Investigating the Psychological Factors Underlying Tokophobia in Women Following Birth Trauma, and the Need for Psychological Counselling of Women who Fear and Avoid Childbirth

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DECLARATION

This work, or any part thereof, has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose. Other than the expressed acknowledgements and references cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

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[Art created by ‘Heather’]
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ABSTRACT

The aims of the study were to uncover the major psychological factors underlying tokophobia, their impacts, and whether there is likely to be a role for psychological counselling to help women and their families.

Nine women who indicated that they fear and avoid childbirth despite wanting a baby, volunteered and participated in a semi-structured interview. Six of these interviews were transcribed and analysed using the guidelines provided by Smith, Jarman & Osbourn (1999), from which tables of individual themes were created.

For the participants, violation of expectations led to enduring distress, which manifests as symptoms of post-traumatic stress. ‘Loss of control’ and ‘loss of self’ are powerful themes that support existing literature. The theme ‘need of acknowledgment’ adds to the existing literature. As difficulties adapting to changes in lifestyle were expressed, a seven-phase transition model was suggested as a way of explaining and understanding difficulties faced by women with regard to changes in identity and lifestyle.

It was concluded that the presentation of ‘secondary tokophobia’ does not fit with the term ‘phobia’. A reclassification of tokophobia was suggested for women who experience fear and avoidance of childbirth following a traumatic birth.
SEARCH STRATEGY

Searches were made of electronic journal databases such as Cinahl, Medline, Psychinfo and Swetwise. The internet was also searched using the search engines Google and Google Scholar. The following keywords were used in searches: tokophobia; fear of childbirth; avoidance of childbirth; post-traumatic stress disorder; post-traumatic stress disorder following childbirth; traumatic birth; caesarean section; trait anxiety; shame; motherhood; postnatal depression; CBT; EMDR; narrative therapy; exposure therapy; transition theory; qualitative research; Interpretative Phenomenological Analysis (IPA). Searches were also made of the OPAC catalogue at the university as well as the NHS Trust library where the researcher currently works. References from articles were followed up. Articles were obtained from the electronic databases that offered full-text; from journals held by the university and NHS Trust Library and some were ordered from the British Library.
SECTION 2 - LITERATURE REVIEW

What is ‘Tokophobia’?

‘Tokophobia’ is a term that was first used by Hofberg & Brockington (2000); the aim of their study was to classify tokophobia for the first time in medical literature. They define ‘tokophobia’ as an intense anxiety that leads to some women dreading and avoiding childbirth despite desperately wanting a baby. Hofberg and Brockington (2000) classify tokophobia as either ‘primary’, ‘secondary’ or ‘tokophobia as a symptom of depression in pregnancy’. They describe primary tokophobia as a dread of childbirth that pre-dates pregnancy and secondary tokophobia as a phobic avoidance of pregnancy that is secondary to a traumatic delivery.

In their study, twenty-six women, who presented as having an ‘unreasoning dread of childbirth’ were interviewed - qualitative analysis of the interviews was carried out. Twelve women were referred by obstetricians, while fourteen were new referrals to a Mother and Baby Unit. Detailed enquiries were made about diagnoses of depressive episodes, anxiety disorders and Post Traumatic Stress Disorder (PTSD); obstetric history; sexual relationships; relationship with each baby, and childhood sexual abuse and rape. The majority of the women in the study desired a Caesarean Section (CS). For those women who achieved the delivery of their choice the outcome was more positive, with adverse effects such as depression, PTSD and bonding disorders associated with the evaluation of a traumatic birth. The researchers conclude that, “Tokophobia is a specific and harrowing condition that needs acknowledging” (Hofberg & Brockington, 2000, p.83) and is associated with anxiety, depression, PTSD, and bonding disorders.
Hofberg & Ward (2003) consider pregnancy and childbirth and the relationship with depression, eating disorders, prior sexual assault and/or abuse, and pathological fear of childbirth. They report that more than 6% of pregnant women describe a fear of childbirth that is disabling. Elsewhere estimates of severe anxiety or intense fear of childbirth in pregnant women range from 5-10% (Waldenstrom, Ryding & Hildingsson, 2006; Geissbuehler & Eberhard, 2002). These estimates do not account for the women who never become pregnant because of their fear.

Hofberg & Brockington (2000) and Hofberg & Ward (2004; 2003) have successfully introduced ‘Tokophobia’ into psychiatric, medical and obstetric literature, notably Hofberg & Ward’s (2004) paper entitled, ‘The Obstetric-Psychiatric Interface’. Hofberg & Brockington (2000, p.85) state, “Tokophobia is a distressing psychological disorder that may be overlooked.” It is necessary therefore for the condition to be discussed within psychology.

Factors Associated with Fear of Childbirth

Research indicates that there are many different factors which may explain fears associated with pregnancy and childbirth. A useful model of fear to use as reference when considering childbirth-related fear is that defined by Rachman (1990) which consists of three main components:

- The subjective experience of fear;
- The objective psychophysiological changes caused by fears;
- Attempts to escape certain situations.
It is documented that antenatal fear is a predictor of pain and distress in labour (Wuitchik, Hesson & Bakal, 1990); distress in labour increases the risk of emergency Caesarean Section (CS) (Ryding, Wijma, Wijma & Rydhstrom, 1998).

Reported fears related to pregnancy and childbirth include:

- Concerns regarding complications in pregnancy (Melender & Lauri, 1999)
- Concerns for the baby’s health and survival (Melender & Lauri, 1999; Sjogren, 1997)
- Changes and effect upon lifestyle and relationships (Bernazzani, Saucier & David, 1997)
- Pain and obstetric injury (Melender & Lauri, 1999; Sjogren, 1997)
- Emergency CS (Melender & Lauri, 1999)
- Negative stories told by others (Melender & Lauri, 1999)
- Losing control during labour and not being capable of delivering the baby (Sjogren, 1997)
- Dying during childbirth (Szeverenyi, Poka, Hetey, 1998; Sjogren, 1997)
- Negative experiences of prior childbirth (Soet, Brack & Dilorio, 2003)

Saisto, Salmela-Aro, Nurmi & Halmesmaki (2001) warn that childbirth-related fears can increase the risk of postnatal emotional instability.

Melender’s study (2002) involving 329 pregnant women in Finland found that 78% expressed fears relating to pregnancy, childbirth, or both. Specific fears were related to childbirth, the child’s and mother’s well-being, health-care staff, family life, and CS. Causes of fears included negative mood, negative stories told by others, alarming information, diseases and child-related problems, and in parous women causes also
included negative experiences of previous pregnancy and/or childbirth. Fears presented as symptoms of stress, effects on everyday life, and a wish to have a CS.

Prior to Melender’s study (2002), there had been little research regarding the manifestation of childbirth-related fear, although an increasing number of women requesting CS had been reported (Atiba, Adeghe & Murphy, 1993; Ryding, 1993). Melender asked questions related to manifestation of fear of the 257 participants who had reported fear. All statements loaded positively onto four factors; the categories (2002, p.107) are summarised below:

Factor 1. Stress Symptoms
   - Having cried
   - Talking a lot about fears
   - Sleeplessness
   - Thinking a lot about fears
   - Tachycardia
   - Restlessness and nervousness

Factor 2. Influence on Everyday Life
   - Tenseness
   - Counting fetal movements more often than needed
   - Having changed daily activities
   - Feeling paranoid
   - Unable to enjoy the pregnancy

Factor 3. Wish to Have Caesarean Section
   - Having asked for caesarean section
   - Having thought about asking for caesarean section
   - Feeling uncertain

Factor 4. Wish to Avoid Current Pregnancy and Childbirth
   - Having postponed this pregnancy
   - Having thought about having an abortion
   - Sometimes getting into a panic and wishing to avoid pregnancy and childbirth

This study serves to highlight the impact that fear of childbirth has upon women who experience it.
Melender’s report (2002) that 78% of pregnant women express fear of some aspect of pregnancy and/or childbirth implies that such fear is a normative response. This is not surprising given the inevitable prospect of impending pain and life-change that childbirth brings. It is important to note however, that the women in Melender’s (2002) study were pregnant at that time, suggesting that their level of fear was not so intense as to prevent them from contemplating childbirth. As stated earlier, Hofberg & Ward (2003) report a much lower figure - 6% of pregnant women - who describe a fear of childbirth that is ‘disabling.’ While estimates of fear of childbirth typically range between 5-10%, as outlined earlier, it is not made clear in the literature what qualifies as ‘disabling,’ ‘intense’ or ‘severe’. The current study highlights a population of women for whom fear of childbirth has impacted upon their lives to the extent that they have experienced a dilemma; where their fear prevents them from embarking upon a desired pregnancy.

A study by Eriksson, Westman & Hamberg (2005) advanced understanding of childbirth-related fear by exploring experiential factors. The Swedish study analysed questionnaire responses from 558 women and 552 men who had a healthy baby born between 1997-1998. The study was conducted from the perspective of symbolic interactionism. Eriksson et al., (2005, p.63) refer to Charon’s (1998) work on the topic explaining the premise of the perspective; “..individuals perceive and construct their emotional experiences in interaction with oneself and the environment.” As Eriksson et al., (2005) argue women’s experiences are influenced by their perceptions and interpretation of events, which are developed by their interaction within society.
From the factors that were identified by Eriksson et al., (2005) as being associated with fear of childbirth, ‘Exposedness and Inferiority’ had the greatest explanatory power in women, and was a more significant factor than in men. It was reported to a significantly higher extent by women with intense fear. An example of a statement in this category is, “I felt inferior to other women because of my fear related to childbirth.” As Eriksson et al., (2005, p.69) state, “..disparaging feelings about oneself could be an effect of experiencing intense fear.” Eriksson et al., (2005) make the link between disparaging feelings of self with ‘shame’. They refer to Scheff (2000) who reports that feelings of shame arise from individual’s perceptions that they are viewed negatively by others and who consequently feel a threat to their social bond with others.

Young describes shame as:

The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws (1999, p. 13).

Harris (2003) highlights the notion that shame is a response to, or fear of, criticism or disapproval by others. He argues that when an individual’s attention is externally focused, they are motivated to conform to others’ values, and shame occurs when it is perceived that they have not. A number of perspectives argue that shame is more closely associated with failure, the perception of not having lived up to one’s ideals (Harris, 2003).

The majority of women who experience childbirth are not disabled by their fear and are able to proceed with a subsequent pregnancy. Speaking more generally, Harris comments:
“Whereas some people are able to recognise that things have gone wrong, attempt to repair the situation and move on, others react by withdrawing, placing blame on others, or feeling depressed and helpless” (2003, p. 457).

It may be possible that an explanation for why some women continue to fear and avoid childbirth following a traumatic birth lies in the way in which women experience shame. Tangney (1991, cited in Harris, 2003) hypothesises that those individuals who are prone to feel shame will cope with failure less adaptively, because its intense focus on negative aspects of the self is much more painful and crippling.

This idea links with Young’s (1999) theory of maladaptive schemas, which he describes as “unconditional beliefs and feelings about oneself in relation to the environment” (p. 9). It could be possible that some women who fear childbirth have a pre-existing maladaptive schema involving shame which would account for their difficulty in resolving their fear. Harris (2003) argues that shame-proneness identifies individuals who are more likely than others to respond to transgressions by feeling bad about themselves. Harris (2003) uses the analogy of bullying to argue that ‘victims’ of a shameful event (for example, experiencing a difficult birth), are more likely to internalise shame without discharging it. Harris’s (2003) argument that negative self-evaluation associated with shame may only become problematic when it is not discharged, could enhance understanding of the maintenance of women’s fear, along with Young’s theory of schemas (1999). Issues around shame and negative self-evaluation can potentially be worked through in therapy with a Counselling Psychologist. The aim of therapy would be to alleviate the painful feelings; for these women not to suffer the stress of childbirth to such a crippling extent.
Another reason that ‘Exposedness and Inferiority’ had greater explanatory power in women than in men in the Eriksson et al., (2005) study, could be to do with societal views and expectations of ‘Motherhood’. Childbirth is a major life event. The way in which a woman responds and adjusts to becoming a mother is affected by her expectations and experience of the events of childbirth and motherhood (Ball 1993). It is also influenced by cultural and social attitudes to parenting. Smith (1992) states that while mainstream psychology may pathologise the individual woman in, for example, her failure to adapt to motherhood or successfully bond with her child, some feminist writers argue that it is societal factors that typically conspire to translate becoming a mother from a potentially fulfilling experience for a woman into one where the negative consequences for her can become predominant.

Oakley (1980) for example, argues that pregnancy represents overwhelmingly a loss of identity and reduced status for women, as they undergo major changes. The critical factor is that these changes are socially constructed as incurring lower status. Oakley (1980) suggests further that additional losses are faced around the time of the birth: loss of control as medical technology and ‘expertise’ take over, and loss of the child from inside the mother. Oakley (1980) argues that postnatal depression (PND) can be seen as a normal response to these losses and suggests that it is surprising that all women do not become depressed after childbirth, not because of intrinsic pathology but because of the losses they endure. Oakley (1980) and Nicolson (cited in Smith, 1992) both indicate the need for studies that focus on the accounts of women themselves:

‘Woman-centred’ refers to a perspective which takes women’s accounts as central and does not consider women to be at the ‘mercy of their hormones’ or in any other way intrinsically pathological. It relies on the assumption that whatever individuals report about their experience should
Another experiential factor highlighted by Eriksson et al., (2005) is ‘Communicative difficulties’. While a need to talk about one’s fear was highly loaded, other statements indicate that this is not always easy to do. 11% of the women with intense fear reported that talking about their feelings heightened their fear. Eriksson et al., (2005) suggest that this avoidance of talking serves to control the negative implications of their fear. It could also be argued that communicative difficulties are related to feelings of shame as outlined above, with individuals ‘covering’ their fear in an attempt to fit in with what they perceive as societal expectations.

To a lesser, although significant degree in women, was the factor, ‘Norms of harmony’. Statements described societal expectations of harmony during pregnancy while steering away from attitudes towards childbirth-related fear. In women the highest loading was obtained for the statement, “In facing childbirth you are expected to be positive and expectant”. Eriksson et al., (2005) argue that as pregnant women are easily identified in the second half of pregnancy, they are more often subjected to comments and reactions than are men and so are more exposed to normative perceptions of what it is to be a woman, and expectant mother.

Eriksson et al., (2005, p.70) suggest that the low explanatory power of, ‘Insecurity and danger’ indicates that perceptions of childbirth as a “risky and potentially dangerous event” were widely shared among the respondents. They report that when Johnson & Slade (2002) measured fear of childbirth in pregnant women, they also found ‘riskiness’ to explain the least of the variance. Eriksson et al., (2005) suggest
that the medicalisation of virtually all births communicates a contrary message to the fact that mortality and morbidity risks during labour and delivery are low in Western societies. As a result ‘danger’ and ‘threat’ with regard to delivery and labour have become culturally accepted expressions of fear.

Ryding, Wirfelt, Wangborg, Sjogren & Edman (2007) set out to investigate the association between personality and fear of childbirth by comparing the responses of self-reported questionnaires of pregnant women who sought help for their fear of childbirth, with a control group of pregnant women from routine antenatal care. Calculations were made of the correlations between fear of childbirth, personality variables and experience of childbirth, from four self-assessment scales. Ryding et al., (2007, p.819) conclude that personality variables “are significantly related to a pregnant woman’s tendency to fear childbirth.” Women in the index group had significantly higher scores on the Fear of Childbirth scale than the comparison group despite having received counselling.

The index group tended to describe themselves as significantly more anxiety-prone than the control group (Ryding et al., 2007) as well as scoring higher in monotony avoidance, lower in socialisation and lower in social desirability. The index group also tended to be more aggressive. At the second point of measurement (1 week after delivery) the index group reported a more negative, frightening experience of their recent delivery compared with the control group. One of the most significant differences between the groups was the difference in socialisation. Consequently Ryding et al., (2007) argue that “women with intense fear, who were low in
socialisation and high in psychasthenia1, had a more negative experience of their own current childbirth.” The study highlights the need for more consideration of the special needs of vulnerable women with problematic relationships in childhood, asthenia, and more intense fear of childbirth, as these women pose a higher risk of a more negative birth experience.

Laursen, Hedegaard & Johansen (2008) conducted a study between 1997 and 2003 in which they described the association between fear of childbirth and social, demographic and psychological factors in a cohort of 30,480 healthy nulliparous women with uncomplicated singleton pregnancies. Quantitative analyses were conducted on the responses to telephone interviews in which respondents were required to answer structured, closed questions. They found that low educational level, lack of a social network, young age and unemployment were associated with fear of childbirth and conclude that fear of childbirth among nulliparous women most often occurs among women with few social and psychological resources. In line with earlier research Laursen et al., (2008) observed that depression and anxiety were significantly associated with fear of childbirth among nulliparous women.

The link between fear of childbirth and theories of anxiety in general are discussed in an earlier study by Zar, Wijma & Wijma (2001). As may be expected, fear of childbirth has a clear affinity with anxiety proneness in general (Wijma & Wijma, 1992; Wijma, Wijma & Zar, 1998, cited in Zar et al., 2001). Zar et al., (2001) cites Spielberger (1972) as a cognitive theorist who distinguishes conceptually and operationally between anxiety as a transitory state and as a relatively stable

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1 A psychological disorder characterized by phobias, obsessions, compulsions, or excessive anxiety
personality trait. Spielberger, Gorsuch, Lushene, Vagg & Jacobs (1983, cited in Zar et al., 2001) distinguish between state and trait anxiety: anxiety states are characterised by subjective feelings of tension, apprehension, nervousness and worry activated by arousal of the autonomic nervous system. Trait anxiety is described as a personality trait that indicates relatively stable individual differences in anxiety-proneness.

Within a framework of anxiety theory, fear of childbirth can be viewed from both state and trait perspectives (Zar et al., 2001). For most women the event of childbirth evokes a degree of uncertainty and nervous anticipation, which is indicative of state anxiety. Zar et al., (2001) argue that the degree of state anxiety depends on the success of the physiological process of labour and delivery and the woman’s interpretation of what happens, including her tendency to perceive the situation as dangerous and her capacity to cope with what she appraises as difficult. This state anxiety is a transient reaction, while fear of childbirth as a trait refers to the characteristics of an individual woman that give her a tendency to react with fear of childbirth (Zar et al., 2001).

Tokophobia can be seen to fit into this framework of anxiety. Women’s differences in trait fear could be greatly influenced by their individual past experiences (Zar et al., 2001). For example, women who present with primary tokophobia could be influenced by the degree of negative information they have received about childbirth, or by their life experiences which may include for example, physical or sexual abuse, or an eating disorder. In women who present with secondary tokophobia, differences in trait fear could be influenced by how negatively they have experienced a previous delivery. Zar et al, (2001) argue that of central importance to women’s trait fear of
childbirth is their ruminating about what may happen during a future delivery. Beck & Emery’s (1985) description of what happens for individuals with trait anxiety is typical of women with trait fear of childbirth: “…the patient is hypervigilant, constantly scanning the environment for signs of impending disasters or personal harm.” (1985, p.31, cited in Zar et al., 2001)

In Zar et al’s (2001) study, the State Trait Anxiety Inventory (STAI) was administered in late pregnancy along with the Wijma Delivery Expectancy / Experience Questionnaire (W-DEQ). The W-DEQ version B was administered 2 hours after delivery and 5 weeks postpartum. 77 nulliparous and 86 parous women gave complete responses on all three measures. According to their scores on the Wijma Delivery Expectancy/Experience Questionnaire during late pregnancy, women were divided into 3 groups: high, moderate and low levels of fear of childbirth. At the first measurement, women with low fear of childbirth had lower trait anxiety than women with moderate fear and in turn, high levels of fear of childbirth. Nulliparous women had a higher level of fear of childbirth but a lower level of trait anxiety than did parous women. Zar et al., (2001, p.75) argue that the findings suggest that “fear of childbirth comprises a considerable part of trait anxiety, with the risk of a vicious cycle,”; in other words, that during labour women experience what they are afraid of, which also influences the women’s postpartum cognitive appraisal of the delivery.

Literature to date has not considered the part that anxiety levels play in the maintenance of avoidance of childbirth in women who present with primary tokophobia. Zar et al’s (2001) finding that nulliparous women had a higher level of fear of childbirth than did parous women is to be expected, given that for nulliparous
women there is the element of ‘fear of the unknown’. What is interesting is the finding (Zar et al., 2001) that nulliparous pregnant women had a lower level of trait anxiety than did parous pregnant women. It would be useful to investigate trait anxiety in women who present with primary tokophobia, who actively avoid childbirth, to find if they have higher trait anxiety than nulliparous pregnant women who indicate levels of fear of childbirth.

**Primary Tokophobia**

Literature on primary tokophobia is sparse. The few studies that have been conducted on fear of childbirth include research on pregnant nulliparous women whose fear predates their pregnancy. However, the researcher has not located any studies that explore the experiences of women whose fear of childbirth prevents them from getting pregnant at all. Strictly speaking, women are only ‘tokophobic’ if they avoid pregnancy.

There have been a handful of articles written in the press about tokophobia since Hofberg & Brockington’s (2000) study and classification of the condition. All present a similar format: a brief summary of the study and classification, and a few anecdotes from women said to be suffering from primary tokophobia. With the lack of research, these anecdotes are the only source ‘out there’ that gives a sense of what it is like to experience primary tokophobia. Hill’s (2001) article presents such anecdotal evidence:

“*I feel like a failure and am desperately ashamed. Women who ask for Caesareans are lambasted by society and dismissed by doctors as selfish, but unless I can find a doctor to give me one, I might go through life unable to become pregnant, something I would always regret.*” (Paula: Hill, 2001)
Feeling a sense of ‘failure’ and ‘shame’ is consistent with the existing literature on fear of childbirth.

More recently The Daily Mail ran an article in which it was reported that the actress Helen Mirren had declared that she has been tokophobic. Helen blames her childlessness on a graphic video of childbirth that she was shown as a 13-year-old schoolgirl. She says:

“I swear it traumatised me to this day…. I haven’t had children and now I can’t look at anything to do with childbirth. It absolutely disgusts me.”

(Helen: Nicholas, 2007, p.26)

The article also features a woman called Rachel who empathises with Helen Mirren. She describes how when she was a small child her mother returned home from hospital with her baby sister and Rachel overheard her mother talking to a friend on the phone, telling her about the ‘horrific’ birth and ‘24 stitches’:

“It has stayed with me my whole life… it led to a profound dread and disgust of childbirth.” (Rachel: Nicholas, 2007, p.26)

“The truth is that the very thought of having something almost alien-like growing inside me is disgusting.” (Rachel: Nicholas, 2007, p.26)

Rachel feels this way despite longing to become a mother. She reports having been labelled as ‘cold-hearted’ and a ‘baby-hater’ by some friends who she has discussed her fears with.

Maureen Treadwell, founder of the Birth Trauma Association, is quoted (Nicholas, 2007) as saying that that she hears this sentiment on an almost daily basis from other tokophobia sufferers. Treadwell argues that there needs to be a big change in the attitude of other women towards those suffering from dread of childbirth. People need to recognise, she argues, that each woman is different and there are plenty who have a
very genuine and morbid fear of pregnancy and childbirth and they need support, not condemnation. Treadwell highlights the lack of support services for women with tokophobia which, she says, leads to many women feeling ashamed if they try to speak out. The social context of the issue is alluded to:

“Childbirth should not be held up as some sort of competition – but it frequently is.” (Treadwell: Nicholas, 2007, p.26)

Anna and her husband would love to start a family but Anna admits to feeling, “physically repulsed by pregnancy and childbirth” (Anna: Nicholas, 2007, p.26). Anna claims that she cannot trace her terror to anything in her childhood. However she goes on to say that she has had an aversion with anything to do with pregnancy and birth since sex education and biology lessons at school and admits to being, “quite squeamish”. Like Rachel, Anna finds it very difficult to speak out for fear of being branded ‘cold-hearted’; she argues that this is due to common public perception:

“There’s an idea out there that all women want to experience the joy of giving birth and that it’s the most natural thing in the world.” (Anna: Nicholas, 2007, p.26)

Retired obstetrician Michael Pawson has written a book entitled, ‘Psychological Challenges in Obstetrics and Gynecology’ and is quoted in the Daily Mail as saying that the medical profession should be more understanding:

“Doctors can be very arrogant and don’t take kindly to women who tell them what they want… Obstetricians should be sympathetic to the needs of tokophobic women who are frightened to death of childbirth, and offer them Caesareans and extra guidance to help alleviate their fear.” (Pawson: Nicholas, 2007, p. 27)

Meredith O’Donnell wrote recently in The Mail on Sunday about her own experience of primary tokophobia and interestingly comments upon ‘secondary tokophobics’ saying, “which doesn’t help those in the primary division at all, confirming as it does
everything we suspected” (O’Donnell, 2008, p.40). This comment hints at the difficulty of working cognitively with someone who presents with tokophobia. O’Donnell echoes the research findings that some women doubt their own ability to cope with childbirth:

“I can’t credit myself with the physical strength or stamina required to endure giving birth, and that depresses and enrages me” (O’Donnell, 2008, p.40)

The sense of dilemma and heartbreak for women with tokophobia that the current study hopes to convey is portrayed vividly by O’Donnell’s comments (2007, p.40):

“I feel inadequate next to those women who have been through it. How have I ended up like this: paralysed, stuck on the window ledge, unable to go back or forward in my life, while everyone else seems to skip through to the next ‘natural’ stage?”

“As long as I think there is a prize worth walking through the fire for, then there is torment.”

“Recently my mother announced that she intended to give away my crib, ‘seeing as you won’t be having any now.’ This casual comment, my ‘fait non-accompli’, caused a stab of pain. I want to make that decision, not be told by someone else, or be dictated to by fear.”

Secondary Tokophobia: Traumatic Birth and Post Traumatic Stress Disorder

Secondary tokophobia is diagnosed in women who have developed a fear of childbirth as a direct result of their prior birth experiences. The existing research indicates that childbirth-related posttraumatic stress symptoms (PTSS) and Post Traumatic Stress Disorder (PTSD) constitute a serious mental health problem. Studies of postnatal PTSD (PN PTSD) in the UK, Europe, North America and Australia suggest that approximately 1% - 2% of women will develop clinically significant, chronic PTSD which Ayers, Eagle & Waring (2006) state would result in between 6000 and 12000 women developing PN PTSD every year in England and Wales. These figures do not account for the women who experience symptoms of postnatal posttraumatic stress (PN PTS) who do not meet the criteria for PTSD or who go
undiagnosed. The prevalence of PN PTSD is particularly alarming given that the Department of Health (2004) identified psychiatric illness as the single largest cause of maternal death in the UK.

PTSD is classified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV) (American Psychiatric Association, 1994). It can occur after an event when:

- The event involved actual or threatened death or serious physical injury to the person or to others; *and*
- The person responded with intense fear, helplessness, or horror.

The *perception* of threatened death is a significant factor for women who develop post-traumatic stress symptoms following childbirth. Some women incur physical injuries (tearing for example) during childbirth and many others experience an intensity of pain that they had not expected. The experience of pain and injury, especially when this is unexpected, can lead some women to respond to the event of childbirth with feelings of intense fear, helplessness or horror.

Symptoms of PTSD fall into 3 clusters:

1) Re-experiencing of the event, for example, flashbacks, nightmares, intrusive thoughts;
2) Avoidance and numbing, for example, avoiding any reminders of the event, feeling emotionally numb and detached; and
3) Arousal, for example, increased startle response, irritability, anger.

Symptoms need to be evident for at least 1 month and cause significant distress or impairment to personal functioning. Not all women who appraise their childbirth experience as traumatic will go on to develop PTSD, as illustrated below in Figure 1:
Although the study of PN PTSD is in its infancy, there is a growing consensus within the literature that some women are traumatised by childbirth. However, as Ayers (2004) points out, labelling traumatic responses to birth as ‘PTSD’ assumes some equivalence between childbirth and other traumatic stressors such as disasters, and this clearly is not the case. Childbirth differs from other traumatic events in that it is broadly predictable, is usually entered into voluntarily, is viewed positively by society, and can include positive aspects. Even when a woman has a traumatic birth she may see her baby as a positive outcome that makes the experience ‘worth it’ (Ayers, 2004). It is this distinction which gives strength to the theory that a woman’s perception of childbirth as traumatic is of central importance. Perception and appraisal of childbirth as traumatic will be discussed later in this thesis. Needless to say the majority of women do not appraise childbirth as traumatic; this, coupled with
society’s positive view of childbirth, can have a devastating effect upon women who do experience PTSD as a result of childbirth.

In their review of research into PTS following childbirth, Olde, van der Hart, Kleber & van Son (2006) conclude that the following have been found to be risk factors for the development of posttraumatic stress symptoms:

- **Antenatal:**
  - History of previous mental health difficulties
  - Previous traumatic childbirth
  - Trait anxiety

- **Perinatal:**
  - Mode of delivery / obstetric procedures
  - Lack of control
  - Intense distress
  - Lack of support by staff and partner

In another review, Ayers (2004) draws a few “tentative” conclusions about prenatal, delivery, and postnatal risk factors for traumatic stress responses. Ayers (2004) states that appraising birth as traumatic is primarily associated with obstetric factors such as type of delivery, type of analgesia, duration of labour, blood loss, pain and medical intervention. As Ayers (2004) indicates, appraisal of birth as traumatic does not necessarily mean that all women who appraise birth as traumatic will have symptoms of psychopathology.

A severe traumatic stress response is associated with a range of broad factors (Ayers, 2004):

- **Psychosocial:**
  - Anxiety
  - Neuroticism
  - Poor coping
  - Low self-efficacy for birth
  - Low support in pregnancy
Obstetric factors: Type of delivery
- Pain
- Low support in labour

Subjective factors: Control
- Violation of expectations

Postnatal factors: Additional stress
- Coping
- Low support

In summarising the main findings of the research that she reviewed, Ayers (2004, p.562) devised a diagram to illustrate how vulnerability and risk factors for postnatal stress responses may develop into PN PTSD. This diagram is replicated in Figure 2 below:

Fig 2: Ayers (2004) Illustration of how vulnerability and risk factors for postnatal stress responses may develop into PN PTSD

Soet, Brack & Dilorio (2003) substantiate the view that obstetric interventions such as emergency CS, forceps delivery, ventouse extraction, epidural, and episiotomy play a
role in the perception of childbirth as traumatic. Soet et al., (2003) also found an association between the experience of pain in labour and the development of PTS symptoms. Czarnocka & Slade (2000) attribute the associated distress linked with the pain to the development of PTS symptoms. Olde et al., (2006) argue that while experiencing pain is not necessarily harmful, it may lead to catastrophic interpretations. Research has also indicated that normal vaginal deliveries can be associated with PTS and PN PTSD (Soderquist, Wijma & Wijma, 2002). It is most likely therefore that the development of PN PTSD can be predicted by a combination of factors (Olde et al., 2006). From their meta-analysis of risk factors for PTSD in trauma-exposed adults, Brewin, Andrews & Valentine (2000) argue that it is inadvisable to create a single risk factor model for PTSD.

Slade (2006) provides a synthesis of knowledge about post-traumatic stress symptoms following childbirth and outlines a framework for understanding these experiences. Slade (2006) suggests that one possible way of conceptualising the factors that have been explored to date is in terms of a two-dimensional matrix. She suggests that one arm relates to a time frame of predisposing factors, precipitating factors and maintaining factors. At each stage factors may relate to either internal, external or an interaction between the two. The conceptual framework is reproduced in figure 4 below and includes key elements that have been highlighted in earlier research.
<table>
<thead>
<tr>
<th>Predisposing factors (pregnancy related and pre-existing)</th>
<th>Internal</th>
<th>External</th>
<th>Interactional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of labour</td>
<td></td>
<td></td>
<td>Unplanned pregnancy</td>
</tr>
<tr>
<td>Depressive symptoms in pregnancy</td>
<td></td>
<td></td>
<td>Perceptions of low social support</td>
</tr>
<tr>
<td>History of mental health difficulties</td>
<td></td>
<td></td>
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<tr>
<td>Trait anxiety</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>History of sexual trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precipitating factors (perinatal)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High fear for self and / or baby</td>
<td>Emergency Caesarean</td>
<td>Perceptions of lack of support from partner</td>
<td></td>
</tr>
<tr>
<td>Perceived low control / powerlessness</td>
<td>Instrumental delivery</td>
<td>Perceptions of lack of support from staff</td>
<td></td>
</tr>
<tr>
<td>Negative gap between expectation and experience</td>
<td>Partner not present</td>
<td>Feeling poorly informed</td>
<td></td>
</tr>
<tr>
<td>Severe pain</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Personality as a risk factor for PTSD in general has been studied, and in earlier papers neuroticism has been suggested (Olde et al., 2006). However more recently Brewin et al., (2000) did not find personality traits to be influential. The most frequently studied personality trait in PN PTSD research is trait anxiety. Czarnocka & Slade (2000) report a relation between trait anxiety shortly after delivery measured with the STAI and PTS symptoms. Anxiety sensitivity, which is associated with the fear of anxiety-related sensations, is indicated as being related to PTS symptoms (Fairbrother & Woody, 2007; Keogh, Ayers & Francis, 2002) strengthening the evidence for a relationship between anxiety as a trait and PTS symptoms (Olde et al., 2006). There is a lack of research into other personality dispositions in the area of PN PTSD.
One of the questions in the PTSD literature is whether there is a generic PTSD or whether there are specific types of PTSD according to trauma group (Bailham & Joseph, 2003). Bailham & Joseph (2003) argue that evidence suggests that there are at least some idiosyncratic features in the presentation of PN PTSD. Sexual avoidance is one manifestation of the avoidance criteria. Some women avoid sexual activity as it causes them to re-live and re-experience the pain and distress that they experienced during their traumatic labours. Furthermore, some women who are ‘tokophobic’ will avoid sexual intercourse to ensure that they do not get pregnant. Dread of childbirth can be so severe that some women may request termination if they accidentally conceive (Hofberg & Brockington, 2000).

As well as sexual avoidance, mother-infant attachment difficulties and related parenting problems also seem to feature in the presentation of women with PN PTSD (Bailham & Joseph, 2003). The child can be a reminder of the traumatic delivery and elicit re-experiencing of the event in the woman, which is consistent with the DSM-IV criteria for persistent re-experiencing of the trauma. Some women who present with PN PTSD also experience numbing, which can interfere with the attachment process with the child. Bailham & Joseph (2003) report that studies that have looked at the parenting behaviour of depressed women in interactions with their babies indicate that they demonstrate diminished emotional involvement, impaired communication, are less responsive to the child, and demonstrate less synchrony with their infants. Other symptoms of PTSD, such as increased arousal could lead a woman to become more irritable, critical, and anxious with her child (Lovejoy, Graczyk, O’Hare & Neuman, 2000).
Ayers (2007) conducted a qualitative study exploring women’s thoughts and emotions during traumatic birth. Ayers (2007) concludes that women are more likely to develop symptoms of PN PTSD if their experience of birth includes more panic, anger, thoughts of death, mental defeat, and dissociation. Beck wrote two papers based on qualitative research that focus upon ‘The aftermath’ of traumatic birth (2004ii) as well as exploring the meaning of women’s birth trauma experiences (2004i). 38 stories of PTSD following childbirth were analysed which yielded the following themes (Beck, 2004ii):

- Flashbacks and intrusive memories;
- Losing ‘self’;
- Needing answers;
- Downward spiral of anger, anxiety and depression;
- Isolation from motherhood.

The theme of ‘isolation from motherhood’ is particularly poignant and is best captured through qualitative research. Beck (2004ii) describes how mothers’ dreams were shattered as they became isolated from “the coveted world of motherhood” (p. 222). Hopes and expectations of motherhood are destroyed. Beck (2004i) elicited the following themes regarding the meaning of women’s experiences:

- Poor staff-patient interaction – lack of care;
- Lack of communication;
- Loss of control;
- End justifies the means.

The last theme reflects how mothers believed that, “the bottom line in considering a delivery as a successful and fulfilling experience was the outcome of the baby” (Beck, 2000i, p. 34). Beck makes this impassioned comment:

“Women who perceived that they had experienced traumatic births viewed the site of their labor and delivery as a battlefield. While engaged in battle, their protective layers were stripped away, leaving them exposed to the
Beck (2004i) remarks that mothers perceived that their traumatic births often were viewed as routine by clinicians. Beck (2004i, p.28) concludes that as the experience of trauma is a matter of personal perception, “birth trauma lies in the eye of the beholder.”

Ehlers & Clark (2000) propose a cognitive model of PTSD, arguing that persistent PTSD is associated with people who process the trauma in a way that leads to a sense of serious, current threat. The model seems to fit comfortably with the development of PN PTSD when one considers the significance of the individual’s appraisal of childbirth experience. Ehlers & Clark’s (2000) model is shown in Figure 3:
Conceptualising PTSD from a cognitive perspective has until recently presented a quandary. Ehlers & Clark (2000, p.320) argue:

“PTSD is classified as an anxiety disorder. Within cognitive models, anxiety is a result of appraisals relating to impending threat. However, PTSD is a disorder in which the problem is a memory for an event that has already happened. We suggest that this apparent puzzle can be resolved by proposing that persistent PTSD occurs only if individuals process the traumatic event and/or its sequelae in a way which produces a sense of a serious current threat.”

Their model proposes that two key processes lead to a sense of current threat:

1) Individual differences in the appraisal of the trauma and/or its sequelae;
2) Individual differences in the nature of the memory for the event and its link to other autobiographical memories.

Once activated, the perception of current threat is accompanied by intrusions and other re-experiencing symptoms (Ehlers & Clark, 2000). The perceived threat provokes a series of behavioural and cognitive responses that are intended to reduce the threat in the short-term, but in fact these responses serve to prevent cognitive change and therefore maintain the disorder (Ehlers & Clark, 2000).

**Implications of Tokophobia**

The debilitating effects of living with depression and anxiety are well documented in the general literature. For women with tokophobia this is compounded by society’s positive view of childbirth and motherhood and the general lack of knowledge and understanding by the public and medical professions of the condition. In the absence of research data, anecdotal evidence indicates the various levels of distress to which women with primary tokophobia are subjected. Not only do tokophobic women have to live with the adverse reactions of a phobia (like other groups of people who experience a phobia), but their fear actually prevents them from having a much-wanted baby. For women with primary tokophobia this is particularly distressing.
because if their fear is not overcome, it could mean that they live their life childless. This has obvious implications for personal relationships and lifetime happiness and satisfaction. This is exacerbated by living in a culture that does not understand this fear.

The Birth Trauma Association (BTA), a charitable trust set up to support women and families who are affected by birth trauma, comment that it is perhaps difficult to understand how a process as seemingly ‘natural’ as childbirth can be traumatising, but points out that it has become clear that women can suffer extreme psychological distress as a consequence of their childbirth experience. The general lack of understanding can have devastating implications:

“…the difference between the common perception of childbirth and some women’s experience of it means that women who suffer PN PTSD symptoms frequently find themselves very isolated and detached from other mothers. They also find themselves without a voice in a society which fails to understand the psychology of childbirth and which therefore expects mothers to get over their birth experience very quickly.” (BTA, 2005, p.2)

Consequently women affected by PN PTSD can feel misunderstood by both health professionals and other mothers who have not had traumatising births. This can isolate sufferers who often feel they are somehow ‘weaker’ than other women (BTA, 2005). From the accounts received by the BTA from women affected by birth trauma, the suggestion is that women can feel detached from others and relationships with friends and family can deteriorate. Fear of childbirth often leads to the avoidance of sexual intimacy, which has obvious implications for relationships and there is even the suggestion that some women may also try to avoid medical treatments such as smear tests.
For women who present with secondary tokophobia, PN PTSD has far-reaching effects not only for the individual but also for their partners and families, affecting relationships and having implications for bonding and attachment with the infant. Ayers, Eagle & Waring (2006) conducted a qualitative study in which they analysed semi-structured interviews from six women who presented with PN PTSD. The women reported negative effects on their relationship with their partner and the mother-baby bond was also seriously affected. The researchers conclude that PN PTSD can have severe and enduring effects on women and their relationships with their partner and children.

When exploring the effects of PN PTSD on the women’s relationship with their partner, two subthemes arose:

1) **Support.** This included a lack of understanding and a lack of emotional support.
2) **Strain on the relationship.** All the women reported strained relationships; one woman had separated from her partner and a further two women had come close to separating.

Three subthemes were elicited in relation to the women’s relationships with their child:

1) **Differences in attachment.** Women reported either avoidant or over-protective behaviour towards their baby. The two women who had a second child reported differences in their behaviour towards their two children.
2) **Early feelings about the child.** The majority of the women reported initial feelings of rejection towards their baby and a lack of connection.
3) **Later feelings about the child.** Most of the women reported that their feelings towards the child developed over time, although two women continue to experience difficult relationships with their child.

[Ayers, Eagle & Waring, 2006, p.394-396]

Postpartum psychological distress is shown to adversely influence the quality of the early mother-infant relationship. In a current, unpublished study a group of
researchers have examined mothers’ perceptions of their infants by comparing responses from mothers who have PN PTSD, with mothers with partial symptoms and a non-symptom group. Mothers in the PTSD group perceived their infants as less emotionally warm and more emotionally demanding and disturbing than did the partial symptoms and non-symptom groups. When analysed using depression scores as covariant a significant difference remained, with the mothers with PTSD viewing their infant as less warm (Davies, Slade, Wright & Stewart, 2008).

Within the PN PTSD and tokophobia literature, many women express a preference for elective CS; some state that it is the only condition under which they feel they could proceed with pregnancy. Medical literature expresses concern at the rising rates of CS across the Western world. The National Institute for Health and Clinical Excellence (NICE) (2004) guidelines for CS identify 19 observational studies that report rates of maternal request for CS. NICE (2004) report that the rates of preference for CS expressed by the women that were surveyed during pregnancy in the UK, Australia and Sweden range from 6% to 8%. Within these studies there was a consistent relationship between women’s preference for CS and either previous CS, previous negative birth experience, a complication in the current pregnancy or a fear of giving birth.

The NICE (2004) guidelines declare:

“Maternal request is not on its own an indication for CS and specific reasons for the request should be explored, discussed and recorded..... An individual clinician has the right to decline a request for CS in the absence of an identifiable reason.”

NICE (2004) argue that when a woman requests a CS because she has a fear of childbirth, she should be offered counselling to help her to address her fears in a
supportive manner because this, they claim, results in reduced fear of pain in labour and shorter labour. It is interesting that a large-scale Swedish study (Waldenstrom, Hildingsson & Ryding, 2006) found that fear of childbirth in combination with counselling may *increase* the rate of elective CS and was associated with an ‘acceptable’ birth experience. They also conclude that fear without counselling may have a negative impact on the subsequent experience of childbirth. It would appear that many women with fear of childbirth benefit from counselling and as Waldenstrom et al., (2006) point out, their findings suggest that a more important effect of the counselling was to facilitate the implementation of women’s wishes to have an elective CS, rather than to reduce the CS rate. Counselling Psychology would certainly be of benefit in validating women’s fear and would facilitate exploration of the underlying issues for the individual.

If these findings were found in the UK it would surely be a disappointment for NICE, who indicate the costs involved with CS. They include an ‘economic model’ in the guidelines which:

> “shows that encouraging women who request a CS to choose planned trial of labour instead leads to a crude cost saving of around £1257 per birth” (NICE, 2004).

However, they would need to offset the cost of therapy to get a more accurate figure of saving. This fails to recognise the cost to the women who are terrified of experiencing vaginal delivery. There is no guarantee that counselling will help them feel ready for a vaginal birth and in fact the Waldenstrom paper detailed above suggests that the opposite may be more likely. If an obstetrician then refuses a CS, not having control over such a monumental decision can heighten anxiety and increase the likelihood of a negative birth experience, which in turn can lead to
postnatal distress. If the women are lucky enough to access psychological services, this usually comes at more financial cost to the National Health Service (NHS).

CS is not without its risks however, and the NICE (2004) guidelines advocate that women should be informed of these. CS is a major operation which carries associated risks of infection and blood loss. Although the figures of incidence are low, women are more likely to go into Intensive Care following a CS (9/1000) than with a vaginal delivery. Women who have a CS suffer post-operative pain and have an increased risk of thromboembolic disease. Hall & Bewley (1999) state that estimates from the confidential enquiries into maternal deaths in the UK suggest that the mortality from an elective CS is 3 times higher than in a vaginal birth. However, the mortality data for elective CS are drawn largely from a population of women who have medical indications for the operation, and these indications may adversely affect maternal outcome (Devendra & Arulkumaran, 2003).

The legal and ethical issues of CS by maternal request are complex and the validity of informed consent for non-indicated surgery is unclear (Devendra & Arulkumaran, 2003). While the General Medical Council in the UK states that patients have the right to refuse intervention even when a refusal may result in harm or death, it is unclear whether a positive right to insist upon an intervention exists legally (Devendra & Arulkumaran, 2003). Devendra & Arulkumaran (2003) highlight the ethical debate and difficult decision making that obstetricians face when considering CS by maternal request. It is reported that 69% of obstetricians would perform a CS for maternal request (Cotzias, Paterson-Brown & Fisk, 2001) Devendra & Arulkumaran (2003) suggest that this indicates that these obstetricians believe that the
risks of CS are so close to the risks of labour and vaginal delivery that maternal choice can be allowed to influence this decision. Devendra & Arulkumaran (2003) acknowledge that the psychological stress that some women endure regarding childbirth can be very debilitating and they advocate the importance of listening to women in conjunction with informing them.

