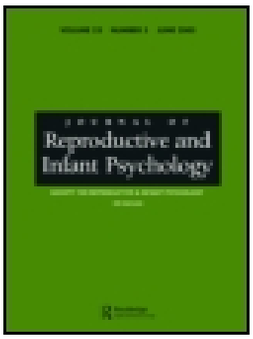

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Women's experience of post-traumatic growth following a traumatic birth: an interpretive phenomenological analysis

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ABSTRACT

Background: Approximately 3–5% of women experience post-traumatic stress disorder following birth; positive experiences that can follow traumatic birth are under-researched.

Aims and Objectives: To explore how women experience post-traumatic growth following a traumatic birth.

Methods: Interpretative Phenomenological Analysis was used to explore experiences of women who self-identified as having found positive benefits through coping with a traumatic birth. Eight women who had birthed in the past five years in the UK were recruited online and interviewed face-to-face.

Results: Three superordinate themes were developed: *'The total opposite to what I'd expected'* (participants' struggle to understand and integrate their birth experience in the postnatal period); *'I see it a bit differently now'* (processes experienced in coming to a place of growth); and *'A much better place'* (experienced growth 'outcomes').

Discussion: Faced with shattered assumptions whereby their birth experiences contrasted with their expectations, participants felt their identities as women and mothers were challenged. In overcoming these challenges, participants described actively striving to cope and make sense of their experience. Multiple factors facilitated this, notably partner support, telling their birth story, acknowledging the impact and developing a compassionate narrative. Although growth was experienced in ways commonly reported by survivors of challenging life events, some aspects appeared pertinent to birth trauma.

Conclusions: Widening our understanding of the range of experiences following traumatic birth and making these narratives public may offer hope for some women and families and inform health professionals' education and practice. Further research would be needed before advocating interventions to foster post-traumatic growth.

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Introduction

There is no consensus on how to define or systematically measure birth trauma (Elmir et al., 2010). A helpful definition is 'an event that occurs during any phase of the childbearing process that involves actual or threatened serious injury or death to the mother or

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This article has been corrected with minor changes. These changes do not impact the academic content of the article.

her infant' (p. 229; Beck & Watson, 2008). Whilst birth trauma is more likely following an obstetrically complicated birth or poor clinical outcome, any birth may be experienced as traumatic. Ultimately, trauma is 'in the eye of the beholder' (Beck, 2004).

Experiencing traumatic birth is associated with increased vulnerability to poorer mental health and relationship outcomes, and can impact on future reproductive choices (Greenfield et al., 2016). A range of traumatic stress responses can occur, including secondary tokophobia (fear of childbirth), diagnosable post-traumatic stress disorder (PTSD) or sub-threshold PTSD symptoms. Approximately 3–4% of birthing women in community samples meet criteria for PTSD during the perinatal period (from conception until one year postpartum), increasing to 18% in high-risk samples (e.g. women with a history of abuse, babies born with complications; Yildiz et al., 2017); rates in trans and non-binary birthing people are unknown (Greenfield & Darwin, 2021). In this paper, we refer to women and this reflects the language used in the policy and research evidence being quoted and to the sample included here; however, we recognise that not all people who birth are women, and that not all women who are parents have given birth.

In England, services are being developed for women experiencing mental health difficulties related to maternity experiences, including trauma and loss (NHS England, 2019). There is also a commitment to maternity services becoming trauma-informed (Law et al., 2021). Some women who experience PTSD-type symptoms following birth will recover 'spontaneously' within three months of the traumatic event, as is seen with traumatic stress responses in other populations (Ayers, 2004) however for many women and families, the impact of traumatic birth is considerable and long-lasting. Debate continues concerning the timing and nature of intervention (De Graaff et al., 2018).

Evidence shows that positive outcomes can follow traumatic experiences (Linley, 2003). Tedeschi and Calhoun's model of post-traumatic growth (PTG) proposes that the traumatic event disrupts the individual's assumptions and beliefs about the world, resulting in emotional distress and rumination (Tedeschi & Calhoun, 1995). When this experience is met with either successful emotional regulation or self-disclosure leading to increased support, PTG is facilitated through the construction of a narrative including new and positive meanings from the trauma (Tedeschi & Calhoun, 2004). In this model, PTG arises specifically from the struggle to cope with the effects of the trauma. Unlike resilience, where individuals return to normal functioning following adversity, PTG results in changed functioning or beliefs beyond pre-trauma functioning. These changes can include: improved relationships, personal strength, spiritual development, new possibilities for one's life and a greater appreciation of life (Tedeschi et al., 2018).

