

DISENFRANCHISED GRIEF IN POSTPARTUM WOMEN: A HEURISTIC INQUIRY
INTO WOMEN'S LIVED EXPERIENCE OF LOSS OF THE DREAMED-OF BIRTH

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Abstract

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The childbearing year is of utmost significance in a woman's life, carrying inherent possibilities of empowerment and self-actualization. Most women create a vision of their "dreamed-of birth" that represents their beliefs about birth and their role in the process.

However women's expectations about birth are often subverted by the authoritative knowledge and practices of the Western maternity care system or by the unpredictable nature of the birth itself. The pregnant woman repeatedly becomes the object of the "medicalized gaze" of a technocratic medical system that places her in the passive role of "compliant patient," being "delivered" by professionals and robbed of her inner power and embodied knowledge of giving birth. Coming out of the childbirth experience with feelings of being uncared for, silenced, and even abused can cause serious long term psychological reactions in postpartum women.

Many of these women are left unacknowledged and unsupported by professionals who unwittingly contribute to the disenfranchisement of their grief. Furthermore their grief remains invisible if they continue to appear capable and productive in their lives.

This phenomenological study explores how a sample of nine women whose actual birth experience violated their “dreamed-of” birth coped with associated feelings of loss and unacknowledged grief. Employing Kenneth Doka’s concept of disenfranchised loss and grief as the theoretical framework, I conducted informal conversational in-depth interviews and employed a heuristic approach in order to explore women’s lived experience of postpartum grief. From my findings, I draw specific implications for clinical social work knowledge building and practice.

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Introduction

1. Statement of the Problem

The childbirth experience is one of the most profound life-changing moments in a woman's life (England, 2010; Mauger, 1998, 2000; Simkin, 1991). Women inevitably create expectations about the childbirth experience (Beaton and Gupton, 1990; Gibbins and Thomson, 2001; Melender, 2002, 2006; VandeVusse, 1999) which reflect their social contexts, previous birth experiences or birth stories they were exposed to. Prenatal psychologists believe that women hold the embodied knowledge about the birthing process from their own experience of being born and the intergenerational stories of birthing in their families (Emerson, 1998; England & Horowitz, 1998; Mauger, 1998).

There are many factors which contribute to women's satisfaction or lack thereof with the childbirth experience. One main factor that has a role in women's satisfaction with birth is feeling supported and treated with dignity during labor and the postpartum period (Brown and Lumley, 1998; Callister, 2004; Green, Baston, Eastone, & McCormick, 2003; Halldorsdottir & Karlsdottir, 1996; Lundgren, 2005; Lyerly, 2006, 2013; MacKinnon, McIntyre, & Quance, 2005; Ogden, Shaw, & Zander, 1998; Waldenstrom, Hildingsson, Rubertsson, & Radestad, 2004). Another contributing factor is women's sense of control during the process (Bramadat and Driedger, 1993; Corbett and Callister, 2000; Gibbins & Thomson, 2001; Homer et. al., 2002; Matthews and Callister, 2004; Slade et al., 1993;; VandeVusse, 1999; Walker, Hall, & Thomas, 1995). A third factor is the experience of pain during childbirth, which can cause negative

psychosocial outcomes for women (Slade et al., 1993; Stern, 1997), but can also be a source of feeling empowered and capable as a birth-giving woman (Lowe, 2000; Lundberg & Dahlberg, 1998; McCrea and Wright, 1999; Salmon, Miller, & Drew, 1990; Waldenstrom et al., 1996).

A woman's perception of her childbirth experience can affect the transformational process of becoming a mother (Callister, 2004; Gaskin, 2011; Madsen, 1994; Mauger, 1998, 2000; Simkin, 1991). What medical professionals see as a successful or "normal" birth may not always be perceived by the woman as such (Davies-Floyd, 1992, 2001; England and Horowitz, 1998; Freedman, 1999, Grant, Sueda, & Kaneshiro, 2010; Lavender, Walkinshaw, & Walton, 1999). Very often when women voice their concerns and feelings about a difficult and/or disappointing birth experience they are invalidated and even shamed for focusing more on their own experience than on the delivery of a healthy baby. Although women desire a healthy baby above all, they can still be very unhappy with the actual childbirth experience when it does not meet their expectations (Grace, 1978; Hodnett, 2002). Women may have conflicting feelings of guilt and disappointment when the actual event of birth deviates from their expectations (Stern, 1997). If their coping with labor and pain does not go as they have planned, they may perceive it as a personal failure (Lowe, 2000; Oakley, 2004; Page, 2001) and feel disempowered and incomplete (Gamble & Creedy, 2009; Hauck, Fenwick, Downie, & Butt, 2007; Karlstrom et al., 2007; Wiklund, Edman, Ryding, & Andolf, 2008). These negative feelings can have an impact on the woman's adjustment to her new role as a mother (Ayers, Eagle, & Waring, 2006).

Because they may be unacknowledged or trivialized, the negative feelings women report after a disappointing or traumatic birth experience can be considered a form of disenfranchised grief. Kenneth Doka (1989) explains that the disenfranchisement of grief can complicate and exacerbate many of the emotions associated with grief – anger, despair, anxiety, sadness, depression, loneliness and numbness. He argues that people will experience intensified feelings of anger, guilt and powerlessness when denied their right to grieve over a loss unacknowledged by society (Doka, 1989). This study aims to give voice to women who have experienced disenfranchised grief following the loss of a dreamed-of birth.

2. Purpose of the Study

Clinical research has grown in the field of postpartum mental health disorders such as postpartum depression, postpartum anxiety and psychosis (Chabrol et al., 2002; Church et al., 2009; Cooper and Murray, 1995; Gaynes et al., 2005; Hunker, Patrick, Albrecht, & Wisner, 2009; O’Hara & Swain, 1996; Webster, Nicholas, Velacott, Cridland, & Fawcett, 2010). New understanding and acknowledgment has been brought to post-traumatic stress disorder after childbirth and birth-giving trauma (Ayers, 2004, 2007; Ballard, Stanley, & Brockington, 1995; Beck, 2004a, 2004b, 2006; Beck et al., 2011; Creedy, Shochet, & Horsfall, 2000; Crompton, 2003; Czarnocka & Slade, 2000; Olde, van der Hart, Kleber, & van Son, 2006; Soet, Brack, & DiLorio, 2003).

Even though many studies have identified a grief response following disappointing or traumatic childbirth experiences (Davies et al., 2008; Davies-Floyd,

1992; Fisher, Astbury, & Smith, 1997; Grace, 1978; Kendal-Tackett, 2002; Kitzinger, 1994, 2006a; Madsen, 1994; Moloney, 2010; Peterson, 2008; Wolf, 2001), there has been no specific research interest into acquiring more in-depth knowledge about the lived experience of these women. The disenfranchisement of women's feelings of loss and grief can lead to long term difficulties with self-esteem and self-actualization, intimate relationships and attachment/bonding with the baby (Davies-Floyd, 1992; DiMatteo et al., 1996; Madsen, 1994; Mozingo et al., 2002; Zadoroznyj, 1999). Furthermore, this silencing acts to subjugate women and furthers their gender oppression and discrimination (Davies-Floyd & Sargent, 1997; Gaskin, 2011; Hunter, 2006; Johnson, 2008; Odent, 2009; Rudolfsdottir, 2000; Simonds, Rothman & Norman, 2007; Wolf, 2001).

Without an understanding of the loss of the dreamed-of birth and the disenfranchisement of their grief, professionals may unwillingly contribute to the invalidation of women's feelings and experiences. This failure to understand exacerbates emotions of anger, loneliness, guilt and despair and impedes the postpartum healing process for women. They may be misdiagnosed with, and treated psychotherapeutically and pharmacologically for, PPD or PTSD by professionals who are uninformed about this form of grief. Professionals working with these women need to acquire a more in-depth knowledge and understanding of their grief in order to avoid pathologizing their reactions unnecessarily. Thus, in order to bring more awareness and clarity to women's feelings of loss and grief after disappointing and dispiriting birth experiences, more research is in order. The presented qualitative study helps to meet this need as well as empower women

to claim their own voices, validate their lived experience, and break the silence surrounding an under-researched but frequently occurring phenomenon.

3. Research Question(s)

This research strives to gain a deeper understanding about the experience of a negative or disappointing childbirth and associated postpartum grief. It looks into how women grieve the loss of their dreamed-of birth. How were their expectations and beliefs about birth different from the actual experience of childbirth? What is lost for these women? What is the place of the lost dreamed-of birth in their newly acquired identities as mothers? What messages do they receive from others about their experience of loss? How does the grief influence their self-actualization during the postpartum period? Where do they find support and validation of their loss and grief?

4. Significance of the Study

It is of an utmost significance to have a better understanding and awareness of the grief some women experience after their childbirth expectations are not met by the actual event. Since many of these women may not meet diagnostic criteria for a mental health diagnoses, they may go unnoticed by various professionals who might be able to refer them to specialized help. Many professionals are not aware of the existence of this phenomenon and might disregard any concerns women voice about their birth experience.

The disenfranchisement of women's loss and grief can further alienate them from professional help and contribute to the deepening of their disempowerment and marginalization. Without adequate support for and validation of their grief, women can feel silenced by professionals and broader society. In turn, they may silence themselves in a way that impedes the postpartum process of healing and growth. At the onset of the childbearing year, social workers can foster prevention by promoting holistic childbirth education and preparation. If encountering women who have experienced a disappointing birth, they can play a crucial role in advocacy, support and therapeutic intervention. Social workers can be the important link between medical systems and women and their families, bridging the gaps between the medicalized technocratic view of childbirth and women's wishes for more intimate and self-directed experience. With an increased awareness of the grief phenomenon and the disenfranchisement women may be exposed to in a medicalized culture, social workers are better equipped for early detection and immediate provision of services to women who are either at risk of or have experienced a disappointing birth.

5. Theoretical Framework

The approach I have adopted for this research has a strong narrative theory influence. Narrative theory uses personal narratives to understand the way people make sense of the world around them (Connelly & Clandinin, 1990). Personal narratives carry important information about the different milestones and memorable experiences people go through and reflect their understanding of those experiences. Therefore, narrative

theory is interested not only in the content of the narratives, but also in the ways people interpret and integrate them in their personal lives (Gubrium & Holstein, 1998).

Birth stories carry valuable information about women's views of self, their role as participants in the process and the values they assign to the birthing process (Colton, 2004). Narrative theory offers a framework for understanding how dominant cultural narratives about birth and women's roles in birth influence the individual narratives about who they are as women and mothers (Callister, 2004; Davies-Floyd, 1992; DiBlasio, 2002; England & Horowitz, 1998; Murphy-Lawless, 1998). I aimed for a better understanding of the various stories of healing to capture the multifaceted experiences of grief and loss of women's expectations and beliefs about birth. According to narrative theory one's world is built on his/her assumptions and beliefs about the world which can be disrupted by any type of loss (Whiting & James, 2006). Therefore, a central task of grieving is to come to terms with disrupted assumptions about one's world in the service of revising long-held beliefs and dreams (Bosticco & Thompson, 2005; Gillies & Neimeyer, 2006). Hence, narrative theory guides my research of disenfranchised grief and inform my understanding of women's postpartum narratives of loss, the meanings of their unexpected experiences of labor and postpartum reconciliations with the lost dreamed-of birth.

This study is based on Kenneth Doka's (1989) theory of disenfranchised grief and loss. During my literature review and reading personal birth stories I found multiple similarities between the emotions women have after a negative childbirth and the disenfranchised grief Doka presents in his work. Therefore I use his concept to bring

more clarity to the process of the disenfranchisement and silencing women are subjected to when they are unhappy with their birthing experience.

In the literature review I encountered multiple feminist writings on the topic of autonomy and agency during the childbearing year, a literature that is pertinent to women's experiences of labor. Throughout I have paid specific attention to the relational nature of childbirth and the themes of power and control, silence, disenfranchisement, and women's unique ways of knowing. My aspiration for this research came from the core social work value of serving women with dignity and respect especially in vulnerable times like the childbearing period; re-establishing and maintaining social justice in the maternity care system; enhancing the competence and integrity of professionals who work with women during their childbearing year; and bringing to light the importance of human relationships during and after childbirth.

With all the above in mind, this research aims to explore a phenomenon which has gone under-researched. My aim was to let the research interviews unfold as freely and unstructured as possible, leaving the opportunity for women to tell their own truths in their own voices.

II. Literature review

This dissertation research explores the lived experience of grief which women may encounter postpartum if their experience of giving birth violates their prenatal expectations and beliefs. I interviewed women who live in USA; therefore I focus mainly on the birthing culture in our country. Where in my writing I refer to U.S. women or

American women, I imply women who live in the United States of America without regard to their cultural or ethnic background. The literature review contains research from Europe, Australia and New Zealand as well as the United States. Although the birthing culture is slightly different in those countries, the research appears relevant and applicable to the U.S. reality. Whenever local literature was available I favored it as the closest reflection of the American culture of birth.

The dearth of previous research on this topic illustrates the multi-leveled disenfranchisement of women's grief about the loss of their dreamed-of birth by society, researchers and professionals involved in their care. This study aims to break the silence around the lived experience of grief after a disappointing or unexpected birth experience. It brings more understanding and clarity to the loss of the dreamed-of birth some women encounter after a negative childbirth event.

1. Dreaming about the birth – women's expectations and beliefs about childbirth in contemporary America

Research shows that women inevitably develop expectations about childbirth (Gibbins & Thomson, 2001) and some authors believe that these expectations influence the process of birth and women's perceptions of it (Green, Coupland, & Kitzinger, 1998; Highsmith, 2006; Hodnett, 2002; Tulman & Fawcett, 2003). Therefore, it is important to be aware of the forces that shape women's beliefs and expectations of childbirth so we can understand their perceptions and psychological responses to their birth experiences.

The section below reviews the various expectations that are explored in the literature on childbirth, including cultural influences in the United States related to knowledge, gender, medicalization, fear and control.

1.1. Authoritative knowledge about birth and its influence over women's expectations and beliefs about childbirth

In an attempt to explain the mechanisms of shaping women's views and beliefs about birth, feminist theorists look into broader societal norms. Jordan (1997) coined the term "authoritative knowledge" to demonstrate how beliefs about childbirth become so entrenched in our society that they are not questioned. The power of authoritative knowledge, Jordan (1997) says, "is not that it is correct but that it counts" (p.58). Medical knowledge about the childbearing process supersedes and delegitimizes other potentially helpful sources of information such as women's own sensations and knowledge of their bodies. The superiority of the medical knowledge over women's embodied knowledge during childbirth is seen in the multiple interventions and protocols followed by hospital staff, sometimes without acknowledging women's body awareness and autonomy. Jordan (1997) argues that during pregnancy and birth "woman's knowledge counts for nothing" (p.64) and often during labor she is not allowed to follow her natural instincts but rather mandated to listen to experts' advice. Authoritative knowledge in childbirth shapes women's expectations of childbirth very powerfully and instills in them compliance, fear of the process and alienation from their own bodies (Jordan, 1997; Katz-Rothman, 2007).

Authoritative technocratic knowledge is particularly powerful in United States culture (Davies-Floyd, 1992). Most American women accept information derived from technology as inherently authoritative knowledge and expect to have access to such information during pregnancy and labor (Browner and Press, 1997; Draper, 2002; Hays, 1996; Martin, 2003; McCoyd, 2010). The portrayal of pregnancy and birth by the medical profession and broader society as innately dangerous and risky processes subjects women to the “medical gaze” from the first days of their pregnancy and even before that – at conception (Katz-Rothman, 2007). Women are expected and expect to accept intensifying prenatal surveillance which may contribute to their disempowerment and alienation from their innate wisdom and instincts (Davies-Floyd, 1992; Kitzinger, 2006a). This institutionalized surveillance of birth “drains power from the birthing woman and gives it to the institution itself, as it homogenizes the experience” (Katz-Rothman, 2007, p.71). Beyond the individual experience, Katz-Rothman (2007) sees the influence of institutionalization of childbirth on a cultural level given that hospital birth is a cultural norm. The hospital birth becomes casual and the institutionalization of childbirth – a necessity. It is “...as if birth itself depends on the institution” (Katz-Rothman, 2007, p. 72), not on the laboring woman.

In the context of authoritative knowledge, Lazarus (1997) sees pregnancy and birth in the U.S. as “a medical event controlled by the medical profession” (p.134). Even though some women see birth as a natural phenomenon, they show a deeply ingrained medical view of it in their fears that at any moment something can go wrong and that medicine has the control over this uncertainty (Davies-Floyd, 1992). Pregnancy and birth are seen as abnormal, risky and the woman’s body as an imperfect version of the male

body (Davies-Floyd, 1992; Gaskin, 2011; Kitzinger, 2006a). The notion of inherent risk in pregnancy and childbirth shapes many women's beliefs and expectations that childbirth is a scary and uncertain ordeal. Fear of potential complications and harm to the fetus shapes women's beliefs of birth as risky business that needs to be controlled to ensure safe delivery (Lyerly et al., 2009; Melender, 2002). Thus women often feel pressured to "choose" high technology births in the controlled and scrutinized environment of the hospital even when they see the process as normal and natural. As a result, they often find themselves in inferior positions to medical professionals who are believed to have the knowledge and technology to control this "dangerous" process (Darra & Norris, 2008; Johanson & Newburn, 2002; Jordan, 1993; Katz-Rothman, 1994; Nolan, 2002; Rashad, 2003; Saxell, 2000; Walsh, El-Nemer, & Downe, 2004; Wilson, 2002). Being socialized to a highly technocratic and medicalized culture of childbirth sets the scene for women long before pregnancy and labor begin.

Considering only the "medical gaze" which women are subjected to throughout the childbearing year would be presenting only the obvious side of the story. Many authors find the internalized control and self discipline during pregnancy and birth of equal importance for understanding the mechanisms that shape women's expectations and behavior throughout the childbearing year (Gaskin, 2011; Martin, 2003; Reiger & Dempsey, 2006). Internalized control and self discipline, as well as culturally and socially imposed gender roles, all add to the power and influence of authoritative medical knowledge on the birth experiences of many women.

1.2. The internalized gender technologies of power and their influence over women's expectations about childbirth

Cultural factors have been shown to influence women's concerns and perceptions of self during the childbearing year. These culturally accepted beliefs about how women should behave in public are gendered in their nature and can influence the way a woman acts during one of the most gender loaded events in her life (Carter, 2009; Martin, 2003; Chadwick & Foster, 2012). Martin (2003) sees the gender technologies of power as "those aspects of the gender system that are in us, that become us" (p.56). Following Foucault's notion of 'technologies of power' she argues that women have internalized gender technologies which discipline them during labor and influence their expectations about labor, themselves and the other participants in it (Martin, 2003). The expectation to control from within may supersede women's urge to ask for what they need or to oppose their birth attendants' views and practices during labor (Martin, 2003). When asked prenatally some women report worries about an inability to perform in socially accepted ways during labor (Carter, 2009; Martin, 2003; Saisto & Halmesmaki, 2003). They may approach birth with apprehension about their capabilities to handle its intensity and pain with dignity (Chadwick & Foster, 2012; Martin, 2003; Mauger, 2000).

Martin (2003) suggests that despite the cultural portrayal in popular movies or TV shows of women in labor who are self-centered, screaming and demanding drugs, some women are concerned about such behaviors during labor. This contradiction "reveals that an internalized sense of gender plays a role in disciplining women and their bodies during childbirth" (Martin, 2003, p.54). In interviewing 26 middle class white women about their childbirth experiences, Martin (2003) found that some women self-disciplined

themselves during labor so they could maintain internalized gender characteristics of being polite, kind and selfless, enacting Gilligan's (1982) understanding of engendered characteristics of women's behavior. This self-discipline may interfere with their central role during the process of giving birth, thus making labor difficult and bringing passivity and disempowerment while surrendering control to the attending practitioner or hospital staff (Martin, 2003).

The internalized technologies of gender have been unacknowledged and under-researched by scholars, but, as Martin (2003) argues, become powerful agents of culturally imposed self-discipline during labor. Martin (2003) finds that women "...continued to be nice, kind, relational, and selfless...despite the physical demands of labor and childbirth." (p. 61). This research also indicated that when gender technologies broke down during childbirth, women often felt apologetic and ashamed for putting their needs first or being too demanding or difficult. Furthermore, some women valued their husbands' or birth attendants' views of their childbirth more than their own lived experiences (Martin, 2003). This phenomenon can be observed not only during labor, but also prenatally and postpartum in some women's self-disenfranchisement of the grief they may experience when the birth does not conform to their expectations.

1.3. Fear of pain and the promise of painless childbirth

Women tend to expect that birth is a painful process, which causes fears in many expectant mothers (Hodnett, 2002; Lally et al., 2008; Melender, 2002). The medical establishment and the natural childbirth movement agree on offering women different

possibilities to minimize pain or even achieve painless childbirth. There are multiple childbirth preparation methods which promise women a variation of pain-less birth. Lamaze and Bradley methods were developed in the 60s and used different breathing techniques to minimize labor pains, followed by various hypnobirthing methods, water birth, and even orgasmic birth childbirth education methods (Gagnon, 2000). Many medical approaches to pain management including IV narcotics, gas, scopolamine, and the current most favored one – the epidural/spinal block--have been used. All these methods promise to minimize and even take away the pain and suffering from labor in another effort to control the birthing process and actively manage labor.

The natural childbirth movement and its founder Grantly Dick-Read at first saw labor pain as unnatural and therefore a sign of women's fears in labor (Beckett, 2005). He believed that when fears are present during childbirth the woman cannot relax completely and her muscles contract under the tension that produces the pain in labor. In this version of childbirth, if the woman complains of labor pains it is a sign that she is not able to let go of her fears, trust the process and relax her body completely. Even though the intentions of Dick-Read and the natural childbirth movement were to normalize birth and empower women to give birth with confidence in their bodies, it is clear how these teachings can lead to blaming women for failing if they experience prolonged and difficult labors. Suggesting that women's fears and unresolved trauma lead to complicated or painful childbirth can be further traumatizing for them (Beckett, 2005; Crossley, 2007).

The belief that the power of one's mind can determine the course of labor and its outcome can lead to self blame and shame when one is already dealing with a negative

birth experience (Crossley, 2007). With time the natural childbirth movement evolved into seeing labor pains as normal and part of the healthy process of labor; thus childbirth preparation classes now give expectant parents different natural tips and techniques for dealing with pain (Gaskin, 2011). Some of these techniques present birthing under self-induced hypnosis, using guided imagery, and breathing techniques. Women often leave childbirth education classes with the belief and expectation that, if they follow the prescribed routine during labor, their childbirth experience will be pleasant and maybe even ecstatic; but as research shows no single technique or combination are found to be effective for every woman (Hodnett et al., 2006). At times failures to control labor pain with such natural techniques may strengthen women's negative views of their coping and birthing abilities, especially when they experience unexpected complications during labor or the level of pain they endure is beyond their expectations (Darra, 2009). Women may blame themselves following others' comments about how their complicated labor could have been avoided.

The medical answer to painful labor is anesthesia and intravenous drugs, but they are not without a risk. For example, complications such as prolonged labor, maternal fever, higher risk of instrumental delivery, cesarean delivery and other complications may result from the administering of an epidural/spinal block (Soliday, 2012). At times the medical pain relief does not work as promised and may leave women with disappointment and dissatisfaction, even trauma (Hidaka & Callister, 2012; Soliday, 2012). In cases where complications arise after the use of medical pain relief, women may blame themselves for their choice of pain management and feel guilty for not researching the procedure more thoroughly. Pain management suggestions are rarely free

of cultural, social and institutional influences, therefore the responsibility for making choices needs to be shared between the woman and her care providers (Beckett, 2005; Reiger & Dempsey, 2006; Soliday, 2012).

1.4. Intergenerational transmission of birth expectations

In addition to socio-cultural factors, the fear of childbirth emerges within families. Intergenerational stories of birth trauma and negative experiences during childbirth may be passed along and sow seeds of birth-giving trauma in women (England & Horowitz, 1998). Many women report that their mothers taught them how to approach childbirth (Darvil, Skirton, & Farrand, 2010). This finding supports the understanding of intergenerational transmission of birth trauma from a mother to a daughter (England & Horowitz, 1998; Mauger, 1998) and may explain the prevalence of fear and negative attitudes toward birth in so many contemporary American women. Since the beginning of 20th century birth has been industrialized and scrutinized. Women were heavily sedated and delivered of their babies by the obstetricians well into the 70s. Due to an influx of births and too few practitioners to attend them during these years, instrumental deliveries (usually by forceps) became the norm (Wolf, 2009). Heavily sedated for their births, many women emerged from the experience with no or fragmented memories of their actual labor and delivery which led to alienation and anxiety about subsequent childbirths (Gaskin, 2011; Wertz & Wertz, 1989). Stories of trauma were shared with other women and with their daughters and granddaughters, demonstrating how accounts of the trauma and abuse of institutionalized treatment become part of today's collective narrative of childbirth (Reiger & Dempsey, 2006).

