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Original Article

Lived Traumatic Childbirth Experiences of Newly Delivered Mothers Admitted to the Postpartum Ward: a Phenomenological Study

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ABSTRACT

Introduction: Childbirth is a stressful event in every woman's life, leading to traumatic deliveries in half of the cases. This study aimed at describing mothers' lived experiences which make them perceive their childbirth as traumatic.

Methods: In this descriptive phenomenological study, based on the DSM-V-A criteria, 32 mothers who had perceptions of a traumatic event during their labor and delivery were explored through semi-structured interviews, and the collected data were analyzed using the Colaizzi's method.

Results: Four main themes could be extracted from the experiences of the mothers. The first theme was sensational and emotional experiences followed by clinical experiences, legal experiences and human dignity, and environmental experiences. The sensational and emotional experiences included four main categories (anxiety, fear, sorrow, anger). The theme of clinical experiences included two main categories (avoidable and unavoidable childbirth complications). The theme of legal experiences and human dignity included two main categories (non-observance of the charter of patient rights, and non-observance of human rights). The theme of environmental experiences also included two main categories (lack of proper supervision and management).

Conclusion: To prevent traumatic childbirth and its negative effects, different psychological aspects of childbirth need to be identified.

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Introduction

Childbirth is an important and potentially traumatic event.[1] There is now substantial evidence that women can suffer from a range of psychological problems during this time.[2-4] According to DSM-V-A, a trauma is a stressful event in which a person experiences a feeling of threat, injury, or death for himself/herself or one of his/her loved ones.[5] Now, if during a childbirth, the delivering mother is in a frightening situation where she feels her or her baby's life or health is threatened, she will perceive her childbirth experience as a trauma, and the term "traumatic childbirth" is used to describe this experience which has a prevalence of 47% of in Iran.[6,7] If, after at least one month, the newborn mother is not able to cope with the recent stress caused by the traumatic event, she will manifest symptoms which are called "postnatal posttraumatic stress disorder",[5,8] which is seen in approximately 3.71% of the cases.[9]

Research evidence of women's traumatic experience indicates experiences of intrusions, maladaptive beliefs, avoidance, re-experiencing, emotional numbing and arousal, hyperarousal, flashbacks and nightmares, dissociation, sense of threat, shame, anger and fear.[10]

Among the consequences of post-traumatic stress disorder are wife-husband relationship disturbance,[11] postpartum depression,[12] impaired cognitive develop ment of the infant, sudden infant death syndrome, more frequent readmissions to the hospital, disturbances in the quality of the mother-baby relationships[13] and negative effects on having a child in the future.[14-16] In a study by Beck and colleagues, which was carried out in New Zealand in 2004, mothers with post-traumatic stress disorder were asked to describe their experiences, and after hearing the description and the nature of their lived experiences, it was concluded that scant attention had been paid to decrease their posttraumatic stress disorder; as Margaret Wolfe Hungerford mentioned it in her novel for the first time In 1878" beauty is in the eye of the beholder".[8] However, the traumatic childbirth also lies in the eyes of the beholder and what a woman perceives as traumatic,[17] may be viewed as a routine childbirth by clinicians.[18] Preventive interventions including debriefing, structured psychological interventions, cognitive behavioral counseling,[19] and encouraging skin -to- skin contact with healthy newborns immediately post partum[20] can all be effective. However, since traumatic childbirth does not often receive due attention, and some obstetricians and gynecologists are not well-informed about this issue[18] and since the few studies so far done worldwide on posttraumatic stress disorder emphasize the emotions and thoughts of mothers who experience childbirth trauma, this study aimed at exploring Lived Traumatic Childbirth Experiences of Newly Delivered Mothers Admitted to the Postpartum Ward, so that the experiences and perceptions of the mothers who had a traumatic childbirth can be studied shortly after the event can in an effort to prevent post-traumatic stress disorder in the future childbirths.