PTG has been examined in relation to foetal anomaly (Lafarge et al., 2017) and other perinatal losses (Black & Wright, 2012) using the Post-Traumatic Growth Inventory (PTGI), which was developed to assess PTG in a range of populations (Tedeschi & Calhoun, 1996). The prevalence of PTG following childbirth is not established and the relationship between PTSD symptoms and growth is unclear (Sawyer & Ayers, 2009; Sawyer et al., 2012). A traumatic birth is different to other traumatic events in several ways (Horesh et al., 2021). For example, there are societal expectations that pregnancy and birth are 'positive' events, whereas other kinds of traumatic events (e.g. assaults, accidents, significant illnesses) are generally assumed to be negative. Furthermore, the outcome of a successful birth is commonly a wanted child and, for those who are first time mothers, a desired new role of motherhood. At present we do not know whether these aspects of the pregnancy,

birth and parenting experience affect PTG. A 2016 qualitative study sampling women from several countries between five months and 19 years post birth trauma asked participants to provide a written narrative about their experiences of any positive changes in their beliefs or life that resulted from their traumatic birth (Beck & Watson, 2016). Using a descriptive phenomenological analysis they demonstrated the presence of growth in women who had experienced birth trauma. Further research is needed that investigates issues specific to the aftermath of birth trauma to develop interventions that are tailored to birth trauma survivors. Psychological research has focused on negative outcomes following childbirth and continuing research gaps include the conceptualisation of growth and its application to clinical practice (McKenzie-McHarg et al., 2015), and how growth following childbirth is experienced (Thomson, 2017). Responding to these gaps, this study aims to explore women's experiences of growth following a traumatic birth.

Methods

Design

This qualitative study used Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) which involves exploring individuals' experiences and how they make sense of them.

Recruitment

Following ethical approval from the University of Leeds School of Medicine Research Ethics Committee (MREC17-085), a purposive sample was recruited by publicising the study via social media and voluntary organisations for parents and those affected by traumatic birth. Interested participants received telephone screening. Inclusion criteria were: women aged ≥18 years; living in England; self-defined as having had a traumatic birth in the previous five years; and reporting positive benefits through coping with their difficult birth experience. Initially, eligibility was restricted to birth in the previous year; this was revised following discussions with potential participants and a voluntary organisation who suggested that PTG would be unlikely to occur or be recognised so soon. Women were not eligible if: their baby had died; if the birth was pre-term; if the woman or baby had required admission to an intensive care unit, or if the women had been under the care of a psychiatric team at any time in the perinatal period. Current trauma symptoms were screening using the Primary Care Post-Traumatic Stress Disorder Screen (Prins et al., 2016), with screen-positive women excluded to avoid exacerbating distress.

Data collection and analysis

A semi-structured schedule was devised for the study, using the guidelines in Smith et al. (2009) and in consultation with an expert-by-experience. Open questions such as 'How would you describe the positive changes you experienced as a result of coping with the traumatic birth?' were used in a flexible and responsive way so that each interview was participant-led. All interviews were face-to-face and audio-recorded for verbatim transcription.

Analysis was typical of Interpretative Phenomenological Analysis (IPA): each transcript was read several times to develop familiarity and ensure participant experience was central to analysis (Smith et al., 2009) before developing emergent themes from each account. The group analysis process was iterative whereby emerging themes were checked against transcripts, attending to similarity and difference in accounts. IPA accepts that the interpretation of themes is influenced by the personal and professional experience and theoretical knowledge of the researchers. Quality checks included the lead researcher's use of a reflective journal and attending an IPA research group with peers to promote reflexivity. Credibility was promoted through regular supervision throughout the analysis process, whereby all authors contributed to consideration of alternative interpretations. In presenting the findings, attention has been paid to quality guidance (Nizza et al., 2021) with the aim of producing a clear and compelling narrative.

Reflexive accounting

Professionally, the researchers have backgrounds in Psychology and mental health, including psychological trauma. Two (ZD, LMc) have expertise in perinatal mental health, including one (LMc) who has worked clinically as a midwife. Researching PTG was new for the full team. Personally, three had experienced births, with two having given birth.

Participants

Nine women initiated contact, eight of whom responded to further contact, were confirmed to be eligible and were interviewed. All eight participants were White British and aged 30–39; all were living with their male partner, who was also their baby's father. All women birthed in hospital, and the hospital environment was a factor in their negative experiences. See, Table 1 for further details, which includes a summary of their birth trauma and growth experiences.

Results

Analysis of the data generated three superordinate themes, with the first two concerning the journey to growth and the final capturing the experienced growth outcomes.

