a negative result for the amniotic fluid, she intuitively knew the staff were wrong.

My daughter was born ten weeks prematurely and it was a spontaneous birth. There was no warning, it happened within a two-hour period at 30 weeks. So that was the trauma. I went to the hospital, thinking something was wrong ... that intuition, something is not right. I was told, 'No, no, you're imagining it. You're being paranoid. Just go home.' I refused to leave the hospital. I said to my husband 'I'm not going until my OB (obstetrician) comes in.' He was supposed to come in at six that morning. I arrived at the hospital at three and she was born at just before six. I was told the problem was probably indigestion. I felt the need to bear down and now I know why [laughing]. It was my first child but I just knew this isn't right. So I actually felt her head, I reached down, and said 'No!' So my husband ran out in the hallway and started screaming. A nurse came

running in and she believed me. So she's the one who delivered her. She was the only one who was there and believed me; an amazing event.

Hillary and her husband were not heard. The nurses did not read Hillary's symptoms or consider her distress. Thus, her subjectivities were ignored in preference to taking as real, the information from a technological source, data that was seen by the HCPs to be more legitimate or perhaps more credible. Hillary's body was labouring and she knew that it was too soon, that something was wrong; yet, all the messages she received from her body were dismissed. A woman is in control of her body, is acutely aware of her foetus and every aspect of her embodiment up until the moment she walks into the hospital (Bondas and Eriksson 2001). For Hillary's care the usual assessment practices of palpation and timing of contractions whilst comparing to the fetal monitor for evidence of contractions were deemed not necessary (Fraser and Cooper 2009). No one looked in on her and the staff failed to take her concerns seriously.

Hillary had a strong sense that something was amiss. She expressed feelings of being disrespected, disregarded and abandoned while in labour and without appropriate assessments. Hillary felt that denying her experiences and not being heard compromised her child's life. She talked about it as a "crazy-making" experience when her labour as a first-time mother was discounted by staff. These instances of disbelieving a woman's reported concern is not uncommon (Hollins-Martin 2008).

Women have a legitimate knowledge of their own bodies (Butler 1999; Foucault 1978; Grosz 1994; Spender 1987). Yet, once hospitalized, the woman's body becomes the property of the medical profession (Cahill 2001; Davis-Floyd 1994, 2001). Even with straightforward pregnancies and birth, once a woman presents herself to the hospital she is subjected to routine procedures such as fetal surveillance, intravenous infusions and perhaps inductions of labour

(Lothian 2006a). Women without complications are also encouraged to have electronic fetal monitoring and epidural analgesia. Women frequently labour and deliver in the dorsal recumbent or lithotomy position (Johanson et al. 2002). In Hillary's case, the HCPs did not act because they saw her as asymptomatic. This experience left Hillary in a subjugated position of not knowing what was going on and feeling patronized.

A woman's bodily signs of pregnancy are representations of social inscriptions binding all subjects, according to sex, class, race, cultural and age codification. Grosz (1994) likens scarification to the ways in which society "writes" the female body. Grosz (1994) speaks of "inscriptions of the subject's body coagulate corporeal signifiers into signs, producing all the effects of meaning, representation, depth, within or subtending our social order" (141). Being female and pregnant enjoins HCPs to "work to keep the body confined, constrained, supervised and regimented" (Grosz 1994:141). Furthermore, these body markings or scars, are permanent and impermeable reminders of a transgressed body. For Hillary, the underlying messages or signifiers were that she was a pregnant woman; yet, she represented something outside of what the legitimate "knowers" or HCPs wished to see. Consequently, technological tests confirmed the HCPs were correct, despite Hillary's protestations.

Hillary remarked that her treatment was dehumanizing, disbelieving and strange. She described her appreciation and the fortunate occurrence of the respiratory therapist who was there to help her daughter (see Illustration 4.1 of the hat given to Lara from the respiratory therapist). He responded to the call and intubated Hillary's baby within "10 minutes." Hillary shared that this was a shocking time in her life and that of her child's. After five days the HCPs removed the infant from the respirator and Hillary shared her thoughts that "maybe there's a

chance it's going to end OK. In the end it did and she was in hospital ... and was growing. She was lucky.”



Illustration 5.1: Hillary’s daughter’s hat and teddy bear

Hillary reported that the baby did not have any lasting effects, just a small scar on her face from the tape from the feeding tube. Today, her daughter is “absolutely fine.”

Illness and Suffering: Confounding Acts of Care

In a very different circumstance, Carol also experienced preterm labour. She, however, was given credit for what she knew about her body, perhaps because she was a registered nurse (RN), a colleague. Carol received a plethora of care approaches that nearly exhausted her. Living with her husband in the United States, at 30 weeks gestation Carol had been hospitalized for several weeks with an undiagnosed kink in her ureter.

There was so much unknown. I literally went into full blown labour every night and it was back labour. Just so much pain ... So, that went on for weeks, weeks and weeks. And every night it was like here comes the torture. It was excruciating. I was eating the right diet, exercising, doing

everything. This is going to be the healthiest baby and we are doing ultrasound, amniocentesis, checking the lung maturity and even an X-ray of the full abdomen. And like, you know—that was *like what!* So everything [that happened was] against my principles—because they were still trying to figure out what was putting me into labour.

She described her experiences as dreadful, her pain agonizing and her enormous suffering. Her care although diagnostic was experienced as torture accompanied by endless nightly pain.

However, after the stents were placed in her ureters, Carol’s membranes ruptured spontaneously and she underwent an emergency caesarean section. Her baby was hospitalized for many weeks prior to discharge from hospital (see Illustration 4.2 of the foot and fingerprints from birth). Looking back, Carol felt she was listened to as a knower of her own body. She was believed and respected despite myriad tests and professionals guiding her care.

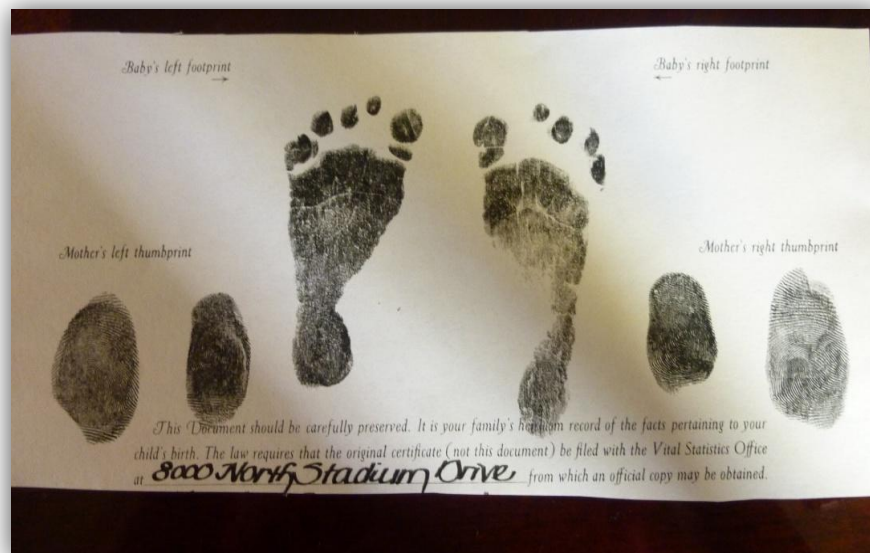


Illustration 5.2 Carol’s fingerprints and her infant’s footprints

As a nurse, Carol worked one floor below where she had been hospitalized. She felt gratitude for the people who alleviated her suffering and pain. Despite her feeling of being partnered in her health care there are aspects of deep suffering for Carol.

Managing Unpredictability: Controlling the Corporeal

Isabelle, who experienced PPD with her two previous children, said her third child was a preterm delivery. She recalled her story and the complications with her third pregnancy as a preterm birth accompanied by a ruptured appendix.

Appendicitis is a rare presentation in pregnancy “occurring in approximately 1 in 1,500 pregnancies” (Young et al. 2009:543). Yet, it is one of the most common surgical problems requiring immediate intervention (Pastore et al. 2006). The danger of delay in diagnosis is associated with a greater risk of complications such as “perforation of the appendix, infection, preterm labour and risks of fetal loss (1.5 to 9 per cent) and 36 per cent if the appendix ruptures” (622). Isabelle recalled her thoughts and conversations while awaiting surgery.

My husband came in and said ‘Is the baby OK?’ The physician said

‘We’re going to save your wife first, then we’ll worry about the baby.’

Whew! So that realization that you’re really on the edge of life and death

and the baby’s on the verge of life and death. So that really hits you to

your core.

She understood from the doctor’s responses that this was a dire situation for both of them. The cumulative effect of stressors for Isabelle was almost overwhelming. Her preterm labour and birth were stimulated by the ruptured appendix and subsequent surgery. The post-operative analgesics masked the symptoms of early labour and it was only when she passed her mucous

plug that Isabelle recognized labour pains. She told me of her condition following surgery, “it was surreal. It was almost like I was over top looking down. I was there but I wasn’t there.”

She was not given pain medication during labour to ensure the foetus was not narcotized at birth as this may suppress respirations and her preterm the baby was already highly compromised (Beech 1999). Beech (1999) describes how drugs administered during labour affect the development of the newborn. Even though women give informed consent for the use of drugs, the reality is the majority of women have little information about the drugs administered during labour and the impact they have on the newborn. Despite effects on the newborn, HCPs employ “propaganda to promote the advantages of drug use” but say very little about the side effects, particularly the long-term implications (Beech 1999:1).

Listening to Isabelle describe her experience as surreal, almost an out of body experiences, I recalled several women in the past who talked to me about “leaving” their body during delivery. Transcendence from pain, is a situation where a woman separates from her physical existence as the pain is too much to bear. Recalling the labour during delivery of my firstborn, I could not help but feel touched by this comment, an experience that resembled my own when I felt as if I was leaving my body. However, it is not only the level of pain but also the ministrations of medications and medical techniques and their effects on the foetus that are concerning for women.

Partners, family and friends are also deeply affected when emergency situations arise. Isabelle described the birth of her baby and her concern for her husband.

So there I was trying to push out this baby [laughing] with this abdominal incision and he was nine weeks preemie. So it was very difficult. I think it

was harder, in some ways, on husband than me because I was so doped up with analgesics that I was a little bit out of it.

I remember talking to our physician afterwards and saying ‘You know, it must be awful.’ He said ‘I knew I was doing everything that I could do at the time.’ He said, ‘By the time we were in fetal distress the baby was so low [in the birth canal] it was easier to have the vaginal birth completed because we didn’t really want to bring that baby out by opening up your uterus that we’d just cleaned up from a ruptured appendix.’ Then he was black when he came out, really blue, awful ... little.

Vulnerability tends to be a complex phenomenon with linkages and consequences that affect many human processes (Penuel et al. 2013). Vulnerability speaks of risks, limited control and an inability to affect outcomes. Isabelle was experiencing a situation with a real risk of losing her infant and perhaps even her own life, a situation not lost on her or her husband (see Illustration 4.3 emphasizing the prematurity of the infant).

Thirty-one years later Isabelle shared her thoughts on the birth and her life at that time.

When I told my husband you [this researcher] were coming, I said I opted to do it [participate in the research] because of [the] third baby’s birth. He said, ‘Yes that was a pretty hard time wasn’t it?’ From a distance you think, yes it was a pretty hard time. When I think about it in detail, it was devastating. But on the other hand, when you go through it you just keep putting one foot in front of the other. You don’t really spend a lot of time thinking, ‘Wow, this is really hard.’



Illustration 5.3: Photos of Isabelle’s son in the incubator and a preterm diaper

Shrouded Suffering: Unrelenting PPD

At home Isabelle had a five year-old and a two year-old with special needs. She recalled, “I don’t even really remember the whole first year of the baby’s life because I was so exhausted from the birth and being sick. I also suffer from terrible postpartum depression (PPD) as well.” Isabelle experienced PPD with her other births and with each subsequent pregnancy PPD can increase in severity (Buist et al. 2006; Misri 1995).

I remember when they told me he could come home from the hospital ... he was in the hospital for a month, six weeks. I said ‘I don’t want him. Keep him.’ I was hysterical. ‘I don’t want this child; I can’t cope [laughing]. Leave him where he is.’ I remember my husband phoning the doctor and saying ‘She can’t take him home.’ It was terrible. That was partly the birth and the surgery. I suffer from postpartum depression and it had gotten worse with each pregnancy. So I think that was part of it too. I had postpartum depression.

Isabelle talked about her earliest recollections of the infant and the desperation she felt during this early period of mothering.

I don't remember [the] baby's first year at all. It's just a total blur, total blur. I don't remember his first smile. I don't remember his first bath. I sort of remember him. I start to remember him as a young child when he was about a year to 16 months old. Finally, sort of, I was able to think about him. I don't think it was that I didn't care about him. I don't think so.

Isabelle's description of her depressive state and that of Diana whose memory of the postnatal period was vague, are similar. Postpartum depression is very much a misunderstood experience for many women, one that is not diagnosed with any accuracy and therefore not treated (Canadian Mental Health Association [CMHA] 2013). There is stigma associated with PPD. However, the rising rates and the increasing medicalization of childbirth are rendering PPD an increasingly common condition that seems to be normalized in language such as "baby-blues" (Beck 2006). Women who suffered from PPD frequently complain of symptoms that are different from and often milder than those used to describe postpartum depression in medical textbooks or the DSM-V (APA 2013) thus rendering this elusive condition more difficult for HCPs to identify (Ugarriza 2002). PPD has also been described as a disorder that may well be a culture-bound syndrome in industrial Western nations (Harkness 1987).

Postpartum depression is an umbrella term that encompasses several mood disorders that follow childbirth, with many cases remaining undiagnosed due to constraints such as time and concern about the social acceptability of screening (Ayers et al. 2006; Barr 2008; CMHA 2013;

Miller 2002). Chaudron et al 2007 speculate that mothers might find questions about PPD intrusive or stigmatizing thus, mothers might avoid HCPs in fear they will be misjudged.

Authors of the American Psychiatric Associations, DSM-IV (2013), suggest the importance of early recognition of depression and its effect on maternal–child interaction, on role gratification and on the child and family. Logsdon et al. (2006) questioned why depression is not a legitimized part of the “typical” assessment following every birth experience.

Stigma and Medicalized Birth: Normalizing PPD

The CMHA (2013) explains that PPD is poorly defined, under-studied and under-reported. The majority of PPD cases are probably not diagnosed due to social stigma (Thurgood et al. 2009). Women with this condition may suffer hopelessness, tearfulness, have feelings of inadequacy, guilt, anxiety, irritability and fatigue (Beck 1993, 1995, 2004; Miller, 2002). An estimated 50 to 100 per cent of women with PPD will develop PPD with subsequent children (Thurgood et al. 2009). Furthermore, women who suffer with PPD usually delay seeking help due to the shame and stigma (Pyne et al. 2004; Riecher-Rossler and Hofecker Fallahpour 2003) and the misinterpretations of symptoms lead to misdiagnosis. Community and public health services may not adequately address the woman’s context(s), thus care needs are ignored.

Women with PPD may view their child with ambivalence, negativity or disinterest which can have an adverse effect on the bonding between mother and child bonding (CMHA 2013) which can affect the entire family (Bergstrom 2013; Goodman 2004). PPD can begin at any time following from delivery to six-months postpartum and may last from several months to a year. It is important to recognize and acknowledge the symptoms of PPD but this can be difficult, since the depressive feelings often involve intense and irrational feelings of fear. The mother may

think she is losing her mind or be reluctant to seek help as others may think she is unfit to be a mother.

Isabelle told me how her children suffered and how her PPD exhibited itself in her life and feelings.

So really I wasn't coping. I didn't cope well for that first year at all. So that was really hard on the other two because I had no patience. No patience at all. It was hardest on my eldest son because he was five, needing more attention and caring, he suffered the most. He suffered more than the other two did. My middle son was special needs, so he got our attention because you were always running off to speech therapy, physiotherapist, occupational therapist and all those things; medical appointments. I think that magnified what happened with the difficult birth for the older son. If it had been a normal birth, less traumatic and easier to get over, it would just have been the postpartum depression. But, as it was, I was physically sick too. I lost a lot of weight. I couldn't move. I was really tired.

Experiencing tiredness from the birth, the stress and worries for her preterm infant, it is not surprising Isabelle developed postpartum depression. She had an appreciation for her children's care but was unable to answer their needs while recuperating. For Isabelle there was no relief, no day-to-day help to support her or her family. She was alone. The depths of her depression are epitomized by suicidal thoughts—thoughts she shares with her husband, in a joking sort of way, “I used to say to him, take [our son's] meds to work with you [laughing]. I was so afraid I might take them.”

Social expectations might depict that women should be happy, in a state of wonderment with their new baby (Misri 2005). However, Isabelle presents a different picture.

Of course, there's still so much stigma about depression. People didn't say they were depressed. This was years ago, I was a nurse and thought that I should be able to cope. And I couldn't. There wasn't much help. You didn't want to say you're depressed, wondering what people would think of you then. I think baby was about ten months old. Because I was breastfeeding, which was interesting—I actually loved breastfeeding—I didn't want to give that piece up because I did feel like I was doing something for this child, poor baby [laughing]. He was about ten months and the doctor finally said 'You really need to take something but you need to quit breastfeeding if you're going to do that.' Which I did; which was hard. But with baby, I never had as much milk production as I did with the other two. I think because I was sick, I was never engorged. I was never full. I had enough for him but barely. I think a lot of that was the physical piece.

On top of that I developed rheumatoid arthritis because of the trauma of that birth. So that was also layered on top of that in that first year. I was physically tired and achy in the joints. It did affect that. It was really hard on my husband because he had to pick up a lot of the slack dealing with this woman who was beside herself.

Looking at stress and preterm birth, Hobel (2004) studied chronic stress and anxiety in pregnancy. Hobel (2004) found that the complex interaction of maternal behaviours and life

characteristics combine to develop what McEwan and Stellar (1993) term an “allostatic load” where activities and events in one’s life accumulate to a point that homeostasis cannot be maintained. The effects of stress stimulate a release of hormones that place repeated strain on the body and changes in metabolism that lead to chronic wear on tissues and organs (Hobel 2004; Lu and Halfon 2003; Stojanovich 2010). Transmitted to the foetus through the endocrine system the allostatic load creates the potential for preterm birth (Hobel 2004; Lu and Halfon 2003). The allostatic load was Isabelle’s breaking point. Her body could not manage with the stressors that she faced in her everyday world and her immune system was overwrought. Isabelle experienced the development of a generalized primary arthritis over her entire body. She suffered painful joints and found movement and activities difficult, further compromising her ability to care for her children.

Failure of the Corporeal: PPD and Thoughts of Suicide

All of the women who experienced a preterm birth had a heightened awareness of their infant’s needs. Normal practice for women who have preterm births is to pump their breasts for milk as they have very little physical contact with their baby. The care of the newborn is managed by staff in the Neonatal Intensive Care Unit (NICU). A mother feels a sense of helplessness, uselessness and rejection as she stands beside the incubator and gazes at her infant, standing beside the incubator. Isabelle spoke of self-doubt and guilt for not being able to keep the baby inside her.

Even looking at the birth you think, did I work too hard? Did I not look after myself? Did I not eat right? What is it that I did that made this birth happen the way it did? You get to the point where you realize it wasn’t really anything you did. It was just the luck of the draw. It does take a long

time [to get to that], I think it does. It's probably even five years ago I was still working on it.

She had a deep sense of pain and wondered what she could have done differently. Mothers of preterm infants indicate they experience significant levels of stress (Black et al. 2009; Davis et al. 2003) from seeing the appearance of a fragile, sick infant, fear for their infant's survival, alteration of their parental role and the separation brought about by hospitalization (Davis et al. 2003; Sawyer et al. 2013). All the women who experienced preterm birth spoke of their concerns and worries about how things could have been had they not had a preterm birth.

Overwhelming Circumstances: Prematurity, Fragility and the Threat of Loss

Pregnant with her first and only child, in a relationship with her long-term partner Linda, Lyanne experienced a preterm birth at 30 weeks gestation. Lyanne was hospitalized for several weeks prior to the birth.

She was just two pounds at birth. The first 72 hours they told us it was touch and go. She actually did really well for being that preemie. She didn't have to have a respirator. They put her in a little oxygen tent for the first 24 hours, and then she was breathing on her own. So that part was quite miraculous. There's always the risk that they might get an infection or something like that in the first 72 hours. That was like hold your breath and cross all your fingers and toes and pray. And she wouldn't keep food down. She wouldn't keep breast milk down. She couldn't breast feed. I had to pump. Then she got jaundiced. All that kind of stuff that happens with preemies. But that first 72 hours is really the critical time but you still worry because there's always the risk of them getting sick.

Lyanne and her partner were wracked with worry and concern. Modern medicine was keeping their child alive through specialized care, techniques and equipment. Like other families in this situation, the postpartum period becomes an entirely different experience for couples who have a preterm infant (Black et al. 2009; Sawyer et al. 2013). Many factors play a part in the tenuousness of early birth. For Lyanne, the placenta was not functioning well and the foetus was smaller than expected. The baby had intrauterine growth restriction (IUGR), a condition where the foetus is undernourished for gestational age, with little amniotic fluid (Platz and Newman, 2008).

Re-Igniting PTSD: Embodying New Injuries

In the tertiary care centre, Lyanne connected with staff and physicians who showed her respect by including her in the decision to deliver the baby. However, she was a survivor of incest and when they strapped her down on the operating room table, Lyanne said that she felt re-traumatized. Being secured to the table ensures that Lyanne does not fall during the surgery (Potter et al. 2013). However, she “was already really scared and they put you on the table and they strap your arms down. And that just really sent me. So, when they let Linda in that helped.”

Little is ever included in hospital admission forms about an individual’s life contexts and how to avoid exacerbations of traumas such as rape, torture or incest (Klaus 2010; Parratt 1994; Seng et al. 2009; Seng et al. 2014). Women who have previously experienced trauma continue to experience both psychological and physical distress long after the initial event (Runtz 2002). Additionally, during pregnancy, labour and birth women can often experience memories that had been forgotten (Epstein and Bottoms 2002; Klaus 2010). Furthermore, “posttraumatic stress disorder (PTSD) may be a direct consequence of childhood abuse and depression is more likely to occur in other stressful situations in later life” (Hobel 2004:864).

Klaus (2010) recommends that caregivers can benefit by recognizing indicators of an abuse history and elements in perinatal care that may become triggers for memories or adverse reactions for survivors of abuse (Courtois and Riley 1992; Grant 1992; Kitzinger 1992; Rose, 1992; Simkin 1992b). Procedures such as vaginal and speculum examinations, restraints, words and phrases used in coaching women in labour and the feelings of the baby during birth, can trigger memories of abuse (Parratt 1994; Rose 1992).

Overwhelming Stressors and Coping with Preterm Birth

Lyanne described other stressors at the time of birth. “Well, number one was the emergency of it. That this has to happen, and ‘oh my God, it’s not time ... What did I do wrong?’ I started to blame myself.”

Women blame themselves for their preterm births. They feel their body has failed to sustain the pregnancy to full term. The sense of blame involves a cause or reason that early birth is somehow the woman’s perceived failure to engage in the prescribed care. Bartky (1988) insists surveillance is “a form of obedience to patriarchy” (81). Self-blame is a disturbing phenomenon seen with preterm birth in this study and in studies conducted by others (Buckley and Charles 2006; Rodriguez et al. 2005). Lyanne shared the cumulative effects of hospitalization for a complicated pregnancy.

Waiting in the hospital for two weeks, not knowing what the heck was going to happen. They give you a tour of the NICU to show you what it’s like. And that just increased my anxiety, just crazy. I almost would have preferred not to have seen it because actually once you’re in it you adapt as much as you possibly can.

Hospital staff are familiar with the technology and the highly structured care provided. Often staff neglect the family's newness to the environment and the day-to-day functioning of acute care centres (Arnold et al. 2013). Much of the research on NICUs encourages prior parental visiting to minimize distress after the baby is born (Griffin et al. 1997). For Lyanne, the NICU tour added to her stress and her concerns mounted when she wonders how breastfeeding will go.

Breast Milk and the Premature Infant

Lyanne talked of her desire to breastfeed her baby. She recognised the importance of her breast milk, which protects infants from many complications, while it is also “inexpensive, readily available and virtually risk free” (Rodriquez et al. 2005:109). Breast milk is considered superior nutrition as it is perfectly attuned to the infants' digestive system in terms of infant growth and decreases infant infection rates (Rodriquez et al. 2005).

For three months I pumped. Yes, that was huge. She wouldn't breastfeed, she just wouldn't. My theory is that she was born so hungry because she wasn't getting enough food. Then they tube feed them—that was another really hard part to watch—their stomach is full instantly. Then they start switching over to bottle feeding, I don't know if it was the bottle or just her but she would just suck it back so fast it caused her some GI [gastrointestinal] difficulties. Then when we got her home, we tried a dozen different nipples to get her to slow down a bit, but she would just holler. Then when I tried to breastfeed her; it wasn't coming fast enough. She wasn't having anything to do with that no matter how hard I tried, it just didn't work. But she thrived really well.

Despite the baby not latching to breast feed, Lyanne pumped her breasts and the expressed milk was given to her infant through tube feeding or a bottle (Buckley and Charles 2006). Her baby was slow to adjust to life outside Lyanne's body (see Illustration 4.4 cradle that wrapped around Lara). Among all the stressors faced by Lyanne, it was the profound complexity of circumstantial change that influenced her own health and overwhelmed her.

Postpartum Depression, PTSD and Hospitalization

Beck (1998), a leading nurse scholar on depression and the postpartum period, has studied many aspects of depression and PTSD in pregnancy (Beck et al. 2011a) in which panic attacks are “terrifying physical and emotional components of panic [that] paralyze[s] women, leaving them feeling totally out of control” (1998:133). The women stated they felt as though they were losing their minds and sought to discover the triggers to their panic attacks. They also experienced lower self-esteem and avoided going out in the public.

Lyanne was admitted to a psychiatric ward. She spoke about the adjustment to her medications and the nature of the hospital care,

I knew I was tired. I wasn't sleeping well because I was so anxious about leaving Lara; and I was at home sleeping in my bed and my kid is not even here, my baby. Then when she came home I started to have panic attacks. I went quickly [into depression]. I was scared, just totally scared all the time. So when I got suicidal, they decided it was time to do something about that. The nurse at my doctor's office took one look at me, when we took Lara in for a check, and said 'You are not doing well.' And I said, 'No.'

It took them a while to figure out what was going to work. The first thing [medication] I tried didn't work. They tried one that I had been on previously and it didn't work. Then they decided to treat my thyroid at the same time. It took a while to get it under control. I was there for a week, and they said you really need to stop pumping because they thought that that wasn't helping because it was so stressful. So I did. That was when I decided I can't do that anymore.



Illustration 5.4: Photos of the cradle that wrapped around Lara when in the incubator

The women grapple with the sudden, mental and emotional intensity of their preterm birth. Some suffer with PPD, guilt, thoughts of suicide, concern and distress. Three of the women—Carol, Isabelle and Lyanne—experienced a highly technological approach to preterm birth. In contrast, Hillary delivered her infant with the help of one nurse. All the infants were hospitalized for weeks prior to discharge. During hospitalization, all the mothers feared that the child would not survive. Technology aided in saving the lives of each of these infants. However, the sense of stigma, depression, guilt and failure are resounding in many of the women's stories

of preterm birth. The need to allocate blame and stigmatize individuals (Goffman 1986) who find themselves in unpredictable events, such as preterm birth, are overwhelmingly assigned to the mother (Beck 2001). If the woman is seen as not following advice, recognizing symptoms or being overly stressed, then she is stigmatized and feels guilt for her lack of effort or awareness (Mollard 2014). She has done something that has put her infant at risk through knowing or not knowing the correct actions. For example, Isabelle and Lyanne both felt a deep sense of guilt that they had done something wrong. They questioned themselves about their actions, their self-care, ability to influence events that might have brought on labour and birth. Social and cultural processes privilege medical interests over women's experiences and it is these structural processes that inhibit the interests of women being capably served (Goodwin-Smith 2012).

Six of the women said they were very prepared for childbirth. They had attended physician or midwifery appointments, prenatal classes, read about birth, sought expert advice and talked with family and friends about their experiences. Diana and Gillian did not complete prenatal classes; both were 19 years old. Diana felt she did not need to attend the classes due to her presence at her mother's birth only months before, which she felt was excellent preparation. Gillian was busy working with her husband in their business. It is a taken for granted practice in Canada that all pregnant women should participate in what might be best described as the medical preparation for birth (Morton 2009). Looking more closely, however, what is being enacted is a system of surveillance designed to keep women's activities restricted; controlling their lives (Forssen, 2012; Goodwin-Smith 2012; Mitchinson 2002).

This chapter has examined the mechanisms of structured surveillance of the pregnant woman through prenatal education and medicalized care designed to keep her actions restrained. The control of corporeality does not rest with the woman who is experiencing pregnancy. The

taken-for-granted and the modes of surveillance reside outside the woman and rest with the HCPs who view her as object. The pregnant body is seen through the eye of the public and the scrutiny a woman may experience is thorough and comprehensive. The foetus is privileged over the woman and her subjectivity is in question (Duden 1993). Viewing women's experiences, her ownership of her body through awareness of valid feelings offers a new way of valuing woman's subjectivities (Merleau-Ponty 1999).

In this chapter, four women's experiences of preterm birth, as well as the worries they faced, have been explored. Two women struggled with PPD and one woman with PPD and PTSD. Their births were unpredictable and resulted in all of the infants remaining in NICUs for many weeks prior to discharge. The women interviewed experienced feelings of shame and blamed themselves for the premature births. The next chapter looks at the experiences of women who had term births and how their non-attendance at prenatal education was used against them. They were penalized for their perceived negligence through harsh and punitive care that can be read as unethical (Jacobson 2009a, 2009b). Two women who also had term pregnancies will be introduced and their narratives will highlight their own particular struggles.

Chapter 6 Failing Bodies, Stigmatized Embodiment and Birthing Women's Struggles

Birth is a rite of passage (Neiterman 2012) that involves a transformation for the woman (Draper 1997) as she emerges into the realm of motherhood (Dixon et al. 2014; Kitzinger 1987a). Women's experiences are shaped by the manipulation and instrumentation they undergo giving birth. The women in this chapter experienced scarring from their births. This scarring can be seen in their bodies as wounds from episiotomies and tears into surrounding tissues that create further illnesses and prolonged recovery. They also experienced mental and emotional scarring through marginalization, when their voices were not heard, information was not shared and their embodiment ignored (Chrisler 2011; Goodwin-Smith 2012). They were treated as objects and the outcomes of objectification affected their identity, their sense of self and their understandings.

The Biomedical Model of Childbirth: Whose Interests Do They Serve?

Historically, birth was attended by midwives and lay women who had experience with women in labour, birth and the weeks following childbirth (Brodsky 2008; Donegan 1978; Donnison 1988; Litoff 1978; Wertz and Wertz 1989). Over the past two centuries, what was once a female or midwife-supported event (Brodsky 2008) and with the introduction of male midwifery and the development of the field of obstetrics mutated into the biomedical model we know now (Donegan 1978; Donnison 1988; Wertz 1989). For the past 50 years, pregnancy, perinatal care and childbirth in Canadian health care has changed drastically (Mitchinson 2002) and become a biomedical event defined as "pathological in spite of its experiential non-disease nature" (Bondas and Eriksson 2001:824).

Today, the heritage of the biomedical model remains strong, seeing the mother as an incubator (Duden 1993; Fausto-Sterling 1992; Lloyd Thomas 2013) "housing" the foetus for

which she is solely responsible and accountable (Wetterberg 2004). For the medical professional, the “normal process” of labour and birth is to deliver “a healthy baby” no matter what (Larkin et al. 2012), an aim that discounts the woman’s experience (Lazarus 1997). Despite the woman’s careful decisions over the course of her pregnancy to have a vaginal delivery, many births become usurped by medical processes (Bryant et al. 2007; Draper 1997).

In the interests of safety, the HCPs take over the woman’s body (Goodwin-Smith 2012). Her vulnerability and “assumed” lack of knowledge and ability to control herself, prohibits her making decisions that are aligned with what she has planned or desired (Chrisler 2011; Ussher 2006; Young 1984). She may feel betrayed that her body has let her down, she may feel a failure, she may feel wounded, out-of-control and dismissed (Etowa 2012; Mercer 1986). Women feel this way because they are labelled a failure by medical personnel who view them as not able to birth without help (Cindoglu and Sayan-Cengiz 2010). Medical professionals lose sight of what birthing means for the woman, focussing solely on the baby’s “safe” delivery (Larkin 2012). For many women the sense of wonderment is absent as they may have struggled with birthing and their focus is on the need to recover and to overcome complications (East et al. 2012; Gabrysch and Campbell 2009).

This chapter explores four women’s experiences of birth as they share how their births were compromised when their interests were not placed at the centre of care. Births that were medically managed and how these births unfolded in terms of meanings for those participants are explored.

Gillian and Diana

I have heard HCPs share derogatory and denigrating comments about women who neglect attending prenatal sessions. You will recall Gillian and Diana were both 19 years old and

did not attend prenatal classes. There are unspoken rules about the necessity of women to attend these classes. Gillian and Diana's lack of attendance plus being young made them more vulnerable to medical procedures and discrimination. Cultural and historical aspects of pregnancy care construct women's realities and shape inspection to identify those who do not comply. Scrutiny shapes, controls and regiments women to conform to structured oppressive practices that work against women's autonomy.

Stigma and discrimination also underscore oppressive health care practices and deny equal treatment with respect to services, care or treatment (Farmer 2004, 2006; Ho 2007). Gillian and Diana had their actions scrutinized and were punished for their perceived lack of cooperation with medical authority.

Gillian was pregnant with her first child. She worked with her husband in their business and was preparing for the birth. Gillian recalled, "I had a very healthy pregnancy. I didn't do any prenatal. I was 19 years old. I was very naïve, I was super naïve and I guess I was almost in denial perhaps" [laughing]. She described her labour.

My water hadn't broken but I was obviously having contractions. I'm phoning a girlfriend and she said 'Oh, you're having contractions'. I'm like, 'Oh, so what do I do?' I didn't even know what to do or whether to go to the hospital. I was so naïve and stupid. So finally I ended up, later in the evening, phoning the hospital. They said, 'You should come in' because my contractions were very close.

Part of the assessment involves whether the woman can or cannot speak through the contraction. If she is not able to talk and can only focus on her contraction, then labour is well established. Gillian mentioned that she was unaware of when to go to the hospital and the finer points of

identifying labour progression (Dixon et al. 2014). Gillian spoke of being in denial, yet also aware of her body's work.

So around nine at night and I'm ten cm dilated. I'm ready to have a baby.

Of course I arrive, they're all panicking. My doctor's called in. They put the monitor on and discovered [the baby was in distress]. It was a prolapsed cord. So instantly I'm having a C-section.

The HCPs see what Gillian is experiencing as a high-risk complication. The term "risk" is a discourse that indicates a given situation will be medically managed in a specific way with close monitoring—practices stemming from the discourses of surveillance.

Umbilical cord prolapse is uncommon and a life-threatening emergency for the foetus as the blood flow through the umbilical vessels is compromised by cord compression (Khan et al. 2007). A number of risk factors have been reported to be associated with cord prolapse, including malpresentation, multiple gestations, prematurity, multiparity, premature rupture of membranes, polyhydramnios (excessive amniotic fluid) and a small foetus (Murphy and MacKenzie 1995; Roberts et al. 1997). The incidence of umbilical cord prolapse has been reported as "1 in 160–714 deliveries" (Khan et al. 2007:487). Delay in medical management has been associated with "a perinatal mortality of 36 to 162 per 1000 births, mainly due to prematurity, birth asphyxia and occasionally congenital anomalies" (Khan 2007:488). If the cervix is not completely dilated, prompt delivery by caesarean section offers the best chance for a favourable fetal outcome (Critchlow et al. 1994; Dare et al. 1998).

Gillian recalled not being included in the conversation, dismissed as if she were not part of the experience. Instead of talking to her and providing information, staff are talking over her

as if she were an object. She was given a general anaesthetic, the norm during these times, as epidurals and spinals were uncommon and not routinely used for caesarean births (Klein 2004).

Stigma: Ignored Suffering

Gillian awoke following the anaesthesia and surgical birth. She had experienced a shift from the pregnant self with child to the non-pregnant self and the moment of separation had been missed. She recalled “The next thing, I wake up, I have a son. I hadn’t done a lot of babysitting in my life. I had no experience with little babies [laughing]. So, of course I’m presented with and shown how to nurse my baby.” However, over the next day Gillian becomes increasingly ill. No one listens to her complaints of fever, malaise or takes note of her worsening condition.

Quite early on, within a day or two I was sick. Of course, I’d just had surgery. I was very weak. I couldn’t hold my baby and I was in such pain. I ended up having a pelvic infection that went undiagnosed for a whole week. The nurses were so horrible to me. They thought I was rejecting my child. They kept making me get up, move and walk. You get to the end of the hall and literally I crawled along the wall. They were talking to my husband, telling him ‘There was something wrong with your wife you’d better talk to her.’ He was not sure what to do but he seemed to be on their side. I kept asking him to phone my Mum and he said, ‘Well we don’t need to phone her yet.’ Don’t need to phone her yet!

There are multiple layers of hegemonies at play that dictate what unfolded. Gillian had no authority over her care nor does she have a voice or sense of autonomy. Based on her experience, nurses treated Gillian as if she was a malingerer and whose complaints are not listened to. It is as if she is being punished or perhaps some of the nurses were deeply concerned. She may have

been blamed for coming in completely dilated with a complicated birth. She may have been left to suffer due to her absence at prenatal classes. It is not clear what they are blaming her for however, the blaming leads to stigmatization for her lack of awareness as a dissident. Gillian spoke of the way the staff questioned and accused her of rejecting her baby.

Gillian said her husband did not call her mother as she requested as he was being guided by the authority of the medical and nursing staff. I question what other factors played a role in the staff dismissing her complaints. Gillian recalled,

I didn't know what was going on. I knew I wasn't well. Then they're telling me I'm rejecting my baby. I'm trying. I didn't even have the strength to hold him and I was afraid because I didn't want to drop him. I had a fever, I had incredible pain and I didn't know what was happening to me and nobody was listening. I felt terrified.

Gillian highlighted the frustration of not being listened to or indeed noticed. Her experience of pain and other symptoms were not considered credible by the nurses. Her symptoms of infection were missed or overlooked. She said she suffered terrible pain in her pelvis including excruciating pain above the hips, tachycardia, malaise and other symptoms (Hallett 2005).

At times, HCPs make judgmental comments about patients and their families which can prejudice engagement with the person concerned. These comments serve to discredit the woman, discount her experiences and make a public spectacle of her failure to all those around her (Goffman 1986). Negative perceptions and discriminatory comments are made without concern for those overhearing. It is almost as if the staff feel justified in their thoughts in spite of viewing these conditions through a lens of stigma (Lyerly 2006).

Gillian recalled her “angel nurse” who recognized her symptoms, affirmed and alerted her to the severity of her illness and told her to call a specific obstetrician from a neighbouring town. The next morning, Gillian told her husband to get another doctor no matter what. She described how the new obstetrician assessed her abdomen and diagnosed her condition. Immediately, they placed her in isolation, giving her antibiotics and blood transfusions.

As she recounted the experience, I found myself wondering why the nurses did not recognize her illness, show her empathy or question the physician’s orders. The nurses ignored her symptoms and displayed tunnel vision to her classic presentation of illness (see Illustration 5.1, photo of Gillian with her three children).

Unethical Actions: Systemic Patriarchy

Gillian mentioned one of the nurses saying that the first obstetrician, “smelled like booze” when he came in for the caesarean section. Despite the nurse’s suspicions of his alcohol use prior to surgery, the nursing staff upheld the social, cultural, ideological and economic influence of patriarchy and male authority. The physician’s power within the organization maintained his dominance despite his, apparent, intoxicated state. However, Gillian filed a complaint against the doctor.

So, I wrote a letter and sent it to them [College of Physicians and Surgeons]. They said, ‘Thank you for sending the letter. We’re sorry about your pain. The doctor is going to be retiring this year and we don’t want to tarnish his career. So thanks for writing, but ...’

The operating obstetrician’s assessment and treatment of Gillian had become the care plan for the first half of her hospitalization. No one seemed to question the doctor’s opinion, despite the clinical evidence to suggest otherwise.

So that was my first birth experience; horrible. In the end I did file a complaint with the College of Physicians and Surgeons against my doctor. One of my nurses said nobody liked him. What came of it, I got pregnant again pretty quick. I had my next child 2 years later. So when I got pregnant he said I'd have a C-section. So I saw another doctor. He read the report and said it was mostly illegible. I'd lost blood and there were some other things and he really questioned what happened. In not so many words, he indicated that this was a big botch job.



Illustration 6.1: Gillian with her three children

Diana: Stigma and Forced Labour

A similar set of circumstances of questionable practices and subsequent care was something Diana experienced as well. She was a 19-year-old woman who also did not attend prenatal education. Diana through my interviews conveyed being treated with disdain, disrespect and less than optimum care and attention.

Diana was pregnant after several months of dating her boyfriend. She was living at home with her mother who, at the time, was also pregnant. While pregnant, Diana attended her brother's birth several months prior to her own child's birth. She understood the realities of giving birth despite not attending prenatal classes. She affirmed that nothing could compare to the experience of witnessing birth, no dialogue or conversation could ever replicate the experience (Dixon et al. 2013). She learned about labour and birthing while observing delivery.

I went to the hospital with my Mum and was with her the entire time. I got to sit beside the doctor and had the 'foot view' watching the whole thing. So understanding was better for me than any prenatal class. This was dilating, this is what's going to happen, there was a head, you've got to stop and wait and make sure everything is suctioned out of the mouth and then keep on going. But mine had many more hiccups. Some were little, some larger hiccups. And the lack of energy because of blood lost too. I wasn't really a person for so many months. I was a person but not able to do the things that you expect to be able to do. A zombie really is how I felt (laughing). I looked like one too. There was no awake or alert, not for months.

Feeling like a zombie is an unusual comment to make but gives one the image of the walking wounded; tired, pale and mindless, merely walking through life. Diana stated she felt terrible after the birth and has little recollection of this time in her life.

Diana told of her induction of labour. Prostaglandin was inserted in the cervix; she was monitored with external fetal monitoring and then sent home to await the commencement of regular contractions. It was not until later that evening that Diana felt the first contractions. She

returned to the hospital at dinner time and the doctor decided to use oxytocin, a drug given intravenously to enhance labour. She stated the drug given to her was increased by one half above the normal dosage usually administered. Her forewaters broke spontaneously.

What Diana experienced is called “active management of labour,” a method developed to enhance “the experience of childbirth by preventing prolonged labour in first-time mothers” (Frigoletto et al. 1995:745) and to lower the caesarean birth rate (O’Driscoll et al. 1969, 1996). The approach speeds up delivery by shortening labour through rupturing the membranes and infusing high-doses of oxytocin (Frigoletto et al. 1995). However, once medical care begins, further interventions such as pain management are often needed; however, with these actions there is an increased risk for complications (Davis-Floyd 1994, 2001; Johanson et al. 2002). This method of active management relieves staff of the frustrations of waiting out “tedious hours,” which places the focus of care on the staff’s interests (O’Driscoll and Meagher 1986).

Labour progressed and Diana began to vomit. They gave her Demerol (pethidine), which allowed her to sleep between contractions but she awoke vomiting and contracting. With the rupture of membranes there was meconium present, which means the foetus had been distressed in utero (Gelfand et al. 2004). Diana then had an epidural as induced labour often increases the amount of pain with contractions (Welsh 2008) and she progressed to being fully dilated. She said she pushed for two and a half hours, then due to little progress they called in the obstetrician for assistance. “I was young, 19 and my first pregnancy. I also did not do prenatal classes. So they were concerned that things weren’t moving along because [they thought] I didn’t know what I was doing.” The denial of her own understanding from being present at her mother’s birth experience went unrecognized.

Diana described the birth,

My doctor was on my right side and pushing with both his hands from the top of my stomach, just underneath my breasts, just to get the child out and the obstetrician was at my feet. I was very, very frozen from the epidural. He put in forceps. Even as frozen as I was, putting that first forceps in I felt like my [bottom] was getting ripped from the inside out, excruciating pain. The second one went in a little easier.

The umbilical cord was wrapped around the baby's neck twice.

Once the baby was born Diana's partner, Dave, presented their son to her bundled in blankets. She looked at her newborn and shared, "I should have been loving and caring and you know happy and excited. I felt no emotion." All she said was, "Oh, you're there, neat!" Then fell asleep. Two hours later, "I'm on the gurney [going] into the operating room. I had passed out because I had lost two pints of blood in the delivery. I got a tear in my cervix and I had an episiotomy that also tore."

Diana described the doctor pushing on the top of her uterus, this method is called "fundal pressure" designed to assist vaginal delivery and avoid prolonged second stage of labour or the need for operative delivery. Fundal pressure is a controversial manoeuvre and there is little evidence to demonstrate its use is effective to improve maternal and/or neonatal outcomes (Shimada and Suzuki, 2013; Verheijen et al. 2009). Several anecdotal reports suggest fundal pressure is associated with maternal and neonatal complications: for example uterine rupture (Pan et al. 2002; Vangeenderhuysen and Souidi 2002) and neonatal fractures and brain damage (Amiel-Tison et al. 1988). An increased risk of anal sphincter damage has also been reported (Cosner 1996; De Leeuw et al. 2002; Zetterstrom et al. 1999). I have never seen this technique used. A sage nurse described her experience, in the United States years earlier, of the use of

fundal pressure as punitive and out of the ordinary. The obstetrician's actions were questionable in terms of the controversial procedures used and the forced labour that ensued.

Despite sensations being blocked by the epidural, Diana felt the first forceps being placed near or on her cervix and felt excruciating pain, which is unusual. Perhaps it was the pulling on the forceps that tore her cervix. The hemorrhage necessitated surgical repair of the cervix, under general anesthesia, as well as repair to her perineum and extension of the episiotomy or third degree tear. According to the doctors, she did not need a blood transfusion to replace blood loss, which Diana felt lengthened her recovery period. She also learned after the birth that she had been anemic during her pregnancy. She recalled the first few months following delivery: "It took me three months to remember the day-to-day activities."

The biggest challenge was "the doctor not explaining things to me, not explaining what was going on. I don't ever remember the obstetrician coming to check on me [while] I was in the hospital." Usually the specialist would come and check on the patient post-delivery and to make arrangements to see her six weeks post-operatively. Based on her observations of her mother's birth experience ten weeks earlier Diana had formed her own expectations. These were thwarted by her own birth experience with the induction, technology and mechanization that endorsed the obstetrician to pull Diana's baby from her body.

Amber: Birth from the Margins

Amber told of her first pregnancy and birth: "I was 35 when I had Avril. I was in really good health. I knew that it wasn't going to be painless or easy but for some reason going forward ... I wasn't worried." Amber was concerned about breastfeeding as she had heard that it could be challenging. With all her preparation and reading she stated, "I wasn't as prepared for it [birth] as I should have been."

Labour started in the early morning and Amber was dilating and having pain with the contractions, she tried going into a shower or tub of water when labouring but, she stated, that did not work for her.

So finally, they decided that I would like an epidural. So I got an epidural and everything went smoothly. But I was blocked from the epidural; I felt no sensation—nothing. I had no sensation of contractions. You know no pressure, nothing, I was progressing. But I would sleep; actually it was quite lovely because I couldn't feel anything.

Her language is interesting; “they decided” that she would like an epidural. There appears to be little advocacy or explanation offered by the HCPs to her. She stated, “It was a Sunday and it was a very quiet day.” There was no one else in labour, no one drawing on the nurses' or doctors' time. Later in the afternoon, Amber recalled:

They decided they would break my water and progress it along because I think the doctor wanted to deliver the baby. We had a feeling she was going out and wanted to get the baby delivered. They decided it was time for me to push. I wasn't feeling anything, right. They had to turn her a bit and she just wasn't coming. So they used forceps and suction to get her out. I think everything was OK (voice shaky). Her Apgars were OK.

Amber was not consulted about how the labour should progress. It was not about what her body was doing but, rather, enacting someone else's agenda. Amber spoke of people doing things to her; there was no discussion or information from the doctor about interventions or procedures employed. They decided what would be done. Her voice and her agency were

marginalized. Validation of her experience by her own mother after the birth was a touchstone for Amber.

My Mum [an RN] maintains that I probably should have been a C-section—because it was so difficult getting her out. I got a third-degree tear and it wasn't until they got her out that I realized how difficult it was. I was oblivious to it because I wasn't really feeling anything. It was 'a disconnect' there.

Amber described her experience as a sense of separation and a lack of involvement in her own delivery. This notion of disconnect is mentioned by other women in their birthing stories (see Illustration 5.2 of Amber's daughter being assessed after birth).

Body Scarring

Forty-eight hours after discharge from hospital, Amber experienced “quite a bit of pain in her perineal area.” However, breastfeeding “went so easy, so that wasn't a concern.” Amber said if it was not for Allan, her husband, being home writing his dissertation, “I don't know if I would have managed because we had no family where we were living. He was awesome.”

Amber is supported by her husband, an unusual circumstance in Western culture (Bailyn 1993) but one that promoted caring, supported adjustment to motherhood and created family closeness. Amber described the next few days.

About five days later, my pain intensified and I went to the doctor. I had an infection in the perineal area with the stitches. Then I had to go on antibiotics which were quite traumatic because I was breastfeeding. Should I be on antibiotics? So that was another stressor that was a result of that whole birth process.

She developed further complications from being on the antibiotics.

I got C-difficile. I was very sick and breastfeeding. We went into emergency and they gave me some [intravenous] fluids and more antibiotics. So that is why I would consider it difficult because the whole process went on for so long. I was surprised I had more children after that.



Illustration 6.2: Amber's daughter being assessed after birth

Clostridium difficile, (C-difficile or C-diff) is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon (Mayo Clinic 2011). Illness from C-difficile commonly affects older adults in hospitals after the administration of antibiotic medications (Mayo Clinic 2011). In recent years, infections have become more frequent and severe and also more difficult to treat (Coia 2009; Debast et al. 2009). More recently, the population susceptible to C-difficile has now broadened to include pregnant women (Unger et al. 2011) who are then treated with antibiotics. Being on antibiotics and breastfeeding was a concern for Amber, who knew drugs taken by the mother reach the baby through breast milk and can have untoward effects on infants in the short and long term (Mathew 2004). There is also an

ethical issue of administering drugs to a breastfeeding woman, as testing for safety and efficacy is not carried out in pregnant and lactating women (Mathew 2004).

Amber told of other problems following birth. She spoke of one taboo topic; “We had difficulties having intercourse after that because of the way they had stitched things and the scarring.” The description cast questions about the mutilation of such sensitive tissues, a destruction that seems to go unquestioned (Way 2012).

Asking and talking about sex is considered a “delicate subject.” It is rare for professionals to pose questions about sexuality due to various obstacles, “such as lack of knowledge and experience concerning how to ask such questions, lack of time, as well as a desire to avoid embarrassing the women or themselves” (Wendt et al. 2011:251). This lack of dialogue leaves women and partners alone to problem solve sexual intercourse considerations after delivery.

Scarring: Medicalized Births and Untold Risks for the Mother and Baby

Amber stated, “My life was back to normal—six months.” Women cannot prepare for the sequelae of instrument or forceps births. Amber provided some thoughts on the lack of information sharing from the doctor.

Doctors don’t tell women. What I learned from that first one [birth] was I knew the process and knew what to expect. But one of our concerns having forceps and suction was there is an increase chance of seizures with an infant. She was doing some funny little things like staring. Allan was concerned because that was his area of research. He was concerned she was having seizures but in fact she wasn’t. She has never shown any signs of seizures. But it got me anxious.

Seizure activity following the use of forceps has been documented (Christensen et al. 2011; Pressler and Hepworth 2000); however, in my experience I have never heard a physician explain these concerns to women prior to their use of instruments, assuming, I suspect that to do so they feel they would frighten the women. Perhaps the medical staff feel the risks are worth it or, is birth is so objectified that any such questions about the outcome of a technical procedure are irrelevant and immaterial to the delivery of the baby.

Tears and the Object Body of the Corporeal Self

The use of instruments at birth is indicated to avoid caesarean delivery and to expedite birth. In North America, the preference is for forceps. “Unfavorable results are almost always caused by the user’s unfamiliarity with either the instrument or the basic rules governing its use” (Enkin et al. 2000:398). Instrumental deliveries result in significantly more perineal trauma, both episiotomies and lacerations, than from spontaneous birth (Enkin et al. 2000).

