Spring 5-15-2015

Women's Experiences With Traumatic Childbirth

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ABSTRACT

WOMEN'S EXPERIENCES WITH TRAUMATIC CHILDBIRTH

by

TAMARA DENNIS

Postpartum Depression (PPD) and posttraumatic stress disorder (PTSD) following childbirth range from 10% to 40% (Beck, 2008a) and 1 to 6% respectively (Ayers 2007; Joseph & Bailham, 2003). These disorders have detrimental effects on the maternal infant dyad and significant implications for women's future birth choices, child development, and spousal relationships. Although PPD is widely recognized, PTSD, specifically the overlap of depressive symptoms with posttraumatic symptoms, following childbirth has not been as widely investigated. The purpose of this interpretive phenomenological study was to explore the meaning of traumatic childbirth in order to expand the current body of knowledge and gain a deeper understanding of the lived experience of traumatic childbirth.

Phenomenology was used to describe the experiences of 20 mothers who reported a traumatic childbirth event. Participants ranged from 24 to 61 years of age at the time of the interviews. Audiotaped, in-depth interviews were conducted for the study. Data analysis was accomplished through the hermeneutic process and following the methodology of van Manen (1990). Three patterns and 10 themes were identified: 1) "Never Being the Same" which had 4 themes of 'Knowing", "Losing Control", "Bearing the Pain", and "Being Afraid"; 2) "Making a Difference" which had 3 themes of "Knowing What They Are Doing", "Unnerving to Them", and "Sharing All That With Me" and 3) "Getting to the Other Side" which included "Praying", "Being Angry" and

"Looking Back". These patterns and themes defined the meaning of traumatic childbirth for these participants traumatic birth experience.

The first pattern highlighted the life changing experience of trauma during childbirth recognizing that bad things can happen to people. The second pattern focused on the important roles of healthcare providers, spouses, family and friends when a mother experiences a traumatic childbirth event. Finally, the third pattern revealed women's reflection of and resolution with the traumatic childbirth event. The implications of this study included recommendations for education, research, and practice. The study emphasized the need for collaboration among healthcare providers and long term follow-up care for women experiencing a traumatic childbirth.

WOMEN'S EXPERIENCES WITH TRAUMATIC CHILDBIRTH

by

TAMARA DENNIS

A DISSERTATION

Presented in Partial Fulfillment of Requirements for the Degree of Doctor of Philosophy
in Nursing in the Byrdine F. Lewis School of Nursing and Health Professions
Georgia State University

Atlanta, GA

2015

ACKNOWLEDGEMENTS

Sincere appreciation is extended to Dr. Margaret Moloney for serving as the Chair of my committee and for her invaluable support and guidance. Gratitude is also expressed to my committee members, Dr. Cecilia Grindel and Dr. Shannon Self-Brown, for their generous contribution of support and time. I would also like to thank my peer reviewers—Lisa Hedenstrom, Debbie Greene, Kate Fouquier, and Winsome Stephenson. The research team provided insight and understanding in reaching the study findings. A special thanks to fellow students Jamie Holland and Lisa Hedenstrom for their untiring support throughout both course work and dissertation adventure. I must also recognize my friends and colleagues, Becky Arnold and Patricia Barber for their enduring faith in me during this dissertation journey.

I must express my gratitude to my mother, Laverne Rogers and late father, Emory Rogers, who instilled in me a deep appreciation for education. I am also grateful to my sister, Suzanne Leroux, and her family who opened my eyes to the reality of PTSD following childbirth. I dedicate this dissertation to my husband, David, and our children, Matthew and Trey, all of whom supported me unconditionally over the years of conducting this work.

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LIST OF ABBREVIATIONS

PPD	Postpartum Depression
PTSD	Posttraumatic Stress Disorder
EPDS	Edinburgh Postnatal Depression Scale
DTS	Davidson Trauma Scale

CHAPTER I

INTRODUCTION

Focus of Inquiry

Pregnancy, childbirth, and becoming a mother are pivotal points in women's lives. The transition is generally perceived by society to be joyous and natural for all women. When the transition to motherhood does not meet societal expectations, psychological stress may occur. Researchers in the previous two decades have focused primarily on the psychological disorder of postpartum depression (PPD) (Beck, 2004a; 2008a, 2008b, 2009; Kitzinger, 2007). While postpartum depression has long been recognized as a disorder following childbirth, posttraumatic stress disorder (PTSD) has not been considered as relevant to the experience of childbirth as it has been to the experiences of veterans of wars, victims of sexual abuse, and accident victims (Ayers, Joseph, McKenzie-McHarg, Slade, & Wijman, 2008; Bailham & Joseph, 2003). Only recently have healthcare providers recognized that childbirth, when it is perceived as traumatic, can be an event that leads to the development of PTSD (Ayers, 2007; Bailham & Joseph, 2003; Beck, 2004a; Beck, 2004b; Beck, 2006a). PPD may also be co-morbid with PTSD following childbirth. Similarly, general depression is also reported to be co-morbid with PTSD among other populations (McFarlane, 2004; McNally, 2003). The incidence of PPD and PTSD following childbirth may have long term consequences for a mother, her child, and her spouse.

The possibility of PTSD following childbirth remains a controversial issue with some researchers who suggest PTSD is not a result of the childbirth experience. Research by Cohen and colleagues (Cohen, Ansara, Schei, Stuckless, & Stewart, 2004) suggested the occurrence of postpartum stress events appears to be more related to stressful life events and depression than related to pregnancy, labor, and delivery. Additional studies have indicated PTSD may arise from consequences related to the birth process such as significant vaginal lacerations, emergent cesarean section and fear of death for either the mother or the child (Ayers, Eagle, & Waring, 2006; Ayers, McKenzie-McHarg, & Eagle, 2007; Beck, 2004a; 2004b; Beck, 2006b). Childbirth may also precipitate PTSD related to a previous traumatic incident in the woman's life (Ayers, 2007; Bailham and Joseph, 2003; Seng, 2002; Seng et al., 2001). The emergence of PTSD from a prior traumatic experience versus the occurrence of PTSD related to the childbirth experience remains a relatively unexplored area in need of further consideration. Case studies suggest women with PTSD have been misdiagnosed with postpartum depression (PPD) (Ayers et al., 2008; Bailham & Joseph, 2003; Beck & Driscoll, 2006). Further study is needed to improve the current understanding of PPD and PTSD following childbirth.

Current research suggests that PTSD related to childbirth has psychosocial factors which are unique to childbearing women such as: tocophobia (a fear of labor), resulting poor maternal-infant attachments, a negative effect on spousal relationships, as well as a negative effect on infant well being (Parfitt & Ayers, 2009; Mapp & Hudson, 2005; Nichols & Ayers, 2007). Primary research has focused on the measurement of PTSD symptoms within 4 weeks postpartum and up to 1 year postpartum. Very little is known

about the long-term outcome of women who experience PTSD related to traumatic childbirth (White, Matthey, Boyd, & Barnett, 2006). Long term consequences specific to women of childbearing age such as the decision not to have more children due to tocophobia, a resulting delayed maternal-infant attachment, and possible deteriorating spousal relationships suggest a need to further investigate PTSD following childbirth. Research is needed to understand the experience of traumatic childbirth through the real life stories of mothers reporting PTSD symptoms after the labor and delivery of an infant.

Also of concern are the reports of the increased frequency of depressive symptoms and posttraumatic stress symptoms co-occurring in the postpartum period (Ayers et al., 2008; Beck, 2006a; Beck & Driscoll, 2006). One study by Taubman-Ben-Ari and colleagues (Taubman-Ben-Ari, Rabinowitz, Feldman, & Vaturi, 2001) indicated primary care providers were more likely to diagnose depression among postpartum women than to diagnose PTSD in the postpartum period. A contributing factor to misdiagnosis may be that depression is a more recognized disorder in the postpartum period than PTSD with reports of PPD ranging from 12% to 30% (Bailham & Joseph, 2003; Beck, 2008a; White et al., 2006). Due to the high rate of misdiagnosis healthcare providers may not evaluate for the occurrence of PTSD once a diagnosis of PPD has been made and treatment ordered.

Women who describe their childbirth as traumatic may decide to never have more children due to their fear of labor, may be unable to attach to their infants following delivery, and may experience a dysfunctional spousal relationship following the birth (Ayers, 2007). Long term outcomes have not been adequately explored among women experiencing PTSD and depression following childbirth. Further research is needed to

understand women's psychological experiences following traumatic childbirth to assist nursing in developing assessment measures, interventions, and evaluation of women experiencing distress related to PPD and PTSD after the delivery process. A study to understand the experience of traumatic childbirth and the psychological consequences of such a birth is needed to expand the current knowledge base to improve assessment and interventions for women in order to prevent long term consequences for the childbearing family.

Background of the Study

Childbirth and Trauma

I completed a small qualitative preliminary study (Dennis & Moloney, 2009) exploring the experience of PPD in rural women with findings which suggested two of the participants had experienced symptoms of PTSD such as flashbacks, hyperarousal, and avoidance behaviors. These findings from the study resulted in questions concerning the overlap of PPD and PTSD following childbirth. A review of the literature focusing on the overlap of PPD and PTSD revealed limitations of previous research including: small sample sizes, the use of a variety of different screening measures for determining prevalence rates of PPD and PTSD, controversy surrounding characteristics of both disorders as well as predictor variables, and vulnerability variables associated with the co-occurrence of PPD and PTSD following childbirth. A review of current studies exploring PTSD and childbirth are limited to small sample sizes and a lack of findings concerning the effect of previous PTSD symptoms or traumatic events in women prior to childbirth (Allen, 1998; Ayers, 2007; Beck, 2004a; Beck, 2004b; Beck, 2006a; Beck, 2006b).

Women have perceived childbirth in many different ways ranging from positive experiences to negative experiences (Ayers & Pickering, 2005; Ayers, McKenzie-McHarg, & Eagle, 2007). Considerable research exists exploring the mental health of new mothers following childbirth (Ayers & Pickering, 2005; Beck, 2008a; Bailham & Joseph, 2003). The focus of this research has primarily concentrated on mothers' experiences of postpartum depression (PPD) (Beck, 2008a; Leeds & Hargreaves, 2008; White et al., 2006). Recently researchers have begun to closely examine anxiety disorders among postpartum women with an increased consideration of psychological outcomes such as traumatic stress symptoms and PTSD (Ayers, 2007; Ayers & Pickering, 2005; Wenzel, Haugen, Jackson, & Brendle, 2005). The women in my preliminary qualitative study (Dennis & Moloney, 2009) self-reported PPD and two of the participants talked about flashbacks of the birth and the fear that the baby was dead. Women who do report PPD need further clinical evaluation for the assessment of symptoms which may be related to their perception of a traumatic childbirth, or previous PTSD and appropriate intervention for their symptoms (Ayers, McKenzie-McHarg, & Eagle, 2007).

A high rate of co-morbidity of PTSD and depression exists in other populations (Cairney, Corna, & Streiner, 2010; McCutcheon et al., 2010; McFarlane, 2004; McNally, 2003) suggesting that PPD and PTSD are also co-morbid following childbirth. Healthcare providers have recognized that difficult childbirth can be an event that leads to the development of PTSD (Bailham & Joseph, 2003; Beck, 2004a; Beck, 2004b; Beck, 2006a). Research originally conducted to investigate the occurrence of PTSD following childbirth has found PTSD to be co-morbid with PPD and it is unclear whether

depression develops at the same time as PTSD or as a consequence of PTSD (Ayers, McKenzie-McHarg, & Eagle, 2007; Bailham & Joseph, 2003). Another possibility is that women may have experienced a previous trauma and PTSD symptoms were triggered by the event of labor and delivery (Seng, 2001; Seng et al., 2006; Soet, Brack, & Dilorio, 2003). Psychological distress following childbirth has been well documented (Ayers and Pickering, 2005; Beck, 2008a; Bailham & Joseph, 2003). There is no single causal factor for PPD and research has shown that various sociological and physiological (Bloch, Rotenberg, Koren, & Klein, 2005; Dennis, 2004; Douma, Husband, O'Donnell, Barwin, & Woodend, 2005) factors may influence postpartum depression (Boath, Bradley, & Henshaw, 2005). However, PTSD following childbirth has been linked to a perceived traumatic event such as pain during the childbirth process, unexpected childbirth procedures, perceived negative attitudes of healthcare providers, and intense fear of childbirth (Ayers, 2007; Ayers & Pickering, 2005; Beck, 2006a, 2008a, 2008b, 2009; Zar, Wijma, & Wijma, 2002). The fear of childbirth may increase as more women access media sources such as reality television and internet blogs which focus on the more complex, high risk delivery processes where mother and infant are at increased risk for injury (Dempsey & Reiger, 2006; Kitzinger, 2006; Kitzinger & Kitzinger, 2007). Long term review of the effects of traumatic birth is needed to understand why women experience the psychological effects of PPD and PTSD following childbirth.

The Intersection of PPD and PTSD

Controversy continues to exist about whether or not PPD is unique from any other major depressive disorder at other times in women's lives (Bernstein et al., 2008; Jolley & Betrus, 2007). Co-morbidity of PTSD with PPD complicates this problem of incorrect

diagnosis in women following childbirth. Factors associated with depression occurring in the context of labor and delivery specific to the postpartum period versus a major depressive disorder include events such as unanticipated obstetric complications, dissatisfaction with the labor and delivery experience, and irritability similar to hyperarousal (Ayers, 2007; Beck, 2008b; Beck & Gable 2001; Creedy & Shochet, 1996; Creedy, Shochet, & Horsfall, 2000). These factors have also been found to be associated with PTSD following childbirth suggesting a relationship between PPD and PTSD following childbirth.

Symptoms associated with PTSD following childbirth include hyperarousal (irritability), avoidance (isolation), and intrusions (Ayers, 2007; Ayers & Pickering 2005; Beck, 2006b, 2009; Beck & Indman, 2005; Leeds & Hargreaves, 2008; Seng et al., 2001; White et al., 2006) which are also common symptoms in other populations who experience PTSD such as sexual abuse victims, survivors of natural disasters, and combat veterans (McFarlane, 2004; McNally, 2003). Hyperarousal may be defined as difficulty going to sleep or remaining asleep with recurrent nightmares in which reliving the event occurs. Hyperarousal is also described as being easily startled or on guard as if something bad was going to happen as well as being overly responsive to noises or movement (APA, 2000; National Center for PTSD, 2007). Avoidance is an effort to stay away from any person or situation that may trigger memories of the event and amnesia may occur as a form of avoidance while generalized numbing occurs when the person feels isolated or can no longer enjoy previous activities (APA, 2000; National Center for PTSD, 2007). Emotions are "numb" and the person is described as being distant. Intrusions are described as re-experiencing which involves reliving the traumatic event. The person may

have unexpected memories or triggered memories (APA, 2000; National Center for PTSD, 2007).

Current studies have also suggested that women who experience PTSD following childbirth have features similar to other groups with posttraumatic symptoms (Ayers, 2007; Beck, 2006b, 2009; Mason, Rice, & Records, 2005; Ayers, Joseph, McKenzie-McHarg, Slade, & Wijma, 2008; Olde, van der Hart, Kleber, & van Son, 2006) but also experience symptoms related to childbirth. Features which have been found to be unique to women following childbirth included: tocophobia (Elkit, Hartvig, & Christiansen, 2007; Hofberg & Brockington, 2000), delayed or decreased mother-infant attachment, and increased parenting problems (Ayers et al., 2008; Ayers, Eagle, & Waring, 2006; Bailham & Joseph, 2003; Sawyer & Ayers, 2009). Particular features of women experiencing PTSD after childbirth also included sexual avoidance and a mother's fear of her own death or the fear of her infant's death (McKenzie-McHarg, 2004; Stadlmayer et al., 2006). Similar to women experiencing PTSD following childbirth, women with PPD have also been found to have difficulty with infant attachment, disruption in sexual function and parenting issues (Ayers, Wright, & Wells, 2007; Beck, 2004a, 2006b, 2008a, 2008b, 2009; Dennis, 2004). The defining factor separating the two disorders is the occurrence of a traumatic event in the childbirth process predisposing a woman to PTSD.

Such considerable overlap in symptomatology requires further investigation of PPD and PTSD following childbirth. Investigation to determine the significance of the co-occurrence of PPD and PTSD in the postpartum period (related to the childbirth experience, traumatic birth, support, loss of control, and satisfaction with childbirth

experience) distinct from PPD is also needed. Further investigation is needed to determine if there is a relationship between posttraumatic stress symptoms and postpartum depressive symptoms (See Appendix A). Understanding the relationship between PPD and PTSD is essential before additional research can be undertaken to address the issues related to the management of posttraumatic stress symptoms in conjunction with PPD. Few theoretical frameworks have been specified by the current research associated with the phenomenon of PPD and PTSD in childbirth. Based on the findings of my preliminary qualitative study (Dennis & Moloney, 2009) and current literature, women reporting PPD may also have experienced PTSD. Continued research to expand the knowledge base regarding the co-occurrence of PPD and PTSD in women following childbirth will provide insight into the phenomenon to allow nurses and healthcare personnel better understanding of the disorders to improve management of psychological stress following childbirth. Findings may have long-term implications for women's health, infant health, family relationships, and healthcare policy related to reproductive health.

The phenomenon of distress following childbirth needs to be viewed in a broader context than simply postpartum depression. Understanding the long term outcomes of PPD and PTSD related to infant attachment, relationships, and mothers' mental health is needed in order for women to receive appropriate psychological care following childbirth. Appropriate assessment may prevent a misdiagnosis and treatment of only PPD in women with PTSD or women with both disorders (Edworthy, Chasey, & Williams, 2008; Ford & Ayers, 2009; White et al., 2006; Zaers, Waschke, & Ehlert, 2008). Treatment for the two disorders varies emphasizing the need for a correct

diagnosis. Treatment for PPD varies with the severity of the disorder including antidepressants, supportive psychotherapy, group therapy, and family therapy (APA, 2000; Beck 2008; Kramer et al., 2005). PTSD treatment is focused on the event itself, the individual, and the recovery environment. The use of cognitive behavior therapy, Eye Movement Desensitization Therapy (EDMR), and implosion therapy (flooding) are evidence based practices successful in the treatment of PTSD in the general population (APA, 2000; Ayers et al., 2008, Ayers, McKenzie et al., 2007).

It is important to recognize that vulnerability (such as personality type and trauma history) and risk factors may vary among women (Ayers, 2003; Beckett, 2005; Edworthy et al., 2008). Appraisal of the birth event, pain perception, and support from health care providers plays a unique role in the development of posttraumatic symptoms following childbirth (Ayers, Eagle, & Waring, 2006; Ayers & Pickering, 2001; Bailham & Joseph, 2003; Beck, 2006a; Ford & Ayers, 2009). A research study by Edworthy et al. (2008) suggested the role of personality or preconceived ideas about the childbirth process (childbirth as a positive, perfect experience) plays a role in the prevalence of PTSD symptomatology and indicated women who may have issues with meeting realistic goals particularly related to control and power may be more at risk for development of PTSD symptoms following childbirth (Edworthy et al., 2008). The finding supports erroneous societal views that childbirth and motherhood are joyous, happy, uneventful occurrences through which all women transition without difficulty (Beckett, 2005).

The idea of meeting unrealistic social standards for motherhood and the medicalization of childbirth may contribute to the disempowerment of women in what was once a natural process (Beckett, 2005; Kitzinger, 2006; Kitzinger & Kitzinger, 2007;

Wagner, 2007). Current births involve technologically intense care which has created more obstetrical intervention, more operative births and more morbidity associated with these events (Beckett, 2005; Fenwick, Gamble, & Hauck, 2006; Wagner, 2007). An increase in such interventions creates more opportunity for traumatic events to occur (Ayers, 2007; Beck, 2004a; Beck, 2006a; Beck, 2006b;) and in turn decreases a mother's voice in the childbirth process (Beckett, 2005; Kitzinger, 2006; Wagner, 2007). Certainly this loss of voice in such a life transforming event predisposes women to PTSD and the consequences of PTSD such as depression, disempowerment and disconnection. Allowing women to tell their own stories of traumatic childbirth will add to the current knowledge base of valuable information from the woman's perspective.

Stories allow the researcher to share the experience of the participant and come closer to the lived experience of the participant (van Manen, 1990). The researcher asks the participant about her story and opens the way for the participant to share goals, values and concerns about what it means to be a person living the experience of the phenomenon of interest. Through the completion of my preliminary qualitative study (Dennis & Moloney, 2009) of rural women with postpartum depression (using interpretive phenomenology) I have broadened my concept of the meaning of PPD. Before the interviews, I had a more descriptive concept of PPD based on the signs, the symptoms, and the treatment defined in textbooks. Following the pilot study, my definition of PPD recognizes the importance of women's lived PPD experiences. Phenomenology involves the mode of inquiry which focuses on how the social world is interpreted, understood, experienced, produced or constituted. Defining features of qualitative research include:

the interpretive reframing of data, generalizations, use of expressive language, and an interactive approach (Sandelowski, 1995).

The Heideggerian view suggests the person is self-interpreting or the experience is filtered through the life lens of the person (Heidegger, 1962). Contextually, women with PPD or PTSD do not know that they have the potential for PPD or PTSD until they actually have the disorder. In my preliminary qualitative study with PPD among rural women (Dennis & Moloney, 2009) the participants did not associate depressive symptoms as a traumatic effect from the labor process, birth process or postpartum process. For example, prior to the postpartum period, the women expressed the ideals of the perfect pregnancy and the dream of future goals for being the perfect mother. These women were not cognizant of the possibility of PPD until their dreams for the ideal were destroyed and PPD became a reality. The goal of hermeneutic inquiry was to understand the experiences of women who had lived with PPD which was achieved through the PPD pilot study. Based on the interpretation from the pilot study (Dennis & Moloney, 2009) findings suggest two of the participants expressed symptoms of both PPD and PTSD. Phenomenology is an appropriate method for describing the experiences of women who had traumatic childbirths.

Purpose and Research Questions

The purpose of this study is to gain an understanding of women's perceptions of traumatic childbirth. Heideggerian hermeneutic phenomenology will be used to reveal the nature of traumatic childbirth as women who self-report a traumatic birth experience tell their stories about that event. The narratives from these women will be used to describe

their experiences. The research question is: what is the lived experience of women who perceive their own childbirth as traumatic?

Significance to Nursing

Traumatic childbirth has a dramatic effect on the new mother, the child, and partner relationships. By exploring women's stories of traumatic childbirth, healthcare providers may better understand the repercussions of perceived trauma during birth and postpartally. Nurses are the frontline care providers during the labor and delivery process contributing a significant influence on the childbirth experience. A better understanding of women's perceptions of a traumatic childbirth will help nurses to improve interventions and establish trusting relationships with laboring women to create a "good" birth experience. We know that obstetrical emergencies and unplanned interventions create a loss of control for laboring women. However, nurses often focus on the medical outcomes in the laboring woman with little reflection on the psychological outcomes even with medically uneventful births. The findings from this research will assist healthcare providers in implementing assessment, treatment and follow up standards in the care of childbearing women.

Summary

Few qualitative studies have been conducted exploring the experience of women who describe their childbirth as traumatic and express symptoms of PPD and PTSD. The purpose of this study is to gain an understanding of women's perception of their own traumatic childbirth and the co-occurrence of depressive symptoms. The use of interpretive phenomenology will allow for a reflection of women's experiences. This study will provide the researcher with the opportunity to hear women tell their stories

about the birth process and the trauma they associate with the process. The findings will be used to supplement the current literature concerning PPD and PTSD in women following childbirth including: the overlap of PPD and PTSD, the perception of the childbirth experience, the role of providers during childbirth, and the long term outcomes of PPD and PTSD. The narratives of the participants will be used to further nursing knowledge concerning psychological assessment of the childbearing woman, effective interventions during the childbirth process, and appropriate follow-up for women who perceive their childbirth as traumatic. Effective assessment and follow-up are important to preventing or decreasing the incidence of tocophobia, poor infant attachment, and deteriorating spousal relationships for women experiencing PPD and PTSD. The next chapter will review the current research literature and theoretical perspectives implicit to understanding women's experience of traumatic childbirth.