Superordinate theme one: 'The total opposite to what I'd expected'

This theme describes the participants' struggle to understand and integrate their birth experience in the postnatal period.

'I thought it was a conspiracy'

Participants' expectations and assumptions about the birth and how they would cope – shaped by 'positive birth stories' from professionals, family and friends, and television shows – differed from their reality. Compounding the immediate traumatic experience was a sense of shock or betrayal that others had not prepared them well. Some spoke of

Table 1. Sample characteristics and summary of traumatic birth experience and reported growth.

Pseudonym	Index birth; parity	Time since index birth	Traumatic birth experience	Reported growth
Heather	1st; 1	<6 months	Felt dismissed and out of control. Experience physically intrusive and with multiple (male) staff involved *'the worst possible scenario'*	Experiencing her worst fears and surviving led to considerable improvement in confidence. Improvements in relationship due to less reassurance-seeking
Sally	1st; 1	6–12 months	Extreme anxiety. Emergency surgery – ongoing physical complications. Pre-existing fear of medical interventions	Feeling 'invincible' after facing feared medical experiences – determination to engage with other feared experiences. Improvements in coping with medical anxieties
Amy	1st; 1	6–12 months	Felt out of control and vulnerable. Unwanted interventions including induction and epidural 'the exact opposite' of what she had hoped for	Improved relationship and shift in priorities. Increased sense of vulnerability leading to improved help-seeking/ care-receiving
Alison	2nd; 2	1–2 years	Felt uncared for. Severe pain – untreated despite requests. Bad tear leading to surgery in postnatal period, missing out on time with baby.	Improved confidence due to involvement in staff training (public speaking). Experienced stronger bond with baby following sense of shared trauma.
Tracey	1st; 2	2–5 years	Felt terrified – feared losing baby (previous miscarriage) and pain unmanageable – wished for death.	Negotiated better-managed second labour and delivery. Used experience to support others
Angela	1st; 1	1–2 years	Felt anxious due to hearing others' labour and had not wanted induction. Distressed by her own lack of assertiveness – unwanted emergency caesarean	Shifting priorities – addressed longstanding eating difficulties and became engaged with Buddhism.
Helen	1st; 2	2–5 years	Distressed as home birth became unmanageable. Series of negative interactions with hospital staff. Unwanted caesarean. Husband unwell during labour process (later diagnosed cancer) – felt alone.	Sense of pride in complaint resulting in apology and improvements for others – became involved in supporting other women. More empathic, less stressed.
Sarah	2nd; 2	2–5 years	Extreme anxiety, experienced voices. Feared death. Requested pain relief not provided.	Improved relationship. Christian faith initially shaken but now much stronger.

Notes: Index birth here refers to the birth that was experienced as traumatic

the dilemma about how to best prepare others. Alison summed this up: '*You don't want to scare women to tell them that this could happen; but equally you're not prepared in the slightest for anything like that*'.

There were also feelings of loss concerning the hoped for (in some cases idealised) birth experience. As Helen described: *'I was gonna wake up- have my baby and then have my tea and toast and in my own bed and it was all going to be a dream. And actually it was a nightmare*'. Tracey spoke about her anticipated postnatal 'tears of joy' that she contrasted with '*tears of . . . pain and terror and horror; and just this kind of sense of "Why, why me?"*'.

'I'm supposed to be good at this'

Participants described struggling to integrate their birth experience and responses with their identity as a woman and a mother, commonly feeling guilty and that they had 'failed'. Tracey experienced this self-criticism and blame acutely, explaining: '*I didn't go into labour. And then I somehow reflected that on me as my failure*' and '*If something*

happened when I was giving birth, that would be my fault cause that's my body and it means I didn't do it right'. This was echoed by Angela, who described thinking '*I'd let him down. This little thing that couldn't speak for itself and the first thing I'd done, as his mum, was to let him down*'. These experiences were particularly upsetting in the context of beliefs like '*that's not how it was supposed to be . . . I'm supposed to be good at this*' (Amy).

Having a medicalised birth left some feeling they had not done birth 'properly'. Some participants reported usually being assertive but during the birth did not feel able to behave this way. Indeed, some underwent unwanted interventions or did not receive pain management that they requested (see, Table 1). This lack of power had a significant effect on Angela: '*That is the moment that really hurts my heart bigtime . . . there's not been many occasions that I've not, if I really feel strongly about something, that I've not said something*'.

Superordinate theme two: 'I see it a bit differently now'

This theme portrays the processes the women experienced on their journey to growth as they actively strived to cope and make sense of their experiences. Some had sought formal support in doing this, for example, having met with hospital staff to discuss their birth and/or accessing therapy.