To use forceps or a vacuum apparatus the woman is positioned in lithotomy position, on her back and semi-recumbent, her legs in stirrups and draped with sterile sheets for birth (Chalmers 2012; Davis-Floyd 2001). When using forceps, the usual practice is the performance of an episiotomy, a cut into the perineum to enlarge the opening (Chalmers 2012; East et al. 2012). When used with forceps, this cut often extends into the surrounding tissue, usually the rectum, but can extend to the labia, clitoris and urinary meatus (Altman and Lydon-Rochelle 2006). When tears occur into the anal sphincter, they are referred to as third- and fourth-degree tears. These tears can be further defined as partial or complete rupture of the anal sphincter muscles and are an uncommon complication of vaginal delivery (Sultan et al. 1994; Thakur 2003; Walsh et al. 1996). Such lacerations have been associated with a higher likelihood of incontinence where problems may persist for decades (Lieberman and O’Donoghue, 2002). East

et al. (2012) state that the effects of perineal trauma can have long-term effects, such as painful sexual intercourse for up to eighteen months after giving birth. Williams' (2005) study of women's experiences with third-degree tears indicate that these tears cause significant emotional and psychological impact on women's physical and emotional well-being. Furthermore, they found evidence that partners also need emotional support in order to address their own anxieties such as hurting their partner during coitus (Williams 2005).

Perhaps if Amber had been left to unthaw after the dense epidural, she would have been able to feel her contractions and push more effectively to birth the baby. Enkin et al. (2000) recommend that when a woman has epidural analgesia, ample time for the analgesic effect to wear off need to be allowed. Lengthening of the second stage (the pushing phase of labour) will also reduce the need for the use of these instruments (Enkin et al. 2000). Not only are there physical outcomes from procedures such as forceps, women also experience an alteration in their concept of self (Namey and Lyerly 2010).

Psychic or Emotional Scarring

Psychic scarring in these instances refers to the emotional scarring where women's bodies, as well as their emotional selves, are profoundly wounded by the events that have occurred during birth (Faccio 2013). They experience dismay at their bodies for not performing in ways they felt they should (Chrisler 2011).

Amber spoke of her body changes and her perceptions of herself as altered and disappointing. "It really affected me after; my body changed after that and I didn't feel as healthy. You know in a way I felt my body had really let me down." Amber's body during birth did not perform in the way she imagined (Goodwin-Smith 2012). The technological approach to manage birth with epidurals and instrumentation takes away the birthing expectations that she

holds for herself (Namey and Lyerly 2010). When personal expectations are not met, her confidence in her ability to birth a child and knowledge of her body's ability to function becomes eroded. Other women in the study spoke of their own disappointment in their bodies after birth.

Eileen

Eileen was educated as an early childhood educator. Like several women in this study, she was in her early thirties. Women who have children in their thirties are an increasing phenomenon (Carolan 2005). Eileen's heritage is part First Nations. She recalled the conversation with her husband about getting pregnant.

We were out for a bike ride one day and I said, 'Do you know, I think I'm ready to have a baby.' He said, 'Really, don't you think we need to save some money?' We weren't even working at the time as we'd just returned from overseas. I said, 'Yes. But how much is enough? How do you set a price on being ready?' And he said, 'Yes, you're right.' So literally that night we got pregnant. That was that. Maybe part of that whole 'feeling ready' was that my body was primed because we had absolutely no problem. We got pregnant and had a good pregnancy.

Having a primary care provider you can trust is a critical element for support during pregnancy, as well as at birth. Eileen pondered the situation of being newly pregnant and the physician of choice.

I had to switch doctors and we didn't have the same relationship. My other doctor was somebody I trusted and been a lot more relaxed with. He was very caring and very aware of people's emotions. He was efficient but he wasn't like, 'OK, let's go, let's go.'

Eileen described the doctor who delivered her baby as someone who

... did birth because she was a woman, it wasn't her calling, her love. I

think that made a difference for us, too. The very fact that she wasn't 'Yes,

this is a very exciting moment in life, this birth.'

For women, expectations about care and philosophy of birth are important aspects when selecting a care provider. Eileen and Evan desired to have a vaginal birth. She recalled her labour, "I had IV antibiotics during the birthing process because I'd had rheumatic fever. So it was just a very, very, long, long exhausting process. I remember being tired and throwing up a lot."

The nurses did not give her oral fluids as she was vomiting. Usual practice is to administer intravenous fluids as women can become dehydrated during labour particularly when vomiting. Nurses also check the women's urine for ketones every hour during labouring. This by-product of fat breakdown from fasting is toxic to the foetus. If ketones are moderate to high, then nurses usually administer dextrose-rich intravenous fluids to reduce ketones and prevent newborn toxicity. Furthermore, dehydration severely impedes labour (Davidson et al. 2012).

Scarring: Failure to Acknowledge the Corporeal Experience

Eileen and Evan had researched birthing approaches and understood the implications for surgical birth (caesarean birth). As labour ensued, Eileen remembered the doctor being irate with her.

I wasn't dilating. It was just hard contractions and they weren't getting me anywhere. I remember it was very painful and towards the end falling asleep. I remember the whole thing as being very difficult. Three months later I was still exhausted by the whole event.

It was taking too long and that was stressful [weeping]. Wow. I didn't realize that until just now. I remember her coming in saying that she wanted to do a C-section. The doctor was yelling at me. We said, 'Give us a bit more time to just see if it happens.' But she was angry with me for going through with the vaginal birth.

Yelling at the patient is considered unacceptable, unprofessional and a form of bullying (Davis-Floyd 2001; Farrell 2007; Hodge 2009). Eileen spoke up for what she wanted but the physician was angry with her. While Eileen tried to make decisions, her authority was in question. She emphasized that the doctor "was really angry with me because she couldn't say, 'OK it's an emergency, now you have to [have a caesarean section]!' She just wanted me to be done and out of there."

Other information added to Eileen's unease and mistrust of the doctor who delivered her baby:

It was interesting. She had very specific ideas. The doctor ended up losing her licence later on because she made some mistakes. She would come in too late when there was a problem. One teenage Mum went in and the nurses didn't hear a heartbeat. So the doctor didn't even do a proper check. She broke the amniotic sac so that the girl would miscarry the baby. Then realized, oops, the baby's actually fine. Then she said, 'Well, there's not much we can do so you have to go home. Do bed rest because the amniotic fluid will keep making itself and the baby might survive?' The baby didn't. She made a few errors like that, just very rushed. So there

were a lot of complaints and when you get a few serious complaints like that ... [Shrugging].

In her story Eileen shares the profound nature of dismissal in her doctors' approach to another woman. In her particular case, the physician showed little appreciation to the substance and embodiment of the women she was caring for. For Eileen experiences of a protracted labour and long hours of contractions wore away her stamina. Combined with the knowledge of the physicians' poor reputation and being bullied to consent to a caesarean birth, Eileen's confidence in her doctors' abilities are eroded.

Scarring: Marginalized Subjectivity

Eileen described her birthing as "It just wasn't a good experience. It wasn't something that I'd want to repeat." In addition, Eileen's dehydration had implications for her child. "She was a little over five pounds when we left the hospital." Despite the baby's weight loss, Eileen left the hospital. She described the situation and spoke about her newborn.

It was hot. She was born in a very strange heat wave. The hospital didn't have air conditioning. She didn't sleep for three days. I think she was just traumatized by the whole birth. She was exhausted and lost a pound. She's always been tiny ever since, below ten per cent on the growth curve and the lowest weight percentile.

Losing over ten per cent of birth weight is cause for concern. Usually, common practice dictates that newborns are not discharged if they have lost this amount of weight without a well-thought out plan and stringent follow-up (WHO Breastfeeding 2013). Normative infant weight loss is usually five to seven per cent, peaking on day three after birth (Davanzo et al. 2013; Martens and Romphf 2007; Nommsen-Rivers et al. 2008; Riordan 2005). A ten per cent loss of

weight is considered an indication for further evaluation by health care personnel (Fraser and Cooper 2009; Lawrence and Lawrence 2005).

Dahlenburg (1981) found that infants lost more weight if mothers received intravenous fluids compared with women who only received oral fluids. A woman may experience nipple pain and poor milk transfer or lower milk volumes which, in turn, can affect an infant's weight gain (Hirose et al. 1997). In a recent study, Chantry et al. (2011) notes excessive weight loss is relatively common in term breastfed infants, occurring in up to 16 per cent of firstborn infants. Also, delayed onset of milk production and suboptimal infant breastfeeding behaviour is associated with excess weight loss (Chantry et al. 2011).

Scarring: Recuperation from Medicalized Care

It took Eileen months to recover. Her husband decided to stay at home in order to care for them both. Evan did all the cooking and housework. Eileen tried to make sense out of her hospital experience. She reflected how the birthing experience was formative in how she and Evan raised their baby, Eva.

In terms of meeting [her] needs, she rarely cried. So it brought us very close as a family. She had the close bonds with her father because he did everything. She could depend on him for everything except food.

The breastfeeding made Eva very attached and close. It really affected her personality and our relationship. The breastfeeding and that difficult birth and, really, having to think about our actions, how we did things after. Like the fact that I was very uncomfortable with the stitches [and] the whole process.

It is not uncommon for women in their thirties, like Eileen, to embrace childbearing and childrearing in a more concentrated way (Carolan 2005; Cooke et al. 2010). Eileen spoke about her relationship with her child.

She seems even more amazing because it was so difficult. It made us more intense parents in some ways. It does make you a different Mum. There's a fair bit of research out there that really describes that intensity with which you take it so seriously. At 24 [years old] you might not.

Because it [the birth] was difficult it increased the intensity of care, that desire you have to do the best [and] your ability to be that effective caregiver. If it had been easy I wouldn't have that same awareness. Ooh, things can really go wrong quite quickly or quite easily. But it made us more comfortable with having her close where we could keep an eye on her. I think to a certain extent [the intensity of care] continued.

Eileen expressed happiness with her partner and how they have managed their choices of early parenting, breastfeeding and mutual support in the intensive work of being a new parent (see Illustration 5.3 Eileen's daughter's favourite bunny rabbit).

This chapter has examined the stigmatization of women (e.g. Diana and Gillian) who do not conform to the taken-for-granted rules of sanctioned maternity care. It is unclear what to make of these approaches to women. Was it punishment? Was it youth? Was it judgment or discrimination? Whatever the reasons for these poor practices, it was unwarranted and harsh, compromising the health and the lives of both mother and infant.



Illustration 6.3: Eileen's daughter's favourite bunny rabbit

This chapter also has seen the impact that medicalized birth had on Amber and Eileen. Their narratives of birthing experience literally and figuratively describe scarring inflicted through episiotomies and tears that signify wounds on the body and cause further physical and emotional suffering. Additionally, there is scarring of the woman's psychic or emotional self when women are left out of decision-making that are not in her or her infant's best interests. The women developed a different perspective about their bodies after birth and their experience of long recovery periods and their sense of their bodies letting them down. Additionally, the women's autonomy and decision-making were rejected based on the physician's assumption of authority. These women described how their births were compromised when their interests were not placed at the centre of care.

The next chapter follows the narratives of Jennifer and Karen through failed expectations and loss. In addition, Francis' birth, considered to be a post-term pregnancy, will also reveal her experience of shame and sorrow.

Chapter 7 Loss and Unethical Treatment and Post-Term Birth

Birth is a time of great expectations and hope for the future. This chapter presents three birth narratives; one from Jennifer who experienced a profound loss, a second from Karen, who was enrolled in a study without her consent and Francis who experienced a post-term birth that resulted in a dramatic birth experience. The first birthing story presented, Jennifer's, is one of grief and desolation for the mother, partner and extended family.

Jennifer

Jennifer underwent an emergency caesarean for an undiagnosed breech presentation and gave birth to a daughter, Jade. She recalled, "I assumed that it [caesarean birth] wasn't going to happen to me. I didn't have knowledge then about pain control and I was completely incapacitated afterwards." She received little information about pain management prior to being discharged from hospital. Like so many childbearing women, Jennifer reported that she "Rarely even takes a Tylenol®." When a woman has a caesarean birth she undergoes major abdominal surgery, considered one of the most painful incisions and recovery periods. Current practice requires that the nurses, prior to discharge, teach about pain management and recuperation following a caesarean birth. However, this teaching did not occur with Jennifer.

As Jennifer recounted her story of being in labour she stated that no one noted her baby was breech. This would mean that no one assessed her abdomen for presentation, position, engagement, lie and fetal weight (Simkin 2010). Her foetus and contractions were being assessed through an external fetal monitor.

Since 2000, obstetricians have delivered all breech infants by caesarean birth and thus are losing skills in delivering vaginal breech infants (Glezerman 2012; Kotaska et al. 2009; Goffinet et al. 2006). A trial of breech labour refers to the care and attention the obstetrician pays to a

woman and closely monitors her labour to see if the infant will fit through the pelvis for a vaginal birth. Today, guidelines are defined for a trial of breech labour and with an experienced obstetrician Jennifer might have been able to contemplate a vaginal delivery (Glezerman 2012; Kotaska et al. 2009). Despite the current views about handling breech presentation, Jennifer experienced an unplanned caesarean birth, complicated by postpartum depression (Sword et al 2011). These compounding elements from Jennifer's birthing experience were not planned for or anticipated adding to the confusion surrounding a woman's understanding and process of expected birth (Emmanuel et al. 2011; Razurel et al. 2011).

Crumbling Expectations: The Myths that Erode Reality

In birthing lore, the idealized delivery, while painful, produces a beautiful baby that quickly latches to breast and where mother and child, live happily ever after. In fables, lives are simplified in the telling of a story; in real life women's narratives are more complex and multi-faceted. In a qualitative feminist study, Choi et al. (2005) interviewed 25 women about the transition to motherhood and their experiences in relation to the ideology of motherhood. The authors contend that motherhood has been socially constructed as a critical aspect of femininity. The research revealed how unprepared for motherhood the women were and how their expectations were based on various myths. These myths included the image of a happy family, being competent in caring for the newborn, self-sacrifice or selflessness and a sense of being lied to regarding how much work motherhood entails. The findings also reflect other research that showed self-diagnosed depressed women were reluctant to ask for help because of the need to hold up the perceived ideology of motherhood as "supermums" (Choi et al. 2005). Strong and clear recommendations were offered for nursing practice, midwifery, public health and physicians to support women in the antenatal and postpartum period. Lastly, Choi et al. (2005)

challenged the ideological beliefs that giving birth and being a mother are natural and easy for a woman as featured in our construction of motherhood and femininity for women today. These myths and socially constructed reality work against women, causing them to feel inadequate and disappointed, adding to their sense of disillusionment and depression.

Each woman is a product of her own personal history and psychological dispositions that influence how she lives her mothering actions (Barlow and Chapin 2010). Furthermore, she is the product of her own lifetime of experiences and how she has interpreted or made meaning of them. Each mother has learned about and internalized complex cultural models and developed goals, attachments, dispositions, expectations, wishes and fears that exist at various degrees of consciousness, integration and commitment (Spiro 1987). Individual mothers make choices, balancing goals and understandings, compelled by complex motives and intentions (Chapin 2010). However, when a woman's sense of her own goals is not fulfilled, she struggles with her sense of self-worth and identity (Forssen 2012; Simkin 1991, 1992a).

Undermining Confidence: PPD

Typically, mothers are the primary caregivers of infants, regardless of employment and/or marital status (Sevon 2012; Taylor and Johnson 2010). Any factor that impacts a mother also impacts the infant and has public health significance (Sadler 2007). A study by Logdson et al. (2006) looked at the impact of postpartum depression (PPD) on various components of the maternal role, particularly learning to be a mother. They argued that learning to be a mother can be difficult due to the woman's health status, the development of her relationship with the infant, various stressors and the lack of clear expectations of the maternal role.

Upon return home and as a breastfeeding mother Jennifer fed her infant then her partner or mother, who was visiting, would assist with caring for the infant. However, tiny baby Jade was

not gaining weight. Complicating matters, at six weeks after delivery, Jennifer was diagnosed with PPD and two weeks later Jade was diagnosed with failure to thrive and hospitalized.

Jennifer felt it was her fault for the lack of weight gain.

Because of the PPD I felt like people were looking at me thinking, ‘Well, she’s not feeding her. That’s the problem; it’s the Mum,’ which is the way we were treated at the hospital. There was someone constantly looking over my shoulder. ‘Are you feeding her properly?’ ‘What are you doing?’ Feeding was never the problem. Jade could feed from the day we put her on. It was never an issue for us.

Jennifer elaborated that being questioned and supervised was demoralizing by the scrutiny.

So that was another very difficult thing for me to be dealing with, because I’d never been looked at as incapable before. The Friday we went back to feeding every three hours in the hospital and she started to gain a little bit.

The pediatrician ordered an ultrasound that showed Jade had a brain tumour. Jennifer thought,

that’s curable. Everything’s curable nowadays. You go in and you take it out and you’re fine. The doctor responded, ‘I have you set up for the Monday for an MRI [in a children’s hospital]. The discharge papers are ready for you.’

They were sent home.

Crumbling Expectations: Cancer, Suffering and Death

The next morning Jade would not nurse and they returned to hospital where Jade was immediately transferred to the children’s hospital. They placed a shunt into the baby’s head and Jennifer says “it takes 48 hours to get the pain under control.” Jade was never conscious again.

We sat there for a few days and suddenly this woman came to see us. ‘I’m a Fellow in oncology,’ she announced. I said, ‘Well, is it cancer then because you’re talking to us?’ ‘We don’t know yet. We don’t have the biopsy results.’ I said, ‘Well it must be cancer. Why are you talking to us?’ So, of course 24 hours later, we’re being moved to the pediatric oncology ward because it was cancer.

Jennifer described how the ward staff took the family to another room. “There were social workers, palliative workers and all these oncologist doctors and nurses.” They told the family the diagnosis of anaplastic astrocytoma and, at best, Jade had three weeks to live. The World Health Organization classification scheme includes four grades of astrocytomas or glioma. Anaplastic astrocytomas are aggressive tumours that infiltrate adjacent normal brain tissue and have a significant tendency to spread outside of the central nervous system. Jennifer recalled,

We sat there and just waited, it was awful. My Dad came, he’s a urologist and my Mum a nurse and they all flew in. My Dad [said], ‘Pull the NG [nasogastric] tube. Why are you having her pump [her breasts]? This is a palliative case? Why are we prolonging this?’ And we stopped taking vital signs; we just sat and waited [crying]. It was, obviously, awful.

It is difficult for any family to lose a child, particularly a baby to cancer (see Illustration 6.1 of Jennifer’s daughter’s ashes). I can only image what Jennifer and her family went through.



Illustration 7.1: Jennifer holds the ashes of her daughter housed in the teddy bear

Crumbled Future: Living with Loss

After Jennifer told me of this moment, we sat in silence for what felt like minutes but were in fact seconds. I am reminded of what Enkin (2000) stated, that long-term follow-up studies show “a significant proportion, up to a fifth of women interviewed, still suffer from serious psychological symptoms for years after losing a baby” (474). Those women most at risk for developing problems include women who have not seen or held the baby, have an unsupportive partner or social network and who embark immediately on another pregnancy. These situations are not what Jennifer experienced but are further considerations for those experiencing a loss.

When a child dies parents are faced with the difficult but important task of needing to mourn and openly express thoughts and feelings of loss (Capitulo 2005; Macdonald et al. 2005).

The death of a child means the hopes, dreams and plans for the future are turned upside down. This journey is frightening, painful and overwhelming. Feelings may be so intense that one cannot understand what is happening. The positive uses of heuristics or mantras, such as repeating a positive statement of hope or endurance, are part of the healing process when a family loses a child (Renjilian et al. 2013). Heuristics aid in making sense of complex situations, making decisions and communicating these decisions to others. Renjilian et al. (2013) recommend that better understanding of heuristics may improve communications, decisions and support for families who face loss.

The more natural order in life is for a parent to precede their children in death. The death of a child violates nature's way, where the young grow up and replace the old. For parents who lose a child, this also means the loss of personal identity such as the role of mother or father (O'Leary 2009). Parents may feel impotent and wonder why they could not protect their child from death (Renjilian et al. 2013; O'Leary 2009). For Jade, there was little they could do. Jennifer spoke of her grief.

It took a long, long time to even cry. I was still taking Paxil® for probably a month afterwards. I was on a super low dose; this is why I don't take medications because it really affects me. I wasn't reacting to anything. I wasn't happy, I wasn't sad. I was just living life. So I decided to go off of it; I knew I needed to deal with this. I needed to cry. I needed to freak out. The doctor I was dealing with at the time [said], 'This isn't a good idea.' But I did it and then I started to deal with everything. I switched doctors and this new doctor—who I love to pieces—was able to get me into Mental Health where I got assigned the best counselor—life changing.

The loss of a child in a couple's life can be shattering to their relationship (Badenhorst and Hughes 2007). Jennifer shared what she learned from her counsellor and the changes that she created from her learning.

He taught me things, not only to get over an awful situation but for your everyday life; those little annoying things that happen to you. It's absolutely changed me; I've been part of two bereavement groups and a lot of counselling. I find talking about it every so often allows me to get it all out again then start taking steps forward.

Jennifer recalled that she met a doctor who shared his experiences of seeing the type of cancer that affected her daughter.

This doctor has been working in pediatric oncology for 24 years. He said to us he'd 'Never seen a tumour that size in a baby that young.' So there has to be something else because we're two very healthy people. We eat really well. We exercise, we live clean. [He said] 'There's just no reason. There's just one in four million chances and you just happen to be that one.'

She spoke again about the substances that she breathed in during her work spraying pesticides in the bush and about the material safety data sheet (MSDS) that came with every chemical. The doctors said, "It was just a fluke."

Now, Jeffrey and I, we're both intelligent people. We've done a bit of research. I'm pretty convinced it was the pesticides we were spraying at the very beginning because I looked it up. The second we found out I was pregnant we went to the MSDS and it said no teratogenic effect. We're good here. But I still didn't feel comfortable.

Jennifer tried to get help to remedy the MSDS sheets and the lack of adequate warnings. “To be perfectly honest we’ve tried to get lawyers involved, not for the money aspect but I want it written on the MSDS—Do not be pregnant.”

Her actions are helpful for her healing. She told me that she thinks about other parents who lose children and tried to make sense out of her life.

I see parents and their child [is] missing. They just suffer until they get that closure. I feel like we’re going to, forever, live like this; just being one in four million, its shit luck. You’ve got dealt an unfortunate hand in life and now you have to pick yourself up and move forward.

Living with Loss: Moving Forward

Jennifer talked about how she and Jeffrey move through their pain and suffering. She offered their account of grief and what helped them to move onward.

I always cried and he was strong. He cried, but I lost it. He cried after I was settled down and in bed; that’s when he dealt with it. A few times, obviously, he’s expressed it and he’s lost it in front of me. But it’s not at the frequency that I have. I feel like he saved my life because afterwards the depression was so bad. Going through those stages of grief; I spent days and days and days in bed. He came into the room one day and this is a vivid moment: He just said, ‘Jenn, you’re ruining my life.’ I got out of bed because [I thought] I can’t do this to him. He lost a child too, he’s up and eating, watching TV, taking the dog for a walk. Doing those little things and I’m literally not getting out of bed, not showering, eating, not

doing anything. Those words came out of his mouth and I got up. Ever since then I've been able to start taking those steps forward.

Jeffrey motivated Jennifer to start living again, to re-engage in life. That day they went out for coffee. "We just sat, had a coffee. I swear it's like the light turned back on for me. He knew what to do. He knew how to help me. [I would] never trade him in [laughing]. He's a keeper."

Jeffrey encouraged her to engage in life again. But there are other concerns and life goals that she contemplated. Jennifer spent months questioning herself. "I'm never having kids again. I'm never doing this again. Then the way the world is, it's weird, how you want something out of your life. Everywhere you go there was a baby or a pregnant woman." She reflected,

Then after some time in counselling, I was able to say to myself 'no, this is torture to not have a baby; the house was empty.' Nothing made sense.

What was I going to do? Are *we* going to? There's something to be said for people not having kids. It's just a totally different lifestyle, which is wonderful. But after everything we needed a child. So we decided to get pregnant again and I swear to this day Jade gave us the perfect baby.

Jasmine is a great sleeper. She's so funny. She gets her odd little cold but she even handles that well. She's just a dream come true in every way.

Jennifer and Jeffrey know the new child does not replace Jade but their openness to having another child is transmitted in their welcome of Jasmine. The early months of Jasmine's life are also times of concern. "Of course the first three months of her life I spent at the doctor's office saying she has a brain tumour. But after we'd gotten over that three month period, I settled into it and everything has gone really, really well."

It is not uncommon for people who have experienced a loss to project similar worries and fears onto the new child. After perinatal loss, both parents struggle with a second pregnancy and cannot image the child being born alive (O’Leary 2009). It is only when parents are past the time of death of their other child that they are able to move forward.

No Words for Loss

Words and their meanings have additional impact when you lose a child (Macdonald et al. 2005). Jennifer shared some wisdom offered to her:

About losing a child, somebody said to me in one of the bereavement groups, to lose a child is so unnatural that there’s not one language in the world that has a word to describe it. You know ... when you lose a spouse, you’re a widow.

Jennifer’s father shared his knowledge of loss and the pain that does not leave.

My Dad, he’s a doctor and he has patients that are 75 to 80-years-old and he said, ‘they still cry when they talk about the child they lost.’ It’s just a forever area of pain. The whole thing’s traumatic.

She sought counselling and continues to work through her grief at losing her child. Picard (2002) used autoethnography to tell the story of the loss of her brother at three months. She interviewed family members to re-tell the story of loss. What she found was that, 47 years later, her parents, family members and grandchildren—some of whom were not born when the child died—grieved for the infant lost from Sudden Infant Death Syndrome (SIDS) (Picard 2002).

Suffering is a powerful and complex experience and suffering endured cannot be articulated. In searching for meaning to his life, Viktor Frankl, a physician and holocaust (Shoah) survivor, reflected that meaning can be found in even the most hopeless situations and that

meaning can be transformative (Condon 2013). He wrote, “Suffering ceases to be suffering at the moment that it finds a meaning—such as the meaning of a sacrifice” (Frankl 1963:113).

Although suffering may still be felt, it is no longer so isolating and unbearable; it has meaning and the suffering becomes worthwhile (Condon 2013). Jennifer had a desire to use her own knowledge and loss to help others. (see Illustration 6.2 Quilt made by Jennifer’s Mother with Jade’s clothing).



Illustration 7.2: Quilt made by Jennifer’s Mother with Jade’s clothing

Karen

Karen’s story explicates how large institutions can undermine and disenfranchise a women’s sense of choice and take advantage of her pregnancy for their own designs. Strong elements of mechanization and experimentation on the body are of note in her narrative.

Social Construction of Induction: Experimentation on the Corporeal Body

Karen was pregnant with her second child and, due to renal complications, was scheduled to be induced. She was also enrolled in a study on the effects of prostaglandin induction at a large tertiary hospital.

With my middle child, I had a lot of kidney issues. So I had some stents put in [her ureters]. I had some stones and I was very uncomfortable, painful and sick a lot during the pregnancy. When I first got to [the hospital]—I had all my babies there—they said that there was going to be a study—this is the first part of this whole process that ended up just being so horrible—and that I was going to be a study participant.

She added that they must have asked her to be a part of the study “otherwise, why would that have happened. But I don’t really remember the approval or what they were doing.” Karen was already burdened with complications of her pregnancy and in pain and, as a study participant, Karen was not seen by the researcher as a vulnerable woman. For three days she experienced prolonged labour. At the time, Karen did not appreciate the implications of being part of the study.

I was at my parent’s apartment so I went to their place and back to the hospital. This went on for a couple or three days. I finally got into active labour. I remember getting back to the hospital and it was just a total gong show. Nothing seemed to be organized.

This back and forth between the hospital and her parent’s home added to the hardship of being pregnant, ill and suffering.

They had given me an epidural but it wasn't working. I think it was the kidney stones, I was throwing up. It was just horrendous. If I look back on it and visualizing that as a nurse, it was just horrible. So anyway, he was born and flat [a low or absent heart beat and respiration]. They took him away and I didn't see him for, I don't even know how many, quite a few hours.

Karen was exhausted before labour even began and labouring and the birth, plus the dire condition of the newborn added to her concerns. Karen was fraught with physical ailments that adversely increased her anxiety and sense of loss of control during the birth.

Experimental Approaches: Newborn in Jeopardy

Karen's infant was born flat, meaning the baby may not be breathing and the heart rate would be low or absent. The infant was considered a term baby, despite the fact that he was 38 weeks gestation. There is a recent movement focusing on sustaining pregnancy for the full 40 weeks (ACOG 2008; AWHONN 2013) due to the risks and complications of early induced birth (Bakewell-Sachs 2007). In particular, women are encouraged to refuse induction at less than 40 weeks gestation, due to the risks and complications of delivering a preterm infant (Lothian 2006a). It is of interest that women should be required to know the birthing system and to advocate for their own rights or refusal of treatments, when they are not certain they are in jeopardy. Karen described the situation where no communication was shared about her child's health after he was born.

So there's my son, who was obviously really in trouble but I had no real concept because nobody told me anything. So I'm the last [to know], this SCN (Special Care Nursery) call was made out. I'm in excruciating pain

and screaming and he's just taken away with no information to me about what actually is going on with him or what they're doing.

What happened to Karen's baby remained unclear, other than he was very ill (see Illustration 6.3 of the lock of hair, identification band and foot mould). She was never informed of the complications of her son's condition. To this day she has not had access to his information or his chart. Karen speaks about Kalen,

He's 16 now. As the years have gone by, I've just gotten angrier. I think [the birth] was just so horribly handled and he suffered for that and I suffered. So, what the heck was all that about? Why didn't they just section me? [laughing]. I never even got an option. I don't remember my doctor asking me, because Kolby (her first child) was a C-section. It was just assumed that Kalen would be a vaginal delivery. I was also a VBAC [vaginal birth after caesarean] too. You look at the whole situation.

In the past, it was "once a caesarean always a caesarean" (Schell 1923). This was debunked when health care started to attempt vaginal births after caesareans (VBACs) (Martel and MacKinnon 2005). The first known cases of VBAC were reported in 1923 by Schell, who described successful vaginal delivery of mothers who had previously delivered by caesarean birth. Despite the development of guidelines in Canada in the 1980s and positive aspects of this approach (Martel and MacKinnon 2005) today there are few VBAC. There are risks associated with VBAC such as uterine rupture, with recommendations of 18 months to 24 months between the first caesarean birth and the attempted VBAC (Martel and MacKinnon 2005). In addition, other criteria of where the last incision occurred also guides decision making for VBACs. However, Karen was not offered another caesarean birth; instead, she was scheduled for

induction with prostaglandin or a placebo without further scrutiny or review of contraindications (Martel and MacKinnon 2005).

When HCPs care for and protect the mother, they also protect the unborn child. Karen's body became the vessel that houses the foetus (Raphael-Leff 1991); her baby was the product, the object of our concern while the mother is incubator (Fausto-Sterling 1992). Karen was not consulted thus, cannot speak out for herself.



Illustration 7.3: The locks of Karen's child's hair, identification bands and foot mould

Further, she learned nothing of outcomes from the study she was enrolled in. Neither did anyone explain the situation that resulted in her son being very ill. In light of her experience she is still angry, 16 years later.

Recognizing the Hegemony

As a registered nurse (RN) working in an acute hospital maternal child unit, Karen recognizes the predicament she was in while giving birth to Kalen. She is now strikingly aware of the added risks of being a study participant. The foetus may have been compromised from the repeated medications or placebo given to induce labour over three days (Cassels 2014). Karen

reiterated her experience, seasoned with her knowledge of current clinical childbearing practices and described her concerns today.

The days of labour and the subsequent delivery and what happened to him because of that ... was that the best thing for either of us? No! Why would you even ask somebody who's being induced at 38 weeks because of renal issues if they want to be a part of a study? Wouldn't you just give them the real stuff [prostaglandin] regardless, because there's a medical indication here? It's not like you're post date sitting there and everything's fine. This isn't a good time. Thirty-eight week inductions never really go all that well.

Karen recognized the dire situation she faced in retrospect. She understood and experienced the implications of induction when the cervix is not ready to dilate. Being part of the research study was not in Karen's best interests and unknowingly reduced her to an object (Lyerly 2006). Karen did not realize that she could have said, "I don't want to be part of the study. Give me the real medication to commence labour." Obviously, no one explained the study, nor did they obtain informed consent or advised her she could withdraw at any time.

Francis

Francis explained to me that she wanted to be a mother from the age of 18. She had waited for the right time to have a child after finishing acting school and earning a teaching degree. Francis had done everything she could to prepare for pregnancy and birthing.

Then, when it doesn't turn out the way you'd think it should turn out, you think: 'What did I do? What's going on?' After it was all over, of course, I

started blaming everybody else. It wasn't me [laughing]; it must have been everybody else.

Francis wanted a natural, unmedicated vaginal delivery. She had expectations of herself and her birthing experience.

We went for our ultrasound at 20 weeks; they dated it six days later. So [my pregnancy] was 21 [weeks]. But then the midwife said, 'We're *not* going to change your due date [on your chart] because it's within a week.' I didn't realize the ramifications of that as I got to two weeks post-date. So, we went one week post-dates and they [stripped] my membranes and the next week I'm seeing them every few days and they said, 'Well if we don't see you by Monday we would like to induce you.'

Due dates generated by the first ultrasound may be the most accurate tool today for predicting an infant's birth date (British Columbia Perinatal Genetic Screening Program 2009). However, ultrasound due dates have a margin of error of approximately nine days so the HCPs will usually note the original due date, estimated from the first day of the last menstrual period (British Columbia Perinatal Genetic Screening Program 2009). Francis's pregnancy was over 41 weeks of gestation. There are concerns with each additional week the infant remains inside the uterus, as the placenta becomes less effective and the possibility of fetal demise increases (Heimstad et al. 2008; Nakling and Backe 2006; Shearer and Estes 1985). "Stripping the membranes" is a way to initiate the release of prostaglandins that can initiate labour (Wing 2010). In this situation the HCPs inserts a finger into the woman's vagina and separates the membranes from the wall of the uterus.

Post-term pregnancy is associated with longer labour and operative or caesarean delivery (Yale School of Medicine 2013). In addition, mothers are at-risk for vaginal birth trauma from a large baby and the baby is at-risk of birth injury. Birth by caesarean section is twice as likely to occur in a post-term pregnancy, thus, there is an increased risk for infection, wound complications and hemorrhage (Yale School of Medicine 2013).

Multiple Understandings of Post Term Pregnancy

Francis related her understandings of the process. “Women deliver [late] all the time. There are all these stories from the 1950s and 1960s and they go way over.” However, Francis’s midwives tell her difficult news and inform her of the chance of fetal demise with increasing gestational age.

The midwife said, ‘Well I have to tell you ... legally, I’m obliged to tell you, what might happen.’ She’s talking to me and all I heard was, ‘I delivered a dead baby.’ Well, what the hell are you supposed to do with that information? So you go, ‘OK.’ So we’re going in for our non-stress test and we figured, ‘OK, we’ll have this baby tomorrow, because I’m being induced today!’

Francis focused on the potential loss of her child, information that is terrifying and unthinkable.

She shared her story with humour, despite the grave topic matter.

Normalized Medical Practices of Corporeality

So I go in for my non-stress test and then, we wait, then the doctor came in. He said, ‘Hi, I’m Dr. ____ and this is what we’re going to do and we’re going to put it [prostaglandin] on your cervix’ and isn’t this nice. All of a sudden his knuckles are right up there and I’m like, ‘Oh, my God!’

Vaginal examinations feel indiscreet, cause discomfort and are a highly invasive act (Burvill 2002). Despite the use of vaginal examinations to assess for dilatation, women experience pain and discomfort that may be interpreted as punishment (Lyerly 2006). These techniques for assessing the progress of labour have become a routine (Dixon and Foureur 2010; Murphy et al. 1986). Humour works to decrease the gravity of the situation as Francis comes to grips with what was done to her.

Not all countries and cultures, however, use this form of assessment as part of routine maternity practices (Bergstrom et al. 1992; Villar et al. 2001). The ritualistic nature of vaginal examinations reinforces the power and authority of the HCPs over the woman (Dixon and Foureur 2010; Bergstrom et al. 1992). Western medical practice has used the vaginal examination as part of the quantification of labour and the use of centimeters of dilation serve to measure labour progression (Goodwin-Smith 2012; Walsh 2000).

Women are uncomfortable with the lack of information given during the process, the pain and distress of vaginal examinations has been described and women would prefer other options (Lewin et al. 2005). Midwifery purports that cervical dilatation is not required to diagnose labour onset in the majority of women, the job of the midwife/nurse is to watch, listen and interpret cues provided, without physically interfering with a woman's body and the birthing process (Burvill 2002). As a nurse, I have watched women labouring and estimated progress by observing how focused the woman is on her contractions, the depth of respirations, degree of pain and length of each contraction. Through the use of touch to palpate the uterus, the nurse can feel the strength of the contraction to assess the force and the intensity of labour. It is through these assessment skills that nurses estimate progress. However, the vaginal examination is a critical aspect to

estimate the dilatation of the cervix prior to giving analgesia and when a woman can push with purpose.

Embodied Experience of Induction of Labour

Frances recalled the aftermath of the insertion of the cervical gel.

I can't even remember what it's called. Well, it's fast and furious, because they say when you're induced, it's always fast and furious and it's magnified. So that's what it was, holy Hannah, all day for a good eight hours anyway. There was no real break, no rest. But do you think I'd take an epidural? Of course not [laughing], because I'm going to do this right and my baby's not going to be stoned. I'm going to do this!

She had read broadly on pregnancy, labour and birthing, was prepared for childbearing and believed in her body's ability to do this work. The maternity unit was very crowded and bustling with other labouring women and, as Francis laboured, she was moved several times to different rooms.

I get to the hospital. Both of my midwives are busy with other births. So there's my husband and my mother and I am stuck in the assessment room. I'm labouring and it's coming and it's pretty heavy duty. So I decide to have nitrous and I have no idea whether it helped or not. But it helped me with focusing on my breathing, so I could breathe. I knew when I was breathing in and I knew when I was breathing out.

She continues that she was left unattended, with only her family members for support.

It was terrible [laughing]. There were no windows, there was all this machinery and it was just a little examination table. It was pretty small, so

there's my Mum sitting at the end trying not to be there. My husband is trying to be strong and not quite knowing what to do. That's all I remember really because that's all there was. I think there must have been nurses coming in to check on me, but I don't really remember that.

“I'm in Trouble”: Extensive Second Stage of Labour

She was moved to the operating room by her nurse, who was now in attendance.

I'm pushing, pushing, pushing, at hour 4 of pushing, I started asking for help ... So [the nurse] went to get the obstetrician and he came a few minutes later. It's so funny how time becomes irrelevant in these situations, too. You don't really know where the time is.

Francis understood the experience of her body and what was happening for her but she was determined to deliver her child vaginally.

I was in the delivery room. So there's a clock, the hours ticked past and I was pushing and then the midwife was saying, 'it's not long now, I see his head, any minute now, any minute now.' Then another hour would go by and another hour. I couldn't move very well. There was lots of screaming and a lot of all that, this is birth, which is normal.

Normal labour for Francis was what she was experiencing. She had no other notion of what labour could be or if labour could be different than what it was.

But there are tools and stuff everywhere and there's this clock. Most of the time I'm on my hands and knees and Person [the nurse who cares for her] wants me to move because she knows that I need to move. Maybe this baby will move if I move. But I actually can't. I'm in so much pain and

contractions are coming and coming so quickly that I don't have time to move.

They'd say push, push and I'd say 'I'm pushing as hard as I can.' But he's not coming out, he's not coming out. So I'm in trouble. Four and a half hours I pushed for. He was ready to come out, but he couldn't.

Pushing this long without imminent birth indicates that the foetus is obstructed (Davidson et al. 2012). From Francis' description the head was acynclitic, tilted to the side and not in line with the pelvic opening. According to the World Health Organization [WHO] (2013) an obstructed labour occurs when the passage of the foetus through the pelvis is impeded (see Managing prolonged and obstructed labour 2013). The most common causes are a large fetal head passing through a small pelvis, wrong position of the foetus while going through the birth canal and fetal defects. Statistics from around the world indicate that mortality from obstructed labour accounts for one to five deaths per one thousand live births and can cause significant morbidity and mortality for the mother, both in the short and in the long term. Furthermore, obstructed labour requires immediate caesarean section or the mother risks losing the foetus and developing a fistula (WHO 2013).

Pushing for this length of time is outside of current labour delivery standards (Chalmers et al. 2012). Altman and Lydon-Rochelle (2006), citing DeLee (1920), state that "a second stage exceeding two hours has been considered a risk factor for adverse perinatal outcomes since the early 1900s" (315). The standards are based on foetal well-being, maternal vital signs, position of the infant in relationship to the mother's pelvis, maternal exhaustion and many other factors (Davidson et al. 2012). The obstetrical guide used for the developed world, states that the second

stage of labour has long been considered a time of particular risk for the child (Enkin et al. 2000). Despite these rules, however, the guide provides no clear time parameters.

Help Arrives: Loss of Hope for “Normal Birth”

Francis said the obstetrician was called in and, as he assessed her, Francis recalled the doctor’s actions and comments.

So the doctor comes in and he says, ‘Let’s leave her just for a little bit longer to see if she’s pushing properly.’ I thought, you walked into this room and you have no idea what I’ve been doing the last few hours. I’m just pushing because the contractions just keep coming, it doesn’t matter. I’m pushing, pushing, pushing. So then he says, ‘OK, let’s adjust his head.’ So he tries to adjust baby’s head to see if he’ll come out. He’s not coming out. So they try a few more contractions and I think he was trying to guide the baby out. ‘No, we need to try the forceps,’ he said. Okay, forceps.

At this point, I don’t give a shit what’s happening. You know what; you can take my head off at this point for all I care! This is not what I wanted. I did not want an epidural. I did not want forceps. I did not want drugs. I did not want all of this stuff and it seems to be happening. But at this point, I don’t care.

Francis felt she had failed, she focused on being cooperative and staying motionless for the insertion of the epidural despite ongoing contractions.

For the forceps we need an epidural. So let’s call the anesthesiologist.

They’re busy. So it takes probably a good hour since the time I’ve needed

help and real help arrives. The contractions are so bad and they're coming so close and they say, 'You cannot move while we're giving you a needle in your spine.' My God, OK. So my husband went in front of me and I just grabbed onto him so tight and his head was right here. He said, 'You just about ripped my skin right off.' I didn't know!

Trying to remain still for the epidural is almost impossible when labour contractions occur.

So they tried the forceps. I remember seeing the doctor's little green hat between my legs. Of course you don't feel anything. I can't really see anything. But I see his little head and it's shaking like this. It's shaky, shaky, shaky. I'm thinking that's funny. He's like, 'No.' I hear, 'No, no, no.' [He's] doing it again, trying it again, shaky, shaky, shaky, shaky, shaky. He's like 'No, we've got to get this baby out.' So, that's all I remember. Then I remember being wheeled into the O.R. not long after that.

The epidural took hold and Francis got back her focus.

I'm cracking jokes and my husband is talking about the machine that goes ping from Monty Python. I'm having serious surgery, but after that whole thing, this is joy because I know that this baby's coming. So the baby came out. I do remember feeling really disconnected to what's going on.

Francis separated from her experience; she became disembodied, something several of the women spoke of—a disconnection from their own body (see Illustration 5.4 Francis's son at birth). Francis stated she had feelings of being detached and not being connected to what was going on with her body or her baby (Dixon et al. 2014).

So it's true. As soon as I had the epidural I did feel disconnected; physical and emotional disconnect. We did talk to [my nurse] about having him on my skin as soon as we could and I do remember she did try. She did do that in the O.R. I felt his face or that he was close to me. But he did have to have his stomach pumped first. So he came out and then they said, 'Husband, tell her what it is,' because we didn't know it was a boy at this point. He said, 'It's a boy, it's a boy.' My God it's a boy. I said his name. But then it was a while because there was meconium. So, we knew he was in trouble.



Illustration 7.4: Francis's son at birth

Mothers who had experienced prolonged labour with assisted vaginal or caesarean section experienced compromised mother and baby interactions and a negative impact on the connection between mother and baby (Nystedt et al. 2008). Mothers often experience exhaustion and a loss of control. Three major themes were formulated. "Fumbling in the dark" reveals the

women's difficulty recalling the birth events or having a very blurred memory of the newborn. Some of the infants were ill and had been treated for sepsis. "Struggling for motherhood" was seen as a women's ambivalence about taking care of the baby—feelings of sadness and regret that they were unable to breastfeed fully following birth, had no memories of the baby after birth or not able to fulfil the role of mother. According to the authors, most participants reported "achieving confidence in being a mother" and this was marked as a life-changing experience. They also described motherhood as tough and hard work, others described feelings of having to relinquish a part of their concern for themselves in deference to the infant's needs. Nystedt et al. (2008) found that women who experience prolonged labour, struggle with incorporating the birth into their lives, along with establishing their maternal role while recovering from illness. These struggles for a birthing woman, together with the expectations of motherhood, are interwoven with experiences of aloneness or fragility and are difficult to integrate as part of a life transition (Prinds et al. 2014). Francis experienced sadness and regret following her birthing experience and worked to find balance in her life as a mother. Unlike the findings of Nystedt et al. (2008), Francis made a strong connection to her child although she also identified a loss of control and a blurred memory of his birth (Callister et al. 2010).

Failed Body: Disappointment, Suffering and Shame

Francis experienced many things: pain, joy, feelings of being cheated. She had feelings of disappointment and questioned her own decisions.

So there's joy too. But then, I'm getting sewn up, I'm still on the table.

You think, oh yes, I'm having a baby. Of course, I have oxytocin flowing through me. I just felt cheated. I felt like everything had gotten away from me. I did all this research. I read all the books. Nowadays you hear there's

too much medicalization of birth and home births and all of that. So I thought, I'll have midwives but I'll also try to keep a balance. But I got thrown onto that one side of this medicalization of my birth. I don't know whether that was because I was induced, whether it's because it was what my body did that day or what we were doing together? I truly believed that my baby would know what to do. I trusted in my baby. But maybe I didn't trust enough. I didn't stand up and say I don't want this prostaglandin. I want to wait at least another week. So, from the moment I had that baby—in that room with green sheets everywhere and people running around and doctors and pumps and beeps and tubes and all of this stuff—it became this different experience and I felt shame right away.

Reflecting on her experience, Francis posed questions that no one can answer. The fact that control over her body had been usurped, prompted Francis to question whether her body had betrayed her. Now she did not trust her body and doubted her trust in her infant. She critiqued her decisions and those of her care providers.

Milton (2013) speaks about human suffering as “an individualized, subjective and complex lived experience that potentially presents in situations as ethical dilemmas” (226). Each person suffers in a way that no other human being suffers (Nouwen 1996). Each person's pain is so deeply personal that to compare it to another person can scarcely bring any solace or comfort. HCPs may take for granted the unique situations that women face in giving birth and render their suffering homogenous. Milton (2013) claims that the “possibilities of shame arises when the dehumanizing objectification of suffering as a sense of failure or not living up to the expectations in situations where suffering was not relieved or alleviated” (228).

Francis' sense of shame came from not living up to the expectations she held for herself.

People say, 'Well you had this healthy baby and everybody's fine. Don't worry about it. This is what happens!' But I know it got away from me. Something happened; so you go back, all the time, you go back and you think where could I have done this differently?

Recovering Through Embodied Grief and Sorrow

Francis described the weeks following the birth,

I cried in the midwife's offices for six weeks. I cried for all of our appointments. This isn't what was supposed to happen. My incision was infected for months, like for a year. It kept getting bad. It was weeping months and months after. I would have these bumps with pus in them.

Francis experienced a lengthy recovery following her surgical birth, especially how her body failed to deliver the infant on its own and of the surgical birth risks and complications.

I couldn't wear pants even if they were loose. For a good year, year and a half after my caesarean, it was terrible. I remember being at home. They said, 'OK, don't do anything for six weeks. It's a major surgery. So, don't do anything. Don't do this and don't drive and don't do that.' So, we went home and I was in so much pain, although they double you up on pain killers and stuff, so that was fine.

Francis was confined to home following the caesarean birth. Her husband needed to pick up the baby in order for her to breastfeed. "I couldn't lift this kid up. So not only can I not give birth properly, I can't even lift my kid. I can't go to the drugstore, to the library. I'm under house arrest."

She said her “physical body took a long time to recover” and it took the next five years for her to work at healing her anger, shame and frustration.

Some of it’s still there, some of its gone. I had another period after that, which was even more traumatic. In some ways, when I had my second baby, it took me a long time to want to get pregnant again.

Recreating Birth: Attempts to Heal the Pain

Francis could not overcome her sadness at having a caesarean section. The midwives offered advice about a form of re-birthing to help her emotional pain. The midwife recommended she get in the bathtub and “spread her legs and put the baby between her legs and ‘birth’ the baby in the bathtub.” Francis thought,

Okay and I cried and cried and cried and I kept crying about it. So, when we were in the bathtub, I said to him, ‘Baby we didn’t have the birth that I had envisioned for us but we’re here and we’re safe.’ So I did it and I felt really silly. It didn’t relieve all of my anger and fear and shame. I tried it and it didn’t quite work.

It appears that these instances or moments of loss might never be resolved.

Francis spoke about loving her son, Farrell, how he is “the most amazing person she has ever met.” She pondered the birth and its effect on her child and herself.

He is still quite a stubborn kid who doesn’t go the way that I want him to, rarely ever. So regardless of whether it was my fault or the doctor’s fault or whether it was baby’s fault, it wasn’t anybody’s fault, I guess. But that tough birth really informed how he is and in turn it informed how I parent.

How I parented the first time. So he was everywhere, all over the place, [I] couldn't contain him.

Reflecting on the struggle she had delivering Farrell, Francis “echoes his birth was worth it, though.”

Not Being Attended to and the Creation of a “Sad Mother”

It seemed that all the things that could go wrong, did go wrong for Francis. She was well prepared, well read, yet she was not able to have the birth she desired. In considering what made the birth difficult, Francis said, “There’s a huge portion of that birth [when] I didn’t feel attended to, because my support system, my midwives, weren’t available and there wasn’t even a room for me in the hospital.” She considered her the birthing experience “was the worst thing that has ever happened to me.”

Giving birth to a baby by an emergency caesarean section has different meanings for different women. Some women’s may be satisfied with their births (Sandelowski and Bustamante 1986) and others regard it as a major trauma (Creedy et al. 2000). Ryding et al. (1998) interviewed 53 women about their experiences of emergency caesarean section and the women considered their experience traumatic if they reported one or more of the following feelings: “she was very frightened about dying or being hurt, she was very frightened about losing the baby or delivering a seriously ill or handicapped child or, she had lost contact with reality in an extremely frightening manner” (246). Green et al. (1990) reported that loss of control during labour is associated with a more negative birth experience, decreased satisfaction and depression during the postnatal period. According to Lazarus’s (1991) theory of feelings, goal incongruence results in negative thoughts and goal congruence in positive ones. When the goal incongruence involves a threat of sudden, concrete harm, fright is the result. As the goal

incongruence involves a loss of self-esteem, other negative thoughts are also possible, for instance, sadness when nobody can be blamed, anger when someone else is to blame and guilt or shame when the blame is directed internally (Lazarus 1991). Francis felt blame toward others, but also a deep sense of shame. She reflected how her birthing experience

was a pretty spiritual thing. Regardless of what happened, at the end it connects you with other women, that whole line of women before you. I felt it in the baby's birth, I honestly felt it. I felt this pull from the universe, this whole; it was my connection to the universe.

Not only did Francis feel connected to the universe, she felt "this incredible spirituality with my pain." She felt connected with her husband and birth as life-changing event. Francis recalled that the difficult birth made her "more of a sad mother." She sought counselling for "post-trauma stuff" and stated "it's not as bad as it was [yet,] it sort of nags at me." Francis' postpartum period was complicated by an infection in her incision and her baby was diagnosed with a hyperactive immune response. Five years later, Francis and her husband decided to have another child.

The second one, I thought I'm going to be stronger [and] stand up to those guys. I'm not going to be induced. I'm going to have a vaginal birth and I'm going to do all these things. It's going to be my healing birth. It ended up being very different from my first and also quite traumatic, but healing from my first one. So, I think I was able to forgive myself and forgive others after that and even forgive, partly, the 'medical establishment' because they 'saved my bacon' the second time.