The debate regarding maternal request for CS remains a hot topic. The media tend to promote the term, ‘too posh to push’ with regard to women who choose to have a medically unnecessary CS as a lifestyle choice, fuelling the notion that the increase in CS rates is due to maternal request for CS. The most recent figures, produced by the National Sentinel Caesarean Section Audit (NSCSA) (Thomas & Paranjothy, 2001), show that the CS rate in England was 21.3% in 2000. The audit contradicts the myth by reporting that 92.7% of all CSs were done for medical reasons.

Many bodies, such as the National Childbirth Trust (NCT) call for more research into the rising rates of CS and advocate for ‘natural’ childbirth. Dodwell (2002) refers to the work of Denis Walsh (2002) reporting that Walsh believes that tokophobia is ‘a socially constructed phenomenon, largely fostered by modern obstetrics’ obsession with all that can go wrong in labour.’ Walsh’s (2002) suggestion for treating fear of childbirth is by creating a ‘loving and humane environment for birthing women, with supportive caregivers’. Shelia Kitzinger has written extensively about birth crisis. She believes that women in childbirth are treated like products on a factory conveyor belt and states, “Technocracy distorts the birth experience” and that women, “suffer from institutionalised violence” (Kitzinger, 2006). Dodwell (2002) reports that both Walsh and Kitzinger blame fear of childbirth on the medicalised culture of birth. Dodwell
(2002) suggests that the focus on maternal request for CS is misleading and argues that there is the need to look at the real causes of the increases in the CS rate. Dodwell (2002) calls for focus on making intervention-free birth widely available, thereby increasing the ‘normal birth rate’.

While the push for intervention-free birth with supportive care-givers is a positive move for many women, such rhetoric ignores the needs of tokophobic women. Regardless of whether or not ‘tokophobia’ is a socially constructed phenomenon, some women find the notion of childbirth – natural or otherwise – wholly repulsive and / or terrifying. Optimum birthing conditions will not alter the distress that many tokophobic women experience. The underlying issues for individual women with tokophobia need to be addressed before there is a possibility of them considering childbirth at all. Literature discussed so far has highlighted that there are women who have an objectively ‘straightforward’, ‘natural’ childbirth who are traumatised by the experience. The evidence suggests that ‘natural’ childbirth environments per se are not sufficient to alleviate fear of childbirth.

**Treatment and Intervention**

There is nothing written in the literature about treatment for women who present with primary tokophobia. There is some research regarding interventions for PN PTSD and traumatic birth. The NICE guidelines for PTSD (2005) recommend monitoring the individual in the form of ‘watchful waiting’ for the first month post-trauma, offering a 1-month follow-up appointment. The administration of brief, single-session interventions (debriefing), they say should not be routinely offered.
In a survey of postnatal services in the UK for women who have a difficult or traumatic birth, the researchers highlight the controversy concerning debriefing (Ayers, Claypool & Eagle, 2006). Because of the potential to prevent the development of PTSD with just one session, debriefing can be seen as an attractive option. However there is little evidence of the efficacy of debriefing and some evidence that it increases the risk of developing PTSD; its continued use is therefore controversial (Ayers Claypool & Eagle, 2006). It is also not clear what debriefing entails. Ayers, Claypool & Eagle, (2006, p.158) report that Gamble, Creedy, Webster & Moyle’s (2002) review of postpartum counselling concluded that “descriptions of postpartum counselling and debriefing are generalised and non-specific.”

Ayers, Claypool & Eagle (2006) conducted a cross-sectional telephone survey of postnatal services for women who have a difficult birth, in order to ascertain what, if any, postnatal services are offered. Just over a quarter of UK hospitals were selected randomly from the Department of Health list of hospitals. 93 of these hospitals had an obstetrics department and were eligible for the survey; 76% (n=71) completed the survey. Hospitals were asked whether postnatal services were available for women who had a difficult or traumatic birth, and were asked further questions regarding the type of service, funding and evaluation.

The researchers present the results in a table which is replicated and included as Appendix 1. 94% of responding hospitals have formal or informal services in place for women who have a difficult birth experience. Most of these are debriefing services provided by midwives, midwife-counsellors or doctors. 13% were Birth Afterthought programmes which are similar to debriefing services. Ayers, Claypool
& Eagle (2006) state that this means that 78% of postnatal services offered in the UK are debriefing-type services. It was found that psychotherapists (counsellors or psychologists) are involved with 23% of services, most of which are provided and funded by midwifery departments. Ayers, Claypool & Eagle (2006) argue that while it is commendable that most hospitals provide a postnatal service for women who have a difficult birth, and that 14% of these are psychotherapy services as recommended in guidelines for PTSD treatment, the widespread use of debriefing is concerning given the controversy over its efficacy for PTSD as well as the current guidelines not to use it.

The treatment of choice for PTSD (NICE, 2005) is trauma-focussed Cognitive Behavioural Therapy (CBT) from 1-month post-trauma and trauma-focussed CBT or Eye Movement Desensitisation and Reprocessing (EMDR) 3-months post-trauma. The use of CBT and EMDR with women who present with symptoms of PN PTSD will be considered. The researcher also suggests that psychologists consider offering Narrative Therapy as a treatment option. It is the notion of women being pathologised for their ‘failure’ to adapt to motherhood, or their aversion to the childbirth process for example, which has led the researcher to consider the possibility that this therapeutic approach might be useful with this group.

CBT is an established therapy that is typically used with PTSD. For the formulation of PN PTSD Horsch (2008) recommends the use of Ehlers & Clark’s (2000) cognitive model of PTSD, which was outlined earlier. Horsch (2008, p.11) suggests that CBT treatment should consist of the following:

- Assessment and case conceptualisation;
- Explanation of the treatment rationale;
• Psychoeducation and normalising of symptoms;
• Facilitating integration of the fragmented traumatic memory into existing autobiographical memory, which includes reliving, identifying of hot spots, and inserting new information into the traumatic memory;
• Challenging unhelpful peri-and posttraumatic appraisals;
• Reducing unhelpful cognitive and behavioural strategies.

Ayers, McKenzie-McHarg & Eagle (2007) argue that as PN PTSD appears to be etiologically similar to PTSD following other events, this supports the use of CBT for PN PTSD. They also state that some issues in treating PN PTSD are probably unique to this group, in terms of recurrent themes and in the effect it has upon women’s relationships. Postnatal appraisal of events and the woman’s role in the events affect whether the woman has predominantly primary emotions such as fear, or secondary emotions such as shame or guilt (Ayers, et al., 2007). They point out that these different presentations have implications for treatment as fear may respond better to exposure techniques, while secondary emotions may be more responsive to cognitive reappraisal techniques. The researchers include two cases detailing formulation and treatment, which illustrates the use of successful CBT interventions with this group.

Approximately 20 controlled studies investigating the effects of EMDR have consistently found that it effectively decreases or eliminates the symptoms of PTSD, resulting in NICE (2005) recommending this therapy as a treatment of choice. EMDR integrates elements from both psychological theories (e.g. affect, attachment, behaviour, bioinformational processing, cognitive, humanistic, family systems, psychodynamic and somatic) and psychotherapies (e.g., body-based, cognitive-behavioral, interpersonal, person-centered, and psychodynamic) into a standardized set of procedures and clinical protocols. Research on how the brain processes information and generates consciousness also informs the evolution of EMDR theory.
and procedure (EMDRIA, 2008). The Adaptive Information Processing model is the theoretical foundation of the EMDR approach and is included in Appendix 2.

EMDR uses specific psychotherapeutic procedures to:

- access existing information;
- introduce new information;
- facilitate information processing; and
- inhibit accessing of information (Lipke, 1999).

EMDR is used within an 8-phase approach to trauma treatment in order to insure sufficient client stabilization and re-evaluation before, during and after the processing of distressing and traumatic memories and associated stimuli (Shapiro, 2001). A copy of the 8-phase model is included in Appendix 3. In Phases 3 – 6, standardized steps must be followed to achieve fidelity to the method. In the other four phases there is more than one way to achieve the objectives of each phase. However, as it is a process, not a technique, it unfolds according to the needs and resources of the individual client in the context of the therapeutic relationship. Therefore, different elements may be emphasized or utilised differently depending on the unique needs of the particular client (EMDRIA, 2008).

Shapiro (2001, p.2) argues that EMDR is used to:

“(1) help the client learn from the negative experiences of the past, (2) desensitize present triggers that are inappropriately distressing, and (3) incorporate templates for appropriate future action that allow the client to excel individually and within her interpersonal system.”

As such it is clear to see how EMDR is useful in treating PTSD and how it could be helpful in treating PN PTSD. Despite NICE (2005) recommendations for the use of EMDR with PTSD, the researcher was only able to locate one paper that explores the possibility of using EMDR with PN PTSD. Sandstrom, Wiberg, Wilman & Willman (2006) conducted a pilot study consisting of a ‘before and after’ treatment design combined with follow-up measurements 1-3 years after EMDR treatment. Qualitative
data was also collected from four women who participated. All participants reported reduction of PTS following treatment, and after 1-3 years the beneficial effects of EMDR treatment remained for three of the four women. The researchers conclude that the findings from this pilot study suggest that EMDR can be a useful tool in helping women who have been severely traumatised by childbirth.

Seidler & Wagner (2006) performed a systematic review of the literature regarding treatment of PTSD dating from 1989 to 2005 and identified eight publications describing treatment outcomes of EMDR and CBT in active-active comparisons. They report that the results suggest that in the treatment of PTSD, both therapies tend to be equally efficacious. Seidler & Wagner (2006) recommend more research within the framework of randomized controlled trials, but suggest that future research should not restrict its focus, rather it needs to establish which trauma patients are more likely to benefit from one method or the other.

An intervention that has not been considered with women who present with tokophobia is Narrative Therapy. Payne (2000) argues that narrative therapy encourages a focus on the untypical, untypical that is by the individual, and that it is through the untypical that people can escape stories that influence their perceptions and therefore their lives. It is because narrative therapy allows for stereotyped descriptions of experience to become less fixed, that it is an attractive option to use with clients with tokophobia.

Like all therapies, narrative therapy begins with the person being invited to talk about their concerns and difficulties while the therapist listens. People starting therapy often tell stories that are full of frustration, despair and sadness with few gleams of hope.
Payne (2000) discusses how such accounts can be seen as ‘problem-saturated’; a problem-saturated description embodies the person’s present ‘dominant story’ of their life. Payne (2000) talks of ‘naming the problem’, where the person is encouraged to expand on their initial narrative and is invited to give specific names to their problems. Naming can encourage focus and precision, enabling the person to feel more in control of the problem and gives a definition for externalisation of the problem. The narrative therapist uses language which embodies an implicit assumption that the problem is ‘having an effect on’ the person rather than existing within or being intrinsic to them. The aim of externalising language is to help the person separate from their problems and conceive them as the product of circumstances or interpersonal processes, thus avoiding colluding in a view that their problems are somehow caused by their ‘personality’. This approach could be very healing for tokophobic women who see themselves as having ‘failed’.

As referred to earlier, a woman’s response to childbirth is influenced by social and cultural views, while her voice of experience is also marginalized by the dominant medical and psychiatric models of childbirth. Narrative therapy embodies an assumption that cultural, social and political factors affect lives, and in particular that power-based relations in Western society are endemic (Payne 2000). Narrative therapists recognise that people sometimes ascribe the distressing and unjust results of these social factors to themselves, as personal failures, shortcomings or faults. This is true for many women who experience birth trauma – there is typically a discourse of ‘failure’ associated with difficult births, mainly by the women themselves. Payne (2000) argues that a force (in this case, therapy) assisting people to free themselves from the internalisation of blame and guilt can be an examination of issues of social
power. For example, the practice of ‘enforcing’ a woman in childbirth to lie on a bed can be named and examined.

There follows a ‘deconstruction of unique outcomes’ (Payne 2000), which can be seen as a development and more powerful version of ‘reframing’. When the person mentions aspects of their experience that appear to deny, contradict or modify their dominant problem-saturated story, the therapist invites the person to focus attention on how these do not fit with the story-as-told. A further technique is to invite speculation on how other people, important to the person, who witnessed these unique outcomes, may have understood them. Payne (2000) states that it is through this deconstructive process that the person gains a wider perspective on their experience and provides the basis for change. At this point the individual needs to decide whether to remain dominated by the problem-saturated story or whether to take fully into account the richer story that the therapist has encouraged them to tell.

Narrative therapy appears to be a useful therapeutic approach that has not been considered in previous research. It would be useful for further research to explore the efficacy of this approach with women who present with tokophobia.

**Service Implications**

It can be seen that the majority of services for women who have experienced a difficult birth are placed with hospitals and are predominantly medically-led. There are far fewer NHS perinatal psychology services or therapy services within the UK. Horsch (2008) highlights this problem – she reports that more than 90% of women with perinatal mental health problems are currently treated in primary care (DoH,
2007). The remainder access specialist mental health services, liaison services, specialist perinatal services and Child and Adolescent Mental Health Services (CAMHS). There is a lack of clear referral pathways, lack of prioritisation of these women in existing mental health services and a lack of expertise in relation to the special needs of this population (Horsch, 2008). A survey of Primary Care Trusts (PCTs) in the UK showed that only 25% had a fully developed and implemented policy for antenatal and postnatal mental health (DoH, 2007). The survey also indicates that within currently existing specialist perinatal teams, 20% had no representation from psychiatrists or Community Psychiatric Nurses (CPNs) and 74% had no clinical psychologist. Over 30% had limited or no access to prompt provision of specialist psychological treatments.

Church & Scanlon (2002) examine the care pathway system for women who experience traumatic births and explore the role that midwives can take in the prevention of PN PTSD. They recommend the need for a clear definition and systematic evaluation of debriefing and clear guidelines for the referral of women to specialist psychological services. In their article regarding antenatal fear of childbirth, Bewley & Cockburn (2002) highlight the need for the provision of multidisciplinary services for individualised assessment and planning, and suggest that psychologists could lead initiatives to train others to screen, offer simple therapy or make referrals. Five years later the NICE guideline on antenatal and postnatal mental health recommends the development of:

“a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services” [DoH, 2007, p.9]
It is recommended that women whose needs are within antenatal or postnatal mental health should be seen within one month of initial assessment, and those women who present with symptoms of anxiety or depression that do not meet diagnostic criteria, but do significantly interfere with personal and social functioning, should be offered brief CBT or interpersonal therapy (IPT). Horsch (2008, p.12) states that this “implies the need for more psychological therapists, including clinical psychologists.” The researcher would like to point out that counselling psychologists are also well-placed to offer the services that have traditionally been associated with clinical psychologists. However, as Horsch (2008) reports, the Healthcare Commission (2008) found that only 55% of NHS Trusts conducted all the mental health checks identified in NICE guidance for antenatal and postnatal mental health and 42% of NHS Trusts said that they did not have access to a specialist mental health service.

Research on fear of childbirth tends to focus upon women who are pregnant, or who have recently experienced childbirth. The current study will set out to explore the experiences of women who actively avoid childbirth, in an attempt to gain understanding of the phenomenon of avoidance of childbirth. Recommendations regarding how issues raised can be addressed by future research are included within the research report.
SECTION 2: RESEARCH REPORT

Introduction

Since Hofberg & Brockington’s (2000) classification of the term ‘tokophobia’, there has been very little research conducted specifically on this topic. However in recent years there has been a growing interest in fear of childbirth and postnatal post-traumatic stress disorder (PN PTSD). Fear of childbirth is usually cited as a symptom of PN PTSD; the term ‘tokophobia’ is most often bracketed as providing a definition of ‘fear of childbirth’, with inevitable reference to Hofberg & Brockington’s study. It seems that to date the literature has come no further than labelling the condition, something that infuriates Jean Robinson who writes for the Association for Improvement in the Maternity Service (AIMS):

“Words cannot describe my anger when I read a late-in-the-day British article giving the problem a clever Greek name-‘tokophobia’-and leaving it at that. And that's the one that is quoted in the British literature, of course” (Robinson, 2004, p. 4)

The popular press have picked up on the ‘label’ and several articles have been written about ‘tokophobia’ over the last few years, as well as being aired on GMTV’s (March, 2008) LK Today show. These articles highlight the plight of women who present with ‘tokophobia’ and reiterate the points made by Hofberg & Brockington (2000) that ‘tokophobia’ is a harrowing condition that needs considering by health professionals. Unfortunately the articles do not develop understanding of ‘tokophobia’; rather, they serve to regurgitate Hofberg & Brockington’s (2000) findings and highlight the need for greater acknowledgement of the condition. A benefit of such articles and programmes is that they bring ‘fear of childbirth’ and its associated issues into the public’s awareness.
Previous research has investigated factors associated with fear of childbirth and more recently studies have been conducted exploring the experiential factors in women who present with fear. Predominantly these studies have been conducted with pregnant women and women who have recently given birth. The current study aims to focus upon exploring the experiences of women whose fear of childbirth is so intense that they actively avoid pregnancy. It is not known what proportion of women who experience symptoms of PTSD following childbirth also display extreme avoidance of pregnancy and childbirth.

More recently there have been studies that have investigated services and interventions. Ayers, Claypool & Eagle (2006) conducted a cross-sectional telephone survey of postnatal services in the UK for women who have had a difficult birth. They found that while 94% of hospitals in the UK have formal or informal services in place for women who have a difficult birth experience, only 14% of these are psychotherapy services as recommended in guidelines for PTSD treatment. More concerning is that the majority of services provide debriefing, an intervention that is advised against by the National Institute for Clinical Excellence (2005).

Ryding, Persson, Onell & Kvist’s (2003) evaluation of midwives’ counselling of pregnant women in fear of childbirth, revealed that as many as 19% of the women treated for fear of childbirth by a team of midwives, reported considerable post-traumatic stress, or possibly PTSD. They suggest that the result may be reliable as the control group reported 2% of possible PTSD following childbirth, in line with expectations of the general population. While the study group reported overall satisfaction with their interaction with the ‘fear of childbirth’ team in Ryding et al’s.,
(2003) study, women who fear childbirth are particularly vulnerable and may be more susceptible to trauma because of pre-existing fears, a previous traumatic experience, domestic violence or sexual abuse.

Ryding et al., (2003) suggest that some women who express fear of childbirth may require a greater level of intervention than can be provided by midwives with counselling skills. This indication is substantiated by earlier research by Sjogren (1997) who found that women in a study group who had been treated for fear of childbirth reported the same level of satisfaction with their birth experience as a control group. The difference regarding intervention in Sjogren’s (1997) study is that women were treated by a gynaecologist and a social worker who were both trained as psychotherapists, thus offering a different service from that provided by the midwives in Ryding et al.’s., (2003) study. These findings suggest the need for greater psychology input with women who fear childbirth. Robinson (2004) is quite direct in her appeal for appropriately trained professionals to work with this group:

“At AIMS, we have already seen some of the adverse effects of midwives 'debriefing' work and its questionable links with management litigation avoidance, and the morass midwives can fall into and the distressed women that result when they find themselves treading on eggshells while wearing hobnailed boots. Women with a primary fear of childbirth or postnatal PTSD are more likely than others to have a past history of sexual abuse. Amateur or semi-trained do-gooders, KEEP OUT!” (Robinson, 2004, p.4).

Currently in the UK the majority of services for women who have experienced a difficult birth are placed within hospitals and are predominantly medically-led, with few NHS perinatal psychology services. There is a lack of clear referral pathways, lack of prioritisation of these women in existing mental health services and a lack of expertise in relation to the special needs of this population (Horsch, 2008). A survey of Primary Care Trusts (PCTs) in the UK showed that only 25% had a fully
developed and implemented policy for antenatal and postnatal mental health (DoH, 2007). While research indicates the need for greater input from psychologists within antenatal and postnatal services, information provided here suggests that psychologists are greatly underrepresented within PCTs and perinatal services in the UK.

The aim of the current study was to explore the psychological factors that underlie ‘tokophobia’ and the impact of the condition on women and their families. In the original proposal for the study (see Appendix 7) the third research question asked, “Is there a need for psychological counselling of women identified with symptoms of tokophobia?” Following a full literature review and collection and analysis of data, the naivety of this question is apparent. The current study establishes the need for psychological counselling of women who present with tokophobia and considers what services are currently available for women.

The justification for the study from the researcher’s point of view as a counselling psychologist is two-fold. Firstly it is important to raise awareness of ‘fear of childbirth’ as a significant issue that adversely affects women and their families and to introduce the topic into counselling psychology literature. Secondly it is important to acknowledge that counselling psychologists are highly skilled, having received intensive training in therapeutic skills and interventions; primarily person-centred approaches, Cognitive Behavioural Therapy and psychodynamic approaches. This specialist training allows the psychologist to explore different approaches and many counselling psychologists are familiar with other therapies, including narrative techniques. It is known from the researcher’s involvement with the West Midlands
Counselling Psychology Forum that an increasing number of counselling psychologists are becoming trained in the use of Eye Movement Desensitisation and Reprocessing. The researcher therefore suggests that Counselling Psychologists are well qualified to work effectively with women who fear and avoid childbirth.

**Method**

**Methodological Approach and Rationale**

Earlier research has utilised quantitative research methods to provide information regarding factors associated with fear of childbirth and risk factors for the development of postnatal post-traumatic stress disorder (PN PTSD). More recently qualitative research has enriched understanding of birth trauma by exploring women’s experiences of traumatic birth (Ayers, 2007; Beck, 2004i; 2004ii).

The current study explores women’s *avoidance* of pregnancy and childbirth by employing a phenomenological approach. Interpretative Phenomenological Analysis (IPA) was employed to enable a full exploration of women’s experience of fear and avoidance of childbirth. A hypothetico-deductive approach was not suitable for this study which sought to generate understanding of a relatively new concept.

**Ethical Approval**

This study was approved by the Ethics Committees of the University of Wolverhampton, School of Applied Science and Dudley Local Research Ethics Committee. Approval was gained from the following NHS Trusts to recruit participants through their organisations: Walsall Teaching PCT; Sandwell Mental Health and Social Care NHS Trust; South Staffordshire Primary Care Trust; South
Researcher

At the point of beginning the research process the researcher was a Counselling Psychologist in Training at the University of Wolverhampton. While training and working on the research, work placements were undertaken within three NHS trusts in various departments: adult mental health; child and adolescent mental health and an inpatient hospital for severe and enduring mental health problems. Having completed training the researcher currently works as a counselling psychologist within an NHS learning disability service.

Qualitative Research

McLeod (1998) postulates that the aim of qualitative research is to highlight and elucidate the meaning of social interactions and situations with the intention of understanding phenomenon rather than explaining it. The aim of qualitative research is not to predict outcomes; rather it is about asking questions about processes. Researchers utilising qualitative methods tend to be interested in the meanings attributed to events by the research participants themselves. The objective of data collection is to create a comprehensive record of participants’ words and actions (Willig, 2001). According to Elliott, Fischer & Rennie (1999, p.216):

“The aim of qualitative research is to understand and represent the experiences and actions of people as they encounter, engage and live through situations.”

Researchers need to engage in how the world is perceived through the eyes of the participant if phenomenon is to be understood (Denzin & Lincoln, 2000). It is the
investigation of the individual’s perception of the world that sets qualitative research apart from quantitative methods.

Qualitative methods can be used to obtain the intricate details of phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through quantitative research methods. Tokophobia is a relatively new concept and one that has not been investigated directly. The researcher set out to explore women’s experiences of the condition as a way of developing the existing literature on fear of childbirth and to create a new understanding of the process of avoidance of childbirth. Qualitative methods are the most suitable means for exploring this phenomenon.

Introduction to Interpretative Phenomenological Analysis (IPA)

IPA is informed by some of the principles associated with phenomenology, a philosophical concept concerned with the ways that human beings gain knowledge of the world around them (Willig, 2001). By analysing accounts of experiences presented by research participants, the researcher is attempting to gain understanding of someone else’s experience based on their description of it. In phenomenological psychological research, the research participant’s account becomes the phenomenon with which the researcher engages.

IPA is person-centred allowing the participant to explore her own narrative, conveying an experience that is impossible to achieve by the use of other methods such as questionnaires. The open-ended style of questioning allows for full exploration, and this is a particular strength of this methodology.
Kvale (1996, p.52) argues that “the important reality is what people perceive it to be”. As the focus of IPA is upon perceptions this is an appropriate vehicle to use in the current study to explore women’s experiences of fear and avoidance of childbirth. It is crucial that the counselling psychologist understands how the individual perceives and interprets events if effective formulation and interventions are to be suggested in cases of emotional distress.

IPA is characterised as having three defining features: it is idiographic, inductive and interrogative (Smith, 2004). Willig (2001, p.54) describes an idiographic approach as a process “whereby insights produced as a result of intensive and detailed engagement with individual cases are integrated only in the later stages of the research”. Individual tables of themes elicited from interviews in the current study were integrated at the end of the process to produce a master table of themes. Unlike quantitative research, IPA makes no attempt to limit itself by establishing hypotheses at the outset. This inductive approach was taken within the current study; a loose rationale gave flexibility and allowed for unpredicted themes to emerge. The approach encouraged creativity and production of new knowledge. The themes elicited from the analysis did not exist in isolation; they were related to existing theoretical knowledge within the discussion, thus allowing the process to be interrogative. To enable the phenomenon in question to be explored it was important to achieve homogeneity. This was achieved by use of the inclusion and exclusion criteria which ensured that the participants shared particular features; in the current study all participants shared a fear and avoidance of childbirth despite wanting to have a child.
While IPA aims to explore the research participant’s experience from the individual’s perspective, it recognises the impossibility of impartiality and that the analysis will always be touched by the researcher’s own view of the world as well as by the interaction between the researcher and participant. As such, the analysis is always an interpretation of the participant’s experience (Smith, 1995).

As analysis is both phenomenological and interpretative the researcher is “necessarily implicated in the analysis” (Willig, 2001, p. 67). Because of this IPA requires reflexivity from the researcher which will be discussed in the Critical Appraisal of the Research Process section.

Participants

Participants were all women who indicated that they fear and avoid pregnancy and childbirth despite wanting to have another baby (or have experienced this in the past). Exclusion criteria included women who were currently pregnant. There are two reasons for the exclusion criteria: due to the emotive subject matter the researcher did not want to increase anxiety levels which could have health implications for the woman and her unborn child. The second reason is the focus of this research - an exploration of the feelings of women who actively avoided pregnancy because of their fear. Information regarding the participants is included in Table 1 at the end of this section.

A poster was created to ‘advertise’ the research which asked for volunteers to contact the researcher if they wished to participate (Appendix 10). All GP surgeries within South Staffordshire PCT were contacted, many of whom agreed to display a copy of
my poster in their surgery. Posters and accompanying letters (Appendix 11) were sent to family planning services within South Staffordshire and psychology departments within South Staffordshire & Shropshire Healthcare Foundation NHS Trust. The Birth Trauma Association (BTA) agreed to put a notice on their website (Appendix 9) which again asked for volunteers to contact the researcher if they wished to participate in the study. The process of contacting hundreds of health organisations within South Staffordshire was time-consuming and given the time constraints a decision was made not to contact organisations within the other trusts that had been applied to. The difficulties encountered regarding recruitment will be discussed in the Critical Appraisal of the Research Process.

Nine women who appeared to fit the inclusion criteria came forward and agreed to take part in face-to-face interviews. Two women made contact via word-of-mouth; one woman was given the researcher’s details by a psychologist who had previously worked with her; one woman made contact after hearing of the research via an NHS Trust; and five women made contact through the BTA website. All nine women had previously given birth; eight women reported experiencing traumatic births and one woman had presented with primary tokophobia before deciding to go ahead with a pregnancy.

After interviewing the nine women and transcribing their transcripts a decision was made to exclude three of the interviews. One of these women has suffered with Symphysis Pubis Dysfunction (SPD) – while she shares the dilemma of fearing and avoiding childbirth despite wanting a baby, it was felt that her avoidance was connected to her medical condition and as such she differed from the rest of the
interviewees. Another woman revealed during the interview that she had gone on to have a second child despite her fear and after transcribing her transcript it was felt that she did not experience the same level of avoidance as the other women. One of the interviewees had given birth following therapy, having presented with primary tokophobia; her account is of her experience of primary tokophobia and her subsequent experience of pregnancy and childbirth. As her account differs in essence from the accounts of the other participants, a decision was made to exclude her interview.

Three other women made contact with the researcher via the BTA website. Two presented with primary tokophobia; the other with secondary tokophobia following a traumatic birth. The women were keen to take part in the research but due to geographical distance it was not possible to conduct face-to-face interviews with them. They each requested to take part by providing written accounts of their experiences. However as ethical approval was not sought to collect data in this way, it is not possible for these women to participate in the study. Details of the participants in the current study are shown in Table 1 below:

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Marital Status</th>
<th>Age of Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ‘Lynn’</td>
<td>36</td>
<td>White British</td>
<td>Separated</td>
<td>4</td>
</tr>
<tr>
<td>2. ‘Jill’</td>
<td>49</td>
<td>White British</td>
<td>Married</td>
<td>20</td>
</tr>
<tr>
<td>3. ‘Heather’</td>
<td>28</td>
<td>White British</td>
<td>Married</td>
<td>3</td>
</tr>
<tr>
<td>4. ‘Alex’</td>
<td>35</td>
<td>White British</td>
<td>Married</td>
<td>15</td>
</tr>
<tr>
<td>5. ‘Nadine’</td>
<td>22</td>
<td>White British</td>
<td>Married</td>
<td>1</td>
</tr>
<tr>
<td>6. ‘Tina’</td>
<td>29</td>
<td>White British</td>
<td>Married</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 1: Participant Information
Interview Schedule

A semi-structured, open-ended style interview schedule was devised (Appendix 15). The questions for the original schedule were developed after reflecting upon the existing literature and following discussions within supervision. The objective was to gain a rich account of the women’s experiences particularly with regard to their reasons for avoiding childbirth, what it meant to have another baby, and the effect of their avoidance of childbirth upon their relationships. Each interview was conducted individually and analysis did not begin until after completion of all of the interviews. After the first interview the schedule was amended to include a question which asked the women to identify any factors that had been helpful to them or that they believe would have been helpful. All of the participants were asked the questions that were on the schedule. In addition individual participants were asked questions where clarity or elaboration was needed. Copies of individual interview questions are included in Appendix 16.

The interviews varied in length depending upon how much the participant had to say. The taped interviews lasted between 25 – 60 minutes and were followed by a debriefing session which lasted up to one hour. Participants were given a debrief information sheet (Appendix 14). Interviews were analysed using IPA.

Procedure

1. When potential participants made contact via telephone or email their details were checked against inclusion criteria and copies of an Information Sheet (Appendix 13) and a Pre-Interview Question Sheet (Appendix 12) were sent out to them. The Information Sheet outlines the rationale for the current study
and the main purpose of the Question Sheet was to confirm inclusion criteria. Arrangements were made to conduct the interview at a mutually convenient time and at a suitable venue. One interview took place in a therapy room within a psychology department. The remaining interviews were conducted within rooms within health centres. The centres were contacted in advance to discuss room requirements and bookings were made accordingly. All rooms were suitable for therapy and were private to ensure confidentiality.

2. At the point of meeting time was allowed for introductions and to outline the rationale and procedure for the interview – attempting to establish trust is crucial if participants are to feel able to disclose personal information.

3. A consent form (Appendix 8) was given to the participant to sign which outlined issues of confidentiality and advised of their right to withdraw from the study. Participants were advised, in accordance with British Psychological Society’s (2008) guidelines, that transcripts would be anonymised and pseudonyms would be used and that tapes and transcripts would be stored securely.

4. The interview was audio-taped using a Microcassette Recorder (an Olympus Pearlorder J400).

5. A de-briefing session was offered following the interview. As participants discussed emotive personal issues there was the potential for this to provoke difficult and uncomfortable emotions. Debriefing allowed for any difficult feelings to be talked through thus helping to alleviate any painful emotions. Suggestions for suitable therapy were discussed where appropriate.
6. Each taped interview was transcribed and given line numbers [see
   Confidential Attachment for copies of transcripts and Appendix 17 for
   transcription protocol].

7. The transcripts were analysed using IPA, following the guidelines suggested

8. Each script was read and re-read allowing the researcher to immerse herself in
   the narrative. Any issues, thoughts or questions that arose out of engaging
   with the text were noted.

9. Themes that arose from the text were noted and clusters of themes were
   arranged into superordinate themes and were recorded on individual tables
   (Appendices 19-21).

10. Individual tables were used to write memos (Appendix 19) which define the
    themes with the purpose of describing and conveying the individuals’
    experiences.

11. Individual tables and memos were scrutinised and themes were integrated to
    create a master table of themes. This is reported in the results section and
    forms the basis for the discussion and conclusion of this study.
**Analysis**

Individual tables of themes and the theoretical memos (Appendix 19) that were developed from the tables were analysed. A Master Table of Super-ordinate and Sub-ordinate Themes was developed (see Table 2).

Seven super-ordinate themes were identified:

1. Control
2. Physical and mental distress
3. Expectations
4. Need for acknowledgement
5. Enduring distress
6. Implications for self
7. Implications for family life and relations with others
### Table 2: Master Table of Super-ordinate and Sub-ordinate Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Quotes from interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Control</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 1.1 Loss of control | “I’ve only got this, kind of cat-in-the-bath feeling of, of not having anything to hold on to”  
“..contractions which were, horrendous with this pure fact that I couldn’t stop them happening and I had no control”  
“..and I just felt, [tearful] like erm… completely out of control, and, like I couldn’t cope with, I just couldn’t cope with it all but I couldn’t stop it [cries]…” |
| 1.2 Others having control | “whatever they thought you know that’s what I had to do”  
“..it was then in their hands as to whether they helped me…or whether they forced me into having a natural birth” |
| 1.3 The need to be in control | “I was writhing around, trying to, stop it”  
“you know nothing, nothing was going to stop me giving birth at that point” |
| **2. Physical and mental distress** | |
| 2.1 Pain | “Excruciating”  
“dragging out your internal organs and setting fire to your thigh bones” |
| 2.2 Dying | “[starts to cry] Actually I thought I was going to die”  
“I really thought I was, I could’ve died” |
| 2.3 Physical discomfort and distress | “.24-hours sickness… was horrible and the depression that comes with it”  
“I was just bleeding really profusely… pouring out of me” |
| 2.4 Lack of explanation | “They didn’t really explain to me what was going on”  
“So I was kind of a bit in the dark about how much damage had been done down there” |
| 2.5 Negative experiences of hospital | “I think it was being, left on my own… and sort of being told to.. ‘Shut up, stop being a pain’”  
“I heard the consultant say to the midwife, “Oh just leave her she’s expecting something for nothing’” |
| 2.6 Emotional distress | “I ended up in floods of tears and really hyperventilating and screaming…”  
“I just felt shell-shocked” |
| **3. Expectations** | |
| 3.1 Societal expectations of childbirth and motherhood | “..something a woman just does”  
“..subliminal messages…all this conditioning, you must be able to cope…” |
| 3.2 Expectations do not match reality | “..this isn’t, this isn’t going to be, the way you thought it was going to be, at all”  
“I do feel that I had a very rosy view of it beforehand that was then, not matched at all” |
<table>
<thead>
<tr>
<th>4. Need for acknowledgement</th>
<th></th>
</tr>
</thead>
</table>
| 4.1 Lack of acknowledgement | “I didn’t feel as though anybody ever acknowledged what a huge and traumatic thing it was”
|                           | “I don’t think anyone seemed to appreciate what I had been through” |
| 4.2 Dismissal of fears; validation denied | “Don’t be ridiculous,”
|                           | “...you’re not being believed” |
| 4.3 Implications of being dismissed | “I was absolutely gutted” |
| 4.4 Need for validation | “I kept shouting ‘I’m not being a drama queen but I did nearly die. I really did nearly die’ [cries]”
|                           | “That would be, that would be really, that would be nice if someone just gave you the permission to feel like this” |

<table>
<thead>
<tr>
<th>5. Enduring distress</th>
<th></th>
</tr>
</thead>
</table>
| 5.1 Negative memories of childbirth | “the actual birth was just vile”
|                           | “What I can’t get past is the birth thing…but I just can’t” |
| 5.2 Fear and avoidance of childbirth | “I must make damn sure that that never happens to me again”
|                           | “...its a kind of a ‘Catch-22’ situation…I really want another baby, and you know I just don’t feel that I can...” |
| 5.3 Feelings of anxiety and depression | “I was having panic attacks, flashbacks of the birth”
|                           | “I feel very, scared and anxious and worried all the time and on edge” |

<table>
<thead>
<tr>
<th>6. Implications for self</th>
<th></th>
</tr>
</thead>
</table>
| 6.1 Loss and detachment | “I just wasn’t me anymore”
|                           | “I sort of knew something wasn’t right, I didn’t feel right” |
| 6.2 Negative self-perception and appraisal | “I felt a bit of a failure really”
|                           | “I sort of felt, like I was less of a woman really” |

<table>
<thead>
<tr>
<th>7. Implications for family life and relations with others</th>
<th></th>
</tr>
</thead>
</table>
| 7.1 Effect upon husband and relationship | “...causes him a lot of distress”
|                           | “...we were rowing quite a bit...we ended up we went to Relate” |
| 7.2 Relations with children | “I think its made my relationship with my daughter very intense”
|                           | “I decided at that point… that this baby really, wasn’t nice” |
| 7.3 Impact on friends and family life | “..then it took time to sort of rebuild, the relationship because, they didn’t really understand… properly why, I wasn’t able to see them”
|                           | “Just leave me on my own [laughs] what’s the matter with you all?” |
1. Control

The perception of losing control is associated with traumatic birth experience (Ayers, 2004; Sjogren, 1997), while a lack of control during delivery is established as a risk factor to PTSD (Olde et al., 2006). Beck (2004i) argues that for women who perceive that they experience a traumatic birth, control is one of the aspects that are stripped away from them. Oakley (1980) attributes this ‘stripping away’ of control to the increase in medical technology and ‘expertise’.

The theme of ‘control’ is a major feature of all of the interviews analysed. Without exception all of the women convey the sense of losing control. Many of the women illustrate how they had their control ‘stripped away’ from them as they were dominated and overwhelmed by the obstetric machine.

1.1 Loss of control

In the current study ‘lack of control’ was a recurring theme across the interviews. It is fundamentally what led Jill to avoid subsequent pregnancy:

“..the, lack of control” (Jill: 4)

“there’s no control” (Heather: 381)

The spontaneous nature of the contractions was one way in which these women experienced lack of control. During labour Alex felt completely overwhelmed by her contractions – not so much the pain that they brought, but rather the feeling of not being able to control them:
“..contractions which were, horrible with this pure fact that I couldn’t stop them happening and I had no control” (Alex: 291-292)

Labour also became an ordeal for Tina, one which left her feeling out of control:

“and I just felt, [tearful] like erm... completely out of control, and, like I couldn’t cope with, I just couldn’t cope with it all but I couldn’t stop it [cries]...”
(Tina: 134-136)

Tina found it difficult to talk about it, pausing to try to compose herself before her tears overwhelmed her. She recalls feeling unable to move:

“I couldn’t I just couldn’t, I wasn’t, couldn’t think, couldn’t, move do anything...”
(Tina: 150-151).

The repetition of the word ‘couldn’t’ illustrates her inability to function at that point. This feeling of being unable to move (and disabled by the word ‘couldn’t’) is also conveyed by Alex:

“I couldn’t couldn’t sit up, couldn’t do anything I was in a complete state”
(Alex: 220-221)

Like Alex, Heather is perplexed that she has no control over her body. Feeling almost paralysed by the pain she comments:

“I could hardly move, at all” (Heather: 403)
Heather uses animal-imagery to evoke how she felt she had lost control over her body and succumbed instead to an almost primeval state:

“I remember just, roaring like a lion, really just roaring, roaring roaring roaring…”
(Heather: 490-491)

While on the mat, Heather was:

“kind of whining and scrabbling” (Heather: 403-404)

and while she was in the pool:

“I’ve only got this, kind of cat-in-the-bath feeling of, of not having anything to hold on to” (Heather: 508-509)

There is a definite sense of being overwhelmed by the loss of control. Jill remarks:

“.the feeling that erm, I was sort of taken over by it” (Jill: 4-5)

Lynn’s sense of helplessness is summed up with:

“I was sort of lied there” (Lynn: 66-67)

When a doctor tells her that they are going to give her two more injections, Lynn’s sense of resignation to her lack of control shows:
“...and I thought ‘whatever’” (Lynn: 96)

Tina also conveys a sense of resignation when she is told that her husband will be sent home:

“he wasn’t, allowed to stay with me, [clears throat] so I just knew you know, I’d to accept that and that was that” (Tina: 49-51)

Lynn’s sense of loss of control and confusion about what is happening is conveyed by her helplessness as she struggles to put this into words:

“And I was like, you know, I didn’t [blows her nose] that was just like, whatever was going on” (112-113)

Feeling helpless, Heather had hung over the side of the pool:

“You could sort of hang in on the front, like you know like a drunk over a washing-line” (Heather: 428-429)

Alex conveys a sense of helplessness when she recalls her labour:

“I knew I couldn’t get out of bed and walk…..I just couldn’t do anything” (Alex: 899-904). “I think that is one of the problems when you are in labour and you’re at that stage, you are helpless” (Alex: 1293-1294)
1.2 Others having control

The perception of others having control is a feature of all of the interviews. Alex met with a hostile response from a doctor after squirming in pain while being stitched up:

“..he was just like, ‘Put your – bum – back on – the bed.’ So obviously he’s getting quite annoyed” (Alex: 368-369)

This note of authority left Alex in a very submissive position. Likewise Lynn’s futile attempt to regain control was met with:

“Sedate her again” (Lynn: 134)

When Nadine was being prepared for a Caesarean Section she felt overawed by the amount of strangers who had gathered around her:

“I felt overpowered in a way all these people” (Nadine: 188)

Tina had felt she had little ‘say’ or control at the hospital. She had felt railroaded into having her labour induced:

“despite saying I didn’t want to be induced... there was no you know, immediate risks to the baby I still had to be induced” (Tina: 595-598)

Tina perceived the doctors as having control:
“whatever they thought you know that’s what I had to do” (Tina: 257-258) and: “it was all their decisions and that was it” (Tina: 605-606)

Heather describes how, while in the birthing pool, her lack of control left her feeling that she was going to drown:

“every time I had a contraction your whole body gets folded up... and pushing me back in the water” (Heather: 440-442)

In her terror, Heather clung onto the sides of the pool while the midwives prised her fingers away:

“they were trying to get me to let go of the pool... I was really terrified I wouldn’t and they actually curled my fingers off” (Heather: 461-463)

For two of the women their unborn child was perceived to wield power and control over them, taking over their bodies. It feels almost as if Jill saw herself as possessed by an external entity rather than at one with her body:

“I just felt as though, as though I’d got this sort of alien in my body” (Jill: 7-8)

This theme of ‘baby as alien’ was also heard in Heather’s account:

“.the baby is kicking in your body and, you know it’s going to get on with it... alien-style and you’re not going to be able to do anything, about it” (Heather: 382-384).
1.3 The need to be in control

Jill felt the need to exercise self-control by restraining her urges:

“I felt I couldn’t scream oh I wanted to scream” (Jill: 74)

Rather than ‘let go’ and concede to her instinctual desire, Jill conformed to what she felt was expected of her in this situation - she did not want to disturb others around her (Jill: 76-77). Others too felt the need to restrain their emotions:

“I was trying not to cry” (Heather: 371-372)

“I had it in my head that I wasn’t going to scream” (Alex: 347-348)

Left to labour alone in the middle of the night, Alex tried desperately to gain control by fighting her body’s instinctual need to push the baby out – terrified of giving birth while alone she battled to gain control over her body:

“I was writhing around, trying to, stop it” (Alex: 893-894)

This image of Alex fighting to gain control is conveyed later in the process when she is being stitched up:

“I was, actually growling at him and lifting my bum obviously as the needle went in I was shooting up in the air” (Alex: 367-368)
Lynn was more forceful when, sensing imminent threat she took desperate measures in a futile attempt to regain control:

“I punched the anaesthetist…..I was like ‘Get that bloody mask off my face’“ (Lynn: 117-119)

In her desperation Heather found a way of gaining some control over the nature of her contractions:

“if you really pushed hard you could sort of get it to, the pain will sort of stay away from you a bit” (Heather: 511-512)

I get the impression that Heather was pushing in order to send the pain away rather than to deliver her baby per se – her instincts at this time seem to be focussed on survival. Momentum gains and you can feel Heather grabbing back control:

“you now have like a role and purpose in it... you think, ‘I can really push, I can make this over really quickly…’” (Heather: 547-500)

One can sense triumph when Heather states:

“you know nothing, nothing was going to stop me giving birth at that point”
(Heather: 556-557)

Repetition of the word ‘nothing’ serves to emphasise her determination to succeed.
For Alex it was the act of leaving the hospital that helped her to regain control:

“I just felt like I needed to, get home…..do things my own way” (Alex: 635-637)

Reminiscing on her lack of control Lynn considers how she would prepare for future childbirth:

“I would want to know, I would probably have it written down” (Lynn: 425-426)

Here Lynn plans to bring order in an attempt to avoid the chaos that she has experienced. Her comment here indicates that she wishes to keep control and work in collaboration with the medical professionals rather than be controlled and subdued:

“I would want further discussions with doctors and people who were involved”
(Lynn: 442-443)

2. Physical and mental distress

This theme incorporates all of the elements that contributed to the women’s physical and emotional disturbance and serves to illustrate the nature and extent of the women’s emotional upset in connection with their birth experience. A key aspect of this dominant theme is the women’s experience of pain, which is one of the main reported fears related to childbirth (Melender & Lauri, 1999; Sjogren, 1997).

Appraising birth as traumatic is primarily associated with obstetric factors, including pain. Soet et al., (2003) found an association between the experience of pain and the development of PTS symptoms. It has been argued that it is the distress that is linked
with the pain that leads to the development of PTS symptoms (Czarnocka & Slade, 2000).

