Women's Perceptions of the Birthing Experience: An Ever-Changing Phenomenon

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Full Text: Headnote ABSTRACT: The birthing experience may be perceived as a traumatic in women who present with posttraumatic stress disorder (PTSD). Yet a woman's view can change if she gains knowledge about the birth experience. Narrative debriefing, for example, is a source of validation, through the telling and listening of birth narratives. Further, by reading books and articles, taking mental notes, and comparing outcomes women can reevaluate their own experiences and their perceptions change as a result. Women may require repetitive debriefing to facilitate healing from birth-related trauma. KEY WORDS: birth, birthing, mothers, narrative, trauma, memories, perception, PTSD, phenomenon. INTRODUCTION A woman's experience of childbirth may have a profound effect on her sense of self (Callister, 2004). This rite of passage into motherhood, or "matrescence," is often anticipated as a potentially empowering event for the pregnant woman. If this anticipated triumph turns into a nightmare the woman may experience an event so frightening and unlike anything she could have imagined that posttraumatic stress disorder (PTSD) may result. Until the 1995 revision of the DSM, PTSD could only be diagnosed if the incident which caused the stressful response was "outside of normal human experience." (para. 3) The DSM-IV-TR (APA, 2000) now defines triggering incidents as "those that involve actual or threatened death or serious injury. The person's response involves intense fear, helplessness, or horror" (Swalm, n.d.). Traumatic birth experiences may now be considered the cause of PTSD. In 2001, Donley (n.d.) reported that an estimated "7% of women suffer from a syndrome equated to the effects of being on the battlefield!" Treatment for PTSD typically involves debriefing, support groups, cognitive behavioral therapy (CBT), exposure therapy, writing therapy, and medications. Debriefing therapy for birth-related PTSD is controversial in that optimal timing for debriefing has not been determined and conflicting reports of its efficacy exist. The helpfulness and availability of support groups are inconsistent and CBT is risky in that it challenges a woman's emotional response to her birth experience. "Challenging women's irrational thoughts needs to be done with caution: women with PTSD need to have their feelings validated not challenged" (Swalm, n.d., p. 4). Exposure therapy, through narrative, has been shown to be beneficial. However, narrative may not progress to healing without guidance of trained professionals (Swalm). This paper discusses the reasons that the treatment of birth-related PTSD through narrative succeeds sometimes and proposes a hypothesis of why it does not succeed at other times. LITERATURE REVIEW The act of giving birth, for many women, is viewed as a formal rite of passage into the ranks of motherhood. How she endures her passage will remain imprinted in her memory for many years to come. Penny Simkin (1998) discovered that women may recall explicit details of the day they gave birth for more than 20 years afterward. These memories are rich with not only physical but emotional detail. Women have been able to recall (and relive) the feelings they experienced during childbirth many years later. Feelings of joy, triumph, relief, pride, accomplishment, and acceptance are some of the positive ones recalled. Negative feelings include fear, pain (both physical and emotional), sadness, disappointment, resignation, violation, and numbness. It may be that the purposeful nature of childbirth is intensified when the experience goes awry. That which was intended to be a glorious, life-changing event has become devastatingly disappointing. The mother who feels victorious after giving birth may or may not have experienced trauma. It is her perception and understanding of the experience that determines whether or not she has failed to give birth in a manner that she considers acceptable. Through narrative, a woman is able to tell her story as it is perceived by her alone (Barraclough, 2000). No two people experience the same event in precisely the same way-this is what is known and accepted in the study of phenomenology.