Further investigation is needed to determine if there is a relationship between PTSD and postpartum depressive symptoms, if routine measurement of posttraumatic stress symptoms would be useful, and if intervention to prevent PPD and PTSD can be feasibly implemented. Because of the lack of qualitative inquiry into the co-occurrence of PPD and PTSD with childbirth, further phenomenological investigation is needed to understand the experience of childbirth as a traumatic event and the posttraumatic effects including postpartum depression to inform current research, education and clinical practice.

CHAPTER II

REVIEW OF LITERATURE

Research on Childbirth and Trauma

In this section, I will present a synthesis of current research on the experience of childbirth, depression, and trauma. Research with women experiencing postpartum depression and posttraumatic stress following childbirth will be examined. A discussion of a small qualitative study I conducted examining the experience of PPD among rural women will also be reviewed. A description of how this study will further our understanding of depression and posttraumatic stress following childbirth as well as address the current gaps in the literature will be given.

Literary Context

Perspectives on Traumatic Childbirth

Childbirth is a pivotal and unique experience in a woman's life. The myth of an uninterrupted, joyful transition to motherhood for all women is perpetuated by current society (Beck, 2008a; Ford, Ayers, & Wright, 2009; Kitzinger, 2006; Wolf, 2003). The childbirth experience has changed dramatically over the last fifty years with transference of care from the home setting to the acute care setting which is invested in delivery of technologically intensive care and medical intervention (Kitzinger, 2006; Wagner, 2003; Wolf, 2003). When the myth of a happy, uneventful delivery and postpartum period is dispelled, stress may dominate the childbirth experience, and the transition to motherhood can result in the development of postpartum mood and anxiety disorders

such as PPD and PTSD (Ayers, 2007; Beck, 2004b, 2006b; Gamble & Creedy, 2005; Parfitt & Ayers, 2009). Healthcare practitioners have previously focused on the problem of PPD but are currently focusing on the incidence of and characteristics associated with PTSD following childbirth. An important finding in the PTSD research is the co-occurrence of depressive symptoms with posttraumatic stress symptoms in women following labor and delivery of the infant (Ayers, 2007; Bailham & Joseph, 2003; Ayers, Joseph, McKenzie-McHarg, Slade, & Wijma, 2008; Parfitt & Ayers, 2009).

Depression after childbirth is defined as a major depressive episode with onset at four weeks postpartum and lasting at least two weeks in duration (APA, 2000). PPD prevalence rates have been reported to range between 12% and 41.9% in new mothers based on cross-cultural and international research (Beck, 2008a; White et al., 2006). Researchers since the 1980s have examined factors associated with PPD including prevalence rates, moderators such as social support, and risk factors such as a previous history of depression (Beck, 2008a; Corwin & Pajer, 2008; Posmontier, 2008). Current rates vary little even in the presence of interventions such as screening, social support implementation, and increased education (Beck, 2008a; Corwin & Pajer, 2008; Goebert, Morland, Frattarelli, Onoye, & Matsu, 2007) with PPD remaining a significant disorder among women.

The small pilot study I conducted described the meaning of the lived experience of PPD for rural women in a southeastern state. A phenomenological approach was used to collect data about rural women's experiences with PPD with a total of five participants enrolled. The women were demographically similar and self-reported PPD. Qualitative analysis resulted in the themes: No Idea It Would Happen To Me, Losing Myself, A Bad

Place To Be and Working Through. The women reported dramatic shifts from what they imagined motherhood to be like, to the reality of their experience, with unexpected feelings of loss, isolation, and finally adjustment that enabled their survival through PPD. The overall pattern Choosing To Be a Mother described the process of overcoming PPD. Each of the women interviewed talked about the period of time after their childbirth as a period of sadness, denial, blame, stress, role change, and loss of control after the birth of the baby. Two of the participants experienced flashbacks, triggers, isolation and symptoms often associated with post-traumatic stress disorder (PTSD). For each participant with ages ranging from 26 to 50, the emotions associated with PPD were as vivid today as they were in the postpartum period spanning from months to years. The findings supported a need to further explore a connection between PPD and PTSD.

Limited studies have specifically investigated the intersection of PPD and PTSD, although each of the disorders has been studied individually (Ayers, 2007; Ayers, Joseph et al., 2008; Beck, 2009; Fairbrother & Woody, 2007; White et al., 2006). Factors associated with PPD include: obstetric complications, satisfaction with the labor and delivery experience, loss of control in the labor/delivery/postpartum process, and irritability similar to hyperarousal (Beck, 2008b; Beck & Gable, 2001; Creedy, Shochet, & Horsfall, 2000; Ross & Dennis, 2009). PTSD symptoms following childbirth also include hyperarousal, avoidance, and intrusions (Beck, 2009; Ford & Ayers, 2009). Depression may also be a symptom of PTSD (APA, 1994) and the overlap of symptoms suggests PPD may be a symptom of PTSD. The occurrence of depression, hyperarousal, intrusions, and isolation following childbirth needs further investigation to determine if PPD is an unrecognized subset of PTSD. In order for a woman to experience PTSD

following childbirth, a traumatic event during the birth process must have occurred. Investigation must occur within the context of obstetrical intervention, healthcare provider support, a perceived loss of control, and poor satisfaction with the childbirth experience as these factors have been associated with both disorders (Ayers & Pickering, 2001; Beck, 2008a, 2009; Goebert et al., 2007; Parfitt & Ayers, 2009; White et al., 2006).

Limitations of past research of the overlap of PPD and PTSD include the use of a variety of methodologies (Edworthy et al., 2008; Ford & Ayers, 2009; Seng, Schrot, Van De Ven, & Liberzon, 2007), and co-occurring risk factors (Beck, 2009; Ford & Ayers, 2009; Leeds & Hargreaves, 2008; Ross & Dennis, 2009). These issues which have contributed to the uncertainty regarding the co-occurrence of PPD and PTSD will be discussed in this section. Another limitation to current research which is discussed in the theory section is that few theoretical frameworks have been specified and associated with the phenomenon of PPD and PTSD in childbirth. Continued research is needed to expand the knowledge base regarding the co-occurrence of PPD and PTSD postpartally. A better understanding of the disorders in women following childbirth has long-term implications for women's health such as chronic depression, untreated PTSD, poor infant attachment, and interrupted spousal relationships (Beck, 2009; Cho, Hold-Ditch, & Mile, 2008; Nichols & Ayers, 2006; Parfitt & Ayers, 2009). A review of the state of the science and gaps in the literature examining the intersection of PPD and PTSD follows.

PPD and PTSD Literature

Researchers investigating PTSD following childbirth have found PPD to be co-morbid with PTSD (Beck, 2009; Leeds & Hargreaves, 2008; Parfitt & Ayers, 2009; White et al., 2006). It is not known whether depression in the postpartum period

develops at the same time or as a consequence of PTSD (Ayers, McKenzie-McHarg, & Eagle, 2007; Ford & Ayers, 2009; Gamble & Creedy 2005). There is no single causal factor for PPD and research has shown that various sociological and physiological factors may influence postpartum depression (Beck, 2008a, 2008c; Bloch et al., 2005; Boath, Bradley, & Henshaw, 2005; Dennis, 2004; Douma et al., 2005; Ross & Dennis, 2009). However, PTSD following childbirth has been linked to a perceived traumatic event such as pain during the childbirth process, unexpected childbirth procedures, attitudes of healthcare providers, loss of control in the labor/delivery process and intense fear (Ayers, 2007; Ayers & Pickering, 2001, 2005; Beck, 2006a, 2008c; Bryanton, Gagnon, Johnston, & Hatem, 2008; Parfitt & Ayers, 2009). The revised edition of the DSM-IV broadened the definition of a traumatic event to include an event in which individuals witnessed "an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or close associate" (APA, 2000, p. 465). The individual must have responded with the emotions of fear, helplessness, or horror (APA, 2000). This expanded definition allowed the inclusion of an event such as traumatic childbirth to meet criteria for PTSD. PTSD symptoms are categorized into three categories: re-experiencing of the traumatic event including dreams, intrusions, and emotions associated with the event; emotional numbing, detachment, and avoidance of the stimuli associated with the traumatic event; hyperarousal symptoms to include difficulty concentrating, sleeping, irritability, and increased startle response (APA, 2000). Broadening the diagnostic criteria allowed scientists and clinicians to make a clinical diagnosis of PTSD

in women who had experienced traumatic birth (Ayers, Joseph et al., 2008; Olde et al., 2006).

The growing interest in PTSD in the area of childbirth has raised questions concerning the overlap of symptoms in PPD and PTSD (Ayers, Joseph et al., 2008; Parfitt & Ayers, 2009). A pioneering study by Lyons (1998) used a prospective study design (n = 42) using both PTSD and PPD self-report scales to conduct research in postpartum women 1-month postpartally. PPD was measured with the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987) and trauma symptoms were measured using the Impact of Event Scale (IES) (Horowitz, Wilner, & Alvarez, 1979). Findings suggested PPD and PTSD were coexistent 41 % of the time (Lyons, 1998). Depression has also been found to be co-morbid with PTSD in the general population (Seng, 2002; Seng, Low, Sperlich, Ronis, & Liberzon, 2009).

Many women may receive a single diagnosis of PPD when PTSD is also present (Beck, 2008b; Parfitt & Ayers, 2009; Wisner, Chambers, & Sit, 2006). A woman diagnosed with PPD without investigation of PTSD symptoms may consequently receive inappropriate treatment (Beck, 2006a; Bick & Rowan, 2007; Cigoli, Gilli, & Saita, 2004; Ford & Ayers, 2009). PPD has been frequently investigated with assessment tools and interventions implemented in clinical practice with no noted change in prevalence rates (Beck, 2008a; 2008b; Cigoli et al., 2006). Further investigation of PPD and PTSD is needed to examine the overlap in symptoms of irritability, avoidance, and intrusions with depression considered a symptom of PTSD. A review of PPD and PTSD as separate disorders follows.

Postpartum depression.

PPD has been a topic of interest for researchers since the late 1980s. Early researchers defined PPD as a non-psychotic depressive episode that begins or extends into the postpartum period (Cox, Holden, & Sagovsky, 1987) or as a common process that may last from 10 days up to a year following delivery (Kramer, Beaudin, & Thrush, 2005). Currently, the American Psychological Association (2000) defines PPD as a major mood disorder with onset within four weeks postpartum. PPD is a major mood disorder with no differentiation from other non-postpartum episodes other than time of onset (APA, 2000). The disorder is described as a depressive episode with symptoms including appetite disturbance, sleep disturbance, agitation, loss of interest, fatigue, self-deprecation, lack of concentration, and suicidal ideation (APA, 2000). Some researchers suggest women experiencing depression postpartally have higher levels of anxiety and isolation than women with depression at other times in their lives (Rijnders et al., 2006). Four of these symptoms may be used to diagnose PPD (APA, 2000). However, current research in the areas of women's mental health suggests PPD symptoms may also include increased anxiety, hyperarousal, anger, and mood lability which are not included in the DSM-IV criteria for PPD (Beck & Indman, 2005; Fowles, 1998; Jolley & Betrus, 2007) suggesting a more complex disorder that is unrecognized or misdiagnosed.

Although PPD is recognized more often than PTSD, PPD has often been under-diagnosed (Beck, 2008a, 2008b; Jesse & Graham, 2005; Jolley & Betrus, 2007) and under-treated. Under-diagnosis and under-treatment may prolong the disorder increasing a mother's emotional distress and lengthening her recovery time (Beck, 2008a, 2008b). Under-diagnosis may be related to the lack of knowledge among primary care providers

of PPD and lack of reporting due to the stigma related to the disorder (Beck, 2002; Beck & Indman, 2005; Edwards & Timmons, 2005; Jolley & Betrus, 2007). Under-treatment may be related to the overwhelming use of primary care providers instead of specialized mental healthcare providers (Beck, 2008b; Wisner, Chambers, & Sit, 2006). The stigma of having PPD may prohibit women from reporting depressive symptoms to their healthcare provider contributing to under-diagnosis and under-treatment (Jesse & Graham, 2005; Jolley & Betrus, 2007; Spector, 2006). However, PPD remains more widely recognized than PTSD following childbirth (Beck, 2009; White et al., 2006).

Women with PPD may also have been treated unsuccessfully because of a missed diagnosis of PTSD (Beck, 2004a, 2006a, 2008c; Gamble, Creedy, Moyle, Webster, McAllister, & Dickson, 2005). Only within the last decade have scientists and clinicians recognized the occurrence of PTSD related to childbirth (Beck, 2004a, 2004b, 2006a, 2009; Fairbrother & Woody, 2009; Stadylmayer et al., 2006). Women with PPD report symptoms such as anger, hyperarousal, and anxiety which overlap with PTSD symptoms. This lack of proper diagnosis and under-treatment contributes to inadequate care of women experiencing PPD and PTSD following childbirth.

Posttraumatic stress disorder following childbirth.

Approximately 10% of women in the general population experience PTSD with women experiencing PTSD twice as often as men (NIMH, 2007). A study by Taubman-Ben-Ari and colleagues (Taubman-Ben-Ari et al., 2001) found only 2% of participants in a primary care setting were diagnosed with PTSD by structured psychiatric clinical interview (SCID) (APA, 2000) compared to 20% of patients diagnosed with depression by General Health Questionnaire (GHQ) (Goldberg & Hillier, 1979). Findings indicated

primary care physicians were more likely to diagnose depression in comparison to PTSD. Physicians in this study were also less likely to ask about a history of a traumatic event. Reports of PPD range from 12% to 41.9% (Ayers, Joseph et al., 2008; Beck, 2008a; White et al., 2006) while reported PTSD following childbirth averages 1.5 to 5% (Ayers, 2007; Ayers & Pickering 2001; Edge, 2007b).

The use of clinical case studies of women with PTSD following childbirth has been more successful in describing PTSD in women experiencing traumatic births (Ayers, 2007; Beck, 2006a, 2008c, 2009). Case studies, using women's interviews, and self-report instruments such as the Perceptions of Labor and Delivery Questionnaire (Soet et al., 2006) and PTSD-Q (Cross & McCanne, 2001) in prospective studies suggest that PTSD related to childbirth has many precipitating factors unique to childbearing (obstetrical interventions, fear of childbirth, and loss of control) that may create a high degree of overlap with PPD symptoms such as avoidance, hyperarousal, and intrusions (Ayers, 2007; Ayers, Joseph et al., 2008; Beck, 2004a, 2006a, 2008c; Kitzinger, 2004, 2006). A history of previous trauma has also been found to precipitate PTSD following childbirth (Seng, 2002; Seng et al., 2004).

Although avoidance, hyperarousal, and intrusions are key symptoms of PTSD, depression may occur as a result of PTSD. The occurrence of depression and PTSD postpartum could mean a woman will score at higher levels on the most frequently used self-report tools for measuring PPD (White et al., 2006). Higher scores on self-report instruments, such as the Edinburgh Postnatal Depression Scale (EPDS) are reflective of depressive symptoms and may prompt primary care providers to refer women with a diagnosis of PPD to mental health resources. More thorough assessment by structured

clinical psychiatric interview may also uncover symptoms of PTSD. Assessment by psychiatric interview leads to identification of childbirth related trauma symptoms or PTSD (Ayers, Joseph et al., 2008; Seng, Shrot, Van De Ven, & Liberzon, 2007). Women experiencing a traumatic delivery with low depression scores based on self-report instruments such as the EPDS may not be identified for follow-up (White et al., 2006). The overlap of symptoms is presented as bolded type in the following table.

Table 1

*Symptom Overlap in PPD and PTSD**

Depressive Symptoms	Posttraumatic Stress Symptoms
Depressed mood	Flashbacks
Hypersomnia	Avoidance
Anhedonia	**Anhedonia**
Insomnia	**Insomnia**
Fatigue	Feelings of detachment
Sadness	Anger
Suicidal ideation	**Suicidal ideation**
Irritability	**Irritability**
Inappropriate guilt	**Inappropriate guilt**

*American Psychiatric Association. (2000). Text Revision (4th Ed.). *Diagnostic and statistical manual of mental disorders.* Arlington, VA.

Women may not be diagnosed appropriately and miss the opportunity for treatment of PTSD which may have long term implications such as disruption of mother/infant attachment, family relationships, and infant development (Ayers et al.,

2008; Ayers, Eagle, & Waring, 2006; Nicholls & Ayers, 2007). Incorrect diagnosis may also result in discrepancy of prevalence rates (Ayers et al., 2008; White et al., 2006). Discussion of the limitations of past research related to methodological issues of design, sample characteristics, screening measures and predictor variables (characteristics and vulnerability factors) follows.

Limitations of Past Research

Databases including CINAHL, PubMed, PsycINFO, MEDLINE, and ProQuest were reviewed with approximately 40 articles (both quantitative and qualitative) exploring trauma and PTSD in childbirth. Five articles focused on the relationship of depressive symptoms and posttraumatic stress symptoms following childbirth. No qualitative studies exploring the overlap of PPD and PTSD were noted. Research examining the intersection of PPD and PTSD is limited by several factors. Methodological issues such as sample size, the use of a variety of screening instruments to measure outcomes of depressive and posttraumatic stress symptoms, and design issues may contribute to the wide range of prevalence rates. The overlap of predictor variables and vulnerability factors associated with PPD and PTSD has not been well defined (Ayers et al., 2008; Bailham & Joseph, 2003).

Design

A limitation of the current research is the use of a variety of different design strategies and sample characteristics to explore the co-occurrence of PPD and PTSD following childbirth. Previous design strategies include prospective, retrospective, and experimental methods. The homogeneity and size of study samples may have contributed

to the variation in prevalence rates and risk factors reported in study findings (Ayers, 2007; Ayers et al., 2008; Leeds & Hargreaves, 2008; White et al., 2006).

Prospective designs included time points ranging from 34 weeks gestation to 12 months postpartum. Longitudinal designs were initiated at 3 months and continued at 6 months and 12 months (White et al., 2006; Zaers, Waschke, & Ehlert, 2008). Data collection prior to 3 months postpartum meets the definition of acute PTSD based on DSM-IV (APA, 2000) criteria. A retrospective study of women following childbirth met the time criteria but had high attrition rates (79%) contributing poor generalizability (Leeds & Hargreaves, 2008). Only one experimental-between-subjects study was conducted using childbirth vignettes to determine PTSD in women (Ford & Ayers, 2009). Although experimental design is the strongest design method (Brink & Wood, 1998), small sample size and simulation of childbirth experience in the study weakens the overall study design (Ayers, Joseph et al., 2008; Ford & Ayers, 2009).

Sample Characteristics

The sample size of research studies of PTSD following childbirth vary from 20 to 396 participants. Proposed rates of prevalence for posttraumatic stress symptoms vary from 1.5% to 5% immediately postpartum (Ayers & Pickering, 2001) to 14.9% at 6 months postpartum (Zaers, Waschke, & Ehlert, 2008). Lyons (1998) reported 3 of 42 participants scored high posttraumatic symptoms as well as high scores for depressive symptoms. White and colleagues (2006) conducted a longitudinal study (n = 367) over a 12 month period with a prevalence rate reported to be 2% at 6 weeks, while 10.5% of women experienced partial symptoms in two subscales but did not meet criteria for a diagnosis of PTSD. Symptoms of PTSD remained at approximately 2% at 6 month and

12 month surveys (White et al., 2006). Similar PTSD rates of 1.25% at 3 to 6 months postpartally were reported by Cigoli and colleagues in an observational study (n = 160) among women following normal delivery (Cigoli, Gilli, & Saita, 2006). Overall rates were less than the 10% of women in the general population (NIMH, 2007).

Research by Leeds and Hargreaves (2008) retrospectively investigated the postpartum experience of women at 6 to 12 months following delivery (n = 102) to determine rates of PPD and PTSD. Depressive symptoms were found in 21.5% of the sample. Results also indicated 3.5 % of women experienced PTSD symptoms at clinically significant levels while another 19.6% reported subclinical symptoms (Leeds & Hargreaves, 2008). The study also reported 27.2% of women with depressive symptoms also experience posttraumatic stress symptoms. Similarly, Edworthy and colleagues (Edworthy, Chasey, & Williams 2008) reported 10 out of 20 women meeting clinical criteria for PPD also met criteria for posttraumatic stress symptoms suggesting an overlap of PPD and PTSD (*n* = 121). The increased prevalence of subclinical symptoms and overlap of depressive symptoms were important findings in each study.

Sample populations were predominantly married, in professional occupations, and mostly white which decreases generalizability of findings (Leeds & Hargreaves, 2008; White et al., 2006). A single study by Paul (2008) reviewed PTSD following childbirth among Hispanic women. Of the 22 participants, higher scores of trauma symptoms were related to higher rates of perinatal and postpartum complications and avoidance scores among Hispanic women were lower than that of Caucasian women (Paul, 2008). Sample sizes were also small limiting generalizability (Ford & Ayers, 2009; Leeds & Hargreaves, 2008). No difference in prevalence was found among the variables of age, occupation,

marital status, and education which may be related to homogeneity of the sample population (Beck, 2009; Edworthy et al., 2008). Future studies using larger, more diverse samples would be important to identify risk factors and prevalence for both disorders (Ayers et al., 2008; Ayers, Harris, Sawyer, Parfitt, & Ford, 2009).

In summary, a variety of research designs and sample characteristics have contributed to limitations in the current findings to include homogeneity of samples, small sizes and lack of control groups (Ayers et al., 2009; Leeds & Hargreaves, 2008; White et al., 2006). The homogeneity and size of samples decreases generalizability of findings to other populations (Brink & Wood, 1998). A strength of the studies is the contribution to the current knowledge base concerning PTSD following childbirth. Future research should address larger sample sizes and more diversity to increase representation of the population and strengthen the knowledge base.

Screening Measures

In both PPD and PTSD research there is a heavy reliance on self-survey questionnaires. Such surveys do not as thoroughly address criteria for PPD and PTSD as well as the clinical structured psychiatric interview which is the gold standard for diagnosis of depression and PTSD according to the DSM-IV (APA, 2000; Lancaster, Melka, & Rodriguez, 2009). Multiple instruments have been used to measure both depression and posttraumatic stress symptoms in women following childbirth. The use of multiple instruments may account for discrepancies in prevalence rates and predictor variables. Multiple instruments may measure constructs such as a lack of support, traumatic birth experience, dissatisfaction with birth experience, and negative outcomes differently (Brink & Wood, 1998).

Examples of the self-report instruments used to assess for depressive symptoms and posttraumatic stress symptoms include surveys such as the EPDS, the Postpartum Depression Screening Scale (PDSS) by Beck and Gable, 2000. Beck Depression Inventory (BDI-I) (Czarnocka & Slade, 2000; Lyons, 1998; White et al., 2006), State Trait Anxiety Inventory (STAI) (Ford & Ayers, 2009, White et al., 2006; Zaers et al., 2008) and Posttraumatic Stress Disorder Questionnaire (PTSD-Q) (Cigoli et al., 2006). Few studies have used the structured clinical psychiatric interviews to diagnose PPD and PTSD based on DSM criteria (Wenzel et al., 2005).

Two of the most common instruments, the EPDS and Postpartum Depression Screening Scale (PDSS) are appropriate for the measurement of PPD based on previous research (Beck, 2008a; Beck & Gable, 2001; Beck & Indman, 2005). Designed specifically to address depressive symptoms in postpartum women, the EPDS remains the most widely used tool (Ayers & Pickering, 2005). However, instruments originally designed for the general population are frequently used such as: the Beck Depression Inventory – II (BDI-II) for depression and the State-Trait Anxiety Inventory (STAI) for PTSD. Edworthy et al. (2008) reported a PTSD prevalence of 9% using the Impact of Events Scale – revised (IES-R) while Davies, Slade, Wright, and Stewart (2008) reported a PTSD prevalence rate of 1.3% using the posttraumatic stress disorder questionnaire (PTSDQ). The inconsistent use of one specific instrument as well as study design may have created diverse and wide ranges of prevalence rates and risk factors.