Materials and methods

This is a descriptive phenomenological study in which the collected interview data were analyzed, using Colaizzi's approach (Colaizzi, 1978), and the Bracketing technique. Bracketing is most commonly attributed nowadays to Husserlian phenomenology. It centers on 'suspending belief'; that is a researcher goes into the 'field' with no pre-conceived attitudes, beliefs or opinions. They are supposed to go in with 'fresh eyes' that should be prepared to 'expect the unexpected'. The study aims at describing the experiences of the mothers who had a traumatic childbirth and attempts are made to investigate the interpretation of the experience from the point of view of the participants and the researcher. The data include experiences, interactions and interpretations which the researcher came to over the study.[21] The participants were selected through purposive sampling and the study was conducted after the approval and registry of the research proposal by the Center for Health Research of Shahroud University for Medical Sciences.

This study focused on newborn mothers who were hospitalized for their first 48 hours in the postpartum ward in Nohe-Day Hospital in Torbat-e-Heidariye, a city in the north east of Iran in 2016. These mothers had described their childbirth experience as traumatic, as defined by DSM-V-A criteria. Saturation has attained widespread acceptance as a methodological principle in qualitative research. After saturation of data, the study was based on the interviews with 32 women who had experienced traumatic childbirth. Three mothers did not volunteer to take part in the study and hence were excluded, and the ultimate number of the participants was 29. The characteristics of the participants in this study, including their age, education, the number of pregnancies, and the gestational age at the time of delivery are displayed Table 1.

Table 1. Demographic data of mothers participating in the study (N=29)

Variables	Minimum	Maximum	Mean (SD)
Age (year)	18	41	28.4 (6.6)
Education (year)	2	18	11.1 (3.9)
Gestational age (week)	30	42	37.1 (2.7)
Parity (number)	1	6	2.4 (1.4)

The inclusion criteria for the study were an experience of traumatic childbirth, the ability to talk and express emotions and feelings, and the desire to participate in the study. To find out whether the mothers had experienced a traumatic childbirth, each mother was asked four questions based on the DSM-V-A benchmark, and they were probed with further other open-ended detailed questions. The sequence of the questions was not the same for all participants and depended on the interview process for each of the participants, and the interview continued until saturation was reached and no further concepts were detectable in the answers.

1. Do you think during labor, your life or your baby's life was in danger?
2. Do you think during labor you or your baby could be physically harmed?
3. Do you think this childbirth was a hard and stressful experience for you?
4. During labor or delivery, did you feel panicked, worried or helpless?

These criteria have been used in different studies for detecting mothers with traumatic childbirths.[7,22,23] When a mother answered positively to these questions, she was informed of the purpose of the study in a face-to-face conversation and a written informed consent to participate in the study was obtained from her. Ethical considerations and volunteers' right to withdraw from the study were taken into account in this research and the interview started with no reference to the interviewee's name and the participants were assured of the confidentiality of their identities in the publication of the results. After gaining the approval of the authorities, the interview was conducted in a specific room in the postpartum ward. The room which had a calm atmosphere was called the counseling room. In this room, the facilities such as a bed were provided to prevent the mother's fatigue with the aim of making the room look like a private environment and comfortable place. Each interview lasted for 40-60 minutes and it continued as long as the participant was willing to share her experiences, with two interviews even lasting for 80 minutes. An attempt was made to select the participants from diverse socio-economic, cultural and educational backgrounds. Diversity in the delivery type (Vaginal or Cesarean) was also taken into account and rural and urban mothers with instrumental deliveries were included in the study to increase the acceptability and verifiability of the data. During the interview, the participants' talks were audio-recorded and their behavioral and non-verbal reactions were recorded, using field notes. Then, the researcher carefully listened to the recorded files for several times and then they were transcribed.

After the women's comments were transcribed during the interviews, Colaizzi's seven-step method,[24] which is appropriate for exploring and uncovering the meaning of a person's complex lived experiences,[24,25] was used to analyze the data. Berenz believes Colaizzi's method is a logical and authentic approach for descriptive phenomenological studies.[26] The seven steps which were taken to have rich descriptions of the main structures of the lived experiences are as follows:

1) Immediately after each interview, the researcher listened to an audio-file, and after complete immersion in the entire interview, the sentences were transcribed in a verbatim fashion and were repeatedly reviewed by the researcher to understand the meanings as fully as possible.
2) The transcription was read carefully and important words and phrases were underlined to be coded. The sentences that were directly related to the intended topic were extracted and the preceding sentences and phrases were re-listened to, and the participants' behavioral and non-behavioral reactions were also meticulously reviewed.
3) At this stage, significant sentences were highlighted and the initial codes were extracted from the interviews

and the codes which were overlapping with other codes were removed.