Having a second child does not heal the first birth experience, but it does offer another opportunity to try again for the birth experience she desired. Forgiving herself and others comes

at the recognition of another “traumatic” birth. Francis and the other women in this chapter are still working through their birth experiences through reflection, thoughtful action and personal growth.

This chapter has presented three moving and dramatic experiences of birthing. The powerful myths of birthing and expectations for women were evident through Jennifer’s story. Myths about pregnancy and becoming a mother are eroded by the reality of the events such as postpartum depression, failure to thrive and a rare form of terminal brain cancer. The stark reality of depression and working through loss were critical. In Karen’s birthing experience, we see less social value is attributed to the mother. Being enrolled in a clinical study without scrutiny of her complete history is unethical and negligent at best. The consequences of being enrolled in the study placed Karen and her infant in a dire situation with little follow-up or communication about what actually occurred. Karen harbours angry feelings about her birthing experience that remain unresolved today. For Francis, a prolonged delivery resulted in a caesarean section leaving her with feelings of deep shame and sorrow that took many years to resolve.

The following chapter will look at the women who were left alone in labour and the resultant effects on their relationships.

Chapter 8 Being Alone and the Shaping of Relationships

This chapter will illuminate some of the women in this study who were left, for various reasons, isolated during hospitalization or while in labour. Barbara was left after a quarrel with her husband, just as she was going into labour. Carol was on her own due to her husband's work schedule and his unawareness of her suffering while hospitalized prior to giving birth. Isabelle was left when she was in pain, as her husband had to care for their other children. Lyanne was hospitalized in another city hours from her partner. The significance and impact on the women's relationships from being left alone is the focus of this chapter.

Being alone in labour or during times of suffering was distressing to the women. The long-term results were that their worlds were changed forever because of the lack of support; their expectations were dashed, not only in terms of their birth plans but also in terms of their trust. Tensions emerged as each woman shared her experience and I explore the hospital practices that result in separation and aloneness. Women's subjectivities shaped their understandings of birthing are viewed in light of their birthing experience and the subsequent effect on their lives.

Support During Labour and Birth

Support during a pregnancy is often provided by partners, family and friends which includes their acceptance of the pregnancy, the family's anticipation and preparation for the birth and eventual acceptance of the newborn (Bondas and Eriksson 2001). Familial caring and support, displayed through encouragement, touch and attending the woman, is important during labour and birth. Women identified their perceptions of perinatal emotional support intervention during birth as having someone with them to reflect their progress and to reassure that she is doing well (Fenwick et al. 2013). Feeling cared for, such as being able to ask questions and

receive answers and not being made to feel stupid or judged, is a central theme for women. Howarth et al. (2012) explored first-time mother's perspectives on their relationships with midwives and doctors during labour and birth and found that, personal caring by health professionals lessened distress during labour and promoted feelings of well-being about birth experience. When a woman was shown constant understanding, warm and caring support by staff, she felt confident that she could cope with birth (Howarth et al. 2012).

Bearing Witness

When a woman plans her delivery she selects people to support, witness and attest to her perilous journey to motherhood. Usually, the people who attend her birth are those who love her, such as family and friends. It also bonds those who care for the woman and the woman often feels connected to care providers who witness her birth. Naef (2006) describes bearing witness as a moral way of engaging in relationships, of being present and thoughtful to the truth of another's experience. In order to give testimony—to tell, speak and write—one needs to first attend to the genuineness of what the person has experienced (Naef 2006). Bearing witness constitutes a well-articulated and particular way of caring. Bearing witness is a fundamental way of being with an individual; the unfolding of what Parse (1998, 2004) calls the act of “human becoming.”

Bearing witness involves enacting one's moral responsibility arising from the encounter with the other. Levinas (1979, 1998) claimed that the infinity and totality of human existence is reflected in the face of other, calling upon the one who looks into the face of the other to take on an ethical responsibility for the other. This ethics of responsibility suggests that one cannot turn away from the other without negating the other; turning away is an act of violence (Levinas 1979, 1998).

Alone in Labour

A woman requires intrapartum [during labour] care and support from educated and experienced nurses and midwives, plus the support of family members (Adams and Bianchi 2008; Leahy Warren 2005). Nursing's role and policies guide care given during the intrapartum period and extol the value of one-to-one assistance, which includes acting as an advocate for the woman (Liston et al. 2007). Often the supporter is the partner but, a supporter could be a mother, sister, friend, nurse, midwife or doula (Hodnett 2001, 2002; Khresheh 2010). The woman must be able to trust those individuals to know she is cared for and that her interests are being looked after. Yet, for several of the participants in the study, being left alone defines their experience of birthing.

Overwhelming Abandonment: Barbara's Story

Barbara's story of birth is an arduous account of "the abandonment" she felt on many levels. She spoke of having a long back labour and described the emotional family strife building up to the moment of birth. Her husband, Bartoli, was to be her support person.

What made it most difficult was the lack of support I felt around me and the whole experience. My husband, at the time—is from South America and wanted his family to be there for his daughter. My Mother, had 11 kids and a life experience of *doing it all on your own*. You don't have your husband there and you just kind of muscle through it and she passed that onto her daughters. She and I had a lot of difficulty connecting through the years, too. There were a lot of feelings of abandonment on my part about this. When she didn't offer to come for the birth or show any interest. I wasn't really surprised.

In the passage above Barbara spoke of the messages from her mother of “doing it all on your own.” Without the same societal restrictions that limited Barbara’s mother, Barbara was affected by the lived messages. Consistent with Western culture, Barbara did have expectations for herself that included her husband’s support, as outlined in prenatal classes. Bartoli, growing up in a South American home where strong Catholic values and patriarchal roles remained strong, may not have understood the cultural expectations that Barbara held for labour, birth and him.

Bartoli’s brother and mother, in contrast, came for the birth and were staying in their small apartment anticipating the birth. “My husband’s family was very keen to be there and I didn’t really know how to receive that, because it really wasn’t part of my life to have that kind of support.” Barbara related that,

I thought it was a good idea at first. She [mother-in-law] cooked and there were all these nice parts to having family around but something shifted in me and I had no idea what to expect. I knew I needed my husband to be by my side. I was scared. I didn’t have the maturity to own that, to come forward and say I need you to be with me. He was very much wrapped up with his family, doting on his mother and brother. Making sure they bought all the presents for the relatives. I felt very left out. So, being who I am, I spoke up about it. Anyway, it wasn’t the most helpful, because it pushed him away rather than brought him closer. I insulted him ... by suggesting that he spent more time with his mother [and was] over involved with them. I said some really harsh words that absolutely shocked him. I can’t exactly recall what they were— alluding to the kind of relationship he has with his mother, like a Mummy’s

boy. And he left. He walked out of the apartment. And when he left me, I was going into labour. So my whole body seized up with fear.

In her desire to be closer to her husband, Barbara pushed him away. After Bartoli left, Barbara called her mother, “She really didn’t get it. Really didn’t get it,” which meant she was not coming to be with her daughter. Then she called her younger sister, who planned to be with her in labour, yet, was not aware of how to support her. Barbara’s sister organized transport to the hospital by ambulance.

Then my husband showed up and we hadn’t talked and I was still very hurt that he’d left me. You could tell he was still pretty low, too. But I was glad he was there. I had contractions and things were progressing. I had back labour which was pretty painful. So I jumped in the shower. Because I had the herpes virus, he wouldn’t touch me, wouldn’t go near me for some reason. He didn’t want the baby to be contaminated. He didn’t want to be around rubbing my back and supporting me. So he created an issue and after a while he went home to have a sleep. My sister came in and she was exhausted and tired so she, too, went home to sleep. So everybody left, so I was alone in the hospital for a while and I said, ‘Yeah, OK, get some sleep.’

Her family left while she was in active and prolonged back labour. Back labour, persistent occiput posterior means that the baby was facing upward creating a larger head diameter in relation to the internal maternal pelvis. This causes longer, painful labours and often, a need for instrument deliveries (Davidson et al. 2012).

Bartoli seemed unwilling or unaware how to support a labouring woman despite his attendance at prenatal classes. Closer to delivery, he came back to be with Barbara. As the pain escalated and, after a long wait, she was given an epidural. Then a doctor asked if Barbara minded having students witness her birthing process.

If I could do it again, I would have said, 'NO! Get someone else who is having their fifth baby. Not me.' Right! Oh my. So at that, it doesn't matter, it just doesn't matter [laughing]. You are giving birth, it's out there anyhow. I felt their presence wasn't a good idea. It wasn't. All I could think of was, 'She's gonna come out, she's gonna come out.' They used the forceps and pulled her out.

For Barbara, her back labour set into motion the very aspects of the “obstetric package” namely, epidural analgesia and instrument birth that has become “a widespread but complex, risk-laden and expensive solution to occiput posterior-related labour dystocia and arrest” (Simkin 2010:61). The outcome for this type of birth is usually prolonged healing time and recovery time, at the very least. Advocates for a more “common sense” hands-on approach of experienced experts should include “emotional support, maternal body positions, movements, palliative measures, followed as needed by synthetic oxytocin augmentation, artificial rupture of the membranes, epidural analgesia, manual rotation and instrumental or caesarean delivery” (Simkin 2010:62).

The Medical Model and Violations of Dignity

The organization of the hospital and medical care is arranged to provide the most efficient and effective ways to deliver infants but effective and efficient for whom? Davis-Floyd (2001) has termed the current approach to childbearing as the techno-medical model of medicine,

which is “rigidly hierarchical in terms of the power of the physicians as a group, the emphasis on specialty over primary care and ... the subordination of individual needs to standardized institutional practices and routines” (3). In the Western culture, we have become convinced that altering a natural process, like birth, through technology makes it better, more predictable, more controllable and therefore safer (Davis-Floyd 2001).

However, for Barbara, with no one there to advocate for her, she acquiesces to the presence of residents at her delivery. Barbara was under surveillance by others who had no connection to her or her life; similar to Foucault’s (1978) ideology of the perfect prison design where the system is organized as a panopticon such that inmates are observed by the guard at the centre of a circular building allowing the minimum number of staff to oversee the greatest number of prisoners. However, for Barbara, the view is reversed and she was at the centre being observed, surrounded by residents, HCPs and others. They are observing her intimate moment of birth without introductions or personal connections. For many women, their partners and family act as a buffer for requests such as these, knowing ahead of time what the woman wants for her delivery and birth.

I often wonder if women are in “their right mind” sufficient to give consent when they are in intense labour and whether it is ethical practice to make such requests when a woman is under duress. Perhaps nurses take for granted the caring of women and subject them to the hegemonies of the medical model, without due regard for advocacy when supporting birthing women.

Standing her Ground and Pushing Others Away

Barbara described how something changed inside her when she gave birth. She said a “wolf came out” and she experienced a powerful protective instinct for her child. After a short

hospital stay, Barbara was discharged and returned to her home. Bartoli's mother was helpful, wanting to share her knowledge of infant care.

She was telling Bartoli, 'No she shouldn't be using those baby wipes, you should use a wash cloth and warm water,' which was probably a really good idea, looking back. I found it very threatening and I didn't want her telling me what to do. Bartoli was not trusting me and trusting his mother. I was done and I wasn't going to tolerate it. I marched right into the living room and said 'We are going to have a talk,' to Bartoli, 'I am really not happy with this.' You are paying more attention to your Mum and I might have said something about an Oedipus complex. Anyway, I insulted them terribly and they packed up their bags and left. Part of me was relieved that they left. I felt like I was going a little bit nuts—to be honest with you—inside me. He didn't get it at all. What I didn't expect was for my husband to leave. I thought, at the very least, he could stay with me and he didn't. He left with his brother and mother.

Today, record numbers of fathers (Declercq et al. 2005) who live with their partners attend their partner's births, as do 43 per cent of those who live separately (Kiernan and Smith 2003). Fathers have an expanded role in the birth process; they are expected to reinforce what is taught in prenatal education classes, act as advocates for the mother and to fill gaps in care (Enkin et al. 2000). Earlier studies have found that women whose partners were present and supportive during labour were less distressed (Anderson and Standley 1976; Henneborn and Cogan 1975). Labouring women benefit when they feel "in control" of the birth process and a key component in this is experiencing support from their partner during birth (Gibbins and

Thomson 2001). Support during delivery, provided by a close individual, creates a more positive birth experience for the mother, with a shorter duration of delivery and less pain (Kitzinger 2010; Tarkka et al. 2000).

Lack of Presence and Calming Touch

The use of touch in labour, through supporting the woman in positions to promote labouring, also stimulated contractions and relieved pain (Hedstrom and Newton 1986). Large areas of the woman's body are supported and massaged. Often the woman is held in a sitting position with others around her encouraging her efforts (Donnison 1988; Donegan 1978; Sutor 1981; Wertz and Wertz 1989). This type of touching throughout labour was regarded as positive by the woman, provided shorter labours and affirmed that support was there for them (Bowers 2002; Hedstrom and Newton 1986).

Barbara spoke of the time after Bartoli leaves. "So there I was left alone in the apartment with a new baby. I accrued a lot of that for myself, I pushed them away. I was confused by it all, very confused. I didn't know what I had done. All the support that I needed [wasn't there]!" However, a neighbour came to hold and comfort the baby while Barbara cared for herself.

I remember thinking that I was glad she was there because I was so rattled.

I was concerned that the baby could feel that ... there was a presence in the room that was calm and centred, because I certainly wasn't feeling that way. It took quite a few days to recover. I was feeling very fragmented and adjusting to the breastfeeding and all the newness, lack of sleep, body aching, every part of that was an adjustment.

Shifting and Unstable Ground

Bartoli did return to the apartment but their relationship was tense. Barbara was distressed in case the baby felt the anguish (see Illustration 7.1 Barbara holding a picture from the first week of her daughter's life). They had plans to move to his home country.

So then I had another cultural adjustment to deal with this baby down in South America. I was very isolated and still trying to heal the rift with my husband's family, which hadn't fully healed. With all the risk factors in place, my marriage fell apart and I came home.



Illustration 8.1: Barbara holding a picture from the first week of her daughter's life

Despite prenatal preparation, Bartoli left her during critical times. It is unclear whether it was cultural difference and expectations or fear that did not allow Bartoli to care for Barbara during labour. Being on her own and making it through tough times was expected, as Barbara had seen her mother live this message.

Wilkins (2006) investigated the experience of first-time mothers during the early weeks of motherhood to explore areas of support that women find empowering. The core theme that emerged from this study was termed, “doing it right.” This is when a woman moves through the transition to motherhood and develops confidence and skill to give optimal care to her baby. Barbara also spoke of her early mothering and wanting to do things right for her child.

Webster et al. (2000) examined the social supports for women who were expecting to deliver at hospital. They found that women with low social support in pregnancy were more likely than well-supported women to report poorer health during pregnancy and postpartum, to organize prenatal care late, to seek medical help more frequently and to be more depressed postnatally. Even though “a pregnant woman may feel loved and tangibly supported by her partner, family and friends their results confirm that, if such support is provided in the presence of persistent conflict with the infant’s father, adverse outcomes are more likely” (Webster et al. 2000:101).

Multiple tensions arose from misunderstandings between Barbara and Bartoli. Unspoken expectations, unidentified ways of being and differing family cultural values played a significant part in the disappointments and ultimate dissolution of the couple’s relationship. Barbara expected her husband to be present with her in ways that were not met. Her family experience of “doing it all on your own” was a prophecy that came true, as she was left alone by her mother and sister. Barbara was deeply wounded by her abandonment and found it difficult to heal the emotional pain. The hospital practices of allowing multiple viewers to witness birth depict a form of voyeurism, a self-serving aspect of education for medical practitioners that was not in Barbara’s best interests. The taken-for-granted approaches of hegemonic hospital practices privileged learners over the childbearing women, those who should be at the centre of care. The

next story of being alone also ends in marital breakdown where Carol's narrative of unacknowledged suffering plays a role in the ending of their marriage.

Prematurity, Illness and Facing Suffering Alone

Carol also spoke of her relationship with her husband and her sense of being alone. As discussed earlier, Carol was hospitalized for excruciating back pain at 30 weeks' gestation due to an undiagnosed ureteral kink. She recalls

My Mom and Dad were visiting. I remember I had an argument with my Dad, I was so mad I broke my water [laughing]. So, then I had an emergency C-section. Where was that in my birth plan? So it was difficult because of the pain and all of it. All the things were unexpected. And my husband wasn't there most of the time. Then when he was, it was a good test of the relationship. I found out his inability to be empathetic, so it wasn't good for the marriage. He said, 'I'm going to see a movie.' I'm suffering and miserable and he's going to go out with the boys. He worked off-shore and he hadn't been on land for a while. So go catch up with the boys. So there was that.

The lack of empathy and his leaving were also a theme of their early parenting of baby Carryn.

When asked if the birth affected her relationship, Carol explained that,

Well, with my husband—it was like 'Oh, is this what you are like in these kinds of circumstances?' Oh. 'Not present, not there!' That was a big disappointment. You think that [your] life partner is going to be the one who's holding you up. Ummh. So that definitely affected us and then I think more of a dyad between my daughter and me, than the three of us.

So for sure it did [affect our relationship] because of how I came to see him through that process and it changed my perspective. Maybe if I was more mature I might have said, 'Well he just doesn't know how to cope.' I would have looked at it more charitably. But when you are in that kind of place (shrugging) ... 'Well, where are you in all of this?'

Carol shared thoughts of her reactions and responses from over 20 years ago and believed today, she might not judge him so harshly. The actions taken by a partner to leave or not attend to the other person's needs at their time of crisis, set off a cascade of negative feelings that, in Carol's case, have lasted a lifetime. When the patterns of leaving or abandonment continue then the couple's relationship suffers.

Shaping Understanding and Not Relying on Others

Feeling deserted and alone had lasting and decisive consequences for Carol's and Barbara's marriages. Carol described the enduring impression this behaviour had on her sense of trust with others.

Other relationships ... well, I think in some ways it has formed me, because I was 27 or so. It certainly has made me come to believe that if you want something you have to do it yourself. I had [built] all this support [around me] so I wouldn't have do it all by myself. But with relationships in general, I certainly don't count on anybody. My husband, I couldn't count on him. I was already like that, really independent but it increased my independence because, if you don't count on anyone you can't be disappointed if they let you down. So I tend not to count on people. Right! Right? Whether that is a good way or bad way, this is my

way. So in some ways, it might have coloured my being with people, a little more guarded with friendships. I don't like to expect too much because then I would be disappointed. Does that make sense? Logically, but it also prevents connection. It's a protective mechanism.

Being alone and without family, enhanced Carol's sense of independence and self-sufficiency. She altered her ways of being, to be independent, not to expect much, to be autonomous and guarded. As Carol identified, keeping people at a distance restricts friendships and limits the potential backup that might be available. Two other women, Isabelle and Lyanne, also experienced a sense of being alone in labour. Both these women also had preterm births.

Appendicitis, Preterm Labour and Suffering Alone

Isabelle had felt unwell over the weekend and halfway through Monday, decided to go home, she called her doctor who requested she go to the hospital.

I just thought I had the flu. But I was having some contractions as well as the pain. So I think part of it was that unexpected piece. You're in the hospital, too, and you think about your other children at home. Suddenly, there's this trauma and you have to phone your husband and say, 'I'm at the hospital.' He has to go to the other children rather than be with you because somebody has to look after the other kids. They had to be picked up from daycare and taken home. Then that whole network of your support system kind of hones in to try and make that happen. I think trying to cope with it alone was part of it. The nurses were great. I actually had really good care. But the hardest part was the unexpectedness and then my husband not being able to be there for most of it when I was in a lot of

pain. It was that uncertainty of what was happening. They were thinking it might be an abruption, though there was no bleeding. But the uterus was like a board so they were thinking, what's going on here? Is this an abruption here? Or what's happening?

An abruption is a severe complication of pregnancy, termed abruptio placenta, where the placenta partially or completely shears away from the uterine wall before the foetus is born. Often there is blood loss, either evident or concealed, which can make the uterus hard and board-like. Abruptio placenta can result in the loss of the foetus and loss of the mother (Fraser and Cooper 2009). Isabelle recalled the hardest part of the ordeal was that she was not expecting to go into labour and having to cope on her own. She felt the most alone when she was in pain. Having a loved one there to bear witness to suffering makes pain endurable (Levinas 1998).

Complicating visitation for Ivan, Isabelle's husband, was the lack of family engagement that might have helped care for the other children, allowing him to attend to Isabelle. Limited daycare services, which do not extend beyond business hours, reduce opportunities for families to make special requests in times of hospitalization. Isabelle understood the pressures her husband was under as well as herself. Her recovery was also complicated by her history of postpartum depression (PPD), experienced with both her previous pregnancies, as severe depression following the delivery.

Pregnancy at Risk, Uncertain Relationships and Abandonment

Like Isabelle, Lyanne's circumstances were beyond the couple's control as she was hospitalized, awaiting the growth of her preterm baby. Linda, her partner, needed to continue to work in their home town, only able to visit Lyanne each weekend.

I was quite upset with her for going back to work. I felt a little bit abandoned because I was on my own. There was nobody else there. I have a couple of friends who came and visited for a couple of hours. So that was hard. I felt angry with her for quite a few years about that, but we processed it. I didn't feel like I should be angry, because I knew she had to go back to work. But there's always ways around that too. She came on the weekends of course, Friday, as soon as she could get out.

Over time, Lyanne and Linda worked out the anger that Lyanne felt about being alone. Adding to feeling alone and isolated from family was that Lyanne's father was deceased and her mother lived in another province. She spoke of her relationship with her mother at the time of her birth.

We didn't have a very good relationship, then. We have a better relationship, now. So she didn't come. But she's not very nurturing. I don't think I would have wanted her there. She's just not the Mum-type.

Linda's father died three weeks after the baby came home from hospital, as did one of their friends, making their lives more complex.

So we were coping with that and Linda's Mum lived in another province. Linda's Mum was having a really hard time with us having a baby to begin with, as a same-sex couple. But she did come when Lara was a couple of months old. She came and bonded with her. She loved her just like all her other grandchildren; it was her fear of homophobia. She was worried for the child; which touches my heart. She was worried that she would grow up experiencing a lot of prejudice and hatred. It's not been the case at all. That was just her concern, her generation.

Lyanne was considerate of her mother-in-law's beliefs. Once her mother-in-law saw the baby, she loved her. Lyanne was forgiving, generous and understanding of differing cultural times and appreciated the concerns of bias and discrimination.

By their very nature, hospitals are designed primarily to house those in need of health care. Institutions make little allowances for families who may need to travel to visit loved ones. Limited visiting hours, expense of travel and fees for parking all add to the financial and human cost of attending to loved ones. The isolation due to distance causes women to feel alone. For the women who were left alone awaiting birth or during labour, the situation is perceived as abandonment. Family members may not have been to blame for their lack of presence but the women suffered more deeply when left on their own in times of need.

Two other women were abandoned by the health system, Gillian and Hillary, both women were hospitalized but in both situations they were not believed to be ill or in labour. The women were denied their corporeal experience despite one having an infection and the other on the verge of giving birth.

Six women were left alone during their time of need. Three relationships did not survive when the women were left and they perceived their situation as abandonment. Three women were also left but their relationship persevered, with the couples working things out over time. Isabelle understood the reasons that Ivan could not be there for her due to his caring for their children; however, it still made the situation difficult. Lyanne knew that Linda had to work but Lyanne felt hardship being left alone. When couples have preterm babies, as well as complex health challenges for them, this creates increased complexity and stress in the relationship (Black et al. 2009; Davis et al. 2003).

In the next chapter, I look at the women's feelings of guilt and when they began to bond with their child. The women speak about what made them vulnerable and how each woman carried the experience of a difficult birthing—embodied it—over time.

Chapter 9 Constructed Understandings: Guilt, Love, Vulnerabilities and Mothering

Mothering is a transition into a life experience; an experience different from that a woman has ever known before (Miller 2011). Motherhood is socially constructed and has become a powerful and dominant cultural discourse of control over women (Davis-Floyd 1993; Duden 1993; Goodwin-Smith 2012; Hadjigeorgiou et al. 2012). Earlier work on motherhood focused on experiences and expectations to draw attention to the cultural assumptions about women's "natural" and "instinctive" capabilities (Griffin 1982; Hays 1996; Miller 2007; Oakley 1979; Rich 1979). The assumptions and discourses of natural birthing and mothering have neglected the circumstances, power relations and interests that make women primarily responsible for their experience (DiQuinzio 1999; Nelson 2003; Rich 1979). Furthermore, these assumptions and beliefs can be hard to resist for women becoming mothers, as they play into and accentuate their feelings of disappointment and guilt. The social construction of maternal care frames roles and values, assumptions and judgments, medical indications for high risk birthing situations and those of managed birth where interventions lead to other interventions, laying the blame of birthing gone wrong, not on those in control, but solely on the woman (Davis-Floyd 1993).

I asked each woman in my study, if they felt guilt about their difficult births, the vulnerabilities they felt at the birth, when love for their child began and if they carried the birth event with them into their mothering over time. This chapter looks at becoming a mother and topics that affect mothering, including the women's sense of guilt about their birthing and her sense of self-blame. The chapter also explores participants' descriptions of how each woman carried the difficult birth experience into her mothering over time (Forssen 2012).

How a woman experiences her body and the meanings that she makes from the experiences are referred to as embodiment. For the women in my study, embodiment is the tangible expression of the body, experienced through her difficult birth, and includes her pain and suffering, which she carries with her for years, if not forever.

During a conversation, Isabelle expressed her sense of guilt at her son's preterm birth. Once she raised this point, I adjusted my interview scripts to ask all respondents if they felt any guilt about their difficult birthing. Ten out of the 12 women said they felt guilt about their births. Some of their responses are shared below.

Vulnerable Position: I Shouldn't Feel Guilty

When I asked Amber if she had any feelings of guilt, she stated,

I think it's hard because you shouldn't feel guilty but, on the other hand, you're in such a vulnerable position. I go back to that knowledge and advocacy; having someone there who can speak for you. But you're so vulnerable, how can you speak up for yourself and should you have to?

I have often wondered why women have to advocate for themselves. There are ethical and legal reasons why physicians must adequately inform patients about proposed treatments or procedures, especially in regard to risks and dangers. The physicians should be satisfied that the patient understands and consents to the procedure. Doctors who fail to inform patients about their condition, treatment options or the risks of treatment, may be sued on the grounds of negligence. In practice, however, delivery room consent is either implied or verbal explanations are cursorily given to women about the risks and benefits of practices, such as forceps delivery (Eason et al. 2002; Farrell 2007). Longmore (2007) contends that, within obstetrics, practitioners

routinely fail to inform women what, how and why they will be performing certain obstetrical functions.

Many Levels of Guilt

Barbara spoke of being haunted by guilt about her birth, the dissolution of her marriage and a disconnection from her family of origin.

I had terrible guilt for a long time. I felt guilty that my marriage broke up, so I couldn't provide a father for my daughter, when I remarried she had a step-father who had difficulty connecting to her. I wanted to give her everything, wanted it to be perfect for her. Yes, I had a huge amount of guilt around that. And, being a single parent, doing it on my own, kind of overwhelmed, stressed me out, not enough resources or support around me. There's times when I wasn't a good mother—terrible guilt around that. Times having to go back to her and it was like, 'Bri I'm sorry. I just had a bad day. I'm really sorry, honey.' I know there are times I really hurt her. I know it was because I was hurting in myself. Yes, lots of guilt, it wasn't perfect by any means. I had to do a lot of my own healing work. I had to go back and heal my abandonment with my mother.

Single parenthood, being on one's own raising a child, also places additional demands with juggling work, childcare and mothering/parenting. Being a single parent also entails disadvantages in terms of socioeconomic circumstances and health (Sarsour et al. 2011). Weitoft et al. (2003) conducted a large, longitudinal study from 1991 to 1999 with single parents in Sweden. They found that children growing up in a single-parent family were disadvantaged in terms of the child's health, had increased risks of mortality and higher risks of severe morbidity

and injury. Their study also concluded that disadvantages for single-headed families become more accentuated in countries with fewer social programs compared to Sweden.

Structured Oppression and Feelings of Guilt

Diana said that she feels guilt “every once in a while.” She recalled not attending prenatal classes and pondered what she would have learned (see Illustration 8.1 Diana’s son and her brother).

Well, it would have taught me breathing exercises. I think prenatal would have been beneficial for Dennis. As women, we get in tune with our body and how it’s changing and we know, okay, I can handle this and I can handle that. I felt bad that he didn’t have a better idea of what was going on or what was possibly going to happen. Because of that, I felt sad; because there’s no way that I would have been able to explain that to him. Even knowing now and if we were going to have another child and it was going to go the same way, I still wouldn’t be able to explain it to him really.

The purpose of prenatal education is the claim it prepares the woman and her partner through inclusion and education, key elements for understanding pregnancy and birthing (Hollins-Martin 2013; McKinney 2006; Koehn 2008; Lothian 2008; Schott 2003). Despite the belief that this learning is a critical tool for education about childbearing, Longmore (2004) claims there is little evidence, except anecdotally, on the value of prenatal education (Ferguson et al. 2013).

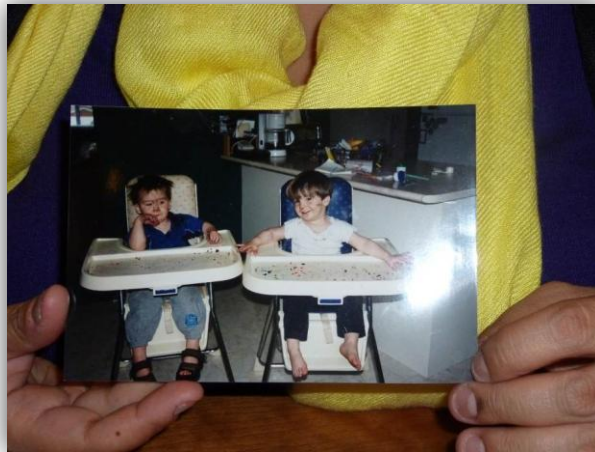


Illustration 9.1: Diana’s son and her brother.

Diana spoke of her understanding of her body. The body “speaks” to the person through sensations anchored in meaning and that meaning is derived through experience in the social world (Corbin 2003).

Medical Birthing and Multiple Guilt: the Structuring of Childbearing

Francis felt badly about her birth and explained

I did feel guilty. I don’t know if I do now. But I did. I felt guilty that I let them induce me. I felt guilty that I didn’t trust him [the baby]. I felt guilty but, I guess I didn’t trust in myself somehow or him ... I remember saying to him as a little baby, ‘I’m sorry that I didn’t give you the birth that we wanted.’ I do remember feeling that. It’s not as strong now as it used to be.

Francis linked her sense of her body and intuitive knowledge of her baby. She spoke of trusting her body and her ability to give birth vaginally (Lundgren and Berg 2007). The resulting outcome of a caesarean birth brought forth her sense of shame and guilt, now diminishing over

time since her second delivery (Forssen 2012). Francis's sense of her embodied knowledge has come undone and she experiences remorse and disappointment with that acknowledgment.

Institutional Agendas and Multiple Guilt

Gillian felt guilt for many years and not just due to her difficult birth. She has two profoundly mentally and physically disabled children she was raising. The childcare system was unable to help her financially with looking after them at home and she finally had to place them in care. Her guilt surrounding her difficult birth is compounded by her other children.

Oh, I used to [have guilt] big time. I was just plagued by guilt for years and years and years. I think I got out of it, probably about ... not that long ago, maybe four or five years ago. I've totally let it go and forgiven myself and forgiven a lot of people. I think there's a lot of forgiveness for me as I know I did the best I could and that's all any of us can do.

So a lot of my guilt was with [my children] of course. That's where my guilt was and I was suffering a lot about them and having them go into placements. So it wasn't until they were of age, where they would have left home, on their own, that I could accept it. So that's a long time.

Because I always wanted them; I wanted to be their caretaker. It was hard.

Gillian wanted to raise her children herself; but, not being able to do so, without financial and material supports, was a heavy burden. Placing the two youngest in care has been a struggle for Gillian.

In the Past: Working Through Guilt

Hillary said now she does not feel guilt and spoke about how she has worked through her feelings.

I did years ago. It was shortly after the birth and that was probably some hormonal stuff too [laughing]. I wondered was it something I did. But the more I learned about premature birth, I didn't [feel guilty]. I know there was nothing that I could have controlled in that situation. I also know there wasn't really much I could have done to change the way it happened. It's one of those things—I've really decided in my life on so many levels—I can't harp on things. It is what it is. That's what happened and you deal with it, you go on. So I really don't feel guilt about her birth, at all. The only thing I feel now about her birth is joy, because the event itself was not a great event. So, that's where I am now. Eleven years on [laughing].

Hillary decided to put aside her feelings and emotions of blame and guilt. She spoke about the aftermath of her first delivery and wonders if she can have another child.

I actually did go through some therapy, before I had my son, because I thought I can never have another child, never, even though I wanted another child. Nobody could tell me why it happened and I still felt very much like I was ignored in the moment. I thought I can't do that again. I'm pretty confident, a fairly intelligent person who can take charge of her life and, at that moment, I felt like I was totally disregarded and I couldn't ever face that again. But I wanted another child. I wanted her to have a sibling if possible. So, five years later I had my son and he was a premie too, but not to such an extreme. He was 36 weeks. So they called him a premie and I thought 'Oh, that's nothing' [laughing]; 'he's fine.'

Hillary's son was born at 36 weeks, a late preterm, with some mild respiratory distress at birth. For her, this was not as concerning as her first childbearing experience and being disbelieved that she was in early labour. Later, Hillary told me that, after her first preterm delivery, the hospital implemented a new procedure to follow up more rigorously with any woman presenting in preterm labour. This procedure outlined a thorough step-by-step approach to assess women who come into the hospital in suspected preterm labour.

Sawyer et al. (2013) looked at parents' satisfaction with care during the birth of their very preterm baby. They identified two distinct factors about parents' degree of satisfaction that are unique to preterm births—the importance of staff appearing calm and staff that take control during the birth. Although parents in this study reported positive experiences of care, two areas for improvement were also identified. First, some women described being in labour or very close to giving birth and the staff either did not believe them, or did not appear to listen to what they said. For Hillary, who experienced preterm labour and birth, being listened to is paramount. Second, parents valued the partner being involved in the birth. Some partners described feeling left out and marginalized and these findings are consistent with other studies on partners (Redshaw and Hutchinson 2007).

The Guilt Box

The birth of Isabelle's youngest son had been a source of contemplation and guilt since his birth. From a health perspective, the birth was probably precipitated by the emergency appendectomy—the rupture of purulent discharge into the peritoneal cavity and surgery that stimulated the uterus to contract (Zhang et al. 2009). There was nothing she could have done. Yet, thinking about it again, she said, helped to “put a little more into that guilt box and put the cover on it.” Isabelle pondered, “What could have been, if only I had done things differently?”

Women bear the burden of blame for not having the perfect birth (Miller 2007). From Isabelle's comments, I realize that blame is part of women's disappointment with their birthing experience and blame adds to their sense of loss.

Ongoing Work: Guilt and Grief

Jennifer lost her baby at three months from a brain tumour. She recalled her grief and the guilt she carries,

For sure as a mother, that carries with you forever. Guilt is a wasted emotion and it will eat you alive. And it ate me alive for a long time because I had so much guilt because it does get to me, like that PPD with Jade. I could have been there, more in the moment, better emotionally for her, if I didn't have that PPD. But I do realize that was out of my control, for whatever reason and I believe that she knew I loved her. You're a Mum you can't deny that.

As much as I realize it is, what it is, it happened. What I know now, for myself, for [my daughter and partner], I can't live in that guilt for the rest of my life. That was a huge part of my depression afterwards. Coming out of it, I got stuck in that for the longest time. It's a mean, mean, place to be. But going back to the counselling, there are things that you're in control of and that's one of the feelings you can control. As much as it's in the pit of your stomach and it can eat at you, to say, 'No I have to put that behind me today. One foot in front of the other, I can make today good, I can.'

Jennifer's sense of working through her grief and guilt were conscious efforts. Some days were better than others and she repeated maxims to get through the harder times. Love serves to counteract their "grief and heals them ... Grief never kills" (Tolstoy 1899:109). It may not kill but it causes untold pain, guilt and suffering.

Guilt: PPD, PTSD and Breastfeeding

Lyanne related the guilt she felt about the birth of her preterm baby and described the complexities of her feelings.

Well, I felt guilty that I must have done something wrong that my baby was born too early. I felt guilty about not being able to be with her. I felt guilty about not being able to breastfeed. I felt guilty about getting PPD and having to be in the hospital away from her. So, yes, there were lots and lots of that. I still have some of that, but it's less because I see that she's just fine and everything's okay. I did the best that I could under very difficult circumstances. I can feel good about that now. I handled it in the best way that I could.

Like the other women who delivered preterm babies, Lyanne wondered what she did wrong and felt guilty for things that were out of her control (Trombini et al. 2008). In the aftermath, she suffered from PPD and was also treated for PTSD which added to her feelings of guilt and loss (Zauderer 2014).

Women's identities are affected in many ways when giving birth (Kitzinger 1978; Lyerly 2006; Mercer 1986; Miller 2007; Rothman 1982; Rubin 1976a, 1976b, 1976c; Ruddick 1995). Motherhood experiences, articulated through women's own stories, offer a vantage point to look at these changes. In particular, women's ability to speak about experiences and the meanings

they have, allow for the disclosure of feelings of love, of struggles and of learning how to mother (Creedy et al. 2000; Green et al. 1990).

Transition to Motherhood and Love

A mother's love has long been written about by singers, poets and philosophers (Lennon and McCartney 1965; Solomon 1988; Tolstoy 1899). Rich (1979) writes that "mother-love is supposed to be continuous, unconditional" (29). Furthermore, Rich (1979) states,

Probably there is nothing in human nature more resonant with charges than the flow of energy between two biologically alike bodies, one of which has lain in amniotic bliss inside the other, one of which has labored to give birth to the other. The materials are here for the deepest mutuality and the most painful estrangement. (218)

Ainsworth (1964) declared that attachment was synonymous with love. Love has been studied as attachment and the lack of love as loss (Ainsworth 1964; Bowlby 1971; Hinde 1976). Scholars have studied attachment theory and described its effects on children and families and no form of emotion is accompanied by a stronger feeling than attachment and the individual recipient of those feelings has a sense of being loved and, the response to being loved, is greeted with joy (Ainsworth 1964; Bowlby 1971; Hinde 1976). Adult humans require the use of metaphor to express their love experiences, as words simply do not express feelings (Bowlby 1971; Vaillant 1985). Later in this section, Jennifer's comments emphasize her inability to find words to express the love she has for her foetus and later child.

When Love Began

I asked participant women about loving their foetus or infant. Based upon the stories women shared, love for their baby began at different times: three said before conception, six

women said at conception, one said during pregnancy, one at birth and one at three to six months after delivery. Below I present a selection of women's thoughts on love.

Love Right at the Start

Amber spoke about when love began for her child.

Right away! I really wanted to be pregnant, so right away. Not like the love that I have for her now, but the beginnings of it. That little seed that's just this baby growing and I really wanted to talk to the baby right then. Then the first tangible moment when you feel the baby move. I always loved that with all three pregnancies, the baby moving and I always miss that afterwards. Then, of course, when I saw her; she just was so perfect. Even now, I look back at pictures and see this little chubby thing. But to me, I thought she was the most beautiful baby and she was just so calm, loving. She just loved to be held and she still does. She's a very loving person; always giving people hugs. So, that little seed started right away. But, the moment I held her and then when I successfully breastfed. It was always easy with her because I could get past her birth and maybe because Avril was such a beautiful baby. So, I did go on to have two more [laughing].

Love after Recovery

Diana, age 19 at the birth of her son, recalled she felt love for her child "probably at about six months or so. No, maybe before that, at about three months; three to six months once he was alive. It was after I got over that initial zombie-like mode that I was in." Diana was anemic prior to giving birth and experienced a hemorrhage following delivery.

Ethnographic research conducted by Weiss (1998) over a six-year period explores the scientific notion of maternal bonding—or, as the author states, falling in love with your newborn. It challenges those who argue for a “singular, essentialist conception of a womanly ethic and ethos of maternal responsiveness, attentiveness and caring labor” (90). Weiss (1998) argues that “motherly love” is a powerful cultural idiom combined with an almost inextricable blend of historical, sociological, medical and feminist discourse.

Love before Pregnancy

When asked when love began for her newborn, Francis was moved to tears.

I'm going to cry because I'm going to say before I even knew he was there, because we wanted him. I wanted him for a long time before I even met Frank [husband]. Then when I met Frank, there were all these other things I wanted to experience with him. Having a baby with him was one and then it took us a long time to get to that place where we could have a baby. Then I got pregnant very quickly. So it was before I was expecting it. So it took me unaware. But I think I loved him then. I loved him as the idea and then I loved him as he was inside of me and then it grew. And it still grows.

Mother's Love for a Third Child

Having had two previous children, Isabelle understood loving and caring for children and spoke of how love started when she was pregnant with her third child.

I think that's part of mothering, isn't it? Your child always tends to come first. For that [third] child I think it started almost as soon as I was pregnant. With my first child, I didn't really want to be pregnant. I didn't

really want a child, didn't really want children. Now I have three. So, for that [first] child, even though I was protective of the child inside of me, I didn't really feel a great affection for him until he was about three to four months old.

Isabelle recalls when she and her husband embrace parenthood and decided "to keep him."

That's when you realize you're really in love with this child. But for my third child, I think that was much earlier. As a mother I had matured; really wanted that baby, wanted him to be healthy, to be a perfect baby. So I loved him earlier even though it was a difficult birth and in an incubator. I still really cared about him right from the beginning or even earlier.

Love: Words are Not Enough

Through loving her child, Jennifer redefined the meaning of the word love. Love is the emotion you feel when you are pregnant but grows with time. She stated,

I think when I found out I was pregnant, automatically, I think that Mama-bear, that protection. You change everything in your life for this little thing that you don't know. That initial period where they lay the baby on your chest, for me, that brought tears to my eyes. That was the 'Oh my God, this is real.' I can see you, touch you. Then it grows and grows and grows and grows until it's just all encompassing. Love is not a big enough word to describe how you feel. In utero its love, it's not the same love. Maybe it's just a different kind of love, more of a protective love. Now it's like, it's weird because I've said so many times, I love her so much I want

to put her back inside of me. It's hard to describe and put words to. It's just too big. It's too much.

Remarkable Occurrence and Early Love

Love, as described by Karen, was the love of a mother for her second child. Like Isabelle, whose difficult birth was her third child, Karen understood the concept of pregnancy and giving birth to a child you will love. Karen related that she loved her unborn child,

When I found out I was pregnant. Not the love when you have that child in your arms. It's just, wow, that's just something else. But, carrying, the concern, the constant acknowledgement, when I found out I was pregnant.

Desperate for a Baby

Lyanne's love for her child began "as soon as I knew I was pregnant." She added, "I so badly wanted to have a baby. I was so happy I got pregnant and under such remarkable circumstances, too. I had to travel to Alberta for the insemination. I got pregnant the first time." Lyanne shared that a friend donated his sperm to Lyanne and Linda and they consider each other family through their daughter Lara.

Aspects of Difficult Birthing and Resultant Vulnerability

Satisfaction, for the birthing woman, is used as the hallmark of a good birth (Howarth et al. 2011). Labour and birth are not just physical but are defined by social, psychological, cultural and environmental influences (Dixon et al. 2014; Nolan et al. 2009). The events that occur during birth can work to render the experience from a potentially empowering life event to one described as traumatic. Vulnerability experienced by women during birth may be described after the event as a difficult or traumatic birth experience and termed as an unsatisfactory or negative birth experience (Cassels 2014). Unsatisfactory birth experiences can affect a mother's early

interactions with her infant (Koniak-Griffin 1993; Waldenstrom et al. 2004). Furthermore, dissatisfying birth experiences are associated with increased depressive symptoms during the postpartum period (Fair and Morrison 2012). In studies conducted in Sweden and America, women expressed dissatisfaction with medical procedures such as inductions, epidurals and forceps deliveries for which they felt ill prepared (Fowles 1998; Waldenstrom et al. 2004). Lack of understanding of the actions taken by HCPs was another area of frustration (Fowles 1998). A study of women's experiences of emergency caesarean section showed a disruption in mother-infant bonding and was described as alienating from the baby, difficult and fearsome (Herishanu-Gilutz et al. 2009). Birth dissatisfaction contributes a risk to family psychosocial well-being (Howarth et al. 2011).

I asked women in this study to identify their experience of vulnerability to gain a sense of how the events of their birth shaped their understandings and the meaning they ascribed to the birthing. Vulnerability may arise from the sense of connection to the fetus and infant and the realization that childbirth is more threatening and frightening than the woman had anticipated. Seven of the women participants had a heightened sense of vulnerability linked to their treatment by HCPs. Three women felt vulnerable due to the prematurity of the newborn and other concerns and one from the experience of the illness and hospitalization of her child. One woman did not experience vulnerability.

Amber Speaks of Vulnerability

It felt like choice was taken away of how that birth was going to proceed.

As a patient, you're sort of oblivious—it's different than being a nurse—you're oblivious to being an advocate for yourself, because it was a first experience with birth, Allan had no clue how to advocate for me or for the

baby. For Avril, she's just obviously trying to come out but has no voice.

So we're supposed to be the voice for her and at that point we didn't seem to have the voice either. I think all three of us. At first you're all coming from it in different sort of perceptives.

Having no choice, no voice and no ability to advocate are strong sentiments for Amber and her family. Waldenstrom et al. (2004) completed a longitudinal cohort study of 2,541 women interviewed through three questionnaires that measured women's global experience of labour and birth at various stages over a one-year period following birth. Risk factors that were statistically significant for women included a lack of control during all or most of labour and birth and dissatisfaction with their inability to participate in decisions about their own care (Waldenstrom et al. 2004). Furthermore, risk factors for a negative birth experience for first time mothers were instrument vaginal birth, augmentation of the first stage of labour, labour pain with epidural analgesia and having their infant transferred after birth to the NICU (Waldenstrom et al. 2004). Amber identified the following aspect of her birth that made it difficult.

I wasn't aware of all that was going on. I really didn't feel like I was informed. That source was taken away from us and information wasn't given to us. To know how to proceed, for instance, they broke my water early [because] they wanted the labour to speed up.

Amber felt that the approach to her labour was about the physician's plans for a night out and used forceps and an episiotomy to hurry things along.

I don't even remember them asking if they could give me an episiotomy. I don't recall that at all. I'd had an epidural, so it wasn't like I was in pain or not paying attention. I was quite focused. So I feel I was vulnerable

because of the lack of information and that choice was taken away from me. So when I had Anna, [second child] I was more informed.

This was not the right choice for Amber, particularly as the infant showed no signs of distress. Amber was not given information or asked about interventions—it was just done. “This is my first delivery. Sure, it’s painful, it’s not pleasant, but [the doctor didn’t] allow me the opportunity to experience that fully for my first time. What was the rush?” Doyal (1995) argues that it is no wonder obstetric technologies instigate fear and that medicalized birth has worked against the interests of women. Moreover, Doyal states, with obstetric technologies “is a fear that the medicalisation of birth has too often been against the interests of mothers, turning actively labouring women into the passive object of medical ministrations” (141).

Barbara Speaks of Vulnerability

I needed people, I needed to rely on people around me and I didn’t know if I could. It scared me. When I did reach out, I was let down many times, yes, in many ways. So, giving birth is a time when I felt incredibly vulnerable and dependent on people around me and needed to feel safe so I could let go and open up and really trust. I didn’t have that. I didn’t feel that container around me. It didn’t feel like that at all.

Barbara’s family members left her on her own, perhaps without realizing how scared and how vulnerable she felt. Fearing for her own life and the life of her child was foremost in her mind. Barbara felt abandoned, physiologically helpless and exposed. Being left alone in labour is rarely mentioned in the literature. However, Barbara’s situation is not unique. In the United Kingdom a survey completed every three years by the Care Quality Commission reported that, in 2010, of the 23 thousand postpartum women who completed the questionnaire, 25 per cent were

left alone by HCPs during labour and birth (Donnelly 2014; Trigg 2013). What the report noted was that the need for midwives (read staffing issues) may be at the heart of this issue (Donnelly 2014). What was not addressed in the report was the potential impact of being alone has on the outcome of women's births. The report also does not address the presence or absence of family members at the bedside.

For Barbara, it was not until after the birth that she found her voice and could speak out for what she needed and wanted. In the absence of her husband, Barbara had no one to rely on, no one to support her; yet, this is what women require (Khresheh 2010; Martin 2003). Childbirth education of all types instructs women that the best way to manage labour and birth is to focus on what is happening and allow themselves to be self-centred (Hodnett et al. 2013; Kitzinger 1987a; Martin 2003). Antenatal education further advises that "women should have support of others including physical and emotional support ... [and] women should tell their support persons and providers what they want" (Martin 2003:63). Barbara had no one.

Not even at the hospital. On many levels; the doctors walking in, to the lack of a consistent person beside my bed, medical professionals, different nurse switching, that kind of thing. Too, I remember the argument I had with my husband, my sister letting me down and all those pieces. Boy, I'd sure do it differently now. I'll make sure my daughter has it different, so much about that.

I couldn't anticipate what I needed before it happened. I didn't know. And it's a very primal, visceral experience that my mind didn't know; but my body felt it in the moment. It's really powerful. It seems like a really

long time ago and it was. Seventeen years ago now; but I can remember it.

I remember it. Yes.

Barbara had a powerful trust in her body's embodied knowing of giving birth (see also Davis and Walker 2010). Her mind could not grasp or express what her body was feeling and knowing on a very visceral level. She needed something that she could not articulate. She knew she wanted people who loved her and who were there to support and nurture her, to attend to her needs and be with her. Furthermore, she needed someone to bear witness to her struggle and suffering at the birth (Levinas 1998).

Carol Speaks of Vulnerability

Carol felt her baby was more vulnerable. She describes the interrelated connectedness of pregnancy.

The baby, absolutely, she was the most vulnerable. Is she going to be able to come out; am I going to be able to carry her to full term. And then, I, as her carrier, was the second most vulnerable. In a way you could say it was me first, because I needed to be able to carry her ... But from my perspective it was her.

Diana Speaks of Vulnerability

Diana felt that her child was more vulnerable than her, despite the instrumental birth, epidural, oxytocin infusion, interventions, postpartum hemorrhage and surgery. She described her son's vulnerability from a physical sense of "being brought into the world and considering the forceps and the cord being wrapped around his neck." She acknowledged his suffering and the risk he faced during birth. Her concerns speak of a woman's desire to do anything to keep her child safe and unharmed.

The nurse who cared for Diana during her intrapartum experience was physically present with Diana during delivery, however her attention was diverted. The nurse did not give her whole hand for Diana to hold; instead she gives two fingers, as she is holding the clipboard. Perhaps the nurse was documenting all of the actions of the doctor and obstetrician while attempting to provide a modicum of support. With the use of fundal pressure and application of forceps that resulted in severe pain, despite having an epidural, the nurse may have anticipated a dire outcome for the infant and the woman. Minute-by-minute documentation clearly outlines the actions of others and a woman's responses.

Lieberman and O'Donoghue (2002) completed a 20 year systematic review of the literature for the unintended effects of epidural analgesia during labour. They found there was sufficient evidence to conclude that epidural anesthesia is associated with a lower rate of spontaneous vaginal delivery, a higher rate of instrumental vaginal delivery and longer labours, particularly in primiparas.

As the obstetrician placed the first forceps into Diana's vagina, she experienced pain at the insertion site (an unusual complaint). The cervix or a portion of the birth canal was caught in the forceps and when the baby's head was pulled, the cervical or vaginal tissue was also torn (see Chalmers et al. 2012). Diana experienced a postpartum hemorrhage, lost consciousness and was taken to the operating room for repair of the cervix and to staunch the bleeding. It is not uncommon to have perineal trauma associated with instrumental vaginal delivery (Marsh et al. 2011; Lieberman and O'Donoghue 2002; Raisanen et al. 2012).

A postpartum hemorrhage is defined as a loss of more than 500 millilitres after delivery and occurs in up to 18 per cent of births (Anderson and Etches 2007; Elbourne et al. 2001). A study in Canada indicates that there has been a recent, unexplained increase in the frequency and

possible severity of postpartum hemorrhages (Joseph et al. 2007). Blood loss that exceeds 1000 millilitres is considered physiologically significant and can result in hemodynamic instability with the potential for further blood loss and other severe complications (Davidson et al. 2012). Today, postpartum hemorrhage continues to be one of the leading causes of maternal mortality around the world (Patel et al. 2006).