Hearing childbirth stories of trauma, fear and institutionalization leaves a mark on women's perceptions of childbirth and their expectations about their own experiences (Kitzinger, 2006a, b; Reiger & Dempsey, 2006). Disconnection from the natural process of giving birth is prominent nowadays. Ironically, iatrogenic trauma is often attributed to the dangerous nature of childbirth and not to its real cause – impersonal and dehumanizing medical practices during the “high-tech low touch” management of labor (Gaskin, 2011).

Another source of intergenerational trauma is the implicit and embodied memory of our mothers' and grandmothers' birth experiences from the babies' point of view. Prenatal psychologists and researchers believe that people have unconscious memories of their own births and prenatal experiences in utero (Chamberlain, 2000). Therefore, something that is experienced as traumatic or anxiety/fear provoking by the mother is also felt by the infant and may be even intensified (Emerson, 1998). Living with this non-conscious tacit knowledge of childbirth is often more powerful than any intellectual education women receive during childbirth preparation classes (England, 2010). Unexplained fears and anxiety about childbirth are correlated with prolonged and complicated labors, leaving women re-enacting their own birth trauma in the birth-giving process (Haines et al., 2012). Therefore, there is a need for in-depth understanding and awareness by practitioners about these subtle processes and experiences so they can support women in changing their birth experiences and associated narratives.

2. Birth expectations vs. lived experience of birth

The beliefs and expectations women hold prenatally can have a powerful impact on their perception of the experience of childbirth (Crossley, 2007; England & Horowitz, 1998; Haines et al., 2012; Hauck et al., 2007; Highsmith, 2006; Nilsson & Lundgren, 2009). Women's expectations have been a long time focus of satisfaction studies (Bryanton et al., 2008; Conde et al., 2008; Goberna-Tricas et al., 2011; Hallgren et al., 1995; Hodnett, 2002; Redshaw, 2008) and the development and improvement of childbirth education (Bailey, Crane, & Nugent, 2008; Koehn, 2002). Some of the research has explored if and how women's beliefs influence the childbirth process and outcome. Interestingly, there are major discrepancies between the findings of quantitative and qualitative studies.

Much of the quantitative research suggests that women's prenatal expectations were met by the actual childbirth event (Ayers & Pickering, 2005; Green, Coupland & Kitzinger, 1998; Green, 1993; Harwood, McLean, & Durkin, 2007; Hodnett, 2002; Waldenstrom, Borg, Olsson, Skold, & Wall, 1996). The answers to in-depth questionnaires of 825 women revealed a correlation between positive expectations and overall satisfaction with the actual experience of childbirth. Women who reported more anxious feelings and fear of labor prenatally experienced childbirth as a negative event later on (Green et al., 1998). In a study of 700 English women, Green (1993) found that women had their labor expectations met. These findings were supported by another quantitative study of 295 Swedish women's childbirth experiences which confirmed that positive expectations about childbirth tended to leave women with more positive psychological outcomes (Waldenstrom, et al., 1996).

Hodnett's (2002) review of 137 descriptive studies, randomized controlled trials, and systematic reviews of intrapartum interventions yielded support for the above findings. Despite some expectations that were not exactly matched with the actual experience of labor, women reported overall satisfaction with the experience of birth; and once again positive expectations led to positive views of the actual experience of labor (Hodnett, 2002). Ayers and Pickering (2005) confirmed the above findings that women's expectations were positively correlated to the birth experience. Their results indicated that strong expectations of control during labor led to positive assessments of the control women had during the actual experience (Ayers & Pickering, 2005). This research also indicated that poorly matched expectations and experiences can leave mothers with negative psychological outcomes which can interfere with the postpartum period of healing and transformation to the new role of mothering.

On the contrary, many qualitative studies have found that in a majority of cases, women's childbirth expectations were unmet, sometimes resulting in adverse psychological outcomes for them and their families (Beaton & Gupton, 1990; Gibbins & Thomson, 2001; Halldorsdottir & Karlsdottir, 1996; Hallgren, Kihlgren, Norberg, & Forslin, 1995; Malacrida & Boulton, 2013; Soliday, 2012). In a phenomenological study of English women, Gibbins and Thomson (2001) found that even though the eight interviewed women feared childbirth complications such as long and difficult labors, they hoped for manageable pain and fast labor. All participants reported that their births violated their childbirth expectations. From another phenomenological study of 16 women's experiences of birth in Iceland, Halldorsdottir and Karlsdottir (1996) concluded that all respondents expected easier or more difficult labor than what they actually

experienced. These findings were supported by another qualitative study by Hallgren and colleagues (1995) which found that 9 out of 11 interviewed women had misaligned childbirth expectations and birth experiences. Malacrida and Boulton (2013) interviewed 22 women about their plans, choices and experiences of childbirth and found a major divergence from women's plans of achieving as natural a birth as possible. Analyzing their birth narratives showed that the lived experience of birth violated women's plans and expectations (Malacrida & Boulton, 2013).

It is important to address the difference in the quantitative and qualitative studies explored above. Waldenstrom et al. (1996) explains the inconsistency between the types of research with the limits inherent in the two methodologies. Closed-ended questions in quantitative studies tend to elicit more positive answers from respondents than the open-ended questions used during interviews and qualitative research. The timing of the research may also impact the discrepancies between qualitative and quantitative results. Many of the large quantitative studies were carried out during the immediate postpartum period when women are inclined to describe their birth experience more positively due to the halo effect of the birth (Waldenstrom et al., 1996). The halo effect is the positive outlook about the experience women typically have closer to the birth, and may be related to relief that the birth is over. The "birth high" usually lasts a few weeks and temporarily overrides the birth negatives (Simkin, 2004). Thus, the data from these quantitative studies need to be considered with some caution. Also during the birth shock immediately after birth, women tend to feel grateful and express satisfaction that does not reflect their overall satisfaction with the experience but rather captures their relief that the ordeal is over and that they and their babies have survived (England, 2011). The same

caution should be applied to the qualitative studies exploring the match between prenatal expectations and actual birth experience. The limited size of the studies' samples leaves most of them with limited representativeness, despite efforts to include diverse respondents in the research.

To further explore the incongruent findings of qualitative and quantitative research studies, Highsmith (2006) incorporated projective drawing techniques in a qualitative phenomenological study. Through the use of projective drawing of their ideal births, Highsmith elicited information about the unconscious fears and beliefs of the interviewed women and argued that these expectations were later met in the actual childbirth event. She concluded that in general, women do get their expectations met; but when interviewed they fail to recognize this because these expectations are unconscious. Understanding the power the unconscious mind has over one's behavior leads Highsmith to advocate for better utilization of creative assessment techniques during prenatal and postnatal counseling and education. Such tools can provide more comprehensive personal and professional understanding of women's tacit beliefs and may promote more positive views of childbirth (Highsmith, 2006).

In another attempt to identify the incidence of matching maternal expectations with the actual experience of birth, Soliday (2012) interviewed 75 U.S. women in two-part semi-structured interviews. The first interview was conducted during the last trimester of the pregnancy and second approximately two months postpartum. After analyzing the interviews for common themes and comparing the themes within each particular case, Soliday (2012) identified common expected childbirth pathways across the interviewed women and compared them with the subsequent birth experiences.

Despite the limited sample size, Soliday's study revealed remarkable resemblance to the national statistical data about women's overall experiences of childbirth. She identified the highest expectancy violation in the hospital natural birth group. She explained this discrepancy due to the clash between women's humanistic childbirth orientation and the dominant technocratic birth culture in the majority of the hospitals (Soliday, 2012). Per women's perceptions, the planned hospital vaginal birth included more points of decision making such as onset of labor, use of technology, and birth attendants, which allowed for the higher rate of expectancy violation (Soliday, 2012). Following the same logic, Soliday found that "childbirth pathways involving fewer decision points – that is, planned cesarean delivery and out-of-hospital birth – had the highest expectancy-confirmation rates, exceeding the others by 20% or more." (p. 133). Soliday's study supported Davies-Floyd's (1992) observations that when the woman's childbirth beliefs match the dominant birth culture of the setting in which she gives birth, she is more likely to have her expectations met by the actual experience. "Mothers whose expected childbirth pathways involved more humanistic or mixed humanistic-technocratic components (natural childbirth, vaginal birth after cesarean, and even "wait and see") and took place in a technocratic setting – a mismatch – had the lowest expectancy-confirmation rates"(Soliday, 2012, p. 134).

3. Shattered Dreams – Adverse Psycho-social Outcomes of Women’s Unmet Expectations of Childbirth

“Birth is not only about making babies. Birth is about making mothers – strong, competent, capable mothers who trust themselves and know their inner strength”

Barbara Katz Rothman

Expectations about childbirth and responses to childbirth are infinite. Davies-Floyd (1992) offers an explanation for why there are many different interpretations of similar childbirth experiences and explores determinants for women’s psychological reactions to the experiences in her book *Birth as an American Rite of Passage*. She interviewed 100 women and mothers about their birth expectations and experiences of childbirth. When possible, the respondents were interviewed before and after the birth in order to capture any transformation in their pre- and postpartum beliefs and self-views. With her findings, Davies-Floyd (1992) demonstrated that there are three main factors to understand regarding women’s responses to their birth experience: “the technocratic model of reality dominant in the hospital, the belief system with which a birthing woman enters the hospital and the ultimate conceptual outcome of her birth experience” (p. 187). The conceptual outcome is defined as the psychological understanding a woman has of her actual birth experience and how it relates to the self-image she holds. Based on the interaction between the dominant birth culture and women’s expectations and beliefs about birth there might be several different types of psychological outcomes, ranging

from empowered and ecstatic women to those who suffer serious physical and psychological trauma (Davies-Floyd, 1992).

3.1. Loss of control and disempowerment during childbirth

Some authors (Freedman, 1999; Mauger, 2000; Simonds et al., 2007) see the childbearing year as an opportunity for identity transformation and a spiritual journey for the woman and her partner. While in traditional societies childbirth is a woman-centered event (Stein & Inhorn, 2002), the Western medicalization of birth has created a power imbalance between the woman and her care provider, putting the birth-giving woman into a passive, receptive position. Instead of coming out of the childbearing year as strong and competent mothers, women often are invalidated and infused with self-doubt and fear (Baker et al., 2005; De Koninck, 1998; Fox & Worts, 1999; Katz-Rothman, 2007). The childbirth event is not an isolated event in the life of a woman. It is a part of her life narrative and, therefore, it is expected that a woman's life experiences and beliefs reflect her expectations toward childbirth. A majority of women today approach their childbearing years later in life, often after successful and fulfilling careers are achieved. These women have some sense of agency and control over their lives. The expectation of maintaining control over the childbirth experience seems to be a natural consequence of their being in charge of their lives up to this point (Kitzinger, 2009).

Experiencing disempowerment and loss of control during childbirth can alienate women from the potentially empowering and life transforming experience (Baker et al., 2005; Wagner, 2001) and create conditions where fear and anxiety prevail (Carter, 2010;

Melender, 2002; Wijma, 2003; Wijma et al., 2002). Such experiences can challenge their beliefs about childbirth and the ways they envisioned themselves during the process.

The perception of loss of control during childbirth can be due to the very nature of labor and its unpredictability or to iatrogenic factors such as hospital protocols and procedures. As Meyer (2013) points out, the concept of control in childbirth is somewhat vague: “It can be viewed in relationship to a woman’s body and labour progression, pain, environment and the ability to request her method of birth.” (p. 218). Numerous studies have shown correlations between a sense of control and satisfaction with the childbirth experience (Cheung, Ip, & Chan, 2007; Christians & Bracke, 2007; Green et al., 2003; Hildingsson et al., 2010). Hence, disempowerment and perceived loss of control during childbirth are associated with decreased self esteem, loss of trust in oneself, increased anxiety and even trauma (Davies-Floyd, 1992; Beck, 2009, 2011) and can go beyond the experience of birth and result in lifelong doubt about one’s own agency, decreased self confidence and a negative self image (Kitzinger, 2006a; Meyer, 2013). Kitzinger reports numerous encounters with traumatized women who have experienced negative childbirths and struggle to integrate these experiences into their lives and identities as mothers (Kitzinger, 2006a).

Despite women’s somewhat limited agency in making uninfluenced decisions about childbirth, there are powerful societal messages that women are solely responsible for the choices they make. Women are sometimes blamed for putting the lives of their babies in danger by making selfish or irresponsible choices (Kitzinger, 2006a):

The logical outcome of the medical paradigm of conflict is that the woman readily becomes both victim of her pregnancy – the fetus a parasite and predator – and also

culpable – an irresponsible mother, who attacks and may even destroy the baby. She can be guilty of child abuse while the baby is still in utero (p.108).

Kitzinger (2006a) concludes that women may internalize this blame and feel responsible for the decisions they make during childbirth without considering the influence of the information they are given by healthcare providers and the institutional power they are subjected to during labor (Kitzinger, 2006a, b; also in Soliday, 2012). Considering the inferior position in which women often find themselves in comparison to their medical providers, and the true power imbalance that exists in the hospital during labor, it is unrealistic to claim that women have the freedom to make self-directed decisions during birth. In spite of the popular view of having plentiful choices, women are sometimes left with few options, or are not presented with comprehensive evidence-based information regarding different procedures and interventions performed routinely during labor. Therefore, it is misleading to portray them as having the sole responsibility for informed birth choices and for consenting to interventions that sometimes involve coercion (Soliday, 2012).

Another form of disempowerment of women during childbirth occurs when their wishes and birth plans are ignored or frowned upon by hospital staff and medical care providers (Lothian, 2000, 2006). The attempt to regain control over the childbirth process by scrutinizing it and stripping it of its uniqueness can leave women with a profound feeling of loss and at times can violate their innate human rights. Women are not always provided with the necessary information about hospital procedures, which hinders their active participation in the decision-making process during labor (Allen, 1998; Beck, 2004b, 2006; Thompson & Downe, 2010). One women's own words capture this

experience: “it was not my birth” and “I was left all alone”, and even more “nobody understood” and “had to accept and be content” (Lundgren et al. 2009). Beck (2004) cites another woman’s experience: “I felt like just a vessel into which you poured hormones hoping for the quick release of another baby” (p. 32). Such a fetocentric approach to childbirth, where the healthy baby becomes the only important outcome of labor, often displaces the birthing woman from her active part in the process, thus disembodimenting her from the actual experience of labor (Rudolfsdottir, 2000). This may render her invisible to medical professionals (Beck, 2004). Wendland (2007) explains the “*vanishing*” of the mother from clinical research and the childbirth process with the almost “religious belief” in technology and the objectivity of evidence-based research. She recounts “how belief in the objectivity of data make women’s experience vanish” (Wendland, 2007, p.227). Wendland (2007) argues against the misuse of “evidence-based obstetrics” given that research is socially constructed and often biased, leading to the omission of women’s lived experiences and perceptions. Therefore, Wendland (2007) warns against the blind use of objective data which only furthers women’s powerlessness and passivity during childbirth and becomes a tool for gender oppression. She argues that such research on childbirth aims “to reinforce norms that cast the female body as deviant and ‘risky,’ to enforce standardization, and to erase the mother from birth” (Wendland, 2007, p.228). Hence, many women feel robbed of the experience of birth, alienated from the process and their own bodies, left grieving the lost envisioned birth and their hoped-for role in the process.

3.2. Lost relationships

In the midwifery/wholistic model of care there is usually a unique bond between the pregnant/laboring woman and her care provider reminiscent of the relationship between a child and mother (England & Horowitz, 1998; Gaskin, 2011; Lundgren & Berg, 2007; Lyerly, 2013; Wolf, 2001). Such trusting relationships are established in the course of prenatal visits which may last an hour each (compared to the usual 10-15 minutes with a main stream medical provider). These visits occur between the mother, the midwife/midwives and anyone else the mother wishes to invite (usually younger children, the mother's partner and other family members). There is a primary focus on the emotional well being of the mother and her overall healthy lifestyle. As Motta (2006) points out, the emotional support that a labor support person provides for the mother creates the holding environment for her during the liminal period of labor (Winnicott, 1965). The Jungian trained psychotherapist Benig Mauger believes that many women experience an awakening of their feminine nature during pregnancy and birth (Mauger, 1998). Regrettably, the Western biomedical model repeatedly fails to acknowledge the relational nature of pregnancy and birth. The biomedical model can generate the fallacies of presenting the birth process as body over mind and soul, the fetus's safety over the mother's integrity, and medical knowledge over the embodied feminine knowledge of birth (Davies-Floyd, 1992; Mauger, 1998).

In the technocratic model of care, women may not be capable of developing such caring relationships due to the mechanization of the process and providers' failure to recognize the spiritual nature of birth and women's related needs (Mauger, 1998).

Goldbort (2009) describes some of the imperfections in U.S. hospital maternity care, including the shortage of staff who provide care to laboring women and the conflict between women's birth expectations and the reality of hospital policies and protocols. Many women report feeling abandoned, alienated from their experience and supportive people, and misunderstood or ridiculed by hospital staff and their birth attendants (Berg & Dahlberg, 1998; Kitzinger, 2006a; Lundgren et al., 2009; Matthews & Callister, 2004; Mauger, 1998). These feelings can foster a traumatic association with the birth process and trigger a grief response to the lost connectedness with the provider (Lyerly, 2013).

A dismissive and disempowering relationship with hospital staff and caregivers was found to be a main predictor of women's perceptions of a traumatic childbirth experience (Beck, 2006, 2009, 2011; Creedy et al., 2000; Stadlmayr et al., 2006; Thomson & Downe, 2010). Beck's (2004) research focuses on birth trauma and PTSD following childbirth and her research indicated the following:

The mothers reported that feeling abandoned and alone, stripped of their dignity, lack of interest in them as unique persons, and lack of support and reassurance all contributed to their birth trauma. One mother said she "felt betrayed by a system that is supposedly there to care for me (Beck, 2004, p.32).

We may see similar feelings in women who did not perceive their birth as traumatic but as negative or disappointing. Forssen's (2012) study of Swedish elderly women and their memories about disempowering childbirth experiences offers insights about the long lasting effects of uncaring and abusive treatment during childbirth on the women's self image. The respondents were women who gave birth 40 to 50 years prior

and still had very clear and articulate memories about their childbirth experiences and the encounters with antenatal providers (Forssen, 2012). The interviewed women consistently reported feelings of shame, guilt and powerlessness stemming from their negative experience with care providers during pregnancy and birth (Forssen, 2012). The accounts of births during which women felt violated and shamed left a life-long impact on their self-image and feelings of disempowerment, self-blame and guilt (Forssen, 2012; Goldbort, 2009). Based on the interviews and the existing literature (Ayers, 2004; Beck, 2011; Simkin, 1991, 1992) Forssen (2012) argues that the life-long effects of disempowering and dismissive attitudes from care providers during childbirth can lead to lowered self-esteem in women, affecting their mental health and changing their attitudes toward seeking medical attention.

Additional factors associated with negative birth experiences include women's perceptions of their care providers (obstetricians and midwives) as inconsiderate and uncaring (Rijnders et al., 2008). Therefore, the lack of trusting and supportive relationships with their birth attendants may result in many women's dissatisfaction with their childbirth experiences despite having had a "normal" or "natural" birth (Beck, 2004; Darra, 2009). Feelings of mistrust are often intensified by the ways the American maternity care system is designed. Women visit big medical practices of obstetricians and midwives for prenatal visits and, despite efforts to meet everyone from the practice, they are not able to establish close and trusting relationships with all of them. During labor they are attended by the practitioner who is currently on call, leaving them with no guarantee that they will know the person and feel safe and secure in their presence (Lyerly, 2013). Some of these problems are remedied by choosing a single obstetrician or

midwife, potentiating some continuity of care and closer relationships. Unfortunately, such choices are limited for many women by insurance coverage or simply by lack of providers who practice independently where they reside.

The presence of an interpersonal relational approach to childbirth can be the remedy for turning complicated or unexpected experiences into birth-giving trauma (Walsh, 2010). Kjaergaardt and colleagues (2007) suggest that midwives (care providers) should remain in nurturing and supportive roles for women, especially when complications arise and high technology is needed to assist in labor. Their presence can keep the birth process women-centered and can allow them to have some control over the labor. Furthermore, the professionals involved in the labor need to maintain a collaborative approach and suspend their professional egos in efforts to meet women's expectations of fulfilling and transformational experiences and maintain their control and power over their births (Lyerly, 2013; Walsh, 2010).

Another important relationship that may be affected by the birth experience is the relationship with an intimate partner. Some studies reveal that women report high expectations of their partners such as providing physical and psychological support during labor, pleading their cause and wishes with providers, and serving as their inspiration to carry on with labor (Kainz, Eliasson & von Post, 2010). When these expectations were met the couple was able to move through the difficult parts of labor, reconcile with any disappointment, and move on toward becoming parents, together as a team (Kainz et al., 2010). Fathers themselves reported a need to be supported by care providers so they could feel included in order to support their laboring partners (Backstrom & Wahn, 2011). When the institution or providers were inconsiderate of

these needs, both parents' expectations were violated resulting in disappointment, trauma a difficult adjustment to parenthood, and possibly a loss of trust in the partner.

Importantly, another relationship that may be affected by a negative birth experience is the immediate bonding with the baby (Lyerly, 2013; Mauger, 2000). Some women have hopes and create prenatal imagery of immediate skin-to-skin contact with their newborn. When these expectations get violated by the course of labor, their own exhaustion and physical condition, or hospital policies they may experience such change in plans as a profound loss of connectedness with their baby (Lyerly, 2013). Furthermore, their grief could be triggered by the disrupted continuum of birth when the baby gets separated from them due to hospital procedures or his/her health issues (Liedloff, 1985). Liedloff (1985) concludes:

If the imprinting is prevented from taking place, if the baby is taken away when the mother is keyed to caress it, to bring it to her breast, into her arms and into her heart, or if the mother is too drugged to experience the bonding fully, what happens? It appears that the stimulus to imprint, if not responded to by the expected meeting with the baby, gives way to a *state of grief* [emphasis added] (p.59).

Liedloff (1985) believes that when the baby is brought back to the mother later when she is in a state of mourning, she may have difficulties bonding with him/her which can induce feelings of guilt and shame for being inadequate as a mother. Understanding these possible reactions and experiences of loss for mothers is an important step toward acknowledging them and providing support to them during the sensitive early postpartum period.

3.3. Possible feelings after losing the dreamed-of birth

The experience of a negative childbirth is not an isolated event. In a large prospective longitudinal study Creedy and colleagues (2000) found that one in three of 499 interviewed women identified a negative birth event and reported at least three trauma associated symptoms during the postpartum period. Women who experienced high level of obstetric interventions and perceived their intrapartum care as dissatisfactory were more prone to developing posttraumatic stress disorder postpartum (Creedy et al., 2000).

The prevalence of negative birth experiences can be explained by the discord between women's expectations of being active participants in their births and the reality of labor management in technocratic hospitals which put them in a passive role. As described above, women may expect to maintain control during labor through support by their partners and birth professionals. They may also expect a positive attitude from their care provider and to receive evidence-based information during pregnancy and labor to help them with decision-making (Declercq et al., 2002; Gibbins & Thomson, 2001). When their expectations are disregarded during labor by care providers and hospital personnel, women may have a difficult time directing their anger and disappointment toward the care providers or the system due to internalized technocratic ideas of the inherent brokenness of their bodies and their presumed inferiority (Davies-Floyd, 1992; Freedman, 1999; Simonds et al., 2007). This difficulty may cause the development of self-blame, guilt and depressive feelings in women during the postpartum period.

In her book “Songs from the womb,” Mauger (1998) describes the self imposed guilt and shame that comes from disenfranchising messages such as: “If we emerge from the experience, relatively physically intact, with a healthy baby, then we have no cause to complain” (p.16). The disenfranchisement of women’s negative reactions to their childbirth experiences can lead to denial of their feelings. Lysterly (2006) suggests that dominant patriarchal birth practices in the Western world increase women’s shame due to viewing themselves as inferior and incapable.

Such self-perceptions may leave women feeling “helpless in the face of science, technology, patriarchy, and institutions“(Davies-Floyd, 1992, p.237). Davies-Floyd (1992) argues that the majority of these women experience mild postpartum depression that eventually turns into anger toward their care providers and the maternity care system. The depression may stem from their inability to blend their devalued self-images as birthing failures with the capable and competent self-images they need to embrace as new mothers (Davies-Floyd, 1992; see also Madsen, 1994; Wolf, 2001). Davies-Floyd (1992) concludes that many women suffer from learned helplessness during the postpartum period as a result of their perceived lack of control over their childbirth experience. Mauger (1998) agrees: “Instead of being empowered to give birth, any trace of ancient knowledge is taken from them as they are forced to surrender to system which knows best. Discouraged, *these women suffer loss of soul* [emphasis added], because the positive aspect of the birth experience is denied them” (p.132). Mauger (1998) calls these women “wounded mothers” and argues that the medicalization of childbirth in Western societies has caused deep and profound soul wounds to mothers and babies who ultimately pay the price for technocracy.