Risk Factors for PPD and PTSD

Although the intersection between PPD and PTSD following childbirth has not been well investigated, prior research findings include risk factors specific for each

disorder. Beck (1992, 1993, 2001, 2008a) reports a loss of control as the primary concept related to PPD. Findings from previous research surrounding PPD suggest the variables of social support, self-esteem, life stress, childcare stress, prenatal depression, and fatigue are also significant to PPD (Beck, 2001, 2008a; Ford, Ayers, & Bradley, 2010; Seng et al., 2006). A meta-analysis by Beck (2002, 2008a) suggested risk factors such as a history of depression, the infant temperament, and low socioeconomic status as contributors to PPD. Perception of decreased control during the labor and delivery process has also been found to contribute to PTSD symptoms (Allen, 1998; Bryanton et al., 2008; Czarnocka & Slade, 2000; Ford, Ayers, & Bradley, 2010; Lyons, 1998; Seng et al., 2006). Risk factors for PTSD following childbirth include: history of previous trauma, unplanned obstetrical intervention, and loss of control during the labor process (Ayers & Pickering, 2005; Beck, 2004a, 2009).

A comparison of known PPD variables and PTSD variables may be helpful in describing the outcome of the labor and delivery experience for women following childbirth. Important variables to address in examining the co-occurrence of PPD and PTSD include: predisposing history of mental illness, lack of social support, birth experience, and powerlessness (Ayers & Pickering, 2005; Beck, 2004a). The literature surrounding the co-occurrence of PPD and PTSD has found risk factors associated with PPD and PTSD symptoms to include: lack of supportive care, perceived loss of control, stressful events, (Ford & Ayers, 2009) traumatic birth, previous history of mental disorder (Ayers & Pickering, 2001; Beck, 2004, 2006a, 2006b), and a history of trauma (Ayers et al., 2009; Ayers, Mc-Kenzie-McHarg, & Eagle, 2007; Ayers & Pickering, 2001; Beck, 2006; Ross & Dennis, 2009; White et al., 2006). Although not part of the

DSM definition, the overlapping factor for PPD and PTSD is the concept of a loss of control. The relationship between previous mental health issues, life stress, and social support need further investigation. The role of the birth experience, healthcare providers, and feelings of powerlessness in the development of PPD and PTSD also remains unclear.

Extensive qualitative study has occurred with the phenomenon of PPD since the original grounded theory established by Beck (1993, 2002, 2007). Findings suggest women are faced with a difficult task of meeting society's vision of the happy, uneventful transition to motherhood. Other findings included delayed infant attachment, sexual avoidance, and isolation from friends and family (Beck, 2002, 2008). Few qualitative studies have been conducted with PTSD following childbirth. Current qualitative research has investigated the experience of women experiencing PTSD in abused women (Seng, 2004), couples and relationships (Ayers, Eagle, & Waring, 2006; Nicholls & Ayers) and the infant relationship (Parfitt & Ayers, 2009) finding negative association in all relationships. No qualitative studies exploring the overlap of PPD and PTSD were found.

Predictor Variables

Postpartum depression has been shown to be associated with specific predictor variables (Ayers & Pickering, 2006; Beck, 1993, 2008a; White et al., 2006). Prior Mental Health issues, life stress, social support, birth experience (Beck & Watson, 2010), previous sexual trauma (Seng, 2002) and powerlessness have been shown to be important to postpartum women in as a predictor of postpartum depression (Beck, 2001; Hobfoll et al., 1995; Hung & Chung, 2001; Hung, 2004; Logsdon & Usui, 2001; Ritter et al., 2000).

Early recognition of postpartum depression has been a primary challenge for healthcare providers and a focus on evaluating predictor variables may be effective in treatment (Beck, 2001, 2002a, 2002b).

Prior Mental Health Issues

A previous history of depression (Ayers & Pickering, 2001; Beck, 2004a, 2006a, 2006b) and a previous history of trauma (Ayers & Pickering, 2001; Beck, 2006a; Ford, Ayers, & Bradley, 2010; Seng et al., 2006; White et al., 2006) have been associated with the co-occurrence of PPD and PTSD. Zaers and colleagues (2008) found depressive/traumatic symptoms in late pregnancy, critical life events, and the birth experience to be predictors of depressive and posttraumatic stress symptoms in mothers at 6 months postpartum. The study found anxiety in late pregnancy as being a significant predictor for both PPD and PTSD symptoms. Consistent with the findings of Zaers et al. (2008) prenatal anxiety also has been found to be a predictor of PTSD in women postpartally (Ayers & Pickering, 2005).

A previous history of depression or trauma was also found to be a predictor of PTSD following childbirth (Leeds & Hargreaves, 2008). Unlike research by Leeds and Hargreaves (2008) research conducted by Edworthy et al. (2008) found no relationship between a previous traumatic event or history of mental health disorder and posttraumatic symptoms in women following childbirth. However, posttraumatic stress symptoms and depressive symptoms were highly correlated in both studies (Edworthy et al., 2008; Leeds & Hargreaves, 2008).

Life Stress and Social Support

Ford and Ayers (2009) found the stressful events in simulated childbirth vignettes were not significant to the development of posttraumatic stress or depressive symptoms in the participants. The study sample completed both negative and positive childbirth vignettes. Study findings suggested social support during childbirth had a greater effect on emotional outcomes than stressful events. In another study, Leeds and Hargreaves (2008) found women experiencing PPD and PTSD reported less social support, more unexpected birth related procedures, and a traumatic perception of the childbirth event as opposed to previous stressful life events. Such findings support a need to further investigate the role of life stress in PPD and PTSD following childbirth to guide development of appropriate assessment and intervention strategies following childbirth.

Research investigating depressive symptoms and anxiety symptoms in new mothers reported mothers' unmet support needs by family and healthcare providers results in increased levels of depressive and posttraumatic symptoms in childbirth (Beck, 2008a, 2009; Cigoli et al., 2006; Stadlmayr et al., 2006). Ford and Ayers (2009) asked women to rate the stress, depressive reaction, and perceived provider support in vignette scenarios. The study found provider support during the childbirth stress event (increased pain, difficult delivery, or nurse/physician support) was more indicative of emotional outcome than the stressful birth event itself (Ford & Ayers, 2009).

Birth Experience

Several studies report the significance of mothers' perceptions of the birth event. Soet et al. (Soet, Gregory, Brack, & Dilorio, 2003) found the childbirth experience to be traumatic (defined as obstetrical intervention, nurse/physician, midwife support, and pain

level) to 34% of participants in a prospective, observational study among 104 women 4 weeks following childbirth. Beck (2004a) defines birth trauma as "an event occurring during labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant" (2004a, p. 28). Birth type, such as operative vaginal delivery (forceps, vacuum extractors) and emergent cesarean delivery, have been found to be a predictor of higher PTSD symptoms in women at six weeks postpartum (Creedy, Schochet, & Horsfall, 2000; Gamble & Creedy, 2005; Rijnders et al., 2008).

Perceptions of the birth process are complex and dynamic. Expectations of the birth process play an important role in the perception of a positive or negative birth experience (Ayers & Pickering, 2005; Ford et al., 2010). Unexpected medical problems (emergent cesarean section, induction, augmentation of labor, medically fragile infants), social issues (unwanted pregnancy, lack of partner support), labor factors (fear, pain, lack of control), and problems with caregivers including nurses and physicians (antenatal, intrapartal, postpartum) have contributed to a negative childbirth experience (Beck, 2008b, 2009; Beck & Watson, 2010; Cigoli et al., 2006; Waldenstrom, Hildingsson, Rubertsson, & Radestead, 2004).

"What a mother perceives as trauma may be seen quite differently through the eyes of obstetric providers, who may see it as a routine delivery and just another day at the hospital" (Beck, 2004a, p. 28). Further investigation into the role of obstetric care in the development of PPD and PTSD is needed as women feel the need for such help and support is not being met by their care providers (Ford & Ayers, 2009; Cigoli et al., 2006; Stadlmayr et al., 2006). Further investigation would provide more insight into the role of healthcare providers as a moderating factor in the perception of the childbirth experience

and outcomes of PPD and PTSD among new mothers (Davies et al., 2008; Ford & Ayers, 2007; Leeds & Hargreaves, 2008; Soet et al., 2003).

Previous Sexual Trauma

Factors such as previous or current history of sexual trauma have been found to be primary predictors of traumatic symptoms. Women who have experienced sexual abuse in childhood or in their present relationship have more complications, adverse childbirth events and more negative perceptions of childbirth (Seng, 2002; Seng, Sparbel, Low, & Killion, 2002; Seng, Low, Sparbel, & Killion, 2004). Women often do not disclose their trauma history due to feelings of shame, fear, traumatic amnesia, and a lack of trust in healthcare providers. A qualitative study by Seng et al. (2004) suggests women with a previous trauma history will experience a childbirth event as traumatic or the childbirth event will trigger PTSD symptoms from a previous trauma.

Powerlessness

The phenomenon of distress following childbirth needs to be viewed in a broader context than simply PPD to avoid a misdiagnosis of PPD in women with PTSD or both disorders (Edworthy et al., 2008; Ford & Ayers, 2009; White et al., 2006; Zaers et al., 2008). It is important to recognize that vulnerability and risk factors may vary among women (Ayers, 2003; Beckett, 2005; Edworthy et al., 2008) and appraisal of the birth event, pain perception, and support from health care providers play a unique role in the development of posttraumatic symptoms following childbirth (Ayers, 2003; Ayers, Eagle, & Waring, 2006; Ayers, Joseph et al., 2008; Bailham & Joseph, 2003; Beck, 2006; Ford & Ayers, 2009; Seng et al., 2009). The unique variable of personality in relationship to the prevalence of PTSD symptomatology indicated women who may have issues with

meeting realistic goals particularly related to control and power may be more at risk for development of PTSD symptoms following childbirth (Edworthy et al., 2008).

Summary of the State of the Science and Gaps in the Literature

In the previous section, a review of the current literature was provided on the state of the science of PPD and PTSD following childbirth. A brief review of a pilot study conducted with mothers about PPD was discussed. Limitations of past research include: small sample sizes (i.e., less than 200), homogeneity of samples, the use of a variety of different screening measures for determining prevalence rates, and overlapping risk factors associated with the co-occurrence of PTSD and PPD following childbirth. Understanding the relationship between PPD and PTSD is essential before additional research can be undertaken to address the issues of possible benefits of routine screening for posttraumatic stress symptoms in conjunction with PPD. It is also unknown at this time what interventions are needed to prevent or reduce the incidence of PTSD and PPD. Past efforts to reduce the incidence of PPD through screening have been ineffective, indicating the need to examine maternal care and assessment of PPD and PTSD. Future research using qualitative inquiry would provide deeper insight into the experience of women who have lived through depression and posttraumatic stress related to childbirth.

Theoretical Context

The current research investigating the intersection of PPD and PTSD has primarily applied a medical framework (medical diagnosis and treatment) without investigating many precipitating psychosocial factors unique to childbearing women such as fear of labor (Hofberg & Brockington, 2000) maternal-infant attachments (Ayers et al., 2006; Rijnders et al., 2006), and infant well-being (Ayers, 2007). An examination of two

theoretical frameworks that are appropriate to study the co-occurrence of PPD and PTSD will be conducted. These theories of postpartum depression and PTSD will be applied to enhance understanding of the incidence of trauma during childbirth and to identify gaps in current education, practice, and research. These frameworks include Beck's middle range theory, "Teetering on the Edge," (Beck, 1993, 2007) and Herman's PTSD Theory of Recovery (Herman, 1992). The concepts in these theories will be used to reflect back on the narratives in the interviews and better answer the research question. In this section I will review these frameworks in the context of PPD and PTSD and use them to inform the qualitative study.

Beck's Midrange Theory of PPD

Beck (1993, 2007) originally developed a mid-range nursing theory, "Teetering on the Edge," to describe the phenomenon of PPD. The basic psychosocial problem and concept in Beck's 1993 PPD theory is a loss of control. Studies have provided support for Beck's theory by reporting that loss of control was expressed as an important emotion by women of diverse racial and ethnic groups experiencing PPD (Amankwaa, 2003; Beck, 2008a; Cunningham & Zayas, 2002). Women experiencing both PPD and PTSD report feeling an overwhelming loss of control (Ayers, 2007; Beck, 2009; Seng et al., 2004) which is the major concept of Beck's framework and appropriate for this study.

Beck's original theory has four concepts to include: Encountering Terror, Dying of Self, Struggling to Survive, and Regaining Control. The key assumption is that women experiencing PPD or other postpartum mood disorders also exhibit the problem of loss of control and work through the four concepts in stages to resolve the loss of control (Beck, 2007). The first concept of encountering terror is defined as having three

attributes including horrifying anxiety attacks, relentless obsessive thinking, and enveloping fogginess. Similar findings are associated with PTSD in women postpartally in the form of poor concentration and panic attacks (Ayers, 2007; Beck, 2004a, 2004b, 2007). Terror as described by Beck has also been described as nightmares and intrusions connected with the delivery which have also been found to occur in women with PTSD following childbirth (Ayers, 2007; Beck, 2004a, 2004b, 2006a; Kitzinger, 2004). The second concept, Dying of Self, is defined as the dying of the mother's normal self as a result of the conditions in the first stage or a consequence including isolating oneself and contemplating or attempting self-destruction. Women experiencing PTSD following childbirth also report a violation of self or a loss of their former selves (Ayers, 2007; Beck, 2006a; Ford & Ayers, 2009; White et al., 2006). Struggling to Survive, the third concept, is defined as a process including: battling the system, praying for relief, and seeking solace in a support group. The fourth and final concept is defined as Regaining Control. The consequences are defined as unpredictable transitioning, mourning lost time, and guarded recovery. These four concepts define the main problem of loss of control experienced by women with PPD (Beck, 1993, 2007). Applied to the context of PTSD, a study by Ayers (2007) reported women reach some resolution by the processing of memories through debriefing or talking about the experience. The main problem of loss of control and the four concepts related to loss of control have been updated to include predictor and risk concepts (Beck, 2007).

Women experiencing PTSD may experience the same symptomatology as women suffering PPD. New mothers experiencing PTSD report symptoms (irritability, a loss of self, guilt, shame, and suicidal tendencies) which are consistent with concepts of PPD as

defined by Beck (Ayers, 2007; Bailham & Joseph, 2003; Ross & Dennis, 2009). An important facet of the theory is that the concept of loss of control is applicable to women who have experienced PTSD postpartally which makes the theory applicable to this study investigating the overlap of PPD and PTSD (Ayers, 2007; Ayers, Joseph et al., 2008; Leeds & Hargreaves, 2008; White et al., 2006).

Beck's theory (1993, 2007) has not been used to study PTSD in women following childbirth. The theory also does not include a feminist perspective. From a feminist perspective, society's double standard where motherhood is either idealized or undervalued (Creedy & Shochet, 1996) is not represented in the model. Mothers' shame and stigma have both been related to PPD and PTSD (Ayers, 2007; Beck, 2008a; Gamble et al., 2005). Existing beliefs and ideologies concerning motherhood, particularly the belief that women inherently know how or want to mother, can be damaging and prevent women from seeking help or acknowledging their negative emotions in the postpartum period (Lee, 2006). The myth of an intrinsic maternal instinct can create feelings of inadequacy for those mothers with stressful and tiring experiences following childbirth and not the overwhelming joy and love for the new child (Beckett, 2005; Mauthner, 2002).

Herman's Theory of PTSD

The most frequently used framework to address PTSD following childbirth is the medical model. Current research suggests that PTSD following childbirth has many precipitating factors which are specific to the childbearing woman. These unique factors include fear of initial birth or subsequent births, problems with maternal-infant attachments, and infant adjustment which are specific to childbearing women (Ayers,

2007; Beck, 2009; Nicholls & Ayers, 2006). Powerlessness has also been associated with PTSD following childbirth. Research also suggests the childbirth process may precipitate PTSD related to prior traumatic events. Previous research suggests childbirth may trigger PTSD in women who have previously experienced a traumatic event such as sexual abuse or physical abuse (Seng, 2002; Seng et al., 2004).

The concepts proposed by Herman's theory include: empowerment, remembrance, and reconnection. These concepts complement Beck's theory which explains the process of losing control following childbirth and regaining control (Beck, 2007). The powerlessness, isolation, and loss of self reported by women with PPD and PTSD, are addressed through the concepts of empowerment, remembrance, and reconnection in Herman's theory of recovery much like Beck's theory of PPD.

"The core experiences of psychological trauma are disempowerment and disconnection from others. "Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections" (Herman, 1992, p. 133). This model described by Herman (1992) uses a feminist approach, using women's narratives to address the symptomatology related to PTSD. Herman's core belief suggests recovery from a traumatic event cannot take place in isolation and without the concept of relationships which supports a feminist approach (Herman, 1992). Herman's theory provides a format to address the issues of empowerment, reconnection, and remembrance for the woman experiencing PPD and PTSD following childbirth. These two theories are a part of the literature that forms a background to explore a connection between PPD and PTSD exist following childbirth (See Appendix K).

Feminist Theory

Feminist theory values the full context of women's narratives and recognizes the importance of a woman's interpretation of her experience of a phenomenon (Bunting & Campbell, 1991). Previous research by Mauthner (2002) found women accepted the medical label of PPD rather than openly talking about the difficulty transitioning to motherhood. Societal views supporting the fallacy of an uncomplicated, joyous, and instinctive transition to motherhood devalue women sharing stories about PPD and PTSD. Women value their feelings and the feelings of others. From a feminist perspective women should be allowed to make decisions based on their interpretation of a phenomenon (Campbell & Bunting, 1991). Feminist theory philosophy is based on positive change for women for a better future. "Epistemological issues include: women's sense of knowing is legitimate, women are expert in their own lives, knowledge is relational and contextual, definitive boundaries between personal and public or personal and political spheres are artificial" (Campbell and Bunting, 1991, pg. 7). Challenging the fallacy of effortless transition to motherhood with narratives of women's experience with PPD and PTSD promotes a broader understanding of the childbirth experience.

The researcher's viewpoint will be reviewed continually during the research process. The findings will be shared among the researcher and the participants for all to verify the researcher's interpretation of the experience the participant intended to convey. A feminist approach supports the validation of women's lived experiences (Campbell & Bunting, 1991).

Phenomenology

Hermeneutic phenomenology approaches an experience from an interpretive viewpoint. Hermeneutics takes the description of a phenomenon and looks for meaning in everyday life experiences (Lopez & Willis, 2004). Heideggerian phenomenology focuses more on an individual's experience as opposed to what the individual knows. An example of this is with my small pilot study of PPD in rural women (Dennis & Moloney, 2009). I had a concrete, text book definition of PPD. However, I did not understand what it meant to experience PPD until I interviewed the women in my small pilot study that experienced the phenomenon. Therefore the aim of phenomenology is to see the meaning of what occurs when an interruption in normal daily activities occur.

Phenomenology is not only a research approach but also a philosophy (Mackey, 2004). The phenomenological method examines subjective human experience which enhances the understanding of the uniqueness of individuals, their environment, and day to day interactions with others (Willis & Lopez, 2004). Phenomenology provides a method for insight into a phenomenon and allows for better understanding of the phenomenon. Phenomenology is the most appropriate method to use in the study of human phenomenon because the method brings to language the perceptions of the human experience (Davidson et al., 2004; Speziale & Carpenter, 2007). Recording an experience with the person's own narrative will contribute to a better understanding of the phenomenon or experience. Van Manen (1990) suggests research scientists give the act of expression to the lived experience through language to recapture the particular experience. Using narrative in a story-telling format provides insight into the experiences

of women with PPD and PTSD allowing researchers to have a better understanding of the phenomenon.

A concept of interpretive phenomenology is that of freedom. Heidegger suggests individuals are completely embedded in a history of culture, social, and political contexts described as situated freedom (Draucker, 1999; Leonard, 1999). Another prominent concept of hermeneutic phenomenology is that the study of human experiences can be understood through individual narratives of the experience or phenomenon of interest (Giorgi, 2005, Patton, 2002). In research, the hermeneutic phenomenologist is more interested in the meanings of individuals' experiences as opposed to descriptive categories of the experience (Lopez & Willis, 2004).

Assumptions of the Researcher

My experience caring for new mothers and newborns in clinical practice has shaped my beliefs as a professional about how mothers transition to motherhood. My experience as a family member observing a traumatic birth has also influenced the way I view the labor and delivery process. Finally, the small pilot study I completed has allowed me to view PPD and PTSD following childbirth from another perspective integrating both the professional and human aspects of the complex process of labor, delivery, and postpartum transitions. Integral to this process is quality and supportive care. Nurses are in a key position to facilitate and support women maneuvering through the labor and delivery process.

The following are my assumptions:

1. Women are experts on their own lives.
2. Women should have a voice in their childbearing experience.

3. Women have the right to talk about ambiguous emotions during the transition to mothering.
4. Women will tell stories about traumatic childbirth experiences.
5. Women's stories about the experience of PPD and PTSD can contribute to understanding the complexities of transitioning to motherhood.
6. PPD will be closely connected to PTSD following childbirth.

My responsibility as a researcher is to act as the instrument in the study to insure that ensure that participants are full partners in the investigation while maintaining sensitivity and understanding that each woman has a narrative to contribute to the current knowledge base.

Summary

Mental health disorders in women have become a focus for healthcare providers over the last two decades with a primary focus on PPD in reproductive health. As new research emerges, PTSD following childbirth is of intense interest. Mothers in labor are concerned for themselves as well as their children, and when in the hospital new mothers may feel powerless and obligated to hospital staff even after delivery (Beck, 2009). Given the predictors for PTSD and PPD (lack of support, unexpected obstetrical interventions, loss of control, and negative perceptions of childbirth), future research is needed to investigate the continuum of reproductive health and the powerlessness women experience in what once was a natural process (Kitzinger, 2006). More exploration is needed to determine the normal as Lee (2006) states: "The increase in the assumption that new mothers cannot cope without professional support reflects the perception that they should not be expected to ably find ways to manage their emotions and negotiate

themselves through the new relationships and experiences that pregnancy and parenthood bring" (p. 50).

Factors influencing the experience of childbirth need to be explored in a wider context than the current medical framework. The idea of meeting unrealistic social standards for motherhood and the medicalization of childbirth reflects the disempowerment of women in what was once a natural process. An increase in such interventions creates more opportunity for traumatic events to occur and in turn decreases mothers' voices in the childbirth process (Beckett, 2005). Future investigation is required to examine this loss of voice and autonomy in such a life transforming event.

Qualitative designs are valuable tools when exploring a new phenomenon that is poorly understood. Interpretive phenomenology will guide the study. Interpretive phenomenology according to Heidegger (1927/1962) is that the lived experience is an interpretive process in and of itself, and that the process brings to light what is already known. In this way individuals are able to reflect and self-interpret, providing richness to the data and to the stories that relate to the experiences, and provide further insight into the meaning between the phenomenon and the individual (Heidegger, 1927/1962). By careful review and analysis of reflective interviews, hidden meanings will appear allowing for greater insight and understanding to be gained regarding the phenomenon under study (Campbell & Bunting, 1991).

Qualitative inquiry provides an opportunity for a woman to tell her story which can empower her as well as provide insight into her childbirth experience. Future investigation is needed to determine if there is a relationship between posttraumatic stress symptoms and postpartum depressive symptoms. This primarily qualitative study will

investigate the experience of women reporting PPD and PTSD following a traumatic childbirth event.