Olde et al., (2006) suggest that it is this distress that can lead to what they call ‘catastrophic interpretations’. Certainly the combination of factors such as high levels of unexpected, unmanaged pain and perceptions of lack of control, can lead to women evaluating their situation as life-threatening. Women in the current study expressed that they feared that they would die during the childbirth process.

Negative experiences within hospitals, including a lack of explanation from staff regarding procedures, contributed to the distress experienced by the women in the current study. Poor staff-patient interaction was highlighted as a theme in Beck’s (2004i) exploration of women’s experience of traumatic birth. Lack of support by staff is recognised as a risk factor in the development of PTS symptoms.

2.1 Pain

All the women reported experiencing labour as extremely painful:

“Excruciating” (Alex: 196)

“I was just in in incredible pain, erm [cries]” (Tina: 114)

“Absolutely excruciating I’d never felt anything like that before” (Nadine: 38)
“..the pain of it, it was just, **absolute agony really, really bad, I mean it had gone from painful to... so intense**” (Heather: 305-306)

“I seemed to have been in **agony for hours**” (Jill: 79-80)

“It is **excruciating pain, it is really scary**” (Jill: 167-168)

Pain is described as overwhelming with some women describing feelings of disbelief at the level of pain and of being unable to cope. Heather describes the intensity of the pain:

“**dragging out your internal organs and setting fire to your thigh bones**” (Heather: 513-514)

Heather is overwhelmed by the pain and just cannot believe what she is enduring:

“..it would still get worse and worse and worse and worse and worse, you know, and you’re like you just got this huge wave of disbelief every single time” (Heather: 397-398)

Nadine was in floods of tears as she told me:

“I was, in terrible pain... I was **crying and yelping in pain**” (Nadine: 86-87)

She sobbed as she told me:
“I’d never felt pain like it and I didn’t know what to expect [gasp] I didn’t think it could get any worse” (Nadine: 67-68)

For Heather, the pain was unbearable:

“No I really can’t, really can’t cope with that” (Heather: 267-238)
“...so intense I’m sure you couldn’t, you know couldn’t cope with that and think what to do, at all” (Heather: 306-307)

Alex felt excruciating pain as she tore extensively whilst delivering her baby:

“It was really painful, really, really painful” (Alex: 1307-1308)

“giving an almighty push, feeling myself, tear then counting to ten again and having to do it... dreading each time because I knew the pain was going to come” (Alex: 314-316).

“with every, push I could feel myself tear, very, very deep” (Alex: 297-298)
“I tore completely if I had stitches up my bum, it was a complete tear, which I felt every bit of it” (Alex: 539-540)

Having the tear stitched up was incredibly painful:

“it really hurt I felt my stitches... I – felt – the needle going through” (Alex: 363-366)
The deliberate pauses between her words are used to emphasise her horror at feeling this pain. Having torn extensively Alex was subjected to an internal examination during the process of stitching up:

“it was so painful, it almost just felt like he just, stuck his hand in and went like that”
(Alex: 343-344)

“someone else came in and, just seemed to sort of ram a toilet-roll sized, tampon up there which again, made me squeal quite loudly and hurt a lot” (Alex: 356-358)

The thought of someone ‘ramming’ anything up her torn vagina is just horrific.

The suffering was made worse by the women’s inability to ease their pain:

“Well this isn’t alleviating the pain, its doing nothing” (Jill: 69-70)

“[cries] I was trying to lie down ’cos it.. just tried to ease it anyway I could but it didn’t, it didn’t work” (Nadine: 109-110)

Lynn was overwhelmed by the pain of delivering the placenta and pleaded for pain relief:

“..give me painkillers give me more and more, give me all the drugs” (Lynn: 58-59)
Despite the level of pain that the women experienced, and their inability to ease their pain, some of the women were denied pain relief or were offered ineffective relief:

“I asked the midwife for some, erm pain killers and I think it was about an hour and a half before she brought them over” (Tina: 72-74)

“I asked for some but they just said they could give me some paracetamol… and that didn’t make any difference at all” (Nadine: 62-63)

“I wasn’t given any pain killers” (Alex: 283)

With labour well under way Alex was denied the use of the tens machine she had brought with her:

“”No no no no you don’t, you don’t need it that’s much later” (Alex: 213-214)

Having been denied pain relief throughout her labour, towards the end stages Alex was told:

“It’s far too late you can’t have anything now” (Alex: 276)

2.2 Dying

Lack of control and the intensity of pain led some of the women to fear that they would die during childbirth:

“[starts to cry] Actually I thought I was going to die” (Nadine: 65)
“Oh, I’m actually going to drown now” (Heather: 444-445)

Heather’s instinct was to try to survive this ordeal:

“I was just hanging on like grim death to absolutely everything” (Heather: 467-468)

“I remember describing it as a near death experience” (Jill: 113-114); “I really thought I was, I could’ve died” (Jill: 114)

Complications following her son’s delivery resulted in an actual threat to Lynn’s life. Amidst the frantic actions of those around her Lynn tries to make some sense from what ensues and is frightened by a monitor reading:

“Oh my God how am I alive?...How come I just haven’t…” (Lynn: 80-81)

In recalling this Lynn is unable to complete her sentence, mirroring maybe how she is still not fully able to contemplate the horror of having nearly lost her life.

Lynn loves her son dearly and the thought that she might not have lived to mother him, she finds unbearable:

“And that was the scariest thing because... if I’d have died [sobs] I would never have seen my son” (Lynn: 255-256)

It was incredibly painful for her to express the words ‘if I’d have died’; the instantaneous sob is an indication of her depth of feeling.
2.3 Physical discomfort and distress

Some of the women were taken aback by the extent of their bleeding following their deliveries:

“I just bled, I had it was down my legs, it was all obviously soaked through my pyjama bottoms” (Alex: 391-392)

“I was bleeding a lot... totally unprepared” (Alex: 512-513)

“.you’re all stitched up, and you’re all bleeding from everywhere” (Jill: 117-118)

“I was just bleeding really profusely... pouring out of me” (Lynn: 76-77)

Lynn talks of having two potent injections which were a final attempt to stop the bleeding, but:

“.it didn’t stop, it didn’t stop” (Lynn: 102-103)

Her repetition indicates the despair she felt at that time and suggests that she still struggles with this recollection. Lynn became terribly upset when she recalls how her baby’s outfit had become covered in her blood as he lay next to her:

“[cries] his romper suit was just covered in blood up to his tummy it was just red... covered with blood” (Lynn: 49-51)
Again the repetition ‘covered with blood’ emphasises how this image remains a powerful one. The interventions that Lynn was subjected to she describes quite graphically and feels very invasive:

“..squeezing it in manually... get the blood in” (Lynn: 88).

“..uterus... squeezed it down into a ball... tied it up... stitched it back up” (Lynn: 175-179)

This feels quite brutal, the ‘squeezing’ and ‘stitching’ and hints at feelings of being attacked.

2.4 Lack of explanation

Many of the women felt that they were ‘left in the dark’ and the lack of information and explanation added to their sense of chaos and lack of control, intensifying their fear:

“Now you don’t know what’s coming, no you don’t know how bad its going to be and you don’t really know, you know, what’s going to happen or what they’re going to do about it” (Heather: 344-346)

“They didn’t really explain to me what was going on” (Lynn: 47)

Lynn’s lack of knowledge and understanding about what happened that day continues to needle her:

“..how come it did all happen, why did it happen” (Lynn: 537-538)

Alex did not understand what was happening to her and no-one explained it to her:
“I was unaware of what was going on” (Alex: 715-716)

“I was just like, ‘I don’t really want to know what you’re talking about, what on earths gone on down there?’” (Alex: 374-376)

“wouldn’t tell me how many stitches I’d had... not answering sort of vague” (Alex: 377-378).

Consequently Alex has never known the extent of her injury:

“so I was kind of a bit in the dark about how much damage had been done down there” (Alex: 379-381)

Tina asked about the pain, but explanation was not forthcoming:

“when I asked you know, “What’s the pain?” nobody would explain you know, what was happening” (Tina: 250-251)

Tina also feels resentful of having her labour induced, against her will and without explanation:

“none of that was explained to me really why, you know why that was necessary” (Tina: 599-600).
2.5 Negative experiences of hospital

Three of the women were in labour during the night and all felt alone and abandoned to some extent:

“But no-one had actually looked in at any stage” (Alex: 237)

Alex had perceived hostility from staff earlier in the night and felt she was dismissed and left to cope alone:

“I think it was being, left on my own... and sort of being told to.. ‘Shut up, stop being a pain’” (Alex: 761-762)

At one point she feared that she would give birth alone:

“Part of me just thought I’m going to give birth to him here, on my own, you know, and no-one’s interested” (Alex: 895-896)

Nadine was also left on her own all through the night:

“I was left for, quite a few hours” (Nadine: 100)

“I didn’t see many of the midwives that night so it was very lonely” (Nadine: 11-12)

Nadine conveys a sense of having been neglected:

“If I’d been checked during the night I think I would have been given some [pain relief].. but they said they’d.. leave me the night and then check me in the morning” (Nadine: 89-91)
After midwives had begun to induce Tina’s labour, her husband was sent home for the night leaving Tina feeling very lonely and isolated:

“I just remember feeling really lonely [holding back tears] you know, for the whole of that night” (Tina: 53-54)

This feeling of being disregarded continued:

“I felt as if, you know I was being ignored” (Tina: 238-239);

“no-one, sort of, you know asked if I was okay or needed anything” (Tina: 241-242)

This disregard led to Tina feeling worthless. As labour progressed the midwives kept a distance leaving Tina feeling neglected:

“no-one, was able to help me I just felt completely on my own, nobody could help and you know nobody really seemed interested in helping” (Tina: 136-138)

These women expressed the need for the security of their partners and were affected by their absence:

“I said to [boyfriend] later, ‘Why did you take so long?’...[boyfriend] said, ‘Oh they did call me but they said don’t worry about it to take my time,’ “ (Alex: 245-248)

“[crying] I felt very scared and nervous and lonely because I wanted him with me all the time” (Nadine: 183-184);
“..feeling you know really anxious...thinking that, ‘I’m going to have to go through all this on my own because my husband’s... going to have to go, and then I’d be on my own to cope with it all’ “ (Tina: 116-120)

A lack of empathy and support from midwives was reported. Jill describes the attending midwives as ‘cold’ (Jill: 66) and she felt unsupported by them:

“[midwives] don’t want the, the hassle of you getting in a state you know, they don’t want it” (Jill: 169-170)

She refers to their lack of empathy:

“midwife saying, ‘Women in Russia give birth in the morning and they’re out in the potato fields in the afternoon,’ that was the level of... concern I got” (Jill: 96-98)

In the late stages of labour Tina felt unsupported by the midwives:

“I just remember them shouting across the room to breathe properly” (Tina: 131-132)

Tina’s husband sought guidance, asking:

“‘Is it ok for her to push?’ And they just shouted over, “Yeh, that’s fine.”” (Tina: 157-158)

Tina recalls: “the only time I remember them being with me is just before she was born” (Tina: 158-159).
Two of the women report perceived hostility from staff. Alex had struggled changing the first nappy and required another one - the midwife:

“came down and looked, really really cross with me” (Alex: 559)

Another instance was when Alex was unable to get milk to flow from a bottle:

“she snatched it off me with such force” (Alex: 598-599) and: “again she was absolutely furious and kind of shoved it back at me” (Alex: 603-604)

Even the woman who brought the tea around to the ward showed cold impatience when Alex changed her mind about wanting a cup:

“she was fuming, she was furious that I had changed my mind” (Alex: 507-508)

Alex’s conclusion is: “I felt obviously intimidated by it all” (Alex: 632)

When a ‘crowd’ of staff had congregated in the cubicle to observe Tina being examined, the consultant entered in this hostile fashion:

“she just came into the cubicle, slammed her bag down on the floor, and you know, just examined me as though, I was just a big inconvenience” (Tina: 84-86)

When the consultant heard Tina ask the midwife for pain relief, the consultant’s comment damaged Tina’s self-esteem and she cried after telling it to me:
“I heard the consultant say to the midwife, “Oh just leave her she’s expecting something for nothing”’” (Tina: 101-103)

The fact that the consultant talked about Tina, in front of her, without addressing Tina directly, adds to the feeling of worthlessness that Tina experienced. This carried on as Tina followed (in pain) the midwife back to the ward:

“and [sighs] the midwife’s just you know she’s just holding a clipboard and she just kept looking back at me and tutting” (Tina: 105-107)

It was a heavy sigh that Tina gave and I could feel Tina’s sense of worthlessness as I listened to her. At one point Tina could not move due to the pain and her husband tried to help her to sit up – the midwife said:

“Oh leave her don’t help don’t do that she can do it herself” (Tina: 248-249)

This comment would make Tina feel useless as well as helpless.

A significant factor in Tina’s ordeal was the lack of privacy that she had. Before going to the delivery suite Tina was left to labour on the ward:

“one of the big things that I found, quite.. traumatic and humiliating really was being on the main ward with just a curtain around me and, you know other people’s visitors and everything” (Tina: 60-63); “during the afternoon the curtains were left open and I was on the monitor..” (Tina: 242-243)
At one point a ‘crowd’ of people descended into the cubicle to observe Tina’s internal examination, just feet away from others’ visitors, which Tina felt overwhelmed by:

“I’d never seen [consultant] before, she came into the cubicle, by this time the cubicle was just full of, midwives and student midwives..” (Tina: 81-82)

Tina conveys feelings of indignity; conscious that others outside of the curtain would have heard every exchange:

“I was just really humiliated [unintelligible word] because... everyone turned you know, ‘Oh look at her poor thing,’ you know..” (Tina: 94-96)

Another example of this indignity happened after Tina’s waters broke while she was in the bath. Staff left the door of the bathroom open:

“I just remember looking out of the bathroom door to see other people, standing in the corridor looking at me and I was naked at this point..” (Tina: 122-124)

A lack of consistency of care is reported:

“I didn’t see the same midwife, at any point” (Alex: 1279-1280)

“I think the continuity of care because I didn’t see the same doctor once, all through my erm antenatal appointment” (Tina: 582-583)

2.6 Emotional distress

Fear was communicated:

“I was quite scared” (Alex: 877)
As Nadine talked about the pain and being alone with it during the night, I sensed her fear. I remarked that it ‘sounds really frightening’ (80) and her fear was almost tangible as she replied:

“It was, yeh and when I was going to the toilet I was, losing a lot of blood... going back and trying to [unintelligible; crying] [quietly, sounds in pain, almost whimpering] I was really in pain” (Nadine: 81-83)

Seeing her husband’s fear etched in his face reinforced Heather’s own fear, offering her no assurances of safety:

“[husband] just looked completely freaked at this point... he was just big big eyes” (Heather: 492-494) and: “every time I looked at him it was like, ‘That’s not reassuring, that kind of terrified face’” (Heather: 496-497)

Heather was unable to articulate her fears:

“but he didn’t realise this, I didn’t have a breath to tell him” (Heather: 323-324) and:

“I couldn’t really speak to people either” (Heather: 454-455)

Fear gave rise to panic:

“I was in such a mess and I was hyperventilating” (Alex: 255)

“I was really panicking” (Heather: 518)
“I was erm hyperventilating” (Tina: 138)

Heather felt desperate to escape the whole torturous situation:

“I started thinking, ‘Crawl over to the wall, I could knock myself out on the wall’”
(Heather: 414-415)

The violence in the next image portrays both Heather’s desperation and the level of pain that she was experiencing:

“If I could put my head under a sledge hammer at that point I really, I really would have” (Heather: 473-474)

There was a feeling of disbelief at the gravity of their experiences:

“[drops her voice to a whisper] ...I was just so stunned” (Jill: 106);
“I just felt shell-shocked” (Jill: 140-141)

“I just thought this can’t be happening to me” (Nadine: 197-198);
“shell-shocked” (Nadine: 249)

“I just remember really you know shaking and I felt a bit shocked..” (Tina: 168-169)
3. Expectations

The way in which a woman responds and adjusts to becoming a mother is affected by her expectations and experience of the events of childbirth and motherhood (Ball, 1993). As Eriksson et al., (2005) state, pregnant women are exposed to normative perceptions of what it is to be a woman and expectant mother. Western societies tend to hold positive views of childbirth and motherhood; when a woman’s expectations of a positive birth experience are dashed, she can be left feeling inadequate as well as disappointed, which can give rise to feelings of shame. In her qualitative research of women who reported experiencing a traumatic birth, Beck (2004ii) found that for the women in her study hopes and expectations of motherhood were destroyed. Violation of expectations is associated with a severe traumatic stress response (Ayers, 2004).

In the current study women found a mismatch between their expectations of childbirth and the reality of their experience. Most of the women talked about the influence of societal views.

3.1 Societal expectations of childbirth and motherhood

Some of the women were explicit in expressing what they perceived as societal views regarding childbirth and motherhood:

“..*something a woman just does*” (Lynn: 529)

“*Oh you should have babies*” (Lynn: 529-530)

“..*as a woman you have an expectation that you’ll be naturally equipped to deal with [childbirth]*” (Jill: 210-211)
“...subliminal messages...all this conditioning, you must be able to cope...” (Jill: 214-216)

“...from the midwives point of view... ‘obviously she’ll be really happy with this she’s got to have this fantastic, natural birth’” (Heather: 535-538)

“A caring mother would, hold her baby up and check she’s alright” (Heather: 615-616); “Everyone expects me to be this mum” (621-622)

3.2 Expectations do not match reality

None of the women had a dread of pregnancy and childbirth that predated their pregnancies and they were not averse to their impending birth experiences:

“I certainly wasn’t fazed...I wasn’t that worried” (Lynn: 560-561)

“it’ll all be fine” (Heather: 66)

However their expectations did not match reality:

“.it was a lot worse than I ever thought it could be” (Nadine: 38-39)

“.this isn’t, this isn’t going to be, the way you thought it was going to be, at all”

(Heather: 342-343)

“I didn’t expect it to be as painful as it was” (Jill: 58)
Jill was unprepared for the impact pregnancy and childbirth would have on her life:

“..it, happened so soon and I hadn’t really got used to the idea of being pregnant before wow!” (Jill: 14-16)

Jill expresses her disappointment at not experiencing pregnancy and childbirth as she had expected to:

“..it was disappointing...[quietly] yes, it was disappointing, [resumes volume] it was disappointing to feel so dreadful” (Jill: 181-183)

Jill ponders the first ‘disappointing’, pauses and then drops her voice to almost a whisper to repeat it, which may indicate her sense of discomfort at expressing this. She then adds, more directly, that it was disappointing ‘to feel so dreadful’, which may indicate that she feels more comfortable with being disappointed at feeling ‘ill’ rather than feeling disappointed with the experience per se. Alternatively it is possible that she is internally processing her experience at this point.

Nadine cried as she talked about the CS, saying that she was “very disappointed” (Nadine: 212). She has a sense of having missed out on what she was expecting from childbirth:

“I couldn’t hold him so I felt like I missed out that way that I really wanted skin to skin with him, and to breastfeed him from birth but, I didn’t get to hold him or anything” (Nadine: 234-236)
Her experience was in contrast to images she had seen portrayed by the media:

“it felt quite weird because, in magazines and on television you always see the mother holding the baby after the birth but I didn’t…” (Nadine: 236-238)

There is no doubt that Nadine found this terribly disappointing and this expectation contributed to her sense of having failed.

Perhaps most disappointing of all for Heather is the mismatch between her expectations of greeting her newborn child:

“I was really, really looking forward to meeting her, I really was” (Heather:167)

with the reality: “but neither did I think that I would hate her and I would be terrified of her and really wouldn’t want to be with her” (Heather: 738-739)

Anticipating childbirth Heather had thought:

“it’ll be you know a good kind of pain rather than a broken leg kind of pain” (Heather: 127-128)

However, reality did not match her expectations and she remarks:
“I can remember that and thinking, [mock-slaps her face and smiles] give myself a bit of a slap because, you know, what a load of cobblers, really, to be honest” (Heather: 129-131)

Heather admits: “I do feel that I had a very rosy view of it beforehand that was then, not matched at all” (Heather: 590-591)

Heather had attended childbirth preparation classes with the National Childbirth Trust (NCT) – she conveys a sense of frustration with them for presenting (in her opinion) a very positive view of childbirth:

“I also think that, they’ve got a beautiful view of, of childbirth that isn’t…”
(Heather: 589-590)

Heather and Jill both convey feelings of having been misled, or duped by others into believing that the whole experience would be positive:

“.which is part of why I felt so disappointed if somebody had been, honest, you know, it’s going to hurt like hell, bear in mind you probably will want some drugs…”
(Heather: 591-593)

“I really felt as though from start to finish it was an enormous con” (Jill: 165-166)

I have the sense that Jill feels let down by others, both professionals and she refers to her own mother, who have not prepared her or even told the truth:
“nobody sort of levelled with me” (Jill: 167)

4. Need for acknowledgement

The need for acknowledgement and validation of experience was not picked up in the literature. It was however, of particular significance in the current study. Having fears dismissed had the effect of intensifying fear as well as leaving the women’s self-esteem in tatters. Not being acknowledged or listened to affects our sense of worth, and all the women perceive that their experiences have not been validated.

4.1 Lack of acknowledgement

In the current study women felt that the extent of their suffering had not been recognised:

“I don’t think anyone seemed to appreciate what I had been through” (Lynn: 352)

“Well what about me? What about me you don’t realise what has happened to me” (Jill: 126-127)

“I didn’t feel as though anybody ever acknowledged what a huge and traumatic thing it was” (Jill: 161-162)

“You haven’t even noticed that I’m in a complete jibber and this is awful” (Heather: 661-662)
4.2 Dismissal of fears; validation denied

For some, the lack of acknowledgement went further where it was perceived that fears, and in some cases pain, were dismissed or even questioned. When Jill describes the birth to her doctor as:

“the most horrible experience I’ve ever had” (Jill: 130), he responds with: “No, no it was fine” (Jill: 131)

thus denying and disputing Jill’s personal account. Others had similar experiences:

“I could see the peaks of my contractions as I was feeling them and she said to me, ‘See nothings happening’ “ (Alex: 156-157)

“.she’s just said, ‘Be quiet,’ you know, ‘just go to bed and be quiet’ “ (Alex: 161-162)

“.you’re not being believed” (Alex: 708)

“.they didn’t believe that I was in any pain [fighting back tears]” (Tina: 107-108)

4.3 Implications of being dismissed

Having one’s feelings and perceptions challenged or dismissed had a detrimental and damaging effect upon the women.

“.being told I wasn’t in labour so you start, questioning because if someone’s saying to you, ‘No you’re not,’ but you can feel something happening, so you then sort of, ‘Well what’s this then?’ “ (Alex: 705-708)
“...every time I got up, felt this enormous sense of guilt and like I was being a pain”
(Alex: 874-875)

“[cries], wondering you know, ‘If this isn’t labour you know how am how am I going to cope with labour?’... erm. and just really feeling you know really anxious” (Tina: 115-116)

4.4 Need for validation

Lynn’s desperation to be heard and acknowledged is felt when she says:

“I kept shouting ‘I’m not being a drama queen but I did nearly die. I really did nearly die’ [cries]” (Lynn: 254-255).

Her cry here is almost pitiful, like she feels the pain of what she is expressing and as if the cry represents the empathy that she would like from others (although she fears that others will view her negatively, as a ‘drama queen’). Alex describes the beneficial effect of empathy that she received:

“So yeh again someone else has noticed, ‘cos you do think you’re being a bit neurotic, noticed there was obviously an issue” (Alex: 1408-1409)

Commenting on the current interview, Lynn says:

“it was good for me to talk about it again... otherwise it just gets forgotten” (Lynn: 577-578)
This process endorses Lynn’s need to tell her story; by recording it in this format she is ensuring that metaphorically, her story is ‘etched in stone’.

Jill states that it would be ‘great’ if:

“it was just acknowledged, that for some people it is like this” (Jill: 295-296)

For Jill, acceptance and validation that childbirth can be, and is, experienced as an ordeal would be very helpful and healing:

“That would be, that would be really, that would be nice if someone just gave you the permission to feel like this” (Jill: 296-298)

Jill almost stumbles through this sentence; it’s as though she senses that validation is too far away and that her vision is more of a fantasy than a possibility.

Recognition is powerful. For a long time after the birth Tina was unable to talk freely about how she felt for fear that she would not be understood. She says:

“I think that if there was something, you know to say it can happen, it does happen to other people... I would have told someone then how I felt.” (Tina: 282-284)

Tina has recently found an internet message board for women who have experienced birth trauma and she has found this to be validating and very helpful.
“it’s just really good, to know that its recognised, you know and that, it’s not just me being weak and, not able to cope with childbirth, you know that it’s a real it’s real”
(Tina: 564-566)

5. Enduring distress

Not surprisingly all of the women evaluate their childbirth experience as traumatic. Their negative memories serve as a constant reminder of their trauma, and they all feel regret that such memories are attached to such a monumental occasion, one that all of the women had been anticipating would bring them joy, as their much-wanted child was born.

The experiences of the women with secondary tokophobia in the current study have led all the women to avoid childbirth. While fear and avoidance of childbirth has been covered in the existing literature, studies to date have focussed on women who are pregnant. The women in the current study have not moved beyond their fear, which disable them to the point where they will face a future without another child, which is a source of distress and regret for the women.

Most of the women in the current study have been affected by anxiety and most have been depressed. The excerpts from the transcripts indicate the extent to which anxiety and depression affects almost every aspect of their lives. Although the women describe symptoms that are associated with PTSD, none of the women were formally diagnosed, although several were treated for postnatal depression.
5.1 Negative memories of childbirth

All of the women hold negative appraisals and memories of their child’s birth:

“I had an extremely traumatic birth” (Lynn: 7-8)

“Bloody awful” (Lynn: 341)

“.the actual birth was just vile” (Jill: 37)

“.writhing back in agony” (Heather: 140-141)

“.a traumatic experience” (Alex: 3)

“The traumatic and upsetting experience I experienced by giving birth to my son” (Nadine: 3-4)

For some these memories continue to cause them anguish:

“.natural birth... its left huge dents in me” (Heather: 595)

“I still cannot get my head around what happened” (Alex: 1091-1092)

“What I can’t get past is the birth thing...but I just can ’t” (Alex: 1120-1121)

“.its all still there” (Lynn: 401)
“I think I’m dealing with it well… I’m getting on with it, but…” (Lynn: 579-580)

The word ‘but’ speaks volumes – Lynn trails off here which suggests that while she puts on a front of having dealt with her ordeal, underneath the surface she harbours more difficult feelings.

5.2 Fear and avoidance of childbirth

All participants report their fear and avoidance of childbirth:

“..no way would I have another baby – absolutely no way” (Lynn: 449-450)

“I must make damn sure that that never happens to me again” (Jill: 155-156)

“I can’t kind of contemplate... there’s the whole birth... I just can’t even I won’t I won’t go anywhere near that” (Heather: 886-888)

“I just said, ‘He’s an only child that’s it’ “ (Alex: 1136);

“[re thought of pregnancy] Ooh, horrified, absolutely horrified” (Alex: 956)

“I thought I can’t let my body go through this again I never want to do it again, and its stayed with me right until now” (Nadine: 283-284)

“[sighs] all I can think is that I’d just be terrified, giving birth [tearful] again” (Tina: 312-313)
This avoidance has caused distress as all of the women would like to have (or have had) another child. For Jill (now middle-aged), she harbours feelings of regret:

“I think there’s a lot of guilt associated with the fact that she’s an only one” (Jill: 252-253); “Oh you should’ve done it again” (Jill: 241); “You couldn’t, you know, you couldn’t why couldn’t I have gone through that again?” (Jill: 237-238)

For others the dilemma is current:

“I don’t think I have addressed it fully yet” (Lynn: 309-310)

“Our family is not complete... I do want another one but, I really couldn’t face one, at all at the moment” (Heather: 877-878)

“I always think, ‘I wish that was me, with more than one,’... I always wanted that myself so it, it upsets me that I won’t be able to have that because of the experience I had” (Nadine: 380-383)

“.its a kind of a ‘Catch-22’ situation... I really want another baby, and you know I just don’t feel that I can..” (Tina: 526-527)

5.3 Feelings of anxiety and depression

Five of the women report symptoms of Post Natal Depression with four of them having been treated with anti-depressants. Jill describes herself in terms of mental instability:
“post-natally deranged” (Jill: 18)

“Why are you coming to visit me when I am demented?” (Jill: 138)

Tina was severely depressed following the birth and was referred to a psychiatrist and a Mother and Baby Unit for treatment. She describes these feelings of helplessness and disconnection from her emotions:

“I wasn’t going out I couldn’t, I felt that I couldn’t cope with anything” (Tina: 422-423); “I felt, as though every.. things weren’t real” (Tina: 170); “.one morning I just couldn’t get out of bed I just couldn’t, felt like, the only way I could describe it was that I felt flat” (Tina: 198-199)

This sense of hopelessness is conveyed by Jill:

“suddenly I was just hopeless, helpless, useless” (Jill: 23-24)

Two of the women expressed feelings of needing to escape:

“I just went out… I didn’t know where I was going or what I was doing, I just knew that I had to get away I didn’t know where, to, [fighting back tears]” (Tina: 192-195)

“I remember going down to the beach and thinking, ‘Yeh I really could, just walk off into the sea at this point,’ “ (Heather: 858-859)
Five of the women talk about triggers that continue to remind them of the birth, which provokes anxiety. They also report having had flashbacks and nightmares. It is quite significant that more than four years after the birth, Lynn is still affected by the thought of her baby’s romper suit:

“[sobs, gasps for breath] whenever I see it that little blue romper suit, it’s a real [gasp] trigger still, well even talking about it. That just sums it up for me that little, blue suit…” (592-594).

This was a very powerful exchange and one in which I could feel Lynn’s pain. I wonder if the bloody romper-suit has such a powerful effect because she does not want to associate her son with the trauma. Her periods serve to remind her of her blood loss during childbirth:

“Sometimes when I have my periods now I get scared… it just reminds of it… the blood…and the amount…” (Lynn: 322-326)

For a long time Heather’s baby served to remind her of her ordeal:

“but the birth really used to bother me because when I saw her, you know, I’d be back in the pool” (Heather: 791-792)

Tina is tearful as she talks about her avoidance of pregnant women:

“I avoid erm pregnant women, erm, mainly because it brings back, the memories of my own experience” (346-348)
For two of the women association with the hospital triggers unwelcome anxiety:

“I can’t bear to think about [the hospital] or go past in the car or anything or anything that reminds me of it” (Nadine: 288-289)

“I can’t, can’t go back to that hospital again... I’ve drove past it a couple of times... that’s quite difficult, I just can’t, face going back really” (Tina: 548-550)

Images of childbirth or hospitals in the media continue to trigger anxiety:

“I still don’t like watching television...you know birth references...films cinema... might sneak some birth reference in... its really distressing” (Heather: 850-856)

“.if its on TV... actors, on TV, in labour, I get that, it goes really tight and... I just can’t watch it... and I close my ears so I can’t hear it” (Alex: 1140-1144)

“Anytime I see it on the internet or, see the word ‘hospital’ in a, newspaper or on the television or any documentaries on, birth or anything like that” (Nadine: 294-295)

Intrusive memories of the childbirth experience are reported:

“I don’t really know what flashbacks are but suddenly when you start thinking about it I wouldn’t be able to get it out of my head” (Alex: 1255-1257)
“I started to, get erm, like memories of the birth, erm, which, I couldn’t make go away” (Tina: 186-187); “I was having panic attacks, flashbacks of the birth” (Tina: 423-424)

For many of the women anxiety manifests itself in nightmares and affects their sleep:

“[becomes tearful] I used to dream about erm lines and blood’ (Lynn: 357-358); “I was scared...of going to sleep” (354-355)

“.you’d be having nightmares about it, every time I saw the baby I’d be thinking about it” (Heather: 848-849)

“.it would just be in my head and I wouldn’t be able to sleep and I’d get myself in a real state, you know and your heart racing and you’re sort of reliving it a bit” (Alex: 1258-1260)

“[crying] I’ve had nightmares that I’ve been trapped in there and can’t get out... I still get them now, on a regular basis” (Nadine: 298-300); “I’ve trouble sleeping, and staying asleep sometimes, I’ll, wake up a few times in the night [cries] crying and... its affecting my moods as well and eating” (Nadine: 349-352)

“I’ve started having erm bad dreams again” (Tina: 472)

The women describe other symptoms of generalised anxiety as well as feelings of panic and of feeling ‘unsafe’:
“I used to be on tenter-hooks the whole of the time” (Heather: 733-734)

“I feel very, scared and anxious and worried all the time and on edge” (Nadine: 346)

“I used to, earlier on, get very anxious and panic-attacky” (Alex: 1254-1255)

Since the birth Tina has suffered with anxiety and panic attacks. She admits to self-harming although she does not give any detail (421-423). Tina conveys her fear of being alone:

“at the beginning of the illness, I couldn’t, go out on my own, I couldn’t stay in the home on my own” (Tina: 367-368)

Her anxiety got worse:

“It got to the stage where I couldn’t even go out. if I was with someone, I would start to erm really you know panic attacks” (Tina: 371-373)

The feeling of not wanting to be alone continues into the present:

“I can’t bear the thought of having to stay on my own... I don’t feel I can stay on my own, all day every day” (Tina: 374-377); “[sighs] but even now, I still find it really difficult to, go into new situations” (Tina: 401-402).

There’s something about Tina not feeling safe. Reflecting upon when she briefly returned to work, she says:
“if someone new came into the classroom I felt really, alienated again, and, not, comfortable at all” (Tina: 503-504)

The punctuation in this sentence conveys her discomfort. She adds:

“I don’t feel safe, there” (Tina: 511-516)

I feel this is reminiscent of Tina’s experiences in hospital: when staff piled into the cubicle while she was being examined; being exposed when the bathroom door was left open, and staff talking over her without consulting her.

Difficulty in talking about their experiences and feelings was expressed by most of the women:

“[becomes tearful]…I could hardly talk about it…I couldn’t talk about it without crying…” (Lynn: 250-252)

Four years on and Lynn obviously still finds it difficult to talk about it, indicating that maybe she still has not processed her feelings about her experience.

“..the birth thing I hadn’t really talked it through with anybody” (Heather: 844-845)

”I got myself in quite a state and I was shaking, I was sobbing and everything trying to, tell him what happened” (Alex: 1237-1238)
I asked Nadine if she had been “able to talk to friends and family about it” to which she replied:

“No… I just, don’t feel I can open up to them” (Nadine: 307-313)

I was struck by how difficult Nadine had found talking with me. She struggled through the interview, shaking and sobbing and she did not elaborate on many of her responses. Her pain was very raw.

“I didn’t tell anyone how I felt about the birth, it was just, thought that I’d got post-natal depression” (Tina: 202-203)

“I just felt, so ashamed, ‘cos I thought it was only me, that I didn’t, you know, tell anyone” (Tina: 284-285)

Tina’s discomfort and sense of shame is apparent in the punctuation of her sentence.

6. Implications for self

Loss of ‘self’ is also a theme elicited from analyses of interviews conducted by Beck (2004ii). For the experience to have affected the very core of the women is an indicator of the scale of the issues for these women. The theme of ‘loss of self’ was very powerfully conveyed in the current study. Oakley (1980) talks of the loss of identity that comes with this major life change; this was reflected in at least two of the accounts.
Self-esteem in this group is very low, with all women berating themselves. Their low opinions of themselves commonly arise from unfavourable comparisons with women who do not present with tokophobia. In many cases the women feel useless and worthless. Their negative self-appraisals can lead to feelings of shame, which in turn can lead to the women becoming isolated in their misery.

6.1 Loss and detachment

Perhaps the most poignant loss that the women reported was a sense of losing their ‘self’:

“..completely different, sort of irrational” (Jill: 27)

“..you’re just not the same, not the same person” (Jill: 118-119)

“I just lay there then afterwards and I felt different, like a different person, [holding back tears]” (Tina: 68-69)

“I just wasn’t me anymore” (Tina: 199-200)

“I don’t think I’ve been the same since before I had him, I feel like a different person”

(Nadine: 342-343)

The theme of ‘loss’ was significant for Jill:

“All your body’s just taken over and that’s such a loss to you” (Jill: 16-17)

Both Jill and Heather convey life changes in terms of loss:
“I didn’t like the fact that I had lost my life as well” (Jill: 11)

“.a lot of what used to really make me feel sad... I didn’t have my horse and I didn’t have my husband, your home isn’t really your own any more and I don’t really pay attention at work any more either, a lot of it’s the whole life change” (Heather: 786-790)

A sense of detachment is conveyed; a disconnection from emotions that leaves the individual feeling lost somehow:

“I felt, as though every.. things weren’t real” (Tina: 170)

“[crying]…. I just thought, ‘This isn’t real,’ it didn’t feel real it felt like a very bad nightmare” (Nadine: 196-197)

“I sort of knew something wasn’t right, I didn’t feel right” (Tina: 184-185)

“I just felt really excluded from everything you know like it wasn’t my body and it wasn’t my baby, [tearful]” (Tina: 255-256)

6.2 Negative self-perception and appraisal

Measuring themselves against societal expectations and their own beliefs of what it means to be a woman, the women evaluate themselves as having failed:

“I felt a bit of a failure really” (Lynn: 532)
“..it’s dreadful...you do feel...[sighs]...very much as though you’ve failed” (Jill: 212-213)

I felt disheartened and disappointed that I hadn’t pushed him out, you know, I felt like, I’d given up somehow” (Nadine: 215-217)

I remarked to Nadine that I was struck by how it seemed that she blamed herself for the problems and viewed herself as failing – she replied:

“Yeh, I still feel like that” (Nadine: 458)

“..it leaves you feeling...inadequate because if its normal you should be able to deal with it” (Jill: 152-153)

The following negative self-evaluations are expressed:

“..its like a little bit of self-preservation that you don’t do it again...you feel quite selfish” (Jill: 203-204)

“..it is a very selfish decision” (Alex: 1025)

“..it was just pathetic” (Alex: 1153)

“..you think...there’s some, basic defect in me...why can’t I do it” (Jill: 199-200)
“I really didn’t want her, at all which, which makes you feel really bad” (Heather: 690-691)

As Tina’s experience does not fit with her schema of femininity and motherhood, Tina is left feeling lacking:

“I sort of felt, like I was less of a woman really” (Tina: 205)

It feels very sad to hear Tina say:

“I thought you know that I was weak, and, you know, I wasn’t a woman, ‘How can I be a proper woman if I can’t cope with something as natural, as childbirth?’” (Tina: 280-282); “I just felt, so ashamed” (Tina: 284-285)

As a result of her experience, Tina has lacked confidence in her own ability to be a mother. Recalling her first morning in the hospital as a mother, Tina recalls:

“I started to I saw the other moms that were washing and dressing their babies so I did the same” (Tina: 174-176)

The work that Tina has done with the psychologist has helped her to gain some confidence:

“I think my confidence grew as well then, in my ability to be a mom because, before that I felt that because of how I was feeling, I couldn’t look after myself let al.,one my daughter” (Tina: 465-467)
For all of the women, their negative self-evaluation will have an effect upon their own happiness and relationships with others. Some express feelings that illustrate the extent to which this will continue to impact upon their lives. Lynn’s fragile sense of self is revealed:

“I think, I think I might actually fall to pieces” (Lynn: 409)

The pause after the first ‘I think’ suggests that Lynn has not actually processed this thought before.

While acknowledging the damaging effect that her decision not to get pregnant again has upon her husband and family, Alex considers how her choice causes upset to those people and asks herself:

“so what does that mean about me?” (Alex: 1060-1061)

7. Implications for family life and relations with others

Secondary tokophobia has a tremendous impact upon the women’s partners and upon their relationships. Not only do their partners have to witness and live with the woman’s distress, anxiety and depression, but they are obviously affected by their partners’ decision not to have another child. In the case of one of the husbands, this is even more significant as he does not have any children of his own. Consequently marital discord is reported in many of the accounts.
Relationships with the children are not discussed explicitly (with the exception of Heather). However with most of the women experiencing depressive symptoms one can speculate on the affect this will have had on the bonding relationship and later attachments. Some of the women hint at the numbness and detachment they felt as their children were born. It needs to be acknowledged how difficult it is to admit to having negative feelings towards your child in a society that sees this as taboo.

The accounts in this study illustrate the far-reaching affects of women’s tokophobia upon extended family and friends. The women in the current study refer to the disappointment from prospective grandparents and friendships that are damaged by avoidance.

7.1 Effect upon husband and relationship

Some of the women talked about the distress caused to their husband as a result of their avoidance of pregnancy:

“..my husband who desperately wants...to have his own child’ (Alex: 1045-1048);
“..causes him a lot of distress” (Alex: 1057)

“[husband] definitely struggled sort of every 6 months... he would get quite depressed” (Alex: 981-982)

“..he’s always wanted to have more than one... so I feel like I’d be denying him a child” (Nadine: 390-391)
“I feel quite guilty, and for my husband because, we’d always planned together you know, that we’d have, you know three children” (Tina: 355-356)

Depression and anxiety inevitably affect close relationships. Detrimental impacts upon marital relationships were reported in this study:

“..we have split up and I don’t know how much of an effect this had on our relationship” (Lynn: 517-518)

“..if he went and picked her up first, before he came to see me I would be furious with him” (Heather: 698-699); “..marriage... before this happened...which were really happy and we really enjoyed...I felt you know she’d sort of stolen him away from me” (Heather: 706-707)

“..we were rowing quite a bit...we ended up we went to Relate” (Alex: 982-984)

“..quite fundamental because it’s hard to watch someone else’s... there’s a lot of guilt because, it’s a decision I made... I can see how much my my decision impacts on someone else” (Alex: 1022-1025) “..we were going through the adoption process because of this” (Alex: 1027-1028); “..we’ve had an awful lot of distress, heartbreaking distress with that [adoption process]” (Alex: 1168)
7.2 Relations with children

Three of the women gave me the impression of feeling disconnected with their child after birth and as all three went on to suffer with depression, I wonder what effect that had upon the bonding process:

“I remember her being born, and I just, you know I just looked down and I just felt really numb” (Tina: 164-165)

“..they took him out of me... they took him out the room” (Nadine: 227-228)

“I held her and she was alright” (Jill: 109)

Through having only the one child, Jill’s relationship with her daughter has been intense:

“the overwhelming feeling of responsibility” (Jill: 123-124); “I think its made my relationship with my daughter very intense” (Jill: 263-264)

No-one described their difficult relationship with their child more graphically than Heather. As the searing pain of labour became unbearable, Heather’s feelings towards the baby inside her changed:

“I decided at that point... that this baby really, wasn’t nice” (Heather: 468-469)

She saw her baby as vicious:

“its going to rip its way out of you” (Heather: 383)
In her imagination the baby became a monster:

“I started imagining her with little demon things and fangs and teeth sort of clawing the way out” (Heather: 470-471)

Her depth of feeling is conveyed as she objectifies and demonises her child in one phrase:

“now this evil thing’s been born” (Heather: 638)

Heather’s feelings towards her newborn child are very negative:

“she’s very hideous looking” (Heather: 569-570); “she felt so horrible to me” (Heather: 574)

Not only did Heather not bond with her baby as she was born, she also conveys feelings of rejection towards her child:

“from the second she was born, erm, I really didn’t want her, at all” (Heather: 690)

As her baby was handed to her she thought:

“Fucking get it off me” (Heather: 570)
Heather realised her responsibility for her child but struggled with the dilemma of her feelings:

“you’ve got to look after it and you don’t want it” (Heather: 638)

Keeping her dilemma secret, Heather’s plea was silent:

“I’ve changed my mind now take her away... I want to go home leave her here”
(Heather: 693-694)

“.from the very first minute of her birth I’m pretending to be a mum instead of, enjoying and actually being one” (Heather: 622-623)

“.because of the birth, I started out hating her from the second she was there, you know, sort of very resentfully” (Heather: 782-784)

Heather also resented the close bond that had formed between her husband and daughter:

“I sort of completely jealous of her” (Heather: 697-698)

7.3 Impact on friends and family life

Two of the women returned to work following childbirth but despite returning to careers that they had both previously enjoyed, they found the experience of work overwhelming and made the decision to stop work:
“..work became a bit of a downhill spiral” (Heather: 744)

“I haven’t been able to go to work” (Tina: 363)

Feelings of isolation and disconnection from others were communicated:

“..no-one had been through anything like I had been through” (Lynn: 349-350)

“Just leave me on my own [laughs] what’s the matter with you all?”

Extended family is also affected by a women’s avoidance of pregnancy and this was communicated in this study:

“Upset and, bit disappointed as well, ‘cos I’d really like, to give them another, grandchild and, but I know that won’t be able to happen” (Nadine: 400-401)

“.ramifications across the whole of my family... it is massive... [husband] had to tell his parents... they’ve got no grandchildren... the disappointment from them has affected [husband] as well” (Alex: 1044-1055)

Because of her avoidance of pregnant women, Tina kept away from both her best friend and her sister-in-law when each was expecting their first child following Tina’s birth experience – she says:
“… that was just an awful time” (Tina: 392); “..then it took time to sort of rebuild, the relationship because, they didn’t really understand… properly why, I wasn’t able to see them” (Tina: 395-398)

Discussion

Hofberg & Brockington’s (2000) study successfully highlighted ‘tokophobia’ as a harrowing condition and introduced it into the medical literature. The numerous articles and interviews within the media in recent years suggest that the topic is of significant interest to the general public. While there can be no doubt about the intense fear experienced by the women in Hofberg & Brockington’s (2000) study, it is noted that all of these women had become pregnant despite their fear.