At times women's negative experiences are intensified by their feelings of disappointment and guilt about being unable to fulfill their dreamed-of birth and initial plans (Kjaergaard et al., 2007). Many women are caught between the two polarized paradigms of technocratic and natural childbirth which can be another source of trauma and internalized feelings of failure (Kjaergaard, 2007; Walsh, 2010). Walsh (2010) sees the "dichotomized thinking regarding natural and medical birth" as contributing to women's stress and ambivalence about the childbirth experience (p. 492). When birth steers away from preset ideals or norms women may feel like failures and be deeply hurt and disappointed by their experience (England & Horowitz, 1998; Madsen, 1994; Wolf, 2001). Mauger (1998) uses her clinical experience working with women during the childbearing year to describe the postpartum experience of a mother who had a disappointing birth:

The new mother feels disappointed and physically low after a difficult birth; she feels violated and deeply wounded and she may also be battling with a sense of guilt and failure that she has not been able to give birth naturally... She feels guilty that she should feel so bad about the experience; after all, she had a healthy baby, so what she has to be so miserable about? (p.76)

Mauger (1998) notes the occurrence of self- and societal disenfranchisement which many women experience when they express negative feelings about their childbirth. The disenfranchisement of a loss or denial of the right to grieve complicates the healing process of reconciling a disappointing childbirth. This in turn hinders integration of the experience in the mother's life narrative.

3.4. The impact of negative childbirth experience on reproductive decisions and adaption to motherhood/parenting

Dissatisfaction with the childbirth experience can last for prolonged periods, even a lifetime. Sixteen and a half percent of Dutch women reported being unhappy about their childbirth experience three years after birth, with larger numbers of first time mothers recalling their births as negative experiences (Rijnders et al., 2008). The impact of the negative birth experience is far reaching and can influence the reproductive decisions of women, even leading to decisions to not have more children (Porter, Bhattacharya, & van Teijlingen, 2006; Thomson & Downe, 2010; Waldenstrom et al., 2004). Negative feelings and anxiety about childbirth often are re-triggered by consecutive pregnancies, causing additional stress and fears about labor (Freedman, 1999; Madsen, 1994; Mauger, 2000). Some women prefer to schedule an elective cesarean section after traumatic previous births in an effort to have more control over the process and ensure its predictability (Nilsson et al., 2010; Wiklund et al., 2008). Other women react to the negative experience of medicalized birth by choosing a birth center or homebirth for their next child (Davies-Floyd, 1992; Hodnett, 1989). A small group of women who have experienced disempowering interactions and have lost trust and connectedness with their birth attendants plan an unassisted homebirth for their future pregnancy (Miller, 2009; Shanley, 1994).

Childbirth in all forms includes changes in hormone levels. Complicated or intervention-intense childbirth can interfere with the natural release of hormones during and after labor (Odent, 2001), inflict additional postpartum pain and exhaustion, and

impact mother-baby bonding and the woman's self-esteem (Fisher, Atbury, & Smith, 1997). The separation of mother and child after birth interferes with the release of the natural hormones and chemicals which facilitate their initial bonding, and also may trigger anxiety, fears about the well-being of the baby and grief over not holding the baby immediately after birth (Berg and Dahlberg, 1998; Gaskin, 2011; Liedloff, 1985).

Women who were separated from their babies after birth reported feelings of panic, sadness, numbness, loss, and at times alienation from the baby when reunited (Gaskin, 2011; Madsen, 1994). Additionally, they may blame themselves for not advocating for gentler treatment of their babies and for the failed plans to bring their children peacefully into the world (Berg & Dahlberg, 1998; Scott et al., 2007). Feelings of guilt and shame can complicate the experience of grief and hinder emotional and physical healing.

The process of reconciling the actual birth with the imagined one is seen as part of the bonding process with the new baby and transitioning to a new identity as a mother (Galinsky, 1981). Freedman (1999) sees it as a profound opportunity for change and growth through forming new nurturing relationships with the baby, a woman's partner and her extended family. The childbearing year has transformational power, presenting an occasion to women for growth in many different aspects of their lives. Therefore, women may have a continuous need for support, especially support from other women, on their way to becoming mothers (Freedman, 1999). Unfortunately, a fragmented and mechanized approach to childbirth often leaves women with feelings of incompleteness and inadequacy which can be transferred later to their view of themselves as mothers (Mauger, 1998). Women's feelings can be exacerbated by the guilt and shame they may internalize for not being capable of birthing on their own and protecting their newborns

from harsh medical treatment (e.g., forceps delivery, separation after birth, cesarean births) during birth.

4. Disenfranchised grief and the lost dreamed-of birth.

“My heart aches with grief, for not birthing my precious baby the way he should have been birthed...” (Scott, Hudson, MacCorkle, & Udy, 2007, p.58)

“People keep telling me at least I have a healthy baby, but they don’t get it. She is healthy, but I am not. I don’t know when the healing will come... I pray it will soon.” (Scott et al., 2007, p.28)

Mauger (1998) describes with empathy the grieving triggered in some women who have experienced negative or disappointing childbirth:

...she is mourning for something, she is not sure what. She is grieving for the loss of her ideal birth. Feeling that she will not be understood, she turns inward into her pain and sense of shame... (p.76)

Invalidation and disenfranchisement by others can complicate the natural processes of grieving and reconciliation with the birth experience. Therefore, an exploration of the disenfranchised theory of loss and grief is indicated. Doka (1989) coined the term “disenfranchised grief” to explain the type of grief people experience when their mourning is not socially accepted or endorsed. His definition of the term is “...the grief that persons experience when they incur a loss that is not or cannot be openly

acknowledged, publicly mourned, or socially supported” (Doka, 1989, p. 4). The definition itself suggests that every society has formal and unwritten rules about who has the right to grieve and how the process is structured – time, place, how and for whom people can grieve and be publicly supported. These grieving rules may not reflect the actual nature of attachments, the perception of different types of loss, and the feelings of the griever, leaving their grief disenfranchised (Doka, 1989). Doka’s (1989) theory of disenfranchised grief applies to the ways some women mourn the loss of their dreamed-of birth and how their feelings about the childbirth experience may be silenced by society and by themselves.

Doka (1989) identifies three separate circumstances that lead to disenfranchised grief. The **first** occurs when the relationship between the bereaved and the deceased is not socially recognized due to lack of acknowledgement of various attachments we form to people who are not of kin. The roles of friends, lovers, neighbors, co-workers, and caregivers may be socially recognized, but the intensity of the mourner’s loss may go unacknowledged, thus foreclosing the opportunity to fully and openly grieve this loss. The **second** circumstance of disenfranchisement occurs when the loss is not socially recognized because it is not believed to be significant for the survivor. In this situation we see perinatal losses, abortions, giving a child for adoption or being a surrogate mother. The **third** type of disenfranchisement happens when the griever is not socially recognized due to different inherent characteristics such as age or mental disability (Doka, 1989).

Reflecting on the characteristics of the **second** type of disenfranchisement it appears that the loss some women experience after negative or disappointing childbirth can be described as such. Some women are met with dismissive and invalidating

treatment by their care providers and broader society when voicing their dissatisfaction with birth (Kitzinger, 2006; Madsen, 1994; Mauger, 1998). They report being judged for focusing on the birth and not being happy about producing a healthy baby as the favored outcome. Such comments are understandable in the predominant fetocentric childbirth industry in America. Even though many women express feelings of profound loss of the dreamed-of birth or being robbed of the active participation in the experience they envisioned (Davies-Floyd, 1992; Fisher et al., 1997; Hodnett, 2002), their grief is often attributed to postpartum baby blues or to “being hormonal.” Women may be judged for having unrealistic expectations toward birth (Gaskin, 2011; Kitzinger, 2006a) and therefore not allowed the social space to grieve the loss of the envisioned birth.

Disenfranchised grief due to one’s role in society is also present in women’s reports of their postpartum experiences. New mothers are expected to be elated and joyous with the birth of a healthy baby (Grace, 1978). They are expected to display certain characteristics which do not allow for negative feelings and expression of grief. Women should be grateful to their care providers for the good outcome of the labor ordeal. “It is all too easy to assume that any negative feelings parents have about their maternity experience are somehow cancelled by the joy of the arrival of a healthy baby” (Grace, 1978, p.19). Mourning after a disappointing birth experience is not socially accepted unless the woman has given birth to a child with serious health conditions or has lost her child. Another time when the mother’s sadness is endorsed by society is if she suffers from postpartum depression. When there is no support or recognition of her lived experience, it is difficult for the new mother to talk about her grief and feelings of loss after a birth that has violated her expectations and beliefs.

“Yet there is ambivalence even in the happiest situation. The parent who discovers strong inner feelings of dismay, regret, fear, or anger when s(he) ought to be happy may find those emotions personally unacceptable. The parent’s dilemma increases if the assisting people around convey the message that such feelings are unacceptable to them, as well. *S(he) cannot resolve feelings because s(he) cannot admit they exist. S(he) does not have room to grieve* [emphasis added]” (Grace, 1978, p.19). The very nature of disenfranchisement complicates the grieving process by removing social recognition and support from the mourner and thus not allowing free expression to aid the healing process. The emotions which are associated with normal grief such as sadness, anger, loneliness, depression, hopelessness and emotional numbness can get complicated by the disenfranchisement of the grief. Doka (1989) and other authors report intensified emotions of anger, guilt and powerlessness due to the lack of recognition of a griever’s suffering, resulting in further alienation and shame about the experience (Attig, 2004; Lenhardt, 1997; Neimeyer, 2005).

Other factors that may complicate grieving include ambivalent relationships and concurrent crises (Doka, 1989). The transitional states of pregnancy, birth and the postpartum period foster a new identity as mothers for women. Often unacknowledged is their ambivalence about losses of status, previous roles and relationships. It may be present in the mother and also within the couple. The ambivalence in the partner relationship is also noted by authors who assert that having a child is a major crisis in the couple’s life (Darvill, Skirton, & Farrand, 2010; Placksin, 2000). The postpartum period is a time of increased emotionality and sensitivity called by Winnicott “primary maternal preoccupation” when the mother enters a “psychological condition” which can be defined

as “almost illness” if it were not a normal aspect of pregnancy and early motherhood (1956, p.301). If bonding with the infant is affected by the mother’s grieving the loss of her envisioned birth experience, she may have feelings of guilt and not being good-enough. She may disenfranchise her own grief in an effort to suspend the mourning process.

As Kauffman (1989) explains:

While in societal disenfranchised grief the source of disenfranchisement is the failure of others to acknowledge and recognize the grief, in self-disenfranchised grief the source is one’s own lack of acknowledgement and recognition of it. (p. 25).

Self-disenfranchised grief is informed by shame. When people are ashamed of their loss or are ashamed to grieve publicly, they are more likely to inhibit the free expression of the grief or deny the grief process. The grievers might sanction themselves and the expression of grief without the influence of others’ opinions. Kauffman (1989) clarifies that “in self-disenfranchised grief one is disenfranchised by one’s own shame” (p.26). When people know that their grief is not acceptable by society, it is inhibited through shame. Kauffman (1989) also believes that shame protects people from emotions which are too intense to experience and provides protection. Shame is often related to people’s feelings of vulnerability and self-exposure during times of grief (Kauffman, 1989).

As also argued by Kauffman (1989) feeling shame in the face of helplessness and powerlessness when mourning a loss is even more common but less recognized.

Helplessness is closely related to inadequacy and inferiority. As discussed in the previous sections of this proposal, women may experience the loss of touch with their feelings, numbness, self-alienation, a weakened sense of self, and decreased self-esteem as a result of disappointing or negative childbirth experiences (Berg & Dahlberg, 1998; Goldbort, 2009; Hodnett, 2002).

Pregnancy and birth are very vulnerable and sensitive periods when a woman is able to reconnect with her self, be exposed to her deepest fears and feelings, and transition to motherhood with a newly born identity (England & Horowitz, 1998; Gaskin, 2011; Madsen, 1994; Mauger, 1998). Likewise, during grieving one faces “the exposure of the deepest layers of its existence” and endures life-long changes (Kauffman, 1989, p.27). Grace (1978) compares the mourning experience with labor and believes that they are very much alike but progress in reverse: “After the initial shock and numbness, the bereaved experiences recurrent spasms of overwhelming sensations and all interest is withdrawn from others to deal with inner events. Gradually, the grief episodes become less frequent, of less duration, and less powerful; and interest in the outside world is reestablished” (p. 18-19). The demanding work of grief may be interrupted by others’ comments or by women’s gendered need to cater to others’ requests and expectations. Therefore, well-meant comments and encouragement toward the woman to move on and be positive can be damaging for the hard inner work she is doing to reconcile with a difficult birth. Grace (1978) believes that once suspended the “...grief may resurface at a later time – frequently during a subsequent pregnancy” (p.19). Therefore, she urges professionals to be sensitive toward women’s emotional life “consider the possibility that loss has occurred” (Grace, 1978, p.19).

Many women expect more than a healthy baby-healthy mother outcome from their birth. Therefore, when the birth experience does not meet one's expectations, little acknowledgement is offered of the loss and its effect on the woman's psyche (Grace, 1978). Despite studies that demonstrate that women who experience surgical interventions during childbirth are more vulnerable to a grief reaction (Fisher et al., 1997), many professionals remain insensitive toward women's loss of their envisioned birth. Their lack of acknowledgement and resulting disenfranchisement of women's lived experience is reflected in the research literature. During my literature review I identified only one article on this topic published in a peer reviewed journal in 1978. The article was based on the clinical experience of the author, Jeanne Grace, on which she drew to make recommendations about changing the postpartum care provided to mothers and families. Grace (1978) advocated for more sensitive and inclusive approaches toward parents, providing a safe space for them to voice and process the experience of labor and any expectancy violations. Unfortunately, such support rarely exists 35 years later and continued marginalization and invalidation of women and their lived experiences occurs.

Moreover, social disenfranchisement of women's loss of the dreamed-of birth may be internalized and become the source of self-disenfranchisement. Women's feelings of inadequacy and not being good-enough mothers may be intensified by blame and shame that they did not perform up to expectations during labor (Berg & Dahlberg, 1998; Davies-Floyd, 1992). At times, women are blamed for creating birth expectations and plans since childbirth is unpredictable and not always straight-forward process (Kitzinger, 2006a). Furthermore, women may feel ashamed and blame themselves for having a negative reaction to the birth and not being solely happy for the baby (Mauger,

1998). A new mother describes her experience of an unexpected cesarean section and her frustration with not being able to take care of her baby after the operation: “That first night, I drop my baby. I can’t take care of her – can’t even hold her. Can’t be grateful. Can’t feel joy. All I feel is pain and tiredness and *frustration of not being able to start being a mother* [emphasis added].” (Scott et al. 2007, p.24). As noted earlier, intensified feelings of guilt and shame triggered by women’s grieving the loss of the dreamed-of birth may hinder the bonding with their baby: “...I was so guilty that I felt like I wasn’t in love with my son...I felt like such an awful person and unfit to be a mother.”(Scott et al., 2007, p.36). Thus, we see the vicious cycle of compromised bonding with the baby producing more grief and feelings of inferiority, incompleteness and inadequacy as a mother. As many authors point out, the solution to this problem is breaking through the disenfranchisement and silencing of women by validating their negative experiences and listening to their stories of disappointment, shattered dreams and loss (England & Horowitz, 1998; Freedman, 1999; Grace, 1978; Kitzinger, 2006a; Mauger, 1998).

5. Disenfranchised grief after a loss of the dreamed-of birth and the creation of new self-narrative

This section reviews the literature about grief and narrative reconstruction to allow for an in-depth understanding of the internal transformational experiences women may go through after a disappointing birth. This section also highlights some good

practices for addressing grief and some therapeutic interventions which may offer validation and facilitate healing postpartum.

Seeing personal responses to loss as contextual in nature is a fairly new paradigm in our theoretical and clinical understanding of grief. Viewing mourning as private but also public broadens scholars' understanding that grieving, healing and reconciliation occur in relationship with others and cannot begin until one's loss is socially validated. The construct of meaning making in grieving is defined by Attig (2001) as the process in which "... we are self-consciously active, take deliberate initiative, and bring new meanings into existence as we grieve" (p. 34). Part of the meaning making in grieving is relearning the world and revisiting our role/place in it after the loss that has occurred.

There are significant similarities between the process of coming to terms with a disappointing birth experience and the process of creating a grief narrative. Attig (2001) describes the manner in which the development of a grief narrative may strengthen self-confidence, self-esteem, and self-identity and provide a sense of peace and consolation." Authors who study negative or complicated birth experiences which violate women's prenatal expectations point to the same tasks which women face in the postpartum period (Freedman, 1999; Madsen, 1994; Mauger, 1998, 2000). Women often are left with shaken beliefs about birth, others and themselves that they need to revisit. Some seek to make sense of their difficult experiences and what they mean to them as women and new mothers (England, 2011; Parratt, 2002).

The attempts of women to create a new meaning of their unexpected birth experiences and position their transformed selves in the newly created birth narrative are

essentially attempts at re-storying their experiences. Narrative construction encompasses the complex process of weaving one's life story into the interpretation of meaning of identity and exploring opportunities that arise from the transformational power of grief (Attig, 2001; Neimeyer, 2001).

A loss has the potential to disorganize one's life story and disrupt his or her sense of continuity and self-coherence (Neimeyer, 2001). The disenfranchisement of the loss further complicates the experience and impedes the process of reconstructing the narrative of self. Neimeyer (2001) emphasizes the social and relational nature of reconstructing one's story after a loss and the importance of support during this time. The disenfranchisement of women's loss (here, of the dreamed-of birth) and their right to grieve ("you should be happy--you have a healthy baby") can lead to complicated and prolonged grieving due to the lack of support and validation. Neimeyer (2001) sees the reconciliation of grief as a conscious effort to integrate the loss into one's life story. This is seen in women's efforts to find a new meaning of their birth experience and integrate it into their transforming narrative of womanhood (Freedman, 1999).

Metzger (1992) sees a remedy for the disenfranchisement and silencing of women after a negative childbirth experience in story-telling. She states "when it is our own life story that we are telling, we become aware that we are not victims of random and chaotic circumstances that we, too, despite our grief are living meaningfully in a meaningful universe" (Metzger, 1992, p.55). She sees the therapeutic relationship as the needed holding environment for one's meaning reconstruction process. The witnessing of one's grieving can provide the validation of new meaning making and its transformational

powers. She writes “Stories heal us because we become whole through them. As in the word ‘remember’, we re-member, re-store, re-claim, re-new” (Metzger, 1992, p. 71). Disenfranchisement of one’s right to grieve one’s loss robs women of the opportunity for support during healing and reconciling with the negative childbirth experience. This may impact the reconstruction of their life story that incorporates the loss of the dreamed-of birth they experienced. The self-disenfranchisement of their grief is inhibited by feelings of guilt, self-blame and shame and contributes to their struggles to find meaning of the experience of difficult labor and birth.

The purpose of this study is two-fold: to bring more depth and clarity to the phenomenon of disenfranchised grief in women whose negative births have left them with a sense of unrecognized and invalidated feelings of loss and grief; and to raise the awareness signs of active grief in postpartum women so that they and their families can receive appropriate support and services.

III. Methodology

1. Research Design

To explore the intense phenomena some women experience after an unexpected negative childbirth I used phenomenological theory. Phenomenology encompasses feminist, intuitive and innovative approaches (Patton, 2002). It also allows the researcher to explore the lived experience of people as they perceive it (Grbich, 2009). Van Manen (1984) synthesizes the benefits of using this approach:

Phenomenology differs from almost every other science in that it attempts to gain insightful descriptions of the way we experience the world. So phenomenology does not offer us the possibility of effective theory with which we can now explain and/or control the world but rather it offers us the possibility of plausible in sight which brings us in more direct contact with the world. (p.38)

By its very nature, phenomenology helped to illuminate the understanding of childbirth as a unique experience for every woman and allowed for knowledge situated in her own reality. Listening to women's stories of the dreamed-of births and their losses helped to create safe space to uncover the grief some women otherwise suppress. To achieve this, I kept an open and flexible stance so that themes could unfold free of my preconceived understanding of the phenomenon.

This study did not attempt to create a theory about the postpartum grief some women experience after they lose their dreamed-of birth. It did not try to answer why and how broader society, professionals and family members disenfranchise women's loss and grief. Instead, it aimed to illuminate the actual experience of grieving and what it meant for study participants to lose their envisioned birth. It sought increased clarity of the phenomenon of disenfranchisement from society and from themselves that postpartum women experience, and how this disenfranchisement could hinder their healing, transitioning to mothering and self-actualization. This research method was not intended to be a treatment but, as previous research suggests and the interviewed women confirmed, the process itself validated women's experiences and allowed healing to begin.

Pursuing increased clarity about the lived experiences of a sample of women who have lost their envisioned birth experience permitted an exploration of a deeply human experience. Phenomenological theory is rooted in “what it means to be human” (van Manen, 1984, p.38) and captures the manner in which meaning is shaped by “sociocultural and the historical traditions which have given meaning to our ways of being in the world” (van Manen, 1984, p.38). Hence, phenomenological research allowed for a broader understanding of what women may experience while grieving the loss of their dreamed-of birth, and how this experience may shape their selfhood as women and mothers.

The research design for this study was created in the tradition of the phenomenological theory of heuristic research. Heuristic research encourages connectedness and relatedness rather than researcher detachment. “Such a process is guided by a conception that knowledge grows out of direct human experience and can be discovered and explicated initially through self-inquiry” (Moustakas, 1990, p.17). It suggests a mutual effort from the researcher and the participants (called “co-researchers,”) in discovering knowledge about the phenomenon (Moustakas, 1990). The method recommends a personal calling to the topic of interest. Moustakas (1990) suggests: “From the beginning and throughout an investigation, heuristic research involves self-search, self-dialogue, and self-discovery; the research question and the methodology flow out of inner awareness, meaning, and inspiration” (p.11). The mutual effort of researcher and participant speaks strongly to me due to my experience with the loss that the research explores. I have personal experience of losing my dreamed-of birth and grief that followed. Due to my personal experience of grief I grew interested in this

under-researched topic, leading me to do an extensive literature review and to online blogs and forums where women shared their birth and postpartum stories.

The exploration of underlying themes and experiences that are part of my research question was possible only with another key heuristic dimension – the tacit knowing which stands behind every heuristic discovery (Moustakas, 1990). The understanding that we know more than we can describe with words allows for the tacit knowledge of the parts and the whole of a phenomenon (Moustakas, 1990; Polanyi, 1983). Tacit knowledge informed my inquiry throughout the process of self-inquiry and conducting the interviews while giving “birth to the hunches and vague, formless insights that characterize heuristic discovery” (Douglass & Moustakas, 1985, p. 49).

The bridge between the tacit dimension and the explicit knowledge is intuition because it allows for understanding of the essential to the new discovery of inquiry according to Moustakas (1990). Intuition guided my inquiry in discovering the deeper meaning of the phenomenon in question by identifying qualities, patterns and meanings within it.

Other key heuristic processes I relied on during my research were these of indwelling, focusing and relying on an internal frame of reference. Moustakas (1990) describes indwelling as an essential process for heuristic inquiry because it allows for a conscious inward gaze into the studied phenomenon. Indwelling is closely connected to focusing which is presented as “an inner attention, a staying with, a sustained process of systematically contacting the more central meaning of an experience” (Moustakas, 1990, p. 25). Focusing allows the researcher to remove muddle from findings and experiences

and to tap into awareness of his/her own experience of the phenomenon (Moustakas, 1990). Unifying all processes and principles of heuristic research is the internal frame of reference which guides the understanding of the meaning and essences of the studied experience. Heuristic research relies heavily on the internal frame of reference of the co-researchers but also of the main researcher who uses his/her own experience and internal frame of reference to create connectedness with co-researchers and their unique stories. The methodology requires awareness about one's experience as a path to self-reflection. This process leads to personal growth and understanding along with the heuristic discovery of aspects of the illuminated phenomenon (Pena, 2006).

2. Sampling and Recruitment

I used a purposive sample of nine women who had experienced disappointment and other intense negative reactions following a childbirth that was not as they had hoped and anticipated. I used a snowball method, which allowed for potential participants to refer others. Two of the participants were referred to the study by one of the co-researchers who saw the recruitment letter posted in a virtual support group for postpartum women.

After the successful dissertation proposal defense and University of Pennsylvania IRB approval in February, 2014, I contacted a local Internet group of childbirth professionals (childbirth educators, midwives and doulas) to introduce my research and invite referrals for the study (Appendix C). I also posted the recruitment letter on my Facebook wall and asked for assistance from local birth professionals and friends to refer

women to me who meet the inclusion criteria. My recruitment letter was re-posted by childbirth professionals and women themselves in other local support groups for postpartum women and one group for holistic mothers.

During the first week of recruitment I screened fifteen women for inclusion in the study. Two of these women were excluded due to having had premature births. Another four women were asked to remain as backup participants if the desired sample size could not be achieved. This was because in-person interviews with these potential co-researchers were logistically challenging (i.e. residing very far away).