CHAPTER III

RESEARCH PLAN

The research plan is described in this chapter including: methodology, participants, data generation, and data analysis. Measures to support methodological rigor will be addressed. The protection of human subjects, sample characteristics, recruitment plans, informed consent, and potential risk/benefit to participants will be defined.

Research Design

A Qualitative Approach

The purpose of this study is to gain understanding of women's experiences of PPD and PTSD following traumatic childbirth. A mixed method approach is used with qualitative inquiry as the primary methodology. A quantitative instrument will be administered following the interviews to provide better understanding of each participant's experience of traumatic childbirth either supporting or not supporting clinical/subclinical symptoms of PPD/PTSD in the year following the childbirth experience. A qualitative approach is chosen because qualitative methods are useful when the research goal is to understand a new or unknown phenomenon (Speziale & Carpenter, 2007). Heidegger (1971, p. 57) states:

> To undergo an experience with language, then, means to let ourselves be properly concerned by the claim of language by entering into and submitting to it. If it is true that man finds the proper abode of his existence in language – whether he is aware of it or not – then an experience we undergo with language will touch the innermost nexus of our existence.

A qualitative approach is used in this research proposal to examine the experience of women with PPD and PTSD following childbirth. Interviews will be conducted using open-ended questions to give women the opportunity to share their story of traumatic birth.

Heideggerian Hermeneutical Phenomenology is the methodology of choice for the study of women with traumatic childbirth. Heideggerian hermeneutics is the interpretive piece of phenomenology. For Heideggerian phenomenology the role of story telling is important in communication. Stories convey an experience unique to the participant. The participants verbalize the story in their own words. Traditional scientific method does not allow the full potential of the human-being to be experienced (Heidegger, 1927/1962). Stories allow the researcher to share the experience of the participant and come closer to the lived experience of the participant (Benner, 1994). The participant shares goals, values, and concerns about what it means to be a person who has experienced a traumatic childbirth with subsequent PPD and/or PTSD. The screening tools for PPD and PTSD will provide better insight into each participant's experience of clinical/subclinical symptoms of PPD and PTSD following traumatic childbirth.

Screening Instruments

A mixed methods approach will be used to provide another perspective to the study and to assist in the interpretation of findings. Two instruments will be used to enhance findings from the participants' narratives. The participants will be asked to choose answers to the instrument questions based on the emotions experienced within the first year postpartum following their traumatic birth experience. The Edinburgh Postnatal

Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987) will be used retrospectively to determine symptoms of PPD and the Davidson Trauma Scale (DTS) (Davidson et al., 1997) will be administered to determine posttraumatic stress symptoms occurring in the of the postpartum period. Completing the survey instruments following the interview allows women to reflect on the details of the birth process recalling specifics of the experience. This strategy will be used to provide insight into the individual postpartum experiences of each participant and the interview narratives. The two instruments are important in either supporting or not supporting clinical/subclinical symptoms of PPD and PTSD in the postpartum period in each of the participants.

Participants

Participants will be obtained through purposive sampling. The sample for this study will be accepted based on self-report of a traumatic childbirth. Recruitment will occur through word of mouth referral from professional and personal colleagues. A snowballing technique will be used as I ask fellow nurses to assist in recruiting by word of mouth. Flyers will be placed in physicians' offices, hospitals offering obstetrical services, and public health departments (See Appendix C). Advertisements will also be placed in local news publications. A maximum of 20 participants will be recruited. Participants will be accepted into the study if they are 18 years old, if they are able to speak, write, and understand English, and self-report a traumatic childbirth. There is no upper age limit for participants seeking to enter the study. The age requirement for women to be 18 years old or older was based on developmental parameters. Late adolescence (18 to 19 years old) is considered a time when women can think abstractly, are capable of decision making, and have accomplished a sense of identity unlike

adolescent women struggling with self-identity, concrete thinking, and an inability to make decisions with relationship to consequences. Eighteen is considered the age of maturity and individuals are presumed to have the maturity and capacity to make life judgments at this age. Research supports women's recall of childbirth years after the event was accurate (Simpkin, 1991, 1992; Conde, Figueiredo, Costa, Pacheco, & Pais, 2008).

A method to enhance recruitment will be to involve the maternal/child nurse educators in several hospitals to recruit participants for the study as well. The nurse educators in the hospitals come from different ethnic backgrounds and participate in support groups that are ethnically diverse. Hospitals included in the recruitment plan will be from area hospitals: Colquitt Regional Medical Center (Caucasian – 40%, African American – 40%, and Latino – 20%), Tift Regional Medical Center (Caucasian – 45%, African American – 40%, and Latino – 15%) and Phoebe Putney Memorial Hospital (Caucasian – 30 %, African American – 52%, and Latino 18%). Both institutions serve low socioeconomic populations with average incomes of 24, 000 dollars annually and a Medicaid population of between 60 and 75 percent for all institutions. These serve populations similar to the United States Census Bureau's Georgia statistics: Caucasian – 60%, African American – 30%, Latino – 8% (2009). A maximum of 20 participants are anticipated for the study. A tentative plan is to recruit approximately twelve Caucasian women, four African American women and two Latino women based on state statistics. The researcher recognizes that these percentages may be difficult to achieve due to the reluctance of many women to report PPD or PTSD. The nurse educators often moderate support groups and have communication with women experiencing or who have

experienced PPD and PTSD. The nurse educators may provide a valuable link to the researcher. One African American nurse educator and a Latina healthcare interpreter will be supportive in recruiting participants. Including an established health provider may increase the trust of the participant and aid in establishing a relationship between the researcher and the researched (Tee & Lathlean, 2004). Recruitment will also occur through circulars, newspaper advertisements, and posters placed in physician offices and public settings. Exclusion criteria will include women younger than 18 years-old and those who do not speak, write, and understand English.

The women in the pilot study received an incentive payment of twenty-five dollars for participation in the study. An incentive payment of twenty five dollars for the participant's time investment in this larger study would ease participant burden and enhance participation. Participants in the pilot study were demographically similar to the sample in this study.

In summary, inclusion criteria will target women who self-report a traumatic childbirth, are 18 years of age or older, and who are able to speak, write, and understand English. African American women, Latina women, and other ethnic groups will be recruited for this study. Institutional Review Board (IRB) approval from Georgia State University will be obtained prior to recruitment. A convenient time and location for the participant will be agreed upon for the interview. Prior to the interview I will encourage participants to think about their childbirth experiences.

Data Generation

Screening of participants will occur for entry into the study after contacting the researcher by phone. The screening process will be conducted by the researcher during

the initial phone contact. After the screening process (See Appendix D), I will meet with each participant at an agreed upon time and place. Each participant will be interviewed in a private location chosen for the convenience of the participant. Consideration of safety for both the researcher and the participant will be considered when interviews are scheduled. The purpose of the study along with risks and benefits will be explained on initial contact and again at the beginning of the interview. Informed consent (See Appendix E) will be obtained after the purpose and risk/benefits of the study are explained to the participant. The consent form will be reviewed with the participant by the researcher and the signature obtained prior to the interview. A copy of the consent form will also be given to the participant. The interview will be tape recorded using an audio-recorder with a backup audio-recorder to protect from data loss in the event of technical problems.

The interview process allows the participant to tell the story from her perspective supporting underlying tenets of both feminist theory and Herman's PTSD theory. Women will be asked to share their experiences following traumatic childbirth. Data generation strategies will include semi-structured interviews with open ended qualitative questions. The questions for the research study will be reviewed and evaluated by nursing professionals with qualitative research expertise before the interviews are conducted to insure question clarity. Interviews will begin with the same set of questions (See Appendix F) with each participant and then continued based on participant responses.

The main question will be: "Tell me about your birth experience." Open ended questions will be developed to encourage the participants to verbalize their experience.

Examples of open ended questions are: “Tell me about the baby’s birth”, “Describe your feelings during this time.” Clarifying questions will be asked when further information is needed. The interview will continue until the participant has completed her narrative. Field notes will be recorded after each interview. Notes will include a description of the interview setting, the participant, any nonverbal observations, and any concerns not captured through the audio recording. Follow-up interviews will be conducted for clarification of information. A journal will also be implemented to record beginning understandings and researcher reactions.

Self-report measures for depressive symptoms (EPDS) and traumatic stress symptoms (DTS) will be completed by each participant after the interview has been completed (See Appendix G and H). The findings from the self-report instruments will help in understanding the participant’s experience. Demographic information will be obtained at the end of the interview. Participants will be asked to complete a socio-demographic questionnaire to assess the following variables: age, ethnicity, marital status, education, occupation, obstetrical history, previous history of depression, and previous history of trauma (See Appendix I). Demographic information, the EPDS and DTS will be obtained at the end of the interview process.

A transcription service will be used to transcribe interviews. Audiotapes will be labeled by number to insure confidentiality. Accuracy of interview transcription will be verified by the researcher listening to the audio recordings while reading the transcripts to make corrections as needed. All identifiers will be removed as the transcripts are reviewed to maintain confidentiality. Analysis will begin as each interview is completed.

Follow-up interviews will allow the researcher the opportunity to ask questions about the interview or verify information from the interview with the participant.

Data Analysis: Qualitative

The first step in analysis in the study will be completed by reading each interview and completing a summary of the narrative as a whole following the methodology of van Manen (1990). Paper copies of each transcript will be printed with participant numbers in the header of the transcript as an identifier and to keep transcripts recognizable without obstructing confidentiality. After each transcript is read for overall meaning, it will be examined line by line for themes and meanings and then by sentences, by paragraphs, and by larger passages. Transcripts of interviews will be reviewed with peer reviewers who are doctoral students and faculty with qualitative expertise. Major themes or intent of sections will be those identified by the researcher and supported by peer reviewers. Themes will then be categorized into groups of ideas that have similar meanings. Each piece of data will be compared against all other pieces until all transcripts are coded. The study will continue until data saturation occurs. Interview transcripts will be returned to participants for verification of content and the opportunity for clarification or continued input.

The researcher will also use a computer qualitative research software program to organize data. A computer software program may offer advantages in storing and sorting data without intruding upon the individualized nature of interpretation of themes and patterns. The use of software may be helpful in helping organize themes if a researcher begins interpretation too quickly in the analysis process. A software program can facilitate coding, organize reflective remarks, and create memos to organize data. A

software program will be invaluable in the organization of data and improving auditability.

Trustworthiness

Demonstration of trustworthiness in qualitative inquiry is best described in terms of credibility, transferability, dependability and confirmability (Lincoln & Guba, 1986). These four criteria will be used for evaluation of the study rigor. Credibility, transferability, dependability and confirmability will be addressed by the following procedures.

Credibility will be addressed through reflexivity, member checking, peer examination, and an audit trail. The audit trail will include interview narratives, field notes, and perspectives from analysis of peers and qualitative experts improving credibility. In qualitative study, the researcher is the tool through which the participant will tell her story. As the researcher, I must be primarily a listener in the interview providing an unbiased report of the participant's views and beliefs. A reflexive journal will be maintained during the study to record my ideas, thoughts, questions and insights. Interview transcripts will be returned to the participants for review and further comments following transcription and study completion. Peers will be included in each component of the study process. Peer review with two fellow doctoral students and an expert qualitative researcher will contribute and critique the process as it develops (Patton, 2002). These steps will provide the truth value or credibility to the study.

Transferability will be accomplished through the use of a purposive sample and rich description provided by the participant narratives extending the understanding of a phenomenon (Lincoln & Guba, 1986; Patton, 2002; Shenton, 2006). The goal of

qualitative study and hermeneutic phenomenology is to provide the reader of the research with a clear, understandable picture of the phenomenon in which the reader can make a connection as to whether the results may be applicable to another particular population. Excerpts from the participant's narrative will provide support in helping the reader make that connection. Reflexivity of the researcher will contribute to transferability. I will use my reflexive journal to describe the setting, body language, and my responses (thoughts, ideas, questions) to the interview providing the research team with information key to the development of the study.

Dependability and confirmability are often supported simultaneously through the audit trail (Lincoln & Guba, 1986; Patton, 2002). These will be assured through maintaining the audit trail of the research process including the research plan, data sources, interview tapes, and interview transcripts. An experienced peer group and expert qualitative researcher will critique the process as each stage develops. The group will be involved in the interpretation, coding, and development of themes and patterns. I will maintain field notes and a reflexive journal throughout the study. The reflective journal will promote self-awareness of my biases and beliefs as the researcher. Confirmability will also be supported through the use of the EPDS and DTS will contribute as another objective data source (Patton, 2002; Shenton, 2006).

To maintain rigor, open-ended questions will be asked of participants in all interviews. Categories will be developed from the qualitative data and coded numerically with codes defined by the researcher. Findings from the qualitative data will be supplemented by the EPDS and DTS findings to enhance the narrative findings and

conclusions. The findings from the quantitative data will be used to provide another perspective of PPD and PTSD to the study.

In summary, trustworthiness will be supported by credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1986). The trustworthiness of the study will be supported by maintaining a transparent audit trail of the research process, maintaining reflexivity, member checking, and peer review. The researcher, as the instrument, is vital to the success of conveying the participants' stories to the reader. The reader ultimately determines the value of the research.

Data Analysis: Quantitative

The use of the EPDS and DTS serve as the instruments to gain perspective into each participant's traumatic birth experience. The strategy of using quantitative measures is supported by acknowledgement that the proposed qualitative sample size will be approximately twenty which does not meet the generally required minimum sample of any quantitative study (Munhall, 2007). The two instruments will be given at the end of the interview retrospectively to describe symptoms related to PPD and PTSD that the participants may have experienced within the first year following the traumatic birth experience. The instruments will determine if the participants meet criteria for clinical/subclinical symptoms within the postpartum period. Data analysis will be conducted using descriptive statistics. The forms will be reviewed for missing data and cleaned appropriately. Analysis will include means, standard deviations, and percentages for description of the different symptoms of PPD and PTSD. The reliability of scaled items will be assessed.

Depression

Depression will be measured retrospectively by the EPDS. The EPDS is a 10 item self-report questionnaire designed to screen for postpartum depression that is written at the fourth grade level. The 10 items are summed to create an overall score ranging from 0 – 30. The 10 items have four possible responses and address anhedonia, self-blame, anxiety, fear or panic, inability to cope, difficulty sleeping, sadness, tearfulness, and self-harm ideas which may have occurred in the last seven days. A Likert-type format is used to record responses to questions including: "I have felt sad or miserable". Responses are scored 0 ("No, not at all"), 1, 2, 3 ("Yes, most of the time") with the total score obtained by summing item responses. The higher score indicates a greater level or severity of postpartum depression. Respondents are asked to underline the best response based on their feelings over a period of seven days in the first year postpartum for this study (See Appendix G).

The EPDS consists of both positive and negative stem items. Initial interpretation suggests a threshold score of 12/13 as adequate to identify all of the participants with an RDC diagnosis of Major Depressive Disorder but a score of 9/10 is recommended to identify minor/major depressive illness (Cox & Holden, 1987). The total time to complete the EPDS is estimated at five minutes. Scoring for the EPDS is expressed as being sensitive, specific, and having a positive predictive value (Beck & Gable, 2000; Cox et al., 1987; Pallant et al., 2006). Previous studies using the EPDS with this population have demonstrated validity and reliability with scores of .77 to .98 (Baker et al., 2005; Beck & Gable, 2001; Hanna et al., 2004; Montazeri et al., 2007; Pallant et al., 2006).

Traumatic Stress Symptoms

Posttraumatic stress symptoms will be measured retrospectively using the DTS. The DTS is a 17-item self-report screen used to measure trauma symptoms as described by the DSM-IV. The screening instrument will be used to describe symptoms within the first year postpartally. The DTS was developed originally to determine symptoms in individuals experiencing different types of traumatic events (Chen, Lin, Tang, Shen, & Lu, 2001; 65

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Davidson et al., 1997). The DTS is based on a 5-point Likert type scale with responses ranging from 0 being "Not at all" to 4 meaning "Every day." The 17 items are summed for an overall score of 0 – 136 based on frequency and severity of symptoms, a frequency score ranging from 0 to 68, and a severity score ranging from 0 to 68. A score of 40 or greater has a diagnostic accuracy of 88% (Davidson et al., 1997). Scores can be calculated for the symptom clusters described in the DSM-IV criteria as well as the three symptom clusters for PTSD DSM-IV criteria (Davidson, Tharwani, & Connor, 2002; Meltzer-Brody, Churchill, & Davidson, 1999). Previous study has found the DTS to have a sensitivity of .86, specificity of .70, and diagnostic accuracy of 88% (Meltzer-Brody, Churchill, & Davison, 1999; Sijbrandij, Olff, Opmeer, Carlier, & Gersons, 2008) and a demonstrated Cronbach's alpha of .96 (Woods et al., 2005).

The DTS has previously been used to measure trauma symptoms in populations who have experienced natural disaster, rape and abuse (Burgess & Clements, 2006; Meltzer-Brody, Churchill, & Davidson, 1999; Sijbrandij et al., 2008). No studies using the DTS to measure symptoms in women following childbirth were found. The DTS will

be used retrospectively in the current study to determine trauma symptoms following childbirth in the study sample population. The DTS will be used subsequent to qualitative inquiry and analysis to support findings. Based on the proposed sample size of 20 participants, quantitative analysis will be used to support the occurrence of trauma symptoms.

Protection of Human Subjects

Following Institutional Review Board (IRB) approval from Georgia State University, recruitment will begin. All women who meet the study criteria will be recruited by snowballing, referrals from colleagues and acquaintances, flyers placed in acute care hospitals, public health departments, physician offices, and local publications. The flyer will provide information about the study, my contact information (telephone number and email address), and a request asking women to call the researcher if they want to participate in the study. On initial contact with the participant, the researcher will emphasize that participation is voluntary and that at any time women can choose not to answer questions or withdraw from the study without repercussions. Emphasis will also be placed on confidentiality. Informed consent will be obtained at the time and place of the interview indicating agreement to study enrollment. Interviews and questionnaires will be coded with participant numbers ensuring confidentiality. Consent forms and code key will be stored separately from the data collected during the study.

Potential Risks/Benefits

There are no risks from treatment, drugs or medical devices. A risk that may occur is that participants may remember events or feelings that are distressful to them. The faculty investigator and the student researcher will help the participant find a referral

for counseling if needed (See Appendix J). Participation in this study may benefit the woman personally by allowing her to come to a greater understanding of her experience.

The study includes the EPDS, a tool for depression symptoms, as a measure of depression and the DTS, a tool for traumatic stress symptoms. Participants with higher scores will be provided contact information for a counselor or mental health services as needed. A referral plan for participants with high EPDS (12 to 13) and DTS (scores will be in place prior to interviews (See Appendix J). Participants who express or indicate an ideation to hurt themselves will be referred to mental health resources. Referral will be to crisis hotlines: Georgia 1-800-784-2433, Atlanta 1-404-730-1600, Albany 1-866-582-7763, Valdosta 1-800-247-2747, Thomasville 1-800-238-8661. The faculty PI will be notified by phone immediately. The area 911 emergency system will be activated as needed upon discussion with faculty PI and research committee members.

Strict participant confidentiality will be maintained. Private areas will be used to conduct interviews. Participants will be assigned a participant identification number. The participants' names and identification number will be recorded on the participant roster. The code key will be secured in another locked cabinet separate from the cabinet containing participant information. Informed consent forms and roster will be maintained in a locked file cabinet with the researcher and faculty principal investigator having sole access to the file cabinet. The informed consent forms and participant roster will be destroyed after five years. The interview audiotapes and transcripts will be labeled with the participant identification number to protect confidentiality. The EPDS and DTS forms will be labeled with the participant identification number. The interview audiotapes, transcripts, and measurement forms will be stored separately in a locked

cabinet at a separate location from the roster and consent forms. Audiotapes, transcripts, and rosters will be destroyed after five years.

Summary

This chapter describes the methodology for the study including the research design as well as the selection, characteristics, settings and recruitment plan for participants. I have described the process of data generation and analysis. Trustworthiness measures proposed for the study are discussed to assure the rigor of the study. The risk/benefit potential and protection of human participants is also described in this chapter.

CHAPTER IV

RESEARCH PROCESS

The research process in this chapter includes how the research plan was implemented. This chapter also describes measures taken to insure methodological rigor and the protection of human subjects and serves as an audit trail allowing for evaluation of the research process, the interpretations of the researcher, and the conclusions. A reflexive journal was maintained throughout the research process. The reflexive journal was developed to describe the researcher's knowledge/bias prior to the interview process, a description of the settings of the interviews, impressions of the participants, and reactions to the interview experience.

Participant Recruitment

Participants were recruited by word of mouth and recruitment posters placed in area hospitals and health departments. Participants were primarily obtained by snowballing for this study. Following IRB approval, I contacted peers, colleagues and friends regarding the study. I asked them to let anyone they knew who had experienced a traumatic delivery to contact me. Recruitment flyers were also placed in public areas, area hospitals and health departments. I had a response of 20 participants from April to September 2011. All 20 participants met inclusion criteria. I screened each participant when she called and set up at time and place for an interview. Seventeen of the participants were recruited through snowballing and three participated based on seeing

the flyers posted. All women who contacted me met the criteria for a traumatic childbirth experience.

During the initial screening, I asked participants where they would like to meet for the interview. If the participant did not have a preference, I offered the local library as an option. I called and reserved a private room at the library for participants who chose the library as the interview location. Three interviews were conducted at public spaces, three at the public library, three in private conference rooms, and eleven in private offices. I had no difficulty with arranging interview locations or with participant cancellations. I arranged interviews to allow each participant time to talk as long as she desired.

The time for each interview varied from 45 minutes to 2 hours. I was worried initially that I would not have adequate interviews but soon learned the women were interested in sharing their stories and time was forgotten. The interview was followed by having participants complete two assessment tools, the Edinburgh Postnatal Depression Scale (EPDS) and the Davidson Trauma Scale (DTS), which also extended the time of the interview. The women also completed a demographic questionnaire following the interview. Interviews were audio recorded indicating the need for adequate recording equipment in relation to interview time.

Audio recording was accomplished with an audio cassette recorder. I carried extra audio cassette tapes in case the participant would need longer than the time available on one cassette tape. The recorder was turned off before the participant completed the scales for depression and trauma. Although all participants agreed to be recorded, a few participants appeared uncomfortable with the tape recorder. If the

participant added information after the EPDS and DTS was completed, I took notes and added the notes to my field memos after each interview. I experienced one mishap with a participant, in which I inadvertently pressed play on the tape recorder instead of play and record. Fortunately I noted my mistake about 5 minutes into the interview and the participant was willing to start the interview from the beginning. I prepared for each interview by having extra batteries, a power cord, and extra recorder but did not double tape which I sincerely regret. In two of the interviews the participant was difficult to hear. Double taping or use of a digital recorder may have enhanced recording quality and eliminated the one recording error I experienced.

I began each interview with an explanation of why I was conducting the study and gave the participants time to read the informed consent while I prepared the recorder for the interview. I explained the interview process after the participant had signed the consent form. I also explained that I had two assessment scales, one for depression and one for trauma, and that I would ask the participant to complete the scales at the end of the interview. I asked if the woman had any questions concerning the study and reinforced that the woman could stop the interview at any time if she desired. All participants decided to continue with the interview.

Following the interview, I thanked each participant for her time and interest. I also gave the participant the $25.00 allowed for participant burden. Most interviews were emotional. Most participants needed tissues during the interview but were calm when the interviews ended. When I returned to my car, I completed field notes following the interview describing the participant, the setting, and any ideas or thoughts I had during the interview. All audiotapes were taken to the transcription company for

transcription with all identifying information removed to maintain confidentiality. I reviewed each audiotape with the transcription and edited for any identifying information. Data from the tapes were reviewed by members of my committee and peer reviewers. My peer review committee included two nurse midwives and two nurse educators from whom identifiers were withheld. Each participant was presented with a copy of their transcript, my first level analysis, and a thank you note for her participation. I provided contact information if the participant had any questions or concerns.