Oftentimes, by simply telling her story, a woman may begin to deepen her understanding of the day she gave birth, but not always. "Converting feelings and images into words can change the way that the person thinks and emotes about the event. To date, however, simply venting emotions without cognitive reflection on the event has not been demonstrated to have health benefits" (Farley &Widmann, 1998, p. 23). It is incumbent on all those who have contact with a new mother, particularly healthcare providers, to listen to the telling and retelling of the birth narrative to gain an understanding of how her experience was perceived. How does this mother view her birthing experience now? Is she alright with it? Does she carry the burden of an unhealed trauma? Beck (Jan/Feb 2004) defines birth trauma "as an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror" (p. 28). Beck investigated the phenomenology of birth trauma among 40 mothers and concluded that "birth trauma lies in the eye of the beholder." Beck's inquiry identified four themes relevant to PTSD resulting from childbirth: (a) To care for me: Was that too much to ask? (b) To communicate with me: Why was this neglected? (c) To provide safe care: You betrayed my trust and I felt powerless; and (d) The end justifies the means: At whose expense? At what price? Waldenstrom (2004) researched the question of why some women change their opinions about their childbirth experiences over time. She was unable to find a definite answer as to why women's opinions change either from positive to less positive, from negative to less negative or, most interestingly, from positive to negative. She could only conclude that negative aspects of childbirth memories took longer for the mother to integrate into her birth recollection. She also determined that "sensitive care and midwife support seemed to have positive long-term effects on women's memory of childbirth" (p. 107). I propose that women change their opinions of their birthing experience because their perceptions change over time and perceptions change with knowledge. Women, through the telling and listening of birth narratives, learn. They learn about other women's birth experiences; about the necessity of medical procedures (or the lack of it). They read books and articles, take mental notes, and compare outcomes. Women compare experiences, reevaluate their own experiences, and their perceptions change as a result. The process follows a typical pattern. The woman gives birth and it is perceived as a positive or negative experience. Over time, she tells her birth story and she listens with new ears to the stories of other mothers. She attends breastfeeding support groups, new mother support groups, "Mommy &Me" exercise classes, etc. She now belongs to the club of motherhood and as Parley &Widmann (1998) explain in "The Value of Birth Stories," when mothers get together, birth story recounting is inevitable. Eventually, she will tell her own story to those who will listen. The telling of her story gives her validation. She connects with others and provides astounding detail her experience of labor, birth, and the period immediately following. She feels heard. Questions arise for her as she compares her experience to those of other women. If she had perceived her experience as a positive one, she may feel triumphant after listening to other mothers tell of less positive experiences. Alternatively, she may realize that her perceived triumph was not so ideal after all. She seeks clarification from books, articles, her healthcare provider, her family-from any source that she feels she can trust because her trust in her earlier perception has been shaken. Clarification leads to one of two outcomes. She either develops an understanding for why certain things were done, accepts them as necessity, and begins to heal. Or, she may learn that her experience was made unnecessarily difficult. Her perception has changed. There is anger, resentment, and lack of understanding. What was once a positive experience is now viewed as negative. The woman who perceived her birth experience as negative may learn that those things that led to her disappointing or frightening experience were not necessary, filling her with yet more regret. She now perceives her birth experience as a failure. Gamble, et al. (2005) studied the effectiveness of counseling intervention on a group of 348 women who had suffered traumatic childbirth. They discovered that "[n]o statistical difference occurred between the number of women meeting criteria for a diagnosis of posttraumatic stress disorder in the intervention and those in the control group at either 4 or 6 weeks postpartum or 3 months postpartum. However, there was a trend toward improvement in the intervention group at 3 months" (p. 14,