Inclusion and Exclusion Criteria

Inclusion criteria included women, ages 21 or older, who had experienced at least one unexpected negative/disappointing childbirth. Since the research focused on the lived experience of enduring childbirth very different from the one envisioned, the co-researchers needed to be aware of their own experiences and be willing to share them with the researcher.

Other than the experience of negative childbirth and age of participants, women in the study were past the six-month recovery period after birth. The medical field considers this period sufficient for some pain relief and physical healing to occur following cesarean or other more difficult births. Studies also show that the period from birth to eight weeks is the time when many women experience fluctuations in their hormonal levels (Godderis, 2010). The emotional lability which characterizes the “baby blues” period may put women in sensitive and vulnerable states which could be exacerbated by the interview process. Dealing with difficult physical recovery and taking care of an

infant is on its own a demanding task for a woman. Therefore, including this time restraint limited interference with the emotional and physical healing process during which women are vulnerable.

Beyond the requirement that subjects had passed the 6-month post-partum period, there was no other restriction on the time that has passed after the birth for potential participants. Multiple studies that researched women's lifetime memories of their childbirth experiences have shown that, even after prolonged period of time, women have vivid and detailed memories about the experience (Forssen, 2012; Kitzinger, 2006a; Lundgren et al., 2009; Simkin, 1991; Waldenstrom & Schytt, 2009). The variation of the time passed after the actual birth experience allowed for a rich portrayal of various women's feelings, recollections and experiences of difficult births. Therefore, participants could be women who previously experienced the disenfranchised grief over the loss of their dreamed-of birth and women who are actively grieving this loss. There were no restrictions on a participant's number of births or the order of birth during which the researched phenomenon occurred.

Exclusion criteria of this study were women who reported having a current serious mental illness or active suicidality during data collection. Women who had suffered stillbirth or premature birth were also excluded due to the different nature of their loss and grief.

Participant Compensation

After the first interview participants were given a \$10 gift card to a local coffee shop and those who completed the second interview received another \$5 gift card to the same store.

Description of Co-researchers

All participants identified themselves as Caucasian women with ages ranging from 27 to 41 years old. The mean age of participants was 35 years old. Eight participants were married and one was single. One participant had completed some college, two women had Bachelor's degrees, four had Master's degrees and two had Doctorate degrees. The household income they reported was as follows: one participant did not disclose income, two participants had household incomes between \$25,000 and \$50,000 a year; three participants reported incomes between \$75,000 and \$100,000 a year; another two had household incomes between \$100,000 and \$150,000 and one participant had household yearly income over \$150,000. Three of the participants lived in Pennsylvania and the other six lived in New Jersey.

Five of the women interviewed reported on one birth, two participants reported on two births, one participant reported on three births and one on four births. The length between their last birth and the time of the interview was a wide range. The shortest range was just seven months postpartum and the longest range was eight years post birth. I interviewed two women who were nine months postpartum, three women who were one year post their last birth experience, and two women who were two years post the birth they talked about. For those women who had multiple births, the time between our first interview and their first birth was as follows: two of them had given birth for the first time eleven years ago, one of them seven years ago and one four years ago. The wide range in time lapsed after the birth experiences allowed for rich and diverse information

about their feelings toward their births, as I captured them in a different states on their healing journeys.

3. Setting

Upon their request, eight co-researchers were interviewed twice in their homes and one was interviewed at her work office. The familiarity of the setting appeared to contribute to creating a safe space for participants to share openly and be less anxious about the recording of our conversations or the content of the interviews. Three of the participants had their infants (eight and nine months old, and a toddler who has just turned two years old) with them during the interview which in general did not distract them from the interview process and contributed to a more relaxed and informal atmosphere.

4. Methods of Data Collection

The data collection consisted of two rounds of interviews. The initial interview data were collected, and transcribed by the researcher. Individual narratives were created for each participant using the lens of disenfranchised loss and grief and identifying repeating themes for each one of them, and then sent to the co-researchers for review and corrections. After this, a second interview was scheduled to discuss co-researchers' thoughts and feelings after reading the interview narratives. The data were collected through informal untimed conversational interviews, which allowed respondents to tell their stories spontaneously. The co-researchers were asked to tell their stories not guided by the clock but following "their inner experiential clock" as described by Moustakas

(1990, p. 46). On average, the interviews lasted between one to two hours. The second interviews were generally under one hour.

This method attempted to avoid questions and answers that only met the researcher's expectations and understanding of the topic and allowed for the natural exploration of the topic. "Dialogue is the preferred approach in that it aims toward encouraging expression, elucidation, and disclosure of the experience being investigated" (Moustakas, 1990, p.47). Dialogue also accepted the co-researchers as partners in the study as opposed to being passive studied subjects. Even though I had some preliminary questions of interest (Appendix A and Appendix B), I left the dialogue as unplanned and unmanaged as possible; therefore I relied heavily on my intuition and self-awareness during the process. I audio recorded and transcribed the interviews. Co-researchers were made aware that the audio recordings would be destroyed after the completion of this project and the transcriptions would be kept in a locked filing cabinet for three years and then destroyed. No participants objected to the recordings or accepted an offer for a copy of the transcribed interview. Six of the co-researchers participated in the second interviews; the rest either lost contact or could not find time for another meeting.

5. Methods of Data Analysis

The recorded interviews were downloaded into a file on a password protected computer which only the researcher can access. After the download the recordings were deleted from the recorder. I was the only person who handled the data and transcribed the interviews verbatim. The transcribed interviews were kept on the same password

protected computer. I used the data from all participants, even the ones who did not complete the follow up interview. I followed the six phases of heuristic research described by Moustakas (1990).

1) During the **initial engagement** with the topic of interest I turned inward to identify any tacit knowledge about the topic and its personal and social significance. I brainstormed with my cohort peers and dissertation mentor possible research questions to better illuminate the disenfranchised grief some women experience after the loss of their “dreamed-of” birth. My initial understanding of the phenomenon evolved and changed into a more balanced and comprehensive view of the different experiences women shared with me later. This phase was initiated in August 2011, in my second year of doctoral studies and seven months after I experienced a very disappointing childbirth with the birth of my second son.

2) **Complete immersion** of the researcher in the phenomenon. I used introspection and journaling to illuminate my initial understanding of the topic, to ponder upon any possible changes in this understanding and expand my view of the phenomenon. This phase included my self-search inquiry, the immersion in the research literature, and constructing and conducting the first interviews with the co-researchers. The literature review broadly explored studies about contemporary childbirth practices in the Western world, perinatal mental health, feminist studies of birth and gender, and traumatic birth experiences. The extensive literature review allowed for an in-depth understanding of the topic of interest. I narrowed my research interest and found the appropriate language to use when talking about the “dreamed-of” birth and the feelings following its loss. During this phase I also attended and completed a Birth Story

Listening training with Pam England and Virginia Bobro which helped me to work through my own disenfranchised grief and gave me a fuller and more balanced view of the topic. As part of the training I interviewed and worked with four women who had experienced negative births and were willing to work through those experiences with me using the “birth story medicine” approach. The experience of witnessing women’s grief and their healing validated my own personal grief and encouraged me to continue the research efforts so I could bring more awareness into this phenomenon.

After I recorded the first interviews with my co-researchers throughout March and April 2014 I engaged in continuous study of the recordings, playing them over and over for weeks to tune into the co-researchers’ meanings and experiences of the phenomenon. I also transcribed them verbatim and read through the transcripts several times without trying to identify any repeating themes. I wanted to become well versed on the text by immersing myself in the data and following the internal frame of reference of the co-researchers.

3) **Incubation** of my ideas and understandings of the phenomenon. This phase took place during the summer of 2014 when I paused the active focus on the question and relied on tacit incubation of ideas and new meanings. Moustakas (1990) states “Incubation is a process in which a seed has been planted; the seed undergoes silent nourishment, support, and care that produces a creative awareness of some dimension of a phenomenon or creative integration of its parts or qualities.” (p. 29). The quotation above inspired me to dedicate my time to my family and my favorite hobby, gardening, during the incubation period. As I planted my flower and vegetable beds, watering and weeding the newly immersed seedlings, I reflected on my own internal process and the

ways my understanding of the topic has changed with time and experience. I continued to journal during that time to facilitate mental clarity and create a map for my journey.

4) During the **illumination** phase I created the individual narratives for each interviewed participant based on the first interview and with the lens of disenfranchised grief and loss. In the analysis I narrowed my focus from the text as a whole to the single statements the co-researchers made. I constructed an individual depiction of the phenomenon using the co-researchers' language and examples from their experiences of the phenomenon. New meaning and the emergence of new discovery about the topic occurred in the narratives. Various themes of loss and disenfranchised grief after a negative childbirth emerged from the data. Using appropriate quotations and my interpretations of the data I constructed nine different birth and postpartum narratives. I emailed the narratives to the corresponding co-researchers and asked them to read the narratives a few times and notice any new feelings and suggest any corrections that they wanted to make to the texts. Second interviews were scheduled and conducted between June and October, 2014. After the new data were collected and the co-researchers reflected on those narratives, the combined data were reviewed and listened to numerous times to allow for a timeless immersion with the data. None of the co-researchers made any changes to their individual narratives.

5) In the **explication** phase I explored new levels of meaning, different characteristics of the phenomenon, and compared the themes of the individual narratives to describe the experience of loss of the dreamed-of birth in its details and fullness. This required me "to attend to their own awareness, feelings, thoughts, beliefs, and judgments as a prelude to the understanding that is derived from conversations and dialogues with

others” (Moustakas, 1990, p.31). In this phase I compared all narratives to the original data from the interviews and to one another, so common themes were illuminated in the creation of a composite depiction of the experience of disenfranchise grief and loss of the dreamed-of birth.

6) In the **creative synthesis** phase of the research I used my “intuition, imagination, and personal knowledge of meanings and essences of the experience” (Moustakas, 1990, p. 50). According to Moustakas (1990) the researcher relies on her tacit knowledge and intuition to present the essences of the phenomenon and the common themes that were earlier depicted in a creative synthesis. This usually takes a narrative form but “it may be expressed as a poem, story, drawing, painting, or by some other creative form” (Moustakas, 1990, p.32). I struggled the most with this phase. I feared, as Moustakas’ warns, leaving my inquiry findings underdeveloped due to lack of confidence in my creativity and self-doubt as a writer. I approached the research with an open mind and trusted that the process of heuristic inquiry would eventually lead me to this final phase in its right shape and form. After an intensive period of writing the findings of the study, I meditated and reflected on my own experience of disenfranchised grief and on my experience of witnessing and immersing myself with the co-researchers’ lived experience of their grief. Then I drew three images to represent the journey of losing one’s dreamed-of birth and mourning its loss. Looking at the drawings and experiencing the same feelings I thought were long ago felt and filed away in my soul and mind, I wrote three free verse poems to compliment the three drawings and create a rich description of the studied phenomenon.

6. Ethical Considerations and Human Subjects Protection

After a successful defense of the dissertation proposal, I obtained an IRB approval from University of Pennsylvania to conduct the study. The confidentiality of the audio-recorded interviews was protected by keeping them in a password-protected electronic file in a password-protected personal computer to which only I have access. The audio recordings of the interviews will be deleted after the completion of this research study. I will keep the transcribed interviews for three years in case they are needed for future analysis. After this period I will destroy them using proper methods, including shredding any hard copies and deleting all hard drive records. Using participant chosen aliases and referring to them only by those chosen names during the interview process and later analyses ensured the respondents' confidentiality. All identifying data such as place of residence, birth place, names of spouse or children and others were removed from the transcriptions and the narratives.

While setting up interview times, co-researchers reviewed the informed consent. Before the interviews, the co-researchers signed the informed consent form for participation in the study (see Appendix D). Permission for further contact was obtained in the beginning of the interviews, so that emerging themes from the analysis could be brought back to them for further elaboration. Co-researchers were warned of the possibility that their feelings of sadness, grief and memories of their negative childbirth experiences might be triggered by the interview process. Thus, they were assured that participation was voluntary and that they could withdraw consent for participation at any time. The interviews and the follow-up discussions of the analyzed interview data were conducted face-to-face in a convenient, private location.

If women expressed an interest in seeking professional help to address any difficult feelings they might have about their birth experience, I located and referred them to mental health specialists who could provide professional help. Two women requested additional information on counseling and support groups and this information was provided. I also sent them materials and books they might find helpful in addressing difficult feelings after going through disappointing birth experiences. Nevertheless, all of the women who were re-interviewed shared feelings of relief, being heard and validated during the first interview which presented them with an opportunity to reconcile with their disappointing birth experience.

7. Discussion of the rigor of heuristic research

As Moustakas (1990) argues:

Since heuristic inquiry utilizes qualitative methodology in arriving at themes and essences of experience, validity in heuristics is not a quantitative measurement that can be determined by correlations or statistics (p.32).

In qualitative studies the researcher aims to maintain trustworthiness of her findings instead of referring to the validity and reliability quantitative research uses to assess rigor. There are multiple measures for evaluating the trustworthiness of a qualitative study as suggested by Guba and Lincoln (1998). The credibility of this study is measured by the meanings generated by the narrative depictions of the experiences of the co-researchers. After I created the narratives using the raw data from the first interviews I pursued establishing good credibility by using a member checking method of

returning to the co-researchers with the depicted essences of phenomena and eliciting their assessment of the accuracy and comprehensiveness of the developed themes. I maintained email contact with one of the co-researchers who volunteered to be available throughout my writing the findings chapter so she could review them and suggest any corrections if needed. I also used a field diary and memoing to record my own thoughts and feelings that emerged during the study which depicted some of my own preconceived ideas and biases about the studied phenomenon.

Another measure of the trustworthiness is dependability. Dependability was assured by the transparency of the process of analyzing the interviews and creating individual narratives, the composite depiction of the phenomenon and the exemplary portrait of the participants. It was also pursued by using quotes from the interviews to portray the themes and to create the so called “thick description” (Denzin, 2001) of the phenomenon.

Limitations

Limitations of this study include recruitment strategy and the small sample size of nine co-researchers. The snowball recruiting provided the researcher with similar respondents in backgrounds, which is demonstrated in the demographic characteristics of the sample. Therefore, this research is unable to provide a scope of experiences of women who come from diverse ethnic, cultural, and socio-economic backgrounds. The small sample size, while limited in generalizability, allowed for detailed in-depth accounts of the lived experience of respondents.

Van Manen (1984) argues that, despite efforts to maintain objectivity, the phenomenological interpretation of one's own and others' experiences is always subjective and influenced by the researcher's preconceived knowledge and understanding about the topic. Thus, a different researcher might have a different interpretation of the themes revealed (Van Manen, 1984). In an effort to remedy this limitation I maintained transparency throughout the data analysis, kept memos, and kept a personal reflective diary on the steps I took during the interpretations of the respondents' narratives.

8. Reflexivity Statement

The heuristic research process is not one that can be hurried or timed by the clock or calendar. It demands the total presence, honesty, maturity, and integrity of a researcher who not only strongly desires to know and understand but is willing to commit endless hours of sustained immersion and focused concentration on one central question, to risk opening of wounds and passionate concerns, and to undergo the personal transformation that exists as a possibility in every heuristic journey.

(Moustakas, 1990, p. 14)

This excerpt from Moustakas's book on heuristic research and methodology encompasses my experience with the phenomenon of disenfranchised grief after the loss of my own dreamed-of birth. Long before I began this research, I had looming questions. And as Romanyshyn says: "Research with soul in mind is re-search, a searching again,

for something that has already made its claim upon us, something we have already known, however dimly, but have forgotten.” (2013, p.4) Tacit knowledge about this kind of grief was buried deep in my wounded soul, and I struggled to find words to describe it. I grew into my calling to turn my personal lived experience into professional and scholarly research. After exploring possible methods to use in this research, I realized that my inquiry had begun long before I read the first pages of a scholarly article on this topic. Somehow, I had gone through most of the phases which Moustakas (1990) describes as heuristic research before knowing about their existence and order. Sela-Smith (2002) argues in her critical review of the method that: “The researcher must remain internally focused and dwell within the feelings of the tacit dimension, allowing the six phases to unfold naturally by surrendering to the feeling state of the subjective “I.” Instead of rigorous planning and controlling the steps, as in Polya’s (1945) heuristics, the researcher must release control and discover whatever the stage has to offer” (p.63).

Surrendering to the process of inquiry brought up suppressed memories about the births of my sons. At times I engaged in vivid reminiscence of my “failed” labors with myself, my spouse, and even my dissertation chair. Struggling to gain an understanding of what went on during both of my difficult labors and the postpartum effect on me as a woman and mother, I realized that my feelings were not related to “baby blues”, trauma, or depression. I wept the same tears I cried when I lost a baby in a miscarriage two years earlier. This was the first time I put words to the tacit knowledge about the loss of my dreamed-of birth. It brought a tremendous relief to name my experience. I was grieving the birth I hoped for and tried so hard to achieve, but could never taste. I realized that my mourning the loss of a self-directed, peaceful and empowering birth experience

encompassed also the grief around my lost selfhood the way I knew it and envisioned it before I entered labor land. I slowly came to the understanding that the objective characteristics of the birth, such as if it was vaginal or cesarean, easy or difficult, in a hospital or at home, did not matter as much to me as did the subjective experiences of loss of self-image and agency during the process of birthing my children.

I have experienced and continue to encounter dismissive attitudes toward my birth stories and my postpartum grief. This encouraged me to look for other women with similar experiences and struggles. The support I received in person and on internet discussion boards has inspired me to bring more awareness to this taboo topic. My natural curiosity moved me to reading, learning more and questioning the literature that currently exists on contemporary birth practices in America and their influence on women's self-esteem and postpartum satisfaction with birth. My professional interest in helping and supporting women who have experienced grief and disenfranchisement of their lost dreamed-of birth guided me to pursue this doctoral dissertation research despite the personal turmoil and soul pain it brought to my life.

My progress has been slow and difficult due to my inner resistance to move through this pain and heartache. It reminds me of the difficult labors I experienced and my fear of the strong contractions. The contractions brought me closer to my babies but the pain made me fear the next one and resist the natural process of labor. My grief and my writing have followed the same pattern – the more I read about birth trauma, dissatisfaction with childbirth and difficult reconciliation with birth, the more my grief rose and consumed me. Because of this process, I slowed down my project in an attempt to avoid the pain and deep feelings which came with it. Fortunately, writing and

participating in support groups provided the external and internal validation of my grieving experience and my loss. This validation brought healing from my difficult birth experiences. Reconciliation with my childbirth experiences gave me renewed motivation and power to continue my inquiry into this phenomenon in order to give other women a voice and bring peace and healing to their lives. Additionally it helped me sustain a level of objectivity that made it possible to avoid imposing my own narrative on the stories of the research participants. Finalizing the findings of this doctoral research brought the culmination in my labor efforts (which I could never experience in childbirth) and provided me with bitter-sweet closure and peace coming from the courage I had to walk the challenging path of soul searching through this heuristic inquiry, allowing my healing after a loss.

IV. Findings

As described in the Moustakas' work (1989) on the use of heuristic methodology in research, I have presented the studied phenomena through individual and composite depictions. He also suggests presenting the experience of the co-researchers in exemplary depictions of two to three participants who are representative to the group. I omitted this depiction in my findings chapter due to redundancy in the data that emerged from the individual and composite depictions. Also the individual depictions presented in this chapter are a shorter version of the original individual narratives created and approved by each co-researcher. For the purposes of presenting the rich and extensive data succinctly, I present the main themes of the studied phenomena in these individual depictions.

Individual depictions

The main characteristics of the co-researchers and their birth experiences are presented in the summary table below followed by their individual depictions of the lived experience of disenfranchised grief triggered by the loss of their dreamed-of birth.

Table 1

Summary of the individual birth experiences of the co-researchers

Name	Age	Marital status	# of births	Time post birth	Birth plan	Actual birth experience	Satisfaction with childbirth
Andrea	35	Married	1	11 months	Hospital vaginal birth with minimum interventions; humanistic paradigm	Hospital vaginal birth with cascade of interventions; technocratic paradigm	Yes
Elizabeth	41	Married	1	9 months	Vaginal hospital birth, humanistic paradigm	Induced labor and a c-section; technocratic paradigm	No
Kaya	34	Married	1	9 months	Midwife assisted hospital birth, humanistic paradigm	Water breaking with no contractions so labor was augmented with	Ambivalent

						Pitocin; Stadol for pain; Humanistic paradigm	
Kelly	27	Married	1	7 months	Vaginal hospital birth with minimum interventions, humanistic paradigm	Labored cesarean due to breech presentation; heavy sedation; technocratic paradigm	No
Liz	31	Married	2	1 – 4 yrs	1 – birth center vaginal birth 2 – midwife assisted homebirth; Holistic paradigm	1 – scheduled cesarean due to breech presentation 2 – unassisted homebirth First birth – technocratic paradigm and second one – holistic	1 – No 2- Ambivalent

Lynn	38	Married	4	2 – 1.5 yrs	1 – vaginal hospital birth All the other three births were scheduled repeat cesareans; Humanistic paradigm	1 – labored cesarean birth 2,3,4 – repeat cesarean births Technocratic paradigm dominant in all four births.	1 – no 2 and 3 – yes 4 - no
Maggie	35	Married, single at time of her first birth	3	1 – 7.5 y	1 – vaginal birth; 2- scheduled repeat c-section; 3 – VBAC Holistic paradigm	1 – labored c-section; 2 – scheduled repeat c-section; 3 – labored cesarean after a VBAC attempt First & second births – technocratic paradigm,	1 – No 2 – No 3 - Yes

						third birth – humanistic paradigm	
Mary	34	Married	2	2 – 4.5 y	1 – midwife assisted hospital vaginal birth 2 – scheduled repeat cesarean; holistic paradigm	1 – labored cesarean, cascade of interventions 2 – scheduled repeat cesarean birth Both births were in the technocratic paradigm.	1 – No 2 - No
Sarah	41	Single	1	3 – 3.5 y	Midwife assisted hospital vaginal birth with no interventions; holistic paradigm	Labored cesarean birth after multiple interventions during labor; Technocratic paradigm	No

Andrea

“Yeah, it was very lonely for sure...I just felt I was in my own world.”

Andrea is a 35 year old, married, Caucasian woman who gave birth once approximately a year before the first interview.

The dreamed-of birth

Andrea prepared for an unmedicated hospital vaginal birth but was open to possible medical interventions in the course of labor. Despite her induction, which she wanted to avoid, she approached labor with a positive attitude. She remained active in labor, which allowed her to feel in control. She used coping techniques she learned in childbirth education classes until the contractions became too strong to endure and she requested an epidural, “which I was OK with...I wanted to go a little further but once I got the epidural she (the baby) had already dropped and the actual pushing was pain free.”

Experiences of loss during childbirth

After the baby was born Andrea started bleeding profusely and the events surrounding this emergency triggered a feeling of loss of agency and control:

So, I knew it wasn't good and you could tell how frustrated they were, and for some reason I felt bad. Oh sorry like my placenta is not coming out! (laughing) I really

don't know what that means, I am not a doctor! But I guess it should come easier and I don't know why it is a problem, I apologize.

Andrea assessed the situation by reading others' faces and listening to their conversations: "...they were also talking in front of me which in a way was nerve racking because I didn't know how they would get the placenta out..." The lack of communication strengthened Andrea's feeling of loss of control and helplessness. She was separated from her baby and her husband, something that upset her: "it wasn't fun but there was nothing I could do." Andrea lost the initial bonding moments with her daughter and when she finally got to hold her: "I was still out of it and I was so cold and shaking".

Four days after she was discharged Andrea was readmitted to the hospital with brain swelling and dangerously low sodium levels. She was not able to tend to her daughter, which deeply saddened Andrea: "I wasn't mentally there or physically there for all of it." The medical complications interfered with her ability to breastfeed, and Andrea felt powerless to let go of that expectation. She associated breastfeeding with good mothering and felt like a failure for not being able to provide enough breast milk for her baby. Andrea tried to breastfeed until she went to her postpartum appointment with her midwife who recognized her distress and "gave me a permission to stop trying." Her grief about the unsuccessful breastfeeding gradually subsided and she was able to begin emotional healing: "After that it was great because I could enjoy her and not fight with her about everything. So I just came to terms with that."

The lack of understanding and support by Andrea's husband strained the relationship and deepened their marital problems: "I felt like I had to hide it from my husband that I made that choice because he wasn't OK with it."

Grief and disenfranchisement

Andrea felt "completely helpless, not informed in some way, and just angry and really sad. Oh my God, I was so sad." She explained the helplessness she felt with the loss of control and agency she experienced postpartum: "I don't even know my own body! You guys (the doctors) tell me what to do." The loss of her intuitive motherly knowledge made her doubt herself as a parent and a woman "...it was so very confusing."

Furthermore, due to the sense of being a failure and an inadequate mother, Andrea silenced her grief and did not reach out to others for support. She felt ashamed and guilty about her difficult feelings toward breastfeeding and early mothering--"just having that pit in my stomach and just feeling ill, and oh my God I can't do this...this is crazy. And also so much anger at my husband because he didn't help, he didn't want to help..."