The aim of the current study was to consider the psychological factors underlying tokophobia – in particular, to explore the experiences of women who actively avoid pregnancy and childbirth. People who have phobias either avoid the situations they fear or are intensely anxious in them (Palmer & O’Broin, 2008) – the existing literature has focused upon women who are intensely anxious during pregnancy and childbirth but to date has neglected to research the group of women whose ‘coping’ strategy is to avoid what they fear.

Having engaged with women who present with ‘secondary tokophobia’ and having analysed their interviews, the researcher has pondered the usefulness of the term ‘phobia’ for those women presenting with avoidance after a traumatic delivery. The British Psychological Society’s (BPS) guide on phobias (Palmer & O’Broin, 2008) defines ‘phobia’ as an extreme ‘irrational’ fear that most people would not fear. An
internet ‘Google’ search of definitions of ‘phobia’ also yields the descriptor ‘irrational’, along with ‘unreasonable’, ‘unrealistic’ and ‘illogical’. It could be argued that there is nothing illogical or irrational about the fear expressed by the women in the current study who have experienced a traumatic birth. Most people who had perceived such trauma would fear, and want to avoid, repeating the experience.

More recently Hofberg & Ward (2007, p. 167) comment on the use of their term ‘phobia’ as applied to women who have experienced a traumatic birth:

“Mothers and doctors alike will challenge the idea that tokophobia secondary to childbirth is indeed a phobia. Both may suggest that the fears could be reasonable and therefore not a phobic state. However, the psychological manifestation remains one of extreme anxiety and avoidance.”

The psychological manifestation for these women is indeed one of extreme anxiety and avoidance, and all of the women in the current study display symptoms associated with post-traumatic stress. Other groups who are classed as experiencing PTSD are not told that they have a ‘phobia’ or, to quote Hofberg & Brockington (2000), ‘an unreasoned dread’. It therefore seems unreasonable to label women who fear and avoid childbirth following a traumatic birth as ‘phobic’, therefore a re-classification or redefinition of the term ‘secondary tokophobia’ could be helpful.

Themes elicited within the current study support those in the existing literature. The theme ‘lack of acknowledgement’ is a significant theme within the current study and adds to current knowledge and understanding. A diagram which illustrates the superordinate themes is shown below in Figure 1. Discussion of the themes will follow.
Physical and Mental Distress

This theme is specifically connected to the women’s experience of childbirth and hospital. While anticipation of pain is a documented antenatal fear (Melender & Lauri, 1999; Sjogren, 1997), it is only within the last five years that a handful of studies have considered women’s experience of pain in labour. Pain in the current study is expressed: “Excruciating” (Alex: 196); “incredible pain” (Tina: 114); “I was, in terrible pain” (Nadine: 86); “agony” (Jill: 80); “dragging out your internal organs and setting fire to your thigh bones” (Heather: 513-514). Pain in labour has been associated with the development of PTS symptoms and PTSD (Ayers, 2004; Soet et al., 2003).
Ayers (2004) reports that the type and effectiveness of analgesia has some bearing on the development of PTS symptoms. Pain relief, or rather the lack of effective pain relief was a feature of the theme of pain in the current study. The women all sought analgesia: “give me painkillers give me more and more, give me all the drugs” (Lynn: 58-59). Yet all of the women reported either ineffective pain relief: “that didn’t make any difference at all” (Nadine: 63) or in some cases they were denied analgesia: “It’s far too late you can’t have anything now” (Alex: 276).

Earlier studies reported fear of dying in childbirth as an antenatal fear (Szeverenyi et al., 1998; Sjogren, 1997), but it was only recently that thoughts of dying in childbirth were reported as an experience of some women in labour and as associated with the development of PN PTSD (Ayers, 2007). Women in the current study expressed that they had thought that they would die during childbirth: “Actually I thought I was going to die” (Nadine: 65); “Oh, I’m actually going to drown now” (Heather: 444-445); “I really thought I was, I could’ve died” (Jill: 114); “Oh my God how am I alive?” How come I just haven’t…” (Lynn: 80-81).

Ayers (2004) reports that blood loss is also associated with the development of PTS. Again this factor features significantly within the current study with several of the women expressing their shock at the level of their blood loss: “I just bled, it was all down my legs” (Alex: 391); “you’re all stitched up, and you’re all bleeding from everywhere” (Jill: 117-118); “I was just bleeding really profusely… pouring out of me” (Lynn: 76-77); “when I was going to the toilet I was, losing a lot of blood” (Nadine: 81).
Modes of delivery and obstetric procedures / interventions have been associated with the development of PTS (Olde et al., 2006; Ayers, 2004; Soet et al., 2003). Two of the participants in the current study had their babies delivered by emergency CS; one had a painful induction of labour (against her wishes); two reported extensive stitching: “I had stitches up my bum, it was a complete tear” (Alex: 539). Soderquist et al., (2002) argue that normal vaginal deliveries can also lead to PTS. In Beck’s (2004i) qualitative study, participants often reported that they perceived that their traumatic births were viewed as routine by clinicians. The current study reveals that this was the case for some of the women: “... the birth, which wasn’t traumatic apparently...was just described as like normal [slight wry laugh]” (Jill: 9-11); “..from the midwives point of view... ‘obviously she’ll be really happy with this she’s got to have this fantastic, natural birth’ ” (Heather: 535-538). Beck (2004i, p.28) argues that it is the woman’s perception of trauma that is important and says, “birth trauma lies in the eye of the beholder.”

Czarnocka & Slade (2000) suggest that it is the distress linked to the pain that leads to the development of PTS symptoms and PTSD. More recent reports substantiate the argument that emotional distress during labour is a predictor of PTS symptoms (Ayers, 2007; Olde et al., 2006). Certainly the women in the current study expressed emotional distress in connection with their painful ordeal: “I was in such a mess and I was hyperventilating” (Alex: 255); “I was really panicking” (Heather: 518); “I was erm hyperventilating” (Tina: 138). The feeling of disbelief at the gravity of their pain was powerful: “I was just so stunned” (Jill: 106); “Shell-shocked” (Nadine: 249); “I just remember really you know shaking and I felt a bit shocked” (Tina: 168-169). Considering the DSM-IV criteria for PTSD it can be seen that the women in the
current study appear to fulfil the first criterion in that they sustained injury and intense pain with perceptions that their lives were at risk.

Themes that were elicited from Beck’s qualitative research include ‘the need for answers’ (2004ii) and ‘lack of communication’ (2004i). These themes are reflected in the current study with the subordinate theme of ‘lack of explanation’. The women report a lack of explanation during pregnancy and childbirth that added to their mental distress: “Now you don’t know what’s coming, no you don’t know how bad its going to be and you don’t really know, you know, what’s going to happen or what they’re going to do about it” (Heather: 344-346). This lack of explanation from medical professionals extended to general negative experiences of hospital. Low support in labour, both by professionals and partners, is associated with the development of PTS (Ayers, 2004; Beck, 2004i). Women in the current study report several types of negative experience:

**Abandonment:**

“*but no-one had actually looked in at any stage*” (Alex: 237)

**Disregarded**

“*I felt as if, you know I was being ignored*” (Tina: 238-239)

**Need for partner**

(All of the women had supportive partners, but in some cases the partner was sent home and the woman was left to labour alone).

“*[crying] I felt very scared and nervous and lonely because I wanted him with me all the time*” (Nadine: 183-184)
Lack of empathy and support from staff

“I just remember them shouting across the room to breathe properly”

(Tina: 131-132)

Hostility from staff

“she just came into the cubicle, slammed her bag down on the floor, and you know, just examined me as though, I was just a big inconvenience” (Tina: 84-86)

Lack of privacy

“one of the big things that I found, quite.. traumatic and humiliating really was being on the main ward with just a curtain around me and, you know other people’s visitors and everything” (Tina: 60-63)

Lack of consistency of care

“I didn’t see the same midwife, at any point” (Alex: 1279-1280)

There is no doubt that the negative experiences of hospital that the women report had a detrimental effect upon them.

Need for Acknowledgement

The theme of ‘acknowledgement’ has not been picked up in the existing literature, but is a significant feature in the current study. Several of the women expressed that they felt that their suffering had not been recognised: “I didn’t feel as though anybody ever acknowledged what a huge and traumatic thing it was” (Jill: 161-162). Jill had experienced a trauma and was feeling “shell-shocked” (141) and yet others around her were nonchalant, regarding the event as ‘normal’ (11). It is little wonder then that Jill became “post-natally deranged” (18).
Not only did the women have little or no acknowledgement of their suffering, but in some cases this was disputed: “they didn’t believe that I was in any pain” (Tina:107-108). Tina fought back tears at the recollection of this painful memory. Jill’s personal account of her experience as “the most horrible experience I’ve ever had” (130) was denied and disputed when her doctor responded with “No, no it was fine” (131). Having their perceptions challenged or dismissed intensified the suffering: “[cries], wondering you know, ‘If this isn’t labour you know how am am I going to cope with labour?’… erm.. and just really feeling you know really anxious” (Tina: 115-116). Reflecting after the event, the women recognise that validation of their accounts is very important: “it was good for me to talk about it again... otherwise it just gets forgotten” (Lynn: 577-578). Jill comments on the need for ‘childbirth as a traumatic experience’ to be recognised as a reality for some women, saying it would be, “great if… it was just acknowledged, that for some people it is like this” (Jill: 295-296).

**Enduring Distress**

Part of the enduring distress for the women in the current study is their fear and consequent avoidance of pregnancy and childbirth. In Melender’s (2002) study in which 78% of the women expressed a fear of childbirth, a reported cause of the fear for parous women was a previous negative experience of childbirth. The women in the current study differ in that their fear is so significant as to prevent them becoming pregnant. While the current study highlights the intensity of the women’s fear in that they avoid a further pregnancy, it is not understood why women in previous studies have chosen to go ahead with pregnancy despite their fear. This will be highlighted as a need for further study.
Ryding et al., (2007) investigate the association between personality and fear of childbirth by comparing the responses of self-reported questionnaires of pregnant women who sought help for their fear of childbirth, with a control group of pregnant women from routine antenatal care. The researchers reported that the index group described themselves as significantly more anxiety-prone than the control group; this correlated with the index group reporting a more negative experience of birth one week after the event. Zar et al., (2001, p.75) reported “fear of childbirth comprises a considerable part of trait anxiety, with the risk of a vicious cycle,”; in other words, that during labour women experience what they are afraid of, which also influences the women’s postpartum cognitive appraisal of the delivery. Unfortunately little is known about trait anxiety in the current group as this was not investigated. However, research speculates the existence of trait anxiety for women who present with fear of childbirth following a traumatic birth. For the women in the current study, trait anxiety may have been present prior to their birth experience or it could be that the birth experience led to a development of trait anxiety. As indicated in Table 3 below, all of the women in the current study report ‘triggers’, which is further evidence of the existence of trait anxiety. The triggers prompt state anxiety, which causes unpleasant physiological symptoms as well as serving to feed and maintain underlying trait anxiety.

Five of the women in the current study report symptoms of postnatal depression, four of them were treated with anti-depressants: “I wasn’t going out I couldn’t, I felt that I couldn’t cope with anything” (Tina: 422-423). The DSM-IV (APA, 1994) classifies symptoms of PTSD into three clusters:

- Re-experiencing: flashbacks; nightmares; intrusive thoughts;
• Avoidance and numbing: avoiding reminders; feeling emotionally numb and detached;

• Arousal: increased startle response; irritability; anger.

The women in the current study report experiences from each category, almost across the board; this is illustrated below in Table 3. It is worth noting that the women were not assessed for posttraumatic stress symptoms during the interview and were not asked direct questions alluding to symptoms. As the women volunteered information during exploration of their experiences, it is possible that they experienced more symptoms than is revealed in the interview. A key to symptoms is included after the table.

Table 3: Incidence of PTSD symptoms in the PTS group

<table>
<thead>
<tr>
<th></th>
<th>Re-experiencing</th>
<th>Avoidance + numbing</th>
<th>Arousal</th>
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<tbody>
<tr>
<td>Lynn</td>
<td>FB / NM</td>
<td>AR / EN</td>
<td>ISR / IR / AN</td>
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<tr>
<td>Jill</td>
<td>/</td>
<td>EN / D / AR</td>
<td>ISR / IR / AN</td>
</tr>
<tr>
<td>Heather</td>
<td>FB / NM / IT</td>
<td>AR / EN / D</td>
<td>ISR / IR / AN</td>
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<tr>
<td>Alex</td>
<td>FB / NM</td>
<td>AR</td>
<td>ISR</td>
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<tr>
<td>Nadine</td>
<td>FB / NM</td>
<td>AR / EN</td>
<td>ISR / IR</td>
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<tr>
<td>Tina</td>
<td>FB / NM / IT</td>
<td>AR / EN / D</td>
<td>ISR / IR / AN</td>
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Key to Table 3:

Re-experiencing:

FB = Flashbacks; NM = Nightmares; IT = Intrusive Thoughts

Avoidance and Numbing:

AR = Avoiding Reminders; EN = Emotionally Numb; D = Detached

Arousal:

ISR = Increased Startle Response; IR = Irritability; AN = Anger
Examples of PTSD symptoms in this group include: “[sobs, gasps for breath] whenever I see it that little blue romper suit, it’s a real [gasp] trigger still, well even talking about it” (Lynn: 592-594); “I avoid erm pregnant women, erm, mainly because it brings back, the memories of my own experience” (Tina: 346-348); “I feel very, scared and anxious and worried all the time and on edge” (Nadine: 346).

These findings support Beck’s (2004ii) study which elicited themes of ‘Flashbacks and intrusive memories’ and ‘Downward spiral of anger, anxiety and depression’. Medical professionals and the public are aware of postnatal depression and health visitors and GPs routinely screen for it within weeks of childbirth. However there is no such screening for PTSD and many distressed women are being misdiagnosed, treated for postnatal depression rather than PTSD. It is significant that all of the participants have displayed symptoms of PTSD and yet none of them were treated for this, and many of them have been treated with anti-depressants which will not address the issues of PTSD.

Ayers (2004) states that childbirth differs from other traumatic events in that it is broadly predictable, is usually entered into voluntarily, is viewed positively by society, and can include positive aspects. It can be argued that this intensifies the anxiety felt by women who experience a traumatic birth, as they compare themselves unfavourably with other women, an effect that will be considered later.

Implications for family life and relationships
Even without taking into consideration the debilitating effects of depression and anxiety, for women who avoid pregnancy and childbirth because of intense fear this
can have a devastating effect upon their relationships with others. The BTA (2005) report that women can feel detached from others and relationships with friends and family can deteriorate. This is partly due to society’s lack of understanding of the psychology of childbirth and the expectation that mothers should quickly get over their childbirth experiences (BTA, 2005). Feelings of isolation and disconnection from others were communicated in the present study: “no-one had been through anything like I had been through” (Lynn: 349-350). Tina illustrates how close relationships can be damaged by this fear and avoidance: “then it took time to sort of rebuild, the relationship because, they didn’t really understand... properly why, I wasn’t able to see them” (Tina: 395-398).

Fear of childbirth often leads to the avoidance of sexual intimacy, which has obvious implications for relationships. Ayers, Eagle & Waring (2006) conducted a qualitative study with six women who presented with PN PTSD. Two subthemes arose when exploring the effects of PN PTSD on the women’s relationship with their partner: ‘support’ and ‘strain on the relationship’. In the current study the notion of ‘support’ was not focussed upon. Three of the women talked about their husbands being supportive; interestingly these same women gave the impression that they were content within their relationships.

In the current study, women’s accounts of relationships with their partners indicate ‘strain on the relationship’. Two of the women in the current study separated from their partners within two years of the birth: “we have split up and I don’t know how much of an effect this had on our relationship” (Lynn: 517-518). Alex remarried a few years later but reports discord in her relationship with her husband as a direct
result of her avoidance of pregnancy: “we were rowing quite a bit... we ended up we went to Relate” (Alex: 982-984). Jill recalls there “were arguments about anything” (Jill: 283).

Ayers, Eagle & Waring’s (2006) study also revealed that the mother-baby bond was affected. Three subthemes were elicited in relation to the women’s relationships with their child: ‘Differences in attachment’, ‘Early feelings about the child’, and ‘Later feelings about the child’. Again, these themes are reflected in the current study. As in the earlier study, avoidant attachment is expressed: “you’ve got to look after it and you don’t want it” (Heather: 638), as well as overprotective attachment: “I think it’s made my relationship with my daughter very intense” (Jill: 263). Feelings of rejection and disconnection were reported: “from the second she was born, erm, I really didn’t want her, at all” (Heather: 690); “I remember her being born, and I just, you know I just looked down and I just felt really numb” (Tina: 164-165). On reflecting upon therapy, which continued for two years after the birth of her daughter, Tina hints at the difficulties she experienced with regard to bonding with her child: “I think my confidence grew as well then, in my ability to be a mom because, before that I felt that because of how I was feeling, I couldn’t look after myself let alone my daughter” (Tina: 465-467). Relationships with children were not investigated directly in this study. While the impression was given that all the women had resolved their earlier more negative feelings towards their children, it is not known to what extent this has impacted upon the child’s development and attachment to their mothers.
‘Lack of control’ is cited as a risk factor for PTS (Olde, 2006; Ayers, 2004), and is a theme elicited in Beck’s (2004i) qualitative study of women who had experienced a traumatic birth. All of the participants report perceptions of losing control: “and I just felt, [tearful] like erm... completely out of control, and, like I couldn’t cope with, I just couldn’t cope with it at all but I couldn’t stop it [cries]…” (Tina: 134-436).

There appears to be something about the involuntary nature of the contractions that left some of the women feeling out of control: “contractions which were, horrendous with this pure fact that I couldn’t stop them happening and I had no control” (Alex: 291-292). A sense of being overwhelmed by the loss of control is conveyed: “…the feeling that erm, I was sort of taken over by it” (Jill: 4-5). Kitzinger (2006) indicates the debate around the term ‘control’ as applied to childbirth. She makes a very interesting point:

“How can you be in control of an elemental force any more than you can control the tides of the sea and the blowing of the wind? A woman who plans to have control over the power of her uterus faces disappointment.”

[Kitzinger, 2006, p.12]

The futility of ‘fighting’ the contractions is illustrated by Alex who tore extensively as she delivered her baby: “I was writhing around, trying to, stop it” [Alex: 893-894]. Despite her ordeal, Heather’s account of the delivery of her daughter illustrates how the process can be more productive when one works with the contractions rather than try and resist them: “you now have like a role and purpose in it... you think, I can really push, I can make this over really quickly” (Heather: 547-500). Kitzinger (2006) advocates that accurate information regarding the nature of labour pain needs to be communicated and women need to be ‘in touch’ with the pain, rather than running away from it – this would allow the woman to feel that she was in control rather than
being under attack. There is something about ‘losing control’, for both groups of women, that is extremely disturbing for them; ‘horrendous’ and overwhelming. This fear of losing control is an issue that could be explored in therapy.

All of the participants reported feeling at the mercy of others who were perceived to have control over them. Oakley (1980) attributes this loss of control to medical technology and the ‘takeover’ by ‘experts’. Kitzinger (2006, p.12) refers to this as ‘active management of labour’ which she reports is: “a system aimed at achieving vigorous obstetric control of labour and birth.” She claims that this practice was introduced in the 1960s and has spread around the Western world. Kitzinger (2006) states that it is common practice in hospitals to artificially rupture the membranes (break the water), induce labour while often providing fragmented, and sometimes chaotic care. She argues that when this is combined with powerful drugs designed for abortion and haemorrhage, continuous fetal monitoring and being tethered to machines, a woman has all control taken from her. Consequently “Childbirth becomes torture” (Kitzinger, 2006, p. 13). Women in the current study experienced this sense of being taken over: “despite saying I didn’t want to be induced... there was no you know, immediate risks to the baby I still had to be induced” (Tina: 595-598); “I had that strapped round my chest... I couldn’t walk around with that strapped on me” (Nadine: 104-106); “Sedate her again” (Lynn: 134). Kitzinger (2006) suggests that the concept of control needs to extend to being able to opt between alternatives, rather than being given obstetric ultimatums, and that women need to have control over the environment in which their labour is taking place.
The current study did not establish why some women perceived a loss of control during a seemingly ‘uncomplicated’ vaginal delivery. While many vaginal deliveries are described as ‘uncomplicated’ within the norms of institutional practices, this does not mean that the women experience the kind of control that would support them. This is an area that warrants further exploration.

**Expectations**

Ball (1993) argues that the way in which a woman responds and adjusts to becoming a mother is affected by her expectations and experience of the events of childbirth and motherhood. Violation of expectations is associated with a severe traumatic stress response (Ayers, 2004). The women in the current study had held positive expectations of childbirth prior to the event: “I certainly wasn’t fazed... I wasn’t that worried” (Lynn: 560-561); “it’ll all be fine” (Heather: 66). However, expectations did not match the reality of childbirth: “it was a lot worse than I ever thought it could be” (Nadine: 38-39).

The women expressed what they perceive to be societal views and expectations of childbirth: “something a woman just does” (Lynn: 529); “subliminal messages... all this conditioning, you must be able to cope” (Jill: 214-216). This supports the argument made by Eriksson, Westman & Hamberg (2005) that pregnant women are exposed to, and affected by normative perceptions of what it is to be a woman and expectant mother.

It was no surprise that the women were influenced by societal ‘norms’ in this way. Experiencing childbirth in contrast to expectations expressed as the ‘norm’ left the
women feeling threatened and ashamed. It is interesting to speculate as to what perpetuates these ‘norms’. It would seem that in wider society expectations of childbirth are expressed as extremes; either in terms of ‘gore’ (perpetuating the tale of horror) or as the rosy ‘ideal’ images that Nadine referred to in the glossy magazines.

Two of the women convey feelings of having been misled, or duped by others into believing that the whole experience would be positive. Heather had attended childbirth preparation classes with the National Childbirth Trust (NCT) and conveys a sense of frustration with them for presenting her with a positive view of childbirth: “I also think that, they’ve got a beautiful view of, of childbirth that isn’t…” (Heather: 589-590). Jill remarks: “nobody sort of levelled with me” (Jill: 167), a sentiment that is echoed by Heather: “… which is why I felt so disappointed if somebody had been, honest, you know, it’s going to hurt like hell, bear in mind you probably will want some drugs…” (Heather: 591-593). Violation of expectations does seem to play a crucial part in women’s evaluation of childbirth. There is an example here of a woman who was ‘prepared’ for a natural childbirth, but she found the experience of pain to be so overwhelming that it left her feeling shattered. In contrast other women in the study have been at the mercy of medical intervention and experienced a stripping away of control. Expectations not being met appear to lead to the distress that is experienced by the women in the current study. Maybe women’s expectations could be more balanced and realistic if they receive unbiased information regarding childbirth, have true choice regarding analgesia and procedures, and as Kitzinger (2006) suggests, control over the environment in which they choose to birth.
In Beck’s (2004ii) qualitative study of women’s experience of traumatic birth, she argues that the women’s dreams were shattered as they became isolated from, “the coveted world of motherhood” (Beck, 2004ii, p.222), which destroys hopes and expectations of motherhood. This was also found in the current study: “it felt quite weird because, in magazines and on television you always see the mother holding the baby after the birth but I didn’t” (Nadine: 236-238). Perhaps most disappointing of all for Heather is the mismatch between her expectations of greeting her newborn child: “I was really, really looking forward to meeting her, I really was” (Heather:167), with the reality: “but neither did I think that I would hate her and I would be terrified of her and really wouldn’t want to be with her” (Heather: 738-739).

The beliefs of the women in this group run deep and they hold an array of ‘evidence’ that childbirth is horrific and something to be feared. This is where counselling psychology can be beneficial. CBT and EMDR can be used to challenge evidence and reframe cognitions, and narrative therapy could be useful in exploring the concepts and creating new, healthier narratives. In addition to CBT and EMDR which are the recommended treatments for trauma, counselling psychologists offer other effective therapies. Attachment-related approaches, such as psychodynamic, might also be of benefit in addressing the relational aspects of the experiences, and person-centred approaches could be powerful in achieving the validation and internal locus of control that is missing.

**Continuing dilemma**

Memories of childbirth, which is a fundamental and supposedly joyous life-event, are blighted for the women in the current study: “Bloody awful” (Lynn: 341); “the actual
birth was just vile” (Jill: 37). These negative memories serve as a constant reminder of their trauma and for some these memories continue to cause them distress:

“natural birth... its left huge dents in me” (Heather: 595); ”What I can’t get past is the birth thing... but I just can’t” (Alex: 1120-1121).

Fear of childbirth leads all of the women to actively avoid pregnancy: “I must make damn sure that that never happens to me again” (Jill: 155-156); “I can’t kind of contemplate... there’s the whole birth... I just I can’t even I won’t I won’t go anywhere near that” (Heather: 886-888). As all of the women would like to add to their family, this avoidance causes them an on-going dilemma: “it’s a kind of a ‘Catch-22’ situation... I really want another baby, and you know I just don’t feel that I can” (Tina: 526-527).

The researcher has not located any studies that detail the effects of this dilemma and feels that it is an area that has been overlooked. It is an important issue as the dilemma causes on-going distress for the women and their partners. For some women, such as Jill in the current study, not overcoming their dilemma leaves them with feelings of regret and sadness later in life. It is certainly an issue that deserves recognition and awareness by psychologists and other healthcare practitioners.

Implications for self

Both ‘loss of self’ and ‘negative self-perception and appraisal’ are powerful subordinate themes elicited in the current study. In exploring women’s experience of traumatic birth, Beck (2004ii) also elicited a theme of ‘loss of self’. Eriksson et al., (2005) reported that ‘Exposedness and Inferiority’ is associated with fear of childbirth
and had the greatest explanatory power in the women they surveyed. They conclude that; “disparaging feelings about oneself could be an effect of experiencing intense fear” (Eriksson et al., 2005, p.69). Women in the current study all expressed disparaging feelings of self. Feelings of failure and inadequacy were conveyed: “I felt a bit of a failure really” (Lynn: 532); “it leaves you feeling... inadequate because if it’s normal you should be able to deal with it” (Jill: 152-153). Tina’s sense of inadequacy is conveyed as she compares her self-perception with her schema of what it means to be a woman and mother: “I thought you know that I was weak, and, you know, I wasn’t a woman, ‘How can I be a proper woman if I can’t cope with something as natural, as childbirth?’” (Tina: 280-282). The findings of the current study support those from earlier research that make a link between disparaging feelings of self with ‘shame’ (Eriksson et al., 2005). Themes elicited in the current study suggest the women compare themselves unfavourably with cultural and social attitudes to childbirth and motherhood, which consequently leads to low self-esteem and feelings of isolation from others.

‘Loss of self’ was powerfully conveyed in the current study: “you’re just not the same, not the same person” (Jill: 118-119); “I just wasn’t me anymore” (Tina: 199-200); “I feel like a different person” (Nadine: 343). Loss was also expressed in terms of the change in lifestyle: “I didn’t like the fact that I had lost my life as well” (Jill: 16-17); “a lot of what used to really make me feel sad... I didn’t have my horse and I didn’t have my husband, your home isn’t really your own any more and I don’t really pay attention at work any more either, a lot of it’s the whole life change” (Heather: 786-790). The current study adds to existing literature in that
negative experience of, or fear of lifestyle changes has not been previously investigated in connection with avoidance of childbirth.

Due to the lack of research in this area, the researcher has looked towards psychosocial transition theory as a way of helping to make sense of understanding ‘life events as processes’ (Sugarman, 2001), as applied to women who avoid childbirth. Pearlin (1980, cited in Sugarman, 2001) argues that the life course can be viewed as a “continuing process of adjustment to external circumstances.” Adult life can be seen as a continuing process of coping with internal and external events and non-events. It is useful for counselling psychologists to consider how people typically respond to stress or major upheaval in their lives and also how they make sense of their experiences.

A transitional perspective on life-span development focuses on life events entailing change (Schlossberg, N.K., Waters, E.B. & Goodman, J., 1995). This perspective gives a general structure for understanding how people manage transitions and change while allowing for different individuals and different transitions. Sugarman (2001) points out that it is argued that such upheavals trigger a relatively predictable sequence of responses and feelings, known as the ‘transition cycle’. The researcher suggests that a transition cycle can be a helpful guide to understanding clients’ experiences, in much the same way as a ‘cycle of grief’ is useful in bereavement therapy. A particularly useful model is a seven-phase model of stages that accompany transition, which Sugarman (2001) has adapted from Hopson (1981, cited in Sugarman 2001, p.144). The model is replicated and included in Appendix 22. These seven phases represent a generally recognisable sequence of responses accompanying
a wide range of transitions. This cycle is recognised as generalisable; not everyone’s response to change follows an identical path. In particular, there will be differences in response according to whether the change is desired or not, resulting in the two alternate paths outlined in phase two of the model.

The transition cycle is set in motion when any event, or non-event, “results in changed relationships, routines, assumptions, and roles” (Schlossberg et al., 1995, p.27). With regard to the current study the various stages are outlined below:

1. **Immobilisation** - occurs following childbirth. This stage is characterised by a sense of being overwhelmed.

2. **Reaction** – during this stage the sense of shock gives way to feelings of either elation or despair, depending on the nature of the transition and its evaluation. For a negative event the mood shifts from anything from slight disappointment to despair. Over time the initial post-shock reaction is most often followed by some form of minimisation. For example the situation may be reassessed as being less dire than was originally thought. However, for those women who continue to experience symptoms of post-traumatic stress beyond childbirth, it is likely that minimisation does not take place and they either get ‘stuck’ at this stage in the cycle with feelings of despair or move to ‘self-doubt’.

3. **Self-doubt** – Sugarman (2001) states that the boundaries between the phases of the model are not distinct. She argues that with negative events, the minimisation phase may not be noticeable and the individual might seem to pass directly from despair to self-doubt. This dip in mood is associated with the growing realisation of the reality of the changes in one’s life space.
(Sugarman, 2001). This can be seen clearly in Jill and Heather’s accounts outlined above. Originally this third phase was labelled ‘a period of depression’ but this was altered to self-doubt (Hopson, 1981, cited in Sugarman, 2001) following realisation that depression was not the only response during this stage. Self-doubt might also be manifested in other ways, such as anxiety, anger, or sadness (Sugarman, 2001).

The symptoms of PTS that are experienced by the women in the current study suggest that they may be at this stage in the transition cycle. It could be argued that they are ‘fixed’ or ‘stuck’ somewhere between stages two and three of the cycle and as yet, are unable to pass through the remaining stages.

4. Accepting reality and letting go – until this point the individual has still been attached to the past in a way that inhibits her from moving forward. The reality of the change must be accepted and the hold on the past needs to be loosened (Sugarman, 2001). The process of ‘letting go’ can be traumatic; it marks an emergence from the experience and a commitment to face the future (Sugarman, 2001). It is at this point that therapy could be helpful in assisting the person to move forward.

Sugarman (2001) remarks that letting go undoubtedly requires courage and inevitably involves a plunge into the unknown. Bridges (1980, p.11) suggested that transitions actually begin with an ending: “We have to let go of the old thing before we can pick up the new.” From this perspective, ‘letting go’ is the first part of a transition, rather than the midpoint.
5. *Testing* – described as an experimental period during which we can begin to explore alternative ways of being.

6. *Search for meaning* – Sugarman (2001) describes this phase as a conscious striving to learn from the experience; a cognitive phase during which people seek to make sense of what has happened to them. It is a healthy form of reflective thinking without which the individual would not be able to develop a deep understanding of the meaning of the change in her life.

7. *Integration* – the completion of the transition process. New behaviours that have been acquired, the new self-conceptions, and understandings of events have become an integral part of the person’s view of the world. The transition has become integrated into the person’s life and no longer dominates it (Sugarman, 2001).

By considering a transitional perspective, the counselling psychologist can help facilitate understanding of the various stages of the cycle and enable women to explore their issues within this framework.

**Research Issues Arising from the Study**

The majority of the interviews were conducted within a period of less than four months and so some interviews had not been transcribed before the next interview was conducted. However, in line with the idiographic approach of Interpretative Phenomenological Analysis (IPA), the transcripts were analysed one by one, enabling an intensive and detailed engagement with individual cases. In addition, notes were made and significant points were highlighted following each interview. For example although Lynn, the first participant, was not asked about interventions that may have been helpful to her, she talked about a debriefing session and group support that she
had received, which prompted the researcher to ask about interventions in subsequent interviews. True to IPA principles, the questions were open-ended thus allowing an exploration of the participant’s life-world. This was further enhanced by the researcher’s training as a Counselling Psychologist – therapeutic skills were utilised to draw out aspects of the participant’s experience.

Data collection for IPA is usually based on purposive sampling, whereby participants are selected according to criteria of relevance to the research question (Willig, 2001), in this case fear and avoidance of childbirth despite wanting a child. There is a homogenous sample of participants within the current study. The advantage of this is it allows for a generalised understanding of the phenomenon. A limitation in this study however, is that the group could be said to be too homogenous. All of the participants are white, mostly well-educated, all in stable relationships and appear to be living comfortably, not in poverty. All of the women initiated contact with the researcher after becoming aware of the study, six of whom did so through the Birth Trauma Association (BTA). It could be argued that the women in the sample are all motivated to enhance understanding of avoidance of childbirth and to make changes for themselves. The findings are therefore limited in that they cannot be generalised to the whole population as no account was taken of cultural difference or low socio-economic background.

The researcher had decided not to take a measure of current anxiety as it was felt that this would not add to the data. However, as analysis progressed it became clear that it would have been useful to have more knowledge regarding the participant’s past, in particular any previous episodes of depression or anxiety. The researcher did ask
some of the participants if ‘they had felt this way before’, but this is insufficient and a questionnaire based on past experiences would have enhanced the data. In line with the existing research it would have been interesting to see if the participants in the current study had trait anxiety. Similarly the researcher failed to investigate the presence (or absence) of pre-existing fears and phobias, such as fear of needles.

Although links with sexual abuse and eating disorders had been made (Hofberg & Brockington, 2000) the researcher made a conscious decision not to take up this line of questioning due to ethical consideration. Due respect was paid to the fact that these participants were taking part in a ‘one-off’ interview and were not in continuous therapy; it was therefore deemed unethical to unearth difficult emotions that could not be followed up.

While a question was asked regarding relationships with ‘others’, the researcher did not ask specifically about the nature of the relationship with the child. Some of the women talked about their child although without focus. In light of the existing literature regarding bonding issues, this was a shortcoming with regards to the current study. Another limitation is that little consideration was taken regarding current support systems surrounding the women.

**Summary and Conclusion**

The participants in the study presented with fear and avoidance of childbirth following a traumatic birth, a condition that Hofberg & Brockington (2000) termed ‘secondary tokophobia’. Violation of expectations led to the enduring distress that the women experience, which manifests as symptoms associated with post-traumatic
stress (PTS). This enduring distress has implications for the women’s sense of self and affects their relationships with others. As the presentation does not appear to fit with definitions of ‘phobia’, reclassification of ‘secondary tokophobia’ is proposed.

The theme of ‘need for acknowledgement’ adds to the existing literature. A concern about ‘loss of control’ was a powerful theme for all participants and supports the current literature. The ‘loss of self’ was a powerful theme elicited in the current study and supports earlier research (Beck, 2004ii). Difficulties adapting to changes in lifestyle were expressed, an issue that does not appear to have been researched in connection with women who fear and avoid childbirth. A seven-phase transition model was suggested as a way of explaining and understanding the difficulties faced by women with regard to changes in identity and lifestyle.

The current study advocates an increased awareness in psychology literature of the affects of the dilemma of fear and avoidance of childbirth upon women and their families. Recommendations are made for counselling psychologists to work within a consultancy model as part of multidisciplinary teams within primary care settings, as well as offering therapeutic interventions to women who present with fear and avoidance of childbirth.

Trauma-focused CBT and EMDR are effective treatments for women who present with PN PTSD. Narrative Therapy is suggested as an additional intervention for all women who present with fear and avoidance of childbirth, as a way of exploring underlying issues and concepts of ‘self’ and ‘change’. Person-centred approaches are recognised as having the potential for women to achieve validation and an internal
locus of control, and attachment-related approaches such as psychodynamic might also be of benefit in addressing the relational aspects of the experiences.

**Service Implications and Recommendations for Therapeutic Practice**

A 2006 review (Ayers, Claypool & Eagle) of postnatal services revealed that services for women who have had a difficult birth consist predominantly of debriefing, despite the fact that the NICE guidelines (2005) advocate *against* its use. Horsch (2008) argues that there is a lack of clear referral pathways, lack of prioritisation of these women in existing mental health services and a lack of expertise in relation to the special needs of this population. The researcher agrees with Church & Scanlon’s (2002) recommendation of the need for a clear definition and systematic evaluation of debriefing and clear guidelines for the referral of women to specialist psychological services. Bewley & Cockburn (2002) highlight the need for the provision of multidisciplinary services for individualised assessment and planning, and suggest that psychologists could lead initiatives to train others to screen, offer simple therapy or make referrals. Counselling Psychologists are well placed to offer this kind of consultancy work which could also involve offering supervision to other practitioners, thus working collaboratively. The (2007) NICE guideline on antenatal and postnatal mental health recommends the development of:

“a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services” [DoH, 2007, p.9]

However, currently there are few perinatal services within the UK (Horsch, 2008) and meanwhile there is no current recognition or recommendations for interventions for women with tokophobia.
Women with post-traumatic stress (PTS) symptoms following childbirth need to be recognised as experiencing anxiety and referred for treatment accordingly. Women could be routinely screened for PTS postnatally by health visitors or GPs at the same time as being screened for postnatal depression. Health practitioners in primary care and psychologists within mental health settings need to be aware of postnatal PTS (PN PTS) and postnatal post-traumatic stress disorder (PN PTSD). The treatment of choice for PTSD (NICE, 2005) is trauma-focused Cognitive Behavioural Therapy (CBT) from 1-month post-trauma and trauma-focused CBT or Eye Movement Desensitisation and Reprocessing (EMDR) 3-months post-trauma. Counselling Psychologists are well placed to offer these treatments.

While CBT and EMDR are appropriate treatments for symptoms of trauma, Narrative Therapy could be a useful intervention for helping women who avoid childbirth to explore aspects of ‘self-concept’. The current study found ‘loss of self’ and ‘negative self-appraisal’ to be powerful subordinate themes. As discussed earlier, counselling psychologists can also offer other therapies such as attachment-related and person-centred approaches.

It is advisable to treat the depressive or anxious symptoms of the trauma first of all. If the individual is willing to explore underlying issues and deal with concepts of ‘self’ and ‘change’ then alternative therapies could be offered by the counselling psychologist. The concept of life-span development as a process of narrative construction acknowledges a person’s individuality and allows us to have an active role in authoring our own story. Whilst we may not control everything that happens to us, we can shape the meaning that we give to these events (Sugarman 2001).
Counselling psychologists can assist in this shaping so that the person gains a more positive sense of meaning and therefore a greater sense of well-being. The creative nature of the narrative approach is inspiring, giving hope, as when constructing narratives, “our sources are wildly varied, and our possibilities, vast” (McAdams 1993, p.13).

**Suggestions for Future Research**

All women in the current study experience a continual dilemma as they battle between their desire to have a baby and the fears that lead them to avoid becoming pregnant. This dilemma is overlooked in earlier research and yet is a significant factor within the current study. This area could be focused upon to unpack the features further, particularly in relation to the affect the dilemma has upon women’s lives. This would be useful in highlighting the issues of tokophobia and PTS following traumatic birth with regards to proving the need for services for women who experience this dilemma.

While the current study provides a rich account of six women’s experience of avoiding childbirth, research needs to be carried out with women who come from low socio-economic backgrounds, women with low educational levels, and women who come from different cultural and ethnic backgrounds. Earlier research indicates an increased likelihood of a PTS response following childbirth for women from these groups. Issues that arise for women from these groups need to be investigated to increase understanding of the effects of primary tokophobia and PTS with avoidance of childbirth. Women from these groups are particularly vulnerable, as are the children born to them. When the effects of PN PTS are considered and then combined
with poverty and deprivation, there are implications for attachment, child
development and mental health.

Over-medicalisation of childbirth is indicated as a predictor of PTS in previous
research as well as the current study. It would be interesting to investigate the
prevalence or otherwise of PTS and avoidance of childbirth in cultures where natural
approaches to childbirth predominate. It would also be useful to investigate the role of
postnatal support in preventing PTS and avoidance of childbirth in groups of women
from different cultural backgrounds.

Research is needed to enhance understanding of the factors that contribute to a
presentation of primary tokophobia. Exploration of anxieties and fears in women with
primary tokophobia would facilitate understanding of the role that rumination plays in
the maintenance of anxiety. It would also be useful to establish whether or not fear
and avoidance of childbirth in childless women can be described as a phobia. Women
referenced within anecdotal evidence in the existing literature convey a sense of
revulsion at the notion of pregnancy and childbirth. It would be useful to determine
where this repulsion stems from. It would also be interesting and helpful to examine
the differences in experiences of women who eventually give birth despite their fears,
and women who remain unable to contemplate childbirth. Understanding these
differences could lead to effective interventions to enable more women to prepare for
pregnancy and childbirth.

It would be interesting to explore the prevalence of fear of life-changes amongst
women in the general population. The question could be posed as to whether or not
women with tokophobia or PTS with avoidance of childbirth experience more difficulty negotiating the transition cycle than do women who do not present with these conditions. A comparative study could be made between women with tokophobia and PTS with avoidance of childbirth and a control group of women who do not present with these conditions.
SECTION 3 – CRITICAL APPRAISAL OF THE RESEARCH PROCESS

My initial interest in the topic of tokophobia was generated as I searched areas around the subject of ‘motherhood’. I knew that Dr Hofberg had set up an impressive mother and baby unit at St George’s Hospital in Stafford, where I was training at that time. When I came across her work on tokophobia I was fascinated by what was a new concept to me at that point. Over the last three years I have had countless people ask ‘What’s tokophobia?’ when asking me about the topic for my thesis. Many of these people have been health care practitioners, which at this point in the process makes me even more determined to raise the profile of fear and avoidance of childbirth and its impact upon women and families.

My initial interest was also fuelled by my own position as a mother, having given birth three times myself. I have had three very different birth experiences, including a difficult delivery with my first child. I remember feeling ‘taken aback’ when I sat down to read women’s accounts of their traumatic birth experiences on the BTA website. Whilst hit by the horror that the women described I realised that my own birth story could be included on the website’s pages. And yet I had not evaluated the event as ‘traumatic’. I was hooked by this revelation, wanting to learn more, and yet I have needed to be very aware of my own experiences and how they have the potential to affect the research process.

Meeting the participants and analysing their interviews have been the most productive and enjoyable parts of the process. It has however been an incredibly
difficult path to get to that point. Getting the proposal through ethics committees was a painful process but that does not compare with the battle that ensued as I tried to persuade people to allow me to attempt to recruit participants through their organisations. The process of securing participants for the study became a nightmare.

My first taste of what was to come came as I telephoned a GP surgery that I had selected at random. An ethics committee had told me to obtain two letters from GPs that would state that they would allow me to display a poster in their surgery asking for volunteers for my study. My request was declined as the receptionist casually stated, “Oh you won’t get women ‘round here to do that.” My feeling of dismay grew as it took time to obtain the two letters.

It took over a year for my proposal to be accepted by the university’s ethics committees, after being rejected at the first attempt. NHS ethics could not be applied for until the proposal had been accepted by the university. The process of gaining approval from NHS ethics is notably arduous. Having successfully negotiated LREC I found that I had to wait for individual NHS Trusts to decide my fate. After sitting through various committee meetings, five Trusts agreed to give me ‘the go-ahead’. It was disheartening to be rejected by two PCTs on the grounds that they could not see how the study would be beneficial for users of their trust.

By this point I was nearing the end of my training and the stress was ‘kicking-in’ on a grand scale. The process of recruiting participants was truly soul-destroying. I had gained employment upon completion of my training programme and yet I had only conducted two interviews and completion of the research project looked as far away
as ever. It literally took months to trawl through the hundreds of GP surgeries and other health organisations and that was just within one trust. I began the tedious, painful process of telephoning each surgery, going through my script, attempting to persuade practice managers to display a copy of my poster in their surgery. Many were positive, although I wonder how many actually displayed the poster that I subsequently emailed to them. Several refused to display a poster commenting that the research would not be of benefit to their patients (I can only assume that they had no female patients and only dealt with single male clients!) The worst comment was when a manager relayed a message from one of the GPs at her practice, which basically challenged the existence of the condition, dismissing it entirely. This battle continued as I was refused display of my poster at several public places.

Apart from feeling demoralised and demotivated, the events of the previous couple of years had left me feeling marginalised and undervalued, on reflection rather like the group of women whose experiences I wanted to investigate. Most of my cohort had submitted MSc theses and were now chartered; two others had submitted their doctoral theses. I felt completely alone. Not being able to conjure an image of myself completing my doctoral research, I was plagued by self-doubt and often thought that I would have been ‘better off’ going down the MSc route, submitting a discourse analysis to avoid all problems with recruiting participants.

It felt as if I would never get participants and the research would never be completed. Amending my notice on the BTA website to inform that I would consider travelling anywhere within the UK seemed to spark a change in my fortunes. Over the next few months a steady stream of women made contact with me and were willing to be
interviewed. I travelled far and wide to conduct the interviews, but by this point I was desperate! Once the interviews were conducted I felt a huge relief as I knew that all that stood between me and completion was sheer, focused hard work, and that did not frighten me as I knew that was in my own hands.