4) In the fourth stage, the organization of the rich meanings was formulated into clusters of themes. Similar codes were merged and categorized, and then the categories were named, based on the concepts and themes. Following Colaizzi, at this stage, having repeatedly reviewed the initial codes in the third stage, the researcher formulated the concepts within the categories and thematic clusters and level 2 conceptual codes were obtained.

5) The results were collected in a comprehensive description of the studied topics, and by combining the first level codes and second-level codes, Level 3 themes were formed. Meanwhile, the categories extracted from the interviews were compared and merged, and thus the main themes emerged.

6) The researcher summarized the description of the lived experiences under study and presented it as a clear statement of the basic structure of the topic.

7) To resolve any possible ambiguity and validate the findings of the research, the validity of the findings was examined through member-checking. The accuracy of the research findings was further checked through Guba and Lincoln's four criteria, including credibility or acceptability, dependability or trustworthiness, confirmability, or verifiability and transferability.

The good rapport of the researcher was effective in attracting the trust and confidence of the participants and increased the acceptability of the data. Moreover, the colleagues and team members were asked to review the findings to ensure their dependability. The reliability in this study was attained by reading and re-reading the transcripts to familiarize the researchers and make sure its overall meanings were understood. The transcripts were checked by listening to the audio recordings to make sure the errors were not introduced during transcription and coding. During the coding process, the data were constantly compared with the codes to ensure that no changes occurred to the meaning of the codes. The validation in this study was attained by applying triangulation to enhance the research credibility through triangulating various sources.

The interview, as the primary data, was supported by the secondary data from home- and hospital-based medical records to ensure the accuracy of the information. Any discrepancies between the events or complications reported in medical records and the information obtained during the interview were checked with the respondents. Member checking, also known as participant or respondent validation, is a technique for exploring the credibility of the results. The data or results were returned to the participants to check for accuracy and resonance with their experiences. Next, the member checking process was done through phone calls and the polished content of the transcripts and the quotations cited were read out to the respondents. Rich, thick descriptions were used to provide various perspectives on a theme so that the results would become more realistic and richer.

The proposal for this study was submitted to the Ethics Committee of Shahroud University of Medical Sciences and after receiving the approval (IR.SHMU.REC. 1394.170) and before implementation, a written consent was also obtained from the research council of Center for Health-Related Social and Behavioral Sciences Research (94111). Along these lines, the authorities were informed of the aims of the study before the sampling was done; the researcher was introduced to the participants and she explained the goals of the study to the participants; written informed consents were obtained from the participants; they were assured of the confidentiality and anonymity of their identities, the participants were assured of their right to leave the study at any stage, the time, place and duration of each interview were determined at participants' convenience, the participants were assured that the results of the study would be provided to them if so desired.

Results

The extracted texts were analyzed, using Colaizzi's approach, and the conceptual codes were specified and then categorized into several main concepts. Figure 1 shows that, four main themes which illustrated that newborn mothers had experienced a traumatic childbirth were determined. These four themes included sensational and emotional experiences, clinical experiences, legal experiences and human dignity, and environmental experiences. The emotional experiences included four main categories (anxiety, fear, sorrow, and anger). The theme of clinical experiences included two main categories (avoidable and unavoidable childbirth complications). The theme of legal experience and human dignity included two main categories (non-observance of the charter of patient rights, non-observance of human rights). The theme of environmental experiences had two main categories (lack of proper supervision and management). Each of these main categories was subdivided into subcategories and the main codes were extracted.