Nevertheless her self-disenfranchisement led to isolation, leaving Andrea with more feelings of guilt, shame and loneliness: "I tried to stay away from my friends who were pro breastfeeding because I did not want to feel like I was letting them down. It was very lonely for sure...I just felt I was in my own world."

Re-claiming her voice and reconciling with a difficult birth journey

Later in her grief Andrea reached out to online support groups of formula feeding mothers where she found the validation she craved: “Oh, OK I guess it is not such big of a deal then, so that was help – found it from perfect strangers...” She realized that reaching out for support from people who have been through the same experience helps. “Basically if you can’t breastfeed surround yourself with people who can’t breastfeed.”

Almost a year after the birth of her daughter, Andrea shared she now feels empowered and “like I can do anything.” Surviving the difficult birth and muddling through the struggles with breastfeeding allowed her to re-claim her new self as a mother: “I am still alive, she is still alive. She is amazing and strong, and funny. I think I am a great mother.” She was able to experience her postpartum grief as a learning experience: “I think what I learned is not to hold onto any of the loss because everything was what I was not expecting.” Andrea re-created her birth narrative as “not holding onto it and finding a different way to tell the story.” She stated her newly acquired wisdom thusly: “just trying not to focus on the bad memories and knowing that you can never plan anything fully, and certainly not with babies. But that you are strong enough to go through it.”

Elizabeth

“I will always experience a level of sadness...So letting go of that dream is an ongoing process.”

Elizabeth is 41 years old, married, Caucasian woman who gave birth to her son 9 months before the first interview.

The dreamed-of birth

Elizabeth planned a vaginal unmedicated hospital birth with an obstetrician and a birth team consisting of a doula, her two sisters, her husband and an ASL interpreter for her husband. She had always seen childbirth as a natural and inherently feminine process. A long-standing battle with Polycystic Ovary Syndrome (PCOS) caused multiple difficulties getting pregnant, carrying the pregnancy to term and breastfeeding. These complications affected Elizabeth's self-image, and she felt betrayed by her body and "so not feminine and freakish" even before the birth.

Experiences of loss during childbirth

The loss of the feminine self-image resurfaced in Elizabeth's life after the medically induced labor stalled, and she succumbed to one of her greatest fears – having a c-section. The very induction of her labor put Elizabeth in a passive, disempowered role:

I didn't want to be induced. I wanted to go at least two weeks and he (her doctor) didn't want to go over a week. I feel in that situation the doctor holds all the cards, the doctor has all the power...and it still feels like it left me voiceless...

Elizabeth kept her optimistic mindset, and maintained an active role throughout labor until her doctor decided on a c-section. She had a strong emotional reaction which was reprimanded by a nurse: “listen, you got to get a grip of yourself! This day is not all about you! This is the day when your child is going to come to the world. Don’t spoil it for everyone involved!”

Elizabeth blamed herself for failing at natural childbirth: “My body has failed me! Yet again!” Her grief overwhelmed her, and only her sister’s words of empathy and support calmed her down. Elizabeth associated the c-section with the “easy way out” and felt she had failed at the challenge of natural childbirth:

I just lay on the table and they cut me open and took him out. And that doesn’t require any amount of strength, physical...well, maybe emotional yes, but it doesn’t require any effort. I still struggle with that idea like did I really give birth. He was born, but I can’t help but think about they took him out of me, not I gave birth to him. So it feels like I am removed from the reality of his birth.

She felt “robbed of a life experience that I held so dear in my heart” and struggled with emotional acceptance.

Grief and disenfranchisement

Postpartum, Elizabeth felt defeated and invalidated by the people closest to her:

And having had a c-section instead of natural vaginal birth made me feel as a failure as a woman. And that was something that my husband didn’t

understand at all. My family members didn't really understand. And I had validation from other people but those closest to me were like well, he's here, get over it, you got your son, and he's in good health and he's wonderful. Enjoy that! Don't dwell on this c-section stuff.

Not only was her grief disenfranchised but so were her losses of agency, voice, control, and presence. She felt subjected to the position of accepting that scrutinized and medicalized childbirth was considered something normal and what "everyone does nowadays." While listening to Elizabeth's narrative of her experience of grief I heard her sadness and disappointment about the childbirth:

But I had to have time to process my emotions and come to terms with the fact that this is probably going to be my only child and my only birth experience and it was not what I dreamed it to be and what I worked for and planned for, physically and emotionally. It took time. So letting go of that dream is an ongoing process.

Re-claiming her voice and reconciling with a difficult birth journey

To find her voice postpartum Elizabeth pled for empathy from her family: "...oh God, can I have just one ounce of compassion and understanding about this?" She hoped that her husband could just "try to understand and put yourself in my shoes a little bit!" Elizabeth also discussed the birth with the doctor who performed the c-section in order to begin to create a new meaningful birth narrative that would help ease her grief: "I was much calmer at that point. It gave me some peace..."

Due to the PCOS and the c-section, she struggled producing enough breast milk. Once again she was able to ask for support and empathy in dealing with invalidating comments such as “it’s not a big deal if you want to quit; so many people give their kids formula.” She defended her choice: “I am doing this and if you are not going to support me I need you to just stop talking altogether!” Finding her voice gave her back power and agency to fight for the breastfeeding relationship she wanted for herself and her son: “I needed to go through all the struggles until I was able to come to terms that I would never be able to fully sustain him solely on breast milk.” Elizabeth reconciled that loss and did not experience the disenfranchised grief she did with her birth because she felt that she gave it her best: “I needed to inject some sanity and some balance. I had to change my expectations.” She told herself “we did good, we did good...”

Her fierce mother-self was born through the struggles: “whatever I can do to protect him and nurture that I want to do.” Elizabeth agreed that she had reclaimed her feminine self through mothering her son and shared her insight: “that is what helps I think to restore my sense of womanhood.” Being the good-enough mother she pushed herself past her comfort zone and continued her self-work on her trauma and grief: “it helps reminding me to stay as clear minded as I can and to cope in healthy ways and to process in healthy ways because I want him to have the best of me...”

At the end of the interview Elizabeth demonstrated post-loss growth through her wise and balanced thoughts about birth expectations and the reality of birth. She reported mentoring a pregnant colleague: “expect the unexpected; you can have all the plans in the world and those plans can go up in smoke really quickly.” She also reframed her “failed birth” as being an unpredictable and unique birth, concluding that “every birth has its

twists and turns”, and advocating that all women are in this together and should break the silence and disenfranchisement of their experiences: “...if we can share that we’ll be better off...we are all stricken by it.”

Kaya

“The grief I have around it is that I wish I would’ve been more present. I just don’t feel that I was really there when he came out.”

Kaya is a 34 year old, married, Caucasian woman gave birth once vaginally nine months before the first interview.

The dreamed-of birth

Kaya’s birth plan was to have a natural vaginal delivery. This plan informed her choice of a midwife as a care provider. Kaya was afraid of a very fast labor and wanted an option to have a homebirth, so she chose a midwife with home and hospital birth experience. Kaya’s expectations of the birth were that she would have a very short labor and feared that “the baby will come rocketing out of me and that I wouldn’t make it to the hospital on time.” Her expectations were influenced by her mother’s fast labors. Taking prenatal childbirth classes and diligently doing prenatal yoga left Kaya feeling prepared for the labor. She also imagined that she would experience an “Ina May Gaskin hippy-dippy, loving-touchy feely birth.”

Experiences of loss during childbirth

Because Kaya's expectations for the birth were unmet by the very different reality of labor (it was prolonged, past due date, began with her water breaking and became extremely painful) she felt frightened, panicky, and anxious about the process and her baby's health. This influenced her perception of the whole birth experience:

The main thing that happened for me was that I felt very early on that my body was failing me and like I couldn't do it. And, hum I got really stuck on that and that sort of, that just colored the whole thing.

She tried some natural ways to induce labor with no success, and that reinforced her perception of her body failing her:

...we did everything and I just...only once in a while I would start having contractions. I just felt that my body is failing me and that I was doing it wrong. And I was so worried about him (her baby), so scared of having a c-section and I was just totally freaked out.

The fear of failing as a birthing woman paralyzed Kaya. The pain she experienced after her contractions were started with Pitocin was shocking: "I really underestimated the amount of pain that I would be in. The amount of pain was really astronomical. It was unreal." Kaya situated her perception of loss of control over her body and the feeling of failure in accordance to previous themes in her life narrative such as "I am doing this wrong" or "something is wrong with me". She was unprepared for labor to magnify these profound feelings: "I didn't realize that all the things that trigger you in life in general are full size while you're pregnant and in labor."

Because Kaya did not disregard the option of using medical interventions during labor she did not feel robbed of an experience of natural childbirth. She disregarded the fact that her labor was medically augmented when she talked about her overall childbirth experience: “it was really hard and I did have some drugs and some antibiotics but other than that it was totally natural.” Kaya believed that having Pitocin induced labor was medically necessary and felt grateful for having access to it:

And so I was happy I was able to give birth, and I was happy that there were drugs to help and make the birth progress. I don't know what would've happened if he was born at a time I didn't have access to those drugs.

Her perceptions were blurred by the pain and later by the drugs she received: “I was wasted out of my mind. I didn't know where I was. I thought I was dead. I didn't know if the baby was dead.” She felt disconnected from herself and from her birth team. Kaya had a distorted perception of how others saw her and talked to her: “I thought they were yelling at me” or “...my husband will be so mad at me for doing drugs while I'm pregnant”; also “I thought that the doula and the midwife didn't like each other...I had all this stuff going on in my head, while I thought that everyone is mad at each other and everyone is mad at me.” She felt she had disappointed her midwife by not being able to cope with the pain without anesthesia: “are you mad at me that I took the drugs?” Moreover, the drug-induced haze led to her feelings of loss of presence when she reflected on her birth experience postpartum:

I guess what I lost on was being present. The grief I have around it is that I wish I would've been more present. I just don't feel that I was really there when

he came out. I think that I didn't actually experience it because I was so drugged up.

Kaya also felt that her "emotions were so sunken from the drugs" that she did not experience joy. She acknowledged that her feeling of disconnection could have been brought up from the prolonged and difficult labor she experienced, "and I don't know how much was the drugs or how much of that was the lack of sleep and the exhaustion but I feel like I wasn't there."

Grief and disenfranchisement

Postpartum, Kaya encountered conflicted feelings. Her family, husband and friends showed her admiration and respect for enduring a long and difficult labor. She felt proud of herself and happy that she birthed her son vaginally. But the experience of a painful and difficult labor left her fearful:

I think I am scared to even think about doing it again because of how hard it was and because I think I would have the same fear that my body failed and that things would go wrong. I definitely feel like how can I ever do this again? It's not like oh I am so powerful, I did this so I can do it again. I am like Oh my god, how the hell I am going to do it again?!

She shared that she had not had a chance to process her feelings about her birth experience due to being "busy keeping him alive and just being so tired". She wished for a ritual to help women share and achieve closure with their difficult birth experiences.

Re-claiming her voice and reconciling with a difficult birth journey

The loss of confidence in herself as a birthing woman did not transfer to Kaya's perception of herself a mother. The early and strong bond she had with her son after his birth facilitated her transition into motherhood: "...being a mom has changed everything...I feel that it is like biologically in you and your animal instinct is to care for this child and everything else fades away." Being a mother and going through the birth brought to Kaya a newly developed feeling of connectedness to other mothers. She referred to them as "war buddies" and shared that she "feel(s) connected to everyone and every living thing that has ever given birth." Her perception that "we are just all in this together" gave Kaya a confident voice to speak up for herself and other women's rights.

Kelly

"I missed basically his birth and that really weighs heavy on me".

Kelly, a 27 year old, married, Caucasian woman, gave birth once seven months before the first interview

The dreamed-of birth

Kelly and her husband carefully prepared for the birth of their first son. They hoped to experience an intimate and bonding family event. Her husband wanted to be her coach, and he hoped "to be that rock, that person telling you that you can do it, and helping you push through, and holding your hair back, and holding your hand..." Even

though her baby was in breech position, their medical team assured them that there was enough time for him to turn head down.

Experiences of loss during childbirth

Before the baby turned head down Kelly's labor started, and she had to forgo her plans for a vaginal birth. Kelly did not object the need for a c-section but felt robbed of the experience she longed for due to a heavy anesthesia which caused her to miss out on the birth of her child, "and still to look at the pictures is some of the most odd thing because I look at them and I say that's me but I don't remember any of it and I really wish I do, I don't know."

Another violation of her expectations came from her family and in-laws. Kelly and her husband planned to remain by themselves for some time after the birth so they could bond with their newborn baby. Their plans were overthrown by their families, who were excited to see the baby and visited right after they found out about the emergency c-section. They did not notice Kelly's discomfort and difficult recovery. Her mother-in-law took a picture of her and the baby despite her objections:

And it's just a picture but whenever I see it I look at it and it's just a constant reminder of how powerless I was. I couldn't even say no. I couldn't even stop her from doing something so simple as taking a picture of me.

Thinking about the labor experience Kelly recalled only bits and pieces until the day after her baby was born: "I missed basically his birth and that really weighs heavy on

me”. As a result of her passive role during labor, Kelly felt disconnected from her feminine self and that she had failed at childbirth:

And in some ways I feel like I am less of a woman. I guess I can say that I feel slightly less than what I expected to feel because in some ways it just doesn’t feel that it was my experience at all. Like I was looking down on someone else going through all of this and somehow I just have this baby. I see these pictures and I say OK, that person looks like me, that person I guess is me, but I just randomly have this child and there is like this massive disconnect where I feel like there should be more of that connection.

Additionally, she experienced a loss of connectedness and relationship with her birth attendants. Kelly felt unimportant to them; the focus of treatment seemed to be on her as a vessel for the baby’s birth and not on her as a whole person. She felt she was seen as an obstacle that needed to be silenced/removed from the birth scene: “I really wish she would’ve at least asked, because I would have said no, I will be quiet if I am breaking your concentration...” She longed for human contact and empathy from her birth attendants “...and that still to this day really upsets me...I would’ve preferred anything else but just drugging me.”

After the birth, the hospital staff disregarded her wishes to exclusively breastfeed. The baby was given formula without any clear medical indications. Kelly felt disempowered and stripped of her right to decide for herself and her baby. She grieved the loss of her agency and independence.

Kelly envisioned her first moments with her son as magical love at first sight. Instead, she recalled a first photo taken of them: “I am completely passed out and the baby was just sitting in there. I am not even looking at him and it bothers me that I don’t have any of that.”

Another person affected by the technocratic treatment in the hospital was Kelly’s husband. He experienced a loss of his envisioned role in labor as Kelly’s support and her “rock”. Kelly felt sad for him and suffered for his loss.

Grief and disenfranchisement

Kelly struggled to find the words to explain her experience of grieving her loss: “in the beginning I want to say the first few months I would be horribly crying about it. It’s something I think about multiple times a week...I can’t really explain it with anything but that it is just so heavy on me and it weighs on me that I don’t have any of that (memories).”

She attributed her difficult and slow bonding to her son postpartum to the absence of initial bonding after his birth. Kelly recalled feelings of shame and guilt for the lack of bonding:

...at first I felt guilty that I didn’t love him enough...at first I really thought that I didn’t love him as a mother should, I just felt that I was babysitting. And still to this day I feel a little guilty that not only I missed out on the birth

experience but I could've from that moment made more conscious decisions to maybe bond with him and maybe I didn't do that and I should have.

Kelly felt ashamed of her feelings toward the birth and she self-disenfranchised her grief:

It would be so heavy on me that I would be lying in bed sobbing because I didn't...I guess it wasn't how I expected it would be. In some ways I feel, I don't want to say spoiled but sometimes I think of it and when I feel like that I say to myself that is such a spoiled thing to say! Like, you have a wonderful baby and he didn't need to be in the NICU.

Suggestions from others to move on and focus on her baby and his happiness were well meant but dismissed and invalidated her emotional pain. These suggestions encouraged her self-disenfranchisement instead of offering support and empathy:

I don't think I have told anybody because I am just so ashamed that I feel that way. I mean I tell my husband but he hum...he hasn't dismissed my feelings but in a way he's like think of the positives, we have this wonderful boy; he didn't have to go to the NICU; you got to the hospital on time; I was able to see it; we have all those pictures; you can remember it this way - I can tell you about it; etc., etc., etc. But I haven't told anybody, my husband is really the only one who knows the depth of how upset I am.

Re-claiming her voice and reconciling with a difficult birth journey

Kelly tried to integrate this fragmented experience by using her husband's memories and observations to create a meaningful birth narrative. Being supported by her husband brought them closer. Kelly spoke about their post-grief growth and finding her voice again postpartum: "I think now I do feel like a good mom. I do." She suspended her career in an effort to "cultivate some relationship with him (her son)." And that "sacrifice" was motivated by the lost initial bonding with her son: "it did turn me in a different direction". Kelly acknowledged that her grief promoted more conscious effort toward being the mother she wanted to be which brought a feeling of control and ultimately the feeling of "...I am a good mom and I am where he needs me to be."

Liz

"...the silence around it was hard. Both times being able to talk to people who have gone through similar experiences made me feel like I am not alone, I am not broken."

Liz is a 31 year old, married, Caucasian woman who had one cesarean (four years ago) and one unassisted vaginal birth at home (a year and a half ago) at the time of the first interview.

The dreamed-of birth

Liz's beliefs about childbirth as a natural event led her to choose a birth center for her first birth and a homebirth for her second. Using her mother's natural birth experience as a model, she always expected a vaginal self-directed birth experience.

Experiences of loss during childbirth

In the course of her first pregnancy it was determined that the baby was breech, and her care was transferred to an OBGYN hospital practice because of the need for a scheduled c-section. Both Liz and her husband felt helpless and confused in the face of the medical professionals and their expertise. This left them feeling disempowered and passive. Postpartum Liz felt disappointment in herself:

And I think I felt so let down by having a c-section, I felt like failure in some ways...you know even rationally I knew he was a breech baby I did what I could, you know. I did whatever possibly I could do and I don't think there was much more I could've done. So I really felt like a failure.

Liz situated her feelings of loss of her feminine self with her belief that if her mother had all natural vaginal births, she was expected to do the same "and that was kind of like a model and I think I was comparing myself to her – my mom did this and now I can't."

Another profound loss experienced throughout the childbirth and postpartum was the loss of Liz's trusting relationship with her care providers. During her second birth, for example, her midwife failed to recognize the signs of active labor and missed the birth.

The loss of control which Liz and her husband experienced during both births left them angry and disappointed. After the unassisted birth of their second son, Liz's husband was traumatized by the experience of catching the baby. He was unprepared for the event and relied on trained professionals to be present at the birth. They were angry toward themselves for not calling the midwife earlier. Liz rationalized her choice: "I should've known then but I just...I had nothing to compare it to."

The overall medicalized experience of having a cesarean birth affected Liz's early relationship with her first son. She experienced a loss of early bonding which later affected their breastfeeding relationship: "it could've been a different experience if I was able to touch him and hold him...and I don't see any reason why that couldn't happen." The postpartum plans were altered by the cesarean because Liz and her family moved in with her in-laws while her incision healed until she was able to climb stairs. This further interfered with the ability to create an intimate bonding experience for her, her husband and their new baby.

Grief and disenfranchisement

After the cesarean Liz felt shame, failure, and guilt that she "could not birth right". These feelings were deepened and complicated by others' dismissive comments:

And I felt people were going a lot like well, at least you have a healthy baby. That's all that matters. You know what, that kind of stuff. And you know yeah, it was true but I also have a big scar...And I guess you know I feel like a lot of people didn't understand...

Experiencing the disenfranchisement of her losses during her first birth turned into self-disenfranchisement. Liz had a hard time situating her experience of loss and told herself that, because her labor was not traumatic, she did not belong in different birth story healing circles: "I guess I never thought that my stuff was traumatic enough...and I guess that can be sort of disenfranchising – oh, it was little traumatic but not traumatic enough."

After her second birth and complications of perineal tearing Liz felt frustrated but validated in her ability to birth her child naturally without interventions. Liz also reported ambivalent feelings about the course of labor and the aftermath. She expected a quicker postpartum recovery since she followed the wisdom of her body in labor: "I think I had this idea in my head that with vaginal delivery you feel little rough couple weeks later but the recovery is so much faster..." Her anger and frustration after her second birth interfered with her emotional healing and compromised her ability to come to terms with the experience itself. The pain and the difficult recovery also affected her sexual life and, therefore, were constant reminders of her lost dreamed-of birth.

Re-claiming her voice and reconciling with a difficult birth journey

Understanding how most of her plans were unmet by the reality of childbirth, Liz spoke about the importance of remaining open minded when creating them: "I guess you

have to come up with some plan, you can't just completely wing it but it is really hard because there are whole lot of factors that go into it." Liz reflected on the wisdom she acquired post birth/post loss, noting how powerless she felt during birth and learning the importance of remaining mindful of one's limitations.

When asked about what helped with her overall recovery and postpartum adjustment Liz said that getting help and support from her family and friends was the key: "I think having help made a difference." She also emphasized the importance of finding empathic listeners:

...the silence around it was hard. Both times being able to talk to people who have gone through similar experiences made me feel like I am not alone, I am not broken. Sometimes it just happens. And some people really do have that mentally, you had a healthy baby. And it is true, that's what matters but there's also some other stuff in there.

After Liz experienced some healing and closure she was able to self-validate her birth experience but still continued to self-disenfranchise her grief due to lack of societal acceptance of it.

Lynn

"...So, we all go through the same thing no matter the way we birth."

Lynn is a 38 year old, married, Caucasian woman who has four children, all born via cesarean surgery.

The dreamed-of birth

Lynn's first birth was planned as a vaginal hospital birth but did not go as expected, triggering fear and panic: "I was scared to death". Her beliefs and expectations about childbirth were influenced by the media and other women's stories, which she referred to as "myths of childbirth". She did not pursue her ideal birth, an intimate homebirth, out of fear for herself and her baby's safety.

Experiences of loss during childbirth

Lynn was a passive participant in her first birth because an epidural left her with no sensation during the pushing phase. This intervention frustrated Lynn, and she could not use the breathing techniques she had learned in the childbirth preparation class. Her loss of control over the birth and her body culminated in the pushing phase when the baby did not crown despite Lynn's efforts. She agreed to proceed with a c-section and although she was concerned about the outcome "everything went pretty smooth". After the surgery she started shaking uncontrollably which was dismissed by the anesthesiologist as normal, but frightened Lynn: "I felt like I couldn't control it which was so scary."

Lynn's grief was triggered the next day when the doctor informed her that she would be able to have only three children via c-section. She experienced a loss of her dream for a big family "and that was really disappointing to me. I was very very upset by

that.” Lynn did not have any support in her grief, and her reproductive loss went unacknowledged.

Grief and disenfranchisement

Lynn’s grief about the lost big family and her feelings of failure to give birth naturally made her feel like less of a woman. Her loss of her dreamed of birth caused her to disenfranchise her actual birth experience: “at first I felt that I didn’t truly give birth.” Lynn spoke at length about her healing and coming to terms with her four cesarean births. She doubted her ability as a mother since she could not endure labor and vaginal birth of all of her four children: “I was really devastated at first...” She went through times of self-doubt and questioning herself as a woman and mother, comparing herself and her births with those of other women, wishing she could have experienced the same fast recovery, and “not feeling as a true mom because I didn’t do it vaginal.” She felt robbed of an experience with lifetime significance in the beginning of her healing journey: “that was really hard...but it was what it was.” Lynn shared with me her empowered self-talk that led her through the dark moments of grief and self-doubt “...everyone’s experience is different, so stop comparing yourself, that’s silly! But I had to do a lot of that self-talk because there was a lot of self-doubt in the beginning.”

Re-claiming her voice and reconciling with a difficult birth journey

Lynn’s following pregnancies and births helped her heal from the initial disappointment of having a cesarean section: “I felt more confident as a mother and I was like hey, it could be worse.” Lynn situates the beginning of her healing and coming to

terms with her first cesarean a year after the birth. She encountered an old friend from school who made an insensitive comment about her birth: “she told me – you never experienced a true delivery.” Instead of deepening her feelings of being incomplete and inadequate, these words prompted a deeper self-search and exploration of her beliefs about motherhood. Lynn used her strong positive self-talk and her husband’s support to challenge societal messages about the inferiority of cesarean births and to come to terms with the births she had: “I kind of got over it with time but I also healed from it on my own.”

In her process of emotional healing from a disappointing birth, Lynn focused on re-creating her self-narrative in order to make meaning of her birth experience. Learning about the events of her first birth and talking to her midwife helped her to create a new birth narrative more in tune with the way she sees herself as a mother and woman. Finding out the details about labor and that her baby was tightly wrapped in her umbilical cord brought peace and acceptance to Lynn: “may be it was meant to be...” The trusting, warm relationship she built with her midwife, who “was disappointed, too” about the cesarean and lack of presence at Lynn’s first birth, supported Lynn in her grief and validated her feelings: “she made me feel a lot better about what happened.”