Francis Speaks of Vulnerability

Well, the basic answer would be the fact that I'm almost naked. People are poking and prodding at my private areas. Where it used to be private and is no longer a private area. There's also the sense of being vulnerable in the medical arena. Things being taken, like the power being taken away, being physically exposed and emotionally exposed. [I'm] feeling very naked on different levels and, also, the realization that I can't get this baby out. I can't do it on my own and then asking for help, because I really wanted to do it on my own. I'm a woman—hear me roar—and I'm going to do this on my own without medication and without all this stuff. Then going, 'I can't do it.' So that was bad.

In being poked and prodded in her private areas, Frances is speaking about the invasiveness of vaginal examinations (Dixon and Foureur 2010). Research conducted by Bergstrom et al. (1992) videotaped women during the second stage of labour to determine how caregivers (physicians and nurses) performed sterile vaginal examinations. Results of the study showed that examinations were done in a ritualistic manner by all the caregivers and the way the ritual was enacted, repeatedly demonstrated the power of the caregivers over the women (Bergstrom et al. 1992). A more recent study conducted by Swahnberg et al. (2011) in Sweden

on 4,453 female participants demonstrated that most women reported some degree of discomfort during vaginal examinations. In this study, one out of every five woman reported strong discomfort during vaginal examinations (Swahnberg et al. 2011). Further, women who have experienced sexual or physical abuse expressed further traumatization and flashbacks associated with PTSD from vaginal examinations (Seng et al. 2009, 2014). Hassan et al. (2012) interviewed 175 Palestinian women who reported pain, discomfort and embarrassment following vaginal examinations during labour. One woman felt that the doctor was punishing her for being pregnant; others felt the physicians were more aggressive, exposing women's bodies excessively and in an insensitive way (Hassan et al. 2012). Overall, women feel pain, embarrassment and shame during vaginal examinations and practitioners perform this skill in a variety of ways that render women vulnerable.

Francis' feeling of being naked and exposed on many levels is compelling (Lyerly 2006). Her own preparations and hopes for the birth she envisioned were not possible. She was disappointed in herself and has a sense of failure, disempowerment and loss of agency (Martin 2003; Lyerly 2006).

Isabelle Speaks of Vulnerability

I felt a great responsibility to [my son]. As a mother, you feel responsible for that baby growing inside of you. You feel you haven't done what you're supposed to do when you end up with an early birth or something goes awry.

Strangely enough I think of my husband, because he is on the outside looking in and for him it's very scary. When you're actually in it yourself, you're so involved in all of what's happening to you physically [that] you

don't think about your own vulnerability that much. But for my husband he was very vulnerable for the potential loss of his child and his wife. Looking at that, that's huge. Whereas for me, in the middle of it, very sedated a lot of the time, the edge is taken off. You live from second to second, moment to moment, really just trying to get through this tunnel to the end. You don't even really think of the end, you just sit right in the middle. You're right in the moment, so you don't really feel your vulnerability. I remember going to surgery for the ruptured appendix and saying to the doctor, 'Will the baby be all right? Will you look after the baby? Make sure the baby's OK.' I didn't say, 'Would you look after me.' [Rather] would you look after the baby? That's your uppermost concern. I think that's part of mothering, isn't it? Your child always tends to come first.

Kristeva writes that "Nothing is more sacred, for a woman, than the life of her child" (Clement and Kristeva 2001:56). She is writing about her child who is hospitalized as she waits for his return from surgery. She speaks of a mother's connection to her child that stems from "being" and is distinguished from "doing," which will occur only later with the drive, desire and acts of mothering. A mother "is simply there, the mother, with a part of her that is already an *other*," that, outside motherhood, "no situation exists in human experience that so radically and so simply bring us face-to-face with that emergence of the other" (57). Love for a child defies description. Love and a sense of connection to a child extend us and, as mothers, we place our child's welfare before our own. As mothers, we make meaning out of the struggles in life in an effort to avoid going mad.

Lyanne Speaks of Vulnerability

My baby! My daughter, in the beginning and then me, probably, ran a close second. I mean she was more at risk physically. I was more at risk socially or emotionally. The actual birth itself ... there was this huge thing about making this decision about whether or not she should be born or not, at that time. So, I felt really scared about whether or not I was making the right decision. Then there was the experience of having a C-section and being wheeled into the NICU to see her. I felt helpless. I could barely move I couldn't hold her; I just sort of grabbed her hand. Afterwards, I didn't feel a lot of the support that I needed, aside from Linda and a couple of different nurses [at the hospital]—they have such an important and huge job. It's really hard. A social worker came and saw me once. Then nobody did, until I had an incident that I reported. So, I think that lack of support really made me more vulnerable to postpartum depression and PTSD actually.

In this “incident” Lyanne referred to reporting a nurse for being rough with her baby and herself while assisting her with breastfeeding. Lyanne reported that the nurse was consistently harsh and abrasive in her actions to others as well as herself during Lara's hospital stay. Further complicating the situation, Lyanne's baby was intrauterine growth restricted, where the foetus is not growing in the uterus and weighed only two pounds at birth. This diagnosis meant the infant fell into the category of extremely low birth weight (ELBW) and was considered at high risk for medical complications, such as cerebral palsy, visual and hearing impairments, as well as cognitive deficits (Dougherty and Luther 2008). Lyanne's desire to breastfeed her infant ensured

that her baby had nutrition through expressed breast milk (EBM). For the ELBW infant, as for the term infant, breast milk is the optimum nutrition offering the essential fatty acids that enhance gastrointestinal, retinal and neurological development (Innis 2007). ELBW infants who receive expressed breast milk partially or exclusively, while in the NICU, are more likely to have cognitive scores within the normal range with higher motor and behavioural rating scores than do NICU infants who do not receive breast milk (Vohr et al. 2006). Lara received breast milk for several months through Lyanne's dedication and perseverance to express her breasts. Benefits to small infants receiving human milk from an early age include a reduction in length of hospital stay, a lowered incidence of gastric complications, lower case fatality rates and a reduced occurrence of hospital-acquired infections (Ronnestad et al. 2005).

Parents of premature infants assume the role of parenthood under highly stressful hospital conditions before they are ready for it (Valizadeh et al. 2014). Separated from their fragile infant, unable to feel part of their care, concern for their survival and with limited opportunities to interact, it is revealing that mothers report symptoms of depression (Davis et al. 2003; Logsdon and Davis 1997; Miles et al. 1999). Women are vulnerable to a variety of issues due to lack of control and support during labour and birth and exclusion from decision-making and choice. In addition, procedures such as epidurals, forceps and induction undermine women's authority and this disempowers them (Lyerly 2006).

Taking the Experience of Difficult Birthing into Mothering

One could not imagine that a single event that "should" be happy, can so profoundly shape and mould women's mothering experience. All the women were asked if their experience of a difficult birth was taken with them as they mothered. In the comments from the participants we see how a difficult birthing was carried with the woman as she matures (Forssen 2012).

“I Didn’t Have Control like I Thought I Should”

Amber recalled how she has taken her birth experience with her as she mothered her first born, but also her other children.

I think one thing I’ve learned from having kids is sometimes you don’t have control over things [laughing]. Maybe that was the start of it, realizing I didn’t have control like I thought I should. I can’t control my cat or my children. I can educate and support and recommend. But, as Avril gets older, she’s becoming more independent, so it’s not like I have this power over her. So you don’t always have control and that’s what it is.

Amber’s lack of control from her delivery is a theme in her life and her partner’s support added to her sense of working together. “The other part of that was the support that I had and knowing that I’m not alone. That experience opened up, for me, that I have support because Allan was so helpful in supporting me.”

Healing: Legacy of Abandonment

Barbara talked about her difficult birth, how she has matured and has used her pain to heal her own wounds.

The abandonment that I really felt so acutely during her birth ... it’s been a big part of my own personal healing journey. I’ve been very aware of my own experience as a child feeling that. So, as a mother, I’ve been very committed to not repeating that for her. So, it’s been healing for me to have that experience; definitely a deeper awareness of honouring that connection.

Barbara also described a circle of pain that played out within her family.

When I think about her [daughter], her maturity, I think she's felt abandoned, too, by her father and step-father in some ways, definitely. Yet, she and I have always had each other. So it's like our connection became even stronger because of that. She'll say cute little things to me sometimes like, when we think the same thing, she goes, 'Yeah, Mum, that's because we've got a connection.' And she knows it.

The effect of divorce impacts a child socially, economically and developmentally through the altered structure of the family. Barbara's close connection to her daughter and her ongoing personal work to heal her own pain provided strength, dedication and commitment to her daughter's well-being.

“I'm Their Rock”

Carol described the impact of her difficult birth on her children as she has matured and how she sees herself as a mother.

I'm pretty proud of myself because that was really hard. Then I had some hard years with the kids. So it's all wrapped into the whole 'being a mother' experience. It is part of the birth experience, you've got to be strong and you've got to survive. You've got to do whatever you need to do to get that baby into the world. Then you take a job and need to work. It's all related to motherhood. For the most part, I'm crazy about my kids and they're all living with me still, so I must be doing something right. I'm proud of myself to be able to be that rock and that's all related to that birthing experience. It's all stems from there.

“It’s a Cycle”

Diana’s childbirth was an unsatisfactory experience and her difficult birth also stayed with her as she has matured. When we spoke, her husband had been recently diagnosed with a benign tumour, which had been removed. He was now in a wheelchair working towards rehabilitation.

It’s sort of what I’m going through now, with my husband, as well; it’s very much a chapter. It’s a cycle. Because you start with your first, second and third trimester and then there’s this newborn. Then you get the toddler and all of these different levels and preschool. There’s constantly going to be cycles; there are challenges. Childbirth—I shouldn’t say childbirth—labour and delivery was not fun. It was definitely not a fun experience for me. It wasn’t anything that I’d look back on with wonderment and excitement and hopefulness that, sometimes, new mothers get. It was an attitude of okay, this is what’s going to happen. Get the information that I need and let’s work with it and go forward from there. I think that’s how I’ve played out in my life, really. Okay, this is what’s happening. This is a challenge. What are the tools we need to overcome it?

“Close Connections”

Eileen’s response to the question about how her difficult birthing experience affected her as she has matured was that she recalls the birth when she is dealing with current personal strife. She emphasizes that the connection she experienced at birth is a constant reminder of closeness recalled when faced with disagreement with her daughter today.

If we're having issues, I remind myself of when she was first born and laying on me. I thought she was perfect then [laughing]. So she must still be perfect now and I've got to find that perfection again [laughing]. I think for me as an individual, it helps me grow and change. I look at the connection that we once had and so I know that we can still continue to have a close connection. That those ties you've created thirteen years ago are still there; we're here for the long run.

“Pushing and Pulling and Tugging”

Struggling with the birth of her son, Francis saw similarities with her child's current behaviour that causes friction for her as a parent as she sees her difficult birth mirrored in her child's temperament.

I spoke about him being a difficult birth and being, sometimes, not all the time, but sometimes, a difficult, excitable child. Where he's pushing and pulling and tugging. I think it's brought us closer in a way. Just before he went to school, the last few months of day care, he was not happy. He wanted to leave. He was acting out and stuff. And as kids age, they go through phases. There was a while there, when I thought, we're getting on each other's nerves, this is not great.

But with him going to school and the new changes that are happening, it brought us closer, too. So I've been really feeling close with him again. We actually went through his photos just before you arrived, because I was looking for photos for you. And just the look in his eyes and he was, 'Wow, that's you and that's me. Wow! And wow!' I fought to get him

here and I will fight for him until the day I die [laughing]. I guess you think about that. You think, I hope he knows that. I hope he'll know that when he gets older. Sometimes a fight is good when you're fighting the beast out there. We sure know how to fight together against each other. But we're also really close. So that will be with us forever, hopefully, that we'll be close like that.

I used to think it was the worst thing in the world, this birth, it was terrible. As I get older, I've had another birth and I've seen other people have births. And when you mature and you think okay, right, well that was that. Right? That was that and now we're here. It's okay; it's sort of healing, isn't it.

“War Stories”

Thirty-three years later, Gillian is thankful to have her son in her life.

I've taken it [the difficult birth] with me as a story, it's part of who I am. Like with Gage, the crisis and the emergency birth which could have turned out worse, because he may have been affected or not lived. That we got him out of the deal and he's an amazing baby, child, son to this day. He's so worth it. It's just part of my story; it's part of my war stories [laughing]. Gratefully, I can reflect on it honestly and know it was hard but I came through it and I'm okay and participating in this [research], to hopefully change things. Maybe, who knows?

Women do not usually speak of their birthing experiences as “war stories,” such labelling of the birth is emblematic of her sense of having survived difficulty and adversity.

“It’s Always Part of Me”

Hillary felt that her birth story was about her, not about her child. It was her experience and her wound, not her child’s.

It’s always part of me. I mean she knows the basics of the story. I never wanted to make—the trauma of that event in my head and in my heart—it isn’t hers at all. It’s never been something that I’ve wanted to make her story because to me her story is not that. So maybe for me all it’s done is reaffirm how I need to be in situations, medical situations especially. For her, I don’t know if it’s really her story. It’s just one more thing that makes you different. This was your story.

Hillary did not want to burden her child with the story of a difficult preterm birth. She wanted to keep her daughter out of the negative aspects and to recall only that Heather is loved and wanted.

“You Live Around the Scars”

Isabelle’s surgical scar is a symbol of their life together with her husband.

I have this huge scar on my stomach from that surgery, because it was an exploratory laparotomy, so it’s large and I was very pregnant. So Ivan [husband] always talks about it as one of our trophies of our life together [laughing]; just a life experience that we came through. Those are the things you think about. Ivan and I just think about those things as parts of our history, parts of our life together. The hard parts that we lived through and conquered and have come around. Now we’re a happy family. It’s funny, at the time it’s so traumatic and then, when you look back ... We entered the tunnel and we came out the other end and we’re O.K.

When people asked her how she managed through her life with a child with special needs, as well as a preterm infant, Isabelle recalled that

Well, you just stand up and look ahead and move through it. What are you going to do? You can't give him back. You just have to cope with it. I guess that's Ivan's [husband] and my philosophy, too, just get on with it. Those are the scars you bear. Life has its injuries and its traumas and the scars are left, but you live around the scars. You think back about all the good things, remember the good parts. I've always tended to be a glass that's half full, anyways, rather than half empty.

Isabelle talked of the learning she acquired through her life, the losses other people face and finding a way through difficult times.

It gives us wisdom. You learn that you're strong as a couple. That you get through those things. We often thought back. There are lots of couples who fall apart when they have a special needs child or a very difficult delivery with a preemie or a baby that's demanding and needy; trying to deal with two other children as well. But luckily, we were fairly grounded, because so many people don't make it.

Seeing the “Big Picture in Life”

On her difficult birth, Jennifer says that,

It changed me more than I could ever describe and in so many ways. It made me see the big picture in life. The counselling helped me develop so many more qualities. I try and really let the little things go, as best I can.

Fragility and Fear of Loss

Karen reiterated, “Like I’ve said, he’s the fragile one to me [laughing]. So I’ve taken that with us.” She went on to describe her ongoing worries for her child as he moved through high school, how quiet he was:

Maybe that’s from the birth experience and that whole fear. He was just so quiet as a baby, too, and then, going to the hospital when he was two months old for a time with that weird fever. I feel like he was the one I could have lost. I just love him and hug him every moment that I can. I do with all of my kids. They would all say that.

Hypervigilance and Bonds

Being over-protective describes a parent who pays extremely close attention to a child's experiences and problems, particularly at educational institutions (Roiphe, 2012). The term helicopter parent is so named because they hover overhead. Lyanne described her “helicopter parenting,” where she is vigilant in caring for her child.

I’m a little, a lot, working on hyper-vigilance around her safety and her. As I’ve matured, I have, kind of, processed the trauma that occurred. So, for several years, her birthday was really hard for me. I tried to be—I was joyous for her—but for me, it was like a big anniversary of a trauma. I’ve worked through that now and so I don’t have that same experience. As I see her growing to be a healthy, wonderful, beautiful young woman which helps in letting go of the trauma piece, as well and my hyper-vigilance. I think being a mother, just naturally, you just worry about your kids and want to protect them. So I’ve been able to temper that. Linda’s great to

help me do that because she'll say or, even Lara will say, 'You're kind of freaking out about this Mum; I don't really think it's that big a deal.' It's like okay I've got to think about this some more [laughing]. It's fine for her to say that to me; I don't mind at all. It's common knowledge that I have more anxiety in this family than your average one does [laughing]. We've got a really close relationship; I think part of that comes from that [birth] experience. I feel really fortunate about how everything has turned out. Like how we've coped and how we've grown from it and the bonds.

This chapter sums up women's experiences of guilt, love and vulnerabilities they felt during birth. Ten women participants experienced guilt and some feel guilty to this day. Many women had worked through their feelings of guilt and some were still working through aspects of guilt. The women shared when they felt love for their child, their sense of vulnerability, how their difficult birthing experience has affected their lives and how they have taken this event with them as they have matured. Lessons have been learned and their lives have been affected by the births in multiple ways, informing who they are with their children today.

Themes from the Women's Experiences

The women in this study have described their difficult birth and the meanings they made from their experiences. Women have an embodied understanding during pregnancy and birthing that HCPs do not always appreciate or necessarily respect. Being questioned and supervised, for some women, was demoralizing in the hospitals. Following birth, many of the women were surprised about the time it took to heal and recover. For Francis her recovery took a whole year. Women felt shame and guilt when events during birth do not go as planned or anticipated, which

can take years to work through. Being ignored or denied causes great disruption in trusting others and heralds emotional issues that may enhance depression.

Fathers and partners are often left out of situations concerning their partner's childbirth. Yet having a supportive partner, who is there for the woman, can bring about closeness, ameliorate a difficult birth and the effects are positive and lasting for the relationship. Perhaps one of the most profound elements within this study is the impact that leaving a woman alone during labour has on her and her relationships. Fears, uncertainty and abandonment result in profound insights and changes in relationships. A partner leaving a woman during times of difficulty through labour and birth or women who are left alone or abandoned by hospital staff is a recipe for blame and places relationships in jeopardy.

The guilt women feel from birthing situations does not entirely go away; it is processed over time and dealt with in pieces. Women, in this study, loved the thought of having a child and love began prior to pregnancy, during early pregnancy and after birth, depending on the woman. Having a difficult birth can have the effect of a more intense attachment feeling with the child that, for these women, has a lasting effect. Adversity somehow brings people together and makes the relationship between mother and child a closer more intense bond. Women make meaning from their experiences and they take this learning with them as they mature as women and mothers.

Reflections as a Woman, Nurse and Researcher

As I listened to the women tell their stories, I have been amazed how my own participation and unawareness of potential traumatizing effects my actions may have had on women reflecting my taken-for-granted assumptions (restraining women to operating tables). In particular, as Lyanne talked about being restrained, I found myself wondering about the extent to

which I had participated, unknowingly, harming women through the various actions as I engaged in “normal” hospital practices.

I recall working on the postpartum unit, many years ago, and speculate on approaches I supported that have added to the dismissal of a woman’s rights. I remember one particular woman who had been admitted for being at risk for preterm labour. The obstetrician wrote in the physician’s orders that she should not go out to smoke. Later that afternoon, the woman informed me she was going outside to have a cigarette and we strongly disagreed. During the early evening, after a great deal of thought and self-reflection, I realized that I had failed to advocate for her. I apologized to the woman for my belief in the doctor’s power to overrule her personal autonomy. I realized I was complicit in her marginalization and stigmatization.

Similarly stories of birth bring forth a sense of symmetry and cohesion in women’s worlds. During her story of birth Francis shares her distress at trying to give birth after pushing for many hours. I, also, felt this way at my first delivery and understood her desperation. Similarly, when Francis spoke of giving birth she experienced a great connection with all the other women who had given birth before her, I too, felt this way of being connected with all women who had given birth throughout history.

For Diana, I was amazed when she described how she had given birth. I had never heard of fundal pressure or its practice in current day obstetrics. I vaguely recall stories of desperate attempts to dislodge a child in olden times but had never witnessed nor heard of it from current practice. Very little is available in the literature and I sought expertise from a seasoned nurse who described her experiences with fundal pressure when she worked in other countries. I have also pondered the nurse’s actions in Diana’s delivery since hearing this story, trying to imagine what the nurse was thinking and why she did not offer her whole hand as a measure of support of

a laboring woman. Or was the nurse in support of the harsh treatment by the obstetrician and only providing a minimum of support. One can only speculate on the nurses' motivation.

Perhaps most disheartening is the lack of assessment and attention some of the women received by nurses and physician's. In Hillary's story, I felt uncomfortable about her disconnecting and reconnecting the monitor in order to use the bathroom. It raises some serious questions about her physical care and the extent to which her care was lacking. Similarly, I was disheartened and disappointed in the care that other women received at the hands of my professional colleagues and struggled to understand this lack of care.

The next chapter I address the major areas that emerged from the research, including the themes of surveillance and authority of HCPs. The topics under these larger headings include authorial voice, silence, being diminished, ignored, isolated and projections of stigma.

Chapter 10 Difficult Birthing and Surveillance

Six distinct *conceptual dimensions* emerged from the participating women's stories of difficult birth. These narratives are defined by a series of contextually complex events. Many of the conceptual categories overlap and intermingle but have been separated for ease of discussion. The following unfolds as an unravelling of the women's experiences in order to focus on how control of birthing women was perpetuated and sustained through visual surveillance by the authority of health care practices. The major heading of surveillance, described below, is significant to all six areas revealed in this chapter. The ways in which surveillance was enacted is seen through the authority of the HCPs called the authoritative voice perpetuated through the categories of enforced silence; bullying, including being ignored or being made to feel stupid; neglect; isolation; projected stigma; and, ethical issues implicated in practice. I begin by unravelling the relationships supported by patriarchal practices embedded in institutional arrangements.

Surveillance

Surveillance is a means of watching and looking over people (Bentham 1995) and is the methodical monitoring of people or groups in order "to regulate or govern their behavior" (Monahan 2011:498). HCPs engage in examining a patient, in this case the pregnant woman, to assess her perinatal requirements to enact care in ways they deem appropriate for the woman's situation. This care entails observation, scrutiny of physical wellness, inspection of foetal development and supervision of gestational growth. Surveillance of pregnant women requires particular kinds of knowledges, positions and power (Walsh 2010). Medical surveillance can undermine women, as it questions women's understandings of their own bodies and treats them as objects (Goodwin-Smith 2012). Surveillance of this nature also assigns priority to the foetus

where women can be controlled and blamed for the health of their unborn child (Jackson and Mannix 2004; Wetterberg 2004). Furthermore, women are seen as being in an adversarial relationship with their foetus, particularly when the foetus is in jeopardy or requires surgical intervention prior to birth. Women have been ordered by the courts to endure surgeries and other invasive procedures, privileging the foetus over a woman's personal authority or sovereignty (Paltrow and Flavin 2013; Redfern-Vance and Hutchinson 1995).

In addition, language used by HCPs affects the care women receive through privileged knowledge and terminology that is often not shared or understood, thus indirectly keeping women under medical control (Behruzi et al. 2013; Dubriwny and Ramadurai 2013; Hunter 2006; Jacobson 2009a; Martin 1987; Martin 2003). Surveillance potentiates power relationships and is "evident when status and other hierarchies are pronounced" as preferential over others (Monahan 2011:495). Assymetrical relationships of power and knowledge can work to undermine an individual's dignity and may affect health (Jacobson, 2009a, 2009b). Jacobson's (2009b) taxonomy of dignity identifies sixteen social processes that violate dignity and have the potential to affect health. Violations of dignity were categorized as rudeness, indifference, condescension, dismissal, disregard, dependence, intrusion, objectification, restriction, labelling, contempt, discrimination, revulsion, deprivation, assault and abjection.

The Authorial Voice

Doctors, midwives and nurses hold positions of power within the health care system based primarily on their knowledge, skill and expertise with the scientific model's emphasis on efficiency and effectiveness for facilitating control (Jacobson 2009a). The rise of health care technology, particularly in childbearing innovations, has the effect of controlling women's bodies and distancing women from their embodied experience at a time when they are deeply

involved with their bodies (Davis-Floyd 2001; Neiterman 2012). The more technology is made available, the more the birthing processes conform to the patriarchal institutional structural processes, rather than the woman's personal wishes and desires (Behruzi et al. 2013; Davis-Floyd 2001). In the hospital system of childbirth, the beliefs and philosophies of the primary HCPs guide their practice. The combination of power, knowledge, authority and technology congeal into an authorial voice that dictates how care is provided and how birthing will proceed (Behruzi et al. 2013; Hunter 2006).

Enforced Silence: Failure to Inform or Include Women

Women's bodies are seen as objects of study (Haraway 1988) and any object is subject to the control of others (Goodwin-Smith 2012). Women are particularly vulnerable to control during labour and birth. During pregnancy women build relations of trust with medical personnel based on the latter's expertise in birthing knowledge so they can care for the woman during birthing. Over their pregnancy, women work to develop trusting relationships with their physicians and midwives—and later, in labour and birthing, with the nurses—and do not expect that their wishes will be ignored. In this study, ten women spoke of being disrespected, their assessments of their situations were not believed and they were not informed about procedures. They received little or no explanation about the risks of medical interventions, their interests were dismissed, neglected and ignored and those vested with authority were in control (Weingarten 1997). Some of their comments follow.

Amber believed the physician had plans for a speedy birth rather than attending to her labouring and birthing process, however long it took. She experienced artificial ruptured membranes, a complete block from the epidural, forceps delivery, episiotomy with a third-degree tear and complications with C-difficile. Barbara gave birth in front of a group of medical

residents, with one resident performing her episiotomy. It was not the birth she had planned for or desired. Diana was the recipient of a “managed labour,” with an induction that included epidural analgesia, the use of forceps, the application of fundal pressure, a third-degree tear of her perineum, a postpartum hemorrhage, as well as surgery to repair her torn cervix.

Furthermore, her blood loss was not replaced, despite prenatal anemia and her recovery took months. Eileen had a prolonged labour, was overseen by a series of care providers—some competent and others whose practices were questionable. Her physician yelled at her, demanding she submit to a caesarean birth. Gillian had a caesarean birth, performed for a prolapsed cord, by an obstetrician whose breath was described by nursing staff as smelling of alcohol. Gillian hemorrhaged, developed puerperal fever and was not believed by staff when she was seriously ill. Karen was enrolled in a research study that was not explained to her and she had no recall of signing consent forms. Indeed, she should not have been asked to participate due to her complex obstetric history, having had a previous caesarean section and renal complications, which raises the question of the ethical practices of the HCPs.

Birth for these women was not about their process in giving birth. It was about the conveniences of authority afforded to the powerful, institutionally approved HCPs. Here, the women found themselves bound by that control and at the mercy of others. They were not warned or instructed about the consequences of procedures, such as the risk of third-degree tears and potential damage to the infant’s brain and face with the use of forceps during delivery (Birth Trauma 2006). At times, physicians manipulated and intimidated the women through their approaches to health care. Instead, what the women experienced was a series of events lacking in personal caring that amounted to techno-medical birthing that utilized all the professionals’ skills and expertise to control the women and her birthing (Davis-Floyd, 2001; Fenwick et al. 2013).

Complicity of Silence by Nursing: Doing Harm

The complicity of nurses' actions with the obstetrician's approach to care at Gillian's delivery and after the birth is deeply disturbing to me. The nurses did not see her symptoms of illness, fever and infection following surgery and disregarded her complaints because the obstetrician did not believe she was ill. Gillian became increasingly sick and felt she was going to die. Taking up the hegemony of the medical authority, nurses did not identify what was happening to Gillian given their enculturation within the system. Her voice was marginalized and silenced, whereas the power of the physician and his authority are taken up by the nurses. In the absence of any critique, the authorial voice and the authority granted to the physician and the nurses delineated the socially constructed roles that each follows. Gillian's embodied experiences and complaints of illness are unnoticed and she is treated as an object. The nurses dismissed her suffering, ultimately dehumanizing Gillian.

Avoidable disparities between what can be and what is given to women during childbirth become a form of structural violence. The unequal sharing of power, including the decision of where to place attention and resources, are causal factors of structural inequalities (Ho 2007) and can be apportioned to Gillian's experience of birth through the silencing of voice (Farmer 2004; Kurtz et al. 2008). Experiencing the impact of structural violence is understood by people as injustice. Memories, particularly those that are painful, are etched into the body and, in so doing, are carved into the mind (Grosz 1994). Recollections of bodily harm can be interpreted and understood through women's experiences of untold distress.

Diana also experienced highly questionable actions by a nurse who did not provide support or advocate for her during labour. It is uncertain why a nurse would only offer two fingers to hold during birth while continuing to hold a clipboard and pen. The nurse is not

attending to a woman who is in profound pain, there was no advocacy and little evidence of bearing witness to Diana's suffering. The ethical principle of doing no harm has been breached by the nurse who did not advocate for Diana (Cody 2001). If the nurse was concerned about the obstetrician's actions and needed to document the procedures applied, perhaps the nurse could have asked other nursing staff for assistance. The dictates and actions by the obstetrician in using fundal pressure were risky and possibly something the nurse had never witnessed before. The nurse should have recognized that this was an extraordinary action and reported the occurrence. The control of the obstetrician must have been absolute, even for the general practitioner, who willingly performed this controversial procedure without questioning or refusal. These callous actions by all of the HCPs speak of torment and suffering. Yet, no one questions the authority or the ethical aspects of the attending obstetrician; all are in collusion with the hierarchy of authority. The nurse and the doctor are silenced by the obstetrician's status as expert and his influence and power; yet, they go along, compliant with the obstetrician's conduct and complicit in unethical actions. Women are in the hands of the most talented of "healthcare providers, yet are betrayed by those who offer help and claim to have the expertise to help ... [this betrayal] is an experience that carries with it the power to destroy one's faith in humankind" (Cody 2001:295).

When looking at the research on domestic violence one notices that when perpetrators engage in a process of healing they see their part in the oppression (Rose 2013; Walker 1999). Individuals can also benefit through sharing and, in this way, engage in a process of healing (Vachon et al. 2011). Below I discuss the extent to which these experiences of difficult birthing experiences can be described and discussed as a form of violence against women.

Silence or Stifled Responses: Prematurity

For the women (e.g. Carol, Hillary, Isabelle and Lyanne) who experienced premature birth of their children, each situation was highly individual and all women experienced a very different event. With prematurity, there is a loss of control over the birth for the woman and the care providers. It comes as a great surprise to the woman and the HCPs when she presents in preterm labour. One realizes the timing of labour is off and the physicians, nurses and technology work to control and mitigate potential damage (Bick 2012). The event becomes about the process and how it is managed.

Looking at the technology applied to the infant's preterm condition, one sees multiple interventions, such as administration of intravenous fluids or total parenteral nutrition (liquidified food given intravenously). The baby also undergoes tests and blood work that are routine, painful and carry risks of iatrogenic infections and anemia (Higgins 2009; Sekar 2010). The infant may undergo chest X-rays to rule out pneumonia, pneumothorax and other illnesses caused by prematurity. The routes of pain in the application of tests trigger the nervous system and cause repeated instances of suffering (Stevens et al. 2012).

Premature birth is most drastic for the infant but also catapults the mother and family into a highly technical world where the baby's life is watched, monitored and controlled—another aspect of perinatal surveillance. The baby is placed in an incubator and under strict management for all their bodily needs. Staff control when the woman is allowed to touch, hold, feed or care for her neonate (Sawyer et al. 2013). The infant does not belong to the mother and partner; instead, the baby is under the HCPs complete direction and care. Limitations are placed on the woman by the neonatal intensive care units (NICU) staff and mothers are permitted to visit at specific times. The disconnection at birth, the whisking away without explanation, has also made

the woman redundant, powerless and isolated. Lyanne spoke about not holding her infant as nursing staff would say, “She can’t be out of the incubator. If she has too much stimulation, that won’t be good for her.”

A woman’s previous connection with the child is precipitately severed, for both of them. The woman feels a profound loss that the pregnancy is over too soon and her child is so ill. She may feel she did something wrong, that she failed to keep her child inside, safe and protected (Davis et al. 2003; Wood and Quenby 2011). The new mother returns from the NICU to the hospital room or her own home and her dreams of “normal birth and bonding” have drastically ended. Something has replaced these hopes; instead, she is filled with terror, anxiety and concern.

The infant is isolated in a surrogate uterus—the incubator. All of the woman’s bodily processes that kept her child inside have been severed and are now being served by complex machinery, treatments, equipment tended to by others. It is miraculous that technology is keeping the child alive; but, it is foreign, imposing and frightening. For parents and staff, there are many fears about the child’s ability to survive. Now plethoras of revolving professionals are in control; they are privileged with knowledge and imbued with an authorial voice. This can stifle the mother, causing her to feel unimportant and insignificant. At this point, she is superfluous, with the exception of her breast milk, if indeed it is available.

Women’s Silence

Women in these situations often do not advocate for themselves. They remain silent during birthing when things are not going well; perhaps not recognizing the situation they were in or overwhelmed and silenced by the circumstances in which they find themselves. Other situations of oppression stifle voice. When women experience domestic violence, for example,

they often remain silent about the abuse experience. Like domestic violence, the oppression of women during birthing manifests as silence, often overlooked within the institution, excused or denied (Jacobson 2009a). I have often heard that, despite an obstetrician's abusive comments about women or nurses, he or she is a good practitioner and, as nurses, we should put up with this "bad" behaviour, thus failing to acknowledge the damage done by such behaviours.

Women may well be in shock at what was happening to their bodies during labour. I wonder if the uniqueness of the experience hampers her ability to speak out. Perhaps the degree of pain she is feeling stifles her ability to speak (Grosz 1994). The women may be overwhelmed with birthing and cannot put words to their experience in order to ask for something different from what they are receiving.

Recalling my own experience of birthing, I too, did not speak out, could not speak for myself. I was overwhelmed with excruciating contractions. Looking inwardly to my own pain, I could not shift nor focus and did not notice or care about the outside world. I felt pressure that my colleagues would hear my complaints or my inability to cope and so I remained silent. Perhaps the participating women in this study did not speak up for similar reasons. I have pondered over the women's limited ability to speak aloud and perhaps they are speaking in their minds, silently, and not with their voice. Maybe they did speak but did not "speak up" to advocate for themselves. Or, perhaps the powerful hegemony of hospital structures and procedures does not permit a woman to speak. Possibly the pain of birthing and being overwhelmed, as well as the procedures performed on them, are received as normal and, therefore, must simply be endured. Whatever the reasons, many of the women in this study, as well as myself, remained silent as things happened to us.

Every birth is a unique experience, so how can women possibly identify options for themselves, particularly if this is their first experience of birthing? Conversely, what of the partners and their position in advocacy? Perhaps it is too risky for them to speak up; yet they are set up as a coach in an arena where they do not know the rules or how the game is played.

Authorial Voice and Silence: Withholding Information as an Act of Control

What also made the births difficult for these women was the limited information they received, if any, about all aspects of their childbirth. In some instances, HCPs withheld information or explanations—perhaps physician's felt it unnecessary to describe or discuss events that remained in their control. HCPs may take for granted that they know best and go ahead without explaining procedures to the woman and her family. Or, possibly they assume the situation is too complex to explain. There might be assumptions made that women already know or should have known prior to getting pregnant and giving birth. In this way, the HCPs may label this not knowing as ignorance and justify their own actions based on these assumptions (Jacobson 2009a). A function of not fully disclosing the risks of care during labour serves to protect the HCPs from litigation. Whatever the reasons, through their silence, HCPs maintain control over protocols and neglect to fully educate the women about their actions, such as not informing women of the use of forceps and the associated risks or the implications of rupturing the membranes.

Amber, Barbara and Diana all experienced epidurals and forceps delivery and all had an extension of the episiotomy and a tear into their anal sphincter. Not one of these women was informed about the potential for tearing of the perineum with the application of forceps. The women were also not told about the risks of forceps or suction to birth their babies. All of the women had epidural anaesthesia and could have focused on what the physician was saying to

them, as they were not in pain. The physicians had complete control. HCPs should be warning women about the risks of forceps and potential damage to the perineal floor.

When asked about having residents observe her birth, Barbara said she felt pressured to agree. She did not realize the numbers of people who would attend. Barbara felt vulnerable, dependent on the staff and unable to refuse the presence of voyeurs. She also did not realize or consent that a resident would perform the episiotomy.

Other women also pointed to a lack of sharing about things that occur. Diana obtained little information about the pathway of induction. She experienced an “active management of labour” that led to an instrument birth. Later the next day, after delivery, her physician tells her that she should have had a caesarean birth. If Diana had the ability to decide, she may well have opted for a surgical birth. Her physician did not advocate for her to the obstetrician while she was birthing her baby. Perhaps for Diana there is some solace in knowing that the delivery was difficult, as the physician later acknowledged.

Authorial Voice and Silence: Acts of Punishment

Diana’s treatment by her own doctor and by the consulting obstetrician was punitive. She experienced a highly controversial procedure of “fundal pressure” and her cervix and vagina were torn during forceps application; she hemorrhaged but blood loss was not replaced postpartum. Compromising her further, after delivery, her doctor told her that she was anemic prior to birth, yet did nothing to ameliorate her low blood volume either in the antepartum period or following birth. His behaviour could be interpreted as unethical.

Gillian’s knowledge of her own body was rejected and she was given very little information about her condition. During her first week in hospital following birth, her symptoms of infection were dismissed and ignored by many shifts of nurses. It was not until the “angel

nurse” validated how sick she really was that her condition was treated. This dismissal of knowledge is not in keeping with the nurse’s duty to care. I wondered why the angel nurse spoke up—why was she the only one who could see Gillian’s illness.

Karen was never told the reasons that her child was “born flat” and no explanations have ever been forthcoming despite her request for the medical records of her birth. Karen’s enrollment in a research study revealed that a thorough review of her particular situation was not considered or completed. Subsequently, she received a placebo or prostaglandin that had untoward results on her infant son who, when born, was highly compromised. Despite the mandate of surveillance for pregnant women’s bodies, these women experienced a lack of health care scrutiny that speaks of negligence, stigma and abuse.

Kept in the Dark: Silence through Omission

Lyanne’s physician, during her early pregnancy, did not tell her the ultrasound revealed a placenta previa on her first scan. Later, she had a conversation with the physician, who rationalized that she did not want to cause Lyanne distress. This paternalistic behaviour kept Lyanne ignorant of future potential problems.

When a woman gives birth to a preterm infant, the woman questions herself and all her actions and the actions of others as to why this occurred. She often assumes she is flawed, that her body failed to keep the foetus inside until term, thus placing the infant in jeopardy after birth. Assigning culpability or predicting causes of illness are often not discussed with women by their HCPs, leaving women to believe they must be at fault (Miller 2007). To discuss and explore complications of prematurity and its causes, requires time and energy of the HCPs to explain and reassure, which opens up further potential for blame and litigation.

When HCPs hold onto and do not share knowledge, this makes knowledge esoteric. Knowledge seen in this way is powerful, controlled and “sacred.” If the birthing woman is not appropriately informed she remains ignorant and without control. For two of the women (e.g. Gillian, Hillary) their knowledge of their body was ignored and they were not considered legitimate knowers (Green 2011; Lorentzen 2008). Body knowledge is private, non-scientific knowledge, not justifiable in the medical arena. This delineates, very clearly, who is in power and who is not. Birthing women are not always knowledgeable about technological birthing and a lack of sharing knowledge by HCPs is perpetuated as a means of control (Davis-Floyd 2001). Women’s bodies are seen to be made of parts or fragments by the practices of scientific medicine, which profoundly alienates women from science itself (Walsh 2010; Wetterberg 2004). With this reductionist conceptualization of women’s understandings, it is no wonder that knowledge about the body is seen by the HCPs as moving beyond the woman’s ability to understand.

The women participants in my study experienced a deprivation of information concerning what was happening to their bodies and their infants. They were not told the risks. They were not seen as needing to know. They were subjected to the authorial voice of medical science that regulates what is communicated, thereby affirming the control of the women by the power of the institution. The withholding of information is a form of patriarchy and paternalism. Under patriarchy, birth becomes structured misogyny through institutional surveillance. If a woman does not do what is prescribed she is seen as failing and could be punished for her misdoings (Wetterberg 2004).

Authorial Voice: Bullying and “Made to Feel Stupid?”

Women and their partners are encouraged to attend prenatal classes where they learn about birth and the postpartum period (Bergstrom et al. 2009; Fabian et al. 2005; Stoopnikoff 2011). Physicians rely on prenatal classes as a means of saving time and to describe processes the doctor may employ (Koehn 2008). Women are watched and scrutinized about their knowledge of infants and their care in the postpartum period (see Barbara and Jennifer). When some of the women showed a lack of knowledge, they were made to feel inferior and second-rate. They were scorned and shamed for seeking help.

Nursing is described as a helping profession. Yet some of the women experienced pejorative judgements by nursing staff. Six women described situations where they were made to feel inferior, lesser and stupid. The message of being ignorant was another way women were controlled. Women are expected to come into motherhood knowing about the birthing process, albeit a stylized version, which in fact, undermines the realities of what really occurs (Longmore 2004). A neutralized apolitical minefield of structured misogyny, in which an idealized version of reality becomes the normalized depiction of birthing, a fantasy that renders the woman incompetent by the very fact she is not able to meet what is held up to be the usual or standard practice of childbirth (Nolan 1997). The women, ironically, are expected to know about infant care and to advocate for themselves in situations that they have never before experienced (Sturrock and Johnson 1990).

Women imagine they will be guided through the process of delivery (Miller 2007). They also believe that childbearing is predictable and the idealized birth, presented by antenatal education, will be how they experience their own deliveries (e.g. Jennifer). Compounding the

need for informed choice, they are labouring, trying to give birth and they are in pain. This is not the right time for women to focus on self-advocacy.

Barbara shared that a nurse made her feel stupid about not knowing how to diaper her infant. This is a simple task for the maternity nurse comfortable in caring for infants but a more difficult task for a woman who is recovering from birth. The obstetrician believed that Diana did not know how to labour because she had not attended prenatal classes. His indifference is a violation of dignity (Jacobson 2009a). This denial of Diana's body's ability to give birth is the "crazy-making" aspect within the health care system. Birth is a "natural" process and most women are capable of giving birth, yet the system does not believe that the women's body "knows" what to do in normal circumstances and undermines her belief in herself when things go wrong (Goodwin-Smith 2012).

Eileen was treated as though she was ignorant about newborns and their care, despite her extensive knowledge of child care and infant development. Questioned by the nursing staff, Gillian was accused of not wanting her infant and was asked if she had taken care of children. Furthermore, she endured questions about why she was not bonding with her baby or picking him up. Staff take for granted that every woman who is pregnant has cared for children or can care for them.

Hillary was made to feel stupid and the knowledge of her own labouring body was denied. HCPs, both doctors and nurses, did not assess her, palpate her contractions or read the signs of impending birth and dismissed her symptoms of labour and birth as heartburn. Her vaginal swab indicated that the fluid did not test positive for amniotic fluid. Faith in the scientific approach and in technology limited the ability of the staff that night to move beyond their tests

and the constraints of these methods to see what was actually happening (Macionis 1997). HCPs take for granted that their assessments are correct, denying women's embodied experiences.

Bullied into Submission: Ignored and Neglected

Bullying is the systematic abuse of power, characterized by repeated, intentional aggression against another person. Bullying is an imbalance of power (Jacobson 2009a; MacLellan 2014; Olweus 1994). For women abusive relations and power imbalances are often taken-for-granted aspects of female life experiences. Abuse of power is often called oppression and, for women, this tyranny could be termed structural misogyny. For women who are giving birth, the patriarchal system is set up to control them as part of the hierarchical structure of the hospital system (Davis-Floyd 2001). Women are required to be obedient, compliant and acquiescent to the ministrations of others, particularly during birthing (Yoshino 2008). What is perceived as obedience can be described as the everyday expectations to which women are required to adhere (Martin 2003). As with the outcomes of bullying over a child's early life, researchers have identified that the impact of bullying casts a "long shadow" over the health and wellness of those who experience it, a shadow which stretches well into adult life (Wolke et al. 2013).

Aspects of bullying can also be seen in the dismissal and the neglect of women who HCPs are charged with the care of. Isolation and lack of care were experienced by participating women during their hospitalization. Five of the women identified their difficult birthing experience as due, in part, to a lack of care or assessment by staff assigned to look after them. For example, Francis came into the hospital in labour and the maternity unit was completely full of birthing women. She was left for long periods of time to actively labour unattended. When the other deliveries were completed, Francis was seen by the midwife and her nurse. Once there, the

nurse refused to leave Francis to go on a break. There was implicit recognition from the nurse that Francis had not received timely care or appropriate assessment due to inadequate staffing. Francis was seen as the “next in line” for service, giving rise to the idea of production lines rather than health care.

Gillian did not receive a thorough assessment. One week after the birth of her son, another obstetrician diagnosed puerperal fever or sepsis. Now, with the diagnosis of sepsis, her care increased exponentially. Believed to be ill, Gillian was given understanding and empathy, medical treatments of blood transfusion, intravenous fluids and antibiotics and placed in isolation.

Similarly, Hillary received minimal care and laboured on her own with her husband for support. She delivered her baby’s head without a professional in attendance, since HCPs had rebuffed her active labouring. One nurse comes to investigate Hillary’s husband’s call for help soon after the infant’s head was delivered. Hillary’s understandings were marginalized and her embodied experience was ignored and disregarded.

Jennifer was cared for in the labour unit for twelve hours prior to anyone noticing that her baby was in a breech position. Her clinical situation went unnoticed and she suffered hours of unnecessary labour and pain. Following her caesarean section, Jennifer received no information at discharge about post-operative pain management. She also had an infection in her incision and she experienced postpartum depression. Her lack of care speaks of neglect.

Karen was not given a choice about being enrolled in the study on prostaglandins. She did not remember signing a consent form or receiving any verbal or written information. She recalled that, if it had been explained to her, she would not have agreed to be part of the study.

She was shown no empathy or compassion from those who sought her participation. Herein lies significant ethical concern about the lack of consent that can be read as misogyny.

Each of the women discussed above, received inadequate assessment by doctors and nursing staff when they were admitted and for some, throughout their hospitalization. The women's care is best described as shoddy, unethical, punitive and marginalizing. Two of the participating women were not considered to be in labour or assumed to be feigning illness. For eight women, procedures and processes were not explained during birth or after delivery. Eight of the women were also given little or no information about actions to ameliorate pain or things done to their bodies or to their babies. Whether the practices in which the HCPs engaged with these women were part of the multiple hegemonies remains unknown. In the absence of personal advocacy on the part of the HCPs, these women experienced firsthand the taken-for-granted medical empirico-analytical knowledge where the predictability of the normalized birthing process and the vulnerability of women's tacit knowledge about their corporeality, remains unproblematic (Polyani 1967).

Visibility

Some of these women were not seen or attended to in a timely fashion by HCPs. The women were not visible, rendering them marginal and stigmatized. The responsibilities of the HCPs are to work with the efforts of the labouring women and their needs. Perhaps the HCPs were too busy with other concerns and patients, thereby neglecting the immediate needs of other labouring and birthing women. Care given to the women was based on other people's schedules and availability.

Additionally, the authorial medical voice is so powerful and influential that physicians may convince other professionals to view the woman the same way they see her. As a result,

people act in specific ways towards that patient based on someone else's assessment. It is the authorial position, voice and knowledge that really count; it is not the nurse or the woman.

Yet, the participating women in this study expected something more. They anticipated that HCPs would guide them through labour and birthing. They expected that HCPs would tell them what they were doing to their bodies and to their infants (e.g. Amber, Barbara, Diana, Francis, Gillian, Jennifer, Karen and Lyanne). Information was not shared, explanations were not provided and women were left wondering why these things had happened. Lack of visibility is perceived by the women to render them insignificant and unimportant, their identity trivial or inconsequential.

Isolation: Being Abandoned

Six women described being left by themselves during their pregnancy or difficult labours and this caused significant distress. Each woman's situation was unique as to why she was on her own. Four women were left by their partners at various times and two women felt they were left on their own by nursing and midwifery staff. Barbara's husband left her as she goes into labour following a quarrel. He returns to leave again in the intrapartum period and after discharge from hospital in the postpartum period. She was also left alone by her mother, who did not come to her aid when labour began and also by her sister, who had agreed to be with her during delivery. Barbara was alone, in the hands of others, without her interests being served.

For Barbara there was a cultural variation in expectations about birth between her husband, Bartoli, and herself. These cross-cultural misunderstandings had tragic consequences for them all. There are also many inconsistencies in how she could have been supported by nursing staff, if they had come to grips with her situation of being alone. Her nurse might have advocated for her more assertively on many fronts, by imploring the family to stay with her. The

nurse could have advocated for Barbara's need for privacy and respect at the request for myriad learners to the birth. Or, nursing staff might have enquired what Barbara truly wanted for her birthing experience. These events during labour and birthing, along with other circumstances over the next year, ended in marital breakdown. For Carol, the feeling of being left by her husband, combined with "a disconnection" between her first child and husband, ended their relationship following the birth of their second child. The isolation felt by Barbara and Carol was deep and the results were catastrophic for their marital relationships.

Isabelle also felt the absence of her husband as he could not be with her during her appendectomy and during early labour. He was vested in caring for their other two children at home. Isabelle spoke of working it out with Ivan through dialogue and discussion over the years that followed and finally letting it go. Lyanne also described feeling a "little bit abandoned" when her partner Linda returned to work, leaving her alone in hospital during weekdays, feeling far from home. Lyanne recalled that she and Linda spent time over the next few years processing her feelings of abandonment. Francis also reported being left alone, deserted by HCPs who were busy with other women who were delivering. She was not abandoned by her partner, but she was left on her own during long periods of intense labour. Hillary also felt alone when staff refused to believe she was in labour, leaving her as she laboured until delivering the head of her preterm infant.

Clearly, for these women, the experience of being deserted, either through misunderstandings or legitimate reasons, left deep scars. The experiences of these six women, and my own experience of birth, indicate that being alone during birthing can be experienced as abandonment and affects women for many years, if not a lifetime.

Projected Stigma and Ethical Issues: Disrespect, Bias and Discrimination

According to Goffman (1986) stigma pertains to the shame that a person feels when he or she fails to meet other people's standards, causing them to conceal their shortcomings. The resulting stigma comes from a sense of unworthiness reinforcing power over and maintaining the status quo, supporting structural and authorial control. Stigma enhances marginalization that may be seen as bullying.

I have termed what women experienced as "projected stigma," occurring when medical professionals treat women as lesser in value. The reasons for these feelings are that HCPs do not give the women the standards of care worthy of a person, thereby projecting onto the woman forms of stigma based in a belief that the women are valued less. However, it is not the woman who feels this way, rather, it is the HCPs who project their own bias and discrimination onto the woman and treat her as lesser. Perhaps the woman does not meet the HCPs' standards of readiness for labour, birth and mothering and thus the care given was of a lesser and substandard nature.

Five of the women experienced ethical issues such as contempt, bias and discrimination. Hillary spoke strongly of not being believed and ignored while in preterm labour. She felt denied and treated with condescension. Both Diana and Gillian experienced age bias and for not having attended prenatal classes. They were treated as pariahs and unworthy. Their care was callous, discourteous and disreputable on the part of the physicians and staff. Gillian stated that, even today she still cannot understand why she was treated so poorly.

Eileen was treated with disdain on several occasions. She was deemed to be poor and ignorant and heard racial epithets during her hospitalization. Eileen's physician yelled at her, trying to convince her to submit to a caesarean birth, which she refused. Ethical issues such as

labelling and projected stigma occurred when staff did not know or appreciate the woman's context, her values and beliefs. Issues of ethical concern, such as these, make one question HCPs' understandings of the woman, which unleashes a chain of effects that stay with the woman over time. If women do not comply with what was expected of them, then they are marginalized (Jacobson 2009b). Karen was also treated with disrespect and not valued as a person who was ill and in labour. Her needs were dismissed and she was enrolled in a study without her consent which exacerbated her condition at the time.

There was a failure on the part of HCPs, to provide care. Punitive measures were instigated by those in powerful positions when the women did not comply with unspoken standards. Furthermore, the women were made to feel invisible and offered token care as the staff believed them to be ignorant. In addition, staff did not go out of their way to inform themselves or inquire about the individual woman's circumstances. All these actions by HCPs speak of marginalization, superiority and hatred for those who do not play by the rules, treating the women as if they deserved poor care.