'I wanted to understand'

Participants described questioning and seeking to understand, as they struggled to assimilate what had happened. Whereas Sarah drew on her religious beliefs, Alison said: '*I wanted to recognise the things that were affecting me and get 'em dealt with . . . where the positivity comes in because [the therapist], she helped me deal with that*'.

'Maybe I'm not just weak'

Many participants went through a process of reconceptualising their experience. This involved accepting that their responses during and after the birth were valid (sometimes facilitated by validation and support from health professionals and voluntary organisations), and that they could legitimately name their experiences as traumatic. Tracey reflected: '*It felt so dramatic to be talking about the word trauma in the same sentence as childbirth because I'd never heard of birth trauma*'.

Several engaged in trauma-comparison, initially questioning their reaction:

> "*I used to worry about talking about it because I used to think, 'Well, my trauma's not that great compared to some people who have these huge injuries after birth or their babies are terribly sick or . . . their child dies. Like what right have I got to be this . . . upset?' but I feel coming through the whole process and getting to where I am now I realise it's all subjective, isn't it, and you're feeling it*" (Helen).

'It's just a memory now'

Some women felt their birth experience and memories had been processed and were now in the past. Tracey said: '*I suppose I see it a bit differently now; it feels a bit like it happened to someone else*'. For some this shift involved developing a more compassionate narrative for what happened, that released them from self-blame: '*I think what has struck*

me is that I did the best, I did do the best that I could in that situation, at that time . . . But that's come from a lot of work'. (Angela). Without minimising what had happened to them, some women talked about putting their experience into perspective and finding good in what had happened.

Superordinate theme three: 'A much better place'

This theme describes what 'growth' or 'positive benefits' meant to the participants in the context of their birth trauma. The subordinate themes that emerged were closely aligned with the existing domains of the PTGI (Tedeschi et al., 2018), and are presented accordingly in Table 2.

As identified in Table 2, some elements of the experience appeared particularly pertinent to birth trauma and are further elaborated below. The first of these specific elements was women's changed relationships with their bodies (*'I could've let this floor me'*). For example, Heather spoke of her increased body-confidence that followed from enduring such a physically exposing birth, giving the example that she now felt confident to wear more exposing clothes. She also took pride in her body's usefulness in nourishing her baby: '*it makes me happy when I realise that I'm feeding in public . . . there are people here and I haven't even thought that I should cover up*'.

Second was an improved relationship with their partner, which most reported (*'He's so much more capable than I gave him credit for'*). This was a newfound admiration for and improved relationship with their partner, having witnessed them 'step up' during the labour or aftermath of the birth. For some, there was a greater sense of partnership for enduring such a difficult and frightening experience together. Sarah described: '*he was the constant and he was . . . just fantastic. He was like having my own midwife . . . he was trying to sort all that out, sort me out . . . it's made our marriage stronger*'. Experiencing the

Table 2. Subordinate themes of growth outcomes and alignment with the Post-Traumatic Growth Inventory (PTGI).

Subordinate theme of 'A much better place'	PTGI domain	Summary of distinctive elements
'I could've let this floor me': positive changes in how the women viewed themselves, including a sense of strength and pride in what they had overcome, confidence and courage; for some this included a greater acceptance of vulnerability	personal strength or self-reliance	Women's changed relationships with their bodies, including bodily strength
'He's so much more capable than I gave him credit for': positive changes in the women's relationships; particularly with their partner	changes in relationships	Improved relationship with intimate partner, sometimes linked to their present at the birth and having endured the experience together
'Having the confidence to lead something': different paths that women forged for themselves as a result of their experiences, including taking on new challenges at work, changing plans for the future, or using their experience to help others	identifying new possibilities for one's life	High motivation to prevent other women from going through these traumatic experiences
'Why did you let that happen?': engaging with issues around spirituality, e.g. processing new realisations about mortality, or questioning existing faith	spiritual and existential changes	
'Live a life that focuses on important things': reported changes in perspective and priorities	a greater appreciation of life	

trauma together with their baby featured in some of the women's meaning-making. Alison initially associated her baby with the traumatic birth, then reconsidered that they had shared the experience, leading to a close bond: '*She's the only person who's gone through this with me. She's my little . . . partner*'.

Third was high levels of motivation for preventing other women from having traumatic birth experiences or being unsupported (*'Having the confidence to lead something')*, with recognition that birth trauma is relatively predictable and could be better managed psychologically.