1. Emotional experiences

1.1. Anxiety

Data analysis showed that the participants in the theme of emotional experiences had experienced anxiety, fear, anger, hatred, and sorrow. Factors such as the feeling of lack of control, despair, and helplessness can lead to a mother's anxiety. The participants in their recounts said they had the feeling of a lack of control when they felt exhausted, feeble and incapable. Despair and helplessness had been experienced due to factors such as feeling unsecured, excruciating pain, feeling threatened and having negative attitude and misconceptions about childbirth. The participants in this study emphasized the long wait and high age of mothers as factors causing the feeling of incapability and lack of control. Based on the results of the interviews, several factors led to a long wait

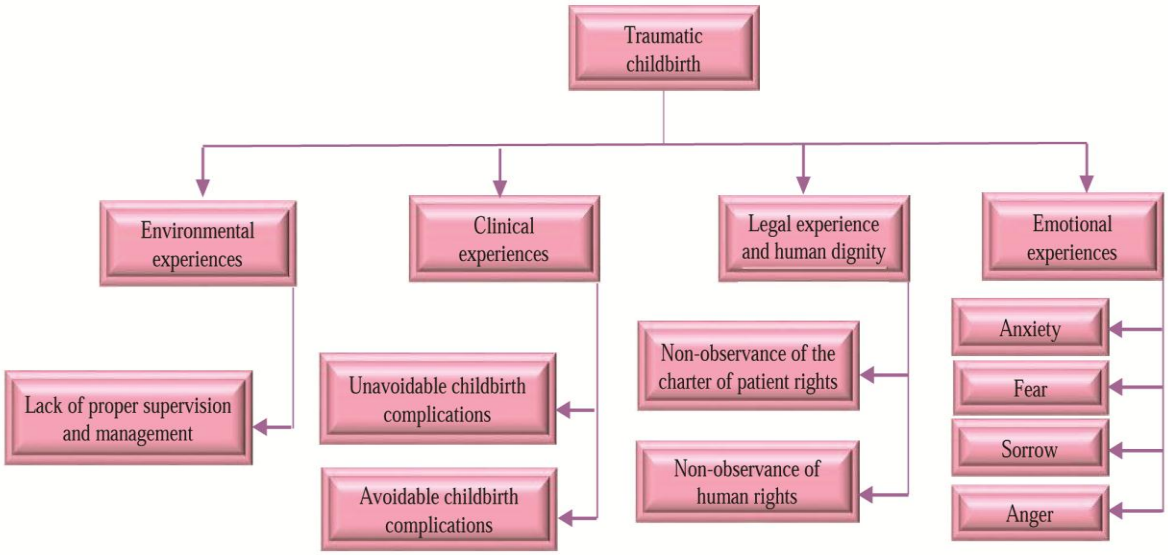

Figure1. Traumatic childbirth thematic

and ultimately a feeling of the mother's incapability, such as the doctor's or midwife's ineptitude to determine the correct time of the birthing mother's admission which could result in her early admission. The tolerance of the long latent phase in the maternity ward is painful to the mother-to-be and her companions and causes fatigue and lethargy and a feeling of disability. However, the problem is not always in determining the time of admission, rather, as many participants observed, most often, the mother goes into labor but the doctor or midwife may diagnose that it is too early to admit her. In this case, the lack of a resting place for the mother or her relatives who come from rural areas or from long distances can lead to their fatigue, which could make it difficult for the delivering mother to cooperate during the childbirth. Laboring mothers suffer from staff's neglect and lack of understanding because the mother who is in pain and under special conditions is isolated from her family and the only people available to her are childbirth attendants and she expects them to be supportive and kind, but when she is treated inattentively by the attendants who are not even willing to answer her questions, she feels insecure and upon repetition, this may lead to her despair and disappointment. The interview analysis indicated that mothers occasionally suffered undue severe and prolonged pains. The pains that could be prevented with a little consideration and compassion on the part of the doctors and other attendants.

"Because the time was not ripe for my admission, I have been waiting behind the maternity ward since yesterday, with agonizing pain, with no proper sleep or nutrition, and no place to rest or even to lie down. Long wait was anxious for me. "

"I did not even know how long I had to endure those conditions and how long more was left to my childbirth. They did not even allow me to see my mom for a moment. They could not understand me at all. I had entrusted myself to God, because every moment I or my baby could die."