Ethical Issues: Childbearing Women Not at the Centre of Care

The last aspect that affected women's birthing experience was the failure of the health care system to place women at its centre; instead, the institution privileged the HCPs. Health care institutions are organized around prescribed ways of working to deal with a steady flow of patients in the most expedient manner. The structured organization in the hospital reflected efficiency, with effective ways to deal with women and to discharge patients as soon as possible (Langan 2006). The social arrangement of the hospital places women at risk when they are labouring and delivering their children and can be said to be a form of structural violence as it supports social and gender inequity (Farmer 2004). The arrangements are structural because they

are embedded in the political and economic organization of our social world and are violent because they cause injury to people (Farmer 2004; Galtung 1969). Structural violence can occur when women undergo painful and invasive procedures that are not explained (Jacobson 2009a, 2009b). Hospitals privilege the rights and power of HCPs, which may be experienced by pregnant women as egocentricity. This privileged position of HCPs exerts a system of structured violence that elevates the HCPs over the needs of the woman.

When pregnant women come into the hospital they are vulnerable. Women trust that others will place their interests and the birth of their infant, at the centre of care. However, eight women in this study described situations that suggest their needs were secondary to those of the physician. Amber believed the doctor had plans to go for dinner and this influenced the decision for managed labour and an instrument birth. The physician remained at the centre and in control, at the expense of women-centred care. Barbara's birthing experience provided the opportunity for residents to view and participate as though the event was staged for their learning. These were not actions that supported the woman's place in birthing; it was all about the needs of HCPs. Diana and Gillian were both seen as not deserving of care and experienced care that was degrading. For Eileen, her physician wanted the birth to be over and done with. She laboured for 30 hours and the doctor demanded to perform a caesarean. Due to an overwhelmed labour ward, Francis was not the centre of care when she showed up in active labour. Staff were caring for other patients and she was left to manage without support. Hillary was seen as being a worrisome and overly concerned pregnant woman who, staff deemed, could not be in labour. Yet, Hillary went on to deliver her infant two hours later after refusing to leave the hospital. For Karen, her immediate needs and medical situation were neither recognized nor seen as important. She was enrolled in a study and her participation, not her interests, was deemed a higher priority. Her

welfare and that of her son were not considered and the situation placed her and her newborn in danger.

Women are vulnerable and often overwhelmed by the authority of HCPs about their care during birth and the postpartum period. Many of the women in this study were given care that fitted the HCPs agenda, their timeframe and perspective and what care the HCPs felt was deserved. The care was not what the woman's situation demanded or what women expected or needed. The "nature" of hospitals is that we feel vulnerable when there as patients, regardless of our issue, because we go there only when we are ill or distressed. However, labour is not an illness, yet the institution makes women vulnerable and women's bodies during labour are particularly vulnerable.

Participants' Responses to HCPs

All of the women had recommendations for HCPs, which help to frame this study. The participants suggested that women develop strong relationships between themselves and their HCPs, ensuring that this connection is there during the birth. Amber stated that communication should be "understood and transparent. Identify what's important for them [women]." She continued:

It's that relational piece of not just seeing someone as a number, but actually seeing who they are and what their needs are and what is important to them. This is a very transformational experience in that you don't want to rush it. Or put your values on it.

Birth is transformative and HCPs need to recognize and appreciate this life changing event.

Women have asked not to be made more vulnerable, that HCPs show empathy and awareness of the inviolability of the birthing experience for women. Barbara emphatically stated that HCPs

should “not take advantage of people’s vulnerability. Again, more empathy around what somebody, giving birth, might be experiencing.” She also felt that “doctors, definitely [need] empathy training and education around the sacredness of what birth is. Awareness around what a mother goes through and what an optimum birth can be like.”

Women require an advocate to support them through the process—whether a surgical or a vaginal birth—and this relationship requires trust. Carol described her perceptions of support. “Well, I think that what did make it a good experience was there was always one person there who I really trusted. Any time [anyone] has a procedure, there always needs to be that coach for the patient.” Other women said that the HCPs should place themselves in the women’s situation and experience what she is experiencing as a form of appreciation of her efforts. Diana recommended that HCPs “Put themselves in my shoes ... have compassion.”

Eileen believes that HCPs should “listen and ask for permission prior to doing ‘things’ to a woman’s body. Let people know what you’re going to do.” She recommended “instead of just diving in saying ‘This is what has to be done’—unless it really does have to be—if it’s optional, say ‘Would you like? This is an option.’ Let that be known.”

Suggestions were also made that HCPs introduce themselves and do not speak about the woman to others without addressing the woman. Francis said that the doctor should have addressed her. “He came in and I know he was talking to everybody in the room, but he was talking about me to other people. Perhaps he should have addressed me as he entered the room. Introduce yourself!”

Gillian said, “I think it’s important to have your voice ... And if it’s not being heard, to have others on board to help you.” Furthermore, she continued, “be aware of what’s happening so that you can speak up for yourself and make sure you’re heard, that’s the biggest thing.”

HCPs need to acknowledge the woman's experience and not dismiss what she is saying. Hillary recommends

To have somebody acknowledge you and say 'Yes, I hear what you're saying. I understand you're worried or you're concerned about this.' Or, 'Yes, we know it hurts.' Whatever it is, just having someone acknowledge you ... is so important. So I think that's what I would say to physicians, nurses, anybody that's attending the birth, not to be dismissive.

Isabelle believes that a woman needs to be listened to; particularly if she is relaying a concern and that these concerns are real. She believes that HCPs need to hear "What the patient says and [to] trust what they're telling you. If they're complaining about something follow it through."

Others suggested personalizing care provided to the woman as she is a person. As Jennifer emphasizes, HCPs need "to individualize care for every person, in every situation. You have to stop for a second and take them in."

Being informed through the entire birthing process was another theme articulated by the women participating in the research. Karen described needing "more information. I feel like that's what I really missed." Furthermore, Karen reflected on her work as a labour and delivery nurse today and her professional experiences.

It's interesting because when you have a baby that's not doing well and they need to expedite delivery, how many of those Mums really get the information on what's happening? Other than, 'your baby's heart rate is dropping; we need to get your baby out as fast as possible. So this is what we're going to do.' However, after birth it would have been very helpful to have information about what happened.

Women are also encouraged to have a voice and to speak up for what is needed and wanted. Lyanne reflected that,

it's more about compassion for parents and support of parents. Being able to be there in a way that they feel supported. They feel comfortable and welcome. And that they let you hold your baby more, because I've since found out that they [preterm babies] can actually be held a lot more than what I was told. I was told twenty minutes a couple of times a day. And that wasn't enough. And to be more supportive around breastfeeding too; that transition.

The participating women have offered their suggestions for HCPs yet the structure of the health care system is about control and scrutiny.

Surveillance and the Construction of Medicalized Care

Surveillance may be accomplished through self-surveillance and monitoring that is both invisible and private. There are expectations of the pregnant woman and how she is required to act (Wetterberg 2004). To be under surveillance is to be scrutinized by others and the care and attention is meted out based on other people's ideas of what is deserved. Surveillance that is visible is conducted through the public eye and includes strangers as well as family members of the woman (Martin 2003). Surveillance of the woman is also carried out by the physician and is private and unseen by others (Jones 2005). There are aspects of compliance and complicity in the idea of surveillance. If the woman does not fulfil those expectations she is seen as a failure. When a woman is perceived as resistant, non-conformist or non-compliant, then HCPs are at liberty to refuse her care.

Motherhood is defined by social expectations (Davis-Floyd 2001; Mitchinson 2002). The extent to which child birthing occurs is dependent upon the ways in which women engage within the hospital as institution. Several of the women resisted the structured procedures in the hospital (e.g. Eileen, Hillary, Francis). Eileen refused to have a caesarean section. A week after birth, Eileen signed herself and her newborn out of the hospital against medical advice. Hillary refused to leave the hospital while she was in labour, awaiting the arrival of her own obstetrician. Francis wanted something different for her birth experience, choosing a midwife. However, she received the full surgical approach for delivery due to foetal distress and malpresentation that made vaginal delivery impossible. Some of the other women tried to resist (e.g. Gillian, Isabelle), attempting to have some say in their care but the health care system is a powerful force that works to undo individual requests, particularly when she is so ill. Many of the women were also overwhelmed with the physical aspects of birth and recovery. If a woman listened to her own body and engaged with embodiment, then it is her tacit knowledge that was at issue (Akrich and Pasveer 2004). Yet, doctors say that medical care can save the baby and the woman's life and thus women's fear of harm motivates them to comply. However, the necessity of sharing information and collaborating with women about their bodies and their infants is desperately needed for a woman's sense of autonomy.

The category of surveillance is an umbrella concept that was enacted through authority. In this study, the authorial voice was perpetuated through six categories that consisted of silence, bullying, neglect, isolation, projected stigma and ethical issues.

The next and last chapter will look at reflexivity, both the participants and my own as researcher.

Chapter 11 Summary: Reflections and Reflexivity

This research unfolded and laid bare the meanings that women made from the experience of a difficult birth and how these births impacted their mothering over time. Feminist research informed by ethnography and critical ethnography have guided the methods. A feminist approach to ethnography is to pay attention to the participants and listen to their voices. The stories and narratives of 12 women and their difficult birthing process have been documented here. Two women said their births were “difficult” and ten women talked about their births as “traumatic.” One woman spoke of re-experiencing post-traumatic stress disorder (PTSD) from childhood sexual abuse following her experience of difficult birthing. Some women suffered from diagnosed PPD, while others suffered without formal diagnosis.

According to the American Psychiatric Association’s (APA 2013) Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V), for an event to be considered trauma, the stressor must be an event that involves “actual, or threatened death, or serious injury, or damage to self, or others” (criterion A1:271). Furthermore, the person’s responses would involve “intense fear, helplessness, or horror” (criterion A2: DSM 2013:271). The main symptoms of acute post-traumatic stress include “persistent re-experiencing of the traumatic event” (criterion A3), “persistent avoidance of stimuli associated with the event and emotional numbing” (criterion C) and symptoms of “increased physiological arousal” (criterion E: DSM-V 2013:272). Symptoms must last at least “one month (criterion F) and cause impairment in daily life” (criterion G: DSM-V 2013:272). Despite the inclusion and exclusion criteria outlined by the DSM-V (2013), all the women in this study considered their labour and birthing event to be difficult and many considered it traumatic such that the event has affected their life in profound ways. Additionally, the women stated that their difficult birthing experience influenced their

interactions more intensely with their children and how they have mothered over time.

Medicalized birthing and its effects impact women in profound ways (Wagner 2001). Scientific declarations made by HCPs are presented as “objective truths, while they are, in fact, thoroughly shaped by the assumptions and values of bodies that are sexed and positioned in certain areas” (Davis and Walker 2010:458).

The intent of this research was to highlight childbearing practices in order to make recommendations for change. The idea of difficult birth was selected, rather than a traumatic birth, a topic that has not been studied. The goals of the research were to shed light on current practice and socio-political contexts to inform and educate nurses, midwives, physicians and others who care for women during pregnancy and birth about what women want and need. The aim of the research was also to make recommendations to current policy to ameliorate and articulate a woman-centred approach to childbirth. This work provides narratives on the practices women experienced and their suggestions for ethical change through relational practice, patient advocacy and human rights.

From my research, I suggest that difficult and traumatic births are cause of women experiencing postpartum depression (PPD) and post-traumatic stress disorder (PTSD). With the current global proliferation of medicalized birthing, we are at risk of seeing increasing numbers of women experiencing difficult and traumatic births and suffering with PPD and PTSD. I would recommend health care practices that prescribe outcomes of labour and birth and support managed births, give way to a woman-centred approach that respects dignity and rights and honours a transformational life event (Jacobson 2009a). With the amelioration of medical approaches that set the stage for difficult and traumatic births, we may begin to see a decrease in the instances of women suffering with birth trauma and a reduction in PPD and PTSD. In

addition, women should not be left alone in labour, by family or care providers, as this also causes a profound sense of abandonment and may jeopardize the relationship between partners and trust in health care personnel. Furthermore, these experiences of being alone cause long-term issues for women that they carry with them into their lives.

Creedy et al. (2000) studied 499 women using a prospective, longitudinal research design to interview women in their last trimester of pregnancy. They conducted telephone interviews at four to six weeks postpartum to explore the management of birth, perception of intrapartum care and the presence of trauma symptoms. They found that some women reported experiencing intense fear, helplessness and a loss of control when speaking about their traumatic births (Creedy et al. 2000). Their study found that one in three women (33 per cent) identified a traumatic birthing event with the presence of at least three trauma symptoms and 28 women (5.6 per cent) met the DSM-IV criteria for acute PTSD (Creedy et al. 2000:104). In an earlier study Green et al. (1990) reported that loss of control during labour was associated with a more negative birth experience, decreased satisfaction and depression during the postnatal period. Among the women in this study, seven stated they were not included in decision-making, ten were made to feel less than equal and, six experienced punitive care that worked to lessen their sense of themselves. Ten women experienced a loss of control over their agency during labour and following their births. When presented with the opportunity to participate in my research project the women chose to do so altruistically, hoping their involvement would facilitate changes in birthing practice through sharing their stories.

Living the Epistemology and Methodology

The central ideas of the research methodology, such as voice, ethics, reflexivity and transformation are foundational for this work on women's experiences of a difficult birth. Many

of the conceptual dimensions unearthed through the women's stories can be identified within these categories. All six of the conceptual dimensions—enforced silence, bullying, neglect, isolation, projected stigma and ethical issues—document points that surfaced during the analytic stage. This portion of the paper will look at the themes of voice, ethics and reflexivity and transformation in light of the women's experiences and the meanings they make from childbirth.

Voice

What happened to the individual woman during childbirth are political acts working to disempower her (Wagner 2001). What a woman chooses and does, have political meaning and consequences. Within our current system, a woman's actions can result in "power over" through the authority of the HCPs privileged positions, which operate to silence women. Developing a voice is a fundamental aspect for feminists yet, when the medical voice supersedes the women's voices, then women are silenced and medical authority is read as domination (Belenky et al. 1986; Cook and Fonow, 1986; Fonow and Cook 1991, 2005; Lather, 1991, 2007; Stanley and Wise 1983). Women are oppressed when they are not listened to, respected or they are "othered" (de Beauvoir 1974). The stories of women in this study disclosed times when they were made silent and invisible, where their embodied realities were ignored.

This research documents the transformations that women make following a difficult birthing experience and their voices, heard here, become a source of knowledge for other women. During this research, the women's experiences were shared through the process of questioning that gave voice and empowerment through the telling of their story (Connelly and Clandinin 1990; Razack 1993). Valuing their storied lives and close listening over the interviews showed the women their experience of birth was an important component of their lives to be heard, valued and understood. Speaking their experience of birth aloud, to another interested

woman, is also an act of empowerment that honours their experience with the potential for change through an ethic of caring (Nodding 1986).

Ethical Concerns: Experiences of Women

Ethical issues in feminist research focus on agency and respecting women for their unique experiences. However, each woman who participated in this research experienced varying degrees of unethical treatment during her birth; the lack of care or assessments that the participating women were exposed to falls under the realm of projected stigma and unethical treatment.

The women's narratives highlight unethical treatment that is exclusive, speaks of experimentation and of structural violence. The women's bodies were violated through the inadequate care they experienced. They were denied their right to informed consent to make decisions for themselves and these intrusions usurped their agency.

There are discourses of injustice in the women's stories (Fisher 2000; Gluck and Patai 1991). Language was used as pejorative behaviour. For example, Eileen overhears racial epithets about a First Nations mother whilst in hospital and staff are unaware that she is part Indigenous. Racist comments and bias work to undermine women's confidence in their care providers.

Six women were left abandoned during times of great distress. When women are left alone in labour or during hospitalization, this works to undermine their ability to act assertively, leaving them isolated, abject and insecure in a world that is foreign, frightening and alienating. These actions by family and HCPs were not intended to harm; however, they did cause great trauma in the women's lives requiring them to work through feelings of abandonment after childbirth.

When considering labouring and birthing women, a feminist framework is not only appropriate but mandatory to unravel the current assumptions about pregnant women and their care. How a woman experiences birth impacts how she begins motherhood and how she mothers for the rest of her life. It shapes how she sees herself and how she responds to her newborn. These women experienced wounds that were physical, emotional, mental and spiritual. A difficult birthing experience shapes how a woman cares for her child, her concerns become amplified and she often measures herself as a failure. As Jennifer explained “I think that birthing experience really does affect you right out of the gate.”

A feminist approach embraces an ethical stance that includes valuing voice, inclusion and participation. For the participating women, I structured a philosophical approach that was women centred to ensure a respectful, ethical process throughout the work.

Reflexivity and Transformation

Reflexivity involves a critical reflection of an experience that results in new ways of looking at life that transforms awareness (Finlay 2002). Many of the women in this study spoke of the deep thinking they engaged in since their infants’ births and offered strong recommendations to others for creating a more respectful birthing experience. Over time since their difficult birth, the participating women’s understandings changed due to the process of sharing their birth stories. All the women wept during the telling of their stories. They wept because of the gravity of the experience recalling their own sense of vulnerability and aloneness, at their fragility and sense of helplessness, their changed relationships and the disconnections they experienced. Maybe they wept for their baby, gravely ill and beyond their protection. Many women were surprised they became emotional. As their weeping subsided, they marvelled at their own sorrow, that they still feel this way. Many commented that they could still feel the

rawness. All the women said that sharing was helpful to them and they had become more enlightened about their own experience. Thus, through reflection on their lived experience participating women made meaning and through reflection and transformations were able to realize their power and work towards enacting new found strength.

The two women (Isabelle, Karen) who had previously given birth, spoke of how their mothering had changed with the child born from the difficult birth. Both spoke of intensified feelings of love, compassion and understanding for that child. They somehow expected more from themselves and from their child because of the difficult birth. The transformation was also expressed as changes in their mothering. For the women whose difficult births involved their first child, they spoke of planning their next birth with an increased thoughtfulness, a more informed approach to childbirth and added scrutiny for the care provider. They became aware of processes to avoid and needed preparations for themselves and their unborn child. Not all reflection unfolds as transformation but it does open awareness for realization and further contemplation.

Reflexivity and Women's Knowledge

Women's knowledges and reflexivity speak to the insights and wisdom they garner as they experience their lives. Reflexivity is also the work of the researcher in unravelling the assumptions, beliefs, values and taken-for-granted aspects of the study. The feminist consciousness of the researcher and the participants are central to feminist epistemology. Throughout the research my own consciousness has been raised, together with that of the participants, by recognition of the practices, discourses and relationships that make up our heterogeneous social world and its manifestation in the hospital as social and cultural institution. By valuing the women, their voices and positions in their world, this study has permitted an

exploration of the self and contributes to the shared understanding of respondents and researcher. This research has led to greater awareness of women's birthing experiences and the hope that their stories of difficult birth will lead to social change.

Reflexivity, empowerment and transformation are part of feminist epistemology that influences the researcher's view of the creation of knowledge (Letherby 2002). The goal is to change and transform patriarchy, to provide a vision of freedom and liberation and to fight against women's exploitation, sexism and oppression (Friere 1970; hooks 2000). Undertaking this research allowed a forum for women's voices to be heard and to offer suggestions for change.

My Own Reflexivity

As I listened to the women's stories of birth, I was deeply affected by what constitutes difficult birth experiences. HCPs are vested with the care of labouring and birthing women and yet, at times, they are the ones who perpetrated actions and processes that rendered the births experienced by the women as difficult and traumatic. As a maternity nurse, I have endeavoured to support women during and following birth. This stems from my own experience of difficult birthing. However, I realized that some of my approaches were also oppressive and I may have unknowingly added to a women's sense of loss and difficulty. Since working through the research with the participants, I have been acutely mindful of the supportive actions the women identified. I have endeavoured, in my care of women today, to advocate and provide voice to their choices and to respect their wishes and desires. In addition, in my nurse educator position, I have made every effort to point out to student nurses the hegemony found as part of the everyday world in maternal newborn nursing. I look at childbearing now with new eyes and guard against the oppressive nature that may be disclosed in the normalized technological practices of birthing

and to do no further harm. What is presented as “normal” is anything but normal and never ought to be considered an appropriate way to care for women during birth.

I see many areas of change for improvement that may be useful to nurses, midwives, doulas and physicians, including debriefing women following their births, even if all things have gone well. In this way, women can identify practices that are inappropriate and also suggest ways for staff to improve care. Women can also highlight those practices that are helpful so these practices may be embraced and replicated by others.

This research offered an opportunity for women to speak about their difficult birthing experiences and these are presented here for other women and families to explore and reflect. This work is important as it gives voice to what constitutes a difficult birth and its causes, rather than merely labelling it as traumatic, PPD or PTSD. In showing this distinction, the root cause of depression can be ameliorated by reviewing routine procedures and treatments that have been normalized as part of everyday birthing. Offering new and more thoughtful ways to give birth may be of benefit for women in that these suggestions could maximize awareness and minimize the outcomes that are read as difficult and traumatic.

Beyond the Margins

The research has facilitated the validation of women’s stories, stories underpinned by cultural, structural and gendered violence (Farmer 2004). The richness of the research stems from the 12 women who participated in the study. No attempt has been made to generalize to a larger population. Instead the study relies on the resonances it offers others and how these stories act to inform practice.

Study Recommendations From Participants

The women stated they would recommend further education for doctors and nurses about appropriate communication styles to improve the depth and breadth of their explanation about procedures and practices that are everyday for them, but are invasive, risky and threatening for women, infants and families. They also warned that HCPs should refrain from placing their values on the women and their birthing process and to avoid taking advantage of women's vulnerability. Women also stated that HCPs need to provide every woman with individualized care specific to her needs. They also felt that HCPs need sensitivity training to enhance their empathy and compassion for the women and to embrace the sacredness of birth.

Some women spoke of the need for HCPs to speak and address the woman directly and not speak over her to others about her care. HCPs need to describe the processes they plan to implement by first explaining the need for the intervention and to explain if this treatment is optional or essential. Further, if a woman says something about her body or her experience, trust that she knows about her embodiment and follow through on her understanding.

The women felt that HCPs need education to learn how to support women who are in labour and giving birth. They recommend that HCPs provide more in-depth descriptions about the procedures they are going to perform. The women needed to have clear guidelines for informed consent to avoid breaching these rights. HCPs need to modify or ameliorate judgmental attitudes that work to discriminate against some women. The women recommended that HCPs treat all women with respect and dignity and to ask for permission prior to completing a procedure or intervention.

The women in the study recommended that women who will be giving birth have someone there to guide and advocate for them so their wishes and desires are honoured and not

dismissed. Several of the women (e.g. Amber, Barbara, Carol, Jennifer) suggested that the partner may not be the best person to advocate or support a woman in labour. The partner may be too close and emotionally involved to provide that depth of support and advocacy that is required. Many of the participants suggested that women need to find their voice and to speak up in all aspects of care, to not be intimidated by others. They caution childbearing women to choose their care provider carefully to ensure that they value the same aspects of birth that birthing women value. Others encouraged women to trust themselves and their intuition. Some spoke of not planning the event but rather to have a roughly sketched understanding of birth, as things may happen that are unanticipated.

Postpartum depression (PPD) is also an area for further study with women who have experienced a traumatic birth. But, as this research has probed, PPD also needs to be thought about when women say their births are difficult but not necessarily a traumatic birth experience. This opens up areas and communication clues through women's spoken words and their meanings about their birthing experiences that have not been recognized or investigated.

Recommendations

The women in my study have offered solid recommendations to improve care during birth. My own recommendations to avoid difficult birthing would be to support women through all stages of labour and never to leave a woman alone. Partners need to be advised during prenatal classes, doctor visits and hospital stays prior to birth of the importance of their presence during birth and to ensure someone is with the woman at all times. Alternate support person's may need to be identified when the partner needs a break or cannot be with the woman. Perinatal nurses need to be reminded that astute attendance to the woman and her needs is paramount for not only the birth but for her on-going development as a mother. Nurses should never leave

women unattended and alone whilst in labour or during times of duress. The employment of doulas whose practice it is to support women in labour might be a consideration for women and families. Physicians and residents who attend women during labour and birth need to be mindful of their action and to explain what they plan to do prior to doing that procedure as a means of explaining and gaining consent for care. Physicians, obstetricians and residents need to speak with women and families after the birth to discuss and describe what occurred and why in order for women to understand and work through their experience. Through this sharing, women have the opportunity to ask questions and clarify their own experience from HCPs. Partners also need the support and nurturance from hospital staff and partners need to be included and coached as well as the women. Further research into partner's particular needs is also necessary. Feedback solicited from women, through questionnaires or telephone calls, after their births could also assist HCPs and perinatal units to improve the care and support they offer to women. Women need to work through their experience of birth that is not straight forward, which may require debriefing and explanations after the event in order for her to process the experience. When women say their birth has been "difficult" this may alert the listener that the birth may have indeed been a traumatic one. Within the community or through the hospital, support groups are needed for women who experience a difficult birth and to offer counselling and strategies for healing and sharing with other women and family members. A story of recent birth and the experiences of Rebecca and Joe (see Appendix L) highlights the need for explanations and debriefing as a part of every birth.

As HCPs we need to recognize that we do harm when our policies and practices do not reflect the real-life experiences of all women, such as those who have previously experienced PTSD. Other means of securing women to operating tables need to be devised to avoid further

traumatization of women who have been restrained (Seng et al. 2013). Admitting processes need to include sensitive ways to ask women about triggers in order to minimize or avoid re-traumatization by staff (Seng et al. 2009, 2013). Each woman who is attended in the antenatal period by HCPs should be investigated for abuse or other traumas in a more concerted way to ensure that triggers and other factors that might assist HCPs to minimize further traumatization can be made possible.

Policies need to be developed outlining the maximum number of viewers at a woman's birth to avoid giving birth in front of an audience. Nurses need to develop their own sensitivity to women who are giving birth and to offer full support and advocacy. Nurses need to listen closely to what a woman is saying and to use their own critical thinking skills to avoid missing clinical symptoms that other HCPs have dismissed. Pregnant women know their body's best and need to be believed about their embodiment. HCPs need to include parents in the care of their preterm infants as much as possible. Additional breast feeding support, through the employment of lactation consultants, is required on perinatal units to assist and advocate for women who wish to breast feed their preterm infants as well as full term infants. Familiarity and experience with the preterm infant only empowers mothers and family members to care for these compromised newborns. Through these suggestions empowerment of women can be influenced when policies and practices embrace equity, professional accountability and respect.

Furthermore, provincial documents need to include a more detailed review of previous birth experiences to alert HCPs of current concerns or similar issues that may arise during the next birth. Nurses should routinely ask about unresolved stressors and be aware that there may be consequences from these issues during their care of the woman (Elliot et al. 2005; Senge et al. 2009, 2014). HCPs need to investigate difficult birth events and implement more awareness,

preventative approaches and resources for women and families who experience trauma while undergoing health care. Remedial approaches must then be devised and implemented to avoid the impact that a difficult birth has on the mother's life. Routine health care procedures need to be reviewed by HCPs, not only as successful and effective for outcome, but also how the event was experienced and the meaning made for those enduring the procedures, as well as their families.

Learning From Mothers

Mothers understand and know their bodies and they also have a deep connection to their child that they carry with them into their lives. Women are deeply affected by the birth of a child but when a birth is difficult women have a profound and deep sense of commitment that is seen in their advocacy for that child, giving the women a greater sense of purpose, a sense of how unpredictable life is and to not take life for granted. Empowerment of the self is also an additional outcome following difficult birth particularly when faced with issues of grief, loss, shame and depression. Guilt for many of the women lasted years and decades making this a significant aspect of this study of women. The women also spoke of being a different parent, more intensive, protective, "supermum," or hypervigilant following a difficult birth. These outcomes from difficult birth are important for the women themselves and have ensured that women care for their children in a more deliberate way. Furthermore, the women in this study transformed their difficult births into positive aspects of mothering through telling their story that spoke of aspects of change that made them stronger, giving an increased sense of purpose in mothering and desire to do their best in parenting. These aspects of enhanced mothering bind women to their children particularly through the difficulty they experienced. All of the women were affected by their difficult births in many ways. Highlighting this point, two of the women

whose births were 30 years ago, shared that their experiences of difficult births are still present in their lives today. They both continue to work on issues such as guilt and loss over their births and their births continue to impact their ideas of themselves and the meanings they made of those experiences years ago. Difficult birthing does impact women, not just in the short term but over time.

Women in this study learned about themselves from their childbearing which enhanced their commitment to their children and in many senses honed who they are as mothers and women. They have also taken these experiences with them as they live their lives today; it changed them, wounded them, enhanced their abilities to manage their lives and also made them stronger. From the women's experiences we can see that birth is an important developmental stage that asks women to adjust, adapt, grow and learn. All of the women presented their births through a lens of vulnerability, strength, resilience and courage.

Other women, families and HCPs can learn from women's real-life experiences of birthing that may shape the approach and care provided by HCPs. HCPs can learn from women's experiences of birth that can guide and direct residents, nurses, doctors and midwives and students in their care of women. Asking the right questions of women to ascertain their impressions of birth and how we can improve care can assist HCPs to improve their own care and has implications for services, policy and legal development as well as programs for women and families. Educational programs for HCPs need to focus more intensely on the process and outcomes of birth in order to prevent difficult births and if they do occur to offer women support in the aftermath. Support programs need to be developed for women and families who experience a difficult birth in order for them to debrief and provided counselling or other services to ameliorate their feelings of loss or abandonment.

Influence on Knowledge and Research Contributions

This study extends our understanding of women's transitions through difficult birthing and motherhood showing how birthing outcomes affect women long-term. In addition, this study makes a substantial and original contribution to knowledge and an appreciation of women's journeys. Combining a critical lens to ethnography, feminism and a woman-centred approach adds to the originality of the research.

A study of women's experiences of difficult births has illuminated how difficult births affect women in profound ways that alter and change how she sees herself and her interactions with her child/ren and family. Although family member's experiences were not included in the study, the ramifications of a difficult birth on the family affect them through the mother's sense of herself through depression, grief, loss, struggle and vulnerability.

Areas for Future Study

This research has looked at the meaning that women make from their difficult birthing experiences; however, further investigation of families and partner's experience of difficult birth would also add to our understanding to provide a full picture of difficult birthing. This work also highlights difficult birth as an area for further study as this is the language that women may use to describe their difficult or traumatic birthing experience. Other areas of future research stemming from this work would include women's experiences of being left alone in labour by HCP and family members. Women's silence and compliance also needs a fresh look when seen as part of women's birthing experiences. Nurses' roles and complicity within the health care system requires further research. In addition, physician's poor medical practices that directly relate to difficult and traumatic birthing may also be of interest within the scope of this research.

A broader view of women's experiences of mothering over time could also be undertaken to gain insights and awareness of lives lived over time.

Monahan (2010) claims that surveillance can be mobilized to bring about conditions of collective empowerment. Furthermore, surveillance can also be used by people who are excluded from traditional arenas of power and influence. From this perspective, surveillance can serve democratic or empowering ends and can bring about "openness, transparency, accountability, participation, and power equalization among social groups and institutions" (Monahan 2011:498). During pregnancy women require care providers who show them respect and seek joint decision making in all aspects of care throughout pregnancy and birthing. Women need to see themselves as knowers of their bodies and trust their bodies in the processes of birthing. Women who are going to give birth and HCPs who work with these women need to come together with their knowledges to construct a joint way of seeing the world and to use knowledge that each possesses in ways that really count.

End Note

i: Television has offered many varieties of fictionalized family life with icons such as June Cleaver featured in the "Leave It To Beaver" series running from 1957-1963 portraying family life in the 1950s and 60s. Carol Brady from the series "The Brady Bunch" ran from 1969 to 1974 was about a large blended family of six children. Kitty Forman was the mother in the series "That 70s Show" which ran from 1998 to 2006 about an eclectic group of friends on the verge of adulthood. Marge Simpson is the mother on "The Simpsons" an animated satirical comedy series which began in 1989 and is still running, focusing on the eponymous family in middle class America.

References

Aamodt, Agnes M.

1982 Examining Ethnography for Nurse Researchers. *Western Journal of Nursing Research* 4(2):209-221. doi:10.1177/019394598200400207

ACOG

2008 ACOG Position Statement: Late Preterm Infants. Accessed July 6, 2013. www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetrics_Practice/Late-Preterm_Infants.

Adams, Ellise, D., and Ann L. Bianchi

2008 A Practical Approach to Labor Support. *JOGNN* 37:106-115. doi: 10.1111/J.1552-6909.2007.00213.x

Adams, Tony, E.

2008 A Review of Narrative Ethics. *Qualitative Inquiry* 14(2):175-194. doi: 10.1177/1077800407304417

Ainsworth, M.D.

1964 Patterns of Attachment Behaviour Shown by the Infant in Interaction With his Mother. *Merrill-Palmer Quarterly* 10:51-58.

Akrich, Madeleine, and Bernicke Pasveer

2004 Embodiment and Disembodiment in Childbirth Narratives. *Body and Society* 10(2-3): 63-84. doi:10.1177/1357034x04042935

Altman, Molly R., and Mona T. Lydon-Rochelle

2006 Prolonged Second Stage of Labor and Risk of Adverse Maternal and Perinatal Outcomes: A Systematic Review. *Birth* 33(4):315-322. doi:10.1111/j.1523-536x.2006.00129.x

American Psychiatric Association

1980 *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*. Washington: American Psychiatric Association.

1994 *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Washington: American Psychiatric Association.

2013 *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington: American Psychiatric Association.

Amiel-Tison, C., C. Sureau, and S. Shnider

1988 Cerebral Handicap in Full-Term Neonates Related to the Mechanical Forces of Labour. *Baillieres Clinical Obstetrics and Gynaecology* 2(1):145-165.

- Anderson, B., and K. Standley
1976 A Methodology for Observation of the Childbirth Experience. American Psychological Association. Washington, D.C.
- Anderson, Elizabeth
1995 Knowledge, Human Interests, and Objectivity in Feminist Epistemology. *Philosophical Topics* 23(3):27-58.
- Anderson, Janice M., and Duncan Etches
2007 Prevention and Management of Postpartum Hemorrhage. *American Family Physician*, 75(6):875-882.
- Angrosino, Michael
2007 *Doing Cultural Anthropology: Projects for Ethnographic Data Collection*. Long Grove: Waveland Press.
- Arendell, Terry
2000 Conceiving and Investigating Motherhood: The Decade's Scholarship. *Journal of Marriage and Family* 62(4):1192-1207. doi:10.1111/j.1741-3737.2000.01192.x
- Argyris, Chris
1993 *Knowledge for Action: A Guide to Overcoming Barriers to Organizational Change*. San Francisco: Jossey-Bass.
- Argyris Chris, and Donald Schon
1978 *Organizational Learning: A Theory of Action Perspectives*. Reading: Addison Wesley.
- Arnold, L., A. Sawyer, H. Rabe, J. Abbott, G. Gyte, L. Duley, L., and S. Ayers
2013 Parents' First Moments With Their Very Preterm Babies: A Qualitative Study. *British Medical Journal* 3(4):1-7. doi:10.1136/bmjopen-2012-002487
- Atherton, Carla
2007 *A Woman Writing Thinks Back Through Her Mothers: An Analysis of the Language Women Poets Employ Through an Exploration of Poetry About Pregnancy and Childbirth*. Saskatchewan, Canada: University of Saskatchewan. Accessed June 2, 2013. http://ecommons.usask.ca/bitstream/handle/10388/etd-08312007112325/atherton_c.pdf
- Atwood Margaret
2001 "Giving Birth" *In Mother Reader: Essential Literature on Motherhood*. M. Davey, ed. Pp. 311. Toronto: Seven Stories Press.
- AWHONN
2013 Promoting the Health of Women and Newborn. Accessed July 6, 2013 [www.awhonn.org/awhonn/content.do?name=02_Practice Resources/2C3-Focus_Nearterminfant.htm](http://www.awhonn.org/awhonn/content.do?name=02_Practice+Resources/2C3-Focus_Nearterminfant.htm)

Ayers, Susan

2004 Delivery as a Traumatic Event: Prevalence, Risk Factors, and Treatment for Postnatal Posttraumatic Stress Disorder. *Clinical Obstetrics and Gynecology* 47(3):552-567.

doi:10.1097/01.grf.0000129919.00756.9c

2007 Posttraumatic Stress Disorder. *In Psychological Challenges in Obstetrics and Gynecology*. E. Jayne Cockburn and Michael E. Pawson, eds. Pp. 131-140. London: Springer.

Ayers, S., and A. Pickering

2005 Women's Expectations and Experience of Birth. *Psychology and Health* 20(1):79-92.

doi:10.1080/0887044042000272912

Ayers, Susan, Jennifer Claypool, and Andrew Eagle

2006 What Happens After a Difficult Birth? Postnatal Debriefing Services. *British Journal of Midwifery* 14(3):157-161. doi:10.12968/bjom.2006.14.3.20577

Babbie, Earl

2012 *The Practice of Social Research*. Belmont: Wadsworth Cengage Learning.

Badenhorst, William, and Patricia Hughes

2007 Psychological Aspects of Perinatal Loss. *Best Practice and Research Clinical Obstetrics and Gynecology* 21(2):249-259. doi:10.1016/j.bpobgyn.2006.11.004

Baillie, L.

1995 Ethnography and Nursing Research: A Critical Appraisal. *Nurse Researcher* 3(2):5-21.

Bailyn, Lottie

1993 *Breaking the Mold: Women, Men, and Time in the New Corporate World*. New York: Simon and Schuster.

Bains, Carol, Patricia Evans, and Sheila Neysmith

1991 *Women's Caring: Feminist Perspectives on Social Welfare*. Toronto: McLellan and Stewart.

Baker, Lisa, Tina Lavender, and Douglas Tincello

2005 Factors That Influence Women's Decisions About Whether to Participate in Research: An Exploratory Study. *Birth* 32(1):60-66. doi: 10.1111/j.0730-7659.2005.00346.x

Bakewell-Sachs, Susan

2007 Near-term Late Preterm Infants. *Newborn and Infant Nursing Reviews* 7(2): 67-71. doi:10.1053/j.nainr.2007.05.001

Barlow, Kathleen, and Bambi L. Chapin

2010 The Practice of Mothering: An Introduction. *Ethos: Journal of the Society for Psychological Anthropology* 38(4):324-338. doi:10.1111/j.1548-1352.2010.01153.x

Barr, Jennieffer Anne

2008 Postpartum Depression, Delayed Maternal Adaptation, and Mechanical Infant Caring: A Phenomenological Hermeneutic Study. *International Journal of Nursing Studies* 45:362-369. doi: 10.1016/j.ijnurstu.2006.10.002

Bartky, Sandra Lee

1988 Foucault, Femininity and the Modernization of Patriarchal Power. *In Feminism and Foucault: Reflections on Resistance* I. Diamond and L. Quinby eds. Pp. 78-96. Boston: Northeastern University Press.

Batliwala, Srilatha

2007 Taking the Power Out of Empowerment: An Experiential Account. *Development in Practice* 17(4-5):557-565. doi: 10.1080/09614520701469559

Beck, Cheryl Tatano

1993 Qualitative Research: The Evaluation of Its Credibility, Fittingness, and Auditability. *Western Journal of Nursing Research* 15(2):263-266.

doi:10.1177/019394599301500212

1995 The Effects of Postpartum Depression on Maternal-Infant Interaction: A Meta Analysis. *Nursing Research* 44(5):298-304. doi:10.1097/00006199-199509000-00007

1996 A Meta-Analysis of Predictors of Postpartum Depression. *Nursing Research* 45(5): 297-303. doi:10.1097/00006199-199609000-00008

1998 Postpartum Onset of Panic Disorders. *Journal of Nursing Scholarship* 30(2):131-135. doi:10.1111/j.1547-5069.1998.tb01267.x

2001 Predictors of Postpartum Depression: An Update. *Nursing Research* 50(5):275-285. doi:10.1097/00006199-200109000-00004

2004a Birth Trauma: In the Eye of the Beholder. *Nursing Research* 53(1):28-35. doi:10.1097/00006199-200401000-00005

2004b Post-Traumatic Stress Disorder Due to Childbirth: The Aftermath. *Nursing Research* 53(4):216-224. doi:10.1097/00006199-200407000-00004

2006 Postpartum Depression: It Isn't Just the Blues. *American Journal of Nursing* 106(5): 40-50. doi:10.1097/00000446-200605000-00020

2008 State of the Science on Postpartum Depression: What Nurse Researchers Have Contributed- Part 1. *The American Journal of Maternal Child Nursing* 33(2):121-126. doi:10.1097/01.NMC.0000313421.97236.cf

Beck, Cheryl Tatano, Robert K. Gable, Carol Sakala, and Eugene R. Declercq

2011a Postpartum Depressive Symptomatology: Results From a Two-Stage U.S. National Survey. *Journal of Midwifery and Women's Health* 56(6):427-435. doi:10.1111/j.1542-2011.2011.00090.x

Beck, Cheryl Tatano, Robert K. Gable, Carol Sakala and Eugene R. Declercq

2011b Posttraumatic Stress Disorder in New Mothers: Results From a Two-Stage U.S. National Survey. *Birth* 38(3):216-227. doi:10.1111/j.1523-536X.2011.00475.x

- Beck, Cheryl Tatano, Barbara A. Keddy, and Marlene Z.Cohen
1994 Reliability and Validity Issues in Phenomenological Research. *Western Journal of Nursing Research* 16(3):254-267. doi:10.1177/019394599401600303
- Beech, Beverley Lawrence
1999 Drugs in Labour: What Effects Do They Have 20 Years Hence? *Midwifery Today* 50: 1-9.
- Behague, D.
2002 Beyond the Simple Economics of Caesarean Section Birth: Women's Resistance to Social Inequity. *Culture, Medicine and Psychiatry* 26:473-502.
- Behruzi, Roxana, Marie Hatem, Lisa Goulet, William Fraser, and Chizuru Misago
2013 Understanding Childbirth Practices as Organizational Cultural Phenomenon: A Conceptual Framework. *BMC: Pregnancy and Childbirth* 13:205-214. doi: 10.1186/1471-2393-13-205
- Belenky, Mary F., Blythe M Clinchy, Nancy R. Goldberg, and Jill M.Tarule
1986 *Women's Ways of Knowing: The Development of Self, Voice and Mind*. New York: Basic Books.
- Benner, Patricia
1985 Quality of Life: A Phenomenological Perspective on Explanation, Prediction, and Understanding in Nursing Science. *Advances in Nursing Science* 8(1):1-14. doi:10.1097/00012272-198510000-00004
- Bentham, Jeremy
1995 Panopticon. *In The Panopticon Writings*. M. Bozovic ed. Pp. 29-95. London: Verso.
- Bergstrom, Linda, Joyce Roberts, Leslie Skillman, and John Seidel
1992 "You'll Feel Me Touching You, Sweetie": Vaginal Examinations During the Second Stage of Labor. *Birth* 19(1):10-18. doi:10.1111/j.1523-536x.1992.tb00365.x
- Bergstrom, M.
2013 Depressive Symptoms in New First-Time Fathers: Associations with Age, Sociodemographic Characteristics, and Antenatal Psychological Well-Being. *Birth* 40(1):32-38. doi:10.1111/birt.12026
- Bergstrom, M., H. Kieler, and U. Waldenstrom
2009 Effects of Natural Childbirth Preparation Versus Standard Antenatal Education on Rates, Experience of Childbirth and Parental Stress in Mothers and Fathers: A Randomised Controlled Multicentre Trial. *BJOG* 116(9):1167-1176. doi:10.1111/j.1471-0528.2009.02144.x
- Bergum, Vangie
1989 *Woman to Mother: A Transformation*. Granby: Bergin & Garvey.

- Betterton, Rosemary
2002 *Prima Gravida: Reconfiguring the Maternal Body in Visual Representation*. *Feminist Theory* 3(3):255-270. doi:10.1177/146470002762491999
- Bewley, Susan, and Jayne Cockburn
2002 *Responding to Fear of Childbirth*. *Lancet* 359(9324):2128-2129. doi:10.1016/S01406736(02)09113-4
- Bick, Debra
2012 *Born Too Soon: The Global Issue of Preterm Birth*. *Midwifery* 28(4):401-402. doi:10.1016/j.midw.2012.06.010
- Binion, Gayle
1995 *Human Rights: A Feminist Perspective*. *Human Rights Quarterly*, 17:507-526. doi:10.1353/hrq.1995.0022
- Birnbaum, Michele
1997 *Radical Hysteria: Female Pathology and Race Politics in F. Harper's Iola Leroy and W.D. Howell's an Imperative Duty*. *African American Review* 33(1):7-23. doi:10.2307/2901298
- Birth Trauma
2006 *Traumatic Birth Injury* Accessed December 27, 2013
http://www.traumaticbraininjury.com/birthinjury/birth_trauma.htm
- Black, Beth P., Diane Holditch-Davis, and Margaret S. Miles
2009 *Life Course Theory as a Framework to Examine Becoming a Mother of a Medically Fragile Preterm Infant*. *Research in Nursing & Health* 32(1):38-49. doi:10.1002/nur.20298
- Blincoe, Alana Juman
2006 *Optimum Maternal Nutrition for a Healthy Pregnancy*. *British Journal of Midwifery* 14(3):151-154. doi:10.12968/bjom.2006.14.3.20575
- Bochner, Arthur P., Carolyn S. Ellis, and Lisa M. Tillmann-Healy
1997 *Relationships as Stories*. In *Handbook of Personal Relationships: Theory, Research and Interventions*. S. W. Duck eds. Pp. 107-124. Chichester: Wiley.
- Bondas, Terese, and Katie Eriksson
2001 *Women's Lived Experiences of Pregnancy: A Tapestry of Joy and Suffering*. *Qualitative Health Research* 11(6):824-840. doi:10.1177/104973201129119415
- Bordo, Susan
2003 *Unbearable Weight: Feminism, Western Culture, and the Body*. Los Angeles: University of California Press

Boston Women's Health Book Collective

2005 *Our Bodies, Ourselves*. New York: Simon and Schuster.

Bourdieu, Pierre

1977 *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

Bourgeault, Ivy Lynn, and Mary Fynes.

1997 Integration of Lay and Nurse-Midwifery Into the U.S. and Canadian Health Care Systems. *Social Science and Medicine* 44(7):1051-1063. doi: 10.1016/s0277-9536(96)00290-0

Bowers, Beverly B.

2002 Mothers' Experiences of Labour Support: Exploration of Qualitative Research. *JOGNN* 31(6):742-752. doi:10.1177/0884217502239218

Bowman, K.G.

2006 Adolescent Postpartum Care: What Daughters Want and What Their Mothers Expect to Provide. *Pediatric Nursing* 32(3):209-213.

Bowlby, John

1971 *Maternal Care and Mental Health*. Geneva: World Health Organization.

1997 *Attachment and Loss*. London: Random House.

Brand, Sarah R., and Patricia A. Brennan

2009 Impact of Antenatal and Postpartum Maternal Mental Illness: How are the Children? *Clinical Obstetrics and Gynecology* 52(3):441-455. doi:10.1097/GRF.0b013e3181b52930

British Columbia Medical Association

1995 *Doctors of B.C. Code of Ethics*. Accessed July 1, 2015. <https://www.doctorsofbc.ca/code-ethics>

British Columbia Perinatal Database Registry

2011 Examining Cesarean Delivery Rates in British Columbia Using the Robson Ten Classification. *A Perinatal Service B.C. Surveillance Special Report* 1(4):1-14. Accessed May 3, 2012. <http://www.perinatalservicesbc.ca/NR/rdonlyres/3CE464BF-3538-4A78-BA51451987FDD2EF/0/SurveillanceSpecialReportRobsonTenClassificationDec2011.pdf>

British Columbia Perinatal Genetic Screening Program

2009 Dating tool. Accessed July 6, 2013, from <http://bcprenatalscreening.ca/?p2=/customcode/genetic/datingtool.jsp>

British Columbia Perinatal Health Programs

2008 *Caesarean Birth Task Force Report*. Accessed June 24, 2015. http://www.powertopush.ca/wp-content/uploads/2010/05/CBTF_REPORT.pdf

- Brodsky, Phyllis L.
2008 *The Control of Childbirth: Women Versus Medicine Through the Ages*. London: McFarland.
- Bryant, Joanne, Maree Porter, Sally K. Tracy, and Elizabeth A. Sullivan
2007 *Caesarean Birth: Consumption, Safety, Order, and Good Mothering*. *Social Science & Medicine* 65(6):1192-1201. doi:10.1016/j.socscimed.2007.05.025
- Buckley, Kathleen M., and Gloria E. Charles
2006 *Benefits and Challenges of Transitioning Preterm Infants to At-Breast Feedings*. *International Breastfeeding Journal* 1(13):1-7. doi:10.1186/1746-4358-1-13
- Buist, Anne, Lori E. Ross, and Meir Steiner
2006 *Anxiety and Mood Disorders in Pregnancy and the Postpartum Period*. In *Mood and Anxiety Disorders in Women*. David Castle, Jayashri Kulkarni, Kathryn M. Abel, eds. Pp. 136-162. Cambridge: Cambridge University Press.
- Bulpitt, Helen, and Peter J. Martin
2010 *Who Am I and What Am I Doing? Becoming a Qualitative Research Interviewer*. *Nurse Researcher* 17(3):7-16. doi:10.7748/nr2010.04.17.3.7.c7741
- Burke, L.
2003 *The Impact of Maternal Depression on Familial Relationships*. *International Review of Psychiatry* 15(3):243-255. doi: 10.1080/09540260305192
- Burvill, Susan
2002 *Midwifery Diagnosis of Labour Onset*. *British Journal of Midwifery* 10(10):600-605. doi:10.12968/bjom.2002.10.10.10619
- Butler, Judith
1988 *Performative Acts and Gender Constitution: An Essay in Phenomenology and Feminist Theory*. *Theatre Journal* 40(4):519-531. doi:10.2307/3207893
1993 *Critically Queer*. *GLQ: A Journal of Lesbian and Gay Studies* 1(1):17-32. doi:10.1215/10642684-1-1-17
1999 *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.
2004 *Precarious Life*. London: Verso.
- Cahill, Heather A.
2001 *Male Appropriation and Medicalization of Childbirth*. *Journal of Advanced Nursing* 33(3):334-342. doi:10.1046/j.1365-2648.2001.01669.x
- Callahan Jennifer, L., and Michael T. Hynan
2002 *Identifying Mothers at Risk for Postnatal Emotional Distress: Further Evidence for the Validity of the Perinatal Posttraumatic Stress Disorder Questionnaire*. *Journal of Perinatal*, 22(6):448-454. doi: 10.1038/sj.jp.7210783

Callister, Lynn Clark

- 2001 Culturally Competent Care of Women and Newborn: Knowledge, Attitudes and Skill. JOGNN 30(2): 209-215. doi.org/10.1111/j.1552-6909.2001.tb01537.x
- 2004 Making Meaning: Women's Birth Narratives. JOGNN 33(4):503-518. doi:10.1177/0884217504266898
- 2006 The Meaning of Giving Birth and Mastery of the Experience. IJCE 21(3):7-8.

Callister, Lynn Clark, Shirley Thacker Holt and Melody West Kuhre

- 2010 Giving Birth: The Voices of Australian Women. Journal of Perinatal and Neonatal Nursing 24:128-136. doi:10.1097/JPN.0b013e3181cf0429

Canadian Institute for Health Information

- 2013 Highlights of 2011-2012 Selected Indicators Describing the Birthing Process in Canada. Accessed December 26, 2013. http://secure.cihi.ca/free_products/Childbirth_Highlights_2011-12_EN.pdf.