Generation of Data

The Interview Process

Determining and implementing the optimal method of access to participants for interviews was essential to successful data generation (Speziale and Carpernter, 2007) as was the approach to conducting the interview. After achieving access to the participants for interviews, establishing rapport and using reflexivity throughout the interview process resulted in interviews with rich description. Recognizing the importance of the mutual respect, engagement, commitment, context and demographics such as age and ethnicity was also instrumental in a rewarding interview experience. The combination of these characteristics contributed to the success of the interviews beginning with the use of reflexivity.

This use of reflexivity opened an avenue for self-reflection prior to and following the interview process. I began preparation for each interview by assessing my own feelings about trauma and the birth experience, reviewing the DSM-IV meaning of trauma and postpartum depression, and reminding myself to be open to all conversation with the participants. As a qualitative researcher it is important to first establish personal

biases and thoughts about the phenomenon in question in order to appropriately function as the instrument in the data collection process (Speziale & Carpenter, 2007). By assessing my own values and thoughts surrounding traumatic birth, I was more open to how women expressed their beliefs about traumatic birth. After preparing for the interview process through this assessment, I was able to successfully approach the interview process with the women participating in the study.

I began the interview process with introducing myself and explaining the purpose of the study. I presented the consent form to each woman so she could read the information in the form and ask any questions she had about the study. After the consent form was signed, I began the interview process by asking the participant, "Can you tell me about your childbirth experience?" In order to explore the participant's beliefs and feelings about the traumatic birth experience, I used an open-ended, unstructured question format for all interviews. As the woman related her story, more open-ended sentences or statements were used to facilitate the interview process. Use of the open-ended, unstructured format allowed women to explore their feelings and share emotions related to the birth experience. Some participants opened up more quickly than others. The last participant I interviewed recited her birth experience in a chronological detailed story without showing emotion and only shared emotions through the use of open-ended questions. Her hesitation was present even after I had tried to establish a rapport prior to the interview. A useful phrase was, "Can you tell me more about that?" The open-ended format and periods of silence often prompted the participant to share more detailed information.

At the beginning of the interviews, I introduced myself and shared with the participants my reasons for choosing a study of traumatic childbirth; and I explained to participants that I would be asking questions to elicit their birth story. I also shared with the women my experience as a labor and delivery nurse, a mother, and my own experience with traumatic deliveries. I believe this established a beginning rapport with the participants. I also assured the participants that my role as a healthcare provider should not dissuade them from speaking honestly about their experience. I was fully engaged with the participants during the interview process in private settings so there was little to no interruption in any of the interviews. I noticed in the early interviews that the participants were very conscious of the tape recorder. After the third interview, I placed the tape recorder in an inconspicuous place while still achieving an acceptable recording. This appeared to help women relax and tell their story. Most participants were more relaxed as they neared the end of the interview than in the beginning of the interview because they had forgotten about the tape recorder. As women relaxed, their emotions and stories seemed to transport both researcher and interviewer back to the time of the birth story. I had not anticipated the raw emotion that would be revealed in the interview process.

The strong emotion expressed by the participants was present regardless of age or ethnicity. The overwhelming consistency was about the birth story. Women can accurately recall their birth experience regardless of age and the length of time that had passed (Conde, Figueiredo, Costa, Pacheco, & Pais, 2008; Simpkin, 1991, 1992) which was confirmed by the participants I interviewed. The first level analysis and journaling allowed the interview to be placed into context. The field notes, journaling, and emotions

noted in the interviews contribute context of each interview. Participants shared not only their stories but their remembrances in the form of photographs and emotions. By developing mutual respect, engagement, commitment, context and recognizing the researcher/participant demographic differences such as age and ethnicity, a rewarding interview experience resulted from each participant encounter and facilitated the process.

Data Analysis: Qualitative

The first step in analysis in the study was completed by reading a copy of each transcribed interview and a summary of the narrative completed following the methodology of van Manen (1990). Paper copies of each transcript were printed with participant numbers in the header of the transcript as an identifier and to keep transcripts recognizable without violating confidentiality. After each transcript was read for overall meaning, it was examined line by line for themes and meanings and then by sentences, by paragraphs, and by larger passages. The transcribed interviews were also entered into the QSR NVivo9 edition of qualitative software for themes, related passages and words. Transcripts were also shared with peer research team members and my dissertation committee. As patterns began to emerge, members of the research team were asked to review the patterns and themes for validation. Interaction with my committee, follow-up discussion with participants, and my thoughts were maintained in a reflexive journal.

In preparation for this qualitative study, I attended a five day seminar on qualitative research with Dr. Margarete Sandelowski. The seminar provided lecture and interactive analysis of sample qualitative data and a specific orientation to Nvivo software for qualitative analysis. I also attended a week long seminar on hermeneutical phenomenological research with Dr. Pam Ironside at Indiana University. Attendance at

both seminars provided me with the opportunity to talk with other researchers familiar with qualitative research as well share my ideas with others interested and experienced in phenomenology. After completing the findings section of the dissertation, I plan to send a letter to all the participants to let them know a copy of the study findings is available for review if desired.

Elements of Trustworthiness

Trustworthiness

Trustworthiness is defined as the degree of confidence the evidence has provided in the qualitative research process (Lincoln & Guba, 1986) and comparative to measures of reliability and validity in quantitative research. Demonstration of trustworthiness in qualitative inquiry is best described in terms of credibility, transferability, dependability and confirmability (Lincoln & Guba, 1986). These four criteria will be used for evaluation of the study rigor. Credibility, transferability, dependability and confirmability will be addressed by the following procedures.

Credibility

Credibility refers to the truth of the data (that the researcher has gotten the participants' stories right and that this reflects the concepts) in a qualitative study compared to the internal validity of a quantitative study. Credibility was addressed through reflexivity, member checking, peer examination, and an audit trail. The audit trail included interview narratives, field notes, and perspectives from analysis of peers and qualitative experts, improving credibility. In qualitative study, the researcher is the tool through which the participant will tell her story (Lincoln & Guba, 1986). As the researcher, I was primarily a listener in the interview attempting to provide an unbiased

report of the participant's views and beliefs. A reflexive journal was maintained during the study to record my ideas, thoughts, questions and insights. The journal consisted of an electronic record but also emails, Skype meeting notes, and notes from phone conversations with my committee members and peer reviewers. Interview transcripts were returned to the participants for review and further comments following transcription. Peers were included in each component of the study process. Peer review with two previous fellow doctoral students and an expert qualitative researcher contributed and critiqued the process as it developed to ensure truthfulness of the data (Patton, 2002). These steps provided the truth value or credibility to the study.

Transferability

Transferability describes the extent to which findings can be transferred to other groups or settings similar to generalizability in quantitative research. In this study transferability was accomplished through the use of a purposive sample. Each participant was screened prior to admission into the study. The screening process assured the participant met the criteria for a traumatic childbirth. Rich description was provided by the participant narratives extending the understanding of a phenomenon (Lincoln & Guba, 1986; Patton, 2002; Shenton, 2006). Each participant provided detailed stories concerning the traumatic birth experience and her perception surrounding the birth experience. The goal of this qualitative study and the use of hermeneutic phenomenology were to provide the reader of the research with a clear, understandable picture of the phenomenon in which the reader could make a connection as to whether the results may be applicable to another particular population. Excerpts from the participants' narrative will provide support in helping the reader make that connection. Reflexivity of the

researcher will contribute to transferability. I used my reflexive journal to describe the setting, body language, and my responses (thoughts, ideas, questions) to the interview, providing the research team with information key to the development of the study.

Dependability and Confirmability

Dependability refers to the consistency of the research and the ability to duplicate the research. Confirmability refers to the neutrality of information and lack of researcher bias. Dependability and confirmability were supported simultaneously through the audit trail (Lincoln & Guba, 1986; Patton, 2002). Both were assured through maintaining the audit trail of the research process including the research plan, data sources, interview tapes, and interview transcripts. Members of the research team and an expert qualitative researcher critiqued the process as each stage developed. The group was involved in the interpretation, coding, and development of themes and patterns. I maintained field notes and a reflexive journal throughout the study. The reflexive journal helped promote self-awareness of my own assumptions and beliefs as the researcher. An example of my bias is that I did not believe it was likely for a mother to experience PTSD symptoms simply related to childbirth. My basic belief is that childbirth is a normal transition to motherhood. I also was able to note bias among the peer group as well. Confirmability was also supported through the use of the EPDS and DTS. The survey results supported many of the findings in the interviews and functioned as another objective data source (Patton, 2002; Shenton, 2006).

Data Analysis: Quantitative

The use of the EPDS and DTS served as instruments to gain perspective into each participant's traumatic birth experience. The use of quantitative measures as a source of

objective data was supported by acknowledgement that the proposed qualitative sample size was twenty which does not meet the generally required minimum sample of any quantitative study (Munhall, 2007). The two instruments were given at the end of the interview retrospectively to describe symptoms related to PPD and PTSD that the participants may have experienced within the first year following the traumatic birth experience. The instruments were used to determine if the participants met the criteria for clinical/subclinical symptoms of PPD and PTSD within the postpartum period. The scales were used primarily to describe individual participants and the sample as a whole. The number of participants, lack of a random sample, and retrospective nature of the survey completion does not provide for adequate data to show a correlation between PPD and PTSD. Data analysis will be conducted using descriptive statistics. The forms will be reviewed for missing data and cleaned appropriately. Analysis will include means, standard deviations, and percentages for description of the different symptoms of PPD and PTSD. The reliability of scaled items will be assessed.

Depression

Depression was measured retrospectively by the EPDS. The EPDS is a 10 item self-report questionnaire designed to screen for postpartum depression. For the purposes of this study, participants were asked to answer the question based on the emotions they had experienced in the first year postpartum. A Likert-type format is used to record responses to questions including: "I have felt sad or miserable". Responses are scored 0 ("No, not at all"), 1, 2, 3 ("Yes, most of the time") with the total score obtained by summing item responses. The higher score indicates a greater level or severity of postpartum depression.

Posttraumatic Stress Symptoms

Posttraumatic stress symptoms were also measured retrospectively using the DTS. The DTS is a 17-item self-report screen used to measure trauma symptoms as described by the DSM-IV. The DTS has previously been used to measure trauma symptoms in populations who have experienced natural disaster, rape and abuse (Burgess & Clements, 2006; Meltzer-Brody, Churchill & Davidson, 1999; Sijbrandij et al., 2008). No studies using the DTS to measure symptoms in women following childbirth were found. This is a first time use of the DTS used retrospectively to determine trauma symptoms following childbirth in the study sample population. The DTS was used to support findings from the participant interviews. Based on the sample size of 20 participants, quantitative analysis was used to measure the occurrence of trauma symptoms.

Protection of Human Subjects

Recruitment

Following Institutional Review Board (IRB) approval from Georgia State University, recruitment began. Women were recruited by snowballing, referrals from colleagues and acquaintances, flyers placed in acute care hospitals, public health departments, and physician offices. The flyer provided information about the study, my contact information (telephone number and email address), and a request asking women to call the researcher if they wanted to participate in the study. Most participants were recruited through snowballing−learning about the study from friends and colleagues. Approximately half of the participants were nurses and responded based on the flyers placed in acute care and public health department settings.

Protection

On initial contact with each participant, I emphasized that participation was voluntary and that at any time the participant could choose not to answer questions or withdraw from the study without any repercussions. Emphasis was also placed on confidentiality. Informed consent was obtained at the beginning of each interview validating agreement to study enrollment and a copy of the consent form given to each participant. Interviews and questionnaires were coded with participant numbers ensuring confidentiality. Consent forms and code key were stored separately from the data collected during the study in a locked file cabinet in my home office.

Potential Risks/Benefits

There were no risks from treatment, drugs or medical devices. A risk was participants told their birth stories which caused them to remember events or feelings that caused emotional stress. A plan was in place for the faculty PI and the student PI to help the participant find a referral for counseling if needed (See Appendix J). However, no participants requested a referral or seemed stressed although many were very emotional. Participation in this study may have benefited women personally by allowing them to come to a greater understanding of their experience. In fact, some participants shared information about the birth with me that they had not shared with anyone else.

The study included the EPDS, a tool for depression symptoms, as a measure of depression and the DTS, a tool for traumatic stress symptoms. Participants with higher scores all stated the scores were indicative of the first year following childbirth and that they no longer had symptoms of depression or PTSD. No participants expressed or indicated an ideation to hurt themselves.

Strict participant confidentiality was maintained. Private areas such as private offices, conference rooms, and public library reserved rooms were used as areas to conduct interviews. Participants were assigned a participant identification number. The participants' names and identification numbers were recorded on the participant roster. The code key was secured in another locked cabinet separate from the cabinet containing participant information. Informed consent forms and roster were maintained in a locked file cabinet with the student investigator and faculty principal investigator having sole access to the file cabinet. The interview audiotapes and transcripts were labeled with the participant identification number to protect confidentiality. The EPDS and DTS forms were labeled with the participant identification number. The interview audiotapes, transcripts, and measurement forms were stored separately in a locked cabinet at a separate location from the roster and consent forms. Plans were developed for the audiotapes, informed consents, and measurement tools to be destroyed after five years.

Summary

This chapter described the methodology for the study including the research design as well as the selection, characteristics, settings and recruitment plan for participants. I discussed the process of data generation and analysis. Trustworthiness measures proposed for the study were described to assure the rigor of the study. The risk/benefit potential and protection of human participants was also described in this chapter.

CHAPTER V

FINDINGS

The purpose of this study was to gain an understanding of the experiences of women who have experienced a traumatic childbirth. In this chapter, I present the demographic data describing the women participating in this study and the findings of the study. Transcripts from the interviews were analyzed through the hermeneutic process. Phenomenology guided the interpretation of the themes and patterns discussed in this chapter. To protect the anonymity of the participants, pseudonyms have been used for each woman. As data were analyzed through the hermeneutic process, three constitutive patterns emerged: Never Being the Same, Making a Difference, and Getting to the Other Side. I used the words and stories of the women that best describe their experiences with a traumatic childbirth.

Description of Participants

Twenty women participated in this study. All of the women at the time of the interviews resided in the southeastern United States. Women were recruited using the snowballing technique and the placement of posters in public locations. First contact was made by telephone and preliminary information was obtained using a screening tool. Initial information from the screening tool included: age, the ability to speak, read, and write English, self-report of a traumatic childbirth, fear for life of herself or her child during labor or birth, and the length of time since the traumatic delivery. Upon conclusion of the qualitative interview, each woman completed a demographic

questionnaire. The questionnaire addressed characteristics of age, race, educational level, current marital status, current occupation, health care reimbursement status at the time of the birth, history of depression, and history of trauma. Participant characteristics are summarized in Table 2.

Table 2

Demographic Data

Participant Characteristics	Participants *n* = 20	
Age		
20-30	3	(15%)
31-40	7	(35%)
41-50	8	(40%)
51-60	1	(5%)
61-70	1	(5%)
Race		
African American	6	(30%)
Hispanic	1	(5%)
White	13	(65%)
Level of Education		
Less than High School	3	(15%)
High School Graduate		
Some College	5	(25%)
College Graduate	8	(40%)
Graduate School	4	(20%)
Current Occupation		
Teacher	3	(15)
Nurse	6	(30%)
Nurse Administrator	2	(10%)
Nurse Practitioner	2	(10%)
Grant Director	1	(5%)
Secretary	3	(15%)
Unemployed	3	(15%)

(Table 2 Continues)

(Table 2 Continued)

Participant Characteristics	Participants *n* = 20	
Current Marital Status		
Married	19	(95%)
Single	1	(5%)
Healthcare Payment Method		
Private Insurance	11	(55%)
Cash	7	(35%)
Medicaid	2	(10%)
History of Depression Prior to Childbirth	8	(40%)
History of Trauma Prior to Childbirth	7	(35%)

The sample for this study consisted of twenty women and their ages ranged from 24 to 61 years at the time of the interview. Participants included thirteen (65%) White women, six (30%) African American women and one (5%) Latina woman. Many of the women described the traumatic birth as a life changing event – not always as the good thing that is espoused by the current media and social climate. The women in the study were from a variety of socioeconomic and cultural backgrounds but told stories similar in detail and emotion. Forty percent of the participants were nurses at the time of the interviews. Four women chose nursing as a career due to the traumatic birth experience. Fifteen percent of participants were teachers, fifteen percent were unemployed and thirty percent were employed in the area of grant writing, teaching and administration at the time of the interviews. Flyers were posted in areas where nurses work which may have contributed to the large number of nurses participating in the study. Findings did not differ for nurses in comparison to those of other professions. Fifty-five percent of the

women carried private insurance, ten percent used Medicaid and thirty-five percent used cash to pay for healthcare services.

Across the time span of three decades of ages, educational levels and cultural beliefs, the truth surfaced that traumatic childbirth held long term consequences for mothers, children, husbands, families and friends. Fifteen percent of participants had less than a high school education while eighty-five percent had obtained a college degree. Five (25%) of the mothers were admitted in an intensive care Unit (ICU) and seven (35%) mothers had babies that were admitted to the neonatal intensive care unit (NICU) as a result of the traumatic childbirth.

The median age of participants during the study was 39.5 years (SD = 7.9) and their children ranged in age from 1 year to 24 years at the time of the interviews. Three of the participants had one child and decided not to have other children following the traumatic birth experience. All participants were currently employed. Three of the participants did not complete high school and most of the participants had a college education. Eight (40%) of the women reported a history of depression at some time prior to the traumatic childbirth. The experience of a traumatic life event prior to the traumatic birth was noted by seven (35%) of the participants. Two of the women experienced the traumatic childbirth less than 2 years ago and two of the women experienced the traumatic birth more than between 20 years and 30 years ago. The other participants experienced the traumatic childbirth between 5 and 16 years ago. Seventy-five percent of participants scored in the range of clinical depression and fifty percent of the women in the study scored in the range of clinical PTSD. One hundred percent of women scoring in the range for clinical PTSD also scored in the range for clinical depression.

Patterns and Themes

As data were retrieved from the first interviews, I noted that the participants had some mild to severe worries and concerns. The participants were concerned about their role as mothers following the traumatic childbirth. The women also talked about the reactions of family and friends to them during childbirth and in the postpartum period. The participants openly discussed their fear following the traumatic birth experience. The women also discussed the impact of the childbirth on their current lives.

I began each interview by asking each woman, "So, can you tell me about your birth experience?" Each participant did not hesitate to recount the story of the childbirth, when it began, what happened in the labor, what happened with the baby even when the woman herself may have been medicated. Three women had general anesthesia but remembered the accounts of the deliveries shared by their husbands and families following the event. Dates and times of birth related events were recited by each woman with clarity.

Although each woman's story was unique, each shared her personal account of events which led to a change in her life. The overall pattern reflected the essence of each of the interviews. Many of the women reported symptoms of depression and posttraumatic stress supported by scores from the Edinburgh Postpartum Depression Scale (EPDS) and the Davidson Trauma Scale (DTS). The women were asked to complete the scales based on emotions they experienced in the first year following the traumatic birth. Women denied current depression and PTSD but many women did express current emotions of anger, guilt and sadness that currently surfaced at intervals.

Based on the women's stories, the patterns identified were: Never Being the Same, Making a difference, and Getting to the Other Side. These themes may seem similar to previous research of normal transition to motherhood (Mercer, 2004). However, for these mothers the transition was full of life threatening events that had negative emotional and physical impacts similar to women who experience PPD and PTSD (Beck, 2004a, 2007, 2008a). The women in this research shared their stories about the interactions they had with healthcare providers (nurses, midwives and physicians) during the traumatic childbirth experiences and the consequences of those patient-provider interactions. The women described the transition from a traumatic delivery, surviving the postpartum period, and becoming a mother from many perspectives. Some women felt the traumatic birth event was part of the process and a natural part of becoming a mother. Unlike mothers with normal childbirth experiences, most women in this study felt they had been denied the joy of an important milestone in their lives. The traumatic childbirth experience changed the women forever and contributed to the first pattern: Never Being the Same.

Constitutive Pattern: Never Being the Same

"I was not the same. I will never be the same."
Anne

The women who participated in this study began the interviews by telling their birth stories. Each mother was able to recite the times and dates, as well as special memories associated with the birth process. These memories included the surrounding events and the emotions occurring at the time of the birth and immediately afterward. The women talked about how the experience forever changed their lives supporting the constitutive pattern: Never Being the Same. Review of the data revealed four major

themes: Knowing, Losing Control, Bearing the Pain, and Being Afraid. These themes were similar to ways women with normal childbirth experience childbirth (Beck, 1992; Mercer, 1985; Rubin, 1975) except for the negative outcomes that produced depressive and traumatic symptoms. However, for the women in this study the themes were related to an experience in which they feared for their life or the life of the child.

Knowing

Participants recalled knowing when changes occurred in their childbirth events and how the events negatively affected them for years. Several of the mothers talked about knowing when emotions and thoughts began to differ from their perception of a normal labor and delivery process to a traumatic childbirth experience. Several women expressed knowing something that their bodies were telling them intuitively and other women expressed knowing their condition had changed based on the non-verbal cues of the healthcare providers. A few women expressed knowing from the perspective of having received medical knowledge through formal education and work experience. These ways of knowing reflected how women's experiences in a traumatic childbirth contributed to long term personal change.

An example of knowing about how your body feels was reflected by Carol's description of the day she went into labor. Carol, a 31 year old woman, intuitively recognized the changes in her own body. She recalled her emotions when she returned home after her traumatic delivery, "Honestly I really never thought that it was going to be a bad end, I just knew it was going to be a harder road."

Another participant, Tangela, a 32 year old mother of four children shared the story of her fourth childbirth experience. She recounted knowing intuitively as a

response within her own body that it was too early for her baby to deliver, "So…my OB knew I was not going to make it full term…I was in labor… She (nurse) checked me and I was about 5 centimeters dilated and about 30 minutes later...she called the nurse in...they called the doctor and…….the RN delivered her (the baby)."

With her previous experiences in childbirth, Tangela knew what to expect. As it turned out, she was surprised because this birth experience could not be compared to the other three deliveries she had experienced. Another example can be described in Kim's story of her second childbirth. Kim, a 44 year old woman with 4 children, had an emergency cesarean section with her first child. She talked about a sensory knowledge related to her childbirth experience. She thought she knew what to expect since this was her second pregnancy but the look of fear in her providers' facial expressions gave her doubt. Kim recalled, "I think that was right before he (physician) had his sudden outburst of [where is the team, this is an emergency]…you know I think that is when I lost it…I was just afraid…it was frightening. It was really frightening to me."

Another example of knowing was shared by Suzanne, a 46 year old mother, who told the story of her only childbirth experience sixteen years ago. Suzanne recalled the exact date and situation when she knew something was wrong, "I had no problems at all. Then all of a sudden, and I can tell you exactly when... things changed so quickly I can tell you the date. It was….and I started feeling bad. I thought I'm sick, something is wrong. I just know something is wrong…I don't feel right. I was admitted to the hospital. I never went home again until after my daughter was born." After her surgery, she was moved to a room on the postpartum floor. Suzanne continued, "I moved out to the floor and I just was not doing well and I kept trying to tell them there is something

wrong, there is something wrong…there is something wrong." Suzanne developed pulmonary edema following her childbirth which went unrecognized by her nurses and physicians. Her persistent complaints of shortness of breath eventually led to a provider ordering a chest X-ray. She was treated immediately and readmitted to the hospital ICU for a severe form of pregnancy induced hypertension. Suzanne knew her body and recognized she needed further treatment. Knowing her body and her persistence resulted in her getting appropriate treatment and a positive outcome. Suzanne scored in the clinical range for postpartum depression (PPD) and posttraumatic stress disorder (PTSD). She did not experience the joyous birth she had expected. Her child was admitted to the neonatal intensive care unit. Her opportunity for bonding and celebrating was denied which caused emotions of anger and resentment that still resurface in the present.