"During the pushing, I tolerated severe pains, squatting for three hours without any pain-killers until finally, I gave birth to my 4200g baby. It's anxious for anyone to endure hard times".

"They constantly spoke English, which exactly meant something had happened to me and a danger was threatening me. Then, they came over and said, "You have to give us your consent for removing your womb and even consent to your own death. Then, I realized it was because I had not gone to have a sonogram to locate the placenta, and now my cervix was open, and either my baby or I myself would die soon."

"The operating room was very scary. People with new clothes, the humming of machines, nested rooms, a lot of stuff and equipment with repeated strange alarms, as if I was dreaming. Oh, God what is going to happen to me in here? "

"My baby was still premature. It was only 34 weeks old. Because my amniotic sac had ruptured, I quickly went to the hospital. They refused to admit me and said the hospital did not have the conditions for my baby's care and it would die there."

The interview analysis showed that mothers are worried during childbirth, especially in the last trimester, and usually they try to obtain more information from those who have a childbirth experience. In this situation, if there are people who have bad the experiences of childbirth, and tell the mother their bad experiences and memories, the birthing mother generalizes these negative experiences to herself during labor and delivery and becomes worried and anxious. "I arrived at the maternity hospital. A woman was screaming in pain, and the midwife came to her bedside and began to curse her and beat her. Oh, God, what is this place? What's going to happen to me? Surely, the same is going to happen to me. I am not an exception to other pregnant mothers here. "

1.2. Fear

The mother is usually filled with fear due to horror. Fear grows because of the doubts and ambiguities which weigh in on the mother during the labor due to reasons such as the physician's uncertainty in decision making,

the doctors gathering at the patient's bedside, changes in the physician's tone of voice, blood transfusion, being asked for a written consent, a doctor's issuing a warning, frequent examinations, birth attendants' concerns, mother's background diseases, observing other mothers' delivery in the same environment, strange environment of the operating room, unfamiliar medical equipment, etc. These reasons may fill the mother with horror and subsequently make her afraid.

"When I was hospitalized and arrived at the delivery ward, we were five people in the room. The women were groaning and moaning in pain, with unkempt appearance, and without proper disguise, and I was very afraid because I thought I would have the same conditions in some minutes."

1.3. Sorrow

The results of the interviews with the participants indicate that at different times during labor and childbirth mothers may feel sorrowful and upset. This feeling could occur for a variety of reasons. Occasions such as the hospitalization of the newborn, not seeing the baby after birth, the feeling of incompetence in the mother when the mother's physique and body are questioned and the mother perceives that she did not have the competence to have a pregnancy and childbirth. These may bring about sadness followed by sorrow in the mother.

"For all the time I was in labor, I was being told that it was a sweet pain because I would hug the gift of God and all my pains would end, but immediately after its birth, they said it did not feel vigorous and it was quickly transferred to another ward. That moment was the most sorrowful part of my childbirth experience because I have not seen her up to now when I am talking to you, and I do not even know what it looks like. "

1.4. Anger

The results of the study indicate that mothers who did not receive good care and support during their labor, and those who believed their demands were ignored by the staff may feel angry. The reason for this anger is that the mother feels having her need constantly ignored will make her demotivated and compromise her readiness to do what she has always been waiting for. Categories such as feeling abandoned, disappointed, and disrespected from codes such as feeling of undue suffering, emergency cesarean, lack of support for the mother, lack of empathy with the mother and lack of understanding of the mother, unacceptance because of dissatisfaction with the baby's gender or unwanted pregnancy, feeling guilty because of hearing unfair judgments constitute the category of anger. The results of this study indicate that mothers sometimes do not think they deserve to be treated badly, because pregnancy or delivery is a divine blessing and they should be treated kindly and gently at this moment. Reactions such as disregard for her dignity which make the mother feel not well understood and feel worthless can make her angry.

"I have had two other childbirths, but they were not as unpleasant as this one. Two of my previous births were at home and I had good and comfortable births, but this delivery gave me a bitter memory, I just want to know why I should be beaten."