emphasis added). The authors concluded "that the intervention [counseling] had a positive effect in reducing trauma symptoms over the longer term." I suggest from these findings that the "trend" would continue as time elapsed. As a mother gains further knowledge in the months (and perhaps years) following her birth experience, she is more likely to benefit from counseling or other forms of psychotherapy because she has a better understanding of what happened to her and why. Furthermore, she is more likely to have acknowledged that a trauma did occur where she had otherwise been unable to identify a source of her discontent. In some regards, this is an instance of "what mommy doesn't know won't hurt her." However, as discussed above, she will indeed find out if she has any contact with other mothers, which she undoubtedly will have. The development of PTSD takes months, if not years. The DSM-IV specifically states that chronic PTSD cannot be diagnosed for at least three months after the occurrence (McKenzie-McHarg, 2004). "Debriefing or counseling offered too soon may interrupt natural mechanisms that allow an understanding of the trauma to be reached and the subsequent acceptance of the event into normal (nontraumatic) memory" (p. 220). Therefore, allowing the mother time to develop and answer her own questions may be the best course. She may do this through the casual storytelling that naturally occurs when mothers congregate either in organized support groups or in informal gatherings. Counseling and/or psychotherapy may be needed should she find herself traveling down the path to being a victim. Moreover, in the comparatively peaceful aftermath of a traumatic birth experience, a woman may be so relieved that she and her baby survived, she may not fully acknowledge the significance of her experience. Only after a certain time period has elapsed does she find herself questioning what happened and why (Cromptom, 2000). Such questions arise in her reactions to hearing other women's birth stories, reading books and newspaper, journal, and magazine articles about birth interventions, and perhaps subconsciously in her dreams or unexplained reactions to certain stimuli. "Being in pain, not being heard, being betrayed, having a powerless relationship with an authority figure, and being out of control are triggers to resurrect a previous event" (White). This delay in acknowledgement of a perceived trauma results in an inaccurate debriefing narrative provided too soon in the period following birth. For some women, trauma is apparent from day one. For others, the trauma is not so easily identified. Instead of a verbally identifiable problem, she only knows that something is wrong. Her baby is alive, healthy and normal. She is alive, recovered, and physically able to have more children. What is the problem? What went wrong? If she had envisioned a birth experience completely different from the one she had, the disappointment is even more profound. The narrative, while validating, opens the door to probing questions about the birth experience. Unlike the mother who finds acceptable answers, understanding, and then healing, the mother whose questions only lead to confusion does not find healing. Instead, she objects, post facto, to her birth experience. There is anguish, resentment, and possibly guilt. "Guilt inclines the mother to blame herself rather than the system" (Donley, n.d.). She knows that despite all she has learned, there will never be a chance to redo that birth. The memory of it is distinct and permanent, as stated earlier. Cognitive therapy is traditionally used for victims of posttraumatic stress disorder, and it is typically combined with exposure therapy. In the case of birth trauma, exposure therapy occurs through the narrative as there is no way to simulate the event. However, no studies have been conducted which prove the effectiveness of either cognitive or exposure therapy with regard to postpartum posttraumatic stress disorder (McKenzie-McHarg, 2004). Perhaps this is because the timing of the therapy has been wrong. The Birth Trauma Association (BTA) of Salisbury, UK recommends that all women be screened for Post Natal PTSD six weeks and six months after birth and that those who have been identified receive help in the form of psychotherapy (BTA). I suggest that women be screened for birth trauma on an ongoing basis, at least annually. The gaining of knowledge is perpetual. The piece of knowledge that finally completes a woman's personal puzzle of her birth experience may materialize at any time. The potential exists for a devastating realization about the unfolding of events surrounding the birth. So long as there is memory of the birth, even unconscious memory, there lies the potential for previously healed trauma to be converted to unresolved trauma. Conversely, there also lies the potential for unresolved trauma to be perceived differently and healing may begin. A clear example would be the