The interviews were more difficult than I had anticipated and the first one left me with a realisation of my own naivety. I had worked for two years in adult mental health and my training as a counselling psychologist had given me therapeutic skills. I was also aware of the sensitive and emotive issues surrounding tokophobia so consequently I felt well-prepared. However I was shocked by the power of the emotions that came from the first participant. Reflecting upon her traumatic birth experience four years previously, her pain was very raw and it seemed to tear through her as she sobbed and gasped for breath. This depth of feeling took me by surprise and I recall at one point having to focus upon containing my own emotional response. Reflecting on this experience helped me to be better prepared in subsequent interviews.

All of the women conveyed their distress during the interviews and without exception, all struggled to contain their emotion. It was apparent that at least a couple of the women currently experience considerable distress and painful feelings; the impact of the women’s experiences upon their lives was apparent. I wonder to what extent written word can convey the power of people’s feelings and the depth of the impact that experiences have upon lives and relationships. I am struck by how this process is dependent upon, and limited by my own ability to express those experiences. A further limitation is that vitality is diminished when voices are
committed to paper. It feels like a tremendous pressure and responsibility to do justice to the women’s rich accounts.

It has been argued that language constructs, rather than describes, reality (Willig, 2001); an inevitable pitfall of IPA is the virtual impossibility of gaining direct access to another’s experience. The process of IPA necessitates intense and detailed engagement with the texts. To this end I found that I became very familiar with each text and could ‘hear’ the individual’s voice and expressions every time I engaged with the case. Detailed transcription notes also helped to bring the interview to life. This level of engagement with the participant’s ‘voice’ assisted my interpretation of their account; by listening very closely I was able to pick up messages from their expressions of emotions and from notes made regarding their body language. It was important to recognise my role in the process, particularly to be aware of my own view of the world and how that might impact, as well as considering the interaction between myself and the participant. I was careful to use open-ended questions that did not lead the participant but would serve to seek clarification and elicit elaboration. Professional boundaries were adhered to throughout the process as an attempt to minimise any influence I might have upon the data.

Through facing the challenges of the research process, I have grown. Looking back on my journey I can see that I have shed much of my initial naivety. I have developed skills both academically and personally and have a definite sense of having gained from the process. I am so glad that I persevered with this research and did not give up, even in the face of the many barriers; people who seemed to either not understand the issues or did not care. I hope that my perseverance will enable me
to achieve my aim of raising the profile and understanding of the issues surrounding fear and avoidance of childbirth.
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www.healthcarecommission.org.uk


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**Appendix 1: Postnatal Services in the UK for Women who have a Difficult or Traumatic Birth (Ayers et al., 2006)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes (%)</th>
<th>Yes but informally (%)</th>
<th>No (%)</th>
<th>% (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is a service provided?</td>
<td>56/71(82%)</td>
<td>73% to 95%</td>
<td>6/73 (8%)</td>
<td>0% to 21%</td>
</tr>
<tr>
<td>Was the service provided within the recommended timeframe?</td>
<td>4/73 (6%)</td>
<td>2% to 14%</td>
<td></td>
<td></td>
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<tr>
<td><strong>What type of service?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Afterthought program</td>
<td>8/74 (11%)</td>
<td>7% to 23%</td>
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<td></td>
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<tr>
<td>Dealing with midwife or O&amp;G consultant</td>
<td>29/76 (39%)</td>
<td>34% to 57%</td>
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<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>13/76 (20%)</td>
<td>12% to 32%</td>
<td></td>
<td></td>
</tr>
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<td>Midwives*</td>
<td>9/74 (12%)</td>
<td>0% to 26%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service provided as part of:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O&amp;G or midwifery department</td>
<td>47/70 (67%)</td>
<td>58% to 80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other hospital service (requiring referral)</td>
<td>17/70 (25%)</td>
<td>17% to 37%</td>
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</tr>
<tr>
<td>Service outside hospital (requiring referral)</td>
<td>3/70 (4%)</td>
<td>2% to 12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service delivered by:</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwives only</td>
<td>38/66 (57%)</td>
<td>43% to 66%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors only</td>
<td>2/66 (3%)</td>
<td>0% to 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist only*</td>
<td>4/66 (6%)</td>
<td>2% to 15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwives and doctors</td>
<td>13/66 (20%)</td>
<td>12% to 31%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwives and psychotherapists*</td>
<td>4/66 (6%)</td>
<td>2% to 15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwives, doctors and psychotherapists*</td>
<td>7/66 (11%)</td>
<td>5% to 20%</td>
<td></td>
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<tr>
<td><strong>Are all women informed of the service?</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35/65 (54%)</td>
<td>42% to 65%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>30/65 (46%)</td>
<td>35% to 56%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How are women informed of the service?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st visit</td>
<td>18/63 (29%)</td>
<td>16% to 37%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation with doctor</td>
<td>2/63 (3%)</td>
<td>0% to 11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st visit with midwife</td>
<td>4/63 (6%)</td>
<td>0% to 11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st visit with midwife and other health professional</td>
<td>3/63 (5%)</td>
<td>2% to 13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine screening</td>
<td>2/63 (3%)</td>
<td>0% to 11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>When are women informed?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During pregnancy</td>
<td>4/62 (7%)</td>
<td>3% to 16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After birth</td>
<td>46/62 (74%)</td>
<td>62% to 83%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During pregnancy and after birth</td>
<td>12/62 (19%)</td>
<td>11% to 31%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How are women referred?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine screening</td>
<td>12/63 (19%)</td>
<td>11% to 30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliance on obstetrician procedures</td>
<td>12/63 (19%)</td>
<td>11% to 30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women have to request it</td>
<td>14/63 (22%)</td>
<td>14% to 34%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Through midwife</td>
<td>24/63 (38%)</td>
<td>27% to 50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1/63 (2%)</td>
<td>0% to 8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Is the service open to all women?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>56/74 (76%)</td>
<td>63% to 97%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>5/74 (7%)</td>
<td>3% to 17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How is the service funded?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery department</td>
<td>54/62 (87%)</td>
<td>77% to 93%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department + contributions</td>
<td>2/62 (3%)</td>
<td>0% to 9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not sure or not funded</td>
<td>7/62 (11%)</td>
<td>0% to 22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How did the hospital decide what service to provide?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence based</td>
<td>20/62 (32%)</td>
<td>22% to 45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence based - evidence based</td>
<td>20/62 (32%)</td>
<td>22% to 45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How long has the service been in place?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>2/61 (3%)</td>
<td>1% to 11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 to 3 years</td>
<td>11/61 (18%)</td>
<td>10% to 30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>17/61 (28%)</td>
<td>18% to 40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 years or more</td>
<td>14/61 (23%)</td>
<td>14% to 35%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not sure</td>
<td>17/61 (28%)</td>
<td>18% to 40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Has this service been evaluated?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes - formal audit of research project</td>
<td>21/61 (34%)</td>
<td>24% to 47%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes - informal feedback</td>
<td>13/61 (21%)</td>
<td>13% to 33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>18/61 (30%)</td>
<td>20% to 42%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not sure</td>
<td>9/61 (15%)</td>
<td>8% to 26%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Psychologists included counsellors and clinical psychologists

**NOTE:** Missing data meant n ranged from 61 to 71.

---

100
Appendix 2: EMDR Adaptive Information Processing

Model

1. Within each person is a physiological information processing system through which new experiences and information are normally processed to an adaptive state.

2. Information is stored in memory networks that contain related thoughts, images, audio or olfactory memories, emotions, and bodily sensations.

3. Memory networks are organized around the earliest related event.

4. Traumatic experiences and persistent unmet interpersonal needs during crucial periods in development can produce blockages in the capacity of the adaptive information processing system to resolve distressing or traumatic events.

5. When information stored in memory networks related to a distressing or traumatic experience is not fully processed, it gives rise to dysfunctional reactions.

6. The result of adaptive processing is learning, relief of emotional and somatic distress, and the availability of adaptive responses and understanding.

7. Information processing is facilitated by specific types of bilateral sensory stimulation. Based on observational and experimental data, Shapiro has referred to this stimulation as bilateral stimulation and dual attention stimulation (Shapiro, 2001).

8. Alternating, left-right, visual, audio and tactile stimulation when combined with the other specific procedural steps used in EMDR enhance information processing.

9. Specific, focused strategies for sufficiently stimulating access to dysfunctionally stored information (and in some cases, adaptive information) generally need to be combined with bilateral stimulation in order to produce adaptive information processing.

10. EMDR procedures foster a state of balanced or dual attention between internally accessed information and external bilateral stimulation. In this state
the client experiences simultaneously the distressing memory and the present context.

11. The combination of EMDR procedures and bilateral stimulation results in decreasing the vividness of disturbing memory images and related affect, facilitating access to more adaptive information and forging new associations within and between memory networks.

[EMDRIA, 2008]
Appendix 3: The 8 Phases of EMDR

1. **History-taking.** In addition to qualifying information, targets are identified for EMDR processing including (a) past events that have set the foundation for the symptoms, (b) present triggers that exacerbate disturbance, and (c) desired behaviours for appropriate future action.

2. **Preparation.** Clients are taught self-control techniques, given appropriate psychoeducation regarding symptoms and treatment expectations.

3. **Assessment.** The target chosen for processing is delineated by (a) specific image, (b) present negative belief, (c) desired positive belief, (d) emotion, (e) physical sensation, and (f) current level of disturbance.

4. **Desensitisation.** The client gives periodic attention to emotionally disturbing material while simultaneously focusing on an external stimulus. Therapist-directed eye movements are the most commonly used dual-attention stimulus, but various other stimuli, including hand-tapping and auditory stimulation, are often used. The client is instructed to ‘just notice’ any thoughts, feelings, or images that arise during this process. Usually this new material becomes the focus of the next sequence. As this process continues, the client begins to make associations to more adaptive material, and this becomes integrated with the traumatic memories.

5. **Installation.** The most empowering positive cognition is identified and strengthened with additional processing.

6. **Body scan.** Any residual physiological responses are targeted with additional processing.

7. **Closure.** Client is returned to a state of equilibrium using imagery techniques, and is instructed in the use of a journal, self-control techniques, and expectations during the subsequent week.

8. **Re-evaluation.** During every subsequent session the maintenance of treatment effects for previously processed targets is examined along with journal reports. New targets are ascertained for subsequent processing according to specialised protocols designed to treat various disorders.
Appendix 4: Copy of Notes for Contributors

CLINICAL PSYCHOLOGY REVIEW
Guide for Authors

SUBMISSION REQUIREMENTS: Authors should submit their articles electronically via the Elsevier Editorial System (EES) page of this journal (http://ees.elsevier.com/cpr). The system automatically converts source files to a single Adobe Acrobat PDF version of the article, which is used in the peer review process. Please note that even though manuscript source files are converted to PDF at submission for the review process, these source files are needed for further processing after acceptance. All correspondence, including notification of the Editor's decision and requests for revision, takes place by email and via the Author's homepage, removing the need for a hard-copy paper trail. Questions about the appropriateness of a manuscript should be directed (prior to submission) to the Editorial Office, details at URL above. Papers should not exceed 50 pages (including references). Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, without the written consent of the Publisher.

FORMAT: We accept most word-processing formats, but Word, WordPerfect or LaTeX are preferred. Always keep a backup copy of the electronic file for reference and safety. Save your files using the default extension of the program used. Please provide the following data on the title page (in the order given). Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors’ affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address.
Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author. Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post publication.

Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address. Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author’s name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes. Abstract. A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.


TABLES AND FIGURES: Present these, in order, at the end of the article. High-resolution graphics files must always be provided separate from the main text file (see http://ees.elsevier.com/cpr for full instructions, including other supplementary files such as high-resolution images, movies, animation sequences, background datasets, sound clips and more).
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Appendix 5: LREC Confirmation Letter

16 March 2007

Mrs Deborah Onley
Counselling Psychologist in Training
University of Wolverhampton
7 Larchmore Drive
Essex
South Staffordshire
WV11 2DG

Dear Mrs Onley

Full title of study: Investigating the psychological factors underlying tokophobia and the need for psychological counselling of women who fear and avoid childbirth
REC reference number: 07/Q28/02/25

The Research Ethics Committee reviewed the above application at the meeting held on 05 March 2007. Thank you for attending to discuss the study.

Ethical opinion:

A well presented qualitative research study investigating the phenomena of Tokophobia (fear of childbirth) using tape recorded, semi-structured interviews. An interview schedule has been provided along with all study documentation.

Volunteers are recruited via posters, which are to be widely distributed amongst GP surgeries and various childbirth associations. As a suggestion, once the interviews have been transcribed these are usually passed back to the participants for verification.

A BECKS inventory scale has been included however there is no provision to exclude women who already have mental health problems.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, noting the following points for consideration:

1. Exclusion criteria should be confirmed (patients with mental health problems)
2. Transcribed information is usually passed back to the participants for verification
3. BECKS depression inventory- are there any plans to correlate the results of this with the interview schedule? If there are plans to make correlation between the two a coding system will need to be used to protect the identity of participants. The committee advise to think about this in relation to the study results.
4. It is unclear how many participants will be recruited

An advisory committee to Birmingham and The Black Country Strategic Health Authority
5. The study could also be advertised with the Miscarriage association (website available), the National childbirth trust, the perinatal institute (which is locally based). Traumatic birth counselors may also be able to provide further contacts to aid recruitment.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. The favourable opinion for the study applies to all sites involved in the research.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The following documents were reviewed and approved at the meeting:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td></td>
<td>31 January 2007</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td>31 January 2007</td>
</tr>
<tr>
<td>Protocol</td>
<td>5.3</td>
<td>31 January 2007</td>
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<tr>
<td>Peer Review</td>
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<td>31 January 2007</td>
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<tr>
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<td>31 January 2007</td>
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<tr>
<td>Interview Schedules/Topic Guides</td>
<td>5.2</td>
<td>31 January 2007</td>
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<tr>
<td>Advantagement</td>
<td>5.3</td>
<td>31 January 2007</td>
</tr>
<tr>
<td>OP/Consultant Information Sheets</td>
<td>5.3</td>
<td>31 January 2007</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>5.3</td>
<td>31 January 2007</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>5.3</td>
<td>31 January 2007</td>
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<tr>
<td>Beck Anxiety Inventory (RAI)</td>
<td>1883</td>
<td>31 January 2007</td>
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<tr>
<td>Debrief Information</td>
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<td>31 January 2007</td>
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<tr>
<td>Pre Interview Information</td>
<td>5.3</td>
<td>31 January 2007</td>
</tr>
<tr>
<td>Supervisor CV</td>
<td></td>
<td>31 January 2007</td>
</tr>
</tbody>
</table>

R&D approval

You should arrange for the R&D office at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research at a NHS site must obtain final approval from the R&D office before commencing any research procedures.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

An advisory committee to Birmingham and The Black Country Strategic Health Authority
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Jeff Neilson
Chair

Email: rebecca.siorey@dudley.nhs.uk

Enclosures:

List of names and professions of members who were present at the meeting and those who submitted written comments

Standard approval conditions

Copy to:

Dr Yvette Lewis
University of Wolverhampton
Psychology Division
MC Block
University of Wolverhampton
Stafford Street
Wolverhampton
WV1 1SB
Appendix 6: NHS Trusts’ Letters of Research and Development Approval

South Staffordshire Healthcare
NHS Foundation Trust

Our Ref: KT/R:76
03 April 2007

Mrs D Oxley
Counselling Psychologist
7 Laurelmead Drive
ESSINGTON
WV11 2DG

Dear Debbie,

Research Proposal: Investigating Factors involved in tokophobia

We have considered your application for access to patients from within this Trust in connection with the above study.

On behalf of the Trust, the Lead Officer for Research Governance (Robina Barry) is satisfied that all the requirements for Research Governance, both nationally and locally have been met, and the Trust is happy to agree to the commencement of the study, with the following provisos:

- That all researchers coming into the Trust will have submitted to Criminal Records Bureau (CRB) checks with satisfactory outcomes.
- That you conform to the requirements laid out in the letter from the LREC dated 16 March 2007, which prohibits any changes to the agreed protocol.
- That you keep the Trust informed about the progress of the project at 6 monthly intervals and project outcomes and, if practicable, you provide final feedback via our R&D presentations programmes.
- That you provide me with a copy of the final report, and acknowledge this Trust in any published work.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely,

[Signature]

Kim Thompson
Research Governance Administrator
2 August 2007

Deborah Orley
T Larchmore Drive
Essington
South Staffs
WV11 7DG

Confirmation of Approval of Research Study

Dear Deborah,

I can confirm that approval has been granted by the South Staffordshire Primary Care Trust Research Management and Governance Office for the following research study, which falls under the requirements set out in the NHS Research Governance Framework.

Title: Investigating Factors in Tokophobia

Study Reference: SS07005

Chief Investigator: Deborah Orley

Sponsor: University Of Wolverhampton

Funder: Self Funded

Research Location(s): South Staffs PCT

NHS Trust(s): South Staffs Primary Care Trust

Proposed local study end date: 31/08/2007

You may begin this research study within the South Staffordshire Primary Care Trust(s) location(s) noted above.

Please read carefully, the following additional information that is applicable to this confirmation of approval.
Please note that your research study may be monitored or audited by this research office or other relevant authority as part of the requirements set out in the Research Governance Framework for Health & Social Care (2005).

In order for us to continue to meet the requirements for Research Governance you are requested to provide us with the following documents (electronic or paper) relating to this study:

- A copy of all COREC Annual progress report(s) (if applicable)
- A copy of the COREC End of study declaration
- A copy of the final report no more than 6 months after completion of the study
- A completed monitoring form for Department of Health reporting purposes (the form will be sent to you for completion)

You are also requested to notify us about any of the following that are applicable to the Trust(s) for which this approval applies:

- Amendments to any documents that require MREC approval
- Changes to study start and end dates
- Changes in personnel/members of the research team
- Any serious adverse events (e.g., SUSAR) within the timescales specified on the COREC website.

In addition, we will from time to time also request you to provide us with up-to-date details of all practices/locations that you know will be, are or have been involved in this study.

Yours sincerely,

P. J. Devall
Pamela Devall
Research Governance Lead
16 October 2007
Deborah Onley
7 Larchmere Drive
Easington
South Staffs
WY11 2UG

Re: Confirmation of an extension to an existing Honorary Research Agreement

Dear Deborah

I can confirm that the Honorary Contract issued with the following details:

<table>
<thead>
<tr>
<th>Dated:</th>
<th>02/08/2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issued to:</td>
<td>Deborah Onley</td>
</tr>
<tr>
<td>Issued for:</td>
<td>South Staffs PCT</td>
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<td>Original contract issued by:</td>
<td>South Staffs PCT</td>
</tr>
<tr>
<td>For the research study titled:</td>
<td>Tokophobia Study</td>
</tr>
</tbody>
</table>

is now being extended with the following new expiry date:

30/06/2008

and with the same terms and conditions. You remain accountable to the Chief Investigator of this study and to Cianda Diver, Head of Service for all research work within the Trusts detailed above.

Yours sincerely,

P J Devall
Research Governance Lead
Our Ref: KT/R/76

03 April 2007

Mrs D Onley
Counselling Psychologist
7 Larchmere Drive
ESSINGTON
WV11 2DG

Dear Debbie

Research Proposal: Investigating Factors involved in tokophobia

We have considered your application for access to patients from within this Trust in connection with the above study.

On behalf of the Trust the Lead Officer for Research Governance (Robina Harby) is satisfied that the requirements for Research Governance, both Nationally and Locally have been met, and the Trust is happy to agree to the commencement of the study, with the following provisos:

- That all researchers coming into the Trust will have submitted to Criminal Records Bureau (CRB) checks with satisfactory outcomes.
- That you confirm to the requirements laid out in the letter from the LREC dated 16 March 2007, which prohibits any changes to the agreed protocol.
- That you keep the Trust informed about the progress of the project (at 6 monthly intervals) and project outcomes and, if practicable, you provide final feedback via our R&D presentations programme.
- That you provide me with a copy of the final report, and acknowledge this Trust in any published work.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely,

[Signature]

Kim Thompson
Research Governance Administrator
Wolverhampton City NHS
Primary Care Trust

Research and Development
The Beeches
Penn Hospital
Penn Road
Wolverhampton
WV4 5NT

ian.burns@wolverhampton.nhs.uk
http://www.wolverhampton.nhs.uk

Our ref: Project No: 170

24 May 2007

Deborah Osiey
7 Lanchmere Drive
Essington
South Staffordshire
WV 11 7RH

Dear Deborah

Title of project: Investigating the psychological factors underlying tokophobia and the need for psychological counselling of women who fear and avoid childbirth

Thank you for supplying the Research and Development Department with the requested documentation. We are pleased to inform you that from a research point of view we are happy for you to undertake the research in line with the protocol you have submitted.

This permission covers: Walsall TPCT and Sandwell Mental Health & Social Care NHS Trust.

This letter outlines your responsibilities while you are conducting research with the above Trusts. Your activities will be overseen by your line manager who is employed by the Trust.

You are considered to be a legal visitor to Trust premises. You are not entitled to any form of payment or access to other benefits provided by the Trust to employees and this letter does not give rise to any other relationship between you and the Trust, in particular that of a contract of employment.

You must act in accordance with Trust policies and procedures, which are available to you upon request, including the Research Governance Framework for Health & Social Care (2003). You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and the premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act (1998). Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that where you are issued an identity or security card, a laptop number, email or library account, keys or protective clothing that these are returned upon termination of this arrangement. Please also ensure that while on the premises

Chairman: Barry Pickles
Chief Executive: Jon Crockett

Wolverhampton & Stourbridge PCT

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you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the Trust accepts no responsibility for damage to or loss of personal property.

Any breach of these requirements will result in withdrawal of the access contained in this letter and will be notified to your employer. Your substantive employer is responsible for your conduct during the research project and any breach may therefore result in disciplinary action against you. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

At some point we are likely to audit your paperwork for this project and it is important that you keep everything secure, especially that relating to informed consent from participants in your research.

If there are any changes to your research, any difficult incidents or if you have queries about conducting the research, please inform R&D office immediately on 01902 444669.

We look forward to hearing the outcomes of your research and receiving a copy of the final report. Good luck with the project.

Yours sincerely,

Ivan Burchess
Chair, Black Country Research Governance Network

Enc. Research Governance Information Sheet
Copy to R&D office, Wolverhampton City PCT
HR Department of the substantive employer
Dr Carolyn Prior, Sandwell MHS&SC NHS Trust
Kirstie MacWilliam, Walsall TPCCT
From: Yvette Lewis
To: C & D Onley
Subject: Ethical approval

Hello Drs.

You'll be pleased to know that your Res2O has been passed by the behavioural sciences ethics committee so just needs to go the school committee next semester.

Well done.

Yvette

Dr Yvette Lewis, PsyD, CPsychol
Senior Lecturer in Counseling Psychology
Psychology Division
School of Applied Sciences
University of Wolverhampton
Millennium City Building
Stourbridge Street
Wolverhampton
WV1 1SR

08/10/2008
Hi Yvette,

I have now examined the RES20b for Deborah Onley and have received comments on it from _____ and _____ makes some helpful comments but does not require any obligatory changes requires some very small changes that do not need to be seen by the committee i.e. they are for 'supervisor to monitor'. There comments are reproduced below. I think that the proposal is fine.

I have signed the proposal and when you have signed it and Debbie AND KEN have also signed it you should forward it to Yvette Foster (Room MA104). At this point you may consider the project approved and Debbie may commence work immediately.

All the best

Neil
School of Applied Sciences Ethics Committee: submission of project for approval

- This form must be word processed – no handwritten forms can be considered
- ALL sections of this form must be completed
- No project may commence without authorisation from the School Ethics Committee

CATEGORY B PROJECTS:

There is identifiable risk to the participant’s wellbeing, such as:

- significant physical intervention or physical stress.
- use of research materials which may bring about a degree of psychological stress or upset.
- use of instruments or tests involving sensitive issues.
- participants are recruited from vulnerable populations, such as those with a recognised clinical or psychological or similar condition. Vulnerability is partly determined in relation to the methods and content of the research project as well as an a priori assessment.

All Category B projects are assessed first at Divisional level and once approved are forwarded to the School Ethics Committee for individual consideration. Undergraduates are not permitted to carry out Category B projects.

<table>
<thead>
<tr>
<th>Title of Project:</th>
<th>Investigating the psychological factors underlying tokophobia and the need for psychological counselling of women who fear and avoid childbirth. <strong>Working title:</strong> Investigating the factors involved in the avoidance of pregnancy / childbirth</th>
</tr>
</thead>
</table>
| Name of Supervisor: | Dr Elvidina Adamson-Macedo  
**(for all student projects)**  
Dr Yvette Lewis |
| Name of Investigator(s): | Deborah Onley |
| Location of Research: | DcounsPsych / Professional Training in Counselling Psychology  
(Module code, MPhil/PhD, Staff)  
<p>| Qualifications/Expertise of the investigator relevant to the | BA (Hons) English with Psychology / PG Diploma in Psychology / Counselling Psychologist in Training |</p>
<table>
<thead>
<tr>
<th>Participants: Please indicate the population and number of participants, the nature of the participant group and how they will be recruited.</th>
<th>I will need around 10 participants. All participants must be women who dread and avoid childbirth despite wanting a / another baby. I will not recruit women who are currently pregnant, due to the sensitive nature of the interview questions. I plan to recruit participants as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Through the Birth Trauma Association (BTA). I have been given permission to put a notice on their website asking for volunteers. [Copy of the notice is attached].</td>
<td></td>
</tr>
<tr>
<td>o I have designed a poster that advertises my research and asks for volunteers [Poster attached]. I will put copies up on notice boards throughout the university campuses.</td>
<td></td>
</tr>
<tr>
<td>o I will put copies of the poster in doctors’ surgeries around Wolverhampton and Stafford.</td>
<td></td>
</tr>
<tr>
<td>o I will distribute posters to psychologists and psychiatrists in Wolverhampton and Stafford who work within Adult Mental Health Services.</td>
<td></td>
</tr>
<tr>
<td>o I will introduce myself to Health Visitors in Stafford and Wolverhampton and hand out posters to them. I will ask for them to talk to any women who they think might be suitable for participating, to let them know about my research.</td>
<td></td>
</tr>
</tbody>
</table>

Continued overleaf
Please attach the following and tick the box provided to confirm that each has been included:

| Rationale for and expected outcomes of the study | ✓ |
| Details of method: materials, design and procedure | ✓ |
| Information sheet* and informed consent form for participants | ✓ |
| *to include appropriate safeguards for confidentiality and anonymity | |
| Details of how information will be held and disposed of | ✓ |
| Details of if/how results will be fed back to participants | ✓ |
| Letters requesting, or granting, consent from any collaborating institutions | ✓ |
| Letters requesting, or granting, consent from head teacher or parents or equivalent, if participants are under the age of 16 | N/A |
| Is ethical approval required from any external body? YES | |
| If yes, which Committee? NHS REC (Stafford and Wolverhampton) | |

*NB. Where another ethics committee is involved, the research cannot be carried out until approval has been granted by both the School committee and the external committee.*

Signed: ____________________________________ Date: __________________.
Supporting information

Rationale for study and expected outcomes

‘Tokophobia’ is a term that was first used by Hofberg & Brockington (2000). The aim of their study was to classify tokophobia for the first time in medical literature. They define ‘tokophobia’ as an intense anxiety that leads to some women dreading and avoiding childbirth despite desperately wanting a baby. In the 2000 study and subsequent publications, Hofberg and Brockington classify tokophobia as either ‘primary’, ‘secondary’ or ‘tokophobia as a symptom of depression’. They describe primary tokophobia as a dread of childbirth that pre-dates pregnancy and secondary tokophobia as a phobic avoidance of pregnancy that is secondary to a traumatic delivery. Their 2000 study included women who had developed a phobic dread and avoidance of childbirth as a symptom of depression in the prenatal period. A qualitative analysis of 26 psychiatric interviews was performed. The researchers concluded that tokophobia is a distressing psychological condition that may be overlooked, and is associated with anxiety, depression, post-traumatic stress disorder (PTSD) and bonding disorders. While Hofberg and Brockington’s papers state clinical
implications, they do not report the nature of the women’s anxiety or psychological roots / causes.

Hofberg & Ward’s paper (2003) looks at pregnancy and the relationship with depression, eating disorders and pathological fear of childbirth. They acknowledge that death from suicide is the leading cause of maternal death overall. It is acknowledged that research in these areas is sparse and their paper attempts to collate what is known. Hofberg & Ward (2003; 2004) conclude that the outcome of all conditions considered in the paper is less good than for other mothers.

The Birth Trauma Association (BTA) was established in 2004 to support women suffering from Post Natal PTSD (PN PTSD) and to offer advice and support to other women who are finding it hard to cope with their childbirth experience. The BTA (2005) believes that too little is known about the psychology of childbirth and this means that the mental health consequences of it are all too often ignored. The BTA (2005) state that the difference between the common perception of childbirth and some women’s experience of it means that women who suffer PN PTSD symptoms frequently find themselves isolated and detached from other mothers. Because awareness is generally poor, many women are wrongly diagnosed with Post Natal Depression and are prescribed medication that may do little to improve their situation.

As part of their charter the BTA (2005) “demands more funding for research to develop our understanding of the experience of childbirth.” They advocate that a traumatised mother is not a ‘healthy’ one and that maternity service providers should understand that childbirth has a psychological outcome as well as a physical one. As psychotherapy helps validate a woman’s experience and reduces the risk of long term trauma, the BTA (2005) “demands that the provision of appropriately trained psychologists and therapists be increased.”

**Research Questions**

1. What are the major psychological factors underlying tokophobia?
2. What is the impact of tokophobia on women and their families?
3. Is there a need for psychological counselling of women identified with symptoms of tokophobia?
Despite the obvious psychological outcomes for women following childbirth, this domain continues to be dominated by the medical field, specifically obstetrics and psychiatry. The study is expected to increase the understanding of the psychology of childbirth and indicate a need for counselling psychology services within this area.

**Details of method: materials, design and procedure**

I am interested in investigating the major psychological factors underlying tokophobia, particularly the fear that individual women have of childbirth whether that be due to primary or secondary tokophobia, or tokophobia as a symptom of depression.

I plan to use qualitative methods to collect and analyse my data; in particular I plan to use Interpretative Phenomenological Analysis (IPA). Qualitative research explores how people make sense of the world and how they experience events and qualitative researchers tend to be interested in the meanings attributed to events by the research participants themselves. In qualitative research, the objective of data collection is to create a comprehensive record of participants’ words and actions (Willig, 2001). According to Elliot, Fischer & Rennie (1999):

> The aim of qualitative research is to understand and represent the experiences and actions of people as they encounter, engage and live through situations.

> (Elliot et al. 1999, p 216.)

IPA shares the aims of other phenomenological approaches to data analysis in that it wishes to capture the quality and texture of individual experience. However, it recognises that such experience is never directly accessible to the researcher. Its founder, Jonathan Smith (1995: 189), characterises IPA as ‘an attempt to unravel the meanings contained in…accounts through a process of interpretative engagement with the texts and transcripts’. Such engagement is facilitated by a series of steps that allows the researcher to identify themes and integrate them into meaningful clusters, first within and then across cases.

I plan to use an open-ended style of interview with no more than a few questions, as the aim is to enable the participant to ‘tell their story’. Possible questions include, “Please tell me as much as you can about your childbirth experience(s)” and, “What does it mean to you not to have any more children?” I will use warmth,
empathy and minimal encouragers in order to encourage the participant to talk about their experiences. All interviews will be audio taped and fully transcribed.

I intend to follow the procedure as set out by Smith, Jarman & Osbourn (1999). This involves re-reading the transcripts using the margins to document emerging themes and theme titles. These themes are further analysed and organised into meaningful clusters, in the form of superordinate and subordinate themes. Throughout the process the researcher ensures the content of the superordinate themes and the subordinate themes are reflective of the original data.

I have omitted the word ‘dread’ from all literature that will be presented to participants and have devised a ‘working title’ as safeguard against ‘leading’ the participant. This attempting to be impartial and not lead is in line with the methodology.

**Detail of how information will be held and disposed of**

All information gathered will be treated confidentially in accordance with the British Psychological Society guidelines (BPS, 2008). Data will be kept in a locked filing cabinet in the researcher’s home and the participant will not be identifiable from the data. Information will be held for up to two years after completion of the study. Following the period all collected data will be destroyed confidentially.

**Details of how results will be fed back**

Copies of the completed study will be made available on request by contacting the researcher by email, or indirectly through the university.
Appendix 8: Consent Form

University of Wolverhampton

CONSENT FORM

Working Title of Project: Investigating the factors involved in the avoidance of pregnancy / childbirth

Name of Researcher: Deborah Onley

This research is carried out as part of the professional training in counselling psychology at the University of Wolverhampton. I would like to explore women’s experiences of traumatic birth and / or avoidance of childbirth.

Your participation will involve an open-ended interview, which will be audio taped and transcribed for analysis. Your responses are anonymous, however I will ask you for some personal details such as age and marital status in order to analyse responses. All potentially identifying material will be removed from the transcripts. A copy of the transcript and a copy of the final report will be available on request by contacting me either by e-mail or via the university.

All information and details that you give to me through the interview and questionnaire will be treated in strict confidence. This signed consent form will be kept separately from your data, which will be anonymous and unidentifiable. Transcripts will be available to the supervisors and examiners only. The findings of the research will be read by supervisors and examiners and will be available for others to read, for example health care professionals. It is also possible that the findings may be published. Confidentiality is assured and there will be no identifiable details within the final paper.

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.
2. I confirm that to the best of my knowledge I am not pregnant, nor do I suspect that I may be pregnant
3. A transcript of the interview will be analysed by the named researcher and will be available to the supervisors and examiners. Information I provide will be treated with strict confidence. I understand that the findings will be read by others such as supervisors, examiners and health care professionals and may be published.
4. The audiotape and transcript of my interview will be stored securely and will be anonymous. All raw data will be destroyed two years following the completion of the study.
5. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. However I understand that I would have to give notice within one month from the date below.
Participant name:      Researcher name:

Signature:       Signature:

Date:         Date:

**Contact details:**
By email: 
[ D.Onley2@wlv.ac.uk](mailto:D.Onley2@wlv.ac.uk)

By post or telephone:  
C/O Pat Lees, Post-Graduate Secretary, Psychology Dept. MC Block, University of Wolverhampton, Stafford Street, Wolverhampton, WV1 1SB.  01902 321376.
Appendix 9: Notice for BTA Website

Notice for Birth Trauma Association Website

Do you avoid pregnancy / childbirth despite wanting a baby? For many women, this is a painful problem that affects their life. In researching this area I hope to increase our understanding of the psychology of childbirth ~ I hope to learn how women and couples who experience this avoidance can be supported.

If avoiding pregnancy is an issue that affects your life, you may be able to assist in this research. I would like to meet and talk with women about their experiences.

My name is Debbie Onley and I am a Counselling Psychologist in Training at the University of Wolverhampton. I am conducting this research as part of my training. If you would like further information about my project and / or are interested in taking part then please email me on: D.Onley2@wlv.ac.uk Please note that I will only be able to interview women who live within a 50-mile radius of Wolverhampton.

Appendix 10: Poster
Do you avoid pregnancy / childbirth despite wanting a baby?

For many women, this is a painful problem that affects their life. In researching this area I hope to increase our understanding of the psychology of childbirth ~ I hope to learn how women and couples who experience this avoidance can be supported. Please note that my aim is to learn more about this issue and unfortunately I will not be able to offer direct support to anyone experiencing difficulties in this area. However, I can give details of agencies that may be able to offer support and information.

If avoiding pregnancy is an issue that affects your life, you may be able to assist in this research. I would like to meet and talk with women about their experiences.

I am employed as a Counselling Psychologist in Staffordshire and am undertaking this research as part of my doctoral training at the University of Wolverhampton. If you are willing to talk to me, please make contact with me via my email address: Deborah.Onley@ssh-tr.nhs.uk or by leaving your name and telephone number with the secretary at the university 01902 321376 (please ask for your details to be passed on to Debbie Onley for her research). I will reimburse any travel expenses.

Many thanks ~ Debbie Onley

Appendix 11: Letter to Professionals
Deborah Onley  
*C/O Pat Lees (Post-Graduate Secretary)*  
Psychology Division  
School of Applied Sciences  
Millennium City Building  
University of Wolverhampton  
Stafford Street  
Wolverhampton  
WV1 1SB

I am a *Counselling Psychologist* currently working for South Staffordshire & Shropshire Healthcare NHS Foundation Trust. As part of my doctoral research, which I am undertaking at the University of Wolverhampton, I am investigating the psychological factors underlying tokophobia (avoidance of pregnancy/childbirth despite wanting a baby).

I would like to interview women who experience this condition with the aim of increasing knowledge and understanding of the psychology of childbirth and of this distressing condition. All interviews will be transcribed and analysed using qualitative methods.

If, during the course of your work, you become aware of women for whom tokophobia may be an issue, could you please consider drawing their attention to my research please? (Please note that I am excluding women who are currently pregnant). I attach a poster that can be displayed or handed to individuals which gives my contact details. Potential participants can be assured of my confidentiality and that participation is completely independent of any involvement that they have with your service.

If you would like further information about my research then please contact me:  
[Deborah.Onley@ssh-tr.nhs.uk](mailto:Deborah.Onley@ssh-tr.nhs.uk)

Thank you

Debbie Onley

**Appendix 12: Pre-Interview Questions**
Pre-Interview Information

Could you please provide the following information:

Age:

Are you currently in a relationship? [please circle]
    Yes / No

If Yes, please tick any boxes that describe your relationship:
    □ Married
    □ Living together
    □ Not living together
    □ Same sex relationship

Do you avoid pregnancy / childbirth? [please circle]
    Yes / No

Would you like to have a / another baby? [please circle]
    Yes / No

If you answered ‘No’ to the last question, have you avoided pregnancy / childbirth in the past despite wanting a baby at the time? [please circle]
    Yes / No

Have you ever given birth? [please circle]
    Yes / No

If you have any children please write down their gender and age:
Appendix 13: Information Sheet

DcounsPsych / Professional Training in Counselling Psychology

*University of Wolverhampton*

**INFORMATION SHEET**

**Working Title of Project:** Investigating the factors involved in the avoidance of pregnancy / childbirth

**Name of Researcher:** Deborah Onley

As part of my training in counselling psychology, I am conducting research on women’s avoidance of pregnancy / childbirth. I would like to explore women's experiences with the aim of increasing understanding of the psychology of childbirth.

I am inviting women who avoid pregnancy / childbirth despite wanting a baby, to take part in this research. Women’s participation will enhance our understanding of this area. Due to the sensitive nature of the topic I will not interview women who are, or suspect that they are pregnant.

Participation will involve an open-ended interview, which will be audio taped and transcribed for analysis. Responses are anonymous and any identifying material will be removed from the transcripts. I will also ask you for some personal details such as age and marital status in order to analyse responses.

All information and details that are given to me through the interview will be treated in strict confidence. The audiotape and transcript of interviews will be stored securely and will be anonymous. All raw data will be destroyed two years following the completion of the study. The findings of the research will be read by supervisors and examiners and will be available for others to read, for example health care professionals. It is also possible that the findings may be published. Confidentiality is assured and there will be no identifiable details within the final paper.

If you require further information, please contact me:

**Debbie Onley**

By email: [D.Onley2@wlv.ac.uk](mailto:D.Onley2@wlv.ac.uk)

By post or telephone: C/O Pat Lees, Post-Graduate Secretary, Psychology Division, School of Applied Sciences, MC Block, University of Wolverhampton, Stafford Street, Wolverhampton, WV1 1SB. 01902 321376.
Appendix 14: Debrief Information

DcounsPsych / Professional Training in Counselling Psychology

University of Wolverhampton

DEBRIEF INFORMATION

Working Title of Project: Investigating the factors involved in the avoidance of pregnancy / childbirth

Name of Researcher: Deborah Onley

Thank you for participating in this research project. As I have asked you to reflect upon personal issues I understand that this may have elicited difficult feelings and thoughts. If you need to talk with me about this then please contact me as detailed below:

By email: D.Onley2@wlv.ac.uk

By post or telephone:
C/O Pat Lees, Post-Graduate Secretary, Psychology Dept. MC Block, University of Wolverhampton, Wulfruna Street, Wolverhampton, WV1 1SB. 01902 321376.

Please note that I am in my final year of training and as such I am not fully qualified. If you need to receive counselling or psychotherapy with a qualified professional, contact details are provided below:

[Details were given for counselling services in their area. Examples are given below]

Sandwell Mind co-ordinates a free counselling service which is open to members of the public: 3rd Floor, Bradfield House, Popes Lane, Oldbury, West Midlands. Tel: 0121 543 3930.

Stafford Council does not offer a counselling service. Advice about local counselling services can be sought from Stafford Citizen’s Advice Bureau, 131-141 North Walls, Stafford, ST16 3AD. Tel: 01785 258673.

Wolverhampton Counselling Services 01902 773375
St Peter’s House, 4 Exchange St., Wolverhampton, WV1 1TS

A list of accredited counsellors and psychotherapists can be found at the British Association for Counselling and Psychotherapy (BACP) website: www.bacp.co.uk

For those affected by birth trauma, the Birth Trauma Association can provide support and information. Their website is: www.birthtraumaassociation.org.uk

Best wishes ~ Debbie Onley
Appendix 15: Original Interview Schedule

Interview Schedule [Provisional]

*You do not have to talk about anything that you would rather not discuss.*

- You have indicated that you avoid pregnancy / childbirth despite wanting a / another child. What is it that leads you to avoid pregnancy / childbirth?

- [For those women who have experienced childbirth] Can you share with me your experience(s) of childbirth?
  [After the participant has finished talking] How did you feel about pregnancy and childbirth before giving birth to your first child?

- How do you feel about the thought of being pregnant?

- [For those women who have not experienced childbirth] How long have you felt this way about pregnancy and childbirth?

- How important is it to you to avoid pregnancy? What measures do you take to avoid pregnancy?

- What does it mean to you to have a / another baby?

- What effect does your avoidance of pregnancy / childbirth have upon your life and relationships?

- Is there anything you would like to add that has not been covered by the interview?
Appendix 16: Interview Questions for Individual Participants

Interview Questions: Lynn

Q: You have indicated that you avoid pregnancy and childbirth despite wanting another child although you just told me that you are not in a position at the moment to have a child, but you would like to think that may be in the future if you had the right relationship you would like a child. What it is that leads you to avoid pregnancy and childbirth in that way?

Q: The first question I asked you was about avoiding pregnancy and childbirth because you may find you want another child in the future and what had led you to avoid pregnancy and childbirth. You just relayed to me your birth experience and I am wondering, it sounds very painful, very traumatic. I am wondering if you want to explore how you were feeling at that time when you woke up in intensive care?

Q: You mentioned during that last part about that you found it quite useful that a psychologist came to talk to you and I am quite interested in, you used the words “follow up” as you feel you would have benefited from some follow up. What would that follow up have been like if you could have chosen?

Q: How do you feel about the thought of being pregnant?

Q: How important is it to you to avoid pregnancy, which might be a difficult question to answer because I know you are in a new relationship at the moment. What measures do you take to avoid pregnancy? How important is that to you?

Q: What does it mean to you to have another baby?
Q: The next question I want to ask you might be a bit difficult in terms of you have already explained to me that you are no longer in a relationship with your child’s father. But the question I wanted to ask was what effect does your avoidance of pregnancy and childbirth have upon your life and relationships? So maybe you could talk retrospectively as well as your current feelings?

Q: Is there anything else you would like to add that hasn’t been covered in the interview?

Q: Can I ask you how you felt about childbirth before you became pregnant for the first time?

Q: Have you got anything else you would want to add?

Q: Are you ok to leave the interview here?

Interview Questions: Jill

Q: You have indicated that you have avoided pregnancy and childbirth despite having wanted to have another child. What is it that led you to avoid pregnancy and childbirth?

Q: So deranged in a sense that a completely different person to what you had been before?

Q: So you had concerns about the care of your first child?

Q: Can you share with me your experience of childbirth?

Q: What wasn’t nice about it at that point?

Q: What stands out to me is that at least twice there you referred to different professionals, health professionals, who referred to the, erm
normality of the situation... and... I'm getting the feeling from you that you felt far from normal.

Q: How does that leave you feeling, you know, what messages was that giving to you?

Q: How did you feel about pregnancy and childbirth before giving birth to your daughter?

Q: How did you feel about the thought of being pregnant after you had your daughter and you have described to me the way you were feeling, you know if you have ever had thoughts about being pregnant again, how did that feel?

Q: How important was it to you to avoid pregnancy? What measures did you take to avoid pregnancy?

Q: What does it mean to you to have had another baby?

Q: What affect, if any, has the avoidance of pregnancy and childbirth had upon your life and your relationships?

Q: Is there anything else you would like to add that hasn’t been covered by my questions?

Q: Do you want to stop there?

**Interview Questions: Heather**

Q: You have indicated that you avoid pregnancy and childbirth despite wanting another child. What is it that leads you to avoid pregnancy and childbirth?
Q: So it sounds like there were two things going on there - post-natal depression, and I’m wondering if you’ve had a traumatic birth as well, from what you’ve said?

Q: Can I ask you, how did your pregnancy proceed through that period leading up to that - did you have a good pregnancy?

Q: Through your pregnancy, coming towards the end of your pregnancy, what were your expectations of the actual childbirth, had you thought it through, you know, what were you expecting or hoping for?

Q: It sounds as if at that time_______ [participant talks over me at this point]

Q: It sounds like quite a positive experience____

Q: And then you’ve taken me to about a couple of weeks before she was due and you had got all these problems with your horse, can you go back to that point?

Q: How did you feel about that?

Q: Did that stress carry on right up until the point where you went into labour or had you got things more settled before?

Q: Did you go into labour spontaneously or did you have an induction - an induced labour?

Q: So at what point did you decide to go to the hospital?