One year postpartum after her first cesarean birth, Lynn was able to see that:

I felt I worked so hard because it was such a serious operation and that is what I tell myself – you went through so much, too. And I had longer recovery with c-sections than other moms who do the vaginal birth, so that made me feel

like, you know what – you did it. You did just as hard work as they did so don't feel this way.

Going through a difficult and disappointing experience with cesarean births for all of her children when she wanted to birth them naturally actually boosted her self-esteem and initiated a post-loss growth: with “each pregnancy I just got stronger and stronger...” and “...the whole experience just made me appreciate everything so much more.” She found herself wiser and more accepting of the unpredictability of life.

Lynn's biggest supporter and confidante was her husband whom she referred to as “my best friend”. She also reached out to “other women and hearing their stories helped, too.” Growing through her birth experiences and subsequent grief facilitated Lynn's connection to other women who shared their birth narratives: “I can empathize with every pregnant woman when they tell me about their pregnancy and birth. It comes all over again as it happened. So, we all go through the same thing no matter the way we birth.”

Maggie

“You don't get to have any magic. They take it all away from you.

And when that's who you are, it means everything to you.”

Maggie is a 35 year old, married, Caucasian woman who had three births, eleven, three and one year ago respectively. All her children were born via cesarean sections, but

her labors and her feelings about them were very different from each other. Her first and third births were labored cesareans and the second one – a scheduled repeat cesarean.

The dreamed-of birth

Maggie's dreams about giving birth naturally to her children started long before she conceived her first child. She believed in "doing things with Nature as my meter." She saw birth as a sacred life event, a rite of passage: "...peace and warmth, and incense and music, like a drum circle...it should be dark and moody, and soothing...just natural and full of positive, loving energy."

Experiences of loss during childbirth

Her actual birth experience was quite different from what she hoped for:

And that is all stripped away when you walk into a hospital. There's nothing. I didn't get to have any of that...They take it all away from you. You don't get to have any magic. You know, and when that's who you are it means everything to you.

During her first birth she agreed to have epidural anesthesia and Pitocin to augment labor but then felt "...it was just drugs being pumped into me..." Her passive role brought on self-doubt. Postpartum, Maggie felt abandoned, scared and confused about "what just happened." Her doctor neither recognized her distress nor offered empathy or validation of her lost envisioned birth: "My doctor didn't come to check on

me not even once after I gave birth. He was done; he has finished his day..." A few years later when pregnant again, Maggie was unsettled and unsure about scheduling a repeat cesarean: "I was really so unhappy about this. This isn't the way it should be." She felt robbed of experiencing spontaneously going into labor: "we were just booked...it felt so unnatural!" Maggie felt responsible for the decision she made: "I took myself out of the equation. It was just the doctor and the baby, and I was just the vessel." Maggie lost her agency and autonomy during her second birth, leading to a sense of disempowerment, loss of confidence in herself as a mother, and alienation from her birth and from herself:

...with my second daughter after I gave birth I felt so unsettled. I felt so unsure of myself. I doubted who I was because I always lived and tried to do things in my own principles...and it (the birth) was so medical, and it was so sanitized and it was so clean and that's not who I am. I need to feel like I am really completely involved in it and that's not how it was with her or even with my first.

The disrupted bonding with her second daughter was slowly repaired with time, but Maggie was still sad: "...that heart thing, that thing you feel with your children I feel it 99% with her but there is this hair of something and that is really confusing."

Grief and disenfranchisement

Maggie spoke at length about the societal disenfranchisement of her loss and the self-silencing that followed: "we don't talk about it...there is no discussion" and also "so I don't bring it up because I don't want to make them feel uncomfortable." Her self-talk

was influenced by her self-doubt and the loss of confidence in herself. She was upset about comments that she needed to move on and be happy for the healthy baby:

But I think when you don't have your tribe and you hear nothing but people criticizing you for speaking negatively about your birth experience you feel like a bad person for having a bad experience to begin with. And that's wrong on so many levels!

Furthermore, Maggie spoke about the need to share one's grief and difficult feelings toward the birth with people who listened without judgment:

...you have to find other people to talk to about it. Otherwise it will just implode. And then your kids suffer from it because they don't get to have you being happy. You try so hard to keep it together that you just lose it completely.

Re-claiming her voice and reconciling with a difficult birth journey

Maggie's journey toward healing and re-claiming her voice--and ultimately herself-- started during the preparation for the birth of her last child. She saw speaking up as a big step toward finding her new self. A newly acquired confidence continued after the empowering birth she had with her son, and she felt comfortable with her parenting choices this time:

But I felt very confident about what I was doing. I don't consider what they are saying [*sic*]. It might hurt my feelings a little bit, but there is a completely different...I have a different outlook on myself.

Maggie found a new practice of midwives who treated her as an equal participant in the process, listened to her concerns, and discussed her options: “they were so receptive to talking to me (laughing). That was such a profound moment!” After discussing her hopes for her third birth with the midwives “I walked out of there in tears because it has made me feel so good and so heard. And that was what was lacking in any of my previous experiences. You know, my voice was heard.” And also:

There was such respect for me that I had never experienced before. I wasn't just another number, I was this person who was going to experience this and they were giving me such an opportunity to do it how I wanted to do it.

Maggie went into labor on her own, but the baby's position was transverse and she made a decision for a repeat cesarean. Maggie describes this moment connecting with her doula:

She hugged me, and she loved me, and she gave me everything I have never gotten before in that experience. That was vital. I don't know how I would have done that without her showing me such compassion and empathy...

Maggie got to labor and experience birth as she always wanted: “I needed to know that I can get through the pain of it. That I can get through the experience of it and I can do it. I can do it! You know? So I did!” She called her labor a “rite of passage” and found the experience healing. She felt she had proven herself to be a capable and powerful woman and mother.

Despite the overall positive experience with this birth Maggie still had a disempowering technocratic exchange with the hospital personnel during the preparation for the c-section:

...nobody was helping me. It baffles me in situations like that! They see me struggling to catch my breath through the contractions and not one from the nurses tried to come over and used any tactics to help me cope with it. So that was really crappy being in a cold OR, waiting for the anesthesiologist, my husband can't be there yet, my doula is not allowed in, and they are not doing anything but prepping the tools! Can I cry?! Can you hold my hand?! Can somebody help me?!

Maggie found support from the operating doctor and communicated her wishes for the birth: "I want to see him! I've never seen one of them come out of me. I need to see him the way I would've pulled him up onto myself. And she did! She was like – whatever you need!" When the doctor pulled out the baby she lifted him up and told Maggie to look at him:

...he's like wrinkly, he's red and bloody and dripping on me...and I am like Oh my God! Oh my God! (crying with excitement) It was...it was the best I can get, but she gave it to me. She gave me that moment.

This time Maggie's birth was full of positive experiences:

It was like this angel was placed next to my bed and it was so good...the nurse put him on my stomach, nowhere near my boob and he wiggled his way and latched on. It was that moment! I was waiting on it, I knew it was possible...and

he did that! He did what nature was...what he was supposed to do and nobody stepped in his way.

Maggie had an easier postpartum adjustment with this birth, and she “didn’t really suffer from the same blues that I had with the other two.”

...with my son I knew that I was the BOSS, I felt like I was the MOM, you know, nobody was telling me that I was doing anything wrong. I felt like me again. I felt like I found me, I found me as a mom, right?

Maggie is clear about the healing and empowerment she felt after her last birth. It’s possible that this last birth helped Maggie reconcile with the other two. She shared that she still struggles sometimes with the way these two births went and with the choices she made for herself and her children: “I love to think that my last birth was super healing but it wasn’t...it didn’t all go away. It doesn’t just go away because you have a good experience.”

Mary

“I was very sad and right after the surgery I was sitting in that dark room I remember crying and feeling just very sad. Once I saw her I was extremely happy, not happy with the birth but happy that she was fine”

Mary, a 35 year old, married, Caucasian mother of two, who had one labored and one repeat cesarean birth respectively eleven and seven years ago.

The dreamed-of birth

Mary expected to have an easy and fast natural birth because her mother had a “scary easy birth, very quick so I kind of expected that.” She had her husband for support and an older midwife to guide her during labor.

Experiences of loss during childbirth

Mary recalled that there was not much discussion with the doctors from the practice and she felt belittled by them. The scheduling of the induction was her first experience of loss of agency and autonomy during the birth. The procedure was not discussed with her but instead she was told “that Thursday I will be induced with Pitocin and then I will have the baby.” Mary later acknowledged how powerless she felt to discuss the induction due to the power imbalance with her doctors “and I just trusted what they said because I didn’t know who else to trust.”

With the support of her midwife, Mary resisted the pressure from the doctors to agree to a cesarean for three hours and remembered not being tired from labor but rather exhausted from fighting them. She felt helpless while trying to make an informed choice for her birth: “I don’t know how to read these things...I don’t know what they are looking at, so I was alright do what you have to do.” Eventually Mary agreed to the cesarean and sacrificed her dreamed-of birth in order to protect her daughter. She followed the doctor’s recommendations but felt “the excitement turned into panic and real fear because I have never ever had surgery in my life, so I was truly afraid not just for her but also for me and I didn’t know what was going on.”

She felt violated due to the forceful way she was “manhandled” during the procedure, which increased her feeling of loss of control. The epidural anesthesia was “weird because I could not feel anything” so she experienced a loss of control over her body, feeling disconnected from it.

The intimate and human face of birth was lost for Mary due to the mechanistic approach to her and her birth. She was not allowed to hold or touch her daughter “and they put her on me for half a second and then they took her away...I just remember looking at her feet and struggling to see her because I just saw her for a second and they took her.”

This abrupt approach led to Mary’s feeling of helplessness as a mother due to her inability to caress and comfort her daughter. She acknowledged the ambivalence in her feelings postpartum: “that’s how I felt, kind of violated, like sad...I was very sad and right after the surgery I was sitting in that dark room I remember crying and feeling just very sad.” But she also experienced joy and relief because her baby was born healthy: “so once I saw her I was extremely happy, not happy with the birth but happy that she was fine...”

In her second birth Mary was prepared to face another surgery, “so when I went in I was totally ready...” In an effort to protect herself from another disappointment she disconnected from her emotions, “and I remember kind of not feeling anything.” Mary described feeling dissatisfied with the whole birth experience because it felt so unnatural to schedule her son’s birth instead of going into labor naturally. Not knowing the sex of the baby brought some normalcy in the birth experience: “it was awesome, so that made

it; that probably made it really nice for us. We made that nice for us. They didn't." The whole experience felt strange and sterile to Mary: "I just wanted to go home; I didn't want to be there at all. I just wanted to start with us."

Reflecting on the scheduled cesarean birth, Mary talked poignantly about the absence of choice she had over the course of events: "the doctors chose it for me even though I picked the date...I don't know but there was sadness..." Her sense of control and agency was restored after she left the hospital "...and when we got home I was like OK, we're good."

Furthermore, Mary blamed herself for losing agency during childbirth, and she felt at fault for not asking the right questions so she could make an informed choice about childbirth:

I didn't do any research; I didn't even know how to look for anything...I pretty much surrendered to the system because I didn't know. It's a horrible experience and nobody is held accountable for it. So you hold yourself accountable for that because who else is going to take responsibility?! You, you did it!

Grief and disenfranchisement

Mary felt incomplete and her grief followed shortly after her first birth. The lost ability to do simple daily activities such as climbing stairs or carrying her baby triggered Mary's grief postpartum: "...just sitting on the stairs with her in my arms, crying like I

can't believe this just happened." She felt helpless and crippled by her cesarean and "I felt like I was violated...like this was a crazy nightmare for me and now I am home alone with her."

After her second cesarean birth Mary put her grieving on hold. Although she felt sad due to the lost natural aspect of the birth of her son, she did not reflect on the experience until years later: "so probably when he was four or five I started thinking that I had choices about the birth and that made me sad." She turned her disappointment in herself into anger toward the medical establishment. Mary felt "taken advantage of and really mad...I had rights and you didn't tell me about them. Why would you do that to me?!" She acknowledged that her doctor was in a powerful position compared to her and she expected that he would have guided her toward making an informed decision:

And I don't think that is right, because you know as a doctor and an educated person you see a young girl come in you should be like – listen, you have these options; what steps do you want to take and how do you want it to happen. And it might not be perfect and I might have to do this, but this is how it might look like. That's what they should've done and that would make my life and my experience a whole lot different.

Moreover, because of the loss of trust in the medical system Mary decided not to have any more children: "...both my husband and I wanted to have more children but that's not the way to do things. I guess that impacted our decision not to have any more kids."

Mary's husband was very supportive of her but could not understand or feel her grief. Mary silenced herself and her feelings: "I actually did not talk to anyone. No one to talk to." Therefore, she felt alone in her mourning and further self-disenfranchised in her grief, which contributed to the unresolved grief she experienced years after the births of her children: "I don't know if I had processed it yet. I still feel guilty about it..." Because nobody asked about her emotional state Mary never spoke about her feelings of loss and grief: "...what would be wrong with it?! I thought that's how it is done."

Re-claiming her voice and reconciling with a difficult birth journey

Years later after Mary found like-minded people, felt validated in her feelings and re-claimed her voice: "always question everything, always question it and I don't care what people think..." Mary found posttraumatic growth stemming from her suffering "because I felt that violation and disempowerment I am not going to have that for my kids." Embracing her losses and self-validating her experiences of grief gave Mary new trust in herself: "I try to stay in the middle, not biased and I think that makes me a better person and a better mom." The loss of control and agency during the births led to self-empowerment years after the births: "that woke me up really...I wanted to be stronger, somebody who's not going to take crap from no one." Her voice became stronger "and when they tell me it's not a big deal I tell them you don't understand unless you go through it..."

Sarah

“Like I disappeared then, I didn’t matter then for twelve other people in the room.

How’s that possible?! I just disappeared...”

Sarah is a 41 year old, single, Caucasian woman who gave birth to her son two years ago via c-section.

The dreamed-of birth

Sarah planned to give birth vaginally, and to maximize her chances for an undisturbed birth she chose a midwife. Because Sarah did not have a partner at the time of the birth she made sure she had supportive people as part of her birth team – her mother, her friend and a doula. She prepared for an unmedicated vaginal birth and felt confident in her ability to birth her son.

Experiences of loss during childbirth

Contrary to what she had envisioned about her birth, the medical procedures started from the moment she entered the hospital. Despite her refusal to have an IV the hospital nurse insisted on putting a stent in her hand and “said we are putting it in anyway.” Sarah was astounded by this open disregard of her agency and autonomy over her own body: “I thought I was allowed to say no to whatever I want to say no to.”

Sarah blamed herself for the loss of agency: “I tell myself that I am dumb for giving away my power.” Furthermore, Sarah’s loss of her personhood culminated during the c-section and the immediate postpartum experience. She recalled feeling so alone,

unheard and isolated, “like I disappeared then. I didn’t matter then for twelve other people in the room...How’s that possible?! I just disappeared.”

She asked the nurses around her if the baby was a boy or a girl but nobody answered, “so the way I found out it was a boy or girl I overheard nurses talking and they said ‘he’. Like really?! You can’t go - It’s a boy! Congratulations?!”

She could not advocate for herself because her sense of self was shaken: “why didn’t I stand up for myself? Why didn’t I...I gave my power away...” She acknowledged that she did not have the sole responsibility for her birth experience and that her midwife and the hospital were hostile and unsupportive, but she still believed that she could have changed her experience if she advocated for herself: “I put my trust in her and instead of listening to my body I followed her.”

Sarah described her profound feeling of loss of connectedness with her midwife. Even more, the midwife tried to suggest that Sarah “failed” at her vaginal birth by saying “well, you pushed wrong in the first hour”. Sarah internalized the midwife’s words and blamed herself for not birthing the right way, but later she was able to “start to put all the pictures together and realized it was really my midwife who didn’t do it right.” Yet, she still doubted her ability to birth vaginally and felt anxious about her next birth:

It made me less confident in my ability to do this again. Before I was like oh, I am so strong, I can do this...and now I am like I don’t know if I can do this. Maybe my body is flawed; maybe I do need a c-section like my mom said. Maybe...

After Sarah's negative birth experience she doubted her womanliness: "maybe I can't give birth, maybe I am not really a woman...at least not a complete, functional woman..." She felt abandoned, like she did not matter, and isolated: "So they wheeled me back to my room and it was empty. And my first thought was I guess they are all looking at the baby." Her mother and her friend were asked to leave the room once Sarah was taken to surgery but she was not aware of that:

I was all alone. I didn't know they wouldn't let them back in so I just thought they were all paying attention to the baby and it was so weird because before everybody was surrounding me and now here I am all alone and I was shaking from the meds. It was like...I was abandoned.

Grief and disenfranchisement

Sarah's midwife showed neither compassion nor empathy toward her and her feelings postpartum: "so my midwife came in and I started crying...and her response was 'Oh, here come the tears!'" Later on Sarah received a similar message from her therapist who was not as cold as her midwife but still failed to recognize the significance of Sarah's lost envisioned birth: "...I feel she is like 'well, you have a healthy baby and everything worked out, everything is good' She doesn't seem to understand." Sarah continued, "...but I could feel the 'you had a healthy baby' and not that she did not care but I don't know...I think a lot of people just don't understand."

Sarah internalized this message "and part of me, I want to feel this way too. I feel guilty for feeling bad that it didn't go the way I wanted it to go." She silenced herself

because she got little understanding even from her family: “I felt very isolated and keeping in the feelings I have.” The inability to openly grieve and share her losses with others complicated Sarah’s grieving process and left her with unsettled feelings including shame, disappointment, frustration and anger two years after the birth of her son:

I felt guilty for having the feelings I had because I had a healthy baby. I was fortunate because I had a healthy baby so why should I complain because I was treated poorly?!

Re-claiming her voice and reconciling with a difficult birth journey

When reflecting on the difficulties describing the lived experience of her birth, she struggled to find the words: “I want to have a healthy birth instead of disaster. And I don’t want to call it a disaster because I have a healthy baby! It wasn’t a disaster but it was a disaster!” Her healing process was hindered, and she struggled to create her post-loss narrative: “it feels just as raw today as it was then” and “...maybe it’s a little bit better but not that much because I still don’t have any answers.” She felt guilty for still needing to talk about her negative birth experience and blamed herself for being faulty at it: “...for the longest time I was like why am I not over this? Why am I not over this? Is it me? Is it because I react poorly to things?”

Composite Depiction

To create the composite depiction of the studied phenomena, I used the data from the transcribed interviews and the individual narratives. After finishing the individual depictions I put them aside for several weeks in order to allow for the incubating of ideas and understanding of the phenomena I had discovered. Then I revisited the transcribed interviews and individual depictions with a focus on characteristics, themes and categories that described the disenfranchised grief and loss the co-researchers experienced after their actual birth violated their prenatal plans and expectations. I also looked at the depictions of the participants' dreamed-of births and their actual birth experiences in order to compare and contrast them. Moving from individual narratives to the whole group, I followed the idiosyncratic method of analyzing the data from the interviews.

In an extensive field diary, I identified themes in each individual interview while transcribing and also during the interview process. After identifying themes I looked for the presentation of each theme in all nine narratives to verify its presence. I included themes represented in at least three of the co-researchers' interviews in the composite experience of the phenomena. I organized the themes into four groups for a clearer presentation: the co-researchers' dreamed-of birth, their experiences of loss during childbirth, experiences of grief and disenfranchisement, and re-claiming their voice toward reconciling with a difficult birth journey. Below I present the themes in each group by their popularity in the co-researchers' stories. Themes that were represented in the most interviews are explored first, followed by themes present in fewer but more than three interviews.

1. The dreamed-of birth

This heuristic inquiry explored the lived experience of disenfranchised grief that some women encounter after losing their dreamed-of birth. To understand their losses and grief, first I gained insight into their childbirth vision by asking the co-researchers to describe their births. While talking about their actual childbirth experiences they spoke about their hopes for labor and how they envisioned themselves and the others around them in the process. Below are the common themes and characteristics of the dreamed-of births of the participants.

Active autonomous birther

All nine co-researchers expected to be active participants in labor, to make informed decisions about their own and their babies' care and to have a central role in the process. Maggie said she "wanted to be able to walk around and squat, and do all those things..." With her last birth she "wanted to labor even though I knew that the end result it's going to be the c-section. It was like I needed to know that I can get through the pain of it; that I can get through the experience of it and I can do it." Sarah talked about her self-confidence as being an active birther. Prenatally she firmly believed in her ability to birth her son: "...it's a natural process; our bodies are meant to do this. I had confidence going into labor and his birth and I had the plan to do it all natural." Elizabeth hoped that she would be able to experience "that essence of womanhood" which she believed was represented by the unmedicated vaginal childbirth she had planned for. Thus all

participants prepared and expected to be able to actively birth their children, and when that did not happen, they saw it as a personal failure.

Agency

As part of their sense of being autonomous adults, all co-researchers approached childbirth expecting to be respected participants in the decision making about their medical care. Sarah expected to be able to decline medical procedures. Andrea, too, expected that any medical concerns would be discussed and that she would need to give informed consent to medical procedures based on the information provided to her. Mary and Maggie expected to decide how their labor progressed but were not consulted about the course of their pregnancies and labor. They both shared feeling coerced to agree to procedures of which they had little information. When the participants were not able to assert their agency and autonomy they felt violated, helpless and out of control over the events of childbirth, resulting in their grief postpartum.

Labor

Despite understanding that birth is unpredictable, all of the participants had some mental images of their labors, often influenced by their mothers' birth stories. All of the nine co-researchers expected to have uncomplicated vaginal births. Most of them also envisioned unmedicated and undisturbed labor, which they referred to as "natural birth." For Elizabeth a c-section was not an option, and she referred to it as "my greatest fear."

She envisioned her “natural vaginal birth with no drugs... I was looking forward the contractions to come, and being able to experience all the pain and work with it. And the vision I had in my mind that I would be able to see him crowning and, like you know, be able to grab him as he came through and bring him to my chest...” Similarly, Andrea sought a natural birth. Her plan included “... to try to obviously not to be induced, to try to have her as naturally as possible, medications – I would try to go as far I could before I got an epidural. Obviously definitely didn’t want a c-section.” Kaya believed that her birth would be rapid like her mother’s. She also recalled “I had imagined that my birth will be on all fours, I will be squatting, and I will have my iPod and walking the halls...” Like Kaya, Mary expected short and uncomplicated labors: “I was expecting a lot...to be perfect. I knew that there is going to be pain, you know, I expected that but I didn’t know what kind of pain exactly because I was young and kind of learned on my own. But I expected a natural easy birth because my mom had scary easy births, very quick so I kind of expected that.”

Other participants like Maggie and Liz each envisioned a serene birth experience and environment. Maggie’s birth vision included peaceful and intimate family centered event where she can feel at home. Choosing a birth center, Liz wanted and planned for laboring and giving birth in a homey environment. She and her husband wanted to avoid the over medicalization of childbirth which often happens in hospitals. With her second baby she planned and prepared for a homebirth due to lack of birth centers near her home, which supported a vaginal birth after cesarean section. Overall, participants had clear expectations of their labor and birth processes that were unmet for varying reasons.

Being supported while in labor

All participants in the study expected and wanted support from their partners or birth attendants while in labor and during the immediate postpartum period. Some of them decided to share the birth experience only with their husbands (Mary, Kelly, Lynn and Andrea) and others had a birth team including friends, mothers, doulas and their partners. Nevertheless, all of the co-researchers shared the same expectations of being emotionally and physically supported while birthing their children.

The golden hour.

The golden hour is the immediate time after the birth of the baby that is marked by skin to skin contact between the woman and her newborn and undisturbed quiet time for bonding and nursing. All co-researchers expected and planned for immediate contact with their babies. Kelly envisioned intimate private time with her husband and their newborn son: “I wanted at least two hours, no one but me, my husband and my son.” Maggie and Elizabeth thought they would be able to pull their babies onto their chest right after they were born. Lynn believed that babies should not be separated from their mothers: “I feel that you should put that baby on the mom as soon as she could hold him.” Liz, despite the scheduled c-section birth of her firstborn, expected to have him with her immediately after the surgery “but I think it could’ve been a different experience if I was able to touch him and hold him, you know. And I don’t see any reason why that couldn’t happen.” Kaya envisioned the golden hour as the baby doing the “breast crawl” undisturbed by any hospital procedures so she could spend as much time as she needed

just bonding and “taking it all in.” Maybe because all of the interviewed women expected and prepared for uncomplicated vaginal birth they also envisioned being able to touch and hold their babies from the moment of birth. Unfortunately this was the most common violation of the dreamed-of birth.