"At the moment of my baby's birth, I unconsciously emptied my bowels, and although I apologized to the midwives, she told me that an animal would give a better birth than me. She told me if I could not damn face it up, why I became pregnant at all".

2. Clinical Experiences

2.1. Unavoidable childbirth complications

Mothers who participated in this study had hard times during labor, or there were some complications in their delivery, or they were considered high-risk mothers during their pregnancy, and this naturally necessitated more prenatal care. Due to these factors, these mothers subconsciously perceived their childbirth more traumatic than other mothers who were at lower risks. Complicated childbirths with neonatal consequences such as the hospitalization of the newborn, premature neonates, preterm deliveries, oligohydramnios, meconium childbirth syndrome, fetal distress, placental abruption, placenta adherens, macrosomia, and inconsistency of the fetal head with mother's pelvis, and sometimes due to maternal outcomes such as bleeding during labor, blood transfusions and emergency cesarean section can threaten the health of the mother and her baby.

"I had diabetes. I took 16 units of insulin per day, and the sonogram showed that the water around my baby was low. I was hospitalized and I had a pressure injection (Induction). I was in terrible pain. It was intolerable, but I tolerated it so that my baby would not die. When the head of the baby did not come down, at every moment I was thinking either I or my child would die ".

2.2. Avoidable childbirth complications

But sometimes childbirth complications are not due to underlying causes and they can be prevented. They can occur due to medical errors and due to lack of knowledge and skill on the part of the gynecologist or midwifery team working in the maternity ward. Such ineptitude and incompetence can lead to the physician's and midwives' inability to make an accurate and timely diagnosis, resulting in complications which are associated with invasive, inappropriate or painful therapies. In these cases, mothers perceive their childbirth as traumatic, and most often they say that if their doctor had not made a wrong decision, this would not have happened to them. Factors such as curettage, revision placenta and invasive therapies make mothers have an unpleasant experience of childbirth.

"Worst of all is when, after the cesarean section, I returned to the operating room due to bladder damage and intra-abdominal bleeding ..... To the gynecologists, we are just guinea pigs to experiment on and learn. Perhaps with a little care from a specialist physician, this could have been prevented ".

"After two and a half hours pushing, the doctor said prepare her for cesarean section. At that moment I said to myself that all the effort was futile, and finally I had a cesarean section. My baby's weight was 4300g. I wish doctors and midwives were not so illiterate and at the very first moment, they could realize that my baby was too large and I could not have a normal delivery. I never forget the film and memories of my

childbirth."

"After a hard childbirth, which lasted for about 15 hours, my baby was born. My placenta was not completely out yet, when the midwife wore a long glove that stood up to her shoulder, and she reached into my womb up to her elbow. I couldn't put up with the pain. Then, they called the specialist doctor to come in. When she showed up, she told me aggressively, "why didn't you let them do their job and dragged me over here?" It was really hard to tolerate the pain and the bullying. She again inserted her arm into my womb, and at that moment, I saw death in front of my eyes."

3. Legal experiences and human dignity

3.1. Non-observance of the charter of patient rights

The results of this study indicate that most mothers experienced traumatic childbirth because their rights were not respected and the mother was invisible as a person who should be involved in her childbirth and can decide for herself to the extent that the physician thinks is expedient. Mothers would like to participate in various stages of labor and childbirth and be aware of what is happening to them at every moment and what is going on. Failure to answer the mother's questions, the use of English words, not asking for the mother's permission for therapeutic actions and examinations, and providing no explanations about why and how the treatment is done are factors that stimulate the mother's negative emotions. Failure to establish proper verbal communication with the mother, failure to involve the mother in decision making, disrespecting the mother's expectations, failing to observe the mother's privacy, or failing to respect the mother's values could make her have doubts about the staff's commitment and not have a true appreciation of the observance of the patient rights during childbirth.

"Then, without being told anything, I was taken to the operating room and I was given a cesarean section, while my husband had allowed them to close my tubes. Now, I do not really know whether or not my tubes were finally closed during the cesarean. Is there a right to know what he wants to do to him? ".

"My midwife called of her colleagues and talked to each other in English so that I could not understand what had happened and did not say anything in response to my question."