well-publicized 2005 review conducted by Hartmann, et al., on the outcomes of routine episiotomy which concluded that routine episiotomies are unnecessary and may cause worse outcomes for women. A woman who experienced a physically and emotionally traumatizing episiotomy years ago, having come to terms with it as necessary for the safe delivery of her infant, may begin to question the necessity of her own painful experience. She may still feel actual pain from the scar, because episiotomy scars, for some women, continue to be painful for many years (Hartmann, Viswananthan, Palmieri, Gartlehner, Thorp &Lohr, 2005). Her birth story has changed because, with the gaining of new knowledge, her perspective has changed. What was once a resolved trauma is no longer resolved. Alternatively, she may glean from the article that her episiotomy was necessary and retain her earlier perspective. Either way, it is her perspective that matters. SUMMARY In conclusion, I reiterate that birth narratives are an important tool for gaining understanding of the woman's perspective of her birth experience. However, the telling of the birth story, and any conclusions drawn from the hearing of it, may be done prematurely or not often enough. Debriefing, while a helpful tool in itself, needs to be conducted at various intervals after the birth experience, particularly the traumatic birth experience, because as time elapses and as mothers gain knowledge from hearing the birth stories of other mothers and from learning about birth procedures through reading and through the media, perspectives may change. A woman may experience delayed realization of birth trauma. Bailham and Joseph (2003) agree and assert that "there is a need for longitudinal research studies to assess risk factors that may contribute to [postpartum] PTSD over time" (p. 167). To assist effectively, clinicians while treating a mother resolving birth trauma should: (1) ask open-ended questions; (2) emphasize that all answers are "correct;" (3) ask for clarification when needed; (4) listen empathically; (5) gently probe for further details; (6) explain the necessity of interventions under certain circumstances while validating feelings; (7) allow venting; (8) accept emotional responses to experiences; (9) allow the mother to express her regrets and/or personal failures and identify strengths; and (10) access pertinent information regarding future birth experiences (Charles &Curtis, 1994; Kaiman &Ancheta, 1997; Nichols, 1996, as cited in Callister, 2004). The mother's version of the birth narrative must be heard with open and attentive ears repeatedly as it will undoubtedly change as her perspective changes. Allowing her to retell it, inserting insight gained through knowledge, will encourage the healing process as she is not only validated for her experience, but she is able to tell the whole story as she views it in the present. The retelling cannot change what occurred, but it can begin the transition from helpless victim to resilient victor as she discovers a new perspective of herself. References REFERENCES American Psychiatric Association (2000). Diagnostic and statistical manual (DSM-TVTR). 4th ed. Washington, D.C.: American Psychiatric Publishing, Inc. Bailham, D. &Joseph, S. (2003). Post-traumatic stress following childbirth: A review of the emerging literature and directions for research and practice. Psychology, Health &Medicine, 8(2), 159-168. Barraclough, R. (2000). After pains: Birth stories don't always have happy endings. New Zealand Treasures Magazine. September issue. Retrieved June 19, 2006 from http:// www.tabs.org.nz/pdfdocs/treasuresart.pdf. Beck, C.T. (2004). Birth trauma: In the eye of the beholder. Nursing Research, 53(1), 28-35. Beck, C.T. (2004). Post-traumatic stress disorder due to childbirth: The aftermath. Nursing Research, 53(4), 216-224. Birth Trauma Association (n.d.). Post Natal Post Traumatic Stress Disorder. Retrieved June 19, 2006 from http://www.birthtraumaassociation.org.uk/publications/Post_ Natal_PTSD.pdf. Callister, L.C. (2004). Making meaning: Women's birth narratives. JOGNN, 33(4), 508-518. Crompton, J. (2000). Post-traumatic stress disorder and childbirth. Retrieved June 19, 2006 from http://www.tabs.org.nz/pdfdocs/jrcrompton%20tabs.pdf. Donley, J. (n.d.). Another article from Joan Donley. Retrieved June 19, 2006 from http:// www.tabs.org.nz/pdfdocs/jdonley.pdf. Farley, C. &Widmann, S. (1998). The value of birth stories. Retrieved June 7, 2006 from http://www. icea. org/0901. pdf. Gamble, J., Greedy, D., Moyle, W., Webster, J., McAllister, M., &Dickson, P. (2005). Effectiveness of a counseling intervention after a traumatic childbirth: A randomized controlled trial. Birth, 32(1), 11-19. Hartmann, K., Viswanathan, M., Palmieri, R., Gartlehner, G., Thorp, J., &Lohr, K.N. (2005). Outcomes of routine episiotomy: A systematic review. JAMA, 293(17), 2141-2148.

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