Q: Can I ask you, what was it that made you feel that, this is going wrong or ‘pear-shaped as you said?
Q: It sounds to me what I'm picking out from you is, there seems as if there was a lack of control in this that seems to have completely floored you, you know, it feels -

Q: What was that final stage like, you know, you've just described the transition and the actual sort of final stage of giving birth, what did that feel like? What were you feeling at the time?

Q: And at that stage, was the overwhelming feeling, was it sort of 'I just need this to stop,' rather than, 'I want to give birth to my baby and see my baby’?

Q: Can you tell me about after, you had given birth and how that felt when they brought your baby back to you and, you know, those early minutes?

Q: That sounds as if, right at that beginning, as if you weren't bonding, with your baby right at the beginnings of her being born

Q: And that feeling lasted until she was about a year and a half you say?

Q: So at what point did you become aware that this was post-natal depression, or did a professional tell you, you had post-natal depression?

Q: You mentioned at the beginning that you’d seen a psychiatrist at some point about PTSD and I was going to ask you about that and I was wondering if that was the feature of PTSD, looking at your baby when she was a baby and it reminding you?

Q: Did you find that service useful?

Q: Well that was one of my questions actually, how do you feel about the thought of being pregnant again?
Q: It sounds as if it’s, one ordeal was the actual childbirth but it also seems like a long ordeal afterwards as well, you know, all the experiences that you have had since then?

Tape ends.

**Interview Questions: Alex**

Q: You have indicated that you avoid pregnancy and childbirth despite wanting another child. What is it that leads you to avoid pregnancy and childbirth?

Q: Yeh, if you wouldn’t mind if you could share your experience of childbirth and the whole, experience of it.

Q: Can I just pick up from erm, going back to when you were actually in labour before you went to the labour ward, erm and you talked about being in a lot of distress, you could feel the distress building -

Q: And yet at the same time, you’ve said a few times that the contractions weren’t painful, as such

Q: So, I think you’ve sort of told me why you were in distress but -

Q: I’m also struck by erm, how much of that, erm, labour period that you were on your own –

Q: I wondered how, how did you feel?

Q: Did you share your feelings about the childbirth experience with anyone after the birth?

Q: At what point did you feel that you couldn’t go through childbirth
Q: Can you pinpoint the main aspects of the whole experience that made you think, ‘I cannot go through that again’?

Q: What do you recall about the first few weeks, after you'd had the baby, in terms of how you felt about the whole experience and about having this baby?

Q: It sounds as if you bonded well with the baby and yet, I was surprised to hear you say erm, “I didn't love him at that stage,” and I wonder what makes you feel that -

Q: Looking back to your childbirth experience what would you have found helpful in terms of support?

Q: How did you feel about pregnancy and childbirth before giving birth to your child?

Q: After your childbirth experience, erm, how have you felt about the thought of being pregnant since then up to date… what does that mean?

Q: What effect does the avoidance of pregnancy and childbirth have upon your life and relationships?

Q: Talking about your inability to make a decision to have another child, do you wish that it was different and you could go forward and have your own child, is it something you would want to do, if you felt you had free choice?

Q: Does it feel like you have free choice?

Q: So the fear of being told you could have an elective caesarean but then, what about if you get pregnant and then you get to the end and
actually they don't – and it doesn't happen, the elective caesarean and that fear seems like a block -

Q: Do you get these feelings for anything else?

Q: What would it mean to you have another baby and by that I mean a child that you’ve given birth to yourself?

Q: How important is it and has it been to you to avoid pregnancy, what measures do you take to avoid pregnancy?

Q: Why did you stop trying to get pregnant after six months?

Q: You mentioned, erm, being sent to counselling for your fears, so you've obviously spoken to health professionals about this fear. Can you talk me through that, what made you decide to go to see someone in the first place and what happened?

Q: Can you think of anything that may enable you to consider getting pregnant?

Q: Is there anything you would like to add that has not been covered?

Q: Do you want to leave it there?

**Interview Questions: Nadine**

Q: You have indicated that you avoid pregnancy and childbirth despite wanting another child. What is it that leads you to avoid pregnancy and childbirth?

Q: Mm, ok. Would you share those experiences with me?
Q: Did your partner arrive at any of the times during this?

Q: What was it like when they gave you that internal examination, you know, in terms of them saying to you, 'You're 6cms dilated' - how did you feel at that point?

Q: And did you feel excited because you thought, 'Ok, right, the baby should be here soon'?

Q: Can you describe the pain up until that point?

Q: And you had had that pain for hours?

Q: When they gave you the, erm, was it like a pessary to start the labour?

Q: Erm, roughly how long was it before the pain started?

Q: And then, did you start to get very regular contractions after that?

Q: So I’m wondering if there was something about, erm, that you’d gone sort of from no pain to a lot of pain in a short space of time?

Q: Is that how it felt?

Q: Erm, and you were saying apart from yourself and your partner, there was no one with you for all of those hours mainly?

Q: Did you have any pain relief during that time?

Q: What was you thinking at that time?

Q: Were you able to tell your partner how you felt at that time?
Q: Oh, right, so this was the time when you were actually on your own?

Q: Did you tell the midwives at any point that you were in pain and that you were losing blood?

Q: So had your partner managed to get back to you when they did that examination that showed that you were now 6cms?

Q: So at that point you must have felt, as you say, excited thinking the end could be near?

Q: Yeh, yeh. And then can you tell me again what happened after that, so, erm they told you you were 6cms dilated and then what happened then?

Q: Was that the same amount of pain that you’d been in as well?

Q: I know this is painful, but can you remember what was going through your mind at that time?

Q: It seems like there’s a lot of shock around how you were feeling. Did you think that this was normal, what you were going through?

I: And then what happened then? So you carried on for about another three hours like that -

Q: And then what happened next?

Q: How did that feel when you were trying to push?

Q: And how did you feel when you kept pushing and kept pushing but, you know, the baby wasn’t coming?
Q: And did the midwife talk you through that at the time?

Q: Do you know why it was taking so long for the baby to come out?

Q: Yeh. And then what happened after about an hour when the baby didn't come?

Q: And did they try with the forceps?

Q: Can you describe what happened to you when they came with the forceps?

Q: Can you remember what happened?

Q: Yeh, if you can just describe what was happening, did erm, did they have to cut you or -

Q: Could you feel anything when they got the forceps?

Q: So it sounds very much as if you just kept doing what they asked you to do?

Q: What was your partner like at this time?

Q: How did it feel to you when they said he’d got to leave the room?

Q: Were there lots of people that had come in, at that point?

Q: How did that feel or did you not have time to think about that?

Q: Yeh, so you weren't even sure what was going on?
Q: What was going through your mind at this point?

Q: Did they do the Caesarean in that room or did they have to take you somewhere else?

Q: Did they fetch your husband in, in time for the Caesarean?

Q: And then can you remember much about the Caesarean? How you felt at that point?

Q: When you realised that they were going to give you a Caesarean, how did you feel about that?

Q: Why were you disappointed?

Q: What was the actual Caesarean like itself? Was it quick?

Q: How did you feel?

Q: How did you feel when the baby came out?

Q: What were the reasons for not giving you the baby straight away?

Q: And then was everything ok with the baby when you went back to your room?

Q: How did you feel at that point?

Q: Did it feel a relief once you'd got the baby out?

Q: How did you feel about your baby after he was born?

Q: Ok. Can you think of anything that might have helped you at the time to cope with your experience?
Q: Did you have chance after you'd had the baby at any point afterwards, to talk to anyone about how you felt?

Q: How were you feeling at that point, six weeks on? What did you say to the doctor?

Q: So you were actually depressed after having the baby?

Q: How long did that depression last?

Q: So, that hasn't got any better in 14 months?

Q: Erm, at what point did you feel that, 'I can't go through this again, I can't have another baby'?

Q: And that's still a strong feeling that you have?

Q: Do you have any thoughts back to that time, so, when you see the hospital, that reminds you -

Q: Are there any other things like that that remind you?

Q: Have you ever had any dreams about it?
Q: Have those nightmares stopped?

Q: Apart from anti-depressants, have you ever been offered any counselling at all?

Q: No? Would that help do you think? To be able to talk through, some of these things?

Q: Have you been able to talk to friends or family about it? About how you feel?
Q: Are there any reasons that stop you from talking openly to people about how you feel about childbirth?

Q: Yeh, and I suppose that at the end of the day he was there with you as well and saw the things you went through

Q: Can I ask you, how did you feel about pregnancy and childbirth before giving birth to your first child?

Q: Had you planned to have your baby?

Q: Yeh, yeh, so was that something that you had wanted for some time?

Q: So you'd not ever had a fear of childbirth before that?

Q: What were your expectations of childbirth before you had your child?

Q: It sounds, from what you've said like, it felt as if all those hours when you were in all that pain like it knocked you sideways almost,

Q: Apart from the obvious things of having the baby, how is life different for you now, compared with before you gave birth, for you as a person?

Q: How do you feel about the thought of being pregnant?

Q: How important is it to you to avoid pregnancy? What measure do you take to avoid it?

Q: What does it mean to you to have another baby, you know, would you like to have another baby at some point?

Q: Yeh, was it always in your plan to have more than one child?
Q: If this feeling that you've got at the moment carried on and you felt that you couldn't have another child, what would that mean to you?

Q: Does that make you feel anxious as well, you know, that there's something that you really want, but you can't go ahead with it at the moment?

Q: What effect does your avoidance of pregnancy and childbirth have upon your life and your relationships?

Q: Does it affect your relationships with friends that have got babies?

Q: Your relationship with your husband, does it affect your relationship with him?

Q: Does he understand how you feel?

Q: Yeh. Have you spoken to family about it?

Q: Is there any expectation from families do you think, that you might have another child?

Q: How do you feel when those conversations come?

Q: Can you identify anything that might be useful now in terms of helping you to move forward, particularly with regards to planning for another pregnancy?

Q: erm and although you've got anti-depressants, they still don't seem to have shifted your mood and I am wondering if you can think of anything that might be helpful at all?
Q: Ok. Would you consider pregnancy again if you were guaranteed to be booked in, say, for a Caesarean and go straight in for a Caesarean with a spinal?

Q: So if, the only way was to risk having a vaginal birth would you think, 'No I can't go through this'?

Q: So the only thing, the only way you could do it is to have, what's called an elective Caesarean where, you're booked in for one in advance?

Q: Yeh, ok. Right, ok. Is there anything you would like to add that hasn't been covered by this interview?

Q: I'm struck by, erm and I don't know whether it comes out on the tape but I'm struck by, how much this affects you at the moment, you know, in terms of feeling really depressed and feeling very anxious you know and that's apparent sitting here with you, erm.. have you ever had depression or anxiety before, you had the baby?

Q: So all of this is completely new to you?

Q: Erm, I know that you've been on to the Birth Trauma Association website, has that been useful or helpful in any way?

Q: How is that helpful, reading about that?

Q: Yeh you've just reminded me, when you were talking about erm, how you felt when they were taking you for the Caesarean, you gave me the impression that you felt a bit, disappointed almost, and, sort of blaming yourself for not pushing hard enough, you know, you said, 'Maybe if I'd have pushed harder maybe I'd have had him,” -

Q: Is there anything else that you would want to say?
Interview Questions: Tina

Q: You have indicated that you avoid pregnancy and childbirth despite wanting another child. What is it that leads you to avoid pregnancy and childbirth?

Q: Were you in pain at this point?

Q: I think I was struck by, erm, when you said, I think it was when you were examined the second time, not examined, but, you were induced for the second time, and you described how the midwife came in with the student nurse and you said, "From that point I felt like a different person." Can you remember how that felt and, and what might have been going through your mind at that point? I'm wondering why it was at that point, something happened to make you feel differently?

Q: And there was something about that midwife that came later the one that actually held your hand, and tried to help you through it, and you said to her, "Don't go," you know almost like a desperation, 'Don't go, don't leave me', and I was thinking that she sounds as if she was the only person that validated, if you like, what you were going through… probably the one person that could help you feel like, 'I am in this real world and this is happening to me?"

Q: Can you think of anything that might have helped you at the time to cope with your experience, and 'by at the time,' I mean, well at that time, immediately after and as the weeks went by, is there anything that might have helped you to cope?

Q: How did you feel about pregnancy and childbirth before giving birth to your daughter?
Q: Mmm. How do you feel about the thought of being pregnant, you know, if you think about it now, how does it feel?

Q: How important is it to you to avoid pregnancy at the moment and what measures do you take to avoid it?

Q: What does it mean to you to have another baby?

Q: That leads me to the next question which is, what affect does your avoidance of pregnancy and childbirth have upon your life and relationships?

Q: You've said that you're currently anxious and depressed still, 2 ½ years later. How does this affect every day life for you?

Q: Did you experience this before you were pregnant?

Q: Have you been offered treatment or support for anxiety and depression?

Q: How regularly did you see the psychologist?

Q: Could you tell me what kind of things that you did with the psychologist?

Q: Did she do EMDR with you?

Q: Did you find the sessions helpful when you look back?

Q: Can you think why that might be?
Q: Actually, when you said you went back to work and you said you didn't want to be left on your own working without somebody with you who you were really familiar with, what was that about for you? Is that about confidence, would you say?

Q: Erm, can you identify anything that might be useful now in terms of helping you to move forward, particularly with regard to planning for another pregnancy?

Q: Is there anything that you'd like to add that hasn't been covered in this interview?

Q: Has it been helpful that site?

Q: Ok, is there anything else you want to say before we end the interview?

Q: How did all of those things leave you feeling apart from worrying about the baby, how did it leave you feeling about yourself and your body?

Q: Ok, do you want to leave it there?
Appendix 17: Transcription Protocol

1. I listened to each tape before beginning transcription in order to get a feel for the participant’s account; this formed part of immersing myself in the data.

2. I transcribed each tape myself, playing short sections of the tapes and transcribing by hand, repeating each section to ensure an accurate record was made.

3. The interviews were transcribed verbatim as this is acknowledged as a requirement of most qualitative methods of analysis (Willig, 2001).

4. To capture subtleties the transcriptions include pauses, interruptions, incomplete sentences, repetition of words, and emphasis on words.

5. Words or phrases that are emphasised are typed in bold.

6. Pauses are indicated by a series of full-stops (for example: ‘…’)

7. Square brackets and italics are used for information on intonation and to denote non-verbal communication such as crying or sighing, for example.

8. Each transcript is set out like a script for a play: each line is numbered and speakers are denoted using ‘I’ for ‘Interviewer’ and ‘P’ for ‘Participant’.

9. Each transcript has been checked against the tape for accuracy.
Appendix 18: Guidelines for IPA (Smith, 1995)

1. Read the transcript a number of times, using one side of the margin to note down anything that strikes you as interesting or significant about what the respondent is saying. Some of these comments may be attempts at summarising, some may be associations / connections that come to mind, others may be your preliminary interpretations.

2. Use the other margin to document emerging theme titles, that is, using key words to capture the essential quality of what you are finding in the text.

3. On a separate sheet, list the emerging themes and look for connections between them. Thus you may find that some of them cluster together, and that some may be regarded as master or superordinate concepts. Do some of the themes act as a magnet, seeming to draw others towards them and helping to explain these others? You may also find that during this process you come up with a new master theme that helps to pull together a number of initial categories you had identified. As new clusterings of themes emerge, check back to the transcript to make sure the connections also work for the primary source material – what the person actually said. This form of analysis involves a close interaction between you and the text, attempting to understand what the person is saying but, as part of the process, drawing on your own interpretative resources. You are now attempting to create some order from the array of concepts and ideas you have extracted from the participant’s responses.

4. Produce a master list of themes, ordered coherently. Thus the process outlined above may have identified five major themes which seem to capture most strongly the respondent’s concerns on this particular topic. Where appropriate, the master list will also identify the subthemes which go with each master theme.

5. Add an identifier of instances. Under each master theme you should indicate where in the transcript instances of it can be found. This can be done by giving key words from the particular extract plus the page number of the transcript. It may also help to code the instances in the transcript with an
identifier. Level and type of coding depend on the size of the project and on your own way of working.

If you have a number of individuals’ transcripts to analyse, analysis can proceed in the following way. Begin the process anew with interview two, going through the stages outlined above and producing a master list for this second interview. The master lists for each interview could then be read together and a consolidated list of themes for the group produced. If new themes emerge in subsequent interviews, they can enlighten, modify or become subordinate to a previously elicited one.
Memo 1: Lynn

Lynn is 36 and is a single-mother to a 4 year-old boy; she has a professional job (degree educated) and works 4 days per week. She lives with her son in Northamptonshire. Lynn has been separated from her husband, the father of her son, for about a year. Following the traumatic birth of her son and post-natal depression, Lynn could not face going through childbirth again (she had an emergency Caesarean Section followed by complications requiring further surgery). She is now in a steady relationship and would like to have another child in the future, especially as her partner does not have children of his own, but she is fearful of going through childbirth again.

Control

While Lynn had gone into hospital with the attitude: “I was quite happy for the doctors to lead” (562), it became apparent that she had not anticipated the possibility of medics taking complete control over her, resulting in her lack of control over herself and her situation. Lynn’s sense of helplessness is summed up with: “I was sort of lied there” (66-67). When a doctor tells her that they are going to give her two more injections, Lynn’s sense of resignation to her lack of control shows: “...and I thought ‘whatever’“ (96).

Lynn’s sense of desperation is glimpsed when she recalls being rushed off to the operating theatre – feeling out of control she needs to ‘touch base’ and seek assurance from her husband. Stating that she wants to speak to him she is met with: “you can’t,
you can’t” (111-112). Lynn conjures up the sense of urgency by describing how the medics ran with her, hurrying her to the theatre. Lynn’s sense of loss of control and confusion about what is happening is conveyed by the fact that she struggles to put this into words: “and I was like, you know, I didn’t [blows her nose] that was just like, whatever was going on” (112-113).

Sensing imminent threat Lynn takes desperate measures in an attempt to regain control: “I punched the anaesthetist.....I was like, ‘Get that bloody mask off my face’ “(117-119). Lynn was unable to establish control however and was ignored as the doctor asserted his authority to subdue her: “Sedate her again” (134).

Reminiscing on her lack of control Lynn considers how she would prepare for future childbirth: “I would want to know, I would probably have it written down” (425-426). Here Lynn plans to bring order in an attempt to avoid the chaos that she has experienced. Her comment: “I would want further discussions with doctors and people who were involved” (442-443) indicates that she wishes to keep control and work in collaboration with the medical professionals rather than be controlled and subdued.

Thoughts about nearly dying

The sense of chaos that is born of a lack of control gives rise to a sense of urgency that signals imminent danger and threat: “I remember her shouting, ‘Get this woman down to theatres now!’ “(106-107). Lynn is objectified in the medical process of saving her life; amidst the frantic actions of those around her Lynn tries to make some sense from what ensues and is frightened by a monitor reading: “Oh my God how am
I alive?...How come I just haven’t...” (80-81). In recalling this Lynn is unable to complete her sentence, mirroring maybe how she is still not fully able to contemplate the horror of having nearly lost her life.

Lynn embraces life: “I’m just so grateful I didn’t die” (262). Lynn loves her son dearly and the thought that she might not have lived to mother him, she finds unbearable: “And that was the scariest thing because... if I’d have died [sobs] I would never have seen my son” (255-256). It was incredibly painful for her to express the words ‘if I’d have died’; the instantaneous sob is an indication of her depth of feeling.

Lynn expresses heartfelt gratitude to blood donors who she believes are instrumental in saving her life and with giving her son a mother: “Thank God for those people. Thank God for them because I wouldn’t have been alive” (273-274). To show her gratitude and to no doubt help others, Lynn asks her friends if they will consider donating blood: “I want [cries] to ask you [sobs]... could you give blood?” (277-278). Lynn’s sobbing again illustrates her depth of feeling and maybe the act of asking her friends to help (as she is unable to donate blood herself because of a blood disorder) may remind her of being indebted to the blood donors who gave their blood to Lynn. She is touched by this saving of life and reminded of her vulnerability.

Need to be acknowledged

Lynn had endured a traumatic experience and she continued to carry the burden of it, seemingly alone – she felt that others did not fully realise the extent of her suffering: “I don’t think anyone seemed to appreciate what I had been through” (352). Lynn’s desperation to be heard and acknowledged is felt when she says: “I kept shouting ‘I’m
not being a drama queen but I did nearly die. I really did nearly die’ [cries]” (254-255). Her cry here is almost pitiful, like she feels the pain of what she is expressing and as if the cry represents the empathy that she would like from others (although she fears that others will view her negatively, as a ‘drama queen’). Indeed in this section Lynn repeatedly refers to herself as nearly dying – when she says: “You know ‘cos I really could have died” (262-263) this feels like a plea for me to hear and understand what was a reality for her.

Commenting on the current interview, Lynn says: “it was good for me to talk about it again... otherwise it just gets forgotten” (577-578). This process endorses Lynn’s need to tell her story; by recording it in this format she is ensuring that metaphorically, her story is ‘etched in stone’.

Need for explanation
The lack of explanation when Lynn was losing an excessive amount of blood: “They didn’t really explain to me what was going on” (47) would only have added to the sense of chaos and tension and served to maintain the control held by the medical professionals. The withholding of information and at times the lack of knowledge: “..we don’t know what is going to happen” (150-151) again added to the chaos and would serve to heighten Lynn’s fear. Lynn’s lack of knowledge and understanding about what happened that day continues to needle her: “..how come it did all happen, why did it happen” (537-538).
Expectations

Lynn expresses commonly held views of what it means to be a woman: “Oh you should have babies” (529-530), as well as the notion that childbirth is straightforward and easy: “something a woman just does” (529).

Lynn’s own expectations of childbirth reflect those held by society: “I certainly wasn’t phased... I wasn’t that worried” (560-561). Lynn had not conceived any notion that the birth would be anything other than straightforward: “I didn’t have any real big ideas about childbirth” (565); the trauma that followed must have been a real shock.

Physical distress

The real ordeal for Lynn began with delivering the placenta; this is when the pain became overwhelming: “..give me the painkillers give me more and more, give me all the drugs” (58-59). The interventions that Lynn was subjected to she describes quite graphically and feel very invasive: “..squeezing it in manually... get the blood in” (88). Her description: “..they extubated me, pulled the tube out... put an oxygen mask on me, sat me up” (138-140) conveys the not only the gravity of her situation but also her complete lack of control at that point. She goes on to describe: “..uterus... squeezed it down into a ball... tied it up... stitched it back up” (175-179) – this feels quite brutal, the ‘squeezing’ and ‘stitching’ and I wonder if at some level Lynn felt she had been ‘attacked’?

Certainly Lynn’s body was under threat by the amount of bleeding: “I was just bleeding really profusely... pouring out of me” (76-77) – ‘pouring’ out like her life-
force ebbing away. She talks of having two potent injections which were a final attempt to stop the bleeding, but: “..it didn’t stop, it didn’t stop (102-103) – her repetition indicates the despair she felt at that time and suggests that she still struggles with this recollection. Lynn became terribly upset when she recalls how her baby’s outfit had become covered in her blood as he lay next to her: “[cries] his romper suit was just covered in blood up to his tummy it was just red... covered with blood” (49-51). Again the repetition ‘covered with blood’ emphasises how this image remains a powerful one.

**Enduring distress**

Lynn continues to experience anguish: “..its all still there” (401). She says: “I think I’m dealing with it well... I’m getting on with it, but...” (579-580) The word ‘but’ speaks volumes – Lynn trails off here which suggests that while she puts on a front of having dealt with her ordeal, underneath the surface she harbours more difficult feelings. This is illustrated again when towards the end of the interview Lynn talks once more about her son’s bloody romper suit: “[sobs, gasps for breath] whenever I see it that little blue romper suit, it’s a real [gasp] trigger still, well even talking about it. That just sums it up for me that little, blue suit…” (592-594). This was a very powerful exchange and one in which I could feel her pain. I wonder if the bloody romper-suit has such a powerful effect because she does not want to associate her son with the trauma.

What is thought to be one of the most monumental moments in a mother’s life and indeed one that defines femininity, is described by Lynn as: “Bloody awful” (341).
Her opening lines were: “I had an extremely traumatic birth” (7-8); this is how she defines her childbirth experience.

Lynn has found it difficult to talk about her experience: “[becomes tearful]… I could hardly talk about it… I couldn’t talk about it without crying…” (250-252) For months following childbirth Lynn was haunted by bad dreams: “[becomes tearful] I used to dream about erm lines and blood” (354-355) – she became so anxious that: “I was scared… of going to sleep” (357-358). There are still triggers that serve to remind Lynn of her trauma: “Sometimes when I have my periods now I get scared… it just reminds of it… the blood… and the amount…” (322-326).

Despite wanting another baby Lynn fears childbirth and avoids it. For the first two years following the birth she would not contemplate it: “..no way would I have another baby – absolutely no way” (449-450). As time passes and she dares to think about the possibility, she counters this with: “Don’t be so silly, don’t risk it, don’t.. don’t” (466). However this avoidance leads to a dilemma: “…ooh, I don’t know, I don’t know how I’ll…” (431-432) – the unspoken words could be ‘cope’ or ‘survive’.

Implications for self

Lynn comments that so much of her time after her son’s birth was spent tending to his needs and in this she acknowledges the loss to herself: “..you don’t have time, to address it” (396-397). Despite acknowledging that she has always been a strong person (405) Lynn has acquired a negative self-concept following her son’s birth: “I felt a bit of a failure really” (532). This links to societal views of childbirth as being something that women just ‘get on with’. Lynn’s fragile sense of self is revealed: “I think, I think I might actually fall to pieces” (409) – the pause after the first ‘I think’
suggests that Lynn has not actually processed this thought; moreover she may have accessed this from her sub-consciousness.

In relation to others

Lynn describes a positive relationship with her son and yet she experiences a dilemma about whether or not to tell him about the traumatic nature of his birth when he gets older (605-606). She says: “I’d hate for him to think that it was his fault… in a way I don’t associate him” (612-613). And yet the memory of his bloody romper-suit is particularly poignant to Lynn. As previously mentioned, I wonder if Lynn does associate her son with the trauma (after all, the trauma did surround his birth) but desperately does not want to acknowledge this and so suppresses her thoughts and feelings.

Lynn separated from her husband a couple of years after their son’s birth. She describes how both she and her husband became depressed following their ordeal and she cannot discount the affect that this had upon their relationship: “we have split up and I don’t know how much of an affect this had on our relationship” (517-518).

In fact Lynn left me with a feeling that her relationships in general have been affected by her traumatic experience. She expresses a sense of isolation from others: “no-one had been through anything like I had been through” (349-350).
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Memo 2: Jill

Jill is 49 and lives in Central England with her husband and their 20 year-old daughter. She is degree-educated and currently works voluntarily for a healthcare provider. Jill found the whole process of pregnancy and childbirth to be overwhelming and was depressed for a couple of years following her child’s birth. She has never been able to contemplate another pregnancy and now feels guilty that she has not provided a sibling for her daughter and feels sad that she has not added to her family.

Control

It is fundamentally: “the, lack of control” (4) that Jill experienced through pregnancy and childbirth that has led her to avoid subsequent pregnancy. She felt overwhelmed by the experience and describes: “...the feeling that erm, I was sort of taken over by it” (4-5). It seems as if she felt detached from the process somehow, almost possessed by an external entity rather than at one with her body: “I just felt as though, as though I’d got this sort of alien in my body” (7-8).

Jill felt the need to exercise self-control by restraining her urges: “I felt I couldn’t scream oh I wanted to scream” (74). Rather than ‘let go’ and concede to her instinctual desire, Jill conformed to what she felt was expected of her in this situation: she did not want to disturb others around her (76-77).

Unexpectedness

Jill was completely unprepared for the way that pregnancy would overwhelm her: “..it, happened so soon and I hadn’t really got used to the idea of being pregnant
before wow!” (14-16). It feels very much as if Jill didn’t adjust to the notion of being pregnant – the months of pregnancy can be a time of transition and yet somehow for Jill, it seems as if she went from being an individual who is not pregnant, to quickly becoming completely ‘taken over’ by the whole process.

Jill expresses disbelief at the nature of her experience: “I couldn’t believe I was so ill” (181). She was also taken aback by the level of pain that she felt during labour and when told she was only 2 centimetres dilated she thought: “You’ve got to be joking that can’t be right” (81).

Jill was also shocked by the: “overwhelming feeling of responsibility” (123-124) that she experienced following the birth of her daughter, and felt totally unprepared and unsure of her new role: “I didn’t know at all what to do” (124-125).

**Expectations**

Jill clearly states: “...birth was vile but that was to be just expected because it just reinforced my opinion of the whole horrible experience” (37-38). I am not convinced that Jill had expected it to be ‘vile’ before she got pregnant as she says: “I was quite happy to be pregnant” (179) and contradicts the earlier statement: “I didn’t expect it to be as painful as it was” (58). I would suggest rather, that Jill’s belief that ‘birth was vile’, serves to reinforce and validate her perception of her childbirth experience as ‘horrible’.

Jill expresses her disappointment at not experiencing pregnancy and childbirth as she had expected to: “...it was disappointing...[quietly] yes, it was disappointing, [resumes volume] it was disappointing to feel so dreadful” (181-183). Jill ponders the
first ‘disappointing’, pauses and then drops her voice to almost a whisper to repeat it, which may indicate her sense of discomfort at expressing this. She then adds, more directly, that it was disappointing ‘to feel so dreadful’ – I wonder if her resuming volume indicates that she feels more comfortable with being disappointed at feeling ‘ill’ rather than feeling disappointed with the experience per se. Maybe she sees this reason as more socially acceptable?

Jill certainly seems to be affected by what she views as societal expectations: “..as a woman you have an expectation that you’ll be naturally equipped to deal with [childbirth]” (210-211). And maybe this is where Jill’s sense of disappointment comes from – the feeling somehow that she wasn’t ‘equipped’ to deal with it. The clue here is with the word ‘you’ – she personalises this view rather than distancing herself from the viewpoint by using third person. Jill goes on to say: “I think you’re sort of expected to erm… just, be back to normal” (160-161). The fact that Jill does not ever feel as though she’s ‘back to normal’ indicates that she may feel a sense of alienation or detachment from others, who she may perceive as being ‘back to normal’ following childbirth. Certainly the pressure that Jill has felt ‘to cope’ is expressed: “subliminal messages… all this conditioning, you must be able to cope…” (214-216).

**Physical and mental distress**

Jill endured sickness through half of her pregnancy that had a debilitating effect:

“..because I was so sick... I couldn’t function” (6). Jill portrays this by describing: “..24-hours sickness... was horrible and the depression that comes with it” (189-191).
While there were no complications with her labour and delivery, Jill experienced childbirth as very painful: “I seemed to have been in agony for hours” (79-80). She comments: “It is excruciating pain, it is really scary” (167-168) – obviously something about the experience, or level of pain, left Jill feeling fearful. What she says indicates that fear of death was probably at the heart of her fear: “I remember describing it as a near-death experience” (113-114). She says: “I really thought I was, I could’ve died, and I really, erm... wouldn’t have particularly cared if I’d died... and erm... I don’t know” (114-115). As Jill had at one point thought that she was going to die, this indicates that Jill was not assured of her safety. The pauses around her statement of ‘not caring’ suggest her discomfort at her own acknowledgment of this feeling.

Jill provides a graphic description of her physical discomfort following the birth: “...you’re all stitched up, and you’re all bleeding from everywhere” (117-118). And instead of feeling the elation that some women describe (and many women hope for) after she’d given birth, Jill was left in a state of shock: “I just felt shell-shocked” (140-141). Dropping her voice to a whisper, Jill says: “I was just so stunned” (106) – it’s almost as if Jill cannot bear to hear the words, or maybe she’s reluctant for me to hear them.

Need to be acknowledged

Following her daughter’s birth, Jill felt that nobody understood the extent to which she had experienced the birth as an ordeal: “Well what about me? What about me you don’t realise what has happened to me” (126-127). I sense that Jill has always felt very alone with her feelings: “I didn’t feel as though anybody ever acknowledged
what a huge and traumatic thing it was” (161-162). Referring to the sickness as a ‘trauma’ Jill says: “I think that’s also not acknowledged and understood” (190-192).

There’s also a sense of a lack of validation for Jill’s experience. When she describes the birth to her doctor as: “the most horrible experience I’ve ever had” (130), he responds with: “No, no it was fine” (131) thus denying and disputing Jill’s personal account. Jill states that it would be ‘great’ if: “it was just acknowledged, that for some people it is like this” (295-296). For Jill, acceptance and validation that childbirth can be, and is, experienced as an ordeal would be very helpful and healing: “That would be, that would be really, that would be nice if someone just gave you the permission to feel like this” (296-298). Jill almost stumbles through this sentence; it’s as though she senses that that validation is too far away and that her vision is more of a fantasy than a possibility.

Change

One gets the impression that pregnancy and childbirth had a huge impact on Jill’s life and completely turned it around. She describes herself as being: “completely different” (27) following the birth. Jill felt a general lack of order in her life: “it was just chaos... home’s not the same because you’ve got this baby” (135-136) and: “everything’s all over the place” (137). This links with the lack of control that Jill felt through pregnancy and labour; feeling ‘out of control’ lasted for a couple of years after the event.
Sense of self

Jill’s traumatic experience and the ensuing changes have deeply affected her: “I didn’t like the fact that I had lost my life as well” (11). It is interesting that Jill did not view her baby as adding to, and enhancing her life in any way; rather, she felt a sense of loss – maybe there’s a grieving for the life that she had before. More significant perhaps is Jill’s description of: “having lost me” (14). Jill gives a powerful account of ‘losing her self’: “I was utterly deranged, utterly unrecognisable to myself” (18-19). The word ‘deranged’ conveys the extent to which Jill felt that she had ‘lost’ herself and takes it beyond comprehension of the term ‘loss’ – here Jill is telling us that she felt disconnected somehow and that at times maybe she had feared for her sanity, such was the extent of her loss.

Jill’s sense of loss (of her self) becomes more complex: “you’re not you as an individual... it’s you and this baby forever” (119-120). It feels as though Jill lost her identity when her baby was born finding it difficult to extricate her own from that of her daughter’s. Jill has commented that she felt: “post-natally deranged” (18) for ‘a couple of years’ following her daughter’s birth and I wonder if it is a coincidence that this would have been around the time that her daughter was starting to become more independent and forging her own personality.

Jill is left with a very negative self-perception: “suddenly I was just hopeless, helpless, useless” (23-24). Pitching herself against societal views she remarks: “it leaves you feeling,... inadequate because if it’s normal you should be able to deal with it” (152-153); she goes on to say: “its dreadful... you do feel... [sighs]... very much as though you’ve failed” (212-213). Reflecting on the thought that many
women go on to have subsequent children, Jill comments: “you think... there’s some, basic defect in me... why can’t I do it” (199-200). Her low self-esteem will surely have contributed to the postnatal depression that she experienced.

In relation to others

Jill’s perception of her daughter’s birth differs from that of others; she uses irony to express this: “the birth, which wasn’t traumatic apparently... was just described as like ‘normal’ [slight wry laugh]” (9-11). She is also ‘at odds’ with others in her feeling of being duped: “I really felt as though from start to finish it was an enormous con” (165-166). Here Jill refers to her view of childbirth as being ‘excruciating’ and ‘scary’ (168) and I have the sense that she feels let down by others, both professionals and she refers to her own mother, who have not prepared her or even told the truth: “nobody sort of levelled with me” (167). This theme is recurrent, as Jill recalls that breathing exercises did nothing to alleviate her pain: “I thought, ‘That’s another lie’” (73).

Jill describes the attending midwives as ‘cold’ (66) and she felt unsupported by them: “[midwives] don’t want the, the hassle of you getting in a state you know, they don’t want it” (169-170). She refers to their lack of empathy: “midwife saying, ‘Women in Russia give birth in the morning and they’re out in the potato fields in the afternoon,’ that was the level of... concern I got” (96-98). This comment would also have served to reinforce Jill’s feeling of inadequacy. The lack of empathy extended to her own friends and family: “This awful thing has happened to me and nobody was concerned” (127-128). This relates back to ‘validation’ – at no point did Jill ever feel that her experience was validated as traumatic. This feeling of a lack of empathy
extends to a sense of isolation from others: “you don’t know how ill I feel… you just have no clue” (187).

A feeling of detachment (from the birth process and from her daughter) is conveyed in the words: “and then she was born” (100). The feeling of detachment becomes more apparent as she describes how her husband held their daughter, looking at her ‘for ages’ (108) and then: “and... erm, I held her and she was alright” (109) – a sense of discomfort is conveyed through the pause and ‘erm’ which may represent Jill’s discomfort when she was given her baby to hold.

Jill conveys a real sense of disconnectedness from the world following her daughter’s birth: “Why are you coming to visit me when I am demented?” (138). She says: “Just leave me on my own [laughs] what’s the matter with you all?” (139). The laugh denotes how 20-years later she sees this through different eyes. Jill shows how she has internalised the subliminal messages that she referred to earlier: “How can you not cope with something that’s entirely natural and people have been doing, you know, forever?” (208-209) and I get the sense that this leaves her feeling disconnected from others.

**Enduring distress**

As with Lynn, Jill’s lasting memory of childbirth is very negative: “the actual birth was just vile” (37). She says: “oh it was just awful and I thought, ‘How can people say this is a nice experience because it just isn’t’” (110-111) – once again Jill demonstrates her sense of ‘difference’ from others.
Jill has actively avoided childbirth: “I must make damn sure that that never happens to me again” (155-156). Jill’s adamance is apparent: “I would have done my utmost to make sure that it didn’t happen, and, to be pregnant again… it’s just unthinkable…”(228-230) – the pauses around the phrase emphasise that for Jill ‘it’s just unthinkable’. Jill refers to ‘madness’ again: “I could quite see that I could end up in a psychiatric ward if I had another one” (205-206) – this illustrates the depth to which Jill experienced childbirth as a complete loss to her self.

Avoiding pregnancy has not been without regret for Jill: “Oh you should’ve done it again” (241). She told me that it would have been nice to have had another child and that she harbours feelings of guilt: “I think there’s a lot of guilt associated with the fact that [daughter’s] an only one” (252-253). Despite acknowledging her own reasons for avoiding pregnancy she berates herself for not having another child: “You couldn’t, you know, you couldn’t why couldn’t I have gone through that again?” (237-238).

**Family life**

Jill remarks that avoiding subsequent pregnancy has affected her relationship with her daughter: “I think its made my relationship with my daughter very intense” (263-264). This is reflected in the earlier discussion regarding Jill’s sense of loss of self; the intense nature of her relationship with her daughter was hinted at there. Jill tells that having a second child: “would’ve required [husband] to change” (273-274). This suggests that it was predominantly Jill who was involved in the day-to-day care of their daughter and running of the home. She describes her husband as “self-contained” (266) and the suggestion is that he maintained his self-identity, whereas
Jill lost hers. Jill says that she: “*would’ve been extremely resentful*” (272) if her husband had not ‘changed’ if they had gone ahead and had a second child. I wonder if she feels resentful anyhow, that she incurred so much loss, while he didn’t, and I wonder how much impact that had on her decision to avoid pregnancy.
### Interview 2 (Jill): Table of Themes from IPA

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| Shock | “[drops her voice to a whisper]...I was just so stunned”  
| Need to be acknowledged | Lack of acknowledgment  
| | “Well what about me? What about me you don’t realise what has happened to me”  
| | “I didn’t feel as though anybody ever acknowledged what a huge and traumatic thing it was”  
| | “…the trauma [of the sickness] was horrible and the depression that comes with it…I think that’s also not acknowledged and understood”  
| | “I said, ‘...that was the most horrible experience I’ve ever had,’ and he said, ‘No, no it was fine’ “  
| | “…that would be really…nice if someone just gave you the permission to feel like this”  
| Change | Within herself  
| | “...completely different”  
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| | “…it was just chaos...home’s not the same because you’ve got this baby”  
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| | “…completely different, sort of irrational”  
| | “…you’re just not the same, not the same person”  
| | “…you’re not you as an individual…its you and this baby forever”  
| | “I was like post-natally deranged”  
| | “suddenly I was just hopeless, helpless, useless”  
| | “…it leaves you feeling…inadequate because if its normal you should be able to deal with it”  

| Lack of order |  
| | “...completely different”  
| | “[towards the child] the overwhelming feeling of responsibility”  
| | “…it was just chaos...home’s not the same because you’ve got this baby”  
| | “…everything’s all over the place”  

| Loss of self |  
| | “I didn’t like the fact that I had lost my life as well”  
| | “...the fact of having lost me”  
| | “…your body’s just taken over and that’s such a loss to you”  
| | “I was utterly deranged, utterly unrecognisable to myself”  
| | “…you have an idea of who you are, and as soon as you’re pregnant…that just went out of the window”  
| | “…completely different, sort of irrational”  
| | “…you’re just not the same, not the same person”  
| | “…you’re not you as an individual…its you and this baby forever”  
| | “I was like post-natally deranged”  
| | “suddenly I was just hopeless, helpless, useless”  
| | “…it leaves you feeling…inadequate because if its normal you should be able to deal with it”  

| Negative self-perception |  
| | “I was like post-natally deranged”  
| | “suddenly I was just hopeless, helpless, useless”  
| | “…it leaves you feeling…inadequate because if its normal you should be able to deal with it”  

| Number of cases |  
| | 117-118  
| | 106  
| | 140-141  
| | 126-127  
| | 161-162  
| | 190-192  
| | 130-131  
| | 296-297  
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| | 20-21  
| | 27  
| | 118-119  
| | 119-120  
| | 18  
| | 23-24  
| | 152-153
| Feeling of not being able to cope                                                                 | “I couldn’t have gone through that again and it seems pathetic” |
|                                                                                               | “...you think...there’s some, basic defect in me...why can’t I do it” |
|                                                                                               | “...it’s dreadful...you do feel...[sighs]...very much as though you’ve failed” |
|                                                                                               | “I didn’t think, I would be able to look after, after my daughter, and be pregnant” |
|                                                                                               | “I didn’t think I would be able to be an alright mother as well as have a baby” |
|                                                                                               | “Actually no you wouldn’t have coped. You would have been demented” |
|                                                                                               | “...its like a little bit of self-preservation that you don’t do it again...you feel quite selfish” |
|                                                                                               | “but erm...... I don’t know... I think I would have lost myself” |
| Implications for self                                                                         |                                                                 |
| In relation to others                                                                          |                                                                 |
| Difference of perception                                                                       | “... the birth, which wasn’t traumatic **apparently**...was just described as like normal [slight wry laugh]” |
| Feeling of being duped                                                                         | “[re breathing in labour] I thought, ‘That’s another lie’ “ |
|                                                                                               | “I really felt as though from start to finish it was an enormous con” |
| Lack of empathy                                                                                | “...nobody sort of levelled with me” |
|                                                                                               | “...midwife saying, ‘Women in Russia give birth in the morning and they’re out in the potato fields in the afternoon,’ that was the level of...concern I got” |
|                                                                                               | “This awful thing has happened to me and nobody was concerned” |
| Sense of isolation                                                                             | “...you don’t know how ill I feel...you just have no clue” |
| Detachment                                                                                    | “...and then she was born” |
|                                                                                               | “I held her and she was alright” |
| Disconnectedness                                                                              | “Why are you coming to visit me when I am demented?” |
|                                                                                               | “Just leave me on my own [laughs] what’s the matter with you all?” |
| Feeling unsupported                                                                            | “How can you not cope with something that’s entirely natural and people have been doing, you know, for ever?” |
|                                                                                               | “[midwives] don’t want the, the hassle of you getting in a state” |
### Enduring distress

| Memories of childbirth | "..the actual birth was just vile”  
| Avoids childbirth       | "..oh it was just awful and I thought, ‘How can people say this is a nice experience because it just isn’t’ “  
|                        | “I must make damn sure that that never happens to me again”  
|                        | “I would have done my utmost to make sure that it didn’t happen, and, to be pregnant again…it’s just unthinkable…”  
|                        | “I could quite see that I could end up in a psychiatric ward if I had another one”  
| Feelings of regret about not having another child | “Why can’t I do it, other people do it…go through all this pain and all this trauma…and still have another one, you, you didn’t”  
|                        | “You couldn’t, you know, you couldn’t why couldn’t I have gone through that again?”  
|                        | “Oh you should’ve done it again”  
|                        | “I think there’s a lot of guilt associated with the fact that she’s an only one”  
|                        | “..but now, it would have been nice to have another one”  

### Family life

| With daughter | “[avoiding subsequent pregnancy] I think its made my relationship with my daughter very intense”  
| With husband  | “[having a second child] ..would’ve required him to change”  
|              | “[implications of having a second child – if he hadn’t have made changes] I would’ve been extremely resentful”  

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Memo 3: Heather

Heather is 28, English and has lived in a small town on the East coast of Scotland since getting married about 4 years ago. She lives with her husband and daughter, who is almost 3 years-old. Heather has an MSc and worked professionally until resigning from work a couple of years ago as she was struggling to balance the demands of the job with being a new-mum as well as having post-natal depression. She is undertaking a part-time creative course while her daughter is in nursery. Although having a ‘straightforward’ water-birth, Heather continues to be traumatised by the experience of childbirth. She was post-natally depressed and has been told that she has Post Traumatic Stress Disorder. Heather has had counselling and produced some artwork to depict her experience of childbirth. The artwork is displayed on the Birth Trauma Association website and Heather has given a copy to me to display within this study. Heather has been referred for Cognitive Behavioural Therapy and is waiting for an appointment. Heather would like to have another child but is unable to go ahead with a pregnancy because of her fear.