With the exception of Kaya, Liz (during her second birth), and Maggie (during her third birth), all participants experienced a loss of their envisioned first moments with the baby at the expense of their initial bonding. Lynn was still deeply disturbed and angered by the hospital procedures that interfered with her first moments with her son. During her first birth Liz did not understand the reasoning behind the separation from her child after the surgery: “why couldn’t the baby be where I am? No, instead I am sitting in the room by myself waiting so I can move my toes (angry).” Maggie and Elizabeth each shared very similar frustrating experiences as the hospital and the staff interfered with their bonding time with their children. For Maggie “the whole experience at the hospital was terrible and just not pleasant and there was a lot of negativity and that sort of spirit.” Elizabeth felt a profound loss of these first moments with her son: “I don’t know how long an hour- two hours he was back with me again but it was like being robbed (sighs). I just wanted him there. I just wanted him with me.” Andrea and Kelly experienced impaired first bonding with their children due to complications during labor and the difficult recovery afterwards. For all of the co-researchers the loss of the initial bonding experience was the most difficult. For some participants, years had passed since the births of their children, but their feelings of disappointment and grief were still very strong and as raw.

2. Experiences of loss during childbirth

The themes that are depicted in this part of the Findings chapter represent the common losses of plans and hopes for the envisioned births that the co-researchers experienced during labor and the immediate postpartum period.

Lost sense of autonomy and agency / Loss of control

The loss of agency and autonomy was profound throughout all narratives and especially in those participants who gave birth via cesarean section. The loss of agency was interwoven with the sense of loss of control for participants; therefore I presented them in the same theme. Kelly experienced the loss of agency as a loss of presence during labor and immediately postpartum because she was heavily sedated. Additionally, no one noticed her semi-conscious state: “I don’t think that anyone really noticed. I often wonder why they didn’t notice anything... (crying)”. Similarly, Sarah experienced a loss of agency as she tried to engage with the medical professionals but was not heard. Liz also shared an experience of “disappearing” on the operating table as the attending team conversed about Christmas shopping and disregarded her presence. Liz reported feeling being subjected to “the hospital standard procedure” and she felt dehumanized and objectified by the way she was treated by doctors and staff. Likewise Mary felt objectified and talked about the lack of control of what happened to her and her babies in childbirth. She felt powerless and helpless due to the way she was treated as well as “kind of violated”.

Maggie spoke about the loss of presence and agency that she experienced during the birth of her second child. Postpartum she felt disappointed in herself for “not sticking up for me, for not sticking up for my baby, for not doing what was right for us.” Sarah too blamed herself for surrendering control to the medical professionals “and it was like I put my trust in her, like I gave my power away. Because I didn’t know any better, because you are exhausted, because you are in pain, you wanted to be over.” Overall all co-researchers who experienced the loss of agency during their births reported feelings of helplessness, confusion and guilt for allowing it to happen. They blamed themselves for losing their agency and surrendering power to the attending medical professionals.

Loss of control over the body’s functioning

As demonstrated above, for some co-researchers the dominant loss of control was the loss of their agency. Others also experienced a loss of control over their body and its functioning during labor and postpartum. Kaya’s perception of loss of control over her body early in labor became a running theme throughout her birth. The feeling of not being in control of her body’s functioning was reinforced by her inability to induce labor naturally. Elizabeth shared a similar experience of feeling failed by her body and losing control over how her body performed during labor. For Lynn, her body’s reactions to the afterbirth hormones and the medications she was given while in labor were scary and anxiety provoking. Andrea felt apologetic for steering away from the uncomplicated pregnancy and birth and having issues with her placenta not detaching from the uterus. These examples illustrate how participants perceived their labors and assumed

responsibility for not being able to encourage their bodies to do what was expected by the attending medical professionals.

Loss of control over childbirth

Another loss of control the participants experienced was the control over their labor. Even though childbirth is a life force that is unpredictable and uncontrollable, most of the participants believed and expected that they were well prepared and would have control over the events of labor and birth. When this did not happen they were left disappointed, confused and scared. Kaya panicked the moment her water broke because she knew that this happens very rarely and she did not expect to have to deal with it. Her efforts to induce labor and manage its course failed, fostering a feeling of “doing it wrong”. The loss of control over the course of childbirth reinforced her previous fear that the world is not a safe place. Similarly Liz felt confused and cheated out of an experience she believed she would have had if she followed her instincts: “I did the natural thing, what you are supposed to do, and it did not end well at all.” Elizabeth too felt confused about not being able to experience vaginal childbirth despite her efforts to apply all the skills and tricks she learned in childbirth preparation classes. Similarly, Mary and Sarah felt helpless and angry with themselves and their teams after they could not experience vaginal birth after all the hard work of labor.

Loss of the feminine self

Another profound loss the co-researchers talked about was the loss of their self-image as being able, active birthers, and for some, a loss of their feminine self-image.

Kelly could not experience the birth of her son due to the sedation during her cesarean surgery. She felt "...in some ways like I am less of a woman." Sarah experienced a loss of her feminine self after her labor resulted in a cesarean and started doubting herself and her ability to give birth. Similarly, Elizabeth felt that she lost her feminine self and power. She had experienced this loss before the birth during her efforts to become pregnant and carry a pregnancy to term. She described a difficult "uphill battle." She hoped to reclaim her feminine self through childbirth, but this was overridden by the very reality of her labor "you feel much betrayed by your body as a woman... it just makes you feel so not feminine and freakish." Maggie also doubted herself as a woman and lost the self-image of the woman she thought she was before the births of her children.

For most of the co-researchers (six out of the nine participants) the loss of their feminine selves due to disappointing childbirth experiences negatively affected their sense of being good mothers and caused additional grief postpartum. Lynn and Mary doubted themselves and their ability to be good mothers due to not being able to give birth "naturally." Also Maggie and Liz experienced confusion and mistrust about their mothering skills due to not following their beliefs in childbirth and surrendering their power to the attending professionals.

For some participants, including Kaya, Elizabeth and Sarah, the self-image of the good mother was not connected to the self-image of the able birther. Stepping into the role of the good mother postpartum gave them back their confidence and for Elizabeth even restored some of her sense of her feminine self: "I recognize that in my mothering I am very feminine. That is what helps I think to restore my sense of womanhood." Therefore they found healing in their mothering and felt supported by others in it.

Lost relationship with the provider

The relationship with the medical provider marks another relationship impacted by the loss of the dreamed-of birth. Some of the women reflected on the lost relationship with their providers while thinking about their lost agency and power during the birth. Other co-researchers reflected on the lost hoped-for relationship with their providers that they never established. Mary felt this loss later when she reflected about her childbirth experience in order to make meaning of it: “educate me then if you think that I am so stupid. Because that’s how he made me feel, then tell me what you want me to know, help me out.” Liz felt abandoned by her providers and she lost trust in them due to miscommunication and a non-empathic approach. Elizabeth and Sarah both experienced a loss of trust in the overall medical system due to the disappointing relationships with their care providers.

None of the co-researchers talked to their providers about the ways they were treated and what their experiences with care were during childbirth. Some of them tried to justify their providers’ actions and explain their behavior as a function of the way Western childbirth is organized. Mary said “I am sure that doctors believe that whatever they do is good and for your good, so I don’t think it is just the doctor but the whole medical system.” Liz also had an understanding of the defensive medicine her doctor practiced and how the choices that were made in her first birth were driven by liability and litigation concerns rather than by her wishes or plans. In conclusion the loss of a relationship with the birth attendant affected the co-researchers’ attitudes toward the

medical system that their providers belonged to and, in some cases, drove future reproductive decisions.

3. Grief and disenfranchisement

Grief and mourning the loss of the dreamed-of birth

The participants started experiencing grief at different times. Some of the co-researchers, including Mary, Kelly, Elizabeth, and Lynn, reported grief over their childbirth experiences immediately after labor ended. For other co-researchers, including Andrea, Liz and Sarah, the grieving process started later in their postpartum periods. Mary (after her second birth) and Maggie shared that they did not allow themselves to grieve and ponder their childbirth experiences until a few years passed. Sarah shared feeling “frustration, disappointment, a lot more anger.” She also wondered how long her grief over her lost envisioned birth would last. Kelly struggled to find words to describe her grief and called it a “heavy feeling” that gets triggered every time she sees a picture of the birth of her son. She acknowledged that her active mourning has changed with time and has weakened in intensity. At the time of the first interview she found herself in “a limbo when I am with my grief as I said my son is absolutely amazing, but then if I am alone and if I look back at pictures it takes me kind of back to that place of not such heavy grief that it was at first but I still feel that (pauses) I can’t believe I didn’t have it. And I don’t know if I ever will 100% get there but it is getting better little by little.” Kelly understood the grief as slowly weakening its intensity but becoming part of her and

her childbirth story: “it is still part of my experience and not that I would ever forget about it but even though it didn’t go perfectly as planned that’s still part of it.”

For Andrea the grieving started immediately after labor was over as she realized that this moment “should be so happy and I don’t feel it was at all. That is kind of a stick out moment – why am I not enjoying this? It was like a sad moment. And just angry really and sad.” Mary recollected similar sadness washing over her after the cesarean surgery was over and she was left alone in the recovery room. Lynn, too, remembered feeling devastated after the loss of the vaginal birth she planned because it also meant losing her dreamed-of large family.

Maggie started thinking about the birth once she was discharged from the hospital, recognizing her grief as “not feeling happy; I don’t know if that makes sense but it didn’t feel right. Everything was not settled, there was no that warm and fuzzy feeling.” Later, when she compared her births and talked about the healing that occurred with the last one, she admitted that she was still actively experiencing the grief about how the births of her first two children went and wondered if others had the same experiences. She wondered how long her grief would last and if she was coping with it properly.

Even though the co-researchers had different timing of their grieving and took different routes on their healing journey, they all reported similar feelings of being sad, overwhelmed, lost in their grief, angry, and guilty. All of them believed in being supported in their grief and stated that the lack of support from others led directly to alienation and disenfranchisement of their grief.

No time for grief.

Some co-researchers reported that they could not find the time and energy to process their grief about the lost dreamed-of birth. Kaya shared not being able to think about her disappointment or grief because of the imperatives of keeping up with her baby's needs postpartum: "I've been so sleep deprived and so focused keeping him alive (laughs), the biological imperative to take care of him that I haven't had a chance to think about myself or think about what happened." Liz, too, situated her grief in the time after the immediate postpartum period was over because she was "...so caught up in doing the stuff that needs to be done that I think it wasn't until a little bit later." Mary also put on hold her grief after her second birth "until years later when I started researching things and meeting with people who were getting into more natural lifestyle, so probably when he was four or five really and then off and on it bothers me." The demands of mothering or dealing with the daily living tasks consumed the mental energy of these co-researchers; therefore they sometimes delayed processing of their feelings.

Societal disenfranchisement of women's loss and grief

At times, family members, friends and professionals, dismissed the co-researchers' grief and related feelings, leading to their sense of disenfranchisement. Sarah's first encounter with others' lack of understanding of her feelings was with her therapist who tried to re-focus her attention on "you have a healthy baby" but these words were perceived as being dismissive. Her mother also did not understand where Sarah's grief was coming from because her son was a healthy, happy kid. Sarah felt that her

mother and her therapist “don’t get it. I don’t know I think a lot of people just don’t understand.” Elizabeth also felt invalidated and disenfranchised in her feelings by her closest family members, including her sisters and her husband, who told her to let go of her grief: “but none of them are inside my skin, none of them have that experience of (sighs) you know, desiring to feel feminine the way I do, the way I have longed for certainly in the most of my adult life.” Elizabeth felt that, by normalizing her cesarean section and not offering support, her family disenfranchised her losses and therefore did not allow for her grief to unfold.

Kelly also experienced a dismissive attitude toward her emotional pain after sharing with a friend the difficult time she had with accepting how her birth went. Despite the fact that Kelly could see past the words “at least you have a healthy child” and agreed that she is truly blessed to have her son, she felt that people reacted with a lack of understanding toward her emotional pain: “in essence – get over it, not that they would say it but I think in some ways they would be thinking it like is it really that important?” Liz shared her experience of struggling with societal taboos toward talking openly about childbirth and its complications, especially if one has negative feelings toward the childbirth experience. She also heard the dismissive words “at least you have a healthy baby, that’s all that matters.” Maggie experienced the societal disenfranchisement of her feelings as not only being dismissive and invalidating but also as mirroring her experience of being objectified during labor:

Oh, yeah there were comments, and they weren’t nice (laughing). Like let it go or at least you had a healthy baby and everything is fine. And they are just dismissive, it just didn’t give you any, you know, it doesn’t make you feel

important. It makes you just... again you are just a vessel, you should be happy because the baby's here.

She acknowledged the need for empathy and validation from others as essential to healing. Maggie also spoke about the ambivalence toward the childbirth experience and toward her baby postpartum. Years later, during our interview, she self-validated her feelings of being happy with her baby but unhappy with the way she was born.

Self-disenfranchisement

For most co-researchers the societal disenfranchisement of the grief and loss they experienced in childbirth resulted in self-disenfranchisement strengthened by feelings of shame and guilt. Sarah blamed herself for having the negative feelings toward her birth experience due to the often mentioned phrase “at least you have a healthy baby.” She isolated and silenced herself because she felt ashamed and guilty for having those feelings. Kelly shared very similar feelings of guilt and shame for having the grief she did. Kelly’s self-disenfranchisement triggered feelings of aloneness in her grief and self-doubt about whether or not her birth experience was traumatic enough for her to be upset about it. She struggled to situate her postpartum feelings: “I feel like I don’t belong in any category, I don’t have a postpartum depression and I don’t necessarily have a happy experience. Again I am in limbo.” She also acknowledged that she had not shared her grief with anyone but her husband “because I am just so ashamed that I feel that way.”

Liz, too, struggled to situate her birth experience and allow herself to be upset about it even if it is “not traumatic enough”. She continued: “I guess I never thought that

my stuff was traumatic enough... and I guess in some ways that can be sort of (looking for the word) disenfranchising. Oh, this was little traumatic but I guess not traumatic enough (laughing).” Mary “did not talk to anyone. I talked to my husband and that’s it and he doesn’t understand because he couldn’t...” Likewise Andrea felt so ashamed for her “failed” breastfeeding relationship that she chose not to share her feelings with anyone: “I can’t really think of anyone (crying) but I did not really reach out to anybody either because I just felt like I wasn’t really giving it my all, I was just half-assing it (keeps crying). Yeah, it was very lonely for sure.” Elizabeth found herself self-silencing due to a lack of understanding by others toward her feelings of the importance of vaginal childbirth “because it is just not worth trying to explain to people who don’t get it, you know.” The self-disenfranchised grief triggered feelings of shame and guilt which further isolated the co-researchers and marginalized their experiences.

4. Re-claiming her voice and reconciling with a difficult birth journey

Here I present themes that emerged about the co-researchers’ efforts to find meaning in their childbirth experiences and re-create their narratives. This process was part of their reconciliation with the actual childbirth and letting go of the dreamed-of birth, which often resulted in re-gained power and voice to tell their stories as they experienced them.

Re-creating the birth narrative/finding new meaning

In an effort to understand what led to her cesarean birth, Elizabeth met with her doctor postpartum. Despite the lack of a clear reason for the induction and the cesarean

intervention, this meeting helped her feel calmer and more accepting of her birth experience. Liz explained that having a plan for childbirth is a normal thing to want and strive for but also that one has to remain open for surprises along the way: “I guess you have to come up with some plan you can’t just completely wing it. But it is really hard because there are whole lot of factors that go into it.” Lynn shared her process of coming to terms with her cesarean birth as she wondered about the factors that played a role in her birth: “that it was kind of meant to be because her cord was wrapped around her neck. What if I had the vaginal? May be it was meant to be...” Andrea, too, saw the circumstances around her hemorrhage in a different light and forgave herself for not being able to breastfeed because complications made it impossible for her body to produce milk. Other co-researchers also offered different interpretations of their childbirth experiences as they strove to understand them better and validate their grief and losses.

Reclaiming her voice

The act of participating as co-researchers in this study reaffirmed participants’ previously gained power and voice. Sarah re-claimed her power and voice while talking to me during our first meeting as she condemned the way she was treated during the cesarean surgery: “it was wrong, you just gave life, why should that be important (sarcastic).” She also voiced her opinion about poor hospital treatment in a survey she received postpartum.

Kelly, too, regained some of her confidence and sense of control postpartum by practicing control in her mothering and other relationships: “and I think part of it has to do with how powerless I felt before and now I know that I have that power that I can say no, this is my son; I am doing it this way. And I don’t need to apologize for it and you have to accept it.” Because of her difficult experience she felt “more empowered, and I feel that I am gaining back that strength and power that was kind of stripped from me before.” Likewise, the difficult and disappointing birth gave strength to Elizabeth postpartum, and she stood up for what she believed was right for her and her baby: “and I finally was like you know what, I am doing this and if you are not going to support me I need you to just stop talking altogether.” She also demanded more empathy and compassion from her husband who had hard time understanding her grief about the cesarean section.

After the life threatening complication of her labor, Andrea felt that “it made me stronger. I feel like, especially now when my daughter is going to be turning a year old, I feel like I can do anything.” She embraced the difficult childbirth experience as it strengthened her coping capacities and turned her into “a great mom.” Enduring the difficult recovery affirmed her strength and helped her respect her body even more for being able to recover after a severe blood loss and brain swelling. For Liz, her unassisted birth brought empowerment and newly acquired self-confidence: “I kind of felt proud of myself.” Lynn also found the empowering part of her birth despite the fact that it did not go as planned. She validated herself as a birthing woman: “and I have a longer recovery with c-sections than other moms who do the vaginal birth, so that made me feel like you know what, you did it, you did just as hard work as they did.” Hence, it seems that most

of the co-researchers were able to find their strength from enduring a birth that did not go as planned and by allowing themselves to grieve that loss of the childbirth they had envisioned.

Post-grief growth

Some co-researchers' post-grief growth enriched them as people and changed their world views. Kelly admitted that the impaired bonding and the loss of presence during her son's birth helped "turn me in a different direction because I probably would've been at work right now working my twelve hour days if it wasn't for the birth and not having this. And I think now...I think now I do feel like a good mom. I do." Similarly Andrea found wisdom and growth in her experience of grief after losing the dreamed-of birth: "What I learned is not to hold on any of the loss because everything was what I wasn't expecting, you know. It's just it is what it is, I can't really help what happens chemically or biologically, so... I am totally fine." Lynn, too, shared that the childbirth experience humbled her, and she surrendered to the idea of having little control over what comes.

Maggie similarly felt that the childbirth experience made her stronger and more resourceful "because it gave me the know-how to speak up for myself. And now even it's giving me like a voice that I might've not had before with my kids." Mary shared the same understanding of growing stronger by going through the difficult birth and grieving the losses she experienced. She found truth in the saying "those kind of experiences make you stronger." Mary found herself becoming more assertive: "I just was a follower and I

don't want to be like that anymore. After that experience that woke me up really." Once experiencing the difficult birth journeys they had, Kaya and Lynn felt connected to "every living creature [who has] ever given birth". The post-grief growth reported by co-researchers turned them toward advocacy, education, and support of others whose childbirth experiences mirrored their own.

Summary

This chapter presented the findings of my research into the lived experience of disenfranchised grief following the loss of the dreamed-of birth. Even though their labors presented with different characteristics and all nine co-researchers had diverse childbirth experiences, common to all was a sense of loss when the birth they had envisioned was violated by the actual birth experience.

Their narratives revealed that such violation of expectations came from different sources – the course of labor and the unpredictability of childbirth; the support or the lack thereof; the environment in which women gave birth; and their subjective perception of control, agency and safety during childbirth. All co-researchers eagerly shared their postpartum experiences of grief and the lack of understanding and disenfranchisement they were subjected to by others and by themselves. The disenfranchisement of their grief and loss deepened their feelings of shame and guilt, and weakened their sense of self. These unfortunate outcomes notwithstanding, many of the co-researchers reported

gaining a sense of increased agency, self-confidence, and reaffirmation of their identities as capable women as a result of their reflective processing of their disappointing births.

In the following chapter I present how these findings contribute to the existing literature on women's biopsychosocial responses to childbirth. Based on my findings, I also make recommendations for clinical social work practice, education, policy formation, and future research. Additionally, I make some suggestions for improving birth practices and childbirth education.

V. Discussion

The discussion chapter summarizes the findings of my heuristic inquiry into the lived experiences of nine co-researchers' disenfranchised grief after the loss of their dreamed-of birth. In addition to comparing and/or contrasting my own findings to those reported in related scholarly literature, I offer recommendations for general medical obstetrics practice, for clinical social work practice and education specifically, and for future research.

The findings from this study portray the unique experiences of grief and loss of the co-researchers in their richness and variations. The participants of the study were at different points in their processes of coming to terms with disappointing births, which allowed for broader and more diverse descriptions of the grief and the reconciliation

processes. Some participants talked about childbirth experiences that were years ago, others gave birth seven or eight months before their participation in the study. Some of the women experienced grief immediately after the birth, others put the grief and reconciliation on hold for months and even years to protect themselves from emotional pain or to immerse themselves in mothering duties. Participants were at varying stages of mourning; some still experienced ongoing grief and others expressed that the process was over. Despite the differences, the co-researchers presented similar experiences of loss during labor and postpartum, and shared experiences of societal and self-disenfranchisement of their grief and loss.

1. Study findings and existing literature on maternal reaction toward disappointing childbirth experiences

Childbirth expectations and the dreamed-of birth

I approached the studied phenomenon with the understanding that the dreamed-of birth is one with certain objective characteristics such as a vaginal birth, or with minimum or no medical interventions, or within certain amount of time. While some of the participants described expectations that the birth would be short, or would start before the due date, and so on, their main expectations and hopes were for labors and births wherein they were active participants. As some of the co-researchers mentioned in their interviews, it was not the method of birth that upset them the most but the ways they were treated by hospital staff or birth attendants and the experiences of being passive patients. Maggie compared herself with being “just the vessel” and felt that she disappeared from

the reality of birth of her children. Hence, my understanding of the dreamed-of birth gradually evolved to include not the objective characteristics of the birth itself but the ways women hoped to be treated during labor and postpartum; the roles they hoped for during their children's births; the relationships they envisioned with care providers and partners; and their first moments with their newborn babies.

While all of the co-researchers had expectations of vaginal or natural birth, this type of birth was not only the way the baby would be born, but encompassed the women's hopes of having a central active role during childbirth. All of the participants prepared for such roles and believed that having their birth attendants and partners present at birth could guide them and would support them in directing the birth of their children. This view of the dreamed-of birth is similar to the "good birth" characteristics, which Lyerly (2013) describes after interviewing 101 women and 30 practitioners. Additionally Goldbort (2009) found what mattered the most to women in childbirth was care, connection and control, and the absence of these led to negative feelings postpartum. These findings were mirrored in some of the co-researchers' experiences of loss of control during their technocratic childbirths that left them feeling disempowered and helpless.

Additionally, researchers such as Darra and Norris (2008), Jordan (1997), Katz-Rothman (2007), Lally et al. (2008) have argued that women are groomed into a culture of fear of childbirth by the dominant authoritative medical knowledge. Many approach labor with apprehension and even expectations for trauma. Only two of the interviewed participants shared such feelings when remembering their emotional states in the early stages of labor. The other participants reported positive expectations and hopes for

natural childbirths. It is surprising that, despite the dominant technocratic culture of childbirth in U.S., they created a different vision for their birth experiences, which unfortunately led to grief and disappointment when these plans were overturned by the reality of contemporary American birth practices.

These findings contradict previous quantitative research findings that suggest a correlation between positive prenatal expectations and high satisfaction with childbirth (Ayers & Pickering, 2005; Green et al., 1998; Green, 1993; Harwood, et al., 2007; Hodnett, 2002; Waldenstrom et al., 1996). Rather, my findings align with those of qualitative studies which reveal that, in the majority of cases, women's expectations and hopes for childbirth were left unmet (Beaton & Gupton, 1990; Gibbins & Thomson, 2001; Halldorsdottir & Karlsdottir, 1996; Hallgren et al., 1995; Malacrida & Boulton, 2013; Soliday, 2012). Conducting my research with co-researchers who were at least six months postpartum allowed for enough time to pass after the childbirth experience and thus avoiding the halo effect of the birth--a variable which may have affected the overall high satisfaction scores in the previous quantitative studies. Therefore, the findings of this study portray the grief women had following their unmet childbirth expectations and allowed for clearer presentation of their postpartum process of relinquishing the birth they had envisioned.

Giving birth while experiencing a loss

Disempowering and dehumanizing experiences in labor are often referenced in the research literature critiquing the technocratic approach to childbirth (Davis-Floyd,

1992, 2001; Kitzinger, 2006a; Wendland, 2007). In this study, some of the co-researchers were astounded that the medical professionals were primarily focused on the medical tools, procedures or the hospital protocols and not on the birthing women and their partners. The reported lack of attention to the subjective experiences of the women giving birth culminated in the loss of agency in the experience of the participants of this study, often generating profound feelings of grief, anger, and inadequacy.