Canadian Medical Association

- 2004 Code of Ethics. Accessed July 1, 2015. <https://www.cma.ca/En/Pages/code-of-ethics.aspx>

Canadian Mental Health Association

- 2013 Postpartum depression. Accessed March 24, 2013. http://www.cmha.ca/mental_health/postpartum-depression/

Canadian Nurses Association

- 2008 Code of Ethics. Accessed July 1, 2015. <https://www.cnaaic.ca/~media/cna/files/en/codeofethics.pdf>

Canadian Women's Health Network

- 2014 Murder by Misogyny? Accessed June 24, 2015. <http://www.cwhn.ca/en/blog>

Capitulo, Kathleen Leask

- 2005 Evidence for Healing Interventions with Perinatal Bereavement. Maternal Child Nursing 30(6):389-396. doi:10.1097/00005721-200511000-00007

Carlton, Troy, Lynn Clark Callister, and Eva Stoneman

- 2005 Decision making in Labouring Women: Ethical Issues for Perinatal Nurses. Journal of Perinatal and Neonatal Nursing 19(2):145-154. doi:

Carolan, Mary

- 2003 Reflexivity: A Personal Journey During Data Collection. Nurse Researcher 10(3):7-14. doi:10.7748/nr2003.04.10.3.7.c5892
- 2005 "Doing it Properly": The Experience of First Time Mothers Over 35 years. Health Care for Women International 26(9):764-787. doi:10.1080/07399330500230987

- Carpenter, Carole H.
1985 Tales Women Tell: The Function of Birth Experience Narratives. *Canadian Folklore = Folklore Canadien* 7.1-2:21-34.
- Carr W., and S. Kemmis
1986 *Becoming Critical: Education Knowledge and Action Research*. London: Routledge Falmer.
- Cassels, Tracy G.
2014 The Long-Term Effects of Birthing Interventions on Childhood Empathy. *Midwifery* 30(4):471-475. doi:10.1016/j.midw.2013.05.015
- Chalmers, B., J. Kaczorowski, B. O'Brien, and C. Royle
2012 Rates of Interventions in Labor and Birth Across Canada: Findings of the Canadian Maternity Experiences Survey. *Birth* 39(3):203-210. doi:10.1111/j.1523-536X.2012.00549.x
- Chalmers, Beverley, Viviana Mangiaterra, and Richard Porter
2001 WHO Principles of Perinatal Care: The Essential Antenatal, Perinatal and Postpartum Care Course. *Birth* 28(3):202-207. doi: 10.1046/j.1523-536x.2001.00202.x
- Chantry, C., J. Nommsen-Rivers, R. Peerson, R. Cohen, and K. Dewey
2011 Excess Weight Loss in First-Born Breastfed Newborns Relates to Maternal Intrapartum Fluid Balance. *Pediatrics* 127:e171-e179.
- Chapin, Bambi L.
2010 "We Have to Give": Sinhala Mothers' Response to Children's Expression of Desire. *Ethos: Journal of the Society of Psychological Anthropology* 38(4):354-368. doi:10.1111/j.1548-1352.2010.01155.x
- Chase, Susan E.
2005 Narrative Inquiry: Multiple Lenses, Approaches, Voices. *In The Sage Handbook of Qualitative Research*, Norman K. Denzin and Yvonna S. Lincoln, eds. Pp. 651-679. Thousand Oaks, CA: Sage Publications.
- Chaudron, Linda H., Peter, G. Szilagyi, Amy T. Campbell, Kyle O. Mounts, and Thomas K. McInerney
2007 Legal and Ethical Considerations: Risks and Benefits of Postpartum Depression Screening at Well-Child Visits. *Pediatrics* 119(1):123-128. doi:10.1542/peds.2006-2122
- Chodorow, Nancy J.
1978 *The Reproduction of Mothering*. Los Angeles: University of California Press.

- Choi, P., C. Henshaw, S. Baker, and J. Tree
2005 Supermum, Superwife, Supereverything: Performing Femininity in the Transition to Motherhood. *Journal of Reproductive and Infant Psychology* 23(2):167-180. doi:10.1080/02646830500129487
- Chrisler, Joan C.
2011 Leaks, Lumps and Lines: Stigma and Women's Bodies. *Psychology of Women Quarterly* 35(2):202-214. doi:10.1177/0361684310397698
- Christensen, R.D., V.L. Baer, and E. Henry
2011 Neonatal Subgaleal Hemorrhage in a Multi-hospital Healthcare System: Prevalence, Associations, and Outcomes. *Journal of Neonatology Research* 1(1):4-11.
- Cindoglu, Dilek, and Feyda Sayan-Cengiz
2010 Medicalization Discourses and Modernity: Contested Meanings Over Childbirth in Contemporary Turkey. *Health Care for Women International* 31(3):221-143. doi:10.1080/07399330903042831
- Clatworthy, Jane
2012 The Effectiveness of Antenatal Interventions to Prevent Postnatal Depression in High-Risk Women. *Journal of Affective Disorders* 137(1-3):25-34. doi:10.1016/j.jad.2011.02.029
- Clement, Catherine, and Julia Kristeva
2001 *The Feminine and the Sacred*. New York: Columbia University Press.
- Cliff, D. D.
1997 Too Much Like School: Social Class, Age, Marital Status and Attendance/Non Attendance at Antenatal Classes. *Midwifery* 13(3):139-145. doi:10.1016/s02666138(97)90004-8
- Cody, William K.
2001 The Ethics of Bearing Witness in Healthcare: A Beginning Exploration. *Nursing Science Quarterly* 14(4):288-296.
- Coia, John E.
2009 What is the Role of Antimicrobial Resistance in the New Epidemic of *Clostridium Difficile* 33:S9-S12. doi:10.1016/s0924-8579(09)70009-3
- College of Midwives of British Columbia
nd Accessed January 16, 2014. <http://www.cmbc.bc.ca/>
- Condon, B.
2013 The Power of Suffering. *Nursing Science Quarterly* 26(3):229. doi:10.1177/0894318413489182.

- Condon, John
2012 Assessing Attachment, a Work in Progress: To Look, to Listen or Both? *Journal of Reproductive and Infant Psychology* 30(1):1-4. doi: 10.1080/02646838.2012.681966
- Connelly, Michael F., and Jean D. Clandinin
1990 Stories of Experience and Narrative Inquiry. *Educational Researcher* 19(5):2-14. doi:10.3102/0013189X019005002
- Connors, Denise Donnell
1980 Sickness Unto Death: Medicine as Mythic, Necrophilic and Iatrogenic. *ANS Politics of Care* 2(3):39-51. doi: 10.1097/00012272-198002030-00005
- Cook, Judith A., and Mary Margaret Fonow
1986 Knowledge and Women's Interest: Issues of Epistemology and Methodology in Feminist Sociological Research. *Sociological Inquiry* 56(1):2-29. doi:10.1111/j.1475682X.1986.tb00073.x
- Cooke, Alison, Tracey A. Mills, and Tina Lavender
2010 "Informed and Unformed Decision Making" - Women's Reasoning, Experience and Perceptions with Regard to Advanced Maternal Age and Delayed Childbearing: A Meta-Synthesis. *International Journal of Nursing Studies* 47(10):1317-1329. doi: 10.1016/j.ijnurstu.2010.06.001
- Corbin, J.
2003 The Body in Health and Illness. *Qualitative Health Research* 13(2):256-267. doi:10.1177/1049732302239603
- Cosner, K.R.
1996 Use of Fundal Pressure During Second Stage of Labour: A Pilot Study. *Journal of Nurse-Midwifery* 41(4):334-347. doi:10.1016/0091-2182(96)00033-x
- Courtois, Christine A., and Claire Courtois Riley
1992 Pregnancy and Childbirth as Triggers for Abuse Memories: Implications for Care. *Birth* 19(4):222-223. doi:10.1111/j.1523-536X.1992.tb00408.x
- Creedy, Debra K., Ian M. Shochet, and Jan Horsfall
2000 Childbirth and the Development of Acute Trauma Symptoms: Incidence and Contributing Factors. *Birth* 27(2):104-111. doi:10.1046/j.1523-536x.2000.00104.x
- Critchlow, Cathy W., Terry L. Leet, Thomas J. Benedetti, and Janet R. Daling
1994 Risk Factors and Infant Outcomes Associated with Umbilical Cord Prolapse: A Population Based Case-Control Study Among Births in Washington State. *American Journal of Obstetrics & Gynecology* 170(2):613-618. doi:10.1016/s00029378(94)70238-1

Cronin, Camille

2003 First-Time Mothers - Identifying Their Needs, Perceptions and Experiences. *Journal of Clinical Nursing* 12(2):260-267. doi:10.1046/j.1365-2702.2003.00684.x

Cruz, Edward Venson, and Gina Higginbottom

2013 The Use of Focused Ethnography in Nursing Research. *Nurse Researcher* 20(4):36-43. doi:10.7748/nr2013.03.20.4.36.e305

CTV News

2009 60-Year-Old Gives Birth to Twins. Accessed Dec. 26, 2013.
<http://www.ctvnews.ca/60-year-old-calgary-woman-gives-birth-to-twins-1.367423>.

Cummings E.M., and P.T. Davies

1994 Maternal Depression and Child Development. *Journal of Child Psychology and Psychiatry* 35(1):17-23.

Czarnocka Jo, and Pauline Slade

2000 Prevalence and Predictors of Post-Traumatic Stress Symptoms Following Childbirth. *British Journal of Clinical Psychology* 39:35-51. doi: 10.1348/014466500163095

Dagan, Yaron, Anat Lapidot, and Michael Eisenstein

1999 Women's Dreams Reported During First Pregnancy. *Psychiatry and Clinical Neuroscience* 55:13-20. doi: 10.1046/j.1440-1819.2001.00778.x

Dahlberg, K., H. Dahlberg, and M. Nystrom

2008 Reflective Lifeworld Research. Lun, Sweden: Studentlitteratur.

Dahlenburg, G., R. Burnell, and R. Braybrook

1981 The Relationship Between Cord Serum Sodium Levels in Newborn Infants and Maternal Intravenous Therapy During Labor. *British Journal of Obstetrics and Gynecology* 87:519-522. doi:10.1097/00006254-198103000-00011

Dahlke, Laura Johnson

2009 Essays on Childbirth: The Why and How. *Women's Studies* 38:577-596.
doi.org/10.1080/00497870902952932

Dare, F., A. Owolabi, O. Fasubaa, and O. Ezechi

1998 Umbilical Cord Prolapse: A Clinical Study of 60 Cases Seen at Obafemi Awolowo University Teaching Hospital, Ile-Ife. *East African Medical Journal* 75:308-310.

Davanzo, R., Z. Cannioto, L. Ronfani, L. Monasta, and S. Demarini

2013 Breastfeeding and Neonatal Weight Loss in Healthy Term Infants. *Journal of Human Lactation* 29(1):45-53. doi:10.1177/0890334412467083

- Davidson, Michelle C., Maria L. London, and Patricia W. Ladewig
2012 *Olds' Maternal-Newborn Nursing and Women's Health Across the Lifespan*.
Toronto: Pearson.
- Davies, Celia
2000 Getting Health Professionals to Work Together. *British Medical Journal*, 320:1021-1022.
- Davis, Deborah L.
2003 Spoilt for Choice: Consuming Maternity Care. *British Journal of Midwifery* 11(9): 574-578. doi:10.12968/bjom.2003.11.9.11692
- Davis Deborah L., and Kim Walker
2010 Re-Discovering the Material Body in Midwifery Through an Exploration of Theories of Embodiment. *Midwifery* 26(4):457-462. doi: 10.1016/j.midw.2008.10.004
- Davis, Leigh, Helen Edwards, Heather Mohay, and Judy Wollin
2003 The Impact of Very Premature Birth on the Psychological Health of Mothers. *Early Human Development* 73(1-2):61-70. doi:10.1016/s0378-3782(03)00073-2
- Davis-Floyd, Robbie
1993 *Birth as an American Rite of Passage*. Berkeley: University of California Press.
2001 The Technocratic, Humanistic, and Holistic Paradigms of Childbirth. *International Journal of Gynecology and Obstetrics* 75(1):S5-S23. doi:10.1016/S0020-7292(01)00510-0
- de Beauvoir, Simone
1974 *The Second Sex*. New York: Vintage Books.
- Declercq, E., F. Menacker, and M. MacDorman
2005 Rise in "No Indicated Risk" Primary Caesareans in the United States, 1991-2001: Cross Sectional Analysis. *British Medical Journal* 330:71-72. doi: 10.1136/bmj.38279.705336.0b
- De Leeuw, Jan-Willem, Mark E. Vierhout, Piet C. Struijk, Hajo J. Auwerda, Dirk-Jan Bac, and Henk C. Wallenburg
2002 Anal Sphincter Damage After Vaginal Delivery. *Diseases of the Colon and Rectum* 45(8):1004-1010. doi:10.1007/s10350-004-6351-5
- Deave, T., J. Heron, J., Evans and A. Emond
2008 The Impact of Maternal Depression in Pregnancy on Early Child Development. *BJOG: An International Journal of Obstetrics and Gynaecology* 115(8):1043-1051. doi:10.1111/j.1471-0528.2008.01752.x

- Debast, S., N. Vaessen, A. Choudry, F. Wiegers-Ligtvoet, R. van den Berg, and E. Kuijper
2009 Successful Combat of an Outbreak due to Clostridium Difficile PCR Ribotype 027 and Recognition of Specific Risk Factors. *Clinical Microbiology of Infections* 15(5):427-434 . doi:10.1111/j.1469-0691.2009.02713.x
- Denzin, Norman K.
1989 *Interpretive Biography*. Newbury Park: Sage.
- Denzin, Norman K., and Yvonna, S. Lincoln, eds.
2011 *The Sage Handbook of Qualitative Research*. Thousand Oaks: Sage Publications.
- Deutsch, H
1944 *The Psychology of Women, Volumes 1 and 2*. New York: Grune and Stratton.
- Dewey, John
1933 *How We Think: A Restatement of the Relation of Reflective Thinking to the Educative Process*. New York: G.P. Putnams and Sons.
- Dick-Read, Grantly
2004 *Childbirth Without Fear: The Principles and Practice of Natural Childbirth*. New York: Pinter & Martin.
- DiIoiro, J.
1982 *Feminist Fieldwork in a Masculinist Setting: Personal Problems and Methodological Issues*. North Central Sociological Association Meetings. Detroit.
- Dillaway, Heather, E.
2006 Good Mothers Never Wane: Mothering After Menopause. *Journal of Women and Aging* 18(2):41-53. doi: 10.1300/j074v18n02_04
- DiQuinzio, Patrice
1999 *The Impossibility of Motherhood: Feminism, Individualism, and the Problem of Mothering*. New York: Routledge.
- Dixon, Lesley, and Maralyn Foureur
2010 *The Vaginal Examination During Labour: Is it of Benefit or Harm?* *New Zealand College of Midwives* 42:21-26.
- Dixon, Lesley, Joan Skinner, and Maralyn Foureur
2013 Women's Perspectives of the Stages and Phases of Labour. *Midwifery* 29:10-17. doi:10.1016/j.midw.2012.07.001
2014 The Emotional Journey of Labour-Women's Perspectives of the Experience of Labour Moving Towards Birth. *Midwifery* 30(3):371-377. doi:10.1016/j.midw.2013.03.009

Dobbin, Frank

2009 How Durkheim's Theory of Meaning-Making Influenced Organizational Sociology. *In* *Sociology and Organizational Studies: Classical Foundations*. Paul S. Adler, ed. Pp. 201-222. Oxford: Oxford University Press.

Donegan, Jane B.

1978 *Women and Men Midwives: Medicine, Morality and Misogyny in Early America*. Westport: Greenwood Press.

Donnelly, L.

2014 Women Left Fearful and Alone in Labour, says Care Quality Commission Report. London. Accessed July 26, 2014.
<http://www.telegraph.co.uk/news/health/news/10513588/Women-left-fearful-and-alone-in-labour-says-Care-Quality-Commission-report.html>

Donnison, Jean

1988 *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*. London: Historical Publications.

Dougherty, Dorothy, and Maureen Luther

2008 Birth to Breast - A Feeding Care Map for the NICU: Helping the Extremely Low Birth Weight Infant Navigate the Course. *Neonatal Network* 27(6):371-377.
doi:10.1891/0730-0832.27.6.371

Doumont, Alexandre, Luc de Bernis, Marie-Helene Bouvier-Olle, and Gerard Breart

2001 Cesarean Section Rate of Maternal Indication in Sub-Saharan Africa: A Systematic Review. *The Lancet* 358(9287):1328-1334. doi: 10.1016/S0140-6736(01)06414-5

Doyal, Leslie

1995 *What Makes Women Sick: Gender and the Political Economy of Health*. Houndmills: Macmillan.

Draper, Janet

1997 Whose Welfare in the Labour Room? A Discussion of the Increasing Trend of Fathers' Birth Attendance. *Midwifery* 13(3):1332-138. doi:10.1016/S0266-6138(97)90003-6

Dubriwny, Tasha, and Vandhana Ramadwai

2013 Framing Birth: Postfeminism in the Delivery Room. *Women's Studies in Communication* 36(3):243-266. doi: 10.1080/07491409.2013.830168

Duden, Barbara

1993 *Disembodying Women: Perspective on Pregnancy and the Unborn*. Cambridge: Harvard University Press.

Dworkin, Andrea

1974 *Woman Hating*. New York: Penguin Books

- Eason, Erica, Michel Labrecque, Sylvie Marcoux, and Myrto Mondor
 2002 Anal Incontinence After Childbirth. *Canadian Medical Association Journal* 166(3): 326-330.
- East, Christine, E., Margaret Sherburn, Catherine Nagle, Joanne Said, and Della Forster
 2012 Perineal Pain Following Childbirth: Prevalence, Effects on Postnatal Recovery and Analgesia Usage. *Midwifery* 28(1):93-97. doi:10.1016/j.midw.2010.11.009
- Easton, Kirsten L., Judith F. McComish, and Rivka Greenberg
 2000 Avoiding Common Pitfalls in Qualitative Data Collection and Transcription. *Qualitative Health Research* 10(5):703-707. doi:10.1177/104973200129118651
- Ecker Jeffrey L., and Fredric D. Frigoletto
 2007 Cesarean Delivery and the Risk-Benefit Calculus. *New England Journal of Medicine* 356:885-888. doi: 10.1056/nejmp068290
- Edoka, Ijeoma P., Stavros Petrou, and Paul G. Ramchandani
 2011 Healthcare Costs of Paternal Depression in the Postnatal Period. *Journal of Affective Disorders* 133(1):356-360. doi:10.1016/j.jad.2011.04.005
- Ehrenreich Barbara, and Deirdre English
 1973 *Witches, Midwives, and Nurses: A History of Women Healers*. Old Westbury: The Feminist Press.
 1978 *For Her Own Good: 150 Years of the Experts Advice to Women*. New York: Anchor.
- Elbourne, D.R., W.J.: Carroli, G. Prendiville, J. Wood, and S. McDonald
 2001 Prophylactic Use of Oxytocin in the Third Stage of Labour. *Cochrane Database Systems Review* 4:CD001908.
- Ellis, Carolyn, Tony E. Adams, and Arthur P. Bochner.
 2010 Autoethnography: An Overview. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 12(1). Accessed July 28, 2015.
<http://www.qualitative-research.net/index.php/fqs/article/view/1589/3095>>.
- Elmir, Rakime, Virginia Schmied, Debra Jackson, and Lesley Wilkes
 2012 Between Life and Death: Women's Experiences of Coming Close to Death, and Surviving a Severe Postpartum Haemorrhage and Emergency Hysterectomy. *Midwifery* 28(2):228-235. doi:10.1016/j.midw.2010.11.008
- Emden, C.
 1991 Ways of Knowing in Nursing. *In Towards a Discipline in Nursing* G. Gray and R. Pratt, eds. Pp. 11-30. Melbourne: Churchill Livinstone.
- Emmanuel, Elizabeth, N., Debra, K. Creedy, Winsome St John, and Claire Brown
 2011 Maternal Role Development: The Impact of Maternal Distress and Social Support Following Childbirth. *Midwifery* 27:265-272. doi:10.1016/j.midw.2009.07.003

- Enkin, M., M.J. Keirse, J. Neilson, C. Crowther, L. Duley, E. Hodnett, and J. Hofmeyr
2000 *A Guide to Effective Care in Pregnancy and Childbirth*. New York: Oxford University Press.
- Epstein, J.
1995 *The Pregnant Imagination, Fetal Rights, and Women's Bodies: A Historical Inquiry*. *Yale Journal of Law and the Humanities* 7(1):139-162.
- Epstein, Michelle A., and Bette L. Bottoms
2002 *Explaining the Forgetting and Recovery of Abuse and Trauma Memories: Possible Mechanisms*. *Child Maltreatment* 7(3):210-225. doi:10.1177/1077559502007003004
- Etowa, Josephine Bassey
2012 *Becoming a Mother: The Meaning of Childbirth for African-Canadian Women*. *Contemporary Nurse* 41(1):28-40.
- Evans R.L., and G.L. Stoddard
1990 *Producing Health, Consuming Health Care*. *Social Science Medicine* 31(12):147-163.
- Fabian, Helena M., Ingela J. Radestad, and Ulla Waldenstrom
2004 *Characteristics of Swedish Women Who do not Attend Childbirth and Parenthood Education Classes During Pregnancy*. *Midwifery* 20(3):226-235.
doi:10.1016/j.midw.2004.01.003
- Faccio, E.
2013 *The Corporeal Identify: When the Self-Image Hurts*. London: Springer.
- Fair, Cynthia D., and Taylor E. Morrison
2012 *The Relationship Between Prenatal Control, Expectations, Experienced Control, and Birth Satisfaction Among Primiparous Women*. *Midwifery* 28(1):39-44.
doi:10.1016/j.midw.2010.10.013
- Farmer, Paul
2004 *An Anthology of Structural Violence*. *Current Anthropology* 45(3):305-325.
- Farmer, Paul, E., Bruce Nizeye, Sara Stulac, and Salmaan Keshavjee
2006 *Structural Violence and Clinical Medicine*. *PLoS Medicine*, 3(10):1686-1691. doi:10.1371/journal.pmed.0030449
- Farrell, M.V.
2007 *The Target of the Bully and the Effects of PTSD*. *Midwifery Today* 82:64-65.
- Fausto-Sterling, Anne
1992 *Myths of Gender: Biological Theories About Men and Women*. New York: Basic Books.

- Fenwick, Jennifer, Jenny Gamble, Debra Creedy, Lesley Barclay, Anne Buist, and Elsa Lena Ryding
2013 Women's Perceptions of Emotional Support Following Childbirth: A Qualitative Study. *Midwifery* 29(3):217-224, doi: 10.1016/j.midw.2011.12.008.
doi:10.1016/j.midw.2011.12.008
- Fenwick, Jennifer, Lynne Staff, Jenny Gamble, Debra K. Creedy, and Sara Bayes
2010 Why Do Women Request Caesarean Section in a Normal, Healthy First Pregnancy? *Midwifery* 26(4):394-400. doi:10.1016/j.midw.2008.10.011
- Fenwick, Jennifer, Jenny Gamble, Elizabeth Nathan, Sara Bayes, and Yvonne Hauck
2009 Pre- and Postpartum Levels of Childbirth Fear and the Relationship to Birth Outcomes in a Cohort of Australian Women. *Journal of Clinical Nursing* 18(5):667-677.
doi:10.1111/j.1365-2702.2008.02568.x
- Ferguson, Sally, Deborah Davis, and Jenny Browne
2013 Does Antenatal Education Affect Labour and Birth? A Structured Review of the Literature. *Women and Birth* 26(1):e5-e8. doi:10.1016/j.wombi.2012.09.003
- Field, Tiffany
1996 Attachment and Separation in Young Children. *Annual Review of Psychology* 47: 541-562. doi: 10.1146/annurev.psych.47.1.541
1998 Maternal Depression Effects on Infants and Early Interventions. *Preventive Medicine* 27(2):200-203. doi:10.1006/pmed.1998.0293
- Figueiredo Barbara, and Ana Conde
2011 Anxiety and Depression Symptoms in Women and Men From Early Pregnancy to 3-Months Postpartum: Parity Differences and Effects. *Journal of Affective Disorders* 132(1-2):146-157. doi: 10.1016/j.jad.2011.02.007
- Finlay, Linda
2002 Negotiating the Swamp: The Opportunity and Challenge of Reflexivity in Research Practice. *Qualitative Research* 2(2):209-230. doi:10.1177/146879410200200205
- Finlay, Linda, and Ken Evans
2009 *Relational Centred Research for Psychotherapists: Exploring Meaning and Experience*. Chichester, West Sussex: Wiley-Blackwell.
- Fisher, Berenice Malka
2000 *No Angel in the Classroom: Teaching Through Feminist Discourse*. Washington: Rowman and Littlefield.
- Foley, Douglas, and Angela Valenzuela
2005 Critical Ethnography: The Politics of Collaboration. *In The Sage Handbook of Qualitative Research*. Norman K. Denzin and Yvonna S. Lincoln, eds. Pp. 217-234. New York: Sage.

- Fonow, Mary Margaret, and Judith A. Cook
1991 *Beyond Methodology: Feminist Scholarship as Lived Research*. Indianapolis: Indiana University Press.
2005 *Feminist Methodology: New Applications in the Academy and Public Policy*. *Signs* 30(2):2211-2236. doi:10.1086/428417
- Forbat, Liz, and Jeanette Henderson
2005 Theoretical and Practical Reflection on Sharing Transcripts with Participants. *Qualitative Health Research* 15(8):1114-1128. doi:10.1177/1049732305279065
- Forssen, Annika, S.K.
2012 Lifelong Significance of Disempowering Experiences in Perinatal and Maternity Care: Interviews With Elderly Swedish Women. *Qualitative Health Research* 22(11):1535-1546. doi:10.1177/104973231244921
- Foucault, Michel
1978 *Discipline and Punish: The Birth of the Prison*. New York: Random House.
2003 *The Birth of the Clinic*. London: Routledge
- Fowles, Eileen R.
1998 Labor Concern of Women Two Months After Delivery. *Birth* 25(4):235-240. doi:10.1046/j.1523-536x.1998.00235.x
- Fox, Nicholas J.
1993 *Postmodernism, Sociology and Health*. Buckingham: Open University Press.
- Frankl, Viktor E.
1973 *Man's Search for Meaning*. New York: Penguin.
- Fraser, Diane M., and Margaret A. Cooper, eds.
2009 *Myles Textbook for Midwives*. Delhi: Gyan Books.
- Freshwater, Dawn, and Gary Rolfe
2001 Critical Reflexivity: A Politically and Ethically Engaged Research Method for Nursing. *Journal of Research in Nursing* 6(1):526-537. doi:10.1177/136140960100600109
- Freud, Sigmund
1962 The Aetiology of Hysteria. *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume III (1893-1899)*, 187-221. Early Psycho-Analytic Publications.
- Friere, Paulo
1970 *Pedagogy of the Oppressed*. New York: Continuum Publishing Co.

- Frigoletto, F. D., E. Lieberman, J.M. Lang, A. Cohen, V. Barss, S. Ringer, and S. Datta
1995 A Clinical Trial of Active Management of Labor. *New England Journal of Medicine*
333(12):745-750. doi:10.1056/nejm199509213331201
- Gabrysch, Sabine, and Oona M.R. Campbell
2009 Still Too Far To Walk: Literature Review of the Determinants of Delivery Service Use.
BMC: Pregnancy and Childbirth 9(1):34. doi:10.1186/1471-2393-9-34
- Gadow, Sally A.
1985 Nurse and Patient: The Caring Relationship. *In Caring, Curing, Coping: Nurse, Physician, and Patient Relationships*. A. H. Bishop and J. R. Scudder, eds. Pp. 31-43. Tuscaloosa: University of Alabama Press.
1999 Relational Narrative: The Postmodern Turn in Nursing Ethics. *Scholarly Inquiry for Nursing Practice* 13(1):57-70.
- Gallagher, Frances, Linda Bell, Guy Waddell, Annie Benoit, and Nathalie Cote
2012 Requesting Cesareans Without Medical Indication: An Option Being Considered by Young Canadian Women. *Birth* 39(1):39-47. doi:10.1111/j.1523-536X.2011.00511.x
- Galtung, Johan
1969 Violence, Peace and Peace Research. *Journal of Peace Research*, 6(3), 167-191. doi:10.1177/002234336900600301
- Gamble, Jenny, and Debra Creedy
2004 Content and Processes of Postpartum Counselling After a Distressing Birth Experience: A Review. *Birth* 31(3):213-218. doi:10.1111/j.0730-7659.2004.00307.x
- Gamble, Jenny, Debra Creedy, Wendy Moyle, Joan Webster, Margaret McAllister, and Paul Dickson
2005 Effectiveness of a Counselling Intervention After a Traumatic Childbirth: A Randomized Controlled Trial. *Birth* 32(1):11-19.
- Garriguet, Didier
2009 Diet Quality in Canada. Accessed January 30, 2014.
<http://www.statcan.gc.ca/pub/82-003-x/2009003/article/10914-eng.htm>
- Gavin, Norma I., Gaynes N. Bradley, Kathleen N. Lohr, Samantha Meltzer-Brody, Gerald Gartlehner, and Tammeka Swinson
2005 Perinatal Depression: A Systematic Review of Prevalance and Incidence. *Obstetrics and Gynecology* 106(5, Part 1):1071-1083. doi:10.1097/01.AOG.0000183597.31630.db
- Geertz, Clifford
1973 *The Interpretation of Cultures*. New York: Basic Books.

Geisel, Janet

2003 Folic Acid and Neural Tube Defects in Pregnancy. *Journal of Perinatal & Neonatal Nursing* 17(4):268-279. doi:10.1097/00005237-200310000-00005

Gelfand, Steven L., Jonathan M. Fanaroff, and Michele C. Walsh.

2004 Meconium Stained Fluid: Approach to the Mother and the Baby. *Pediatric Clinics of North America* 51(3):655-667. doi:10.1016/j.pcl.2004.01.012

Gibbins, Jo, and Ann M. Thomson

2001 Women's Expectations and Experiences of Childbirth. *Midwifery* 17(4):302-313. doi:10.1054/midw.2001.0263

Gibbons, Luz, Jose, M. Belizan, Jeremy A. Lauer, Ana. P. Betran, Mario Meriardi, and Fernando Althabe

2010 The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage. *World Health Report, Background Paper, 30*. Accessed July 20, 2015. <http://www.who.int/healthsystems/topics/financing/healthreport/30C-sectioncosts.pdf>

Gilligan, Carol

1982 *In a Different Voice: Psychological Theory and Women's Development*. Cambridge Harvard University Press.

Glaser, Barney, and Anselm Strauss.

1967 *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.

Glezerman, Marek

2012 Planned Vaginal Breech Delivery: Current Status and the Need to Reconsider. *CME* 7(2):159-166. doi:10.1586/EOG.12.2

Gluck, Sherna Berger, and Daphne Patai

1991 *Women's Words: The Feminist Practice of Oral History*. New York: Routledge.

Goffinet, F., M. Carayol, J. Foidart, S. Alexander, S. Uzan, D. Subtil, and G. Breart

2006 Is Planned Vaginal Delivery for Breech Presentation at Term Still an Option? Results of an Observational Prospective Survey in France and Belgium. *American Journal of Obstetrics and Gynecology* 194(4):1002-1011. doi:10.3410/f.12453.469938

Goffman, Erving

1986 *Stigma: Notes on the Management of Spoiled Identity*. New York: Penguin.

Goodman, Petra, Marlene C. Mackey, and Abbas S. Tavakoli.

2004 Factors Related to Childbirth Satisfaction. *Journal of Advanced Nursing* 46(2):212-219. doi:10.1111/j.1365-2648.2003.02981.x

- Goodwin-Smith, Ian
2012 Bloodlust: A Postcolonial Sociology of Childbirth. *Social Identities*, 18(5):521-535.
doi:10.1080/13504630.2012.667602
- Graham, Hilary, and Ann Oakley
2005 Competing Ideologies of Reproduction: Medical and Maternal Perspectives on Pregnancy. *In* *Medical Sociology: Major Themes in Health and Social Welfare*. G. Scambler, ed. Pp. 110-126. New York: Routledge.
- Grant, Lorna J.
1992 Effects of Childhood Sexual Abuse: Issues for Obstetric Caregivers. *Birth* 19(4):220-221. doi:10.1111/j.1523-536x.1992.tb00407.x
- Green, Fiona Joy
2003 "What's Love Got to Do With it?": A Personal Reflection on the Role of Maternal Love in Feminist Teaching. *Journal of the Association for Research on Mothering* 5(2):47-56.
- Green, Josephine M., Vanessa A. Coupland, and Jenny V. Kitzinger
1990 Expectations, Experiences, and Psychological Outcomes of Childbirth: A Prospective Study of 825 Women. *Birth* 17(1):15-24. doi:10.1111/j.1523-536x.1990.tb00004.x
- Green, Laura
2011 A 'Fleshy Metaphysics': Irigaray and Battersby on Female Subjectivity. *Women: A Cultural Review* 22(2/3):143-154. doi:10.1080/09574042.2011.561115
- Griffin, Susan
1982 *Made From This Earth: Selections From her Writing*. London: The Women's Press.
- Griffin, Terry, Karen Davanaugh, Carmen Fraga Soto, and Melissa White
1997 Parental Evaluation of a Tour of the Neonatal Intensive Care Unit During a High-Risk Pregnancy. *JOGNN* 26(1):59-65. doi:10.1111/j.1552-6909.1997.tb01508.x
- Grosz, Elizabeth A.
1993 Bodies and Knowledges: Feminism and the Crisis of Reason. *In* *Feminist Epistemologies*, L. Alcoff and E. Potter, eds. Pp. 187-216. New York: Routledge.
1994 *Volatile Bodies: Towards a Corporeal Feminism*. Bloomington: Indiana University Press.
- Grote, Nancy K., and Sarah E. Bledsoe
2007 Predicting Postpartum Depressive Symptoms in new Mothers: The Role of Optimism and Stress Frequency During Pregnancy. *Health & Social Work* 32(2):107-118.
doi:10.1093/hsw/32.2.107

Guidelines.

2007 British Columbia Reproductive Care Programs. Accessed June 10, 2010.
<http://www.bcphp.ca>

Guillemin, Marilys, and Lynn Gillam

2004 Ethics, Reflexivity, and “Ethically Important Moments” in Research. *Qualitative Inquiry* 10(2):261-280. doi:10.1177/1077800403262360

Hadjigeorgiou, Eleni, Christiana Kouta, Evridiki Papastavrou, Irena Papadopoulos, and Lena, B. Martensson

2012 Women's Perceptions of Their Right to Choose the Place of Childbirth: An Integrative Review. *Midwifery* 28(3):380-390. doi:10.1016/j.midw.2011.05.006

Hagemaster, Julia Nelson.

1992 Life History: A Qualitative Method of Research. *Journal of Advanced Nursing* 17(9): 1122-1319. doi:10.1111/j.1365-2648.1992.tb02047.x

Haglund, Kristin

2004 Conducting Life History Research With Adolescents. *Qualitative Health Research* 14(9):1309-1319. doi:10.1177/1049732304268628

Hallett, Christine

2005 The Attempt to Understand Puerperal Fever in the Eighteenth and Nineteenth Centuries: The Influence of Inflammatory Theory. *Medical History* 49(1):1-28. doi:10.1017/s0025727300000119

Hammersley, Martyn

1992 On Feminist Methodology. *Sociology* 26(2):187-206.

Haraway, Donna

1988 Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies* 14(3):575-599. doi:10.2307/3178066

Harding, Sandra

1986 *The Science Question in Feminism*. Ithaca: Cornell University Press.

1987 Introduction: Is There a Feminist Method. *In Feminism and Methodology*. Sandra Harding, ed. Pp. 1-14. Bloomington: Indiana University Press.

1991 *Whose Science? Whose Knowledge?: Thinking from Women's Lives*. Ithaca: Cornell University Press.

Harding, Sandra, and Kathryn Norberg

2005 New Feminist Approaches to Social Science Methodologies: An Introduction. *Signs* 20(4):2009-2015. doi:10.1086/428420

Harkness, Sara

1987 The Cultural Mediation of Postpartum Depression. *Medical Anthropology Quarterly* 1(2):194-209. doi:10.1525/maq.1987.1.2.02a00040

Harris, J.R.

1998 *The Nurture Assumption: Why Children Turn Out the Way They Do*. New York: Free Press

Hassan, Sahar J., Johanne Sundby, Adullatif Hussein, and Espen Bjertness

2012 The Paradox of Vaginal Examination Practice During Normal Childbirth: Palestinian Women's Feeling, Opinions, Knowledge and Experiences. *Reproductive Health* 9(16): 16. doi:10.1186/1742-4755-9-16

Hays, Sharon

1996 *The Cultural Contradictions of Motherhood*. New Haven: Yale University Press.

Hedstrom, Louise W., and Niles Newton

1986 Touch in Labor: A Comparison of Cultures and Eras. *Birth* 13(3):181-186. doi:10.1111/j.1523-536x.1986.tb01041.x

Heilbrun, Carolyn G.

1988 *Writing a Woman's Life*. New York: Ballantine Books.

Heimstad, Runa, Pal R. Romundstad, and Kjell A. Salvesen

2008 Induction of Labour for Post-Term Pregnancy and Risk Estimates for Intrauterine and Perinatal Death. *Acta Obstetrica et Gynecologica* 87(2):247-249. doi:10.1080/00016340701743165

Henderson, Dorothy J., Carolyn Sampselle, Fran Mayes, and Deborah Oakley

1992 Toward Culturally Sensitive Research in Multicultural Society. *Health Care for Women International* 13(2):339-350. doi:10.1080/07399339209516012

Henneborn, William J., and Rosemary Cogan

1975 The Effect of Husband Participation in Reported Pain and the Probability of Medication During Labor and Birth. *Journal of Psychomatic Research* 19(3):215-222. doi:10.1016/0022-3999(75)90103-8

Herishanu-Gilutz, S., G. Shahar, E. Schattner, O. Kofman, and G. Holcberg.

2009 On Becoming a First-Time Mother After an Emergency Caesarean Section: A Journey From Alienation to Symbolic Adoption. *Journal of Health Psychology* 14(7):967-981. doi:10.1177/1359105309341205

Hertz R.

1997 *Reflexivity and Voice*. Thousand Oaks: Sage.

Hesse-Biber, Sharlene Nagy

2011 Feminist Research: Exploring, Interrogating, and Transforming the Interconnections of Epistemology, Methodology, and Method. *In Handbook of Feminist Research: Feminist Thoughts on Methodology*. Sharlene Nagy Hesse-Biber, ed. Pp. 2-26. London: Sage Publications.

Higgins, Chris

2009 Iatrogenic Blood Loss and Neonatal Transfusion. *The Biomedical Scientist* 545-547.

Hildingsson, Ingegerd

2008 How Much Influence do Women in Sweden Have on Caesarean Sections? A Follow-Up Study of Women's Preference in Early Pregnancy. *Midwifery* 24:46-54. doi: 10.1016/j.midw.2006.07.007

Hinde, R.

1976 On Describing Relationships. *Journal of Child Psychology and Psychiatry* 17:1-19. doi:10.1111/j.1469-7610.1976.tb00370.x

Hirose, M., T. Hosokawa, and Y. Tanaka.

1997 Extradural Buprenorphine Suppresses Breast Feeding After Caesarean Section. *British Journal of Anaesthesia* 79(1):120-121. doi:10.1093/bja/79.1.120

Ho, Kathleen

2007 Structural Violence as a Human Rights Violation. *Essex Human Rights Review* 4(2): 1-17.

Hobel, Calvin J.

2004 Stress and Preterm Birth. *Clinical Obstetrics and Gynecology* 47(4):856-880. doi:10.1097/01.grf.0000142512.38733.8c

Hodge, Susan

2009 Abuse in Hospital-Based Birth Settings. *Journal of Perinatal Education* 18(4):8-11. doi:10.1624/105812409x474663

Hodnett, Ellen D.

2001 Caregiver Support for Women During Childbirth. *Cochrane Database of Systematic Reviews* 1. doi:10.1002/14651858.CD000199

2002 Pain and Women's Satisfaction with the Experience of Childbirth: A Systematic Review. *American Journal of Obstetrics & Gynecology* 186(5):S160-S172. doi:10.1016/S0002-9378(02)70189-0

Hodnett, Ellen, D., Simon Gates, Justus Sakala, and Carol Hofmeyr

2013 Continuous Support for Women During Childbirth. *The Cochrane Library* 7:1-114. doi:10.1002/14651858.CD003766.pub5

Hollins-Martin, Caroline J.

2008 Birth Planning for Midwives and Mothers. *British Journal of Midwifery* 16(9):583-587. doi:10.12968/bjom.2008.16.9.30881

2013 Women's Views About the Importance of Education in Preparation for Childbirth. *Nurse Education in Practice* 13(6):S12-S18. doi:10.1016/j.nepr.2013.02.013

Holloway, Immy, and Dawn Freshwater

2007 Vulnerable Story Telling: Narrative Research in Nursing. *Journal of Research in Nursing* 12(6):703-711. doi:10.1177/1744987107084669

Homer, Caroline S.E., Lyn Passant, Pat M. Brodie, Sue Kildea, Nicky Leap, Jan Pincombe, and Carol Thorogood

2009 The Role of the Midwife in Australia: Views of Women and Midwives. *Midwifery* 25(6):673-681. doi: 10.1016/j.midw.2009.06.014

hooks, bell

1984 *Feminist Theory: From Margin to Center*. Boston: South End Press.

1992 *Yearning: Race, Gender, and Cultural Politics*. Toronto: Between the Lines.

2000 *Feminism is for Everyone: Passionate Politics*. Boston: South End Press.

Hopkins, Kristine

2000 Are Brazilian Women Really Choosing to Deliver by Cesarean? *Social Science and Medicine* 51(5):725-740. doi:10.1016/S0277-9536(99)00480-3

Howarth, Anne M., Nicola Swain, and Gareth J. Treharne

2010 A Review of Psychosocial Predictors of Outcome in Labour and Childbirth. *New Zealand College of Midwives* 42(42):17-20.

2011 Taking Personal Responsibility for Well-Being Increases Birth Satisfaction of First Time Mothers. *Journal of Health Psychology* 16(8):1221-1230. doi:10.1177/1359105311403521

2012 First-Time Mothers Perspectives on Relationships With and Between Midwives and Doctors: Insights From a Qualitative Study of Giving Birth in New Zealand. *Midwifery* 28(4):489-494. doi:10.1016/j.midw.2011.07.004

Hsu, Kuang-Hung, Pei-Ju Liao, and Chorng-Jer Hwang

2008 Factors Affecting Taiwanese Women's Choice of Cesarean Section. *Social Science and Medicine* 66(1):201-209. doi:10.1016/j.socscimed.2007.07.030

Hudelist, G., H. Mastoroudes, and M. Gorti

2008 The Role of Episiotomy in Instrument Delivery: Is it Preventative for Severe Perineal Injury? *Journal of Obstetrics and Gynecology* 28(5):469-473. doi: 10.1080/01443610802196492

Hunter, Catherine J., Jeffrey S. Upperman, Henri R. Ford, and Victoria Camerini

2008 Understanding the Susceptibility of the Premature Infant to Necrotizing Enterocolitis (NEC). *Pediatric Research* 63(2):117-123. doi:10.1203/PDR.0b013e31815ed6

Hunter, Lauren P.

2006 Women Give Birth and Pizzas are Delivered: Language and Western Childbirth Paradigms. *Journal of Midwifery and Women's Health* 51(2):119-124. doi: 10.1016/j.jmwh.2005.11.009

Innis, Sheila M.

2007 Fatty Acids and Early Human Development. *Early Human Development* 83(12):761-766. doi:10.1016/j.earlhumdev.2007.09.004

Jackson Debra, and Judy Mannix

2004 Giving Voice to the Burden of Blame: A Feminist Study of Mother's Experience of Mother Blaming. *International Journal of Nursing Practice* 10(4):150-158. doi: 10.1111/j.1440-172x.2004.00474.x

Jacobson, Nora

2009a Dignity Violations in Health Care. *Qualitative Health Research* 19(11):1536-1547. doi:10.1177/1049732309349809

2009b A Taxonomy of Dignity: A Grounded Theory Study. *International Health and Human Rights* 9(3):193-194. doi:10.1186/1472-698X-9-3

Jiang Xinyan

2005 Feminist Epistemology: An Introduction. *CSA Academic Perspective* 1:56-58.

Johanson, Richard, Mary Newburn, and Alison Macfarlane

2002 Has the Medicalisation of Childbirth Gone too far? *British Medical Journal* 324(7342):892-895. doi:10.1136/bmj.324.7342.892

Johnson, P., and V. Wiencek

2005 The Relationship Between Amniotomy, Provider Type and Cesarean Section in a University Medical Centre. *CJMRP* 4(2):25-30.

Jones, Helen

2005 Visible Rights: Watching Out For Women. *Surveillance and Society* 2(4):589-593.

Joseph, K.S., J. Rouleau, M.S. Kramer, D.C. Young, R.M. Liston, and T.F. Baskett

2007 Investigation of an Increase in Postpartum Haemorrhage in Canada. *BJOG: An International Journal of Obstetrics and Gynaecology* 114(6):751-759. doi:10.1111/j.1471-0528.2007.01316.x

Kalisch, Beatrice, J., and Philip A. Kalisch

1977 An Analysis of the Sources of Physician-Nurse Conflict. *Journal of Nursing Administration* 2:51-57.

Kalyanadrishnan R., and D. Scheid

2006 Ectopic Pregnancy: Forget the "Classic Presentation" If You Want to Catch It Sooner. *Journal of Family Practice* 55(5):388-395.

Kant, Immanuel

1914 Critique of Judgment. Translated by J.H. Bernard. London: MacMillan.

Karlstrom, Annika, Ingela Radestad, Carola Eriksson, Christine Rubertsson, Astrid Nystedt, and Ingegerd Hildingsson

2010 Cesarean Section Without Medical Reason, 1997 to 2006: A Swedish Register Study. *Birth* 37(1):11-20. doi:10.1111/j.1523-536X.2009.00373.x

Keen Sam

1992 Fire in the Belly: On Being a Man. New York: Bantam Books.

Kelly, S., A. Sprague, D. Fell, P. Murphy, N. Aelicks, N., Y. Guo, and colleagues.

2013 Examining Caesarean Section Rates in Canada Using the Robson Classification System. *Journal of Obstetrics and Gynaecology Canada* 35(3):206-214.

Kerker, Bonnie D., Sarah M. Horwitz, and John M. Leventhal

2004 Patients' Characteristics and Providers' Attitudes: Predictors of Screening Pregnant Women for Illicit Substance Use. *Child Abuse and Neglect* 28(2):209-223. doi:10.1016/j.chiabu.2003.07.004

Khan, Rozilla S., Tahira Naru, and Faryal Nizami

2007 Umbilical Cord Prolapse: A Review of Diagnosis to Delivery Interval on Perinatal and Maternal Outcomes. *Journal of Pakistan Medical Association* 57:487-492.

Khreshch, R.

2010 Support in the First Stage of Labour From a Female Relative: The First Step in Improving the Quality of Maternity Services. *Midwifery* 26(6):e21-e24. doi:10.1016/j.midw.2008.11.003

Kiernan, Kathleen, and Kate Smith

2003 Unmarried Parenthood: New Insights From the Millennium Cohort Study. *Population Trends* 114:26-33.

Kinsella, Michael T., and Catherine Monk

2009 Impact of Maternal Stress, Depression and Anxiety on Fetal Neurobehavioral Development. *Clinical Obstetrics and Gynecology* 52(3):425-440. doi:10.1097/GRF.0b013e3181b52df1

Kitzinger, Sheila

1978 Women as Mothers: How They See Themselves in Different Cultures. New York: Random House.

1987a Giving Birth: How it Really Feels. London: Victor Gollancz.

1987b Your Baby, Your Way: Making Pregnancy Decisions and Birth Plans. New York: Pantheon Books.

1992 Birth and Violence Against Women: Generating Hypotheses From Women's Accounts of Unhappiness After Childbirth. *In Women's Health Matters*. Helen Roberts, ed.

- Pp. 63-80. London: Routledge.
- 1993 *Ourselves as Mothers*. London: Bantam Books.
- 2006 Birth as Rape: There Must be an end to "Just in Case" Obstetrics. *British Journal of Midwifery* 14(9):544-545. doi: 10.12968/bjom.2006.14.9.21799
- 2010 Letter from Europe: Should Fathers be Banned from Birth? *Birth* 37(1):77-78. doi:10.1111/j.1523-536x.2009.00382.x

Kitzinger, Jenny V.

- 1992 Counteracting, Not Reenacting, the Violation of Women's Bodies: The Challenge for Perinatal Caregivers. *Birth* 19(4):219-220. doi:10.1111/j.1523-536x.1992.tb00406.x

Klaus, Phyllis

- 2010 The Impact of Childhood Sexual Abuse on Childbearing and Breastfeeding: The Role of Maternity Caregivers. *Breastfeeding Medicine* 5(4):141-145. doi:10.1089/bfm.2010.9991

Klein Michael C.

- 2004 Quick Fix Culture: The Cesarean-Section-On-Demand Debate. *Birth* 31(3):161-164. doi: 10.1111/j.0730-7659.2004.00300.x

Koch, Tina

- 2006 Establishing Rigour in Qualitative Research: The Decision Trail. *Journal of Advanced Nursing* 53(1):91-100. doi:10.1111/j.1365-2648.2006.03681.x

Koch, Tina, and Ann Harrington

- 1998 Reconceptualizing Rigour: The Case for Reflexivity. *Journal of Advanced Nursing* 28(4):882-890. doi:10.1046/j.1365-2648.1998.00725.x

Koehn, Mary

- 2008 Contemporary Women's Perceptions of Childbirth Education. *Journal of Perinatal Education* 17(1):11-18. doi:10.1624/105812408x267916

Koniak-Griffin, Deborah

- 1993 Maternal Role Attainment. *The Journal of Nursing Scholarship* 25(3):257-262. doi:10.5005/jp/books/10850_25

Kotaska, Andrew

- 2004 Inappropriate use of Randomized Trials to Evaluate Complex Phenomena: Case Study of Vaginal Breech Delivery. *British Medical Journal* 329:1039-1042. doi: 10.1136/bmj.329.7479.1385

Kotaska, Andrew, Savas Menticoglu, and Robert Gagnon

- 2009 Vaginal Delivery of Breech Presentation. *SOCG Clinical Practice Guideline*, 557-566.

- Kulkarni, Jayashri
2014 Women's Mental Health: Still not a Priority, Still not Good Enough. *Australian and New Zealand Journal of Psychiatry* 48(8):701-704. doi:10.1177/0004867414541684
- Kurtz, Donna, L.M., Jessie, C. Nyberg, Susan Van Den Tillaart, and Buffy Mills
2008 Silencing of Voice: An act of Structural Violence. *Journal of Aboriginal Health* 53-63.
- Lacan, J.
1998 *The Four Fundamental Concepts of Psychoanalysis*. New York: MacMillan.
- Langan, R.C.
2006 Discharge Procedures for Healthy Newborns. *American Family Physician* 73(5):849-852.
- Lapierre, Simon
2008 Mothering in the Context of Domestic Violence: The Pervasiveness of a Deficit Model of Mothering. *Child and Family Social Work*, 13(4), 454-463. doi:10.1111/j.1365-2206.2008.00563.x
- Larkin, Patricia, Cecily M. Begley, and Declan Devane
2012 "Not Enough People to Look After You": An Exploration of Women's Experiences of Childbirth in the Republic of Ireland. *Midwifery* 28(1):98-105. doi:10.1016/j.midw.2010.11.007
- Larsson, Margareta, Ulrike Aldegarmann, and Clara Aarts
2009 Professional Role and Identity in a Changing Society: Three Paradoxes in Swedish Midwives' Experiences. *Midwifery* 25(4):373-381. doi: 10.1016/j.midw.2007.07.009
- Lather, Patti
1991 *Getting Smart: Feminist Research and Pedagogy With/In the Postmodern*. New York: Routledge.
1993 Fertile Obsession: Validity After Poststructuralism. *The Sociological Quarterly* 34(4): 673-693. doi:10.1111/j.1533-8525.1993.tb00112.x
2007 *Getting Lost: Feminist Efforts Toward a Double(d) Science*. Albany: State University of New York Press.
- Lavender, Tina, Stephen A. Walkinshaw, and Irene Walton
1999 A Prospective Study of Women's Views of Factors Contributing to a Positive Birth Experience. *Midwifery* 15(1):40-46. doi:10.1016/S0266-6138(99)90036-0
- Lawrence, R.A., and R.M. Lawrence
2005 *Breastfeeding: A Guide for the Medical Professional*. St Louis: Elsevier Mosby.

Lazarus, Emma

1997 What Do Women Want? Issues of Choice, Control and Class in American Pregnancy and Childbirth. *In* Childbirth and Authoritative Knowledge: Cross Cultural Perspectives. R. Davis-Floyd and C. Sargent, eds. Pp. 132-158. Berkeley: University of California Press.

Lazarus, R.S.

1991 Emotion and Adaptation. New York: Oxford University Press.

Leach, Liana S., Helen Christensen, and Andrew Mackinnon

2014 Pregnancy Levels of Depression and Anxiety: A Prospective Cohort Study of Australian Women. *Australian and New Zealand Journal of Psychiatry* 48:1-8. doi: 10.1177/0004867414533013

Leahy Warren, Patricia

2005 First-Time Mothers: Social Support and Confidence in Infant Care. *Journal of Advanced Nursing* 50(5):479-488. doi:10.1111/j.1365-2648.2005.03425.x

Lee, Linda, Y.K., Eleanor Holroyd, and Chun Yuen Ng

2001 Exploring Factors Influencing Chinese Women's Decision to Have Elective Caesarean Surgery. *Midwifery* 17(4):314-322. doi:10.1054/midw.2001.0274

Leeners, Brigitte, Hertha Richter-Appelt, Bruno Imthurn, and Werner Rath

2006 Influence of Childhood Sexual Abuse on Pregnancy, Delivery, and the Early Postpartum Period in Adult Women. *Journal of Psychosomatic Research* 61(2):139-151. doi:10.1016/j.jpsychores.2005.11.006

Leininger, Madeleine M.