Control

Heather was taken aback by the lack of control that she experienced during labour: “there’s no control” (381). Feeling almost paralysed by the pain she comments: “I could hardly move, at all” (403). Her mouth became dry through taking gas and air and she found that: “you’re actually just drooling [laughs] because you can’t swallow” (411). Heather illustrates how she felt she had lost control over her body: “I can remember just seeing little hands scrabbling... scrabble, scrabble, scrabble and I can’t work out what I was trying to do” (400-402). She conveys the image of someone clawing away at the earth, trying to escape. Heather describes how, when in
the birthing pool, her lack of control left her feeling that she was going to drown: “every time I had a contraction your whole body gets folded up... and pushing me back in the water” (440-442). In her terror, Heather clung onto the sides of the pool while the midwives prised her fingers away: “they were trying to get me to let go of the pool... I was really terrified I wouldn’t and they actually curled my fingers off” (461-463).

Feeling helpless, Heather had hung over the side of the pool: “you could sort of hang in on the front, like you know like a drunk over a washing-line” (428-429). Heather describes how she felt that her body had been taken over: “the baby is kicking in your body and, you know its going to get on with it... alien-style and you’re not going to be able to do anything, about it” (382-384). Unlike Jill, Heather gives the impression that she was very aware of her baby as being separate from, and independent of herself. It seems as though she sees that the baby will enter this world of its own volition.

Heather uses animal-imagery to evoke how she felt she had lost control over her body and succumbed instead to an almost primeval state: “I remember just, roaring like a lion, really just roaring, roaring roaring roaring...” (490-491). While on the mat, Heather was: “kind of whining and scrabbling” (403-404); in the pool: “I’ve only got this, kind of cat-in-the-bath feeling of; of not having anything to hold on to” (508-509).

Heather did make attempts to regain control: “every time I had a contraction I tried to get my head over the side” (447). Heather came to realise: “if you really pushed hard
you could sort of get it to, the pain will sort of stay away from you a bit” (511-512). I get the impression that Heather was pushing in order to send the pain away rather than to deliver her baby – her instincts at this time seem to be focused on survival. Momentum gains and you can feel Heather grabbing back control: “you now have like a role and purpose in it... you think, ‘I can really push, I can make this over really quickly…”” (547-500). One can sense triumph when Heather states: “you know nothing, nothing was going to stop me giving birth at that point” (556-557).

Expectations

Heather had maintained a positive outlook throughout her pregnancy: “it’ll all be fine” (66) and: “I do remember going into it with a really really positive outlook” (148). Anticipating childbirth she had thought: “it’ll be you know a good kind of pain rather than a broken leg kind of pain” (127-128). However, reality did not match her expectations and she remarks: “I can remember that and thinking, [mock-slaps her face and smiles] give myself a bit of a slap because, you know, what a load of cobblers, really, to be honest” (129-131).

Heather admits: “I I do feel that I had a very rosy view of it beforehand that was then, not matched at all” (590-591). She says: “I thought, I would be, alright and it really wasn’t, at all” (376-377). Heather had attended childbirth preparation classes with the National Childbirth Trust (NCT) – she conveys a sense of frustration with them for presenting (in her opinion) a very positive view of childbirth: “I also think that, they’ve (NCT) got a beautiful view of, of childbirth that isn’t…” (589-590). She attributes her sense of ‘disappointment’ (591) to this process. Perhaps most disappointing of all is the mismatch between her expectation of giving birth to her newborn
child: “I was really, really looking forward to meeting her, I really was” (167), with the reality: “but neither did I think that I would hate her and I would be terrified of her and really wouldn’t want to be with her” (738-739).

Heather believed that the midwives would expect her to be happy with her childbirth experience: “from the midwives point of view… ‘obviously she’ll be really happy with this she’s got to have this fantastic, natural birth’” (535-538). One can almost hear the irony in the words ‘fantastic’ and ‘natural’. Heather expresses societal expectations: “Everyone expects me to be this mum” (621-622) and: “A caring mother would, hold her baby up and check she’s alright” (615-616). This is in contrast to how Heather was feeling and so will have impacted upon how she viewed herself at that time.

Physical and mental distress

Heather experienced the pain of labour very intensely: “.the pain of it, it was just, absolute agony really, really bad, I mean it had gone from painful to... so intense” (305-306). She describes the intensity of the pain: “dragging out your internal organs and setting fire to your thigh bones” (513-514). Heather conveys how the level of pain for her became unbearable: “...don’t even breathe on my skin because that will, overload the pain receptors too much” (322-323). Heather is overwhelmed by the pain and just cannot believe what she is enduring: “...it would still get worse and worse and worse and worse and worse, you know, and you’re like you just got this huge wave of disbelief every single time” (397-398).
Heather struggled to cope with the level of pain that she felt: “No I really can’t, really can’t cope with that” (267-268). The ‘not knowing’ how bad the pain was going to get and how she would cope with it intensified her fear: “Now you don’t know what’s coming, no you don’t know how bad its going to be and you don’t really know, you know, what’s going to happen or what they’re going to do about it” (334-346). Seeing her husband’s fear etched in his face reinforced her fear, offering her no assurances of safety: “[husband] just looked completely freaked at this point... he was just big big eyes” (492-494) and: “every time I looked at him it was like, ‘That’s not reassuring, that kind of terrified face’” (496-497). Heather was unable to articulate her fears: “but he didn’t realise this, I didn’t have a breath to tell him” 323-324) and: “I couldn’t really speak to people either” (454-455).

The situation left Heather with a complete lack of dignity: “all the dignity’s gone out the window as well because you’re now scrabbling about the floor whining and crying and dribbling” (412-413). Heather felt desperate to escape the whole torturous situation: “I started thinking, ‘Crawl over to the wall, I could knock myself out on the wall’” (414-415). The violence in the next image portrays both Heather’s desperation and the level of pain that she was experiencing: “if I could put my head under a sledge hammer at that point I really, I really would have” (473-474).

While in the pool Heather was sure she would drown: “Oh, I’m actually going to drown now” (444-445). Her situation was so intense it appears that she was disorientated: “I couldn’t really tell whether I was breathing air or breathing water” (449-450). Heather’s panic can be sensed as she recalls how the midwives tried to get her to change her position in the pool: “‘God!’ and at that point I thought, ‘I’m really
going to drown – drop me” (463-464). Heather’s desperation is illustrated: “I’d kept smashing my face on the pool trying not to fall” (452-453). Heather’s instinct was to try to survive this ordeal: “I was just hanging on like grim death to absolutely everything” (467-468).

Baby as alien to self

As the searing pain became unbearable, Heather’s feelings towards the baby inside her changed: “I decided at that point… that this baby really, wasn’t nice” (468-469). She saw her baby as vicious: “its going to rip its way out of you” (383). In her imagination the baby became a monster: “I started imagining her with little demon things and fangs and teeth sort of clawing the way out” (470-471). Completely associating the baby with all of the torture that she was enduring, Heather says: “if she was an alien I wouldn’t have been surprised” (572-573). Her depth of feeling is conveyed as she objectifies and demonises her child in one phrase: “now this evil thing’s been born” (638). Heather’s feelings towards her newborn child are very negative: “she’s very hideous looking” (569-570); “she felt so horrible to me” (574).

Not only did Heather not bond with her baby as she was born, she also conveys feelings of rejection towards her child: “from the second she was born, erm, I really didn’t want her, at all” (690). As her baby was handed to her she thought: “‘Fucking get it off me’” (570). As the midwife took the baby to give her some oxygen, Heather was relieved: “It was like, ‘Great – take it” (578). Heather realised her responsibility for her child but struggled with the dilemma of her feelings: “you’ve got to look after it and you don’t want it” (638). Keeping her dilemma secret, Heather’s plea was silent: “I’ve changed my mind now take her away... I want to go home leave her
here” (693-694). Heather displayed empathy with a young girl she had heard about on the news who had abandoned her baby: “'I'm on your bus girlie get going,'... I really, I could really sympathise with her” (680-681).

Heather resented what she felt her baby had put her through: “because of the birth, I started out hating her from the second she was there, you know, sort of very resentfully” (782-784). Not only did Heather resent her child for the ordeal that she had suffered, but Heather was also incredibly jealous of the attention that her husband bestowed on the baby: “I sort of completely jealous of her” (697-698), “being his most adored thing” (704). Heather felt that the baby came between her and her husband: “I felt you know she’d sort of stolen him away from me” (706-707) and: “suddenly there’s somebody in the house who can monopolise his attention” (712-713). Heather’s sheer frustration with her baby is shown: “I really just wanted to, throw her out of the window, she just used to drive me nuts” (731-732).

Detachment

Heather’s sense of detachment from her husband began during the labour: “[husband]’s getting really a bit upset ‘cos I’d stop stopped talking to him” (300-301). In her thoughts: “I was like, ‘Just don’t touch me,’ I was like, ‘don’t touch anything,’ you know, ‘don’t touch me,’ you know, ‘don’t come near me, ’” (327-328).

Heather also expresses a sense of detachment from the process of her child’s birth: “I was like, ‘What?!’ [laughs] you know, I don’t give a toss about my t-shirt now you know I’m just getting in the pool, I don’t care” (426-428). She felt divorced from the process, as if she need not have been there almost: “There was no reason, why you are particularly conscious at this point... why do you need to be there?” (416-418).
It’s as if she sees her body as acting independently: “getting on with everything” (504) and is separate from her inner ‘self’: “I don’t see why I need to be here, getting subjected to this, at all” (419-420).

In fact when the birth ordeal is over, it feels as if Heather was lost in the aftermath: “I’m just going to sit here and jibber, very quietly to myself in my head” (560-561).

At that point Heather longed to be left alone: “I’d have never been, so pleased just left in a quiet room, on my own” (668-669).

Continuing anguish

As with the other interviewees the memory of childbirth, which should be a monumental moment, is tainted: “writhing back in agony” (140-141). Heather maintains a negative view of childbirth: “which, is then complete agony and traumatises you for years afterwards” (143-144). Heather’s expression: “natural birth... it’s left huge dents in me” (595) illustrates the devastating effect of her trauma. She continued to find it difficult to talk about her experience: “the birth thing I hadn’t really talked it through with anybody” (844-845). The feeling of needing to escape that Heather experienced during labour continued after she got home with her baby. Heather recalls leaving her baby with her mother: “I remember going down to the beach and thinking, ‘Yeh I really could, just walk off into the sea at this point’” (858-859).

Heather used to feel very anxious around her baby: “I used to be on tender-hooks the whole of time, in case, she woke up and needed something” (733-734). For a long time her baby served to remind her of her ordeal: “but the birth really used to bother
me because when I saw her, you know, I’d be back in the pool” (791-792). Heather was also plagued by nightmares: “you’d be having nightmares about it, every time I saw the baby I’d be thinking about it” (847-848). Even now references to birth cause Heather distress: “I still don’t like watching television...you know birth references...films cinema... might sneak some birth reference in... it really distressing” (850-856).

A few months after the birth Heather’s GP diagnosed her with depression. Heather says that although she was aware of ‘dipping down’ (748), she hadn’t realised she was depressed – she was more aware of the anger she felt: “..most of the time I am just furious, completely livid, really furious with this baby and, everybody and everything” (751-752).

Heather continues to avoid pregnancy and childbirth: “I really couldn’t face one at all at the moment” (878). Heather says: “I can’t kind of contemplate... there’s the whole birth... I just I can’t even I won’t I won’t go anywhere near that” (886-888).

Heather’s stuttering here hints at her difficulty in even contemplating childbirth. However her avoidance leads to a dilemma as Heather states: “Our family is not complete” (877) and: “I do want another one” (877).

Pretence and duplicity
Heather displays feelings of being misled. A woman who Heather knows gave birth not long before she did and gave a positive account of her childbirth experience – Heather comments: “No, she is an exception, or she was lying or, you know, or something” (341). Heather feels that others have not been honest with her: “..which is
part of why I felt so disappointed if somebody had been, honest, you know, it’s going to hurt like hell, bear in mind you probably will want some drugs…” (591-593).

Heather is aware of her own pretence: “from the very first minute of her birth I’m pretending to be a mum instead of, enjoying and actually being one” (622-623). “I wasn’t really interested in looking after her but, I was interested in, pretending to be this [laughs] fantastic mum” (683-684). It was important to Heather that she was seen to conform to the stereotype of a new mother: “you know, I can’t say, ‘I don’t want her now, now what am I going to do?’” (685). Heather even fears that by even considering having another baby that she risks lying to, and tricking herself: “..then I think, I bet I’d fall for it again, I’d think it was alright, I’d get back there and I would have lied to myself and tricked myself back into it” (900-902).

Need for acknowledgment

While in labour Heather made a silent plea for recognition of the ordeal she was enduring: “I’m thinking, ‘Help! Help!’ you know, somebody, somebody help me this is awful,’ you know, why are you not helping? Why are you just standing there watching?” (538-540). Heather’s sense of isolation is also portrayed here. Following the birth Heather felt both resentful towards her baby and angry with her husband for what she perceived as his lack of acknowledgement: “You haven’t even noticed that I’m in a complete jibber and this is awful” (661-662).

Life changes

Heather reports that her relationship with her husband changed following the birth: “..marriage... before this happened...which were really happy and we really
enjoyed...I felt you know she’d sort of *stolen* him away from me” (706-707). Heather emphasises the word ‘stolen’ which suggests the level of loss that she feels. Heather’s resentfulness of the attention that her husband bestowed on the baby affected the way she related with him: “if he went and picked her up first, before he came to see me I would be furious with him” (698-699). Heather’s job, which she had enjoyed before the birth, became problematic: “work became a bit of a downhill spiral” (744). Life for Heather changed considerably following childbirth and she conveys sadness at what she perceives as loss: “...a lot of what used to really make me feel sad... I didn’t have my horse and I didn’t have my husband, your home isn’t really your own any more and I don’t really pay attention at work any more either, a lot of it’s the whole life change” (786-790).

**Sense of self**

Prior to childbirth Heather had viewed herself as fit and strong, with “a really high, pain threshold” (375-376). The aftermath of her experience has real implications for her self-concept: “I thought, I would be, alright and it really wasn’t, at all’ (376-377). Heather is left feeling bad about herself: “I really didn’t want her, at all which, which makes you feel really bad” (690-691). She also conveys a sense of sadness and regret that she feels this way. When reflecting on her thought about requesting a Caesarean Section with general anaesthetic, she says: “But then I think there’s something, something sad about, you know, your baby being, cut out of your lifeless body and handed away to someone because you don’t want to be there, for its birth” (896-898).
Heather indicates the isolation that she has felt in that largely, she has felt unable to share her feelings with others, for fear of being criticised or excluded: “you can’t you know that’s an awful thing to think, erm and you couldn’t really tell anybody either” (691-692).
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<td>“...this isn’t, this isn’t going to be, the way you thought it was going to be, at all”</td>
<td>127-128</td>
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<td></td>
<td>“I thought, I would be, alright and it really wasn’t, at all”</td>
<td>129-131</td>
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<td></td>
<td>“I also think that, they’ve [National Childbirth Trust – NCT] got a beautiful view of, of childbirth that isn’t…”</td>
<td>342-343</td>
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<td>“I do feel that I had a very rosy view of it beforehand that was then, not matched at all”</td>
<td>37-39</td>
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<td></td>
<td>“...but neither did I think that I would hate her and I would be terrified of her and really wouldn’t want to be with her”</td>
<td>535-538</td>
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<td>“...from the midwives point of view… obviously she’ll be really happy with this she’s got to have this fantastic, natural birth”</td>
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<td>“A caring mother would, hold her baby up and check she’s alright”</td>
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<td>“...at that point I realised that it was so bad that, like any extra, kind of sensory stimulation was too much”</td>
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<td>“...it would still get worse and worse and worse and worse and worse, you know, and you’re like you just got this huge wave of disbelief every single time”</td>
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<td>“...the pain’s so bad you can’t really feel whether you’re breathing or not”</td>
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<td>“...dragging out your internal organs and setting fire to your thigh bones”</td>
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<td>“No I really can’t, really can’t cope with that”</td>
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<td>“…so intense I’m sure you couldn’t, you know couldn’t cope with that and think what to do, at all”</td>
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<td>“Now you don’t know what’s coming, no you don’t know how bad its going to be and you don’t really know, you know, what’s going to happen or what they’re going to do about it”</td>
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<td>“every time I looked at him it was like, ‘That’s not reassuring, that kind of terrified face’ “</td>
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<td>“...but he didn’t realise this, I didn’t have a breath to tell him”</td>
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<td>“I couldn’t really speak to people either”</td>
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<td>“…all the dignity’s gone out the window as well because you’re now scrabbling about the floor whining and crying and dribbling”</td>
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<td>“I was just <em>hanging</em> on like grim death to absolutely everything”</td>
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<td>“I’ve I’ve got it now and I’m really stuck you know”</td>
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<td>“..she’s just, completely torn her way out of me”</td>
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<td>“I started imagining her with little demon things and <em>fangs</em> and <em>teeth</em> sort of clawing the way out”</td>
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<td>“I wouldn’t have been at all surprised, to see her born with fangs and teeth, and devils horns”</td>
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<td>“..if she was an alien I wouldn’t have been surprised”</td>
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<td>“..now this evil things been born”</td>
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<td>“I decided at that point… that this baby <em>really</em>, wasn’t nice”</td>
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<td>“I can’t do this and I don’t care about the baby anymore”</td>
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<td>“I could not care less about actually meeting her at that point”</td>
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<td>“..she’s very hideous looking”</td>
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<td>“..she felt so horrible to me”</td>
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<td>“..she’s all slimy and horrible looking”</td>
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<td>“I can remember her sort of slithering about wanting to feed”</td>
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<td>“I really didn’t like her”</td>
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<td>“I was just thinking, ‘Fucking get it off me’ “</td>
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<td>“It was like, ‘Great – take it’ “</td>
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<td>“I don’t want her, now”</td>
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<td>“..you’ve got to look after it and you don’t want it”</td>
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<td>“I did not want this to be, dropped off on a bed somewhere, with me being the only one left to care for her”</td>
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<td>“..from the second she was born, erm, I really didn’t want her, <em>at all</em>”</td>
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<td>“ ‘I’ve changed my mind now take her away… I want to go home leave her here’ “</td>
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<td>“I couldn’t <em>wait</em> to get back to work”</td>
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<td>“ ‘..I’m on your bus girlie get going,’ … I really, I could really”</td>
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| **Empathy with baby abandonment** | sympathy with her”  
“I was really angry with her”  
“.if [husband] went he went and picked her up first, before he came to see me I would be furious with him”  
“.used to really annoy me that, you know she, you she would be able to keep me away from him”  
“I felt you know she’d sort of stolen him away from me”  
“.because of the birth, I started out hating her from the second she was there, you know, sort of very resentfully”  
“I sort of completely jealous of her”  
“being his most adored thing”  
“.suddenly there’s somebody in the house who can monopolise his attention”  
“.nobody else could make him, just sort of, drop me like that”  
“I really just wanted to, throw her out of the window, she just used to drive me nuts” |
| **Resentful feelings** | 735  
680-681  
661  
698-699 |
| **Jealous of baby** | 701-703  
706-707  
782-784  
697-698  
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712-713  
713-714  
731-732 |
| **Frustration** |  
| **Detachment** | “[husband]s getting really a bit upset ‘cos I’d stop stopped talking to him”  
“I was like, ‘Just don’t touch me,’ I was like, ‘don’t touch anything,’ you know, ‘don’t touch me,’ you know, ‘don’t come near me,” “  
“There was no reason, why you are particularly conscious at this point… why do you need to be there?”  
“I don’t see why I need to be here, getting subjected to this, at all”  
“I was like, ‘What?!’ [laughs] you know, I don’t give a toss about my t-shirt now you know I’m just getting in the pool, I don’t care”  
“.that was just your body getting on with everything”  
“I’m just going to sit here and jibber, very quietly to myself in my head”  
“I’d have never been, so pleased just left in a quiet room, on my |
| **From husband** | 300-301  
327-328  
416-418  
419-420  
426-428  
504  
560-561  
668-669 |
<p>| <strong>From process</strong> |<br />
| <strong>Being lost in the aftermath</strong> |<br />
| <strong>Wants to be alone</strong> |<br />
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<th>Continuing anguish</th>
<th>Memories of childbirth</th>
<th>“...writhing back in agony”</th>
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<td>Attitude towards natural childbirth</td>
<td>“This really isn’t going to be ok, at all”</td>
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<td>Couldn’t talk about feelings</td>
<td>“...natural childbirth which, is then complete agony and traumatises you for years afterwards”</td>
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<td>Need to escape</td>
<td>“...the whole time I didn’t actually tell her anything I was in such a state”</td>
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<td>Anxiety</td>
<td>“...the birth thing I hadn’t really talked it through with anybody”</td>
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<td>“I remember going down to the beach and thinking, ’Yeh I really could, just walk off into the sea at this point,’”</td>
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<td>“I used to be on tender-hooks the whole of time, in case, she woke up and needed something”</td>
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<td>Feelings of anger</td>
<td>“...whenever I had a quiet moment, I would sit there thinking about it”</td>
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<td>“...you’d be having nightmares about it, every time I saw the baby I’d be thinking about it”</td>
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<td>“I still don’t like watching television…you know birth references…films cinema… might sneak some birth reference in... it really distressing”</td>
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<td>“...most of the time I am just furious, completely livid, really furious with this baby and, everybody and everything”</td>
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<td>Lasting effect</td>
<td>“...natural birth… its left huge dents in me”</td>
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<td>“I would really rather not, not have that sort of living in my mind for ever afterwards”</td>
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<td>Avoidance of childbirth</td>
<td>“It really is, just, sort of, point blank – having them, giving birth to them, in the first place”</td>
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<td>“...I had the, post-natal depression… I don’t want a whole year of misery after it”</td>
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<td>“I really couldn’t face one at all at the moment”</td>
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<td>“I can’t kind of contemplate… there’s the whole birth… I just I can’t even I won’t I won’t go anywhere near that”</td>
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<td>“I just shy away from it”</td>
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<td>“Our family is not complete”</td>
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<td>“I do want another one but, I really couldn’t face one, at all at the moment”</td>
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<td>“.which is part of why I felt so disappointed if somebody had been, honest, you know, it’s going to hurt like hell, bear in mind you probably will want some drugs…”</td>
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<td>Pretence</td>
<td>“.from the very first minute of her birth I’m pretending to be a mum instead of, enjoying and actually being one”</td>
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<td>“I felt that I was pretending it all the time just, completely pretending to be a mum”</td>
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<td>“I wasn’t really interested in looking after her but, I was interested in, pretending to be this [laughs] fantastic mum”</td>
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<td>“.you know, I can’t say, “I don’t want her now, now what am I going to do?” “</td>
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<td>Fear of being tricked</td>
<td>“.then I think, I bet I’d fall for it again, I’d think it was alright, I’d get back there and I would have lied to myself and tricked myself back into it”</td>
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<td>Plea for help / recognition</td>
<td>“I’m thinking, ‘Help! Help!’ you know, somebody, somebody help me this is awful,’ you know, why are you not helping? Why are you just standing there watching?’ “</td>
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<td>Relationship with husband</td>
<td>“.if he went and picked her up first, before he came to see me I would be furious with him”</td>
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<td>“.suddenly there’s someone in the house who can monopolise his attention”</td>
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<td>“.with he and I united, you know in sorting out this, cheeky toddler”</td>
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<td>Sadness at loss</td>
<td>“..work became a bit of a downhill spiral”</td>
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<td>“..a lot of what used to really make me feel sad… I didn’t have</td>
<td>“..a lot of what used to really make me feel sad… I didn’t have</td>
<td>“..a lot of what used to really make me feel sad… I didn’t have your home isn’t really your own any more and I don’t really pay attention at work any more either, a lot of it’s the whole life change”</td>
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<td>my horse and I didn’t have my husband, your home isn’t really</td>
<td>your home isn’t really your own any more and I don’t really pay attention at</td>
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<td>your own any more and I don’t really pay attention at work any</td>
<td>work any more either, a lot of it’s the whole life change”</td>
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<td>more either, a lot of it’s the whole life change”</td>
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<td>“I really didn’t want her, at all which, which makes you feel</td>
<td>really bad”</td>
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<td>“.. you can’t you know that’s an awful thing to think, erm and</td>
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<td>you couldn’t really tell anybody either”</td>
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<td>“But then I think there’s something, something sad about, you</td>
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<td>know, your baby being, cut out of your lifeless body and handed away</td>
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<td>to someone because you don’t want to be there, for its birth”</td>
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<td>“..will I get to a point where, I want to go back and make it right</td>
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<td>by having a good second birth”</td>
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Memo 4: Alex

Alex is 35, employed, and lives in the south of England with her husband, and her 15-year-old son from a previous relationship. Following a traumatic birth Alex has always been adamant that she would not get pregnant again (during labour Alex felt alone, unsupported and out of control – she also tore extensively). However she would very much like to have a baby with her husband of 10 years, and in particular he would desperately like to have a child of his own with Alex. Alex is now in turmoil, torn between her desire to have another child and her absolute terror at the prospect of childbirth.

Control

During labour Alex felt completely overwhelmed by her contractions – not so much the pain that they brought, but rather the feeling of not being able to control them: “..contractions which were, horrendous with this pure fact that I couldn’t stop them happening and I had no control” (291-292). This had been unexpected and added to the feeling of being out of control: “My biggest overriding thing was not being able to control them…..I don’t think I was properly prepared for that” (201-203). It was experiencing the contractions as ‘spontaneous’ and ‘involuntary’ that led to Alex feeling out of control: “..you can’t control something that’s happening to your body when you, do that with every other aspect” (204-205). Experiencing the contractions as highly unpleasant, Alex found it traumatic that she was unable to stop them: “I couldn’t obviously control then I couldn’t stop the contractions” (193-194). This feeling of labour as leaving Alex out of control has carried forward into the present; with Alex reflecting on her inability to commit to having another baby she says: “I don’t actually feel it’s a decision I’m in control of” (1026).
Left to labour alone in the middle of the night, Alex tried desperately to gain control by fighting her body’s instinctual need to push the baby out – terrified of giving birth while alone: “I was writhing around, trying to, stop it” (893-894). This image of Alex fighting to gain control is conveyed later in the process when she is being stitched up: “I was, actually growling at him and lifting my bum obviously as the needle went in I was shooting up in the air” (367-368).

Alex was overpowered in the examples above both by the contractions and by the doctor who stitched her up. Alex conveys a sense of helplessness with her situation: “I think that is one of the problems when you are in labour and you’re at that stage, you are helpless” (1293-1294): “I knew I couldn’t get out of bed and walk…..I just couldn’t do anything” (899-904).

Alex communicates how she felt that others had control, thus diminishing hers, although this will be discussed in a later section regarding hostility from staff. One example here is when Alex was ordered to get out of the bath, not long after she had got into it: “the nurse was just banging on the door” (453).

Following the birth Alex was desperate to leave the hospital in order to gain back control: “I just felt like I needed to, get home…..do things my own way” (635-637). In Alex’s words: “from the minute I was home I was absolutely fine” (684).

Feeling not ‘grown-up’ enough

Alex was young (19) when she became pregnant and had various problems to overcome, including finding somewhere to live with her boyfriend and coping with her mother’s disapproval of her pregnancy. Alex perceived societal disapproval:
“there were a lot of comments being made about sort of you know in public about, my age and sort of people looking at you like you were sort of not...some sort of person...because they’re assuming you’re 14…” (83-86). Alex felt this disapproval when she tried to talk with her antenatal midwife about housing: “the midwife just looked at me with, she just looked sort of just looked, almost utter contempt” (93-94).

Alex felt as though she was treated as a child: “‘You’ve ruined a nappy, what a waste, look at the mess you’ve made!’” (559-561) and: “it was almost like a child again it was like, ‘Well you’ve made a mess and I’m going to have to clean this up now” (565-566). Alex longed to be discharged from hospital but was met with: “‘You’re very young, you know, who’s going to support you, and how will you cope you should stay in for longer’” (644-645). Feeling like a child, Alex felt intimidated: “I felt obviously intimidated by it all in that, I was doing things wrong...its like, you know, like a child eating... and making a mess of it because... they’re aware that they’re doing it wrong so it kind of makes it worse...” (632-635). This implies a self-fulfilling prophecy of Alex being treated like a child and feeling and behaving like a child. She sounds child-like at one point: “‘Can I have a bath, can I have a bath, please can I have a bath?’” (395-396).

Feeling ‘not grown-up’ was a feature of her early pregnancy: “I was living at home, absolutely terrified of telling my Mum... she was absolutely furious” (26-28). This feeling of being in trouble was with Alex after the birth: “I was still kind of feeling that I was going to be told off for not...eating and drinking the tea and toast’ (490-492). Alex describes feeling as if she was being punished. She felt unsupported when beginning to bottle-feed her baby: “you know it’s almost like because I wasn’t
prepared to breastfeed I was going to have to suffer a little bit more” (592-594). In fact she perceived her experience in hospital as punishment for having a baby so young: “the whole thing had been sort of like, almost like a punishment that you felt was sort of like, ‘You’ve made your bed now lie in it...’” (492-494). As a result of how she perceived others’ attitudes towards her, Alex felt inadequate: “I felt that maybe I was doing something wrong” (502). This had a detrimental effect on her self-esteem: “you feel a bit stupid and like you’ve made a mistake” (625).

Physical and mental distress
Alex found the contractions of labour to be very painful: “I had a contraction while I was on the toilet and it was excruciating” (195-196). But this was nothing compared to the pain that Alex felt as she tore and as she was subsequently stitched up: “It was really painful, really, really painful” (1307-1308); “it was so painful” (343). Alex felt herself tear with every push during delivery: “giving an almighty push, feeling myself, tear then counting to ten again and having to do it... dreading each time because I knew the pain was going to come” (314-316).

Alex endured considerable physical distress at this time: “with every, push I could feel myself tear, very, very deep” (297-298): “I tore completely if I had stitches up my bum, it was a complete tear, which I felt every bit of it” (539-540). Having the tear stitched up was incredibly painful: “it really hurt I felt my stitches... I – felt – the needle going through” (363-366); the deliberate pauses between her words are used to emphasise her horror at feeling this pain. The tearing and stitching contributed
considerably to Alex’s ordeal: “I think it was really the stitching up that tipped me over the edge” (467-468).

After the birth she continued to feel pain and discomfort: “I could feel from the swelling there was no way I could sit down” (465-466). Following her discharge from hospital she continued to feel: “incredibly sore” (345) and when she had her 6-week postnatal check-up: “it was excruciatingly painful” (1304-1305). Unfortunately Alex continued to have problems with the stitched area: “I hadn’t healed properly, the stitches hadn’t healed internally and externally... she said they were just like calluses” (1308-1310): “they’d be really uncomfortable and burning inside and outside and round my butt and it was, pretty unpleasant” (1342-1343).

Whilst in hospital Alex was subjected to physical invasiveness: “it was so painful, it almost just felt like he just, stuck his hand in and went like that” (343-344). Then: “someone else came in and, just seemed to sort of ram a toilet-roll sized, tampon up there which again, made me squeal quite loudly and hurt a lot” (356-358). The thought of someone ‘ramming’ anything up her torn vagina is just horrific. At a later point, while she was lying in bed on the ward, someone inserted a suppository into her back passage without talking to her about it first: “I was laying there and someone came in and, [laughs] without warning... put a, a big suppository up my bum and I was quite shocked” (529-531).

Alex recalls that during the labour, as she was taken to the delivery suite: “I was in such a mess and I was hyperventilating” (255). Wanting her ordeal to end she became fixated on the clock: “I just kept saying, ‘How much longer? How much longer? How
much longer?” (253-254). As a doctor stitched her it all felt overwhelming: “this just cold sort of wave of nausea had just like, ‘Oh my God!'” (372-373); she adds: “at that point I was I’d had enough I really had had enough” (366). Having to endure the pain and indignity of her tear and stitches was: “the straw that broke the camels back” (471-472).

Negative experiences in hospital

The whole hospital experience contributed to the ordeal that Alex suffered. She perceived considerable hostility from hospital staff; this may be linked to Alex’s perception that she was viewed as a child. Unfortunately she did not receive nurturance but rather a ‘critical parent’ stance: “and eventually sort of quite exasperated with me she, came back to the ward” (452-453). Alex had bled excessively following the birth and blood had leaked through her pyjamas – she had nothing to change into which gave rise to this response from a midwife: “Oh for Gods sake, for Gods sake” (520). When Alex was being stitched there was no recognition of the agony she was in; instead the doctor: “he was just like, ‘Put your – bum – back on – the bed.’ So obviously he’s getting quite annoyed” (368-369).

Alex had struggled changing the first nappy and required another one - the midwife: “came down and looked, really really cross with me” (559). Another instance was when Alex was unable to get milk to flow from a bottle: “she snatched it off me with such force” (598-599) and: “again she was absolutely furious and kind of shoved it back at me” (603-604). Even the woman who brought the tea around to the ward showed cold impatience when Alex changed her mind about wanting a cup: “she was fuming, she was furious that I had changed my mind” (507-508); “very sort of kind of
ceremoniously threw this cup of tea at me” (510-511). Alex’s conclusion is: “I felt obviously intimidated by it all” (632).

There seems to have been some confusion of identity on the ward which had an unsettling effect: “nurses sort of, talking to the wrong person it was a bit like, ‘No I’m Alex, ’... that happened a few times” (183-185). After Alex had given birth, her mother had phoned the ward for an update and was given information regarding another patient: “yet again, they’d confused me with the woman, that was losing her baby... the distress to my Mum... I think is quite sad” (442-448).

Alex was denied pain relief: “I wasn’t given any pain killers” (283). With labour well under way Alex was denied the use of the tens machine she had brought with her: “”No no no no no you don’t, you don’t need it that’s much later” (213-214). Having been denied pain relief throughout her labour, towards the end stages she was told: “It’s far too late you can’t have anything now” (276).

Alex felt let-down by staff for the delay in calling her partner to the hospital: “I remember saying to her, ‘Can you call my boyfriend?’ because I was getting quite upset... ‘please call him ’” (218-219). Her boyfriend did not arrive until the late stages of labour after Alex had spent hours suffering alone: “I said to [boyfriend] later, ‘Why did you take so long?’... [boyfriend] said, ‘Oh they did call me but they said don’t worry about it to take my time ’” (245-248). It seems as though Alex felt that she was disregarded, and her suffering was not important.
Being left alone in labour for hours, Alex felt a strong sense of abandonment: “I had not had any sort of contact for quite a while” (235); “but no-one had actually looked in at any stage” (237). Alex had perceived hostility from staff earlier in the night and felt she was dismissed and left to cope alone: “I think it was being, left on my own... and sort of being told to... ‘Shut up, stop being a pain’” (761-762). At one point she feared that she would give birth alone: “part of me just thought I’m going to give birth to him here, on my own, you know, and no-one’s interested” (895-896).

The feeling of being unsupported continued after the birth. Following the birth Alex found it very painful and difficult to move and she had asked a midwife for a bottle of milk to feed the baby, Alex recalls: “it’s kind of like a drawn-out process to, get you the bottle... you can see them there its like, ‘Well I’m too busy to do that’” (590-591). Alex also reports a lack of consistency of care: “I didn’t see the same midwife, at any point” (1279-1280). This being so, I imagine that this may well have contributed to Alex’s sense that staff were hostile.

Need to be acknowledged

Alex had her pain not only dismissed, but in effect disputed: “I could see the peaks of my contractions as I was feeling them and she said to me, ‘See nothings happening’” (156-157). Feeling the pain of labour, to be told that she was not in labour caused Alex to feel anxious: “all the distress about being in labour and being told I wasn’t and... getting myself in a real mess over it” (351-353). Not knowing what was happening to her and the isolation of that, led to Alex feeling afraid: “being told I wasn’t in labour so you start, questioning because if someone’s saying to you, ‘No
you’re not,’ but you can feel something happening, so you then sort of, ‘Well what’s this then?’” (705-708).

Alex was not acknowledged at all by the doctor who stitched her tear: “he turned round to his colleague and said, ‘Hmm, this is interesting this bit belongs over here’” (371-372). Not only did his comment alarm her, but it feels dehumanising to be ignored in that process, treated like a piece of meat. On her own and in labour Alex was frightened but felt she was dismissed by staff: “every time I went and found anyone I was kind of really sort of, treated like I was being a pain anyway, you know, ‘Go away.’ ” (734-735); “she’s just said, ‘Be quiet,’ you know, ‘just go to bed and be quiet’” (161-162). The effect of feeling dismissed had a detrimental effect on Alex: “every time I got up, felt this enormous sense of guilt and like I was being a pain” (874-875).

Alex was left with the feeling of: “not being believed” (708). She felt as though she was being accused of lying: “but it was, that sort of attitude of, ‘No you’re not, you can’t be,’ ” (739-740). This feeling arose again later when Alex had feedback on her medical reports: “they told me I didn’t have stitches up my bum, they said its not in the records” (1370-1371). Alex feels very frustrated at not being believed: “and I was told and I know I had stitches up my backside so I don’t know what’s going on” (1373-1375).

Need for explanation
Alex did not understand what was happening to her and no-one explained it to her: “I was unaware of what was going on” (715-716). The final stage of labour lasted for a
long time with no reassurance of what was happening: “you’re giving birth any minute... you know, didn’t happen, a bit longer” (282-283). When the doctor who was stitching made the comment to his colleague, the lack of communication with Alex left her feeling afraid and she thought: “I was just like, ‘I don’t really want to know what you’re talking about, what on earths gone on down there?’” (374-376).

There was a general lack of information and clarification regarding her stitches: “wouldn’t tell me how many stitches I’d had... not answering sort of vague” (377-378). Consequently Alex has never known the extent of her injury: “so I was kind of a bit in the dark about how much damage had been done down there” (379-381).

Validation from ‘outside’ of the hospital

Others who were around Alex or who came to visit her in hospital were able to acknowledge the ordeal that she had experienced. Patients who were trying to sleep in the ward when Alex was in labour said to her: “’My God,’ they said, ‘we can’t believe,’ you know, they were just like aghast, ‘you were left all night, we could hear you’” (905-908). Their comments conveyed a sense of empathy as well as acknowledgment (912-914). When Alex had encountered hostility from the midwife regarding the baby’s milk, her visitors commented on this: “friends... were just like, ‘Oh my God that was really awful, she was really angry,’ you know, so other people had seen her reaction” (605-607). Alex’s mother had visited her and has told Alex: “You looked in a real state” (1391). Feeling validated is very powerful and this will have helped Alex to feel that she was not ‘going mad’; “So yeh again someone else has noticed, ‘cos you do think you’re being a bit neurotic, noticed there was obviously an issue” (1408-1409).
Continuing anguish

Alex’s lasting memory of childbirth is of: “a traumatic experience” (3). She felt from the moment of her son’s birth that she did not want to repeat the experience – when a midwife commented that her baby was ‘gorgeous’, Alex replied: “Yeh he is, but he’s going to be an only child” (475). Although barely 20 years of age, Alex wanted to be sterilised to ensure this: “he was only about 2 weeks old when I, strolled into a erm, er, like a well-woman clinic whatever and asked to be sterilised” (806-808). Alex explains her avoidance of pregnancy and childbirth: “I think I was so horrified, by what had happened to me that it wasn’t a hard decision, to make to not to have more children” (1003-1005). When I asked Alex about the thought of becoming pregnant she replied: “Ooh, horrified, absolutely horrified” (956) and: “feeling absolute, dread and terror and panic” (1136). In her avoidance of childbirth, Alex and her husband have applied to adopt a child – Alex says: “I do, kind of almost view myself as, unable to have children” (1041-1042). When with Alex, I did get the sense that she feels very sad at what she perceives as her inability to conceive, and in that sense it was like having a conversation with a woman who is infertile.

Alex describes the anxiety that she felt following her son’s birth: “I used to, earlier on, get very anxious and panic-attacky” (1254-1255). She used to have intrusive memories: “I don’t know if you call them flashbacks or not but I would suddenly start, sort of re-living it and thinking it” (775-776). She describes the ‘flashbacks’: “it would just be in my head and I wouldn’t be able to sleep and I’d get myself in a real state, you know and your heart racing” (1258-1259). Even now, all this time later, Alex gets: “quite sort of tight-chested” when she thinks about getting pregnant” (1137). There are images that continue to remind Alex of her trauma: “if it’s on TV...
actors, on TV, in labour, I get that, it goes really tight and... I just can’t watch it... and I close my ears so I can’t hear it” (1153-1154) and: “recently we watched a film where someone had stitches, without an anaesthetic and... I had to leave the room” (1150-1151).

The only way that Alex would consider pregnancy is if she was guaranteed to have a Caesarean Section (CS): “if someone promised me [a CS]..... I would have gone with it... I would have done it” (1114-1118). However, a few years ago when Alex consulted with an obstetrician to discuss this, she was denied the option: “but she said, ‘No. You don’t need a Caesarean’” (1250-1251).

Alex found it difficult to talk about her experience and became distressed when she went, years later, to talk to her GP about it: “I got myself in quite a state and I was shaking, I was sobbing and everything trying to, tell him what happened” (1237-1238). Alex continues to feel distressed by it all: “I still cannot get my head around what happened” (1091-1092). Fifteen years on and she is still traumatised: “What I can’t get past is the birth thing... but I just can’t” (1120-1121). Alex says: “the biggest impact on us is our, decision to adopt, and the stress of all of that, which is obviously still ongoing” (1410-1411). And so the legacy of stress lives on.

**Family life**

Alex talks of her husband’s “distress” (1057): “my husband who desperately wants... to have his own child” (1045-1048). Alex’s avoidance of pregnancy and childbirth has had a profound effect upon him: “[he] definitely struggled sort of every 6 months... he would get quite depressed” (981-982); “this sort of grief and angst...
would come out of nowhere from [him]” (985-986). And so it is illustrated, the far-reaching affect of Alex’s trauma: “I can see how much my my decision impacts on someone else” (1024-1025).

In turn this has impacted upon their relationship: “we were rowing quite a bit..... we ended up we went to Relate” (982-984). It has been difficult for Alex to bear the pain of her husband’s anguish: “seeing someone else in pain, and upset about it is quite difficult” (1016-1017). They decided to try to adopt but this has been a very stressful process: “we’ve had an awful lot of distress, heartbreaking distress with that” (1168).

Alex’s decision to avoid childbirth has also impacted on her husband’s family: “ramifications across the whole of my family... it is massive... [husband] had to tell his parents... they’ve got no grandchildren” (1044-1049). Having grandchildren of their own is highly emotive for her in-laws: “so they pin all their hopes on [husband], to carry on this blood line which is quite important in their family” (1052-1054).

Another ‘knock-on’ effect is that her husband has to deal with his parents’ disappointment that he will not be providing them with a grandchild: “the disappointment from them has affected [husband] as well” (1055).