Discussion

This study provides in-depth exploration of women's experiences of positive benefits developed through coping with traumatic birth, captured within five years of the birth trauma. Women's processes to growth began with shattered assumptions about what their birth experience would be like and how they would cope. They spoke of societal and cultural influences on their pre-conceptions of birth, and described how difference between their expectation and reality challenged their sense of identity as women and as mothers. In overcoming these highly challenging experiences, the women described a process of actively striving to cope with and make sense of their experience, facilitated by a variety of factors. The importance of partner support, professional acknowledgement and the opportunity to tell their story was clear. Women identified the importance of acknowledging the impact of the birth as part of developing a compassionate narrative; for some, this included feeling able to name their birth as 'traumatic'.

The changes reported within the theme 'A much better place' align with the domains of the PTGI (Tedeschi et al., 2018), offering validation for this population and giving confidence to researchers and practitioners who wish to use the PTGI in their work with this population. Whilst the current participants reported experiencing growth in similar ways to other trauma survivors, some aspects of growth appeared connected to the trauma being birth. These included a changed relationship with their body, an improved relationship with their partner, and women's motivation to avoid other women having traumatic experiences of being unsupported. Some of these particular manifestations of growth echo the findings of Beck and Watson (2016) and speak to some of the ways in which birth is unique as a traumatic event (Horesh et al., 2021) including the shared nature of the trauma which may include their partner enduring alongside and experiencing the trauma with their baby.

Strengths and limitations

The eligibility criteria were intentionally restricted to pursue a homogenous sample, in fitting with IPA methodology. We focused on those likely to have had more similar birth and care experiences, with a more clearly defined birth trauma (e.g. restricting to those who babies had not required intensive care admission). The sample was also homogeneous in ways that had not been sought, as summarised in the participant characteristics. This can be considered a limitation of the research, and research is needed to explore experiences with more diverse groups. However, recruitment was successful in that the

sample size is considered appropriate for an IPA study (Smith et al., 2009). In addition, the study was enriched by service user involvement, strengthening the study's design, recruitment and study materials.

Future research

Research examining PTG in other groups of parents is warranted, including with those who have accessed services concerning perinatal mental health difficulties or perinatal trauma and loss; for example, using the PTGI as an outcome and conducting qualitative research to explore mechanisms of change in relation to interventions offered. A future study could focus on the partners of women who have experienced a traumatic birth, both to capture their perspective on the women's growth experience and to explore the potential for 'vicarious' growth. Research with cancer populations indicates 'transmission' of PTG to partners of people affected by cancer (Tedeschi et al., 2018) and interviewing couples with a focus on relationship changes following traumatic birth could increase our understanding of how birth trauma and growth might impact and be impacted by the partner relationship. Another area for future research concerns the value of longitudinal study, which would enable exploration of timing of PTG process and outcomes, although consideration would be needed concerning the potential for the research process to influence the process of PTG itself.

Implications for practice

While we focus here on support provided to birth trauma survivors, the possibility of PTG does not reduce the need to prevent traumatic birth, including through ensuring respectful care. Previous work (Beck & Watson, 2016) has suggested sharing findings regarding growth experiences with women following a traumatic birth and the current study could be used in this way if it seemed appropriate. However, interventions specifically designed to foster PTG are still in their infancy so caution is required until more is known about how clinicians can facilitate growth effectively and safely. Existing guidance for fostering growth proposes that clinicians can facilitate and support if attuned to the individual's journey to PTG (Tedeschi et al., 2015).

The participants' reports of the importance of the opportunity to tell their stories and the positive and understanding responses they experienced from clinicians emphasise the importance of this supporter role. Indicated too is the value of clinicians acknowledging and validating that the birth was traumatic. The findings also demonstrate that distress and PTG can co-occur which suggests a focus solely on 'symptom reduction' as a clinical outcome might lead to overlooking growth which could be encouraged. Challenges remain about how best to prepare women for childbirth. It is notable that while these participants identified 'positive birth stories' as having unhelpfully shaped their assumptions, other evidence identifies the role of 'negative' stories in contributing to birth fear anxiety (Fenwick et al., 2015). Finally, giving voice to birth stories that include both trauma and PTG may contribute to the development of varied and positive narratives around birth at a societal level.

Conclusions

Through exploring women's experiences of PTG following traumatic birth and how they make sense of these experiences, this study helps to make visible to women, families and professionals the range of possible responses to birth trauma and offers insights into the processes through which traumatic birth experiences may lead to positive changes, in some circumstances. Further research is needed to better understand how growth may be fostered, including with consideration of any unintended consequences. This does not reduce the urgent need to prevent traumatic birth.

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