1985 Transcultural Care Diversity and Universality: A Theory of Nursing. *Nursing Health Care* 6(4):208-212.

LeMoncheck, L.

1996 Philosophy, Gender Politics and In Vitro Fertilization: A Feminist Ethic of Reproductive Health Care. *Journal of Clinical Ethics*, 7:160-176.

Lennon, John, and Paul McCartney

1965 In my Life ... The Beatles, Rubber Sould Album, George Martin, producer. London, England.

Letherby, Gayle

2002 Claims and Disclaimers: Knowledge, Reflexivity and Representation in Feminist Research 6(4). <http://www.socresonline.org.uk/6/4/letherby.html>, doi:10.5153/sro.665

2003 Feminist Research in Theory and Practice. Buckingham: Open University Press.

- Letourneau, Nicole Lyn, Cindy-Lee Dennis, Karen Benzies, Linda Duffett-Leger, Miriam Stewart, Panagiota D. Tryhonopoulos, and William Watson
 2012 Postpartum Depression is a Family Affair: Addressing the Impact on Mothers, Fathers and Children. *Issues in Mental Health Nursing* 33(7):455-457. doi: 10.3109/01612840.2012.673054
- Levinas, Emmanuel
 1979 *Totality and Infinity: An Essay on Exteriority*. Boston: Martinus-Nijhoff Publishers.
 1998 *Entre Nous: On Thinking-of-the-Other*. New York: Columbia University Press.
- Lewin, David, Brenda Fearon, Valerie Hemmings, and Gail Johnson
 2005 Women's Experiences of Vaginal Examinations in Labour. *Midwifery* 21(3):267-277. doi:10.1054/midw.2002.0326
- Lieberman, E., and C. O'Donoghue
 2002 Unintended Effects of Epidural Analgesia During Labor: A Systematic Review. *American Journal of Obstetrics and Gynecology* 186(5):S31-S68. doi:10.1067/mob.2002.122522
- Lindseth, Anders, and Astrid Norberg
 2004 A Phenomenological Hermeneutical Method for Researching Lived Experience. *Scandinavian Journal of Caring Sciences* 18(2):145-153. doi:10.1111/j.1471 6712.2004.00258.x
- Lippman, Abby
 2004 Cesarean Section on Demand: Not Just a Matter of Choice. *Canadian Women's Health Network* 7(2/3):453-455.
- Liston, Robert, Diane Sawchuck, and David Young
 2007 Fetal Health Surveillance: Antepartum and Intrapartum Consensus Guideline. *JOGC* 29(9):S25-S44.
- Litoff, Judy Barrett
 1978 *American Midwives: 1890 to the Present*. London: Greenwood Press.
- Liu, Shiliang, K. S. Joseph, Michael S. Kramer, Alexander C. Allen, Reg Sauve, I.D. Rusen, and Shi Wu Wen
 2002 Relationship of Prenatal Diagnosis and Pregnancy Termination in Overall Infant Mortality in Canada. *Journal of the American Medical Association* 287(12):1561. doi: 10.1001/jama.287.12.1561
- Liu, Shiliang, Robert M. Liston, K.S. Joseph, Maureen Heaman, Reg Sauve, and Michael S. Kramer
 2007 Maternal Mortality and Severe Morbidity Associated with Low-Risk Planned Cesarean Delivery Versus Planned Vaginal Delivery at Term. *Canadian Journal of Medicine* 176(4):455-461. doi: 10.1503/cmaj.060870

Lloyd Thomas, Katie

2013 Between the Womb and the World. *In* Relational Architectural Ecologies: Architecture, Nature and Subjectivity. P. Rawes, ed. Pp. 191-208. New York: Routledge.

Lloyd, Genevieve

1979 The Man of Reason. *Metaphilosophy* 10(1):18-37. doi:10.1111/j.1467-9973.1979.tb00062.x

LoCicero, Alice Katherine

1993 Explaining Excessive Rates of Cesarean and Other Birth Interventions: Contributions From Contemporary Theories of Gender and Psychosocial Development. *Social Science and Medicine* 37(10):1261-1269. doi: 10.1016/0277-9536(93)90337-4

Logsdon Cynthia M., and Susan Gennaro

2005 Bioecological Model for Guiding Support Research and Interventions with Pregnant Adolescents. *Issues in Mental Health Nursing* 26:327-339. doi: 10.1080/01612840590915702

Logsdon, Cynthia M, Katherine L. Wisner, and Melissa D. Pinto-Foltz

2006 The Impact of Postpartum Depression on Mothering. *JOGNN* 35(5):652-658. doi:10.1111/j.1552-6909.2006.00087.x

Logsdon, C.M., and D.W. Davis

1997 Predictors of Depression in Mothers of Preterm Infants. *Journal of Social Behavior and Personality* 12(1):73-83.

Longino Helen, E.

1997 Feminist Epistemology as Local Epistemology. *Proceedings of the Aristotlian Society, Supplementary Volumes* 71(1):19-36. doi: 10.1111/1467-8349.00017

Longmore, Peter

2004 Informed Consent and Childbirth: Coming to Terms with the 21st Century. *Australian Midwifery Journal* 17(3):6-8. doi:10.1016/s1448-8272(04)80010-5

Lorentzen, Jeanne M.

2008 "I Know My Own Body": Power and Resistance in Women's Experience of Medical Intervention. *Body and Society* 14(3):49-79. doi:10.1177/1357034X08093572

Lothian, Judith A.

2001 Back to the Future: Trusting Birth. *Journal of Perinatal, Neonatal Nursing* 15(3):13-22. doi: 10.1097/00005237-200112000-00003

2006a Saying "No" to Induction. *The Journal of Perinatal Education* 15(2):43-45. doi:10.1624/105812406X107816

- 2006b The Cesarean Catastrophe. *The Journal of Perinatal Education*, 15(1): 42-45. doi: 10.1624/105812406x92976
- 2008 Choice, Autonomy, and Childbirth Education. *Journal of Perinatal Education* 17(1): 35-38. doi:10.1624/105812408x266278
- Lowe, Nancy K.
- 2002 The Nature of Labor Pain. *American Journal of Obstetrics & Gynecology* 186(5): S16-24. doi:10.1067/mob.2002.121427
- 2013 The Overuse of Cesarean Delivery. *JOGNN* 42(2):135-136. doi:10.1111/1552-6909.12025
- Lu, Michael C., and Neal Halfon
- 2003 Racial and Ethnic Disparities in Birth Outcomes: A life-Course Perspective. *Journal of Maternal Child Health* 7(1):13-30. doi:10.1023/A:1022537516969
- Lundgren, Ingela, and Marie Berg
- 2007 Central Concepts in the Midwife-Woman Relationship. *Scandinavian Journal of Caring Science* 21:220-228.
- Lupton, Deborah
- 1999 Risk and the Ontology of Pregnant Embodiment. *In Risk and Sociocultural Theory: New Directions and Perspectives*. Deborah Lupton, ed. Pp. 59-73. Cambridge: Cambridge University Press.
- Lyerly, Anne Drapkin
- 2006 Shame, Gender, Birth. *Hypatia* 21(1):101-118. doi:10.1353/hyp.2005.0146
- Lyotard, Jean-Francois
- 1984 *The Postmodern Condition: A Report on Knowledge*. Translated by G. Bennington and B. Massumi. Minneapolis: University of Minnesota Press.
- Macdonald, M., S. Liben, F. Carnevale, J. Rennick, S. Wolf, D. Meloche, and S. Cohen
- 2005 Parental Perspectives on Hospital Staff Members' Acts of Kindness and Commemoration After a Child's Death. *Pediatrics* 116(4):884-890. doi:10.1542/peds.2004-1980
- Macionis, J. J.
- 1997 *Sociology*. Scarborough: Prentice, Hall, Allyn and Bacon.
- MacKay, Jenna M., and Alexandra Rutherford.
- 2012 Feminist Women's Accounts of Depression. *Affilia* 27(2):180-189. doi:10.1177/0886109912443959
- MacKinnon, Catherine A.
- 1989 *Toward a Feminist Theory of the State*. London: Cambridge University Press.

MacLellan, Jennifer

2014 Claiming an Ethic of Care for Midwifery. *Nursing Ethics* 21(7):69-72.
doi:10.1177/0969733014534878

Mandelbaum, David G.

1973 The Study of Life History: Ghandi. *Current Anthropology* 14(3):177-206.
doi:10.1086/201318

Manias, Elizabeth, and Annette Street

2001 Rethinking Ethnography: Reconstructing Nursing Relationships. *Journal of Advanced Nursing* 33(2):234-242. doi:10.1046/j.1365-2648.2001.01660.x

Marrs, Jennifer

2013 Evaluation of the Impact of a CBT-Based Group on Maternal Postnatal Mental Health Difficulties. *Journal of Reproductive and Infant Psychology* 31(1):72-80.
doi:10.1080/02646838.2012.74767

Marsh, Fiona, Lynne Rogerson, Christine Landon, and Alison Wright

2011 Obstetric Anal Sphincter Injury in the UK and its Effect on Bowel, Bladder and Sexual Function. *European Journal of Obstetrics and Gynecology and Reproductive Biology* 154(2):223-227. doi:10.1016/j.ejogrb.2010.09.006

Martel, M-J., and C. MacKinnon

2005 Guidelines for Vaginal Birth After Previous Caesarean Birth. *SOGC Clinical Practice Guidelines No. 155*:164-174.

Martens, P., and L. Romphf

2007 Factors Associated with Newborn In-Hospital Weight Loss: Comparisons by Feeding Method, Demographics and Birthing Procedure. *Journal of Human Lactation* 23:233-241. doi:10.1177/0890334407303888

Martin, Emily

1987 *The Woman in the Body: A Cultural Analysis of Reproduction*. Milton Keynes: Open University Press.

Martin, Karin A.

2003 Giving Birth Like a Girl. *Gender and Society* 17(1):54-72.
doi:10.1177/0891243202238978

Maslow, Abraham

1943 A Theory of Human Motivation. *Psychological Review* 50(4):370-396. Accessed September 7, 2014. <http://psychclassics.yorku.ca/Maslow/motivation.htm>

- Mathew, J.L.
2004 Effect of Maternal Antibiotics on Breast Feeding Infants. *Post Graduate Medical Journal* 80(942):196-200. doi:10.1136/pgmj.2003.011973
- Mayo Clinic
2011 C-Difficile Infections. Accessed August 6, 2015.
www.mayoclinic.org/diseases-conditions/c-difficile/basics/definition/con-20029664
- McAdams, Dan P., Ruthellen Josselson, and Amia Lieblich
2001 *Turns in the Road: Narrative Studies of Lives in Transition*. Washington: American Psychological Association.
- McEwan, Bruce S., and Eliot Stellar
1993 Stress and the Individual: Mechanisms Leading to Disease. *Archives of Internal Medicine* 153(18):2093-2101. doi:10.1001/archinte.153.18.2093
- McKenzie-McHarg, Kirstie
2004 Traumatic Birth: Understanding Predictors, Triggers, and Counseling Process is Essential to Treatment. *Birth* 31(3):219-221. doi: 10.1111/j.0730-7659.2004.00308.x
- McKinney, D.
2006 A Qualitative Study of the Bradley Method of Childbirth Education. *International Journal of Childbirth Education* 21(3):26-29.
- McPherson, Naomi
2012 *Black and Blue: Shades of Violence in West New Britain, PNG*. In *Engendering Violence in Papua New Guinea*. Margaret Jolly, Christine Stewart and Carolyn Brewer, eds. Pp. 42-72. Canberra: Australian National University E-press.
- Mehta, Brinda
2009 *Notions of Identity, Diaspora, and Gender in Caribbean Women's Writing*. New York: Palgrave Mcmillan.
- Mehta, Ushma J., Anna Maria Siega-Riz, and Amy H. Herring
2011 Effect of Body Image on Pregnancy Weight Gain. *Maternal Child Health Journal* 15(3):324-332. doi:10.1007/s10995-010-0578-7
- Meleis, A. I.
1996 Culturally Competent Scholarship: Substance and Rigor. *Advances in Nursing Science* 19(2):1-16. doi:10.1097/00012272-199612000-00003
1997 *Theoretical Nursing: Development and Progress*. Philadelphia: Lippincott.
- Melender Hanna-Leena, and Sirkka Lauri
1999 Fears Associated with Pregnancy and Childbirth: Experiences of Women who Have Recently Given Birth. *Midwifery* 15(3):177-182. doi: 10.1016/s0266-6138(99)90062-1

Menage, Janet

- 1993 Post-Traumatic Stress Disorder in Women who Have Undergone Obstetric and/or Gynaecological Procedures: A Consecutive Series of 30 Cases of PTSD. *Journal of Reproductive and Infant Psychology* 11(4):221-228. doi:10.1080/02646839308403222

Mercer, Ramona T.

- 1986 *First-Time Motherhood: Experiences from Teens to Forties*. New York: Springer.
2004 Becoming a Mother Versus Maternal Role Attainment. *Journal of Nursing Scholarship* 36(6):226-232. doi:10.1111/j.1547-5069.2004.04042.x
2006 Nursing Support of the Process of Becoming a Mother. *JOGNN* 35(5):649-651. doi:10.1111/j.1552-6909.2006.00086.x

Merchant, Carolyn

- 1983 *The Death of Nature: Women, Ecology and the Scientific Revolution*. New York: HarperCollins.

Merleau-Ponty, Maurice

- 1999 *The Phenomenology of Perception*. New York: Basic Books.

Mezirow, J., and Associates

- 1990 *Fostering Critical Reflection in Adulthood: A Guide to Transformative and Emancipatory Learning*. San Francisco: Jossey-Bass

Michels, Allie, Sue Kruske, and Rachel Thompson

- 2013 Women's Postnatal Psychological Functioning: The Role of Satisfaction With Intrapartum Care and the Birth Experience. *Journal of Reproductive and Infant Psychology* 31(2):172-182. doi:10.1080/02646838.2013.791921

Miles, Margaret S., Diane H. Holditch-Davis, Peg Burchinal, and Deborah Nelson

- 1999 Distress and Growth Outcomes in Mothers of Medically Fragile Infants. *Nursing Research* 48(3):129-140. doi:10.1097/00006199-199905000-00003

Miller, Laura J.

- 2002 Postpartum Depression. *JAMA* 287(6):762-765. doi:10.1001/jama.287.6.762.

Miller, Tina

- 2007 "Is This What Motherhood is All About?": Weaving Experiences and Discourse Through Transition to First-Time Motherhood. *Gender and Society* 21(3):337-358. doi:10.1177/0891243207300561
2011 Transition to First-Time Motherhood. *Practical Midwife* 14(2):12-15.

Millman, M., and R. Kanter

- 1997 *Another Voice: Feminist Perspectives on Social Lives and Social Science*. New York: Anchor.

- Milton, Constance L.
2013 Suffering. *Nursing Science Quarterly* 26(3):226-228. doi:10.1177/0894318413489184
- Milton, Constance, L., and William, K. Cody
2001 Ethical Issues. *Nursing Science Quarterly* 14:288-296.
doi:10.1177/089431840101400404
- Minkoff, Howard L., and Lynn M. Paltrow
2006 The Rights of "Unborn Children" and the Value of Pregnant Women. *The Hastings Centre Report* 36(2):26-28. doi:10.1353/hcr.2006.0031
- Misra Dawn P., Bernard Guyer, and Adam Allston
2003 Integrated Perinatal Health Framework: A Multiple Determinant Model With a Lifespan Approach. *American Journal of Preventative Medicine* 25(1):65-75. doi: 10.1016/s0749-3797(03)00090-4
- Misri, Shaila
1995 *Shouldn't I be Happy: Emotional Problems of Pregnancy and Postpartum Women*. Toronto: Free Press.
2005 *Pregnancy Blues*. New York: Random House.
- Mitchinson, Wendy
2002 *Giving Birth in Canada: 1900-1950*. Toronto: University of Toronto Press.
- Modarres, Maryam, Sedigheh Afrasiabi, Parvin Rahnama, and Ali Montazeri
2012 Prevalence and Risk Factors of Childbirth-Related Post-Traumatic Stress Symptoms. *BMC Pregnancy and Childbirth* 12(1):88. doi:10.1186/1471-2393-12-88
- Mollard, Elizabeth K.
2014 A Qualitative Meta-Synthesis and Theory of Postpartum Depression. *Issues in Mental Health Nursing* 35(9):656-663. doi:10.3109/01612840.2014.893044
- Monahan, Torin
2010 Surveillance as Governance: Social inequality and the Pursuit of Democratic Surveillance. *In Surveillance and Democracy*. K. Haggerty and M. Samatas, eds. Pp. 101-110. New York: Routledge.
2011 Surveillance as Cultural Practice. *The Sociological Quarterly* 52(4):495-508. doi:10.1111/j.1533-8525.2011.01216.x
- Moore, Ann M., Lori Frohwirth, and Elizabeth Miller
2010 Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States. *Social Science and Medicine* 70(11):1777-1744. doi: 10.1016/j.socscimed.2010.02.009

- Morris, Theresa, and Katherine McInerney
2010 Media Representations of Pregnancy and Childbirth: An Analysis of Reality Television Programs in the United States. *Birth* 37(2):134-141. doi:10.1111/j.1523-536X.2010.00393.x
- Morse, Janice M., and Peggy Anne Field
1995 *Qualitative Research Methods for Health Professionals*. Thousand Oaks: Sage Publications.
- Morton, Chrstitine H.
2009 A Fine Line: Ethical Issues Facing Childbirth Educators Negotiating Evidence, Beliefs, and Experience. *The Journal of Perinatal Education* 18(1):25-31. doi:10.1624/105812409X396200
- Morton, Christine H., and Clarissa Hsu
2007 Contemporary Dilemmas in American Childbirth Education: Findings From a Comparative Ethnographic Study. *Journal of Perinatal Education* 16(4):25-37. doi:10.1624/105812407X245614
- Moyzakitis, Wendy
2004 Exploring Women's Descriptions of Distress and/or Trauma in Childbirth from a Feminist Perspective. *Evidence Based Midwifery* 2(1):8-14.
- Munro, Sarah, Jude Kornelsen, and Eileen Hutton
2009 Decision Making in Patient-Initiated Elective Caesarean Delivery: The Influence of Birth Stories. *Journal of Midwifery and Women's Health* 54(5):373-379. doi:10.1016/j.jmwh.2008.12.014
- Murphy, D.J., and I.Z. MacKenzie
1995 The Mortality and Morbidity Associated with Umbilical Cord Prolapse. *British Journal of Obstetricians and Gynecologists* 102(10):826-830. doi:10.1111/j.1471-0528.1995.tb10850.x
- Murphy, K., V. Grieg, J. Garcia, and A. Grant
1986 Maternal Considerations in the Use of Pelvic Examinations in Labour. *Midwifery* 2(2):93-97. doi:10.1016/s0266-6138(86)80023-7
- Naef, Rahel
2006 Bearing Witness: A Moral Way of Engaging in Nurse-Person Relationships. *Nursing Philosophy* 7(3):146-156. doi:10.1111/j.1466-769x.2006.00271.x
- Nakling, Jakob, and Bjorn Backe
2006 Pregnancy Risk Increases From 41 Weeks of Gestation. *Acta Obstetricia et Gynecologica* 85(6):663-668.

- Namey, Emily E., and Anne Drapkin Lyerly.
2010 The Meaning of "Control" for Childbearing Women in the US. *Social Science and Medicine* 71(4):769-776. doi:10.1016/j.socscimed.2010.05.024
- National Aboriginal Health Organization
2008 Celebrating Birth: Aboriginal Midwifery in Canada. Accessed August 6, 2015.
http://www.naho.ca/documents/naho/english/midwifery/celebratingBirth/Midwiferypaper_English.pdf
- Neiterman, Elena
2012 Doing Pregnancy: Pregnant Embodiment as Performance. *Women's Studies International Forum* 35(5):372-383. doi:10.1016/j.wsif.2012.07.004
- Nelson, Anatonía M.
2003 Transition to Motherhood. *JOGNN*, 32(4), 465-477. doi:10.1177/0884217503255199
- Nichols, Mary R.
1995 Adjustment to New Parenthood: Attenders versus Nonattenders at Prenatal Education Classes. *Birth* 22(1):21-26. doi:10.1111/j.1523-536X.1995.tb00549.x
- Nilsson, Christina, and Ingela Lundgren.
2009 Women's Lived Experience of Fear of Childbirth. *Midwifery* 25(2):e1-e9.
doi:10.1016/j.midw.2007.01.017
- Nodding, Nell
1986 *Caring: A Feminine Approach to Ethics and Moral Education*. Los Angeles: University of California.
- Nolan, Mary L.
1997 Antenatal Education - Where Next? *Journal of Advanced Nursing* 25(6):27-28.
doi:10.1046/j.1365-2648.1997.19970251198.x
- Nolan, Mary, Julie Smith, and Jonathan Catling
2009 Experiences of Early Labour (1): Contact with Health Professionals. *The Practising Midwifery* 12(7):21-24.
- Nommsen-Rivers, L.A., J. Heinig, R.J. Cohen, and K.G. Dewey
2008 Newborn wet and Soiled Diaper Counts and Timing of Onset of Lactation as Indicators of Breastfeeding Inadequacy. *Journal of Human Lactation* 24(1):27-33.
doi:10.1177/0890334407311538
- Nouwen, H.J.M.
1996 *Can You Drink This Cup?* Notre Dame: Ave Maria Press.

- Nystedt, Astrid, Ulf Hogberg, and Berit Lundman
2008 Women's Experiences of Becoming a Mother After Prolonged Labour. *Journal of Advanced Nursing* 63(3):250-258. doi:10.1111/j.1365-2648.2008.04636.
- Oakley, Ann
1979 A Case of Maternity: Paradigms of Women as Maternity Cases. *Signs* 4(4):607-631. doi:10.1086/493653
1980 *Women Confined: Towards a Sociology of Childbirth*. Oxford: Martin Robertson.
1981 *Interviewing Women: A Contradiction in Terms*. In *Doing Feminist Research*. Helen Roberts, ed. Pp. 30-61. London: Routledge and Kegan Paul.
- O'Brien, Mary
1981 *The Politics of Reproduction*. Boston: Routledge and Kegan Paul.
1989 *Reproducing the World: Essays in Feminist Theory*. San Francisco: Westview Press.
- O'Driscoll, K., R.J. Jackson, and J.T. Gallagher.
1969 Prevention of Prolonged Labour. *BJM* 2(5655):477-480. doi:10.1136/bmj.2.5655.477
- O'Leary, Joann
2009 Never a Simple Journey: Pregnancy Following Perinatal Loss. *Bereavement Care* 28(2):12-17. doi:10.1080/0268262090299600
- Olesen, Virginia
2011 Feminist Qualitative Research in the Millennium's First Decade: Developments, Challenges, Prospects. In *The Sage Handbook of Qualitative Research*. Norman K. Denzin, and Yvonna S. Lincoln, eds. Pp. 129-146. Los Angeles: Sage.
- Olweus, Dan
1994 Bullying at School: Basic Facts and Effects of a School Based Intervention Program. *Journal of Child Psychology & Psychiatry* 35(7):1171-1190. doi:10.1111/j.1469-7610.1994.tb01229.x
- Onoye, Jane M., Deborah Goebert, Leslie Morland, Courtenay Matsu, and Tricia Wright
2009 PTSD and Postpartum Mental Health in a Sample of Caucasian, Asian, and Pacific Islander Women. *Archives of Women's Mental Health* 12(6):393-400. doi:10.1007/s00737-009-0087-0
- O'Shaughnessy, Sara, and Naomi T. Krogman
2012 A Revolution Reconsidered? Examining the Practice of Qualitative Research in Feminist Scholarship. *Signs* 37(2):493-520. doi:10.1086/661726
- Owens, Kim H.
2008 *Rhetorical Labor: Writing, Childbirth, and the Internet*. Urbana-Champaign, University of Illinois: ProQuest.

Page, Robin L.

2004 Positive Pregnancy Outcomes in Mexican Immigrants: What Can we Learn? *JOGNN* 33(6):783-790. doi: 10.1177/0884217504270595

Paltrow, Lynn, and Jeanne Flavin

2013 Arrests of and Forced Interventions on Pregnant Women in the United States: Implications for Women's Legal Status and Public Health. *Journal of Health Politics, Policy and Law* 38(2):299-343. doi: 10.1215/03616878-1966324

Pan, H.S., , L.W. Huang, C.Y. Lee, Y.L. Tsai, and W.C. Cheng

2002 Uterine Rupture in an Unscarred Uterus After Application of Fundal Pressure: A Case Report. *Journal of Reproductive Medicine* 47(12):1044-1046.

Parfitt, Ylya M., and Susan Ayers

2009 The Effect of Post-Natal Symptoms of Post-Traumatic Stress and Depression on the Couple's Relationship and Parent-Baby Bond. *Journal of Reproductive and Infant Psychology* 27(2):127-142. doi:10.1080/02646830802350831

Parratt, Jenny

1994 The Experience of Childbirth for Survivors of Incest. *Midwifery* 10(1):26-39. doi:10.1016/0266-6138(94)90006-X

Parse, Rosemary R.

1998 *The Human Becoming School of Thought: A Perspective for Nursing and Other Health Professionals*. Thousand Oaks: Sage.

2004 *The Art of Human Becoming*. Accessed December 11, 2013. <http://www.discoveryinternationalonline.com>

Pastore, Patricia A.

2006 Appendicitis in Pregnancy. *Journal of the American Board of Family Medicine* 19(6): 621-626. doi:10.3122/jabfm.19.6.621

Patel, A., S. Goudar, S. Geller, B. Kodkany, S. Edlavitch, K. Wagh, . . . R. Derman

2006 Corrigendum to "Drape Estimation vs. Visual Assessment for Estimating Postpartum Hemorrhage". *International Journal of Gynecology and Obstetrics* 93(3):220-224. doi:10.1016/j.ijgo.2006.08.003

Penuel, Bradley K., Matt Statler, and Ryan Hagen

2013 *Encyclopedia of Crisis Management*. Thousand Oaks: Sage.

Perinatal Services of British Columbia

2011 Examining Cesarean Delivery Rates in B.C. Using the Robson Ten Classification: Part 1: Understanding the Ten Groups 1(4). <http://www.perinatalservicesbc.ca/NR/rdonlyres/3CE464BF-3538-4A78-BA51-451987FDD2EF/0/SurveillanceSpecialReportRobsonTenClassificationDec2011.pdf>

2013 Guidelines and Standards. Accessed October 4, 2014.
<http://www.bcphp.ca/Guidelines.htm>

Picard, C.

2002 Family Reflections on Living Through Sudden Death of a Child. *Nursing Science Quarterly* 15(3):242-250. doi:10.1177/08918402015003011

Pincus, Jane

2000 Childbirth Advice Literature as it Relates to Two Childbearing Ideologies. *Birth* 27(3):209-213. doi: 10.1046/j.1523-536x.2000.00209.x

Platz, Elizabeth, and Roger Newman

2008 Diagnosis of IUGR: Traditional Biometry. *Seminars in Perinatology* 32(3):140-147. doi:10.1053/j.semperi.2008.02.002

Polkinghorne, Donald E.

1995 Narrative Configuration in Qualitative Analysis. *In* Life History and Narrative. J.A. Hatch and R. Wisniewski, eds. Pp. 5-23. Abingdon: Routledge Falmer.

Polyani, Michael

1967 *The Tacit Dimension*. New York: Anchor.

Potter, Patricia, Anne Perry, Janet Ross-Kerr, Marilyn Woods, Barbara Astle, and Wendy Duggleby.

2013 *Canadian Fundamentals of Nursing*. Toronto: Mosby Canada.

Powers, Jennifer R., Liane J. McDermott, Deborah J. Loxton, and Catherine L. Chojenta

2013 A Prospective Study of Prevalence and Predictors of Concurrent Alcohol and Tobacco Use During Pregnancy. *Maternal and Child Health Journal* 17(1):76-84. doi:10.1007/s10995-012-0949-3

Preissle, Judith

2007 Feminist Research Ethics. *In* Handbook of Feminist Research: Theory and Praxis. Shalene N. Hesse-Biber, ed. Pp. 515-534. Thousand Oaks: Sage.

Presser, Lois

2005 Negotiating Power and Narrative in Research: Implications for Feminist Methodology. *Signs* 30(4):2067-2090. doi:10.1086/428424

Pressler, J.L., and J.T. Hepworth

2000 The Conceptualization, Measurement, and Validation of Transient Mechanical Birth Trauma. *Clinical Nursing Research* 9(3):317-338. doi:10.1177/10547730022158618

Prinds, Christine, Niels Christian Hvidt, Ole Morgensen, and Niels Buus

2014 Making Existential Meaning in Transition to Motherhood - A Scoping Review. *Midwifery*, 30(6), 733-741. doi:10.1016/j.midw.2013.06.021

Province of British Columbia, Ministry of Health

2013 *Baby's Best Chance: Parent's Handbook of Pregnancy and Baby Care*: Accessed January 30, 2014. <http://www.health.gov.bc.ca/library/publications/year/2013/bbc.pdf>

Pyne, Jeffrey, M., Eugene Kuc, Paul J. Schroeder, John C. Fortney, Mark Edlund, and Greer Sullivan

2004 Relationship Between Perceived Stigma and Depression Severity. *Journal of Nervous and Mental Diseases* 192(4):278-283. doi:10.1097/01.nmd.0000120886.39886.a3

Raisanen, Sari, Katri Vehvilainen-Julkunen, Mika Gissler, and Seppo Heinonen

2012 Hospital-Based Lateral Episiotomy and Obstetric Anal Sphincter Injury Rates: A Retrospective Population-Based Register Study. *AJOG* 206(347):e1-6. doi:10.1016/j.ajog.2012.02.019

Rallis, Sharon F., and Gretchen B. Rossman

2010 Caring Reflexivity. *International Journal of Qualitative Studies in Education* 23(4): 495-499. doi:10.1080/09518398.2010.492812

Raphael-Leff, Joan

1991 The Mother as Container: Placental Process and Inner Space. *Feminism and Psychology* 1(3):393-408. doi:10.1177/0959353591013005

Razack, Sherene

1993 Story-Telling for Social Change. *Gender and Education* 5(1):55-70. doi:10.1080/0954025930050104

Razurel, Chantal, M. Bruchon-Schweitzer, A. Dupanloup, O. Irion, and M. Epiney

2011 Stressful Events, Social Support and Coping Strategies of Primiparous Women During the Postpartum Period: A Qualitative Study. *Midwifery* 27(2):237-242. doi:10.1016/j.midw.2009.06.005

Redfern-Vance, Nancy, and Sally A. Hutchinson

1995 The Process of Developing Personal Sovereignty in Women who Repeatedly Acquire Sexually Transmitted Diseases. *Qualitative Health Research* 5(2):222-236. doi:10.1177/104973239500500206

Redshaw, M., R. Rowe, C. Hockley, and P. Brocklehurst

2007 *Recorded Delivery: A National Survey of Women's Experience of Maternity Care*. Oxford: NPEU.

Reed-Danahay, D.E.

1997 *Auto/Ethnography: Rewriting the Self and the Social*. Oxford: Berg.

- Reifsnider, Elizabeth, and Sara L. Gill
 2000 Nutrition for the Childbearing Years. *JOGNN* 29(1):43-55. doi:10.1111/j.1552-6909.2000.tb02755.x
- Reiger, Kerreem M., and Karen L. Lane
 2009 Working Together: Collaboration Between Midwives and Doctors in Public Hospitals. *Australian Health Review* 33(2): 315-324. doi: 10.1071/ah090315
- Reinharz, Shulamit
 1992 *Feminist Methods in Social Research*. New York: Oxford University Press.
- Renjilian, C.B., J.W. Womer, K.W. Carroll, T.I. Kang, and C. Fendtner
 2013 Parental Explicit Heuristics in Decision-Making for Children with Life-Threatening Illnesses. *Pediatrics* 131(2):e566-e572. doi:10.1542/peds.2012-1957d
- Rice, Pranee Liamputtong, and Douglas Ezzy
 1999 *Qualitative Research Methods: A Health Focus*. Melbourne: Oxford University Press.
- Rich, Adrienne
 1979 *On Lies, Secrets, and Silence*. New York: W.W. Norton and Company.
- Richards, C.
 2009 The Agenda for Women's Health Care Social Policy. *Social Policy* 391:32-33.
- Riecher-Rossler, A., and M. Hofecker Fallahpour
 2003 Postpartum Depression: Do We Still Need This Diagnostic Term? *Acta Psychiatrica Scandinavica* 108(s418):51-56. doi:10.1034/j.1600-0447.108.s418.11.x
- Riordan, Jan
 2005 *Breast Feeding and Human Lactation*. Mississauga: Jones and Bartlett.
- Roberts, William E., Rick W. Martin, Holli H. Roach, Kenneth G. Perry, James N. Martin Jr., and John C. Morrison
 1997 Are Obstetrical Interventions Such as Cervical Ripening, Induction of Labour, Amnioinfusion, or Amniotomy, Associated with Umbilical Cord Prolapse? *American Journal of Obstetricians and Gynecologists* 176(6):1181-1185. doi:10.1016/s0002-9378(97)70332-6
- Rodriguez, N.A., D.A. Miracle, and P.P. Meier
 2005 Sharing the Science on Human Milk Feedings With Mothers of Very-Low-Birth Weight Infants. *JOGNN* 34(1):109-119. doi:10.1177/0884217504272807
- Rolfe, Gary
 2006 Validity, Trustworthiness and Rigour: Quality and the Idea of Qualitative Research. *Journal of Advanced Nursing* 53(3):304-310. doi:10.1111/j.1365-2648.2006.03727.x

Romano Amy

2006 Research Summaries for Normal Birth. *Journal of Perinatal Education* 15(3):58-60.
doi: 10.1624/105812406x119048

Romano Amy, and Judith A. Lothian

2008 Promoting, Protecting and Supporting Normal Birth: A Look at the Evidence. *JOGNN*,
37(1):94-105. doi: 10.1111/j.1552-6909.2007.00210.

Ronnestad, Arild, Tore Abrahamsen, Sverre Medbo, Hallvard Reigstad, Kristin Lossius, Per I. Kaaresen, Thore Egeland, Inger E. Englund, Lorentz M. Irgens, and Trond Markestad.

2005 Late-Onset Septicemia in a Norwegian National Cohort of Extremely Premature Infants Receiving Very Early Full Human Milk Feedings. *Pediatrics* 115(3):
e269-e276. doi:10.1542/peds.2004-1833

Rose, Anna

1992 Effects of Childhood Sexual Abuse on Childbirth: One Woman's Story. *Birth* 19(4):
214-218. doi:10.1111/j.1523-536X.1992.tb00405.x

Rose, Susan D.

2013 *Challenging Global Gender Violence: The Global Clothesline Project*. New York:
Palgrave MacMillan.

Rosello-Soberon, Maria E., Laiza Fuentes-Chaparro, and Ester Casanueva

2005 Twin Pregnancies: Eating for Three? Maternal Nutrition Update. *Nutrition Reviews*
63(9):295-302. doi:10.1111/j.1753-4887.2005.tb00144.x

Ross Leitenburger, Kimberly A.

1998 *Aboriginal Midwifery and Traditional Birthing Systems Revisited: Interviews with First Nation Elders in North Western Region of British Columbia*. Unpublished Masters Thesis, First Nation's Studies, University of Northern British Columbia.

Roth, Rachel

2000 *Making Women Pay: The Hidden Cost of Fetal Rights*. Ithaca: Cornell University Press.

Rothman, Barbara Katz

1982 *In Labor: Women and Power in the Birthplace*. New York: W.W. Norton and Company.

1984 *Giving Birth: Alternatives in Childbirth*. New York: Penguin Books.

1989 *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*. New York: Norton.

1994 *Beyond Mothers and Fathers: Ideology in a Patriarchal Society*. In *Mothering: Ideology, Experience and Agency*. E. Nakano Glen, G. Chang and L. Forcey, eds. Pp. 139-160. London: Routledge.

- Rouhe, H., K. Salmela-Aro, M. Gissler, E. Halmesmaki, and T. Saisto
2011 Mental Health Problems Common in Women with Fear of Childbirth. *BJOG: An International Journal of Obstetrics and Gynaecology* 118(9):1104-1111. doi:10.1111/j.1471-0528.2011.02967.x
- Rubin, Reva
1967a Attainment of the Maternal Role: Part I: Process. *Nursing Research* 16:237-246.
1967b Attainment of the Maternal Role: Part II: Models and Referent 16:324-346.
1976c Maternal Tasks in Pregnancy. *Journal of Advanced Nursing* 1(5):367-376. doi:10.1111/j.1365-2648.1976.tb00921.x
1984 *Maternal Identity and the Maternal Experience*. New York: Springer
- Ruddick, Sara
1995 *Maternal Thinking: Towards a Politics of Peace*. Boston: Beacon Press.
- Runtz, M.G.
2002 Health Concerns of University Women With a History of Child Physical and Sexual Maltreatment. *Child Maltreatment* 7(3):241-253. doi:10.1177/1077559502007003006
- Ryding, Elsa L., Klaas Wijma, and Barbro Wijma
1998 Experiences of Emergency Cesarean Section: A Phenomenological Study of 53 Women. *Birth* 25(4):246-251. doi:10.1046/j.1523-536X.1998.00246.x
- Sadler, Catherine
2007 Catch Me When I Fall. *Nursing Standard* 21(17):20-22.
- Salvage, Jane, and Richard Smith
2000 Doctors and Nurses: Doing it Differently. *British Medical Journal* 320:1019-1020. doi:10.1136/bmj.320.7241.1019
- Sandelowski, Margarete
1993 Rigor or Rigor Mortis: The Problem of Rigor in Qualitative Research Revisited. *Advances in Nursing Science* 16(2), 1-8. doi:10.1097/00012272-199312000-00002
- Sandelowski, Margarete, Beth Perry Black, Ramona T. Mercer, Vangie Bergum, and M. Colleen Stainton
1994 The Epistemology of Expectant Parenthood. *Western Journal of Nursing Research* 16(6):602-622. doi: 10.1177/019394599401600602
- Sandelowski, Margarete, and Rosa Bustamante.
1986 Cesarean Birth Outside the Natural Childbirth Culture. *Resident Nursing Health* 9(2):81-88. doi:10.1002/nur.4770090203

Sarsour, Khaled, Sheridan, Margaret, Douglas Jutte, Amani Nuru-Jeter, Stephen Boyce, and W. Thomas Hinshaw

2011 Family Socioeconomic Status and Child Executive Functions: The Role of Language, Home Environment, and Single Parenthood. *Journal of International Neuropsychological Society* 17(1):120-132. doi:10.1017/S1355617710001335

Sawyer, A., H. Rabe, J. Abbott, G. Gyte, L Duley, and S. Ayers

2013 Parents' Experiences and Satisfaction With Care During the Birth of Their Very Preterm Baby: A Qualitative Study. *BJOG* 120(5):637-643. doi:10.1111/1471-0528.12104

Sbisa, Marina

1996 The Feminine Subject and Female Body in Discourse about Childbirth. *European Journal of Women's Studies* 3(4):363-376. doi:10.1177/13505068960030040

Scamell, Mandie

2014 Childbirth Within the Risk Society. *Sociology Compass* 8(7):917-928. doi:10.1111/soc4.12077

Schell, J.T.

1923 Once a Cesarean Always a Cesarean. *New York Medical Journal* 637.

Schott, Judith

2003 Antenatal Education Changes and Future Developments. *British Journal of Midwifery* 11(10):S15-S17. doi:10.12968/bjom.2003.11.10Sup.11750

Sekar, K.C.

2010 Iatrogenic Complications in the Neonatal Intensive Care Unit. *Journal of Perinatology* 30:S51-S56. doi:10.1038/jp.2010.102

Seng, Julia, S., Wendy D'Andrea, and Julian D. Ford

2013 Complex Mental Health Sequelae of Psychological Trauma Among Women in Prenatal Care. *Psychological Trauma: Theory, Research, Practice, and Policy* 6(1): 41-49. doi: 10.1037/a0031467

Seng, Julia, S., Lisa M. Kane Low, Mickey Sperlich, David L. Ronis, and Israel Liberzon

2009 Prevalence, Trauma History, and Risk for Posttraumatic Stress Disorder Among Nulliparous Women in Maternity Care. *Obstetrics and Gynecology* 114(4): 839-847. doi: 10.1097/AOG.0b013e3181b8f8a2.

Sevon, Eija

2012 "My Life Has Changed, But His Life Hasn't" Making Sense of the Gendering of Parenthood During the Transition to Motherhood. *Feminism and Psychology* 22(1): 60-80. doi:10.1177/0959353511415076

Shah M., and D. Williams

2004 Cesarean Section on Demand: Round One. *Journal of Midwifery and Women's Health* 49(2):85-85. doi: 10.1016/j.jmwh.2004.01.022

Shearer, Madeleine H., and Milton Estes

1985 A Critical Review of the Recent Literature on Postterm Pregnancy and a Look at Women's Experiences. *Birth* 12(2):95-111. doi:10.1111/j.1523-536X.1985.tb00947.x

Shimada, M., and S. Suzuki

2013 Clinical Significance of Deliveries with Uterine Fundal Pressure Maneuver at a Single Perinatal Center in Japan. *Journal of Clinical Gynecology and Obstetrics* 2(1):10-14. doi:10.4021/jcgo87w

Simkin, Penny

1991 Just Another Day in a Woman's Life? Women's Long-Term Perceptions of Their First Birth Experience, Part 1. *Birth* 18(4):203-210. doi:10.1111/j.1523-536X.1991.tb00103.x

1992a Just Another Day in a Woman's Life? Part II: Nature and Consistency of Women's Long-Term Memories of Their First Birth Experiences. *Birth* 19(2):64-81. doi:10.1111/j.1523-536X.1992.tb00382.x

1992b Overcoming the Legacy of Childhood Sexual Abuse: The Role of Caregivers and Childbirth Educators. *Birth*, 19(4), 224-225. doi:10.1111/j.1523-536X.1992.tb00409.x

1996 The Experience of Maternity in a Woman's Life. *JOGNN* 25(3):247-252. doi:10.1111/j.1552-6909.1996.tb02432.x

2004 Doulas: Nurturing and Protecting the Women's Memory of Her Birthing Experience. *International Journal of Childbirth Education* 19(4):16-19.

2010 The Fetal Occiput Posterior Position: State of the Science and a New Perspective. *Birth* 37(1):61-71. doi:10.1111/j.1523-536X.2009.00380.x

Smith, Nora A.

2006 "Empowering the 'Unfit' Mother Increasing Empathy." *Affilia* 21(4):448-457

Smith, S., and J. Watson

2010 *Reading Autobiography: A Guide for Interpreting Life Narratives*. Minnesota: University of Minnesota Press.

Soet, Johanna E., Gregory A. Brack, and Colleen Dilorio

2003 Prevalence and Predictors of Women's Experience of Psychological Trauma During Childbirth. *Birth* 30:36-46. doi: 10.1046/j.1523-536x.2003.00215.x

Solomon, R.C.

1988 *About Love: Reinventing Romance for our Time*. New York: Simon and Schuster.

- Souza, Joao P., Jose G. Cecatti, Mary A. Parpinelli, Fabiana Krupa, and Maria J.D. Osis
2009 An Emerging "Maternal Near-Miss Syndrome": Narratives of Women Who Almost Died During Pregnancy and Childbirth. *Birth* 36(2):149-158. doi:10.1111/j.1523-536X.2009.00313.x
- Spender, Dale
1987 *Man Made Language*. London: Pandora.
- Spiro, Melford E.
1987 *Collective Representations and Mental Representations in Religious Symbol Systems. In Culture and Human Nature: Theoretical Papers of Melford E. Spiro*. B. Kilbourne and L.L. Langness, eds.161-184. Chicago: Chicago University Press.
- Stainton, M.C., D. McNeil, and S. Harvey
1992 Maternal Tasks of Uncertain Motherhood. *Maternal Child Nursing Journal* 20(3-4):113-123.
- Stang, J., M. Story, and S. Feldman
2005 Nutrition in Adolescent Pregnancy. *International Journal of Childbirth Educators*, 20(2), 4-11.
- Stanley, Liz, and Sue Wise
1983 *Breaking Out: Feminist Consciousness and Feminist Research*. Boston: Routledge and Kegan Paul.
- Steinhauer, Paul D.
1998 *The Least Detrimental Alternative: A Systematic Guide to Case Planning and Decision Making for Children in Care*. Toronto: University of Toronto Press.
- Stevens, Bonnie, Janet Yamada, Grace Y. Lee, and Arne Ohlsson
2012 Sucrose for Analgesia in Newborn Infants Undergoing Painful Procedures. *Cochrane Neonatal Group*. doi:10.1002/14651858.CD001069.pub4
- Stojanovich, Ljudmila
2010 Stress and Autoimmunity. *Autoimmunity Reivew* 9(5):A271-A276. doi:10.1016/j.autrev.2009.11.014
- Stoopnikoff, Karen L.
2011 *A Case Study of Prenatal Education and Online Environments*. British Columbia: UBC Okanagan.
- Street, Brian V.
2014 *Social Literacies: Critical Approaches to Literacy Development, Ethnography and Education*. New York: Routledge.

- Sturrock, William, A., and John A. Johnson.
1990 The Relationship Between Childbirth Education Classes and Obstetric Outcome. *Birth* 17(2):82-85.
- Suitor, J.J.
1981 Husbands' Participation in Childbirth: A Nineteenth-Century Phenomenon. *Journal of Family History* 6(3):278-293. doi:10.1177/036319908100600303
- Sultan, A., A. Kamm, C. Hudson, and C. Bartram.
1994 Third-Degree Obstetric Anal Sphincter Tears: Risk Factors and Outcomes of Primary Repair. *British Medical Journal* 308:887-891.
- Svensson, Jane, Lesley Barclay, and Margaret Cooke
2008 Effective Antenatal Education: Strategies Recommended by Expectant and New Parents. *Journal of Perinatal Education* 17(4):33-42. doi:10.1624/105812408x364152
- Swahnberg, Katarina, Barbro Wijma, and Karin Siwe
2011 Strong Discomfort During Vaginal Examinations: Why Consider a History of Abuse? *European Journal of Obstetrics and Gynecology and Reproductive Biology* 157(2): 200-205. doi:10.1016/j.ejogrb.2011.02.025
- Sword, W., C. Kurtz Landy, L. Thabane, S. Watt, P. Krueger, D. Farine, and G. Foster
2011 Is Mode of Delivery Associated with Postpartum Depression at 6 Weeks: A Prospective Cohort Study. *BJOG: An International Journal of Obstetrics and Gynaecology* 118(8):966-977. doi:10.1111/j.1471-0528.2011.02950.x
- Tarkka, Marja-Terttu, Marita Paunonen, and Pekka Laippala
2000 Importance of the Midwife in the First-Time Mother's Experience of Childbirth. *Scandinavian Journal of Caring Science* 14(3):184-190. doi:10.1111/j.1471 6712.2000.tb00582.x
- Taylor, Jan, and Maree Johnson
2010 How Women Manage Fatigue After Childbirth. *Midwifery* 26(3):367-375. doi:10.1016/j.midw.2008.07.004
- Thakur, R., and A.H. Sultan
2003 Management of Obstetric Anal Sphincter Injury. *Obstetric and Gynecology* 5:72-78.
- Theriot, Nancy M.
1993 Women's Voices in Nineteenth-Century Medical Discourses: A Step Toward Deconstructing Science. *Signs* 19(1):1-31. doi: 10.1086/494860
- Thurgood S., D.M. Avery, and L. Williamson
2009 Postpartum Depression (PPD). *American Journal of Clinical Medicine* 6(2):17-22.

- Tolstoy, Leo
1899 *Childhood*. New York: Thomas Y. Crowell.
- Triggle, Nick
2013 *Worry as Women Left Alone in Labour*. BBC News. Accessed June 4, 2014.
<http://www.bbc.com/news/health-25337909>
- Trombini, Elena, P. Surcinelli, A. Piccioni, R. Alessandrini, and G. Faldella
2008 *Environmental Factors Associated with Stress in Mothers of Preterm Newborns*. *Acta Paediatrica* 97(7):894-898. doi:10.1111/j.1651-2227.2008.00849.x
- Turcotte, Martin
2011 *Women and Education*. *Women in Canada: A Gender Based Statistical Report*. Accessed June 30, 2013. <http://www.statcan.gc.ca/pub/89-503-x/2010001/article/11542-eng.htm>
- Ugarriza, Doris Noel
2002 *Postpartum Depressed Women's Explanation of Depression*. *Journal of Nursing Scholarship* 34(3), 227-233. doi:10.1111/j.1547-5069.2002.00227.x
- Unger, Jennifer A., Estelle Whimbey, Michael G. Gravett, and David A. Eschenbach
2011 *The Emergence of Clostridium Difficile Infection Among Peripartum Women: A Case-Control Study of a C. Difficile Outbreak on an Obstetrical Service*. *Infectious Diseases in Obstetrics and Gynecology* 1-8. doi:10.1155/2011/267249
- Ussher, Jane M.
2006 *Managing the Monstrous Feminine: Regulating the Reproductive Body*. New York: Routledge.
- Vachon, Melanie, Lise Fillion, Marie Achille, Stephane Duval, and Doris Leung.
2011 *An Awakening Experience: An Interpretative Phenomenological Analysis of the Effects of a Meaning-Centered Intervention Shared Among Palliative Care Nurses*. *Qualitative Research in Psychology* 8(1):66-80. doi: 10.1080/14780880903551564
- Vaillant, George E.
1985 *Loss as a Metaphor for Attachment*. *American Journal of Psychoanalysis* 45(1): 59-67. doi:10.1007/bf01262792
- Valizadeh, Laila, Vahid Zamanzadh, Easa, Arzani, and Afsaneh Mohammadi
2014 *Continuous and Multiple Waves of Emotional Responses: Mother's Experience With a Premature Infant*. *Iranian Journal of Nursing and Midwifery Research* 19(4):340.
- van der Kolk, A.
1987 *Psychological Trauma*. Washington, D.C.:American Psychological Press.