Furthermore, most of the co-researchers perceived the loss of agency during childbirth as a loss of humanness and selfhood, a finding also reported in other research literature (Baker et al., 2005; Wagner, 2001). These co-researchers reported feeling objectified by hospital staff or birth attendants, leaving them feeling traumatized and violated. For some, childbirth was the first life experience wherein they felt neither a sense of authority over their lives nor control over their surroundings. Other researchers, including Katz-Rothman (2007) and Kitzinger (2009), reported similar findings. In my study, despite previous research recommendations for tending to women's emotional reactions and perceptions of childbirth (Goldbort, 2009; Lothian, 2000, 2006; Soliday, 2012; Thompson & Downe, 2010) feelings of loss of agency and control were not acknowledged by hospital staff or by the birth attendants. With no one tending to their emotional state, many of the co-researchers felt disenfranchised in their grief. My findings and those of others suggest that the western medicalization of childbirth can leave birthing women feeling confused, disempowered, and silenced.

Virtually all of my co-researchers blamed themselves for forfeiting their agency and voice to their birth attendants or the hospital staff. Accustomed to speaking up and defending their rights in other situations, they reported feeling disappointed and angry

with themselves and felt guilty for not being more assertive in this situation. This finding echoes those of Kitzinger (2006a) and Soliday (2012), both of whom reported that women in their studies frequently internalized feelings of guilt and blamed themselves for the negative outcome of the birth experience they had hoped for.

Davis-Floyd (1992) also found that some of the women she interviewed had internalized the messages of guilt and blame they received from the technocratic and medicalized maternity care system. Therefore, they took a subjugated position to their care providers. By assuming helpless and passive roles in childbirth, many lost their pre-childbirth self-confidence and sense of self. This was the experience of the participants in my study as well. Many experienced their bodies as flawed and failing them, leaving them out of control during labor and postpartum. They blamed themselves for failing at birth when actually they had failed to accept and conform to technocratic definitions of what constitutes a “normal birth.”

Medicalized birth is so ingrained in the prevailing western view of “normal” birth that the co-researchers in my study who had vaginal births mistakenly identified their childbirth experiences as natural when in fact their labors had been medically supervised and choreographed. Other research suggests that internalizing these “failures” can go beyond the experience of birth and result in lifelong doubt about one’s own agency, decreased self-confidence, and a negative self-image (Davis-Floyd, 1992; Forssen, 2012; Kitzinger, 2006a; Meyer, 2013). For example Kitzinger (2006a) reported numerous encounters with traumatized women well into their senior years who had experienced negative childbirths decades earlier and still struggled to integrate these experiences into their lives and identities as mothers.

Another frequently occurring loss in childbirth which co-researchers reported was the routine separation of mother and child. For some, this reinforced low self-esteem and negative self-image as mothers and women. Despite abundant research reporting the benefits of immediate skin-to-skin contact and undisturbed bonding of mother and baby (Berg & Dahlberg, 1998; Gaskin, 2011; Odent, 2001) and the efforts of organizations such as the World Health Organization (WHO Department of Reproductive Health and Research, 1999) and the International Mother Baby Childbirth Organization (Davis-Floyd et al. 2011) to discourage the routine separation, all nine co-researchers in my study reported a profound loss of the first moments with their babies they had envisioned. This loss resulted in additional self-blame and guilt for not being able to stand up for what was right for themselves and what they believed was right for their children, a finding also identified in previous research (Fisher et al., 1997; Madsen, 1994; Mauger, 2000). Liedloff (1985) described how the separation of mother and baby disturbs the bond between them, triggering the mother's feelings of grief, incompleteness, and confusion, feelings also reported by this study's co-researchers. Only three of the co-researchers reported anger at the ways the American maternity care system functions. The remaining six internalized a sense of failure to protect their children and by demanding undisturbed bonding time. This was one of the heaviest losses most co-researchers reported and the one they found most difficult to integrate into their identities as new mothers.

Grief and disenfranchisement

Even though the possible grief reactions of some women to negative childbirth experiences are mentioned in previous research (Fisher et al., 1997; Hodnett, 2002; Madsen, 1994; Mauger, 1998) only one research article, Grace (1978), focused specifically on this special kind of grief. Given the frequent reports on popular blogs and other childbirth related websites of women experiencing such grief, the scarcity of scholarly research on this phenomenon is notable. In my study, viewing the grief women reported in the interviews through the conceptual lens of disenfranchised grief allowed me to better understand the societal and self-silencing of their negative feelings about their childbirth experiences.

The loss of birthing women's previous self-images was one of the main losses reported by my co-researchers. Callister (2004) argued that in birth narratives the death of the old self could be experienced as a failure and personal defeat, feelings that were experienced by all of the co-researchers. When the sense of self was shattered by the disappointing childbirth experience, some women found themselves unable to acquire new maternal selves.

In a sense, the grief my co-researchers experienced became adaptive, in that the mourning process facilitated some resolution of the contrast between the births they imagined and what actually happened. This finding appears similar to that reported by Stern and Stern (1998) of their subjects' use of mourning in reconciling the difference between their "real" newborns and the "ideal" infants they had fantasied. The grief and mourning observed in my study may have also aided co-researchers on their journey of

toward claiming their “new” selves as mothers. The reported post-grief growth which some participants of this study experienced aligns with what Gustafsson, Wiklund-Gustin, & Lindstrom (2011) found in their study of suffering and grief as processes necessary for reconciliation. They saw the process of reconciliation as the necessary ingredient in healing, achieving wholeness, and resolving grief.

Colton (2004) also saw such growth as an opportunity to connect with others and heal in community: “Not only telling our stories, but sharing our stories with others and hearing others' stories is vital to the project of transforming the experience of birth from trauma to transformation” (p.687). One of the co-researchers in my study experienced the immediate postpartum bonding with her baby as an animalistic experience which made her feel connected to “every living thing that has ever given birth” and put her back in touch with her instincts. The co-researchers echoed findings by Freedman (1999) and Mauger (1998) suggesting that the childbirth experience connects women with the collective feminine and affirms their belonging to the group of birth-giving women. Callister (2004) found out that telling their stories allowed them to connect with other women. Even the co-researchers whose experiences challenged their sense of womanhood and feminine self-image reported feeling a heightened connection with other women who had previously given birth. This happened only after they were able to validate the difficult feelings toward their disappointing birth experience and received support from others in their grief. The significance of a sense of connection with other disillusioned women notwithstanding, some of the co-researchers had difficulty finding a place or a group with which to connect. The resulting belief that no one else felt similarly about their childbirth experiences marginalized them and left them feeling alone.

By reporting their disillusion and grief, the co-researchers in this study were challenging the cultural norms of being a good patient and a good girl. Martin (2013) indicated that these cultural norms served as internal mechanisms for disciplining women in childbirth while allowing them to maintain their socially sanctioned characteristics of being nice, caring and relational. By allowing themselves to mourn and talk about their lost dreamed-of births, the co-researchers fought the societal bias that such feelings are not “normal.”

Co-researchers all discussed societal and self-disenfranchisement of feelings and experiences of grief about the way their births were conducted. Keefe (2003) explicitly makes a connection between such grief and the cultural norms requiring women to suppress and disallow negative feelings about their births. Reflective of this societal silencing, all co-researchers experienced comments from others about their grief and loss that they perceived as insensitive and hurtful. Some of them experienced the disenfranchisement of their grief as a parallel to how they were objectified and dehumanized by medical professionals during labor. When sharing their negative feelings and grief postpartum, they were reminded of the happy ending of birthing a healthy baby, as though their own feelings and emotional wellbeing did not matter. Such responses hindered their reconciliation with the lost dreamed-of birth and prolonged or complicated their process of coming to terms with their actual birth experiences.

Interestingly, none of the women in this study reported feeling they met the criteria for a diagnosis of postpartum depression. Neither did they meet the diagnostic criteria for posttraumatic stress disorder; as one of the co-researchers said, she only felt a little traumatized, but not enough for her to seek help. Another participant shared feeling

spoiled and petty for being unhappy with her childbirth, especially when comparing her experience with the experiences of other women she knew. Only two of the interviewed women sought professional help to process their negative childbirth experiences in therapy; but unfortunately their experiences of loss and grief were minimized and dismissed by their therapists. All of the rest suffered silently and alone. Their feelings of shame and guilt for feeling the way they did furthered the self-disenfranchisement of their grief.

Most of my co-researchers were cognizant of the contradictory nature of their feelings and believed that they should be allowed to be unhappy with the birth experience and happy with their healthy child. They also spoke about the differences between surviving a difficult or disappointing childbirth and being a healthy, wholesome person again, stressing that being physically healthy should not be the only goal in modern childbirth. They distinguished between the baby's birth and their own subjective experiences. This distinction is an important point to remember when educating practitioners and birth attendants on the possible emotional reactions to childbirth

2. Clinical Implications

The purpose of this phenomenological study was threefold – to understand better the experience of disenfranchised grief that some women go through after losing their dreamed-of birth in the actual childbirth experience; to create a safe space for women to talk about socially unacceptable grief; and to inform professionals who work with women during their reproductive years of a phenomenon that is common but under researched.

Changing the contemporary clinical practices of technocratic childbirth and humanizing the ways we treat women during their childbearing year and postpartum is well over due. Researchers have argued over and over again about the damaging and disempowering effect of a dehumanized maternity care system on women's wellbeing and that of their families. Applying the findings of this doctoral research to improving clinical practices with pregnant women who are preparing for childbirth, birthing women and their partners, and postpartum women and their newly grown families, can assure a comprehensive and more holistic approach to such an important time in women's lives.

Some of the co-researchers mentioned that previously sensitive themes for them arose once again during childbirth. Understanding that birth does not happen in a vacuum, and is part of women's life narrative and their feminine selves, should inform childbirth education and the maternal care system (England-Horowitz, 1998). Childbirth education should include psychoeducation about previous traumas or losses that can be triggered in childbirth. Such awareness is of a pivotal importance for adequate childbirth education and labor support. Professionals involved in childbirth need to pay more attention to mental health and spiritual and psychological aspects of childbirth so that women can feel prepared to face childbirth with awareness of various possible outcomes. These study findings suggest that an open discussion about the unpredictability of childbirth should be part of well-balanced childbirth education. Such preventative discussion would support women in surrendering control over the events of labor and help them focus on finding adequate support and resources in the face of a possibly disappointing childbirth.

Additionally, de-stigmatizing the grief that some women experience when their actual childbirth experience violates their prenatal expectations can be liberating and validating. It was clear in the study data that women did not discuss their postpartum feelings of grief about disappointing birth due to deeply ingrained cultural norms about how women should feel after birth of a healthy child. They frequently felt ashamed and guilty for having such feelings and preferred to silence themselves rather than risk being perceived as ungrateful or spoiled. Therefore, it may be helpful for medical providers and birth attendants who work with prenatal and postpartum women to be aware of the possibility of grief even if labor was seemingly normal and uneventful. The study findings suggest that if professionals do not ask about the women's feelings toward their childbirth experience, they may not openly share them, thus interfering with their healing. For some of the co-researchers in this study, unresolved grief influenced their future reproductive decisions, the ways they related to medical professionals, and their overall trust in the medical system.

Furthermore, there is a need to raise maternity care providers' awareness of the reality that so-called "normal" childbirth can be perceived by some women as traumatic or disappointing. Understanding their role in women's satisfaction with childbirth can inform birth attendants and care providers to shift their practices from technocratic to humanistic while honoring the central role of the woman in labor. Re-affirming the transformational effect of childbirth on the woman's psychological and social wellbeing could also assist in creating a respectful maternity care system.

3. Implication for clinical social work practice

The findings of this study can be useful in informing clinical social workers about the possible range of feelings about childbirth experiences experienced by postpartum women. For example, hospital social workers who work on the maternity floors have direct access to women and their partners while they are still in the hospital postpartum and can offer invaluable emotional support right after the birth. They can be also a source of information for different services women can benefit from, including counseling for a difficult birth experience that did not go according to plan. Clinical social workers who work in the community as psychotherapists also have direct contact to women and their partners prenatally and postpartum. Other social workers who can offer an important support to women and families are the ones who work in the obstetricians' practices, pediatric offices, or Women, Infants, and Children Program (WIC) offices.

Clinical social workers are traditionally seen as empathic listeners who meet their clients where they are in their healing processes. A raised awareness of the findings from this research can assist social workers in affirming women's narratives about the positive feelings and challenges of motherhood while remaining aware of the possibility of concealed pain and silenced grief when things have not gone as planned. Without such awareness social workers and other professionals who come into contact with women postpartum risk re-enacting the societal disenfranchisement women have previously experienced from unempathic birth attendants. Some of this study's co-researchers

reported experiences with therapists where grief and loss of the dreamed-of birth were either unacknowledged or misunderstood and minimized. Study findings can be incorporated into social work education about women's reproductive mental health issues and childbirth as an important transformational life event in women's lives, thus preparing social workers to be able to provide holistic care to women during their reproductive years and beyond. Such curricular content could be incorporated into Human Behavior and the Social Environment and direct practice courses as well as in electives on women's health.

Such curricula can prepare social workers to distinguish the experience of grief following the loss of the dreamed-of birth from major depressive disorder or posttraumatic stress disorder. Understanding that at times women may present as being depressed when they are actually mourning the losses they have experienced in childbirth is of a great importance for adequate assessment and treatment planning. Not all treatment interventions used for the treatment of mood disorders or posttraumatic stress disorder are appropriate for addressing the negative childbirth experience and the grief it triggers. Absent an awareness of the phenomena revealed in this study, women's experiences of grief may be unnecessarily pathologized by social workers and other mental health professionals. The more openly social workers and other professionals can become aware of and talk about these possible issues, the less stigmatized and more validated postpartum women will feel after experiencing a childbirth that violated their prenatal beliefs and expectations.

4. Future research questions

Gaining an in-depth understanding of this study's co-researchers' experience of disenfranchised grief postpartum posed new questions for me as a researcher and as a clinician who works with women and families. Some of the co-researchers talked about their husbands or significant others also experiencing grief after their envisioned role during labor was overridden by the reality of childbirth. A similar study focused on fathers' emotional reactions toward a disappointing childbirth could bring more awareness of their unique experiences and offer insights about how best to help them come to terms with feelings of loss and grief.

Another recommendation for future research comes from the limitations of this study, notably its small sample. A larger sample could provide more participant diversity and thus be more representative of the general population. Additionally, the purposive self-selected sample represented women who were aware of their grief experiences and were eager to share and reflect upon their grief experience. A larger sample drawn from the general population of birthing women would allow for discovery of a broader variety of possible reactions to unexpected childbirth experiences. Finally, the development of a questionnaire designed to measure phenomena uncovered in this research would help lay the groundwork for larger quantitative studies, thus expanding the scope of inquiry.

5. Creative synthesis

In conclusion, I present a creative synthesis of my own understanding of and emotional responses to the studied phenomena of disenfranchised grief following the loss of the dreamed-of birth. From reflection upon the range of the reactions, feelings, and dynamics I experienced while conducting this study, I created three poems accompanied by three drawings. Below I present one of the poems as illustrative of my own subjective journey alongside these generous, open, and articulate co-researchers. The other two poems are presented in Appendix E.

The Journey

And I am finally here

After climbing and falling,

And starting all over with bleeding knees

And heart...

But the triumph is not at the top

As promised and longed for.

And I am lost even though I have followed

The map I was given and made to believe it's

The Right one.

Such a naïve fool to hope that sun comes after

The storm and I will taste the reward

Of being determined in my knowing and trying

Just to be crushed by the reality of dreams long gone and

Time wasted ...our time of love and tenderness and sacred being.

Sitting on the edge,

Not knowing what is after

This life filled with dreams and beliefs that

Never come true...

I find my new compass on the horizon.

Seeing the green pastures touching

The blue angry skies

I can taste my sorrow and mourn all losses

That I have left behind on the path.

The mist around me feels so magical

Holding me gently and hiding my wounds

From the novice out there

Who still believes in maps and

Beautiful stories of happy endings.

No place to go to,

No need to escape...just being

And feeling what needs to be felt

Holding in me all others who know this place.

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Appendix A

Preliminary interview questions – first interview

Demographics Questionnaire

- Age _____
- Race _____
- Education _____
- Income _____
- Marital Status _____
- Number of Births _____
- Which number of birth(s) led you to participate in this study? _____
- Place where the birth(s) happened _____
- Professional birth attendant(s) _____
- Did you have other support people that were present during the birth? If yes, list who was present during that time.

Open-ended interview questions:

- Let's begin by having you tell me a little bit about your birth experience. What was the birth like for you?
- Would you tell me about the ways in which your labor and delivery turned out to be different from what you had envisioned?
- How would you describe some of the feelings you had postpartum when thinking about your birth experience and the ways it was different from the birth you had envisioned?
- Looking back at your birth experience was there a moment that stands out for you with its intensity that still bothers you and makes you revisit it again and again? Can you tell me more about your thoughts and feelings during that moment?
 - Can you think about such moment from your postpartum period?
- Thinking about this moment from the experience of giving birth, what do you tell yourself about who you are as a woman and a mother?
- If it's OK with you, can we take a moment to reflect on your present thoughts and feelings about these intense times from your childbirth and postpartum period?
- Sometimes women are put in situations where they feel the need to suspend their real feelings about their birth experience. Talk a little about any experiences you had with this.
- How did others react to your postpartum feelings? (friends, partner, professionals)

- How did others' reactions to your feelings about your childbirth influence your ways of coming to terms with the birth?
 - Your self-talk?
 - Your perception of the postpartum period and the birth?
- If you sought counseling to resolve your feelings about your childbirth what was the experience like?
 - Other complementary treatments to counseling? What kind? What was the experience?

Questions that can be asked to get more in-depth information if the participant shares feelings of loss and grief:

- What do you feel was lost from your birth experience?
 - When did you start to reflect on the loss?
 - How did the ways you thought about the loss changed with time?
 - Tell me more about the ways this loss affected your views of yourself as a woman? As a mother?
- Are there any ways in which this birth has changed you? How are you different after experiencing this birth?

- I am interested to find out more about your grieving the loss of your dreamed-of birth. Would you describe for me the experience of grief?
- Where do you think you are in the process of coming to terms with your childbirth experience?
- What influenced your choice to share your feelings with others or keep them to yourself?

Debriefing:

- Is there anything else you want me to know about your experience of a disappointing childbirth?
- Can you reflect on what it was like for you to talk about your postpartum feelings after a disappointing/negative childbirth with me today?
- Is there anything you would like to tell other women who are coming out of similar to yours childbirth experience?

Appendix B

Preliminary interview questions – second interview

Open-ended interview questions:

- Sometimes people have second thoughts or change their opinion about a certain topic. Is there anything else that came to you in reference of your birth experience and your feelings about it after we met?
- If it's Ok with you can you take some time to reflect on my interpretation of the data from the interviews?
- Is there anything else you want to add to the narrative?
- Anything you want to change in the narrative?

Debriefing:

- Is there anything else you want me to know about your experience of a disappointing childbirth?
- Can you reflect on what it was like for you to talk about your postpartum feelings after a disappointing/negative childbirth with me today?

Appendix C

Letter of invitation for participation

Dear potential participant,

I am a clinical social worker and a current doctoral candidate at the University of Pennsylvania School of Social Policy and Practice. I am writing to invite you to participate in my dissertation research study. The purpose of this study is to explore the postpartum experiences of a sample of women whose labor and delivery was unexpected and disappointing compared to the one they had envisioned and planned for. Findings will be used to bring awareness and understanding of the phenomenon and make recommendations for professionals who work with women.

Specifically, I am interested in conducting informal, untimed interviews with women who have had intense emotional reactions after their dreamed-of birth was violated by the actual experience of childbirth. Participating women need to be at least 21 years old and 6 months past the childbirth experience. Your participation is voluntary and you can decide to drop out of the study at any time. You will be asked to participate in a second interview in order to review and reflect on the preliminary findings from the first interview. All of your responses will be audio recorded and the transcripts of them will be de-identified, so your identity will remain anonymous. Anything with your name on it, such as signed consent forms, or any other documents that could be used to identify you, will be kept in a locked file cabinet, separate from your interview recordings and transcripts of those recordings. I am the only person who will listen to and transcribe the

recordings. I will assign a pseudonym to you (or you may decide to choose one during the interview), so the transcripts will not contain your real name.

If you are interested in finding out more information about this research or considering participating in it, please contact me at the contact information provided below. Thank you in advance for your consideration!

Sincerely,

Rumyana Kudeva, LCSW

rkudeva@sp2.upenn.edu

609-576-xxxx

Appendix D

Informed consent form

Dear Participant,

I am a current doctoral candidate at the University of Pennsylvania School of Social Policy and Practice. You are invited to participate in my dissertation research study. The purpose of this study is to explore and better understand the postpartum lived experience of women whose experience of childbirth labor and delivery was different, in a negative way, from what they had hoped and planned for. I intend to interview between 6 and 8 women for the study.

What is involved?

The interview will take place at a convenient for you location where your confidentiality will be protected. There is no specific set time for the interview length; it will end when you feel you have exhausted the topic. I will audio record our conversation and may take notes. In the beginning of the interview I will ask you to fill out brief demographic information. I will ask you questions about your birth experience and the ways it diverged from your expectations and hopes about childbirth. Our conversation will focus on your emotional responses to the unexpected and disappointing events in your childbirth experience and the ways you cope with them during the postpartum period. You may be asked to review my preliminary findings from the first interview and reflect on them in a second interview which should elicit any further information you might have forgotten or corrections to my findings.

Confidentiality

The information gathered through the interviews will be kept anonymous and confidential, and your privacy will be guaranteed. I will be the only person who will listen to the interviews and transcribe them verbatim. I will remove any identifying information from the transcripts and assign an alias to them (or you may choose one during the interview). Consent forms and any other documents with your name on them will be immediately separated from transcribed interviews and stored in a locked file cabinet that only the researcher can access. The audio recording will be erased after the completion of this research study and the interview transcripts will be kept in a locked file cabinet for three years and destroyed later.

What are the risks?

These interviews are not intended as a form of counseling or therapy. I will provide you with information about support groups and professional referrals in case you become interested in such. I do not anticipate any risks associated with participating in this study other than some discomfort when talking about possibly intense reactions and feelings. If such reactions arise please, let me know and we can stop the interview for few moments, or you may decide to stop the interview entirely. You have a choice which questions to answer and not to continue with the interview at any time during this research study. I will do my best to make sure that the personal information obtained during the course of this research study will be kept private. However, I cannot guarantee total privacy. Your personal information may be given out if required by law.

What are the benefits?

There will be no direct benefit from the participation of this study to you. However, some people find it rewarding to share their personal stories and contribute to the development of theory and practice in the specific field. You may find talking about your postpartum experience of reconciling with your negative childbirth validating and healing.

Compensation

Should you decide to participate you will receive a \$10 gift card to a local coffee shop as a token of my appreciation for your contribution to this study upon completion of the interview.

Your participation is voluntary

You may choose not to answer all questions or discontinue your participation at any time. If you have questions about your participation in this study or about your rights as a research participant, you may contact me at any time at xxx-xxx-xxxx or rkudeva@sp2.upenn.edu. You may also call the Office of Regulatory Affairs at the University of Pennsylvania at (215) 898-2614 to talk about your rights as a research subject.

You are asked to sign this form to show that:

- the study and the information above is clear to you
- you agree to participate in the study.

Please sign the form below. Thank you in advance for your participation!

Participant's Name **[print]**

Participant's Signature

Date

Sincerely,

Rumyana Kudeva, LCSW

University of Pennsylvania School of Social Policy and Practice

Appendix E

Creative Synthesis

The lone tree

I am forgotten, buried in my joy of newness

I miss what has never become mine.

There has never been a sun

Shining down on these branches

Filled with sorrow and emptiness.

Long gone is the illusive feeling of power

And yet here I am - strong and centered

Knowing my bounds and feeling my roots

Deeply buried in the cold ground.

Glimpses of love and compassion,

So far away from the spring of my knowing

Not even seen on the horizon,

Waiting dormant under the moss of my dreams.

See the mountain,

She knows my sorrow filled heart.

Welcoming the pain and hiding my flaws

Beneath the deep layers of snow over wounds

And springs over the bloody flesh of my soul.

Have I missed the signs of the raging storm?

Have I trusted the wrong guides and maps?

Where am I and who have I turned into...

Only the tears are strangely familiar.

The Sailing

Stormy seas and deep waters

Floating careless within this ocean of

Sorrow, grief, and the unknown

Of where my land is.

The rain washed away my despair

Of being lost in-between two worlds with no compass.

Remembering the dreamy green pastures of warmth

And connectedness with others' pain and stories

I keep sailing.

The sun is caressing my tired mind and body

And clouds are giving their way to new

Timeless skies bringing long lived peace

And loving on my very own journey.

The breeze rushes through my hair and

Plays with the sails of the boat carrying us

Away...far in a land never mapped

Or seen by the uninitiated ones

But well known to my sisters and me.

This journey had its own pulse and destination

For us, for me...

Finally loving the freedom to just be

A glimmer of sunlight on the water

Weaving my story into seaweed of wisdom,

Waiting to be the breeze in someone's sails

When the time comes.