The theme Knowing was based on women's stories of the first birth as well as mothers having a second or fourth child. Experience in childbirth did not always assure that these mothers knew what to expect in future births. Some mothers expressed knowing they would have a normal delivery which led to powerlessness and loss of control when emergencies were experienced. Loss of Control was the next theme noted in the research process.

Losing Control

Women in this study talked about their labor and delivery expectations prior to their childbirth event. They began the interviews by telling me about their birth plans and the traumatic effects of running into problems or changes in their plans. Such changes included labor induction, emergency cesarean sections, and premature labor. These changes engendered within the participants a feeling of having lost control of the birth

process. One young mother summed it up when she said, "… it was not the experience I thought I was going to have." The loss of control and the trauma associated with the event influenced future childbearing decisions for these women. Several women decided not to risk a future incidence of loss of control in childbirth by making a decision to not have more children. Brittney, a 27 year old woman, with only one child solemnly stated, "I will never, ever have another child." Brittany chose to terminate her second pregnancy because of her fear of another childbirth experience. Similar to Beck's theory of PPD (1993) for women in this study losing control represented a sense of powerlessness with both immediate and sustained consequences associated with a traumatic childbirth.

The participants talked about the problems that precipitated a change in their birth plans. Carol reflected on her birth plan, "Everything was going along just as planned…everything was rocking along and then once we got to the hospital, we were not in control anymore." Another participant, Tara, a 40 year old woman, talked about her emergency cesarean section; she had wanted a natural birth but the baby experienced fetal distress. She remembered the loss of control she experienced when her birth plan was not followed:

> They got me in there and I wanted everything natural…I ended up having to have a cesarean section which was the last thing I wanted…because I was wanting to have a natural birth…it was like if anything could go wrong, it went wrong after my water broke. Up to that point I had a perfect pregnancy, no problems, nothing…but there were situations to me that really, really upset me and after seven years still bother me…

The decision not to have more children resonated throughout the interviews. These women experienced pain, fear, and a sense of trauma that remained with them over a time span as short as a year and as long as thirty two years. Lori expressed this sentiment when she spoke about her labor, pushing for 3 hours, and the delivery, "It was traumatic… It was terrible.' And I did not have any more children. I will never forget the delivery."

A young mother of two premature infants two years apart, Elena, described her experience as also "planning everything to be normal." She described a loss of control that was similar to being in a natural disaster when problems developed in her pregnancy. She was told a cesarean section would be performed to save her life and the baby's life. Elena said, "The situation. You know just like when any type of disaster happens, I don't think anyone would be ready. Like to say okay the tsunami hits tomorrow...I don't think that we would be ready. And that is kind of like the thing that happened to us." Elena scored in the range for PPD and PTSD on the scales she completed post-interview.

Anne, a 54 year old woman at the time of the interview, read through the EPDS and the DTS after telling her birth story which occurred 24 years ago. Anne expressed a sentiment confirmed by many of the mothers. She commented, "I was not the same. I will never be the same." Anne recalled the nurses screaming at her to push and forcefully pushing on her belly to help her deliver her premature infant. She recalled the excruciating pain and fear of what she described as a bad experience. Anne continued, "I will never forget it. I thought then that I am not going to have another child." The desire to not have any more children appeared to reflect an attempt to gain control over a situation in which these women had recognized a complete loss of control.

The loss of control was evident based on the participants' stories of running into problems which were not within their control. Loss of control was an important theme supporting the pattern of Never Being the Same. The pattern was also supported by the theme of Bearing the Pain which reflected physical and emotional pain experienced in the traumatic childbirth experience.

Bearing the Pain

The participants talked about the pain they had experienced with the traumatic childbirth. The pain was described as both physical and emotional. The physical pain was the pain of a contraction, a procedure, or part of the labor process. The emotional pain was related to depression and suicidal thoughts the women experienced in the aftermath of delivery. Each mother talked about the delivery, pregnancy and postpartum period as a spectrum of the childbirth experience which included an intensive care stay for the infant or the mother. Fear and feeling scared were integral to the traumatic birth story. Janet, a 49 year old woman who delivered her first and only child at 18, described bearing with the physical pain. She recalled, "So I am like lined up in this room with these other women… some screaming. I am just a silent crier, so I was bearing with the pain." She described the pushing phase of the delivery and the episiotomy, "I was about to push out my bladder, my rectum and everything else…So, that was pretty traumatic. I can remember when he did the episiotomy… I felt every stitch when he sutured me up...I was like oh my God what are you doing down there, you know..." The physical pain of childbirth changed this mother and influenced her decision to not have more children. Although this mother experienced severe pain, she did not score in range for PPD or PTSD on the EPDS and DTS scales.

Another woman, Brittney, talked about the physical pain being so bad she thought she might die before her epidural was placed. Brittney, who was 17 when her son was born, remembered waiting for the epidural, "…I really just think I would have died right there because of the pain. As you see, I can take pain (laughter as she shows her tattoos – arms, back, face piercings)." While Brittney was sure she wanted the epidural for pain relief, another woman, Irene, described being terrified of the pain. Irene, a teenager at her first and only birth, said, "… I just remember I was in a lot of pain…I wanted to be pain free…It was almost like I felt separated from the baby. I was just worried about my pain, the pain, the pain. I just wanted it to stop."

These participants recounted the story of their pain as if they had experienced it yesterday. These stories supported previous research indicating women can recall the pain of the childbirth experience as vividly as when the childbirth occurred (Beck, 2008a; Goutaudier et al., 2012; Waldenstrom, 2003; White 2007). Physical pain was not the only pain these women experienced. Some women talked of the emotional pain resulting from the traumatic birth including depression and suicidal ideation. Another participant, Elena, a 36 year old woman, talked about her emotional pain following her emergency cesarean section. Her infant was transferred to a neonatal intensive care unit in a hospital over a hundred miles away. She talked about seeing her baby in the intensive care nursery. Elena remembered, "…Like I said, once I started walking I said okay this is the pain that I was not feeling because I was just so stressed, so overwhelmed about what had happened and if my baby was going to make it. My husband took pictures and those pictures… we don't show them because he looked more dead than alive. So, we were afraid they were going to be the only pictures."

The difficulty of bearing the emotional pain was also expressed by Suzanne as she recovered from her cesarean birth in the intensive care unit. She recalled the emotional pain of not being able to see or hold her newborn and talked about the experience of seeing her newborn for the first time in the neonatal intensive care unit 16 years ago:

> My daughter was born at 28 weeks. She weighed 3 pounds and 5 ounces. I spent that night in the ICU and I cried over and over and over, I don't know where the baby is… And…then finally it started sinking in and they started telling me that the baby was in the nursery…on a ventilator…and I had that Polaroid picture and they kept telling me "see, she's fine…and I'm like "but this doesn't look fine". She was very little …very little (crying). They took me to the NICU to see her. We went in there and I remember the two of them standing me up to see her and I looked at her and I was like "oh my God". I got sick and threw up in the trash can.

Linda described a similar experience. Linda, who experienced seizures and resuscitation in the operating room during an emergency cesarean section twenty years ago, recalled the confusion and pain she remembered when looking back at her traumatic childbirth:

> I was unconscious for three days after I had him…I was in ICU. When I woke up my husband showed me the first picture they had taken of him and of course he was all red with his little hands scrunched up and I said "that ugly baby is not mine (laughter)." …… when I woke up I was in ICU at our hospital and of course (husband) was there..… I didn't know how to feel. I was just… it seemed like I had just been in labor and delivery and of course it was three days later. My husband told me that I had had (son's name) and I had missed three days with

> him. Three days. (long pause)….. The first three days of his life and I missed it. (crying) I'm sorry."

In looking back, Linda talked about her emotions during the time following her childbirth. She said:

> I think I was just sad. I was sad a lot. I remember at one point my son was probably 2-3 months old… He had been crying and crying and I started crying and I told (husband)….I think we just need to give him to your Mama. I think we just need to put him up for adoption because he is not ever going to warm up to me. He is never going to realize that I am his Mama.....and I was sad all the time.

Both Suzanne and Linda scored in the range of clinical depression based on their EPDS scores. Both women denied still experiencing depression and described happy, close current relationships with their children. These two women decided against second pregnancies.

The women told stories of unbearable pain, both physical and emotional. They expressed the fear that occurred when the normal, happy delivery process did not happen for them and their children. Bearing the pain changed the women forever. Women who participated in the study also talked about the fear of seeing their newborn in the neonatal intensive care unit. To these women, the actual childbirth experience was connected to the newborn's experience as well as the actual delivery experience. Fear was a concern for women when problems occurred in the childbirth process and reinforced the following theme of Being Afraid.

Being Afraid

Fear or being afraid was a common thread throughout the women's stories. Mothers talked about fear for themselves and fear for their newborns. Women expressed fear of unknown outcomes in the traumatic deliveries and the newborns' intensive care stays. Mothers expressed fear for their children. Tangela, who delivered before her healthcare provider could arrive, described her fear; "It was scary…because I did not know if she would have breathing problems or anything else because she was that early… I was freaking out because I was like oh my God nobody is here…and I was like oh lord nobody is here." This mother was afraid for her child because she felt the baby might have breathing problems related to prematurity and because the appropriate medical personnel were not available to take care of her newborn.

Vickie, a mother with blood pressure problems, experienced fear for her baby, for herself and for her young children at home. She was transferred to a level three hospital where her high risk physical pregnancy problems had the appropriate staff and technology to take care of her. The hospital was located 50 miles away so her family and friends had difficulty with transportation. Vickie remembered her admission to the hospital, "…..so I was okay at first, but then it got really nerve-racking because I realized number one, she is going to the NICU…and I realized, she is not coming home you know. So that scared me…" Vickie did not want to face the fact that she would deliver her baby early. She finally recognized the seriousness of her health and her baby's health when she realized she was going to deliver the baby early.

Unlike Vickie, Rita, who experienced an emergency cesarean section, recognized immediately that she and her baby might not survive the labor and delivery process, "I

was afraid because at that point I didn't realize if I was going to survive or if my baby was going to survive and I just didn't anticipate it would be this way." Rita's daughter was delivered by cesarean section and healthy.

These women expressed being afraid in different ways: some for their lives, some for their newborns' lives, and some for both their own life and their children's lives. Women recognized fear in the people around them - family members, nursing staff, and physicians. The fear was real to each woman just as fear is real to individuals who experience trauma from rape, natural disasters, and war. The fear had life changing results. Most women talked about some point in the childbirth experience where they felt a loss of control. Participants also talked about knowing when something was not right. . The women also talked about their surprise when the pregnancy and delivery did not go as they had planned and problems were experienced. These life changing experiences were examples of women enduring a traumatic childbirth which supported the Constitutive Pattern: Never Being the Same. An additional emerging pattern was Making a Difference.

Constitutive Pattern: Making a Difference

"…… there was somebody and they made a difference with the care they took of us"
Suzanne

All the women in the study talked about the care they received from healthcare providers, family members, and husbands or partners. The interviews included stories of both positive and negative experiences of support from nurses, physicians, husbands, partners, friends, and family. The traumatic birth experience also had significant impact on relationships with long term outcomes. The themes included in the pattern were: Knowing What They Are Doing, Unnerving to Them, and Sharing All That with Me.

Knowing What They Are Doing

The theme Knowing What They Are Doing embodied the feelings participants experienced with their healthcare providers. Most of the women described positive experiences with the nurses, physicians, paramedics, operating room staff and other hospital personnel. However, a few women recalled feeling at some point that the healthcare providers were not interested in their concerns or beliefs. Some women questioned the competency of the providers. One woman, Tara, who experienced an emergency cesarean section commented:

> …they forced me to take medicine I did not need or want…I did not feel comfortable at all…I just did not like the fact that nobody would listen to me…I do not think that they really took my wants or concerns into real consideration…I am not saying that they were bad people…all in all, it really was not a good experience.

Tara appeared angry and paced constantly throughout her interview. Tara was one of 7 mothers who had experienced a separate trauma prior to childbirth. She felt as though her negative experience was related to the nurses and physicians. Tara felt her health care providers did not value her as a patient, contributing to her negative experience.

However, many women had positive experiences with their health care providers. Several participants talked about the nurses and physicians going above and beyond their required duty. Leslie, a mother of two, arrived at the hospital where she had her cesarean after being transported from her hometown hospital. In her hometown hospital, the nurses did not believe her when she told them she had not had any red colored soda to drink after she threw up red tinged emesis. The nurses believed she was lying about

drinking the red soda. Her husband actually requested her transfer to the tertiary center in a larger town. The larger town contained two tertiary hospitals and Leslie was first taken to the wrong hospital by the transport team. She described the experience, "…And then when we get to the other hospital and I was kind of getting the same vibes with these nurses like you know - who are you and what are you doing here? You know, where are you supposed to be? I was like what in the heck is going on? It is not supposed to be like this." Even though she was appreciative of the care she ultimately received, her experience changed her view of healthcare providers. She adamantly responded, "Oh yeah. It did in the fact that I always thought they were placed up on a pedestal because they were more intelligent and they knew everything, but they are human and they make mistakes."

Carol's opinion of healthcare providers improved because of her birth experience. She initially placed little trust in her providers and was assured in her own ability to have control over her labor and birth process. As events progressed, she placed trust and faith in the nurses and physicians who cared for her. Another participant, Lori, remembered her providers in a positive sense even though she questioned the amount of time she was allowed to labor. She was delivered by forceps after hours of pushing. Her efforts resulted in severe lacerations and repair. Lori recalled, "They were excellent. Even my labor and delivery nurse that was with me… she stayed on. She worked days. She stayed with me from 5:00 until 3:03 a.m. when I delivered. She would not go home. The doctor stayed in the hospital… he never left either. I mean, I couldn't have asked for better care.

Vickie, the young mother who experienced an emergency cesarean section at 34 weeks gestation, had a traumatic experience but a positive outlook on the providers and care she received. She reached a level of comfort at the tertiary center in part because of the relationship she established with the nursing staff. She recalled her nurses, saying "They honestly were just the nicest people, very caring…. And actually from the time I got there until I left I had 18 different nurses and I wrote down all their names." Similar to Vickie, Nancy and Suzanne established a bond with the nurses and physicians at the tertiary center. Both women talked about the excellent care they received and the appreciation for the providers' good care. These participants established a long-term bond with their providers. Suzanne recounted her experience with her healthcare providers, "They made a difference and I want them to see what happened 16 years later." Suzanne's daughter at sixteen had excelled at school, was developmentally appropriate and became a cheerleader. Suzanne summarized the overall feeling of participants concerning providers in that the providers made a difference in these women's experience of childbirth. The difference was perceived as negative or positive and created a permanent memory for participants. Healthcare providers made a difference in the childbirth experiences of the women in this study. The constitutive pattern of Making A Difference was supported by the theme Knowing What They Are Doing. The pattern was also supported by a second theme, Unnerving to Them, as women described their families' memories of the traumatic childbirth event.

Unnerving to Them

Family and friends were key to the birth experience for most of the women in the study. Many times family members recalled parts of the birth story that the mother could

not recall because of medications or an amnesia for part of the delivery. The anticipated normal birth experience changed into an unnerving event for many families. Most families were supportive and provided a safe harbor for the mothers following the delivery. Other mothers experienced isolation from their families and friends. Anne remembered, "Nobody wanted to come around. People I worked with would not even visit. My husband's family would not come. So I felt isolated and all alone, I guess." Anne felt like family and friends were uncomfortable or afraid of visiting because her premature baby had cerebral palsy and was still very sick.

Similar to Anne, Sara recalled her experience of support as lacking. Sara remembered her family trying to be supportive but being unsuccessful in giving the support she needed, "They really tried to like draw me in, but them not knowing what I was going through it was just kind of…I could not talk about it." In these two women, a feeling of isolation occurred as a result of a lack of support. Conversely, most women spoke positively about the support offered by family and friends.

Another young mother, Kim, recalled seeing her mother and husband as the healthcare providers rolled her to the operating room past the waiting room. Kim explained, "My husband and my Mom, they all remember how scared they felt…I am sure that was unnerving to them..." Kim's family was supportive and shared the anxiety of her traumatic birth experience. Similarly, Tara found support in her mother, who had to travel in from another state. Tara recalled, "The pain that I had to go through that I did not want and the cesarean section and being on the drugs, no support of my husband. I was in the hospital for like 4 nights and 5 days. My Mom, thank God, flew in from (another state)…she came in the day that I was leaving the hospital to go home." Tara

relied on her mother for support she felt had not been given by her husband while she was in the hospital. Family played an important support role in the traumatic childbirth stories.

Another participant, Nancy, shared a different story. Nancy, the mother of very premature twins, talked about the time following delivery when the twins were in the neonatal intensive care nursery. Nancy considered this a part of her childbirth experience. She described the need to stay in the same place as the twins. The decision meant living at the local Ronald McDonald House. The experience was positive as Nancy and her husband met many people who shared a common "traumatic" birth experience and became supportive friends. Nancy shared:

> I think probably the best thing about whenever we were going through this was having that support from other families at the Ronald McDonald House…I think that their charity and their house there just really is therapeutic. It is more than just a bed to sleep in. It has a lot more of the support there without having to go to a social worker at the hospital. You really get it at the Ronald McDonald House without even knowing that you are getting it.

In Nancy's experience, complete strangers came together under the common shadow of a traumatic childbirth event and became supportive friends.

Suzanne was transferred to a hospital in another town almost 200 miles away. This young mother also remembered her experience as creating a stronger bond with her parents. Suzanne described the support for her daughter, born extremely premature, from a community perspective. She said,

> It is almost like she belongs to so many people. How they say it takes a community or a village to raise a child, it does. We had to have lots of help and just all the things that people did for us….. people we didn't even know. When we were in (tertiary hospital) I can remember sitting in the waiting room and somebody said she is praying for somebody and it was for me…but there was a lot of prayer involved and that is why she is where she is today and I believe that too.

Similar to Nancy, Suzanne received support from family, friends and strangers. These stories demonstrated how family, friends and even strangers can be a support system for mothers' with traumatic childbirth. The childbirth experience was unnerving for the family, which created both positive and negative responses. Some mothers experienced isolation while others felt they became closer to their families. The families as well as the mothers were forever changed by the event. These interviews supported the theme Unnerving to Them in the pattern Making a Difference. Many women talked about how spouses and spousal relationships were affected by the traumatic childbirth. These contributed to the theme expressed as Sharing All That with Me.

Sharing All That with Me

Women talked about the effect of the birth experiences with their husbands or partners in their lives. Both negative and positive outcomes occurred because of the shared experience of a traumatic childbirth. Most women's relationships became stronger. Some women lost relationships because of the childbirth or childbirth consequences. Husbands recognized the possibility that their wife or child might die in childbirth.

Leslie, who was transferred to another hospital because her husband insisted she be transferred, stated, "I think I was just still in a daze. It did not sink in to me at that time how close I came to dying and how quickly I could have lost the baby. It did to my husband of course, you know…He was just so worried…..It all happened so fast and that is why I say sometimes it is like a blur you know and I do not remember a lot of things that happened, but my husband would remember." A life or death event was the way many mothers described the traumatic childbirth. Kim described the connection that occurred best when she said, "It was in all the aftermath of my husband sharing all that with me…."

Nancy, a young mother who delivered premature twins, talked about her experience with her husband. Although the two have different personalities, Nancy and her husband seemed to complement each other, which she said contributed to their survival of the experience. She recollected, "You know…….like I said, I am kind of a take charge personality and he (my husband) is very laid back…So we both really balanced one another really well...that is probably just the survival technique too, looking back." Nancy's story was one of a shared journey to survival. While many mothers had a positive change in their relationship with their spouse, some described negative experiences.

Lori, another woman, expressed the effect the childbirth had on her husband. Lori never anticipated that her husband would respond in a negative manner. He did not agree to have more children and refused to have a sexual relationship with her after seeing the childbirth. Lori remembered, "I will never forget it. You know, they say you forget it. No, I did not forget that. But you know I would have had another child I think. My

husband was very traumatized by that whole delivery. He never wanted kids anymore, never. He had a problem, to me, afterwards being so afraid to touch me at all."

Lori's story was not the only birth story ending in divorce. Candice talked about her birth experience and how it affected her husband. Candice was divorced within 3 years after her traumatic birth experience. Similarly, Brittney's relationship ended after her traumatic childbirth. Her boyfriend left her after the childbirth. She commented, "I lost a child and a man that day pretty much. He was gone after that." Unlike Brittney, Lori, and Candice, Suzanne's relationship had a positive outcome. Suzanne recalled:

> In some ways it probably brought us together. He told me later that before we had the cesarean section you had to sign paperwork to decide which one of us was to be resuscitated in the event that they had to choose between one or the other and he had chosen for me and I was angry with him because he chose me…because I am like… why would you do that? Why would you do that? He said he didn't know what else to do and he said, 'I thought that if I chose you instead of her that you would have the better chance of survival.' So, in some ways it brought him and I close especially trying to figure out how we were going to take care of this baby.

Suzanne's husband worried about making a decision on saving the life of his wife or his child. He thought he would have to choose. Many husbands experienced some trauma when involved in their wives' childbirth. The shared experience of a traumatic childbirth was demonstrated in these stories. Couples shared a traumatic birth that had a life changing impact. Some couples improved relationships while others ended relationships.

These stories included both positive and negative experiences with support from nurses, physicians, husbands, partners, friends, and family. Similar to previous research (Ayers, 2007; Beck, 1993, 2004, 2008a; Goutaudier et al, 2012), opinions about healthcare providers changed from positive to negative or remained positive among women in this study. Family and friends played an important role in the event of childbirth to support the pattern Making a Difference. The traumatic birth experience had a significant impact on the husband /wife relationship with long term outcomes. The themes depicted in the pattern included: Knowing What They Are Doing, Unnerving to Them, and Sharing All That with Me.

Constitutive Pattern: Getting To the Other Side

"But you know, people unless they experience something
like this they do not realize the miracle of birth and the process.
A part of the process that you have to go through to get to the other side"
Linda

Each mother told a story about how she or her family coped with the traumatic events. Faith, which included praying, was the mechanism by which some participants coped. At other times anger was an emotion experienced because each mother believed that the traumatic event should not have happened to them. In most of the interviews women often used the words "looking back" to sum up different emotions or changes that occurred related to the delivery. The looking back was similar to reminiscing about "what if" or a process that had to occur in order to get to the point in life today. Three themes supported the last constitutive pattern: Getting to the Other Side. The themes for this pattern included: Praying, Being Angry, and Looking Back.

Praying

Several of the women talked about how faith played an important role in coping with the traumatic childbirth event. Prayers were offered up for both mother and child. Many women expressed amazement that complete strangers prayed for them. One mother and her husband chose to name their child based on faith. Kim thought her son might not survive during her emergency cesarean section. She recounted her decision to name her son after her anxiety was relieved, "…I actually named him (child's name), which means gift of God, because I felt like he was a gift. I told him he had such a hard time ever getting to this world…. I felt very fortunate that we did come out with a live baby and that he was okay and that I was."

Vickie talked about how prayer helped her through an early hospital admission and her emergency delivery of a premature baby girl. Vickie remembered, "... I prayed a lot you know. God has showed me you know, you are not in control of anything. I give him all the credit and all the glory because it was a hard situation. It could have went the other way. I could have died. She could have died." Vickie recalled, "Prayer was very, very important to me."

When fear and hopelessness were overwhelming, prayer offered solace to another young mother. Rita remembered waking up from her emergency cesarean section. She did not feel her limbs and was afraid she would not walk again. She prayed to God and thanked him when she could move her extremities. Rita recollected, "…I remember praying to God…all night I prayed…because if it wasn't for God I just don't know where I would be today." Much like other women interviewed before and after her, Rita was grateful to God for answering her prayers and helping her through a traumatic childbirth.

She expressed a renewed strength in her faith. Consistent with current research (Lydon-Lam, 2012) some mothers found faith to be an essential aspect of the childbirth experience. Faith through prayer was a crucial aspect of recovery process. Prayer was an important theme in the pattern Getting to the Other Side. While many women talked of renewed faith being a part of the transition process, a few women talked about living with anger after the birth experience. Working through the anger contributed to the following theme Being Angry.