3.2. Non-observance of human rights

Mothers who are not treated in accordance with basic principles of medical ethics will also experience a traumatic childbirth, because they often feel offended and think they have been stripped of their personal dignity and self-esteem. The feeling of threat to one's dignity and losing one's self-esteem can be engendered due to different reasons. A case in point can be disrespect to the mother's religious beliefs, derision and aggressive behaviors to the mother.

"Suddenly, someone without asking for my permission did the vaginal examination with a harsh and painful move. I wish you were treated like human beings." *"With all those problems, I was not in a position to withstand the insulting behavior of the personnel and their invective language or violence. I am having a really tough time, because I have not seen my baby yet, and this is the most painful issue for a mother."*

It was quite evident in the utterances of the mothers who had experienced traumatic childbirth that responding to the mother's needs, paying attention to her concerns and empathizing with her, along with supporting her in doing her tasks such as breastfeeding would make mothers experience a more pleasant childbirth. It is very important and worthwhile to pay attention to the mother as a human being who has passed her pregnancy and labor and all its associated troubles with hopes and wishes. Birth attendants should pay special attention to every single mother, but working in the maternity ward may make the work look routine and commonplace to them while mothers may perceive as very strange and traumatic. The results of the study show that isolating the baby from the mother, inattention to the mother's pain, not using analgesics while the mother is in pain, and disregarding their basic needs can make childbirth an unpleasant experience for the mothers.

"I was pregnant with twins and my babies were premature. They are in the NICU. I do not know whether they will stay alive or not? I wonder how the hospital staff do not respect the rights of a human being. "

"I was on a usual bed waiting for my cervix to open when I suddenly gave birth. One was saying "push", another one saying "don't push". Suddenly I screamed and said, "Help me! help me, the baby is dying and ... Oh my God, my baby's weight was 4700g and it was born spontaneously with no help and support from the midwives. The monitoring of my childbirth process was the minimum to have my rights as human addressed. "

4. Environmental Experiences

4.1. Lack of proper supervision and management

During childbirth and labor, mothers expected close monitoring and careful management in the ward. They expected supervisors to make sure rules and regulations are complied with, and in case their feelings are hurt for any reason, or in cases such as equipment failure and lack of appropriate facilities in the ward, they expected the maternity ward supervisors or managers to deal with the problems.

"They brought three sonic aids from different rooms for me to listen to my baby's heartbeat, but I could not hear it. I thought God forbid that my baby might be dead, until they borrowed the fourth device from another ward, and it was heard. "Moreover, mothers believed the staff did not respect their privacy in the work process and they are never alerted to be more considerate. Mothers regarded factors such as the presence of a man in the operating room, inappropriate coverage, sharing the labor room with other birthing mothers, beating the mother in labor and examination by multiple students among the factors that needed to be amended.

"Even when an animal is giving birth, no one beats it, let alone me. I like the voice of patients to reach the ears of the authorities. "

"Because of an emergency cesarean section, I entered the surgery room and lay on the surgical bed, and nobody was in the room. Suddenly, a man entered and rushed to me and all of a sudden, without asking for my permission, he removed the bed sheet from me and began to pour iodine on my body. I felt

that I had no control over the situation and I had no way to express my objection, and there was no one to warn this man. "
"After I got admitted, I entered the maternity ward and one of the women beside me while defecating gave birth to her baby. Was there no supervision to improve the deteriorated situation there? Isn't there anyone who is in charge of here?"

Discussion

The descriptive phenomenological study of "lived experiences of newly delivered mothers, admitted to the postpartum ward, of traumatic childbirth" led to the emergence of four themes: emotional experiences, clinical experiences, legal experiences and human dignity, and environmental experiences. Sensational experiences and negative emotions, high-risk childbirths, and non-observance of ethical principles, disregard for repairing faulty equipment and disrespect for the mothers' privacy can change childbirth from a pleasant event to a traumatic event. Recent review studies have identified risk factors for psychological trauma, traumatic childbirth and posttraumatic stress disorder (PTSD).