- van der Kolk, B.A., J. Hopper, and J. Osterman
2001 Exploring the Nature of Post Traumatic Memory: Combining Clinical Knowledge with Laboratory Methods. *In* Trauma and Cognitive Science: Meeting of Mind, Science, and Human Experience. I. Freyd and A.P. DePrince, eds. Pp. 10-32. Portland: Book News.
- Van Maanen, John
2011 Tales of the Field: On Writing Ethnography. Chicago: University of Chicago Press.
- van Teijlingen, Edwin R., Vanora Hundley, Ann-Marie Rennie, Wendy Graham, and Ann Fitzmaurice
2003 Maternity Satisfaction Studies and Their Limitations: "What Is, Must Still Be Best". *Birth* 30(2):75-82. doi:10.1046/j.1523-536X.2003.00224.x
- Vangeenderhuysen, C., and A. Souidi
2002 Uterine Rupture of Pregnant Uterus: Study of a Continuous Series of 63 Cases at the Referral Maternity of Niamey (Niger). *La Medicina Tropical (Mars)* 62(6):615-618.
- Verheijen, Evelyn C., Joanna H. Raven, and G. Justus Hofmeyr
2009 Fundal Pressure During the Second Stage of Labour (Review). *The Cochrane Collaboration* 1-17. doi:10.1002/14651858.cd006067.pub2
- Villar, J., G. Carroli, and A.M. Gulmezoglu
2001 The Gap Between Evidence and Practice In Maternal Healthcare. *International Journal of Gynecology and Obstetrics* 75(1):S47-S54. doi:10.1016/S0020-7292(01)00517-3
- Vohr, B.R., B.B. Poindexter, A.M. Dusick, L.T. McKinley, L.L. Wright, and J.C. Langer
2006 Beneficial Effects of Breastmilk in the Neonatal Intensive Care Unit on the Developmental Outcome of Extremely Low Birth Weight Infants at 18 Months of Age. *Pediatrics* 118(1):115-123. doi:10.1542/peds.2005-2382
- Wagner, M.
2001 Fish Can't See Water: The Need to Humanize Birth. *International Journal of Gynecology and Obstetrics* 75(1):S25-S37. doi:10.1016/S0020-7292(01)00519-7
- Waldenstrom, Ulla
2004 Why Do Some Women Change Their Opinion About Childbirth Over Time? *Birth* 31(2):102-107. doi:10.1111/j.0730-7659.2004.00287.x
- Waldenstrom, Ulla, Ingegerd Hildingsson, Christine Rubertsson, and Ingela Radestad
2004 A Negative Birth Experience: Prevalence and Risk Factors in a National Sample. *Birth* 31(1):17-27. doi:10.1111/j.0730-7659.2004.0270.x

- Walker, Lenore E.
1999 Psychology and Domestic Violence Around the World. *American Psychologist* 54(1): 21-29. doi:10.1037//0003-066x.54.1.21
- Walsh, C., E. Mooney, G. Upton, and R. Motson
1996 Incidence of Third-Degree Perineal Tears in Labour and Outcome After Primary Repair. *British Journal of Surgery* 83:218-221.
- Walsh, Denis J.
2000 Part Three: Assessing Women's Progress in Labour. *British Journal of Midwifery* 8(7):449-457. doi:10.12968/bjom.2000.8.7.8108
2010 Childbirth Embodiment: Problematic Aspects of Current Understandings. *Sociology of Health and Illness* 32(2):486-501. doi:10.1111/j.1467-9566.2009.01207.x
- Way, Susan
2012 A Qualitative Study Exploring Womens' Personal Experiences of Their Perineum After Childbirth: Expectatons, Reality and Returning to Normality. *Midwifery* 28: e712-e719. doi:10.1016/j.midw.2011.08.011
- Webster, Joan, John W.J. Linnane, Linda M. Dibley, Janis K. Hinson, Suzanne E. Starrenburg, and Janice A. Roberts
2000 Measuring Social Support in Pregnancy: Can it be Simple and Meaningful? *Birth* 27(3):97-101. doi:10.1046/j.1523-536x.2000.00097.x
- Weingarten, Kathy
1997 *The Mother's Voice: Strengthening Intimacy in Families*. New York : Guilford Publications.
- Weiss, Meira
1998 Conditions of Mothering: The Bio-Politics of Falling in Love with your Child. *Social Science Journal* 35(1):87-105. doi:10.1016/s0362-3319(98)90062-3
- Weitoft, Gunilla Ringback, Anders Hjern, Bengt Haglund, and Mans Rosen
2003 Mortality, Severe Morbidity, and Injury in Children Living with Single Parents in Sweden: A Population-Based Study. *Lancet* 361(9354):289-295. doi:10.1016/s0140 6736(03)12324-0
- Welsh, A.
2008 *Induction of Labour*. London: RCOG Press. Accessed June 13, 2014. <https://www.ncbi.nlm.nih.gov/books/NBK53617/pdf/TOC.pdf>
- Wendt, Eva K., Evy A-S. Lidell, Anna K.E. Marklund, Bertil, R.G. Westerstahl, and Cathrine I. Hildingh
2011 Young Women's Perceptions of Being Asked Questions About Sexuality and Sexual Abuse: A Content Analysis. *Midwifery* 27(2):250-256. doi:10.1016/j.midw.2009.06.008

- Wertz, Richard W., and Dorothy C. Wertz
1989 *Lying-In: A History of Childbirth in America*. New Haven: Yale University Press.
- Wetterberg, Anna
2004 My Body, My Choice...My Responsibility: The Pregnant Woman as Caretaker of the Fetus. *Berkeley Journal of Sociology* 48:26-49.
- Wickramasinghe, Maithree
2010 *Feminist Research Methodology: Making Meanings of Meaning-Making*. London: Routledge.
- Wilde, David J., and Craig D. Murray.
2009 The Evolving Self: Finding Meaning in Near-Death Experiences Using Interpretive Phenomenological Analysis. *Mental Health, Religion and Culture* 12(3):223-239. doi:10.1080/13674670802334910
- Wilkins, Carol
2006 A Qualitative Study Exploring the Support Needs of First-Time Mothers on Their Journey Towards Intuitive Parenting. *Midwifery* 22(2):169-180. doi:10.1016/j.midw.2005.07.001
- Williams, Abimbola, Tina Lavender, David H. Richmond, and Douglas G. Tincello.
2005 Women's Experience After a Third-Degree Obstetric Anal Sphincter Tear: A Qualitative Study. *Birth* 32(2):129-136. doi:10.1111/j.0730-7659.2005.00356.x
- Williamson, Clarie
2006 Nutrition in Pregnancy: Latest Guidelines and Advice. *Primary Health Care* 16(7): 23-28. doi:10.7748/phc2006.09.16.7.23.c6967
- Wing, Deborah A.
2010 Induction of Labor. *In* *Protocols for High-Risk Pregnancy*. J.T. Queenan, J.C. Hobbins and C. Y. Spong, eds. Pp. 140-147. New York: Wiley Publishers.
- Winnicott, D.W.
1953 Transitional Objects and Transitional Phenomena. *International Journal of Psychoanalysis* 34(2):89-97.
1958 *Collected Papers: Through Paediatrics to Psychoanalysis*. New York: Basic Books.
- Wolcott, Harry F.
2005 *Ethnography: A Way of Seeing*. Toronto: AltaMira Press.
- Wolke, D., W.E. Copeland, A. Angold, and E.J. Costello
2013 Impact of Bullying in Childhood on Adult Health, Wealth, Crime and Social Outcomes. *Psychological Science* 1-13. doi:10.1177/0956797613481608

- Wood, Lorna, and Siobhan Quenby
2011 Women's Perceptions of Stressful Life Events in Relation to Pre-term Birth. *British Journal of Midwifery* 19(2):107-114. doi:10.12968/bjom.2011.19.2.107
- World Health Organization
2013 World Health Organization. Breastfeeding: A Joint WHO/UNICEF Statement. Accessed July 8, 2013.
http://www.who.int/nutrition/publications/infantfeeding/bfhi_trainingcourse/en/
2013 Managing Prolonged and Obstructed Labour. Accessed June 7, 2014.
http://apps.who.int/iris/bitstream/10665/44145/4/9789241546669_4_eng.pdf
- Yale School Medicine
2013 Post term pregnancy. Accessed July 6, 2013.
<http://www.yalemedicalgroup.org/stw/Page.asp?PageID=STW026849>
- Yoshino, Ayako
2008 "How Was it in Mummy's Tummy?": Japanese Pregnancy Literature. *Women's Studies International Forum* 31(6):483-491. doi:10.1016/j.wsif.2008.09.003
- Young, Brett C., Benjamin D. Hamar, Deborah Levine, and Henry Roque.
2009 Medical Management of Ruptured Appendicitis in Pregnancy. *Obstetrics and Gynecology* 144(2, pt. 2):453-456. doi:10.1097/AOG.Ob013e3181998424
- Young, Iris Marion
1984 Pregnant Embodiment: Subjectivity and Alienation. *Journal of Medicine and Philosophy* 9(1):45-62. doi:10.1093/jmp/9.1.45
1990 *Throwing Like a Girl: And Other Essays in Feminist Philosophy and Social Theory*. Bloomington: Indiana University Press.
- Zaman, Shahaduz
2008 Native Among the Natives: Physician Anthropologist Doing Hospital Ethnography at Home. *Journal of Contemporary Ethnography* 37:135-154. doi:10.1177/0891241607312495
- Zauderer, Cheryl R.
2014 PTSD After Childbirth: Early Detection and Treatment. *The Nurse Practitioner*, 39(3), 37-41. doi:10.1097/01.NPR.0000425827.90435.e1
- Zelek, Barbara, and Susan P. Phillips
2003 Gender and Power: Nurses and Doctors in Canada. *International Journal for Equity in Health* 2(1):1-5.
- Zetterstrom, J., A. Lopez, B. Anzen, M. Norman, B. Holmstrom, and A. Mellgren
1999 Anal Sphincter Tears at Vaginal Delivery: Risk Factors and Clinical Outcome of Primary Repair. *Obstetrics and Gynecology* 94(1):21-28. doi:10.1016/s00297844(99)00248-3

Zhang, Yan, Yang-yu Zhao, Jie Qiao, and Rong-hua Ye
2009 Diagnosis of Appendicitis During Pregnancy and Perinatal Outcome in the Later
Pregnancy. Chinese Medical Journal 122(5):521-524.

Appendices

Appendix A: Glossary

Abruption	A condition whereby the placenta partially or completely leaves the uterine wall. This is a severe medical emergency. Symptoms include abdominal pain, back pain, frequent uterine contractions, uterine contractions with no relaxation in between and vaginal bleeding.
Amniotic fluid	The fluid that develops around the foetus offering protection from mechanical injury, as well as providing an environment for symmetry of growth and fluid to drink. At full term the approximate amount of amniotic fluid is 800 to 1000 millilitres. If the amniotic membrane ruptures the amniotic fluid will leave the body but the body will also continue to produce it.
Anaplastic astrocytoma	A malignant, infiltrating, primary brain tumor, with tentacles that may invade surrounding tissue. This provides a butterfly-like distribution pattern through the white matter of the cerebral hemispheres. The tumor may invade a membrane covering the brain (the dura) or spread through the spinal fluid through the ventricles of the brain. Spread of the tumor (metastasis) outside of the brain and spinal cord is rare. These tumors are primarily in cerebral hemispheres. Some can occur in the areas of the thalamus and hypothalamus or the diencephalon (responsible for identification of sensation, such as temperature, pain and touch, regulation of appetite/weight and body temperature, as well as connecting the brainstem to the cortex. Gliomas are heterogeneous tumors that are classified according to their most aggressive appearing elements. The World Health Organization classification scheme includes four grades of glioma. Anaplastic astrocytoma is a grade III tumor. It is characterized as being of astrocytic origin but having increased numbers of cells (hypercellularity), abnormal cells and nuclei (cytologic and nuclear atypia), increased proliferation of cells (mitoses) and increased growth of blood vessels (vascular endothelial proliferation). Anaplastic astrocytomas are aggressive tumors that infiltrate adjacent normal brain tissue and have a significant tendency to spread outside of the central nervous system.
Apgar scores	Scoring system for newborns designed by American anesthetist Virginia

	<p>Apgar. This scoring system is used as part of the assessment of the newborn to evaluate the transition from uterine to extrauterine life. Five categories are used that assess respirations, heart rate, position, colour and responses.</p>
Attention Deficit Disorder (ADD)	<p>A condition describing children who display developmentally inappropriate degrees of poor sustained attention, impulsive behaviours, over activity and problems with adherence to rules and instructions.</p>
Biopsy	<p>A tissue sample from the tumor obtained either through a needle or by direct excision during a surgical procedure performed by a surgeon to confirm the diagnosis.</p>
Cord prolapse	<p>A severe emergency condition that occur when the membranes rupture and the umbilical cord exits with the gush of fluid. Hence when a woman has a contraction the foetus' lifeline is cut off from the mother's blood and oxygen supply. Without an emergency caesarean section the foetus is at great risk for death.</p>
Corporeal knowledge	<p>An understanding or awareness of the physical material body.</p>
Doula	<p>A person who provides emotional and physical support to women during pregnancy and childbirth.</p>
Expressed breast milk (EBM)	<p>Milk that is expressed from the breasts following childbirth and can be given to the newborn or saved in a bottle for feeding at another time. EBM can also be kept in the refrigerator or freezer to be given at a later date.</p>
Failure to thrive	<p>A condition where the infant does not gain weight or length as compared to children of the same age. A baby who has failed to thrive may seem slow to develop physical skills such as rolling over, standing, and walking. Slow growth also can lead to delays in mental and social skills.</p>
Forewaters	<p>The amniotic fluid between the presenting part, usually the head, and the intact fetal membranes.</p>
Hematomas	<p>Bruises seen under the skin.</p>
Henoch-Schonlein purpura	<p>A disease that involves purple spots on the skin, joint pain, gastrointestinal problems, and glomerulonephritis (a kidney disorder).</p>
Induction	<p>Labour that is brought on, or induced, when the pregnancy has extended significantly beyond the expected delivery date and the mother shows no signs of going into labour. Generally, if the unborn baby is more than two weeks past due, labour will be induced. In most cases, a mother delivers</p>

her baby between 38 and 42 weeks of pregnancy. This usually means that labour is induced if the pregnancy has lasted more than forty two weeks. Labour is also induced if the mother is suffering from diseases (preeclampsia, chronic hypertension), if there is an Rh blood incompatibility between the baby and the mother, or if the mother or baby has a medical problem that requires delivery of the baby (like a premature rupture of the membranes).

Intrauterine growth restriction (IUGR)

Also known as fetal growth restriction and is a generic term for any delay in achieving intrauterine developmental milestones, most commonly related to maternal substance use, tobacco and alcohol use. IUGR affects high-risk infants with perinatal asphyxia, hypoglycemia, hypothermia, pulmonary hemorrhage, meconium aspiration, necrotizing enterocolitis, polycythemia and complications of infections, malformations and syndromes. Sometimes it occurs without any of these conditions. IUGR is the second most common cause of prenatal morbidity and mortality, after prematurity.

Magnesium sulphate

A medication used to prevent or stop seizures during pregnancy. It is given intravenously or injected into the muscles. Treatment to prevent seizures is usually continued for 24 hours after delivery.

Magnetic resonance imaging (MRI)

A diagnostic procedure that uses a combination of large magnets, radiofrequencies, and a computer to produce detailed images of organs and structures within the body. MRI provides greater anatomical detail than other scan and can better distinguish between tumor, tumor-related swelling and normal tissue. In addition, MRI can distinguish between hemorrhage and tumor cyst.

Meconium

A material that collects in the intestines of a foetus and forms the first stools of a newborn. It is non-odorous, thick and sticky, usually greenish to black and composed of secretions of the intestinal glands, some amniotic fluid and intrauterine debris, such as bile pigments, fatty acids, epithelial cells, mucus, lanugo and blood. With ingestion of breast milk or formula and proper functioning of the gastrointestinal tract, the color, consistency and frequency of the stools change by the third or fourth day after the initiation of feedings. The presence of meconium in the amniotic fluid during labour may indicate fetal distress and may lead to a lack of

oxygen and developmental delays. (Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier.)

Microcephaly

A condition where an infant's head is significantly smaller than normal for their age and sex, based on standardized charts. Microcephaly most often occurs because the brain fails to grow at a normal rate. Skull growth is determined by brain growth. Brain growth takes place while in the womb and during infancy. Conditions that affect brain growth can cause microcephaly; these include infections, genetic disorders, and severe malnutrition.

Neonatal Intensive Care Unit (NICU), Special Care Nursery (SCN), Intensive Care Unit (ICU)

A specialized area specifically designed to care for sick newborns such as those infants born preterm, or with anomalies or conditions that may arise after birth, such as hypoglycemia, hyperbilirubinaemia and other conditions.

Nystagmus

A periodic, rhythmic, involuntary movement of both eyeballs in unison. There is a slow component in one direction and a quick return. The movement may be vertical, horizontal or rotary. Common causes are lesions of the cerebellum or the vestibular apparatus, or increased intracranial pressure.

Ophthalmologist

A physician specializing in the treatment of disorders of the eye.

Oxytocin

A hypothalamic hormone stored in the posterior pituitary, which has uterine-contracting and milk-releasing actions. It may also be prepared synthetically or obtained from the posterior pituitary of domestic animals. It is used to induce active labour, increase the force of contractions in labour, contract uterine muscles after delivery of the placenta, control postpartum hemorrhage, and stimulate milk ejection.

Pelvic infection

See puerperal fever or puerperal sepsis.

Placenta praevia

A condition that occurs during pregnancy when the placenta is abnormally placed and partially or totally covers the cervix.

Postpartum blues

An emotional effect of childbirth experienced by mothers, consisting mainly of transient feelings of sadness for a period of about seventy two hours. If the symptoms persist for a longer period, the diagnosis of depression may apply. The condition may require psychotherapy, use of antidepressant medications or both. It may occur more than once in the same person after subsequent pregnancies and may have serious

consequences if untreated. (Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier).

Postpartum depression	A psychiatric condition that occurs after childbirth, typically from three days to six weeks after birth. It is characterized by symptoms that range from mild "postpartum blues" to an intense suicidal depressive psychosis. Severe postpartum depression occurs approximately once in every two thousand to three thousand pregnancies. The cause is not proved; neurochemical and psychological influences have been implicated. Approximately one third of patients are found to have had some degree of psychiatric abnormality predating the pregnancy. The disorder recurs in subsequent pregnancies in 25 per cent of cases. Some women at risk for postpartum depression may be identified during the prenatal period: those who have made no preparations for the expected baby, who have expressed unrealistic plans for postpartum work or travel, or denied the reality of the responsibilities of parenthood. Depending on the severity of the disorder, psychoactive medication or psychiatric hospitalization may be necessary. (Gale Encyclopedia of Medicine. 2008).
Posttraumatic stress disorder	Considered a mental illness that involves exposure to trauma involving death or the threat of death, serious injury or violence.
Pregnancy	The period from conception to birth. After the egg is fertilized by a sperm and then implanted in the lining of the uterus, it develops into the placenta and embryo, and later into a foetus. Pregnancy usually lasts 40 weeks, or 280 days, beginning from the first day of the woman's last menstrual period, and is divided into three trimesters, each lasting three months.
Premature rupture of membranes (PROM)	Refers to a patient who is beyond thirty seven weeks' gestation and has presented with rupture of membranes (ROM) prior to the onset of labour.
Preterm premature rupture of membranes (PPROM)	Describes ROM prior to 37 weeks' gestation.
Preterm infant	One born before the 37 completed week (259 days) of gestation.
Primipara	A woman who is pregnant for the first time.
Prostaglandins	A group of lipid compounds produced in small amounts that have a large array of significant effects. Those given in tablets or in solutions for oral or IV use effect changes in vasomotor tone, capillary permeability, smooth muscle tone, aggregation of platelets, endocrine and exocrine functions,

and the autonomic and central nervous systems. Some of the pharmacologic uses of the prostaglandins are termination of pregnancy and treatment of asthma and gastric hyperacidity. (Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier).

Pudendal block

Also known as a pudendal block, or saddle block, is a form of local anaesthesia commonly used in obstetrics to relieve pain during childbirth. The anaesthesia is produced by blocking the pudendal nerves near the ischial spine of the pelvis.

Puerperal fever

A systemic disease associated with the presence and persistence of pathogenic microorganisms and their toxins in the blood. The resulting syndrome is a combination of the signs of toxemia and hyperthermia, i.e. fever, mucosal and conjunctival petechiation and evidence of localization in joints, eyes, meninges and heart valves. Proof of disease is by positive blood culture or smear. In puerperal septicemia the focus of infection is a lesion of the mucous membrane received during parturition (the process of labour and delivery in the birth of a child). (Saunders Comprehensive Dictionary, 3rd edition. © 2007 Elsevier, Inc.).

Seizures

Frequently recognized as grand mal seizures that includes the loss of consciousness, followed by a period of stiffness and jerkiness of the extremities that may last seconds to minutes. Following the seizure the person often goes into a deep sleep. During the seizure, accidents such as tongue biting and incontinence may occur.

Shunt

A hole or a small passage or tube which moves or allows movement of fluid from one part of the body to another.

Spontaneous premature rupture of the membranes (SPROM)

The rupture of membranes after or with the onset of labour. Prolonged ROM is any ROM that persists for more than 24 hours and prior to the onset of labour.

Teratogens

Agents that cause congenital malformations and developmental abnormalities if introduced during gestation. (Mosby's Dental Dictionary, 2nd edition. © 2008 Elsevier, Inc.).

Terbutaline

A medication used to stop labour.

Tertiary care

A hospital that offers highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by specialists in state-of-the-art facilities.

Appendix B: Consent Form for Artifacts



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STUDY TITLE: The impact of a difficult birth on mothering

Principal Investigator:

Dr. Penelope Cash, Associate Professor, School of Nursing, Faculty of Health and Social Development, phone number: 250 807-9879 or penelope.cash@ubc.ca.

Co-Investigator:

Lynn Rollison is a PhD student in the Interdisciplinary Graduate Studies program, specializing in nursing. Lynn can be reached at 250 802-1344 or lynnrollison@shaw.ca. This research is the basis for the co-investigator's doctoral dissertation.

Purpose:

This study will investigate the experience of having a difficult birth on mothering and a woman's connection to her child. The findings will help to inform nursing practice, midwifery care and other health care providers and inform change.

Study Procedures:

As a participant in this research study looking at your experience of a difficult birth and the impact this has on mothering, you are invited to share photographs or objects that stimulate memories of the birth and your child (Teddy bears, blankets, toys). At the end of the second interview, the co-researcher will invite you to share images and objects that are significant to you. With your permission, these mementos will be photographed and may be used to elaborate the meaning of your story. These images may be selected for inclusion in the final report, also in any publications and presentations. Anything that identifies your family members will be blurred or cropped to ensure confidentiality. Photographs that contain images of health care personnel will also be blurred or cropped to ensure that those people are not recognizable, or where the photograph was taken.

Potential Benefits and Risks:

By using these mementos in the study you may gain new awareness about your birthing experience. Another benefit is exploring your relationship between the memento and your experience that may lead to new understanding.

The risks associated with this study are that you will be discussing your difficult birthing experience in light of the memento that may bring forth sad memories. If you become upset or distressed the interview will be stopped until you are ready to proceed. You will be offered

support. Should you wish to stop the interview altogether then the conversation will end and another meeting time will be arranged. A list of counselling services will be provided.

Withdrawal:

You have the right to withdraw from the study at anytime. If you choose to withdraw your consent from the study, all of your transcripts, audio-recording and photographs or artifacts will be returned to you and will not be used.

Confidentiality:

Your confidentiality will be respected. Information that disclosed your identify will not be released without your consent unless required by law. All documents will be identified only by code number and kept in a locked filing cabinet. Subjects will not be identified by name in any reports of the completed study.

Only the principal investigator, co-investigator and transcriptionist will have access to the data. A pseudonym will be chosen for you instead of your real name. Your real name, pseudonym and the consent form will be kept separately from the data and stored in a locked filing cabinet in the co-investigators home. Photographs, audio-recording and transcription data will be password protected and kept on the laptop computer and a back-up hard disk. The computer is password protected and is only used by the co-investigator for this research. The storage of all records will be in a locked cabinet in a locked office.

Remuneration/Compensation:

As a participant you will not be paid for your participation. Refreshments will be provided during the interviews.

Contact for information about the study:

Lynn Rollison is available to answer any inquiries concerning the procedures to ensure that they are fully understood. If you have any questions or desire further information with respect to this study, you may contact Dr. Penelope Cash at 250 807-9879, or email address: penelope.cash@ubc.ca.

Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 1-877-822-8598 or the UBC Okanagan Research Services at 250-807-8832.

Consent:

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to the reproduction of select artifacts' to be included in this study and the final dissertation.

Artifact # 1 (photograph, toy, Teddy bear, etc.).

_____ I agree to have a copy of the artifact included in the dissertation and in any other publications or presentations.

_____ I agree to have a copy of the artifact included in the dissertation only.

Name or description of artifact _____

Participants Signature

Date

Printed Name of the Participant

I agree to the reproduction of select artifacts

Family member or friend: I agree to the reproduction of my image in the photograph.

Artifact # 2 (photograph, toy, Teddy bear, etc.).

_____ I agree to have a copy of the artifact included in the dissertation and in any other publications or presentations.

_____ I agree to have a copy of the artifact included in the dissertation only.

Name or description of artifact _____

Participants Signature

Date

Printed Name of the Participant

I agree to the reproduction of select artifacts

Family member or friend: I agree to the reproduction of my image in the photograph.

Artifact # 3 (photograph, toy, Teddy bear, etc.).

_____ I agree to have a copy of the artifact included in the dissertation and in any other publications or presentations.

_____ I agree to have a copy of the artifact included in the dissertation only.

Name or description of artifact _____

Participants Signature

Date

Printed Name of the Participant

I agree to the reproduction of select artifacts

Family member or friend: I agree to the reproduction of my image in the photograph.

Artifact # 4 (photograph, toy, Teddy bear, etc.).

_____ I agree to have a copy of the artifact included in the dissertation and in any other publications or presentations.

_____ I agree to have a copy of the artifact included in the dissertation only.

Name or description of artifact _____

Participants Signature

Date

Printed Name of the Participant

I agree to the reproduction of select artifacts

Family member or friend: I agree to the reproduction of my image in the photograph.

Artifact # 5 (photograph, toy, Teddy bear, etc.).

_____ I agree to have a copy of the artifact included in the dissertation and in any other publications or presentations.

_____ I agree to have a copy of the artifact included in the dissertation only.

Name or description of artifact _____

Participants Signature

Date

Printed Name of the Participant

I agree to the reproduction of select artifacts

Family member or friend: I agree to the reproduction of my image in the photograph.

Artifact # 6 (photograph, toy, Teddy bear, etc.).

_____ I agree to have a copy of the artifact included in the dissertation and in any other publications or presentations.

_____ I agree to have a copy of the artifact included in the dissertation only.

Name or description of artifact _____

Participants Signature

Date

Printed Name of the Participant

I agree to the reproduction of select artifacts

Family member or friend: I agree to the reproduction of my image in the photograph.

Artifact # 7 (photograph, toy, Teddy bear, etc.).

_____ I agree to have a copy of the artifact included in the dissertation and in any other publications or presentations.

_____ I agree to have a copy of the artifact included in the dissertation only.

Name or description of artifact _____

Participants Signature

Date

Printed Name of the Participant

I agree to the reproduction of select artifacts

Family member or friend: I agree to the reproduction of my image in the photograph.

Appendix C: Starter Questions for Interviews with Women



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For each interview I will commence with an introduction to the study and review the woman's time commitment.

Questions for each participant are as follows:

1. You identified your birth as difficult. Can you tell me about that?
2. What about the birth made it difficult?
3. How was the birthing experience for you?
4. Did the birth affect the relationship between you and your child? Between you and your family members?
5. Has the difficult birth affected your mothering?

Appendix D: Advertisement for Participants



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Did you experience a difficult birth with one of your children at least two years ago? If you did you may wish to participate in a qualitative research study being conducted, through the University of British Columbia, Okanagan. For further information please call Lynn Rollison, Registered Nurse, at 250 802-1344 (Nanaimo) for more details. You may also wish to connect with her via email at lynnrollison@shaw.ca. If you are calling long distance to Nanaimo then leave a brief message and the co-investigator will call you back.

Appendix E: Consent Form



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STUDY TITLE: The impact of a difficult birth on mothering

Principal Investigator:

Dr. Penelope Cash, Associate Professor, School of Nursing, Faculty of Health and Social Development, phone number: 250 807-9879 or penelope.cash@ubc.ca.

Co-Investigator:

Lynn Rollison is a PhD student in the Interdisciplinary Graduate Studies program, specializing in nursing. Lynn can be reached at 250 802-1344 or lynnrollison@shaw.ca. This research is the basis for the co-investigator's doctoral dissertation.

Purpose:

This study will investigate the experience of having a difficult birth on mothering and a woman's connection to her child. The findings will help to inform nursing practice, midwifery care and other health care providers and inform change.

Who May Participate?

You are invited to take part in this research study because you have identified that you had a difficult birth more than two years ago. In fact you may have had this difficult birth ten, twenty, thirty or forty years ago and are not being treated for post-traumatic stress disorder. In addition, you will be nineteen years or older and speak English.

Study Procedures:

Your involvement would include a first meeting to describe the study and your potential participation. The study will involve a minimum of three interviews lasting from one to two hours each, at a time that is mutually agreeable in your home or in a public place. You will be asked to share your experience of a difficult birth and how this affected you as a mother. The following questions will guide the interviews:

1. You identified your birth as difficult. Can you tell me about that?
2. What about the birth made it difficult?
3. How was the birthing experience for you?

4. Did the birth affect the relationship between you and your child? Between you and your family members?
5. Has the difficult birth affected your mothering?

Interviews will be audio-recorded and transcribed following each meeting. The interviews will be transcribed by the co-investigator or a transcriptionist (who will sign a confidentiality agreement). At the following and subsequent meetings you will be asked to review the previous meetings transcription for clarity. You will have the opportunity to expand on the ideas and explore additional meanings emerging from the previous interviews.

Potential Benefits and Risks:

By participating in this study you may gain new awareness about your birthing experience. Another benefit is having your story being listened to creating alternative meanings about the birth.

The risks associated with this study are that you will be discussing your difficult birthing experience that may bring forth sad memories. If you become upset or distressed during the interview the interview will be stopped until you are ready to proceed. You will be offered support. Should you wish to stop the interview altogether then the conversation will end and another meeting time will be arranged. A list of counselling services will be provided.

Withdrawal:

You have the right to withdraw from the study at anytime. If you choose to withdraw your consent, all of your transcripts and audio-recording will be returned to you and will not be used in the study.

Confidentiality:

Your confidentiality will be respected. Information that discloses your identify will not be released without your consent unless required by law. All documents will be identified only by code number and kept in a locked filing cabinet. Subjects will not be identified by name in any reports of the completed study.

Only the principal investigator, co-investigator and transcriptionist will have access to the data. A pseudonym will be chosen for you instead of your real name. Your real name, pseudonym and the consent form will be kept separately from the data and stored in a locked filing cabinet in the co-investigator's home. Audio-recording and transcription data will be password protected and kept on the laptop computer and a back-up hard disk. The computer is password protected and is only used by the co-investigator for this research. The storage of records will be in a locked file cabinet in a locked room.

Remuneration/Compensation:

As a participant you will not be paid for your participation. Refreshments will be provided during the interviews.

Contact for information about the study:

Lynn Rollison is available to answer any inquiries concerning the procedures to ensure that you fully understand what is required of you. If you have any questions or desire further information

with respect to this study, you may contact Dr. Penelope Cash at 250 807-9879, or email address: penelope.cash@ubc.ca.

Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 1-877-822-8598 or the UBC Okanagan Research Services at 250-807-8832.

Consent:

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature also indicates that you consent to participate in this study.

Participants Signature

Date

Printed Name of the Participant Signing Above

Appendix F: Letter to Participants



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Lynn Rollison
C/O Dr. Penelope Cash
School of Nursing

January 19, 2012

Dear Potential Participant,

As a perinatal (maternal newborn) nurse and a nurse educator I am looking for women who believe that they had a 'difficult birth' at least two years ago. I am currently conducting a study for my PhD dissertation with the support of Penelope Cash (Principal Investigator) in listening to women's stories about their difficult birth experience that has affected their connection to their child. The idea of a difficult birth is by self-identification. If you are interested it would involve an initial meeting to describe the study and then a minimum of three interviews lasting approximately one to two hours. As the researcher, I, Lynn Rollison, wish to listen and collect the stories of women's births and how the birth may have affected your sense of connection to the child.

Each interview will be audio-recorded and transcribed. I am also interested in mementos or artifacts about your birth that stimulate memories or thoughts about the birth. I would like the opportunity to see and, with your permission, to photograph this artifacts (which may be a Teddy bear, blanket, or photograph). If you do not want to participate in all of these steps you are not obliged to do so. You may select just to participate in the interviews and you can withdraw from the study at any time.

If you are interested you will be nineteen years or older and have given birth over two or more years ago. I am looking for women from a variety of age groups – not just young women – but women who have longevity in their mothering experiences. All participants must speak English.

If you know somebody who might be interested please pass this on. If you are willing to participate then please call Lynn Rollison at 250 802-1344 or lynnrollison@shaw.ca to set up an initial meeting. At the first meeting I will provide a more detailed description of the study, along with consent forms which you will need to sign to become involved.

Yours truly,

Lynn Rollison, RN, BSN, MA, PhD (Candidate)

Appendix G: List of Package Enclosures



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

Faculty of Health and Social Development
School of Nursing
FIN 323 – 3333 University Way
Kelowna, BC Canada V1V 1V7
Tel (250) 807-8077 Fax (250) 807-8085
www.ubc.ca/okanagan

List of package enclosures

1. Letter outlining study, including contact information.
2. Consent form for the study.
3. List of counselling services in your area.
4. List of starter questions.

Appendix H: Confidentiality Agreement



a place of mind
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www.ubc.ca/okanagan

Confidentiality Agreement with Research Assistant and Transcriptionist

Research Assistant and Transcription

Confidentiality Agreement

I, _____, research assistant/transcriptionist agree to maintain full confidentiality in regards to any or all audio-tapes and documentation received from Lynn Rollison related to her doctoral study on The Impact of a Difficult Birth on Mothering.

Furthermore, I agree to:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of the audio-tapes, or in any associated documents.
2. To not make copies of the audio-tapes or computerized files of the transcribed interview text, unless specifically requested to do so by Lynn Rollison.
3. To store any study-related audio-tapes in a safe and secure location as long as they are in my possession.
4. To return all audio-tapes and study documents to Lynn Rollison in a complete and timely manner.
5. To delete any electronic containing study related material from my hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and from any harm incurred by individuals if I disclose identifiable information contained within the audio-tapes and/or files to which I will have access.

Research Assistant/Transcribers name (please print): _____

Research Assistant /Transcribers signature: _____

Date: _____

Appendix I: Contact Information



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

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www.ubc.ca/okanagan

Contact Information

Lynn Rollison, RN, BSN, MA, PhD (Candidate)

Phone number: 250 802-1344 (cell phone, Nanaimo).

Email: lynnrollison@shaw.ca

Dr. Penelope Cash (Principal Investigator)

Phone number: 250 807-9879

Email: penelope.cash@ubc.ca

Appendix J: Poster



a place of mind
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Kelowna, BC Canada V1V 1V7
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www.ubc.ca/okanagan

Looking for Female Participants

For a Qualitative Research Study

Would you describe your birthing process as difficult?

How have you incorporated your birth experience into your life and moved forward?

This study is designed to investigate with the woman her experience of childbearing and mothering following a difficult or difficult birth experience. The participants will be women over the age of 19 who have given birth more than two years ago. Participants must speak English and individuals should not be under the care of a physician for a condition related to delivery or birth.

If you wish to participate in this study or want further information please call Lynn Rollison, RN, BSN, MA, PhD (c) at 250 802-1344 (Nanaimo) or lynnrollison@shaw.ca for a preliminary meeting. Currently Lynn is a PhD candidate at the University of British Columbia, Okanagan.

Appendix K: Counselling Services



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

Faculty of Health and Social Development
School of Nursing
FIN 323 – 3333 University Way
Kelowna, BC Canada V1V 1V7
Tel (250) 807-8077 Fax (250) 807-8085
www.ubc.ca/okanagan

Counselling Services in Kelowna, British Columbia

BC Health Nurse Line

Telephone: 1-866-215-4700

BC NurseLine provides 24-hour, confidential health information and advice.

Canadian Mental Health Association

Telephone: 250-861-3644

Address: 504 Sutherland Avenue, Kelowna, B.C., V1Y 5X2

Kelowna Community Resources

Telephone: 250-763-8008

Address: 120-1735 Dolphin Avenue, Kelowna, British Columbia, V1Y 8A6

Kelowna Community Resources Crisis Line

Telephone: 250-763-9191

Kelowna Family Centre

Telephone: 250-860-3181

Address: 347 Leon Avenue, Kelowna, British Columbia V1Y 8C7

Counselling Services in Nanaimo, British Columbia

NARSF Programs

Telephone: 250-754-2773

Fax: 250-754-1605

Address: 201 - 170 Wallace Street, Nanaimo, B.C., V9R 5B1

Nanaimo Crisis Line

Telephone: 250-754-4447

Nanaimo Family Life Association

Telephone: 250-754-3331

Fax: 250-753-0268

E-mail: reception@nflabc.org

Address: 1070 Townsite Road, Nanaimo, B.C., V9S 1M6

VIHA Youth & Family Addiction Services

Telephone: 250-739-5790

Fax: 250-754-0816

Address: 206-96 Cavan Street, Nanaimo, BC V9R 2V1

Counselling Services in Penticton, British Columbia

BC Health Nurse Line

Telephone: 1-866 215-4700

BC NurseLine provides 24-hour, confidential health information and advice.

Interior Health Mental Health & Substance Use Services

Telephone: 250 -770-3434

Address: 740 Carmi Avenue, Penticton, V2A 8P9

Penticton & District Community Resources Society

Telephone: 250-492-5814

Address: 330 Ellis Street, Penticton, B.C., V2A 4L7

Penticton and District Community Resources Society

Telephone: 1-877-492-5814

Address: 60 Calgary Avenue, Penticton, British Columbia V2A 2T6

Strengthening Families Together

Telephone: 250-493-7338

Fax: (250) 493-0690

E-mail: bcsspenticton@shaw.ca

Address: 205 Martin Street, Penticton, BC, V2A 5K2

Counselling Services in Vancouver, British Columbia

Canadian Mental Health Association

Telephone: 604-872-4902

Website: www.cmha.ca/

Address: 175 Broadway W, Vancouver, B.C.

Canadian Mental Health Association

Telephone: 604 688-3234

Address: 200-1111 Melville Street, Vancouver, B.C.

Website: www.cmha.ca/

Counselling Vancouver

Telephone: 604 925-5779

Address: 306-1687 West Broadway, Vancouver, B.C.

Website: www.counsellingbc.com/

Electra Health Floor Inc. Counselling – Counselling

Telephone: 604-685-HEALTH (4325)

Address: 970 Burrard Street, Vancouver, B.C.

Family Services of Greater Vancouver

Telephone: 604 602-9722

Address: 1616 7 Avenue, West Vancouver, B.C.

Website: www.fsgv.ca/

Jericho Counselling Services

Telephone: 604-619-0482

Address: 101 - 2145 West Broadway, Vancouver, BC

Lower Mainland Purpose Society for Youth & Families

Telephone: 604-526-2522

Address: 40 Begbie Street, New Westminster, B.C.

Website: www.purposesociety.org/

Westcoast Family Information and Referral

Telephone: 604-709-5699

Address: 2772 Broadway E, Vancouver, B.C.

Website: www.wstcoast.org/

YWCA Vancouver

Telephone: 604-895-5777

Address: 535 Hornby Street, Vancouver, B.C.

Website: ywcahealthandfitness.com/

Counselling Services in Victoria, British Columbia**BC Families in Transition**

Telephone: 250-388-4331

Website: <http://bcfit.org/>

Bounce Back Coaching

Telephone: 250-361-1337

Canadian Mental Health Association

Website: <http://www.cmha.ca/bins/index.asp>

Capital Mental Health Association

Telephone: 250-389-1211

Fax: 250-389-1263

Address: 125 Skinner Street, Victoria, B.C., V9A 6X4

Website: cmha@miravictoria.ca

Central Christian Counselling

Telephone: 250-384-3322

Address: 833 Pandora, Victoria, B.C.

Website: http://www.centralchristiancounselling.com/our_services.htm

HealthLink BC

Fax: 250-952-6509

E-mail: HealthLinkBC@HealthLinkBC.ca

Block C-2261 Keating Cross Road, Victoria, V8M 2A5

Website: <http://www.healthlinkbc.ca/>

James Bay Community Project

Telephone: 259-388-7844

Fax: 250-388-7856

Email: askus@jbcp.bc.ca

Address: 547 Michigan Street, Victoria, B.C.

Mental Health and Addictions Services

Telephone: 250-381-3444

Pacific Centre Family Services Association

Telephone: 250-478-8357 or 1-866-478-8357

Website: www.pacificcentrefamilyservices.org

Psychologists, counselors, therapists

Telephone: 250-216-1569

Website: <http://www.counsellingbc.com/directory.html> or www.bc-counsellors.org

Salvation Army – Counselling Services

Telephone: 250-386-8521

Address: 2695 Quadra Street

Website: <http://www.salvationarmycfs.com/programService.htm>

Single Parent Resource Centre

Telephone: 250-385-1114, ext. 224

Address: 602 Gorge Road E., Victoria, B.C. V8T 2W6

Website: <http://www.singleparentvictoria.ca/>

Sunshine Coast Health Centre

Website: www.sunshinecoasthealthcentre.ca/victoria-rehab

Victoria Native Friendship Centre

Website: <http://www.vnfc.ca/>

Women’s Sexual Assault Centre (VWSAC)

Telephone: 250-383-3232, 250-383-5545

Fax: (250) 383-6112

Address: #511-620 View Street, Victoria, B.C., V8W 1J6

Website: <http://www.vwsac.com/>

Workplace Counselling –Employee Assistance Programs

Telephone: 604-732-6933

Website: http://www.familyserviceap.com/aboutus/who_are_we_e.html

Appendix L: Current Practices and Using the Research Knowledge

Looking back at this work, I am constantly reminded that having a difficult birth has long term consequences for women. The phenomenon lasts a lifetime as the participating women testify. The following story highlights how birth can move from an anticipated event to one that requires deep consideration and can change a woman's life immeasurably.

Recently I was scheduled to work an evening shift overlapping two shifts of twelve hours nurses on the perinatal unit or maternity ward. One hour into the shift, I was assigned a woman who had given birth the day prior. Her nurse was reassigned to care for another patient in early labour who just arrived on the unit. I was given a more abbreviated report than one would expect at shift change. The patient, whom I will call Rebecca, and her husband Joe, are both educated and in their mid-thirties. Rebecca works as a manager in a computer company and Joe is a civil engineer with several advanced degrees. Rebecca had given birth to her newborn son fourteen hours previously. Upon admission the couple had made it clear to staff that they would appreciate detailed explanations about any procedures; they also had a detailed birth plan. She had gestational diabetes during her third trimester but otherwise her pregnancy was healthy. Drawing from my own understandings, I am aware that every individual and family have their own unique learning needs but an older, educated couple having a first child often have different information needs and the research to date certainly bears this out (Carolan 2005; Shelton and Johnson 2006).

The nurse who gave me report had been my student ten years prior and I respect her enthusiasm and dedication. She exclaimed "This one's a doozie but she's stable right now!" Following this comment the nurse gave me a brief history of Rebecca's vaginal birth, including medications, physician's orders, parameters for calling the internist if her condition worsened, as

well as a health overview of her infant at present. I had some immediate concern about my new patient and my ability to care for her. The salient issue for Rebecca was that, during labour she had requested an epidural and, when the medication was introduced she went into atrial fibrillation whereby her heart rate increased and became irregular, which can be sustained or intermittent in nature. She had no prior history of this condition. During the second stage of labour when she was pushing Rebecca's heart rate was as high as 250 beats per minute and continued to be irregular. She was experiencing an unexpected and unusual complication. I had not seen or heard of this situation before. I asked if any of the other nursing staff had ever experienced a similar event and no one had cared for a woman with a comparable ailment. During the delivery, internists and anaesthesiologists were immediately summoned to consult with the obstetrician. In addition, the perinatal nursing staff increased to provide additional help and assist with the emergent situation. Other nursing personnel from emergency and the intensive care unit were also called in to provide support, give medications that perinatal staff are not qualified to administer and to offer expertise.

Intravenous medications were given to try and obtain a normal sinus rhythm but Rebecca's heart rate continued to be elevated and remained in an atypical pattern. Rebecca finally gave birth but her cardiac condition remained unchanged. Doctors were not sure if they would move her to the telemetry unit because she was still exhibiting atrial fibrillation. It was not only Rebecca's condition that was significant, after delivery the baby would not suck causing both parents concern. Nothing had turned out as the couple had planned and hoped. Rebecca and Joe were worried about their baby and they were also alarmed about her health and the unresolving condition. I was fretful about my new assignment and concluded that she was my sickest patient and a priority. I reviewed her chart and also the kardex, which is a pencil and

paper nursing care plan kept by nursing staff as an overview of each patient's particular care, including a summary of the nursing assessments completed since delivery, lists of tests and other data.

Upon entering the room I introduced myself and explained the change of patient assignment. Rebecca was resting but short of breath when I first saw her. I gained permission to do some vital signs, assess her physical status and condition. Throughout the early conversation, I began the process of getting to know the couple to establish a helping relationship. Rebecca and Joe shared their experience of the cardiac complication during delivery. Furthermore, they explained their understanding of the consultants' concerns during the birth and the current fears about her on-going atrial fibrillation and how it should be treated. There had been a conversation with the internist and other doctors after delivery that Rebecca might be transferred to the cardiac unit for monitoring on telemetry and perhaps cardiac conversion. The parents wondered about the plans and what would happen over the next few hours and were upset and unsettled. They also shared their fears about the intravenous and oral medications Rebecca was taking in an attempt to rectify the atrial fibrillation and how drugs taken earlier might affect the newborn through the breast milk. They also wondered about arrangements for the baby and if the newborn would be going to the NICU, staying on the maternity unit with Joe or be assigned to the cardiac unit with Rebecca, if she was transferred. Joe shared his worries that if moved to another unit he feared they would not receive the education from perinatal staff about infant care nor get the support they needed to learn about their newborn son and assistance with breastfeeding. I told them I would complete my assessment then speak with the charge nurse a little later about the plans and get back to them.

I then moved to reviewing the feeding plan for the infant and realized that six hours had elapsed since the infant had last been fed. I was concerned because Rebecca had gestational diabetes and the risk for the baby experiencing hypoglycaemia can rapidly and drastically affect the health of the newborn. Hence, early frequent feedings are crucial. Several times Rebecca and Joe disagreed with each other after I asked when the baby last fed and about voiding and passing of meconium. I could sense some underlying stress and tension. I suggested that we feed the baby as Rebecca was hand expressing breast milk (EBM) and was giving the EBM with a syringe. At this point Joe expressed strong feelings of anger and frustration at me. What became evident was that I was contradicting something the day nurse had said about feeding the baby. It was clear that they trusted the day nurse and I now felt any trust they had placed in me was dubious. He said “We need to get some sleep and that is our priority right now.” Knowing that sleep is not something that parents can expect following the birth of a newborn indicated to me that his thoughts were jumbled or there was something else troubling him. Suddenly Joe stood up and began to speak about his need for a plan and his tone became intense and bordered on irritation and rudeness. I tried to think of what had caused this outburst and wondered about the nature of the underlying concerns. He was frustrated and I read his distress as being out of control and afraid. I let him speak and express his distress. I heard further details of the birth and their fears of threatened illness and death with the sudden onset of atrial fibrillation. Joe shared that the internist had said that Rebecca could have stroke, a cerebral vascular accident and named other potential complications she could suffer due to the tachycardia. Joe said he was afraid that Rebecca would die. Rebecca looked like she was going to burst into tears. I felt an immediate sense of compassion for them. I wondered about the impact that an emergency like this has on the family members and if he was at risk for a traumatic event, to say nothing of Rebecca.

Rebecca looked weepy, worried and shaken. I began to understand why he was angry and it was not just about the change in feeding plan. I listened to them, validated their concerns, offered explanations and identified that I needed to develop a plan with them for the immediate period and over the next few hours. I left them briefly to confer with the charge nurse who came into their room to explain that the infant could go to the NICU or with Rebecca if she was moved to another unit. Furthermore, that nursing staff from the perinatal unit would provide teaching about infant care and breastfeeding on the cardiac unit should she be transferred. The flexibility of the plan would be based on what was going to happen with Rebecca's care. Both Rebecca and Joe were relieved after they heard of the arrangements for continuity of care. Joe said he was sorry for his anger. I said there was no need for an apology, as I understood the pressures and fears they were experiencing. I spent time helping to express breast milk, feed the baby, listen and affirm their concerns and to lessen their fears.

Several hours had gone by and we had a plan of action organized. Joe felt settled and would go home to feed the dog, shower and change his cloths. It was only after Joe left that Rebecca began to weep. She shared her fears of dying and explained the unexpected events of her birth. I listened to her. Shortly after, the internist came in to see her, followed by the resident who had been at the birth. The internist shared with Rebecca that they were not transferring her to the cardiac unit as previously discussed; rather, they would wait and see if she would convert to a regular heart pattern or sinus rhythm, on her own. Like a mantra both the internist and the resident said "You just have to focus on regulating your heart rhythm." Each time I heard this I wondered how she was supposed to do this. Joe returned shortly after the doctors had left the room. He had also spoken with the doctors by the nursing station where they had also reassured him.

When Joe returned Rebecca relayed to him her sense of “a very different communication style” from the internist as compared to the previous day. On this occasion the internist was more relaxed and congenial during the discussion giving the impression that his approach the previous day was authoritarian and perhaps full of fear and concern. I read the change in communication as a comparison from extreme stress at the time of birth to a more relaxed but tentative approach to management of her care. What medical staff say during emergency situations compounded by the intensity of the situation are read by patients and family members in particular ways that are then measured against and interpreted with the same degree of concern. This relaying of emotional information is understood by patients and families as moments of stark fear and utter loss of control.

At change of shift many of the nurses who had been on the night prior were returning for their last shift. They demanded to know what had happened since they had left and why Rebecca was not in the cardiac unit on telemetry. The nurse who had cared for Rebecca the previous night was taking over from me and she shared her distress about the birth in more detail, specifically how stressful and disorganized she felt the situation had been. She described the unexpectedness of the event and the drama that unfolded and how she felt “on her own” with such a serious patient condition. Of particular concern was that intensive care unit staff had brought in a monitor to trace Rebecca’s cardiac status and only one among the perinatal staff knew how it worked. Furthermore, there was no paper read out and nowhere to record vital signs, dilation, pushing activity and other information that intrapartum nurses document during birth, thereby making the nurses work more disjointed and complex.

Later that evening, the nursing supervisor, who had also been working the previous night, came to see how Rebecca was doing and engaged in a recounting of the event. What was also

shared was that there was a discrepancy between what the obstetrician ordered for an antihypertensive (to lower the heart rate) and the emergency room nurses experienced opinion on normal dosage for a non-pregnant adult in the emergency room. There was a lot of discussion about physician's orders and other details. Furthermore, there was dissention among the nurses about whose approach was best. The major concern from the perinatal nurses was how the medication might affect the foetus in utero prior to birth, as many drugs are not tested on pregnant women. The perinatal nurses embarked on an exploration of what had happened, a review of the foetal tracing and what could and should have occurred. I listened intently to pick up anything that I could take forward about this situation. I realized that the perinatal staff, as well as the other HCPs, had not dealt with a situation like this before and they needed to share their own fears, thoughts and to be heard. There is always a strong element of learning for everyone in this type of debriefing. It was recommended that this woman's case be taken to obstetric rounds for further learning and discussion.

Rebecca and Joe were discharged from hospital a day or so later. Rebecca's heart rate had still not returned to normal sinus rhythm and she was still experiencing atrial fibrillation.

Over the next two weeks, I worked sporadically and the nursing staff were still discussing Rebecca and her atrial fibrillation. I wondered about this woman and how she was coping following birth, not only with her newborn and breastfeeding, but also with a medical condition she had not anticipated. I spoke with the charge nurse who had been on the first night I cared for Rebecca and we discussed the intense situations in which childbearing women find themselves that could be termed a difficult birth. I expressed my concern for women, such as Rebecca, who endure dire circumstances. Furthermore, I talked about how nursing staff have an obligation to minimize women's experiences of difficult birth through debriefing in order to help them adjust

to the traumas they experience while in our care. Additionally, it is important for HCPs to reflect on everyday actions and communication styles and work to ameliorate the shock our explanations have on women and families and the seriousness of the messages.

I was also acutely aware of the informal debriefing that staff engaged in that was on-going over various shifts and many days. I wondered what, if anything, was offered to Rebecca and Joe. Emergency situations can occur during birth and how HCPs respond and share information can exacerbate fears and terrorize women and families. Once the situation is resolved or less urgent, staff have an obligation to explain and assuage feelings of fear that HCPs may have generated during the crisis. If a review of the emergency event is left undone, women leave the hospital and their fears may escalate into perceiving the birth as not only difficult, but may also be read as traumatic, result in PPD or PTSD and have lifelong consequences.

This narrative offers an opportunity to see how difficult birthing experiences can occur in a woman's life. Many factors from this research play into how this situation could have been handled differently. Perhaps what is missing is thorough explanations and communication approaches that could ameliorate some of the fear and anxiety for the couple. Rebecca and Joe had come fully prepared with a birth plan and had expressed their need to be informed at all times. If someone had explained with Rebecca and Joe what had happened in greater detail after the event, this might have helped the palpable distress I witnessed when caring for them. Rebecca was acutely aware that a life event, such as birth, can turn into a different experience than anticipated and this incident would raise her consciousness and further shape her experience. I wondered if she would ever have another child. I pondered if she had second thoughts about having an epidural for her birth and that the anaesthesia had caused her to

experience a cardiac dysrhythmia that was unresolved. I wondered how her birth will affect how she feels about her child and how she will take her experience of birth into motherhood.

Stemming from the meanings Rebecca makes of her birth, this story provides an example of a situation that has the potential to become a difficult if not a traumatic experience in her life. To my knowledge nothing formally was done to address her fears and concerns about her experience and the couple was left to figure out their own path through the medical miasma. This highlights to me that the potential for difficult birthing and the sequelae of this reading as a marker of harm.