Being Angry

Two mothers were open about having angry thoughts related to people and the childbirth event. Two women talked about being angry because other people with bad habits or poorer physical conditions appeared to have effortless deliveries and healthy babies. Elena, a young mother, remembered, "I said you know…I see other people, younger people, even people that are sick or more overweight than I am and just smoking and why does she have a healthy baby…" Elena talked about being angry because she had an emergency cesarean section and premature baby. She was also angry at her healthcare providers. She said, "…I was angry… because how come they didn't see this? Why didn't they know that this was coming?" Another mother who still spoke of feeling angry in the present talked about her anger. Suzanne recalled the anger she felt initially and how it has still haunted her even today 16 years after the delivery, "But then for the longest time I was very angry at other women because I knew that they had their children without any problems. I was angry because I was supposed to have my baby with all my friends and my family…I had just imagined everything different." Suzanne expressed a sentiment that many of the women talked about in their interviews. She imagined that

everything should have been different which led to her anger. She felt like she missed many of the important steps in a happy birth process. Being angry was part of her process in moving forward from the loss of her dreams and contributed to the pattern Getting to the Other Side. The reminiscence of emotions of anger and the use of prayer supported the third theme in Getting to the Other Side: Looking Back.

Looking Back

Each participant did not hesitate when recalling the story of the childbirth, when it began, what happened in the labor, what happened with the baby including specific details. A few women received pain medicine or general anesthesia but recounted the story told by their husbands or family. I was awed by the details each participant could recall. These words contributed to the theme Looking Back. An example was the detail in Deborah's interview, "This happened in 1976. I was about 26 weeks gestation and this was my second pregnancy." Deborah, a young mother with a 32 week premature infant continued to tell her story by describing the early labor that contributed to the birth of her preterm infant. The women in this study began with their traumatic birth events, continued with how they recovered from the experience during the first year following the delivery, and how the memories of the experience affected them even today. Intertwined in the stories of the traumatic birth were stories of the support received from family members, the change in relationships between couples, the guilt and fear of having been responsible for the outcome, and the long-term repercussions of having experienced a traumatic delivery. These were memories of Looking Back.

Nancy continued with looking back at the morning her twins were transferred to another hospital approximately 150 miles away, "Looking back… all these crazy

scenarios go through my mind. If I had had those babies at home, we would have all just died because I would have bled to death, they would have bled to death and my husband would have died from just the experience itself. Looking back….." Vickie, who scored in the range of clinical depression on the EPDS and PTSD on the DTS, talked about her medications, her physician, and the recognition that she and the baby could have died as a part of looking back. Vickie recalled, "I went to the doctor's office on October 25th, I will never forget the date…my blood pressure was 197/101. Now mind you, I was at 28 weeks…that is basically my story…we could have died."

Three of the women talked about how events may have been different based on their actions. These women delivered prematurely. Looking back they talked about not recognizing early signs or seeking care. Anne said, "But in my mind, if I had gone to the emergency room…it would have been a different outcome…." Leslie felt a similar emotion. She recalled, "…I feel like maybe if I had not had such a horrible experience, maybe I would not have gone through that depression and maybe my baby would not have had to know me like that. I mean…I know I cannot blame everything on them, but it just makes me wonder you know." Nancy talked about her experience, confusion, and doubt. She commented, "I think back and I wonder…Looking back if they had told me that I would not have gone (to the doctor)… just because I am one of those that I will deal with it, it will be fine, I will go tomorrow…" Nancy shared that she felt like her events were part of a process that resulted in the miracle of birth and if she had not gone to the doctor it would have been much worse.

Candice summed it up, "I know the pain probably was a little bit more…but you know it was just one of those things you get through as a mama. Yes I hurt, but mamas

get up and go… It was bad, it was rough, it was painful…I just felt like hey, that is what mamas do. They give birth (laughter)." Similarly, Irene talked about looking back at her only pregnancy with regrets. She shared that the childbirth was an event she would never forget. She recounted, "It is fresh every time for me. I will never forget it. I could talk about it all the time and it seems the more I talk about, I remember more…I enjoyed being a mom.…so, that was the reward for going through it all… he became my little company, my reason, my motivation and it was remarkable what he did in my life." Irene found comfort in her son after her life changing childbirth event.

All of the women described moving into motherhood from the traumatic childbirth process in various ways. Most women talked about their faith through prayer having positive effects. Several of the women spoke of the anger they experienced at having not had the delivery process that they had imagined. They were angry their childbirth did not fit the common belief that all births are joyous, uneventful occasions. Looking Back were the words used by many to reflect on the trauma of their childbirth. These words created the themes of Praying, Being Angry, and Looking Back which supported the constitutive pattern: Getting to the Other Side. All three patterns were reflective of characteristics of women experiencing PPD or PTSD.

Postpartum Depression and Posttraumatic Stress Disorder

The Edinburgh Postnatal Depression Scale (EPDS) and the Davidson Trauma Scale (DTS) were used to gain perspective into the participant's traumatic birth experience. The instruments were completed at the end of each interview to describe symptoms related to PPD and PTSD. The instruments were used to provide perspective to the participant's traumatic birth experience in the first year following the birth.

Depression symptoms were measured using the EPDS. The EPDS uses a Likert type score with higher scores indicating a greater level of depressive symptoms. The instrument was used retrospectively for purposes of this study. Sixteen of twenty participants scored in the range for clinical depression with three participants in the minor depression range and thirteen in the major depression range. Posttraumatic stress symptoms were measured retrospectively using the DTS. Participants were asked to view the scale questions in the past tense. Fifty percent of the twenty participants scored 40 or above suggesting a diagnosis of PTSD (Davidson et al., 1997).

Table 3

Scores for EPDS and DTS

Scale and Possible Range	Participants *n* = 20	
EPDS		
Scores		
	4	(20%)
≤ 8	3	(15%)
9/10 Minor Depression	13	(65%)
13/14 Major Depression		
DTS		
	10	(50%)
Scores		
≤ 40	10	(50%)
40 Posttraumatic Stress Disorder		

All women in this study reported experiencing a traumatic birth event. Five of the women experiencing a traumatic birth event did not experience PTSD symptoms but did experience minor or major depressive symptoms. All of the women who scored within

range for clinical PTSD also scored in the range for clinical depression. Of the 10 women who scored in the range of PTSD and depression only one of the women scored in the minor depression range. Three women who did not meet criteria for PTSD had high subscores under the clusters of intrusions and hyperarousal. All the women in this study denied current depression or PTSD. However, a few women reported occasional PTSD symptoms such as flashbacks of the birth, triggers and anger intermittently.

Discussion

Although each woman's story was unique, each shared a personal chronicle of events leading to a change in their lives and very beings. These themes emerged through the circular hermeneutic process. The overall patterns reflected the essence of each of the interviews. The women described the transition from a traumatic delivery, surviving postpartum, and becoming a mother from many perspectives. Some women felt as though the process was part of becoming a mother while several women felt they had been denied the joy of an important milestone in their lives. I have tried to use the words of the participants that best describe how these women viewed their childbirth experience and the recovery from the trauma.

Trauma has been most associated with victims of abuse, victims of natural disasters, and veterans of wars. Only recently have researchers recognized the possibility of PTSD as a result of childbirth (Bailham & Josephs, 2003; Beck 2004, 2008a; Fenech & Thomson, 2012; White, 2007). In this study women told stories about trauma and depression in childbirth. These women shared the enduring emotions associated with childbirth experiences which changed their lives forever. Their stories destroy the social myth of a predictable, joyous transition to motherhood often supported by the media

(Ayers, 2007; Beck, 1993, 2004, 2008a; Kitzinger, 2006). These mothers suffered both depressive and trauma symptoms during that time period. These mothers' memories are of traumatic experiences different from mothers who experience the normal childbirth with positive outcomes.

Knowing was defined as formal, informal and intuitive experiences. Women talked about preparing for childbirth by reading the pregnancy and birth literature. Several women mentioned the book "What to Expect when you are Expecting" prior to the childbirth. They received formal knowledge from birth resources which allowed the women to recognize when their experiences differed from the proposed normal experience. Women also experienced knowing about childbirth based on informal information from friends and family. Several women expressed knowing that something in the birthing process changed by observing the healthcare provider's expressions and actions. The stories supported a woman's sense of knowing or intuition of changes in her own body that need to be recognized and valued by family, friends and healthcare providers. Knowing information about childbirth from prenatal classes and published resources did not prepare mothers for a traumatic childbirth event.

Many women talked about an intuitive knowledge. These mothers sensed changes in their body and relayed that information to the providers. Consistent with previous research some healthcare providers did not respond to or appreciate the participants' concerns (Ayers et al., 2008; Beck, 2004b, 2007, 2008c). These examples of women understanding a change in their bodies that others could not see supported the importance of women's voices being heard and valued by healthcare professionals. Knowing was an important piece of the pattern: Never Being the Same. Similar to the

other victims of trauma, these mothers learned that normalcy is not a certainty and this Knowing can change a person permanently (Belenky et al., 1986; Crowther et al., 2013; Savage, 2006). Similar to Knowing women also expressed Losing Control as a theme that contributed to Never Being the Same.

Losing Control illustrated the emotions women experienced when deviations from the birth plan or expected birth process occurred. In this study, women were not prepared for the deviations from the normal labor process in the form of oxytocin inductions, the use of forceps, and emergent cesarean sections. Similar to previous research the use of these obstetrical interventions caused a feeling of loss of control or powerlessness for mothers during childbirth (Ayers & Bradley, 2010; Beck 2004b, 2008c; Beckett, 2005). Women talked about being unable to have the birth experiences they had planned. Consistent with previous research, this loss of control contributed to life changing decisions which included not having any more children (Beck, 2009; Beck & Watson, 2010; Ford & Ayers, 2009; Kitzinger, 2006; Zaers et al., 2008). Similar to research by Beck (2004a, 2007, 2008c) women also talked about how the loss of control created a change their attitude concerning health care providers. The findings support the importance of mothers feeing a sense of being in control in the childbirth process. The loss of control also contributed to the subsequent theme of Bearing the Pain.

In the theme Bearing the Pain, many women talked about the severity of the physical pain and emotional pain of the childbirth experience. Several women in these stories spoke of a sense of being prepared for the pain of childbirth but did not realize how severe it would be for them until that pain was experienced. They experienced pain that made them fear for their lives and physical well-being. Similar to other research, the

pain associated with childbirth could not be imagined until the women actually experienced the pain (Ayers & Bradley, 2010; Beck, 2008; Savage, 2006). The emotional pain of a traumatic childbirth was also described by the women. Consistent with previous PPD research by Beck (1992, 1993, 2001) women described depression in the postpartum period and one mother reported experiencing suicidal ideation. The emotional pain of missed bonding was also reported. Findings from this study support the need for women to be close to their newborns even when admitted to the intensive care units. Some mothers reported the emotional pain caused by feelings of inadequacy as a mother (Beck, 2004, 2008a; Engstrom & Lindberg, 2011; Gamble & Creedy, 2005). In previous research findings (Ayers & Bradley, 2010; Beck, 2009; Cho, Holditch-Davis, & Miles, 2008) women rarely shared these painful feelings with anyone unless it was their spouse for fear of being labeled a bad mother. Bearing the Pain was an important theme of the pattern of Never Being the Same. Along with the physical and emotional pain reported by the women, Being Afraid was the next theme in the pattern Never Being the Same.

The theme Being Afraid reflected the fear women experienced during the childbirth or the fear for their child during or following the childbirth event. Fear or being afraid of childbirth has been associated with fear of pain, lack of social support, previous traumatic events and previous traumatic childbirth events (Hall et al., 2009; Otley, 2011). Two women reported the experience of a traumatic event prior to the traumatic childbirth experience, which is consistent with current findings related to PTSD in childbirth (Harris & Ayers, 2012; Hutchinson et al., 2008). The increased rate of obstetrical intervention such as induction, forceps or cesarean section has been shown to

reinforce the belief that birth is a dangerous event to be feared and has to be managed medically in a hospital setting (Chalmers et al., 2010; Fenech & Thomson, 2014; Otley, 2011). The women in the study expressed the fear for themselves as well as fear for the well-being of their children, which is different from women experiencing a normal childbirth with positive outcomes (Mercer, 2004). Being Afraid contributed to the pattern of Never Being the Same.

The themes of Knowing, Losing Control, Bearing the Pain, and Being Afraid described the lived experience of the traumatic childbirth. These themes supported the symptoms of PTSD and PPD posited by Beck (1993; 2004a, 2008). These themes supported the pattern of Never Being the Same. The next pattern, Making a Difference, provided insight into the effect of the traumatic childbirth on professional and personal relationships.

The pattern Making a Difference confirmed the changes in relationships that occur when a person experiences a traumatic event. Three themes supported the pattern: Knowing What They are Doing, Unnerving to Them, and Sharing All That With Me. The first theme was associated with the relationship between the woman and her healthcare providers (nurses and physicians). Previous research suggests that healthcare providers have an impact on the childbirth experience (Beck, 2008; Beck, 2009) with negative results. Different from previous studies, the majority of women in this study found their healthcare providers to be helpful and compassionate which has been found to be consistent with mothers experiencing a normal delivery (Ayers & Pickering, 2005; Boorman et al., 2014; Dixon, Skinner, & Fourer, 2014). The women described one aspect of their care in the theme Knowing What They are Doing.

Knowing What They are Doing illustrated the participants' beliefs in the knowledge and authority of healthcare providers. Three of the participants felt that most healthcare providers did not listen to them as patients or hear their complaints. Similar research by Beck (2009) supported patients' discontent with healthcare providers' treatment with women with PPD and PTSD. Healthcare providers have been seen as authorities on childbirth and as care has become more hospital focused, women's beliefs about their own bodies have been dismissed by healthcare providers (Beck, 2009; Kitzinger, 2006). The participants in this study respected providers but voiced concerns about the providers not listening to their sense of knowing when something adverse was occurring in their own bodies. These findings were consistent with current research suggesting women's positive relationships with providers are related to increased satisfaction with the childbirth experience (Beck, 2008; Chalmers et al., 2010; Engstrom & Lindberg, 2011). The theme Knowing What They are Doing was important to the pattern Making a Difference. Some providers made a difference in the way women adjusted to the trauma related to the childbirth and the depression experienced after the childbirth.

Many women spoke of changed relationships that occurred with family members and friends. Families and friends have been drawn into the myth of the joyous, uncomplicated birth process for all mothers (Kitzinger, 2006). The theme Unnerving to Them described the feelings experienced by family and friends as they were involved in the traumatic childbirth. Family members and friends found the experience unsettling, which is similar to families of victims of other trauma experiences. A majority of women received positive support from family and friends; however, those who did not receive

support reportedly experienced isolation following the traumatic childbirth. Social support has been found to decrease the incidence of PPD following childbirth (Beck, 2002; Chan & Levy, 2002). For most women in this study, social support was present and played a positive role in the experience. For those women without support, the experience was frightening and upsetting. Spouses were also found to be affected by the experience. The third theme in the pattern Making a Difference, the theme Sharing All That with Me, expressed the changes in spousal relationships.

Previous research has indicated that relationships between spouses change following episodes of PPD (Beck, 2008; Chan & Levy, 2002; White, 2007). Women in this study also experienced long-term relationship effects related to the traumatic event. Three women experienced a loss of relationships, while the remaining women felt their relationships were strengthened because of the shared childbirth event. Herman (1997) suggested recovery from a traumatic event could not be achieved in isolation. The theme Sharing All That with Me was an important theme supporting the pattern Making a Difference. The final pattern that emerged from the interviews was Getting to the Other Side.

The pattern Getting to the Other Side reflected the women's transition from the event into motherhood. The pattern was supported by three themes including Praying, Being Angry, and Looking Back. These themes represented the participants' emotional journeys into motherhood. Women remembered the traumatic event and the processes that led to a reconnection to their current role as a mother. For many women, recounting their stories helped them to see the traumatic childbirth in the context of their entire parenting experience causing them to feel reconnected to their current role as a mother.

Many women talked about their faith and the fact that praying became a constant following the traumatic childbirth event. Praying was the first theme in the pattern Getting to the Other Side.

Praying was a coping strategy many of the participants used during the childbirth event and following the newborn's birth. Previous research found faith and prayer to have been associated with protection from postpartum depression (Limlomwongse & Liabsuetrakul, 2006; Mann, McKeown, Bacon, Vesselinov, & Bush, 2008). Religious participation, specifically prayer, was used as a coping mechanism throughout the traumatic childbirth event. Prayer was used by the participants, family members, and friends into early motherhood to cope with the stress of the childbirth and contributed to the pattern of Getting to the Other Side. Several women expressed their emotions of anger which also added to the pattern of Getting to the Other Side.

Being Angry represented the feelings some women experienced following the traumatic childbirth, during the postpartum period, and even in the present day. One mother expressed her feelings of anger in seeing mothers with unhealthy practices having perfect pregnancies and normal children. Several mothers expressed being angry about not having the happy childbirth experience today's media projects to society (Beck, 2008; Ford, Ayers, & Wright, 2009; Kitzinger, 2006; Sword, Clark, Hegadoren, Brooks, & Kingston, 2011; White, 2007). These mothers described feeling angry as a part of moving forward and resolving the loss of the anticipated delivery versus the actual delivery. Feelings of anger and resentment resurfaced for these women when life events reminded them of the missed opportunities women with normal deliveries experience. These emotions were triggered by attending baby showers or seeing pregnant women,

similar to the re-experiencing symptomatology associated with PTSD (Ayers, 2007; Fenech & Thomson, 2013; White, 2007. The final component in the pattern was Looking Back.

The theme Looking Back illustrated the remembrance and resolution process women used to survive the traumatic delivery. Consistent with previous PPD and PTSD research (Beck, 1993, 2004a, 2008; Fenech & Thomson, 2013) many women talked about remembering their expectations for the delivery and recognizing the powerlessness when the delivery was traumatic. By looking back and questioning the birth process, women were able to reconnect with the support of family and friends to find meaning in the traumatic delivery. Women talked about looking back as part of the process of becoming a mother similar to previous research findings (Dennis & Moloney, 2009; Edge & MacKian, 2010; Lawler & Sinclair, 2003).

These findings suggest that mothers who experience a traumatic childbirth do not always develop PTSD symptomatology (Soet et al., 2003). However, of the 10 women who scored in the range for clinical PTSD also scored in the range for clinical depression. The findings suggested an overlap of PPD symptoms and PTSD symptoms, which is consistent with findings in the broader PTSD literature (Ayers, Joseph et al., 2008; Seng, Shrot, Van De Ven, & Liberzon, 2007). The childbirth process can be unpredictable and associated with ambiguous conditions (Soderquist et al., 2004; Zar, 2001) and deviations from the normal birth process are typically not expected disrupting mothers' expectations about the event (Allen, 1988; Beck, 2008; Kitzinger 2006). Some critics may underestimate the incidence of PTSD following childbirth which may lead to a lack of diagnosis and treatment. PTSD undiagnosed or untreated may lead to functional

impairment with negative impacts for the infant, mother and family relationships (Allen, 1998; Bailham & Josephs, 2003; Ballard et al., 1995; Kitzinger, 2006).

The women in this study began with their birth story and how they recovered from the experience during the first year following the delivery, and how the memories of the trauma affected them today. Specific problems with powerlessness, anger, threat to body image (Herman, 1997; White, 2007) have been associated with individuals who experience a traumatic event. It is not uncommon for individuals to react with various defense mechanisms such as anger, anxiety and depression (Herman, 1997). Intertwined in the stories of the traumatic birth were stories of the support received from family members, the change in relationships between couples, the guilt and fear of having been responsible for the outcome, the depression, and the long-term repercussions of having experienced a traumatic delivery.

Summary

In this chapter, I presented the three constitutive patterns which emerged for me from the study: Never Being the Same, Making a Difference, and Getting to the Other Side. The three patterns, together with their relational themes, constitute the experience of knowing trauma in childbirth for these mothers. Women who previously thought trauma could not happen to them experienced it in the most unlikely reproductive milestone – childbirth. For these women, childbirth was an event that changed them forever.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to gain an understanding of women's perspectives on traumatic childbirth. I described the experiences of twenty women who self-reported a traumatic childbirth event. The women were from a variety of ethnic, economic, and educational backgrounds. I interviewed each woman using open-ended and semi-structured questions to explore their emotions, understanding, and perceptions of the birth event. I also administered the Edinburgh Postnatal Depression Scale (EPDS) and Davidson Trauma Scale (DTS) to support the findings of PPD and/or PTSD from the interviews. The women's stories were analyzed using the Heideggerian hermeneutic methodology described by van Manen (1990) and perspectives from Beck's (1993) PPD theory, Herman's (1998) PTSD theory, and feminist theory (Campbell & Bunting, 1991).

The use of phenomenology allowed for the evolution of their stories into three constitutive patterns: Never Being the Same, Making a Difference, and Getting to the Other Side. Each of the patterns consisted of supporting themes. The supporting themes revealed the journey through a traumatic childbirth presented within each of the patterns. Each theme represented a facet of the traumatic childbirth experience. This study built upon earlier research investigating the incidence of PPD and PTSD related to a traumatic childbirth (Ayers, 2007; Beck, 2004a, 2006c, 2008c, 2009; Edge, 2007b; White 2007). The findings from this study also suggest that a traumatic childbirth can result in the

development of PTSD symptoms, diagnosable PTSD in the first year postpartum, and an overlap of depressive symptoms and diagnosable PPD in that time period.

Conclusions

In Chapter V, I described the constitutive patterns and the relational themes that surfaced from the data analysis. In this chapter, I have provided the final conclusions based on the interpretations of the data. The strengths and weaknesses of the study are reviewed in this chapter. Overall, this study demonstrated that not every childbirth event has a happy, joyful outcome and can leave a prolonged negative impact on women.

From the initial interviews, women expressed many emotions reflected in the literature consistent with PPD and PTSD. Beck's theory on postpartum depression described four concepts: Encountering Terror, Dying of Self, Struggling to Survive, and Regaining Control (Beck, 1993) with the underlying assumption that a loss of control occurs and a woman works through the four concepts in stages to resolve the loss of control. All the women in this study women recited feeling a loss of control during the delivery process and into the postpartum period. The use of the term dying referred to the possible death of the woman herself or her child. Many of the women in this study reported a sense of isolation and one contemplated doing harm to herself or her child consistent with findings theorized by Beck (1993, 2009). There was an overlap with symptoms of PTSD as noted by previous trauma research (Herman, 1997).

Ten of the twenty women in the study scored in the range of clinical PTSD on the Davidson Trauma Scale (DTS) with scores supporting the symptoms of intrusion, avoidance, and hyperarousal during the first year postpartum. The loss of control experienced by women resulted in feelings of disempowerment. Most of the women in

this study reconnected to their lives and families as they recovered from PPD and PTSD. Telling their story to share with other women contributed to a sense of empowerment. Participants expressed a sense of frustration and anger when they realized their voices had been undervalued and used the opportunity to express the importance of health care providers listening to the patient in the childbirth process. These women also felt empowered in challenging the fantasy of the effortless transition to motherhood. From a feminist perspective, they expressed a need to let healthcare providers know they were expert in their own lives.

The constitutive patterns and supporting themes revealed both similarities and differences in the theories by Beck and Herman. The occurrence of an overlap in the event of PPD and PTSD was supported by the following patterns and themes. The pattern Never Being the Same was made up of four themes: Knowing, Losing Control, Bearing The Pain, and Being Afraid. The stories in these themes reflected the memories of the childbirth experience and life during the first year following childbirth. The women talked about the birth itself and the adjustment following the birth. Many of the themes were consistent with findings in previous research. Women experienced long term change because of the traumatic childbirth. The change was reflected in the decision to have future births. Many decided the chance of death for either herself or her child was too great a risk to have more children. Several women's relationships were destroyed because of the traumatic birth and some relationships were strengthened. These changes affected both mothers and children in either negative or positive ways.