In the present study, sensational and emotional experiences, for various reasons, such as premature baby and not seeing it after birth and the consequent feeling of frustration and sorrow, can lead mothers to perceive their childbirth as traumatic, which is consistent with Ncube and colleagues' study .[27] Among the themes derived from this study are clinical experiences of childbirth.

Unavoidable and avoidable childbirth complications contribute to the formation of this theme, and in Anderson's study also factors such as increased level of midwifery interventions during labor and delivery, emergency cesarean, instrumental delivery were identified as important in the formation of traumatic childbirth.[28] Women who underwent elective cesarean section with a normal baby had a lower risk of trauma than a high-risk childbirth resulting in emergency cesarean section.[28] But sometimes even women who experienced spontaneous vaginal delivery report a psychological traumatic perception of childbirth.[22,29,30]

A review study reported risk factors for postpartum PTSD as including neonatal complications, insufficient mother support during labor, pregnancy psychological problems and previous posttraumatic stress.[29] In their studies, Soet and colleagues identified a list of risk factors and characteristics of traumatic childbirth that included: severe pain during labor, increased interventions by hospital personnel, loss of control during pains and childbirth, lack of information and awareness of the methods and what is happening during childbirth, dissatisfaction with the way of doing work, lack of sympathetic support and supportive care, emergency cesarean section, stillbirth or giving birth to a sick newborn baby.[22] In the study by Beck and colleagues, deprivation of care, being stripped of dignity, loss of control, neglected communication, being buried and forgotten after the childbirth when all attention is paid to the baby[31] have all been reported to play a role in the mother's experience of postpartum traumatic stress disorder. In Ayers' study, themes that emerged from the mothers' thoughts and feelings of post-traumatic stress disorder included thoughts during birth, mental defeat, panic and anxiety, anger and thoughts of death, over-concentration on the baby, and rumination.[10] In another study by John in 2006, counseling women with posttraumatic stress disorder showed that the decline in the perceived support during labor and delivery was the main cause of harm to the mothers.[29] In a qualitative study by Taghizadeh and colleagues in Iran in 2014 which aimed to assess the response of the mothers to traumatic childbirth, mothers' perception of birth trauma included feelings of fear, disappointment, and feeling of death during delivery.[32] Mothers' perception of fear during labor and delivery[33] and having a feeling of death during childbirth, despite the advances in medical science is still considered as one of the mother's mental trauma during childbirth.[34] In the present study, one of the reasons for the fear was the lack of control over the conditions. In some studies, the mother felt a lack of control over the situation which is in line with some studies in which mother's loss of confidence in her ability and feeling of helplessness and isolation and disconnection from the surrounding were identified.[35,36]

In the present study, the emergency cesarean section was one of the codes that was perceived as traumatic by the mothers, which is not consistent with the studies by Taghizadeh[32] and Ballard[35] But it is consistent with the studies by Andersen and Soet, in which cesarean section was perceived as traumatic by mothers.[22,28] Some of the themes developed in this study are similar to the results of other studies, as mentioned above, but the discussion of each of the themes is not possible. What matters is hearing the mothers' voice to prevent traumatic birth.

Conclusion

Although the events and incidents which occur during labor and delivery are regarded as routine and normal by the staff, they may be very unpleasant and stressful for the mothers and they may have significant negative effects on the mother's health. An individual's assessment of the incidents and events during the labor depends on her perception of the event which can be considered traumatic or non-traumatic to her. Therefore, it is emphasized in this study that the initial assessment of the mothers who are at risk for childbirth trauma should be performed immediately after delivery and appropriate interventions should be created to improve maternal emotional support as soon as possible so that post-traumatic stress disorder can be prevented. It is recommended that future studies develop traumatic childbirth instruments so that an initial postpartum assessment can be performed for all mothers.

This study faced some limitations. First, there was no counseling room in the maternity ward where mothers could describe their experiences. Second, the interview had to be conducted within the first 48 postpartum hours which was practically difficult. Third, sometimes the interviews were interrupted by baby's' crying or therapeutic interventions.

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Ethical issues

None to be declared.

Conflict of interest

The authors declare no conflict of interest in this study.

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