Women talked about the loss of control particularly as a loss of voice. The majority of these women spoke about an intuition concerning their health at the time of

the traumatic birth. They gave voice to the concerns about their bodies and the healthcare providers did not listen to the mothers. A reflection on the birth process when women were the experts on their own bodies is needed to complement the medical model and allow voice to the laboring mother (Kitzinger, 2007; Savage, 2006; Stoll, Hall, Janssen, & Carty, 2013). If women are allowed to have a voice in the process, they may feel more of a sense of control during the childbirth. A stronger sense of control may decrease the fear and pain that is a result of a traumatic childbirth may be lessened.

In the second pattern, Making a Difference, it was clear that Knowing What They Are Doing, Unnerving to Them, and Sharing All That with Me, were a part of a process for reconnection to the support systems in their lives. The support systems included healthcare providers, family, friends, and husbands or significant others. For most of the women, the traumatic childbirth was a shared experience that made a difference in their lives.

The pattern, Getting to the Other Side, represented the mothers' journey from a traumatic childbirth to the new love in their lives. The journey was not joyful but the themes which supported the pattern constituted a recovery from trauma. Praying, Being Angry, and Looking Back were the themes that described how the women in the study were able to process the event and move forward in their lives. In conclusion, ten of the twenty women in this study experienced PTSD during the first year postpartum indicating the need for more extensive psychological evaluation of mothers following childbirth.

Recommendations

Recommendations for Nursing Research, Education and Practice

The hermeneutic analysis of trauma during childbirth added to the understanding of how PPD and PTSD are often part of the childbirth experience. This study reflected how women perceive trauma in childbirth and adapt to the event afterwards when women are held to an impossible standard of motherhood set by society (Fenech & Thomson 2013; Harding, 1987; Kitzinger, 2006). Beck (1993, 2008a, 2009) described such outcomes as a precursor to PPD in mothers. Many women in this study overcame their distress through a process described in Herman's theory of recovery (1997).

Implications for Research

Further research is needed to explore ways mothers can be treated with care and concern during delivery, to decrease the incidence of birth trauma, and ways to facilitate collaboration between the mother and health care providers to keep the mother empowered during this time (Beck, 2006b; Kitzinger, 2006). Implications for further research should also include exploration of the difference between health care providers' interpretation of the childbirth process, a negative childbirth event appraisal, and the women experiencing the process. The results of the current study support the need for a new theoretical model specific to childbirth. More exploration into the variables affecting childbirth such as perception of trauma, social support, a history of previous trauma, and infant outcome is needed to develop preventative and treatment strategies. A need exists to review the previous models of transitioning to motherhood to include the incidence of PPD and PTSD. Current research with PTSD and childbirth tends to focus on incidence, prevalence and treatments that have been successful in other populations

(Bailham & Joseph, 2003; McKenzie-McHarg, 2004). A qualitative (phenomenological) study could be used to develop ideas about triggers in women who already have PTSD, when they are pregnant.

PTSD in childbirth has been addressed in the clinical setting primarily by adding debriefing services in the form of quiet listening, structured debriefing, and brief counseling interventions (Baxter, McCourt, & Jarrett, 2014; Creedy & Gamble, 2005). Childbirth was not recognized as an event leading to PTSD in the new DSM–V (2014). The recognition of childbirth as a potential traumatic event is needed to alert healthcare providers to this serious disorder in women experiencing a traumatic childbirth (Boorman, Devilly, Gamble, Creedy, & Fenwick, 2014; Stoll, Hall, Jensen, & Carty, 2013). Research evaluating risk factors and predictors of PTSD following childbirth has been reported with implications to add questions addressing specific risk in the assessment in the practice setting (Priest et al., 2003). Further investigation of the experience of traumatic childbirth may provide clinicians with insight to current care practices that may increase the risk of PTSD and modification of those practices to decrease the PTSD incidence. Qualitative research through interpretive phenomenology can inform health care providers about women's experiences and mothers' interpretation of the childbirth experience. Research among healthcare providers to determine their beliefs about laboring mothers and childbirth is also needed to bridge the gap between patient beliefs and providers' beliefs.

Some professionals continue to question the validity of a diagnosis of PTSD related to a childbirth event (Beck, 2008; Kitzinger, 2006; Wijma et al., 1997). To recognize childbirth as a precipitating factor in the development of PTSD would mean an

expansion of the criteria to include a traumatic childbirth in the DSM. Healthcare providers have not recognized childbirth as an event similar to medical illness (Tedstone & Tarrier, 2003) and natural disasters.

Implications for Practice

Practicing nurses should be reminded that communication between providers and laboring women will empower women in the childbirth process. Support groups for mothers who have experienced a traumatic childbirth, PPD, and PTSD should be offered in routine postpartum care. Collaboration with mental health providers and obstetrical providers is needed to ensure a smooth transition through the birth process and the postpartum period. Incorporation of mental health initiatives focusing on the woman experiencing a traumatic childbirth should include assessment, interventions and evaluation to address the incidence of delayed bonding, strained spousal and family relationships as well as maternal self-esteem during the first year postpartum.

Implications for Education

Findings from this study have important implications for healthcare providers working with women in pregnancy, during child birth and in the postpartum period. Education for patients regarding traumatic childbirth should be presented in the early prenatal period with follow-up education throughout the pregnancy. Childbirth education providers in hospital and community based setting have an excellent forum to discuss traumatic childbirth with expectant parents. Education should include information about events that can happen during the childbirth to cause trauma. The educational session for parents should also include information concerning symptoms of PPD and PTSD that may occur following a traumatic childbirth experience. Parents should be educated about

resources available to mothers experiencing PPD and PTSD following a traumatic childbirth.

Providing education to nurses, physicians, and social workers concerning the findings from this study could improve healthcare provider recognition of the importance of childbirth as criteria for the experience of PTSD. Nurses should be educated concerning resources in the form of social support from family and friends which is a key component for recovery from a traumatic childbirth. Continuing education for nurses defining resources for the mother experiencing PPD and PTSD are necessary to address the long- term symptoms and outcomes that may occur with PPD and PTSD. Education of new nurses should include a focus on the trauma women may experience in childbirth and the focus on sensitivity to and empowerment of the patient.

The results reflected an occurrence of PPD overlapping with PTSD in women following a traumatic childbirth. Recognition of the possibility of both disorders occurring can alert providers of the need to screen more thoroughly for both disorders. Also, early recognition of PPD and PTSD could lead to prompt intervention and follow-up to improve outcomes form mothers and infants.

Strengths and Limitations

The participants in this study were mothers self-reporting a traumatic childbirth experience. These mothers described the trauma as a fear for their lives or a fear for their newborns' lives. Strengths of this study include the use of phenomenology to reveal common meanings from the detailed stories shared by mothers. The use of interviews provided rich data supported by the scores of the Edinburgh Postpartum Depression scale (EPDS) and the Davidson Trauma Scale (DTS) administered to each participant.

Another strength of the study was the adherence to the qualitative method. Rigor for this study was supported by the use of an audit trail, an experienced research team, reflexive journaling and detailed field notes. The use of a professional transcriptionist also contributed to a strong method of inquiry. The women in this study were from diverse backgrounds including: age, race, educational level and occupation. The diversity of this study was representative of the geographic area in which the study occurred, the Southeastern United States.

The group was representative of a small, regional, rural population in the Southeast region of the United States; therefore, findings have limited transferability to other areas of the United States and globe. The sample covered a large age range from time of birth. For those women with older children, their memory of the experiences could have changed due to the long time period since the traumatic childbirth event. However, women did appear to recall in detail the childbirth event.

Summary

In closing, too few studies have addressed the occurrence of posttraumatic stress disorder in relation to childbirth. Postpartum depression has been widely explored with little consistency in screening items and little success in conventional treatment options. A majority of women experiencing childbirth will not have a traumatic event that results in posttraumatic stress disorder. However, the potential to feel the threat of death to self or child, irreversible illness and harm exist in any childbirth. Not all women will experience trauma in childbirth. Many women have support systems, coping skills, and personality to resolve issues just as many veterans of wars, victims of abuse, assault victims and victims of natural disasters implement these resources to resolve traumatic

events. However, for the women who are unable to resolve the issues of a traumatic childbirth, the devastation is as real as that experienced by the soldier, the abuse victim or the victim of a natural disaster. The medical model framework provides little insight into the complexity of PTSD and childbirth. The DSM (2013) does not recognize childbirth as an event precipitating PTSD. This research using interpretive phenomenology has provided substantive contribution to the literature related to traumatic childbirth and the relationship of postpartum depressive symptoms and posttraumatic stress disorder. Reporting the meaning of mothers' experiences can guide the screening, intervention, and evaluation process in research, education, and clinical practice. This study also extended earlier research on PTSD and childbirth. The findings provided evidence of the existence of PTSD following a traumatic childbirth event. Finally, this research provided insight into the lived experience of mothers who experienced trauma during the childbirth event. It is hoped that the stories of these twenty women will play an important role in educating healthcare providers to understand more about mental health in the women experiencing traumatic childbirth.

> "You know just like when any type of disaster happens, I don't think anyone would be ready. Like to say okay the tsunami hits tomorrow... I don't think that we would be ready."
>
> Elena

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APPENDICES

Appendix A

Criteria for Depression

Appendix A

DSM-IV-TR Criteria For **Depression ***

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. **NOTE: do not include symptoms that are clearly due to a general medical condition, or mood incongruent delusions or hallucinations.**

1. depressed mood most of the day, nearly every day, as is indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful).
2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. insomnia or hypersomnia nearly every day
5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. fatigue or loss of energy nearly every day
7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly everyday (not merely self-reproach or guilt about being sick)
8. diminished ability to think or concentrate, or indecisiveness, nearly every day(either by subjective account or as observed by others)
9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a mixed episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism)

E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

The specifier With Postpartum Onset can be applied to the current Major Depressive, Manic, or Mixed Episode of Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder or to brief Psychotic Disorder if onset is within 4 weeks after childbirth. The symptoms of the postpartum-onset Major Depressive Disorder do not differ from symptoms in nonpostpartum mood episodes.**

**Onset of episode within 4 weeks postpartum

* American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders.* Arlington, Va. 4th Ed. Text Revision.

Appendix B

Criteria for PTSD

Appendix B

DSM-IV-TR Criteria For **PTSD ***
A. The person has been exposed to a traumatic event in which both of the following were present: 1. the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others 2. the person's response involved intense fear, helplessness, or horror. **Note:** In children this may be expressed instead by disorganized or agitated behavior.
B. The traumatic event is persistently re-experienced in one (or more) of the following ways: 1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed. 2. recurrent distressing dreams of the event. **Note:** In young children, there may be frightening dreams without recognizable content 3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated. **Note:** In young children, trauma specific reenactment may occur 4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following: 1. efforts to avoid thoughts, feelings, or conversations associated with the trauma 2. efforts to avoid activities, places, or people that arouse recollections of the trauma 3. inability to recall an important aspect of the trauma 4. markedly diminished interest or participation in significant activities 5. feelings of detachment or estrangement from others 6. restricted range of affect (e.g. unable to have loving feelings) 7. sense of foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span
D. Persistent symptoms of hyperarousal (not present before the trauma), as indicated by two (or more) of the following: 1. difficulty falling or staying asleep 2. irritability or outbursts of anger 3. difficulty concentrating 4. hypervigilance 5. exaggerated startle response
E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning **Specify if:** **Acute:** if duration and symptoms is less than 3 months **Chronic:** if duration of symptoms is 3 months or more **With delayed onset:** if onset of symptoms is at least 6 months after the stressor

* American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders.* Arlington, Va. 4th Ed. Text Revision.

APPENDIX C

Study Poster

APPENDIX C

Georgia State University
College of Health and Human Sciences
Byrdine F. Lewis School of Nursing

Study Poster

XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Are you a mother who had a traumatic childbirth?

You are invited to participate in a research study done through Georgia State University. Please contact Tami Dennis, RN, PhD(c) at (229)891-6214

Tami Dennis (229) 891-6214
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Tami Dennis (229) 891-6214

APPENDIX D

Screening Tool for Participants

APPENDIX D

Georgia State University
College of Health and Human Sciences
Byrdine F. Lewis School of Nursing

Screening Tool for Participants

Date of interview:_____
Initials of Interviewer:_____
How did you hear about the study:_____
(Say): "Thank you for agreeing to participate in this study. I have some questions to ask you that will help decide if you meet the criteria to enter into the rest of the study."

Childbirth Information:

Question	Response	Criteria met
Did you consider your child's birth traumatic?	Yes_____ No_____ (must be yes)	☐
Did you fear for your life or your child's life during labor or delivery?	Yes _____ No_____ (must be yes)	☐

Is respondent eligible for the study? □ Yes □ No If yes, complete information below.

Name of respondent:_____
Phone number(s): Home_____ Cell:_____

APPENDIX E

Participant Consent Form

APPENDIX E

Georgia State University
College of Health and Human Sciences
Byrdine F. Lewis School of Nursing

Participant Consent Form

Title: Women's Experiences with Traumatic Childbirth

Principal Investigator: Dr. Margaret Moloney (PI)
Student PI: Tamara R. Dennis (SPI)

I. Purpose:

You are invited to participate in a research study. The purpose of the study is to investigate the experience of traumatic child birth. You are invited to participate because you are a mother who has experienced a traumatic childbirth. A total of 20 participants will be recruited for this study. Participation will require about three hours of your time over about a three month period.

II

If you decide to participate, you will be asked to talk about your story of traumatic childbirth in an interview. The interview will be audio-taped by the student researcher. You may be asked to participate in another interview. You will be able to choose where the interview will take place. You will also be asked to complete 3 questionnaires at the end of the initial interview. You will receive $25.00 as compensation for your time.

III. Risks:

There is the possibility that participation in this study may cause you to remember events or feelings that are distressing for you. If you experience distress, we will help you find a referral for counseling. If such counseling is needed, you will be responsible for the cost.

IV. Benefits:

A benefit of this study is that you may experience better understanding of your experience with traumatic childbirth. If nurses can understand your experiences, they will be able to better help women with traumatic childbirth. Overall, we hope to gain information about the nature of traumatic labor and delivery.

V. Voluntary Participation and Withdrawal:

Participation in research is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or stop participating at any time. Whatever you decide, you will not lose any benefits to which you are otherwise entitled.

VI. Confidentiality:

We will keep your records private to the extent allowed by law. We will use a code number rather than your name on study records. Only Dr. Moloney, Ms. Dennis, and other members of the research team will have access to the information you give us. Information may also be shared with those who make sure the study is done correctly (GSU Institutional Review Board, the Office for Human Research Protection (OHRP).

The information from your interview will be stored on a firewall protected computer, and in a locked cabinet, and the code name key will be stored separately from the data to protect your privacy. This key will be destroyed one year after the study. Your name and other facts that might point to you will not appear when we present this study or publish its results. The research team will have access to the information you provide to assist with data analysis. Audiotapes will be transcribed by someone who does not know whose tape it is. All information that might point to you will be removed from your transcript. Audiotapes will be stored in a locked cabinet and kept private. The audiotapes will be destroyed after completion of the study.

The health information you give us will be used in this research study. The information will be shared with members of the research team. We will remove all information that can identify you. If you decide you want to be in this study it means that you agree to let us use and share your personal health information for the reasons we have listed in this Informed Consent.

While we are doing this research, the research team may use only the personal health information that you have given us: your name, age, health survey. The people and places that will be able to look at your personal health information are: Dr. Moloney, Ms. Dennis and members of the research team. They will look at it so they can work on this research study. We may also share your information with the Georgia State University Institutional Review Board (IRB). Your personal health information may be shared by the people or places we have listed, but it will be shared in a way that does not fall under the protection of federal regulations that apply to the privacy of health information. This research may be shown to other researchers. This research may be published, but we will take steps to make sure that you cannot be identified.

If you sign this consent form you are letting us use your personal health information until the end of the study. You have the right to say that you do not want us to use your personal health information after we have collected it. If you decide you don't want us to use your information anymore you must write a letter asking us not to use your information. You will need to send the letter to Ms. Dennis who received your completed

questionnaires. This will be the only person who will be able to know which information is yours. We want to let you know that because the questionnaires do not have your name or address on them, we might not know which questionnaire is yours. If you don't want us to use your information anymore, we will stop using it, but any information that we have already used in the study will not be removed.

You may not be able to look or get a copy of your health information that you gave us while we are doing the research; however you will be able to look at or get a copy at the end of the study.

VII. Contact Persons:

Call Dr. Moloney at 404-413-1170 or email her at mmoloney@gsu.edu, Ms. Dennis at 229-891-6214 or email her at tdennis@abac.edu if you have questions about this study. If you have questions or concerns about your rights as a participant in this research study, you may contact Ms. Susan Vogtner in the Office of Research Integrity at Georgia State University at 404-413-3513 or svogtner1@gsu.edu.

VIII. Copy of Consent Form:

We will give you a copy of this consent form to keep.

If you are willing to volunteer for this research and be audio recorded, please sign below.

First Name:_____Last Name_____ _____
Participant Date

_____ _____
Principal Investigator or Researcher Obtaining Consent Date

APPENDIX F

Qualitative Interview

APPENDIX F

Georgia State University
College of Health and Human Sciences
Byrdine F. Lewis School of Nursing

Qualitative Interview

In these interviews, women will be asked the following open-ended questions:

1. "Please tell me the story of your birth experience."
2. "Tell me what it was about the birth experience that made it traumatic."
3. "What was it like afterward?"
4. "Can you tell me about any changes that happened to you after the childbirth?"
5. Do you think your experience affected your relationships with family? How?"
6. Do you think your experience affected your relationships with friends? How?"
7. Do you think your experience affected your relationships with healthcare providers? How?"

APPENDIX G

Edinburgh Postnatal Depression Scale

APPENDIX G

Georgia State University
College of Health and Human Sciences
Byrdine F. Lewis School of Nursing

Edinburgh Postnatal Depression Scale

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

I have been able to laugh and see the funny side of things.
- As much as I always could
- Not quite so much now
- Definitely not
- Not at all

I have looked forward with enjoyment to things.
- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardley at all

I have felt scared or panicky for no very good reason. *
- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

Things have been getting on top of me. *
- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

I have been so unhappy that I have had difficulty sleeping. *
- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

I have blamed myself unnecessarily when things went wrong. *
- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

I have been anxious or worried for no good reason.
- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

I have felt sad or miserable. *
- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

I have been so unhappy that I have been crying. *
- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

The thought of harming myself has occurred to me *
- Yes, quite often
- Sometimes
- Hardly ever
- Never

APPENDIX H

Davidson Trauma Scale

APPENDIX H

Georgia State University
College of Health and Human Services
Byrdine F. Lewis School of Nursing

Davidson Trauma Scale

Each of the following questions asks you about a specific symptom. For each question, consider how often in the last week the symptom troubled you and how sever it was. In the two boxes beside each question, write a number from 0-4 to indicate the frequency and severity of the symptom.

1. Have you ever had painful images, memories, or thoughts of the event?
2. Have you ever had distressing dreams of the event?
3. Have you felt as though the event was recurring? Was it as if you were reliving it?
4. Have you ever been upset by something that reminded you of the event?
5. Have you been physically upset by reminders of the event?(This includes sweating, trembling, racing heart, shortness of breath, nausea or diarrhea.)
6. Have you been avoiding any thoughts or feelings about the event?
7. Have you been avoiding doing things or going into situations that remind you of the event?
8. Have you found yourself unable to recall important parts of the event?
9. Have you had difficulty enjoying things?
10. Have you felt distant or cut off from other people?
11. Have you been unable to have sad or loving feelings?
12. Have you found it hard to imagine having a long life span and fulfilling your goals?
13. Have you had trouble falling asleep or staying asleep?
14. Have you been irritable or had outbursts of anger?
15. Have you had difficulty concentrating?
16. Have you felt on edge, been easily distracted, or had to stay “on guard”?
17. Have you been jumpy or easily startled?

APPENDIX I

Demographics

APPENDIX I

Georgia State University
College of Health and Human Sciences
Byrdine F. Lewis School of Nursing

Demographics

How old are you?_____
What is the highest level you completed in school?_____
Do you work outside the home? □Yes □No
If yes, what kind of work do you do?_____
Do you have a partner or husband? □Yes □No
How do you pay for your healthcare?_____
How many children/ pregnancies have you had? _____
What are the ages of your children?_____

What is your racial heritage?
American Indian or Alaska native □Yes □No
Asian □Yes □No
Native Hawaiian or Pacific Islander □Yes □No
Hispanic or Latino □Yes □No
White □Yes □No

Have you previously been diagnosed with depression? □Yes □No
Have you previously experienced a traumatic experience before childbirth? □Yes □No
(Examples include: physical or sexual abuse, a natural disaster, an accident, veteran of war)

APPENDIX J

Referral Plan

Appendix J

Georgia State University
College of Health and Human Sciences
Byrdine F. Lewis School of Nursing

Referral Plan

For participants scoring 12/13 on the EPDS and 40 on the DTS a referral or crisis hotline number will be provided as well as area mental health providers numbers.

Georgia: 1-800-784-2433
Atlanta: 1-404-730-1600
Albany: 1-866-582-7763
1-912-430-4052

For participants expressing suicidal ideation a plan will be implemented. The faculty PI will be notified by phone immediately. The area 911 emergency system will be activated upon discussion with the faculty PI and research committee members.

APPENDIX K

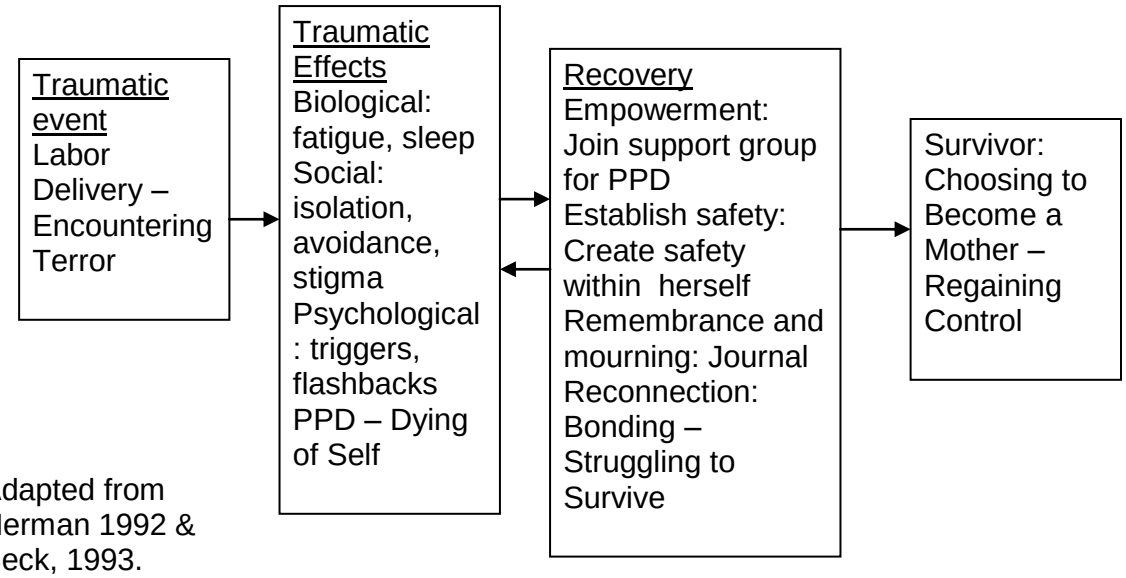
Conceptual Framework

APPENDIX K

Georgia State University
College of Health and Human Sciences
Byrdine F. Lewis School of Nursing

Conceptual Framework

Theoretical Model



Adapted from Herman 1992 & Beck, 1993.