**Implications for self**

Alex is left with a negative view of herself. She berates herself for the impact that her decision has had upon her husband: “it is a very selfish decision” (1025). Alex is critical of how she reacts to images on TV, saying its: “pathetic” (1153). Alex questions her self-concept, pondering why she can be so determined in many aspects of her life, but not so with pregnancy: “regardless how many hoops I’ve got to jump
through, I, I have a goal and I go straight for it. Now that doesn’t match up with [my avoidance of pregnancy]” (1203-1204). While acknowledging the damaging effect that her decision has upon her husband and family, she considers how her choice causes upset to those people and asks herself: “so what does that mean about me?” (1060-1061).
**Interview 4 (Alex): Table of Themes from IPA**

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<td>“Came down and looked, really really cross with me”</td>
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<td>“again didn’t know what I was doing wrong”</td>
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<td>“...the whole thing had been sort of like, almost like a punishment that you felt was sort of like, ‘You’ve made your bed now lie in it...’ “</td>
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<td>“...you know its almost like because I wasn’t prepared to breastfeed I was going to have to suffer a little bit more”</td>
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<td>“I felt obviously intimidated by it all in that, I was doing things wrong...its like, you know, like a child eating... and making a mess of it because... they’re aware that they’re doing it wrong so it kind of makes it worse...”</td>
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| Feeling of inadequacy | “I felt that maybe I was doing something wrong”  
| | “...you feel a bit stupid and like you’ve made a mistake”  
| | “...when you feel that you’re not, sort of, been at your best and maybe you should be best...” | 502  
| | | 625  
| | | 629-630
| Physical and mental distress | Sickness | “I was pretty sick all the way through, erm, I couldn’t keep anything down” | 10-11
| | Pain | “I had a contraction while I was on the toilet and it was excruciating” | 195-196
| | | “...giving an almighty push, feeling myself, tear then counting to ten again and having to do it... dreading each time because I knew the pain was going to come” | 314-316
| | | “...it was so painful” | 343
| | | “I was incredibly sore” | 344-345
| | | “...when I had my 6-week check-up, it was excruciatingly painful” | 1304-1305
| | | “It was really painful, really, really painful” | 1307-1308
| | | “I just bled, I had it was down my legs, it was all obviously soaked through my pyjama bottoms” | 391-392
| | Bleeding | “I was bleeding a lot... totally unprepared” | 512-513
| | | “I was quite sweaty and horrible and just covered in blood and quite nasty” | 396-397
| | Physical discomfort | “I was shaking that much... I was quite wobbly and I couldn’t really stand up” | 415-417
| | | “I knew I couldn’t sit down... there was no way I could sit on it” | 462-463
| | | “I could feel from the swelling there was no way I could sit down” | 465-466
| | | “I couldn’t sleep, I had to lay on my side, I couldn’t sit at all” | 528-529
| | | “...with every, push I could feel myself tear, very, very deep” | 297-298
| | | “...there was no way my legs were going to go together or anything I mean the whole area was swollen” | 384-385
| | Physical distress | “...my stomach was in a mess and I was shaking so much” | 498
| | | “I tore completely if I had stitches up my bum, it was a complete tear, which I felt every bit of it” | 539-540
| | | “...it really hurt I felt my stitches... I – felt – the needle going through” | 363-366
| | Ordeal of stitches | “I think it was really the stitching up that tipped me over the edge” | 363-366
<p>| | | “She said, ‘Well, you’ve got quite a lot of stitches up there, up” |
| Physical invasiveness | “I couldn’t sit on my side I couldn’t put any kind of pressure… it just hurt so much, erm so swollen” |
| | “.the stitching up, but it was just too much” |
| | “I was fed up that I couldn’t sit down, that bothered me quite a lot” |
| | “I hadn’t healed properly, the stitches hadn’t healed internally and externally… she said they were just like calluses” |
| | “.they’d be really uncomfortable and burning inside and outside and round my but and it was, pretty unpleasant” |
| | “.it was so painful, it almost just felt like he just, stuck his hand in and went like that” |
| | “.someone else came in and, just seemed to sort of ram a toilet-roll sized, tampon up there which again, made me squeal quite loudly and hurt a lot” |
| Feeling anxious | “I was laying there and someone came in and, [laughs] without warning… put a, a big suppository up my bum and I was quite shocked” |
| | “I was in such a mess and I was hyperventilating” |
| | “I was just in such a state” |
| | “‘you’re in a bit of a state’ “ |
| | “I got myself in such a state over that I had diarrhoea” |
| | “‘Ooh something’s happening something’s happening!’ “ |
| | “.examined me, massive massive panic, ‘Oh my God,’ you know, ‘get her to labour ward now!’ “ |
| | “I couldn’t see the clock properly which I became fixed on, the time, you know, ‘How much longer? How much longer?’ “ |
| | “I was just staring at the clock, thinking, ‘Oh my God this is like hours later and they keep tell me ‘in a minute’ ‘ “ |
| | “.this just cold sort of wave of nausea had just like, ‘Oh my God!’ “ |
| | “.which then of course terrified, I got into this real state about having to do a poo, I thought, ‘Oh my God, oh my God!’ “ |
| | “I was quite scared” |
| Sense of panic | “your, backside” |
| Wanting the ordeal to end | “I was in such a mess and I was hyperventilating” |</p>
<table>
<thead>
<tr>
<th>Fear</th>
<th>“at that point I was I’d had enough I really had had enough”</th>
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<td></td>
<td>“it was just like the straw that broke the camels back”</td>
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<td>“I was just absolutely aghast”</td>
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<td>Despair</td>
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<td>“they were like, ‘Oh no no we want you to be fully conscious you”</td>
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<th>Negative experiences in hospital</th>
<th>Hostility from staff</th>
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<td>Confusion of identity</td>
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<td>Category</td>
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<td>Denied pain relief</td>
<td>“I was asking for pain relief and I was told, ‘It’s far too late you can’t have anything now’” “I wasn’t given any pain killers” “I remember saying to her, ‘Can you call my boyfriend?’ because I was getting quite upset… ‘…please call him’” “I said to [boyfriend] later, ‘Why did you take so long?’” [boyfriend] said, ‘Oh they did call me but they said don’t worry about it to take my time,’ “I had not had any sort of contact for quite a while” “but no-one had actually looked in at any stage” “no-one was coming”</td>
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<td>Delay in calling partner</td>
<td>“but it got to the stage where I could not stand up I had to ring the emergency bell, to get someone to come to me” “I think it was being, left on my own… and sort of being told to… ‘Shut up, stop being a pain’” “…part of me just thought I’m going to give birth to him here, on my own, you know, and no-one’s interested” “…its kind of like a drawn-out process to, get you the bottle… you can see them there its like, ‘Well I’m too busy to do that’” “I didn’t see the same midwife, at any point”</td>
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<tr>
<td>Abandonment</td>
<td>“and just said, ‘Oh I think I’m in labour,’ and she said, ‘Oh you’re not, I’m sure you’re not you can’t be you can’t be, it’s too soon go back to bed’” “I could see the peaks of my contractions as I was feeling them and she said to me, ‘See nothings happening’” “…you look and you think, ‘Well I’ve just seen I,’ and yet, someone who knows has just told me that I’m not” “…all the distress about being in labour and being told I wasn’t and… getting myself in a real mess over it” “being told I wasn’t in labour so you start, questioning because if someone’s saying to you, ‘No you’re not,’ but you can feel</td>
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<td>Feeling of being dismissed</td>
<td>something happening, so you then sort of, ‘Well what’s this then?’</td>
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<td>‘...she’s just said, ‘Be quiet,’ you know, ‘just go to bed and be</td>
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<td>quiet’ ‘---------------------------------------------------------</td>
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<td>‘...basically left me with instructions to, ‘Shut up, stop disturbing</td>
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<td>her’ ‘----------------------------------------------------------</td>
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<td></td>
<td>‘...he turned round to his colleague and said, ‘Hmm, this is</td>
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<td>interesting this bit belongs over here’ ‘---------------------</td>
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<td>‘...every time I went and found anyone I was kind of really sort of,</td>
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<td>treated like I was being a pain anyway, you know, ‘Go away.’ ‘</td>
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<td>‘...every time I got up, felt this enormous sense of guilt and like I</td>
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<td>was being a pain’ ‘------------------------------------------</td>
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<td>Effect of being dismissed</td>
<td>‘...because you’re not being believed’ ‘------------------------</td>
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<tr>
<td>Feeling of not being believed</td>
<td>‘...but it was, that sort of attitude of, ‘No you’re not, you can’t be,’ ‘</td>
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<tr>
<td>Frustration at not being believed</td>
<td>‘...they told me I didn’t have stitches up my bum, they said its not in the records’ ‘</td>
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<td>Not knowing what’s happening</td>
<td>‘...and I was told and I know I had stitches up my backside so I don’t know what’s going on’ ‘</td>
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<td>Not being informed</td>
<td>‘...wouldn’t tell me how many stitches I’d had’ ‘</td>
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<td>‘...not answering sort of vague’ ‘</td>
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<td>‘...so I was kind of a bit in the dark about how much damage had</td>
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<td>been done down there’ ‘---------------------------------</td>
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"I said again, ‘Well how many have I got?’ ‘Oh I don’t know,’ “

Validation from ‘outside’ of the hospital

Of abandonment

“.the other mums that were in there…just said, ‘My God,’ they said, ‘we can’t believe,’ you know, they were just like aghast, ‘you were left all night, we could hear you’ “

“.their comments were just like, ‘Oh my God, you poor thing, we feel really sorry for you, we heard you, you did really well,’ you know, ‘how distressing,’ you know, ‘can’t believe they just left you,’ “

Of hostility

“.friends… were just like, ‘Oh my God that was really awful, she was really angry,’ you know, so other people had seen her reaction”

Of ordeal

“. [Mum] said, ‘You looked in a real state,’ “

“. [Mum] actually said, ‘I’m actually quite relieved, I don’t want to see you looking like that again’ “

Glad to be acknowledged

“So yeh again someone else has noticed, ‘cos you do think you’re being a bit neurotic, noticed there was obviously an issue”

Continuing anguish

Childbirth memories

“.a traumatic experience when I had my son”

“.the actual birth was very painful”

“And I said, ‘Yeh he is [gorgeous], but he’s going to be an only child’ “

“I just said, ‘He’s and only child that’s it’ “

“.he was only about 2 weeks old when I, strolled into a erm, er, like a well-woman clinic whatever and asked to be sterilised”

“I’d clearly sort of, quite adamantly decided… ‘I want to be sterilised’ “

“[re thought of pregnancy] Ooh, horrified, absolutely horrified”

“I am not going to have any children this is it”

“I think I was so horrified, by what had happened to me that it wasn’t a hard decision, to make to not to have more children”

“I do, kind of almost view myself as, unable to have children”

“.feeling absolute, dread and terror and panic”

“.don’t want to have any more children, this is it and actually didn’t have sex for about 5 years”

“I do get, quite sort of tight-chested”

“I used to, earlier on, get very anxious and panic-attacky”
| Feeling anxious | “...if it's on TV is... actors, on TV, in labour, I get that, it goes really tight and... I just can’t watch it... and I close my ears so I can’t hear it and just... ‘Please tell me when its stopped’” | 1137-1254-1255 |
| Reminders of childbirth trauma | “I can’t watch it, I can’t watch it, because you can... you can identify too many things” | 1140-1144 |
| | “...recently we watched a film where someone had stitches, without an anaesthetic and... I had to leave the room” | 1153-1154 |
| | “I got myself in quite a state and I was shaking, I was sobbing and everything trying to, tell him what happened” | 1150-1151 |
| Distress at talking about trauma | “...the only guarantee I can have...is a Caesarean” | 1237-1238 |
| Importance of Caesarean Section | “...if someone promised me [a Caesarean]...I would have gone with it...I would have done it” | 1096-1097 |
| | [only option] “Having a Caesarean. That’s it.” | 1114-1118 |
| | “...but she just said, ‘No. You don’t need a Caesarean’ “ | 1277 |
| Being denied a Caesarean | “I don’t know if you call them flashbacks or not but I would suddenly start, sort of re-living it and thinking it” | 1250-1251 |
| Experience of flashbacks | “I don’t really know what flashbacks are but suddenly when you start thinking about it I wouldn’t be able to get it out of my head” | 775-776 |
| | “...it would just be in my head and I wouldn’t be able to sleep and I’d get myself in a real state, you know and your heart racing and you’re sort of reliving it a bit” | 1255-1257 |
| | “...every so often it would pop up” | 1258-1260 |
| | “I still cannot get my head around what happened” | 1262 |
| | “What I can’t get past is the birth thing...but I just can’t” | 1091-1092 |
| | “ ‘For Christ’s sake, this is still not over,’ “ | 1120-1121 |
| | “…the biggest impact on us is our, decision to adopt, and the stress of all of that, which is obviously still ongoing” | 1316 |
| | “I think I’ve suppressed my feelings too much” | 1410-1411 |
| Continuing distress | “[husband] definitely struggled sort of every 6 months... he would get quite depressed” | 981-982 |
| Numbened feelings | “...this sort of grief and angst would come out of nowhere from [husband]” | 985-986 |
| Impact on relationship | “..it was very difficult for him all round really”  
|                        | “..my husband who desperately wants…to have his own child”  
|                        | “..causes him a lot of distress”  
|                        | “..this would be everything he wanted, his own little family”  
|                        | “..we were rowing quite a bit”  
|                        | “..we ended up we went to Relate”  
|                        | “..seeing someone else in pain, and upset about it is quite difficult”  
|                        | “..quite fundamental because it’s hard to watch someone else’s… there’s a lot of guilt because, it’s a decision I made”  
|                        | “I can see how much my my decision impacts on someone else”  
|                        | “..we were going through the adoption process because of this”  
|                        | “..its not, something you take lightly but its the position [adoption] we are only taking because of my inability to, get my head around being pregnant”  
|                        | “..ramifications across the whole of my family… it is massive… [husband] had to tell his parents… they’ve got no grandchildren”  
|                        | “..so they pin all their hopes on [husband], to carry on this blood line which is quite important in their family”  
|                        | “..the disappointment from them has affected [husband] as well”  
| Impact on family | 999-1000  
|                  | 1045-1048  
|                  | 1057  
|                  | 1131-1132  
|                  | 982  
|                  | 984  
|                  | 1016-1017  
| Implications for self | 1022-1023  
|                  | 1024-1025  
|                  | 1027-1028  
|                  | 1073-1074  
|                  | 1044-1049  
|                  | 1052-1054  
|                  | 1055  
| Negative self-concept | 370-371  
| Questioning own self-concept | 1025  
|                  | 1153  
|                  | 1060-1061  
|                  | 1203-1204  
|                  | 296  

Memo 5: Nadine

Nadine is 22 and lives with her husband and young son (14 months old) in Derbyshire. Nadine’s son’s birth was difficult; having tried unsuccessfully a vaginal delivery and forceps, Nadine eventually delivered her son by emergency Caesarean Section (CS). Nadine was overwhelmed by the pain and has been left traumatised by the ordeal; she experiences symptoms of Post Traumatic Stress Disorder. She presented as depressed and anxious. Nadine has been prescribed with anti-depressants although she has not been offered any counselling. Nadine would love to get pregnant again as she has always wanted to have 2 children close together in age but feels unable to go through with another pregnancy.

Pain

In Nadine’s words: “it was really the pain that, I was in that.. that really made the experience, very bad for me” (259-260). Nadine was in floods of tears as she told me: “I was, in terrible pain... I was crying and yelping in pain” (86-87). Nadine perceived labour as extremely painful, the level of which was unexpected: “Absolutely excruciating I’d never felt anything like that before” (38). She sobbed as she told me: “I’d never felt pain like it and I didn’t know what to expect [gasps] I didn’t think it could get any worse” (67-68).

Nadine was unable to ease the pain, no matter how she tried: “nothing eased it either, sat up, lie down, stood up, walked around, nothing helped at all” (44-45). It seems as if it was the incessant nature of the pain that Nadine found overwhelming: “[cries] I was trying to lie down ‘cos it.. just tried to ease it anyway I could but it didn’t, it didn’t work” (109-110). Nadine did not receive effective pain relief: “I asked for
some but they just said they could give me some paracetamol... and that didn’t make any difference at all” (62-63).

The pain that Nadine felt was so utterly consuming that she sobbed as told me: “Actually I thought I was going to die” (65). The prospect of giving birth to her baby took second place to needing her ordeal to end: “I just wanted the pain to be all over” (97). Nadine says that she tries to block the memory of the pain: “I try and blank it out in my mind because it’s so painful” (69-70).

Fear
As Nadine talked about the pain and being alone with it during the night, I sensed her fear. I remarked that it ‘sounds really frightening’ (80) and her fear was almost tangible as she replied: “It was, yeh and when I was going to the toilet I was, losing a lot of blood... going back and trying to [unintelligible; crying] [quietly, sound in pain, almost whimpering] I was really in pain” (81-83). She went on to say, through her tears: “I felt very scared and nervous and lonely” (183). Nadine had felt very frightened as they took her to the operating theatre for an emergency CS: “I had a spinal anaesthetic, and that was very scary because I really hate needles [cries]” (163-165). Nadine could barely say the words ‘hate needles’ without it reducing her to tears.

Abandonment
Nadine went through much of her labour on a ward on her own during the night: “I was on my own as well there was no-one else on the ward, so it was just me” (10-11). The theme of loneliness is repeated several times – she comments: “I didn’t see many
of the midwives that night so it was very lonely” (11-12). Nadine had needed the security and reassurance of having her husband with her: “I just needed my husband with me really” (188-189). She felt the weight of his absence: “[crying] I felt very scared and nervous and lonely because I wanted him with me all the time” (183-184).

It seems as though Nadine felt that her pain and distress were disregarded and that she was left to suffer: “I told them that I was, in terrible pain they could see from the state I was in I was [cries] crying and yelping in pain... they said that all they could give me is, paracetamol” (86-88). It feels as if Nadine was neglected: “if I’d been checked during the night I think I would have been given some [pain relief]. but they said they’d. leave me the night and then check me in the morning” (89-91).

Lack of control

When the morning came midwives strapped a monitor around Nadine’s chest which left her unable to move and feeling trapped (pinned down and unable to ease her pain): “I had that strapped round my chest... I couldn’t walk around with that strapped on me” (104-108). As Nadine was prepared for the CS her husband was sent from the room and ‘lots’ of people had come in – Nadine felt overwhelmed by her lack of control: “I felt overpowered in a way all these people” (188).

Experience of childbirth was not how she had imagined

The pain of labour had been far more intense than she had expected: “it was a lot worse than I ever thought it could be” (38-39). The final stage of labour was very difficult with Nadine pushing fruitlessly for a long time; she felt disheartened: “I felt quite disheartened because I didn’t know how long it’d take” (137).
Nadine conveys a feeling of failure as she describes the final stage of labour:

“pushing for an hour, and that failed... try with forceps and that failed as well” (15-16). Nadine perceives this failure as her own, as though the problems were due to her own shortcomings: “I felt disheartened and disappointed that I hadn’t pushed him out, you know, I felt like, I’d given up somehow” (215-217). I remarked to Nadine that I was struck by how it seemed that she blamed herself for the problems and viewed herself as failing – she replied: “Yeh, I still feel like that” (458).

Nadine cried as she talked about the CS, saying that she was “very disappointed” (212). She has a sense of having missed out on what she was expecting from childbirth: “I couldn’t hold him so I felt like I missed out that way that I really wanted skin to skin with him, and to breastfeed him from birth but, I didn’t get to hold him or anything” (234-236). Her experience was in contrast to images she had seen portrayed by the media: “it felt quite weird because, in magazines and on television you always see the mother holding the baby after the birth but I didn’t…” (236-238).

There is no doubt that Nadine found this terribly disappointing and this expectation contributed to her sense of having failed.

As Nadine was taken for a CS she was over-awed by the experience and had a sense of disbelief: “I just thought this can’t be happening to me” (197-198). Nadine was left in a state of shock - following the birth she was “shell-shocked” (249).

Enduring distress
As I met with Nadine I was struck by how anxious she appeared and as the interview progressed it became apparent that she is still quite depressed. She told me that she
had spoken to her GP about feeling “down” and that he prescribed anti-depressants (267-268) as she had also got a high score on a ‘postnatal depression questionnaire’ (269-271). She told me: “I’m still depressed now” (275).

Nadine remains very anxious and cried as she told me about her fear of hospital: “I’ve had nightmares that I’ve been trapped in there and can’t get out... I still get them now, on a regular basis” (298-300). She is adversely affected by any reference to the hospital: “I can’t bear to think about it or go past in the car or anything or anything that reminds me of it” (288-289). She cannot even bear to see the word ‘hospital’ written down and is affected by any reference to birth on the television (294-295). Nadine describes her anxiety: “I feel very, scared and anxious and worried all the time and on edge” (346). This level of anxiety affects every aspect of her daily life: “I’ve trouble sleeping, and staying asleep sometimes, I’ll, wake up a few times in the night [cries] crying and... its affecting my moods as well and eating” (349-352).

Nadine says that the thought of getting pregnant again: “Terrifies me a lot, it really does” (356). Her fear leads her to avoid pregnancy: “I thought I can’t let my body go through this again I never want to do it again, and its stayed with me right until now” (283-284). Her feelings about avoiding childbirth upset her: “I always think, ‘I wish that was me, with more than one,’... I always wanted that myself so it, it upsets me that I won’t be able to have that because of the experience I had” (380-383). This avoidance impacts on her husband and leaves Nadine feeling bad about herself: “he’s always wanted to have more than one... so I feel like I’d be denying him a child” (390-391). Nadine also feels upset about the impact that her choice will have upon her parents and in-laws: “Upset and, bit disappointed as well, ‘cos I’d really like, to
Detachment

Nadine conveys a sense of detachment. With regard to the childbirth experience she says: “[crying]….. I just thought, ‘This isn’t real,’ it didn’t feel real it felt like a very bad nightmare” (196-197). Nadine took a long pause before speaking, the distance between herself and her words almost mirror the sense of detachment from the process. There was something impersonal about the way she described her son being born that hints at a feeling of detachment there too: “they took him out of me... they took him out the room” (227-228). She adds: “I think one of the doctors or one of the other people in the theatre said, ‘What is it?’ And he said, ‘It’s a boy’” (230-232) – I think that the fact that she did not ask this herself is indicative of the trauma that she was enduring.

It feels as though Nadine is detached and isolated from others in her inability to talk about her experience. I asked her if she had talked with friends and family about how she was feeling and she replied: “No... I just, don’t feel I can open up to them” (313). Certainly I felt that Nadine found it very difficult to talk with me about her experience – it was obviously very painful for her.

The whole experience has impacted greatly on her and I sense detachment within herself. She says: “I don’t think I’ve been the same since before I had him, I feel like a different person” (342-343). Towards the end of the interview Nadine was unable to identify anything that might be useful in helping her to move forward and I was
struck by how ‘stuck’ she felt. I shared this thought with her and she agreed that she felt ‘stuck in the situation’ (402-407).
## Interview 5 (Nadine): Table of Themes from IPA

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<td>“A few of the midwives came in and checked every few hours but other than that I was on my own”</td>
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Husband’s fear "[re Caesarean] [cries] Very disappointed.. and upset, and frightened”
“[cries] I was very scared because, I’d never experienced anything like it before”
“I didn’t, really like hospitals before, but I really don’t like them now so the thought of going in one again [cries] really scares me”
“Very, nervous, because he obviously he didn’t know what was going to happen”
“..it felt like a very long time to him because he didn’t [cries] he was very scared for me and things like that”
“..my husband was very, worried”
“I was on my own as well there was no one else on the ward, so it was just me”
“A few of the midwives came in and checked every few hours but other than that I was on my own”
“I was left for, quite a few hours”
“[crying] I felt very scared and nervous and lonely because I wanted him with me all the time”
“I didn’t see many of the midwives that night so it was very lonely”
“I told them that I was, in terrible pain they could see from the state I was in I was [crying] crying and yelping in pain… they said that all they could give me is, paracetamol”
“..if I’d been checked during the night I think I would have been given some [pain relief].. but they said they’d… leave me the night and then check me in the morning”
“I just needed my husband with me really”
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<td>“I just thought this can’t be happening to me”</td>
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<td>“[thought of being pregnant] Terrifies me a lot, it really does”</td>
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<td>“I always think, ‘I wish that was me, with more than one,’… I always wanted that myself so it, it upsets me that I won’t be able to have that because of the experience I had”</td>
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<td>“[crying]….. I just thought, ‘This isn’t real,’ it didn’t feel real it felt like a very bad nightmare”</td>
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<td>“..they took him [baby] out of me… they took him out the room”</td>
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<td>“I think one of the doctors or one of the other people in the theatre said, “What is it?” And he said, “It’s a boy,” “ “..it was erm.. strange if that’s the sort of a word to use very strange, past 24 hours.. yeh”</td>
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<td>“ I: Have you been able to talk to friends and family about it? P: No… I just, don’t feel I can open up to them”</td>
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<td>“ I: Can you identify anything that might be useful now in terms of helping you to move forward…?”</td>
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P: … Erm….
I: Because it feels very much at the moment as if you’re stuck in this situation
P: Yeh”
Memo 6: Tina

Tina is 29 and lives in Central England with her husband and 2 ½ year-old daughter. She is currently taking sick leave from her career. Tina experienced a health complication in pregnancy and suffered a bereavement days before giving birth. She was overwhelmed by the pain and indignity of her childbirth experience and suffered severe post-natal depression. Tina remains depressed and anxious, finding it difficult to cope with many situations. Her life is affected by the torment she feels with her desire to have another child combined with her total fear of childbirth.

Control

Labour became an ordeal for Tina, one which left her feeling out of control: “and I just felt, [tearful] like erm... completely out of control, and, like I couldn’t cope with, I just couldn’t cope with it all but I couldn’t stop it [cries]...” (134-136). Tina found it difficult to talk about it, pausing to try to compose herself before her tears overwhelmed her. Tina recalls completely lacking control during labour and felt unable to move: “I couldn’t I just couldn’t, I wasn’t, couldn’t think, couldn’t, move do anything...” (150-151). The repetition of the word ‘couldn’t’ illustrates her inability to function at that point.

Tina had felt she had little ‘say’ or control at the hospital. She had felt railroaded into having her labour induced: “despite saying I didn’t want to be induced... there was no you know, immediate risks to the baby I still had to be induced” (595-598). This next quote serves to illustrate how Tina became resigned to the ‘authority’ that she perceived the hospital to have: “he wasn’t, allowed to stay with me, [clears throat] so I just knew you know, I’d to accept that and that was that” (49-51). Tina perceived
others as having control: “whatever they thought you know that’s what I had to do” (257-258) and: “it was all their decisions and that was it” (605-606).

Abandonment

After midwives had begun to induce Tina’s labour, her husband was sent home for the night leaving Tina feeling very lonely and isolated: “I just remember feeling really lonely [holding back tears] you know, for the whole of that night” (53-54). Tina remained in this unhappy state until visiting time the following afternoon: “I was just left pacing then until my husband came in at 1” (76-77). As labour progressed the midwives kept a distance leaving Tina feeling neglected: “no-one, was able to help me I just felt completely on my own, nobody could help and you know nobody really seemed interested in helping” (136-138).

Humiliation

A significant factor in Tina’s ordeal was the lack of privacy that she had. Before going to the delivery suite Tina was left to labour on the ward: “one of the big things that I found, quite.. traumatic and humiliating really was being on the main ward with just a curtain around me and, you know other people’s visitors and everything” (60-63); “during the afternoon the curtains were left open and I was on the monitor..” (242-243). At one point a ‘crowd’ of people descended into the cubicle to observe Tina’s internal examination, just feet away from others’ visitors, which Tina felt overwhelmed by: “I’d never seen [consultant] before, she came into the cubicle, by this time the cubicle was just full of, midwives and student midwives..” (81-82).
Tina conveys feelings of indignity; conscious that others outside of the curtain would have heard every exchange: “I was just really humiliated [unintelligible word] because... everyone turned you know, ‘Oh look at her poor thing,’ you know.” (94-96). Another example of this indignity happened after Tina’s waters broke while she was in the bath. Staff left the door of the bathroom open: “I just remember looking out of the bathroom door to see other people, standing in the corridor looking at me and I was naked at this point.” (122-124).

The feelings of humiliation that Tina had already endured affected her later when she returned to the ward after having been monitored on the delivery suite. She recalls her horror at having to return to the curtained cubicle: “and I just remember walking on to the ward and just seeing all the people again, and I just felt, so, panicked and I said, “I just can’t you know I can’t be here”” (108-110).

Physical and mental distress

Tina felt the pain of labour was overwhelming: “I was just in in incredible pain, erm [cries]” (114) and she felt immobilised by it: “I was in a lot of pain I couldn’t move.” (247). The level of pain was unexpected: “I remember feeling quite shocked really by how painful it was” (223-224). Tina expresses feelings of being shocked by the pain: “I just remember really you know shaking and I felt a bit shocked.” (168-169).

Tina also conveys a sense of panic during labour: “I was erm hyperventilating” (138). Fearing that her husband would be made to leave again Tina became anxious: “feeling you know really anxious... thinking that, I’m going to have to go through all...”
this on my own because my husband’s... going to have to go, and then I’d be on my
own to cope with it all”” (116-120).

Negative experiences in hospital

A delay in administering pain relief caused Tina distress: “I asked the midwife for
some, erm pain-killers and I think it was about an hour and a half before she brought
them over” (72-74) – it is not only the pain that Tina endured without relief, but also
the feeling of being disregarded. This feeling of being disregarded continued: “the
whole afternoon really I felt as if, you know I was being ignored” (238-239); “no-one,
sort of, you know asked if I was okay or needed anything” (241-242) – this disregard
led to Tina feeling worthless. When a ‘crowd’ of staff had congregated in the cubicle
to observe Tina being examined, the consultant entered in this hostile fashion: “she
just came into the cubicle, slammed her bag down on the floor, and you know, just
examined me as though, I was just a big inconvenience” (84-86).

The hostility continued. When the consultant heard Tina ask the midwife for pain
relief, the consultant’s comment damaged Tina’s self-esteem and she cried after
telling it to me: “I heard the consultant say to the midwife, “Oh just leave her she’s
expecting something for nothing”” (101-103). The fact that the consultant talked
about Tina, in front of her, without addressing Tina directly, adds to the feeling of
worthlessness that Tina experienced. This carried on as Tina followed (in pain) the
midwife back to the ward: “and [sighs] the midwife’s just you know she’s just holding
a clipboard and she just kept looking back at me and tutting” (105-107). It was a
heavy sigh that Tina gave and I could feel Tina’s sense of worthlessness as I listened
to her. Tina refers to this dismissiveness twice more: (151-152) and (264-266). At one
point Tina could not move due to the pain and her husband tried to help her to sit up – the midwife said: “Oh leave her don’t help don’t do that she can do it herself” (248-249). This comment would make Tina feel useless as well as helpless.

Along with the hostility from staff, Tina experienced a lack of support. She felt she was left to cope with her labour with little guidance or support: “so I didn’t have anyone with me apart from my husband” (130-131). Even in the later stages of labour Tina was unsupported by the staff: “I just remember them shouting across the room to breath properly” (131-132). Tina’s husband sought guidance, asking: “Is it ok for her to push?” And they just shouted over, “Yeh, that’s fine.”” (157-158). Tina recalls: “the only time I remember them being with me is just before she was born” (158-159).

Tina has very unpleasant memories about her antenatal visits to see the doctor with regard to the gestational diabetes that she developed. She talks of a lasting memory when the doctor told her that if she was not careful then her baby could “drown in sugar” (19-20). Tina says: “I just remember going home and all the next day I was crying, because I’d just got this image, of my body was killing my own baby” (570-572). While Tina appreciates the dangers that gestational diabetes can present to the unborn child, she did exactly as advised regarding her diet and did not have any further problems during her pregnancy. She therefore felt that the doctor’s undiplomatic comments were unnecessary: “the comments that he made about women that have been to the hospital you know... and the baby’s heartbeat had stopped and the baby’s died, I didn’t really need to know all that at that stage” (574-577).
Tina commented that seeing different doctors throughout the pregnancy was not helpful, as they all gave differing opinions, which she found stressful: “I think the continuity of care because I didn’t see the same doctor once, all through my erm antenatal appointment” (582-583).

Need to be acknowledged

Following being induced Tina was in pain and the monitor indicated that the baby’s heartbeat kept dropping. When she was examined the consultant announced that Tina was not in labour and therefore could not be in pain: “then she said... I wasn’t in labour, [holding back tears], erm so I couldn’t be in any pain” (86-88). This dismissal of Tina’s pain continued, with a student midwife saying: “Oh, it’s just niggles its nothing” (92-93). When Tina asked for pain relief, this was denied: “Well you’re not really you’re not in labour at the moment,” you know, “you’re not in pain”” (99-100).

Tina fought back tears as she recalled not being believed: “they didn’t believe that I was in any pain” (107-108). Not being believed led Tina to become distressed as the uncertainty about what was happening to her was frightening: “[cries], wondering you know, ‘If this isn’t labour you know how am how am I going to cope with labour? ’... erm... and just really feeling you know really anxious” (115-116). The pauses and stumbling over her words indicate how difficult it was for Tina to recall this memory.

Recognition is powerful. For a long time after the birth Tina was unable to talk freely about how she felt for fear that she would not be understood. She says: “I think that if
there was something, you know to say it can happen, it does happen to other people…” (282-284). Tina has recently found an internet message board for women who have experienced birth trauma and she has found this very helpful: “it’s just really good, to know that its recognised, you know and that, it’s not just me being weak and, not able to cope with childbirth, you know that it’s a real it’s real” (564-566). This goes some way to validating Tina’s experience.

Need for explanation

As outlined, Tina’s pain was dismissed and disputed, leading her to feel afraid. She asked about the pain, but explanation was not forthcoming: “when I asked you know, “What’s the pain?” nobody would explain you know, what was happening” (250-251). Tina also feels resentful of having her labour induced, against her will and without explanation: “none of that was explained to me really why, you know why that was necessary” (599-600). She felt she wasn’t informed about the progress of her labour: “I also remember people whispering about erm, emergency C Sections” (251-252).

Continuing anguish

Tina’s ordeal has left her with a fear of childbirth: “[sighs] all I can think is that I’d just be terrified, giving birth [tearful] again” (312-313). As a result of her fear, Tina avoids pregnancy and childbirth: “I just don’t want to go all through that again” (208-209). She describes her fear as being “like a phobia” (305) and talks about her avoidance: “sometimes I can’t even think, about being pregnant again it just, its like something in, inside just stops me, and I just can’t imagine it again” (308-309).
This avoidance of pregnancy causes a dilemma for Tina as she would like to have another child: “it’s a kind of ‘Catch-22’ situation... I really want another baby, and you know I just don’t feel that I can.” (526-527). Tina told me that she has begun to have conversations with her husband recently about having another baby and she has noticed also a recent deterioration in her mood and anxiety levels: “and I’m thinking now, if I’m gonna do this, you know if I’m gonna have another baby, I want it to be soon, and I don’t know whether like subconsciously that’s affecting me” (475-479).

Since the birth Tina has suffered with anxiety and panic attacks. Tina says: “at the beginning of the illness, I couldn’t, go out on my own, I couldn’t stay in the home on my own” (367-368). Her anxiety got worse: “It got to the stage where I couldn’t even go out, if I was with someone, I would start to erm really you know panic attacks” (371-373). The feeling of not wanting to be alone continues into the present: “I can’t bear the thought of having to stay on my own... I don’t feel I can stay on my own, all day every day” (374-377); “[sighs] but even now, I still find it really difficult to, go into new situations” (401-402).

There’s something about Tina not feeling safe. Reflecting upon when she briefly returned to work, she says: “if someone new came into the classroom I felt really, alienated again, and, not, comfortable at all” (503-504). The punctuation in this sentence conveys her discomfort. She adds: “when I was off work there was a lot of rumours going around... that’s left, a mark really where I just think you know, I don’t feel safe, there” (511-516). Both examples I feel are reminiscent of Tina’s experiences in hospital: when staff piled into the cubicle while she was being
examined; being exposed when the bathroom door was left open, and staff talking over her without consulting her.

Tina was treated for postnatal depression and attended a support group. At that time Tina was self-harming (422) and a health visitor at the group referred her to a Mother and Baby Unit. It was here that a change in medication helped to prevent Tina from being admitted to the unit, and she was referred to a psychologist, who she saw for a couple of years. The psychologist told Tina: “she said that I was suffering from Post-Traumatic Stress Disorder from the birth” (440-441).

Tina had intrusive memories of the birth: “I started to, get erm, like memories of the birth, erm, which, I couldn’t make go away” (186-187). These made her very anxious: “I was having panic attacks, flashbacks of the birth” (423-424). Mondays (the day of the birth) were particularly difficult: “every Monday then, I would just relive the birth, all day” (189-190).

It was on one of these Mondays that Tina felt the need to escape. While her husband was at home, she put her baby on the floor and left the house: “I just went out... I didn’t know where I was going or what I was doing, I just knew that I had to get away I didn’t know where, to, [fighting back tears]” (192-195). Other times when Tina would like to take flight are when she sees a pregnant woman: “I just feel like running away” (381).

Pregnant women provoke strong feelings within Tina: “I feel quite, jealous and envious of them” (348) and she is hypervigilant when she leaves her home: “I find
myself looking at every woman that I see to see whether she’s pregnant” (380-381).

Tina tells me about an incident in which her anxiety became overwhelming and she nearly lost control: “I got quite abusive really, to erm, a pregnant woman, because I just felt so angry toward her” (382-383). She is tearful as she talks about her avoidance of pregnant women: “and like I say the anxiety around pregnant women, I avoid like the plague really” (378-379).

There are various triggers that act to remind Tina of her birth experience: “I avoid erm pregnant women, erm, mainly because it brings back, the memories of my own experience” (346-348). Also the hospital where she gave birth: “I can’t, can’t go back to that hospital again... I’ve drove past it a couple of times... that’s quite difficult, I just can’t, face going back really” (548-550). As Tina’s anxiety levels have started to increase again: “I’ve started having erm bad dreams again” (472).

Tina had found it difficult to talk about the birth: “I didn’t tell anyone how I felt about the birth, it was just, thought that I’d got post-natal depression” (202-203). Not having heard about birth trauma, Tina feared how her account would be received: “I just felt, so ashamed, ’cos I thought it was only me, that I didn’t, you know, tell anyone” (284-286). She eventually began to tell her husband how she felt, which was difficult for her: “gradually then that I started to, tell my husband, how I was feeling, erm, and that was really difficult” (203-205).

Family life

Tina’s husband will have no doubt suffered from witnessing his wife battling with depression and anxiety. There have been times when he has taken time off work in
order to care for their child when Tina has not felt able to. Tina says: “I feel quite guilty, and for my husband because, we’d always planned together you know, that we’d have, you know three children” (355-356). As for other men whose partners suffer from fear and avoidance of childbirth, avoidance of pregnancy affects them too. Tina has observed: “tiny little babies, [tearful] I see him looking at them, and I do think to myself, ‘Is he wondering whether that will ever be us again?’” (359-360).

Tina has been unable to work for most of the 2 ½ years following the birth: “I haven’t been able to go to work” (363). This has financial implications for the couple as well as the emotional impact upon Tina. She explains: “I don’t feel able to work on my own without anyone else, without someone else who I’m really, familiar with and I feel confident with” (365-367).

Tina’s fear and avoidance of childbirth has also impacted upon her relationships with family and friends. She avoided seeing both her best friend and her sister-in-law while they were pregnant: “my sister-in-law... I didn’t see her through the whole of her pregnancy, and my best friend... I didn’t see her through the whole of her pregnancy... that was just an awful time” (387-392). This was very distressing for Tina as she cares deeply about these two women and she was aware of the damaging effect of this avoidance upon her relationships with them: “then it took time to sort of rebuild, the relationship because, they didn’t really understand... properly why, I wasn’t able to see them” (395-398).
Implications for self

Tina conveys a sense of having lost her ‘self’ following the birth: “I just lay there then afterwards and I felt different, like a different person, [holding back tears]” (68-69). She adds: “I just wasn’t me anymore” (199-200). Tina describes how she felt ‘different’ after being induced for the second time (which was painful) – it feels as if Tina felt violated in some way. She says: “I just remember, feeling like.. erm, I suppose like my body wasn’t my own anymore” (218-219). As Tina’s experience does not fit with her schema of femininity and motherhood, Tina is left feeling lacking: “I sort of felt, like I was less of a woman really” (205).

It feels as though Tina became disconnected from her emotions. Recalling the painful second induction she says: “I just remember lying there, I just felt quite empty afterwards” (224-225). About her daughter’s birth, Tina says: “I remember her being born, and I just, you know I just looked down and I just felt really numb” (164-165). Tina describes feeling empty after she had returned home: “I just felt like a shell” (200); “one morning I just couldn’t get out of bed I just couldn’t, felt like, the only way I could describe it was that I felt flat” (198-199). Tina conveys a sense of detachment when she recalls how she felt the day after the birth: “I felt, as though every.. things weren’t real” (170). This detached feeling continued as the weeks passed: “I sort of knew something wasn’t right, I didn’t feel right” (184-185).

Tina’s experience of the hospital was of being treated as an object: “it wasn’t you know just wasn’t my, my body, you know it was all their decisions and that was it” (605-606). As decisions were being made around her regarding the delivery of the baby, Tina felt excluded and ‘surplus to requirements’: “I just felt really excluded
As a result of her experience, Tina has lacked confidence in her own ability to be a mother. Recalling her first morning in the hospital as a mother, Tina recalls: “I started to I saw the other moms that were washing and dressing their babies so I did the same” (174-176). As I have played back the tape I have felt a wave of deep sadness at this remark – a sadness that exudes from Tina as she remembers it and also the poignancy that she felt so unsure of herself, especially given that she had trained and worked as a nursery nurse. She also told me: “she wouldn’t feed properly wanted to breastfeed her and she wouldn’t feed... so I just gave up” (178-183). It is the resignation of ‘defeat’ that feels so poignant to me, rather than the act of stopping breastfeeding. Because of Tina’s anxieties about being left on her own she has spent little time alone with her daughter: “I’ve never really, been on my own with her, in the house with her” (338-339). The work that Tina has done with the psychologist has helped her to gain some confidence: “I think my confidence grew as well then, in my ability to be a mom because, before that I felt that because of how I was feeling, I couldn’t look after myself let alone my daughter” (465-467).

Tina has been left with a negative self-concept. Referring to the gestational diabetes she says she felt like a failure: “It made me feel that my body was failing my baby, that my own body couldn’t look after my own baby” (589-590). It feels very sad to hear Tina say: “I thought you know that I was weak, and, you know, I wasn’t a woman, ‘How can I be a proper woman if I can’t cope with something as natural, as childbirth?’ ” (280-282); “I just felt, so ashamed” (284-285).
**Interview 6 (Tina): Table of Themes from IPA**

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| **Control**         | Lack of control          | “...he wasn’t, allowed to stay with me, [clears throat] so I just knew you know, I’d to accept that and that was that”  
|                     |                          | “...and I just felt, [tearful] like erm… completely out of control, and, like I couldn’t cope with, I just couldn’t cope with it all but I couldn’t stop it [cries]...”  
|                     |                          | “..I couldn’t I just couldn’t, I wasn’t, couldn’t think, couldn’t, move do anything...”  
|                     | Others having control    | “...despite saying I didn’t want to be induced… there was no you know, immediate risks to the baby I still had to be induced...”  
|                     |                          | “...whatever they thought you know that’s what I had to do”  
|                     |                          | “...it was all their decisions and that was it”                                                                                                                                                                                                                                           | 49-51          |
| **Abandonment**     | Loneliness               | “I just remember feeling really lonely [holding back tears] you know, for the whole of that night”  
|                     | Needs husband            | “I just I was just, counting down the minutes then to when my husband could come in at 1.00 O’clock...”  
|                     | Felt left alone          | “I was just left pacing then until my husband came in at 1”  
|                     |                          | “...and you know no one, was able to help me I just felt completely on my own”                                                                                                                                                                                                         | 53-54          |
| **Humiliation**     | Lack of privacy          | “..one of the big things that I found, quite.. traumatic and humiliating really was being on the main ward with just a curtain around me and, you know other people’s visitors and everything”  
|                     |                          | “I’d never seen her before, she came into the cubeicle, by this time the cubeicle was just full of, midwives and student midwives...”  
|                     |                          | “I just remembered looking around, so many people there”  
|                     |                          | “..during the afternoon the curtains were left open and I was on the monitor...”  
|                     | Feeling of indignity     | “I was just really humiliated [unintelligible word] because… everyone, turned you know, ‘Oh look at her poor thing,’ you know...”  
<p>|                     |                          | “I just remember looking out of the bathroom door to see other...”                                                                                                                                                                                                                       | 60-63          |</p>
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<th>people, standing in the corridor looking at me and I was naked at this point. “...and I just remember walking on to the ward and just seeing all the people again, and I just felt, so, panicked and I said, “I just can’t you know I can’t be here.” “</th>
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<td>I just remember really you know shaking and I felt a bit shocked.”</td>
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<td>“...feeling you know really anxious...thinking that, ‘I’m going to have to go through all this on my own because my husband’s... going to have to go, and then I’d be on my own to cope with it all’ “</td>
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<td>“...and [sighs] the midwife’s just you know she’s just holding a clipboard and she just kept looking back at me and tutting”</td>
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<td>“...the midwife you know she just casually walking along with her clipboard just looking back [imitates midwife – tuts; rolls</td>
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| “..so I didn’t have anyone with me apart from my husband”  
“I just remember them shouting across the room to breath properly”  
“..my husband said you know, “Is it ok for her to push?” And they just shouted over, “Yeh, that’s fine.” “I just remember going home and all the next day I was crying, because I’d just got this image, of my body was killing my own baby”  
“.the comments that he made about women that have been to the hospital you know… and the baby’s heartbeat had stopped and the baby’s died, I didn’t really need to know all that at that stage”  
“I think the continuity of care because I didn’t see the same doctor once, all through my antenatal appointment” | 130-131 158-159 131-132 157-158 570-572 574-577 582-583 |
| Doctor’s unhelpful comments |  
| “..the comments that he made about women that have been to the hospital you know… and the baby’s heartbeat had stopped and the baby’s died, I didn’t really need to know all that at that stage” | 582-583 |
| Need for explanation |  
| Lack of explanation | “..when I asked you know, “What’s the pain?” nobody would explain you know, what was happening”  
“.none of that was explained to me really why, you know why that was necessary”  
“I also remember people whispering about emergency C Sections” | 250-251 599-600 251-252 |
| Not being informed |  
| Pain is dismissed | “..then she said… I wasn’t in labour, [holding back tears], erm so I couldn’t be in any pain”  
“.she said, “Oh, its just niggles its nothing.” “I said you know, “I’m in quite a lot of pain, can I have any pain relief?” And they said, “Well you’re not really you’re not in labour at the moment,” you know, “you’re not in pain.” “I couldn’t walk I was, you know doubled over, and it was just completely ignored”  
“.they didn’t believe that I was in any pain [fighting back tears]” | 86-88 92-93 99-100 260-261 107-108 |
| Need to be acknowledged |  
| Pain is dismissed |  
“..then she said… I wasn’t in labour, [holding back tears], erm so I couldn’t be in any pain”  
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“.they didn’t believe that I was in any pain [fighting back tears]” | 86-88 92-93 99-100 260-261 107-108 |
| Effect of not being believed | “[cries], wondering you know, ‘If this isn’t labour you know how am I going to cope with labour?’… erm. and just really feeling you know really anxious”

“I think that if there was something, you know to say it can happen, it does happen to other people… I would have told someone then how I felt.”

“[re message board] it’s just really good, to know that its recognised, you know and that, it’s not just me being weak and, not able to cope with childbirth, you know that it’s a real it’s real” | 115-116

| Needs recognition | 282-284

| Continuing anguish | 564-566

| Fear of childbirth | “[sighs] all I can think is that I’d just be terrified, giving birth [tearful] again”

“I don’t feel that I can, go ahead again with another pregnancy”

“…so that’s really why I avoid childbirth at present at the moment because… I just don’t want to go all through that again”

“.whereas now, I think its like a phobia”

“…sometimes I can’t even think, about being pregnant again it just, its like something in, inside just stops me, and I just can’t imagine it again” | 312-313

| Avoids pregnancy and childbirth | 5 207-209

| Dilemma of wanting another baby | 305

| Fears of childbirth | 308-309

| Fear of childbirth | “I really do want another baby, you know at the moment, but, it’s just really important to me at the moment not to, get pregnant I just, can’t imagine it, at the moment.”

“.and I’m thinking now, ‘If I’m gonna do this, you know if I’m gonna have another baby, I want it to be soon,’ and I don’t know whether like subconsciously that’s affecting me”

“.its a kind of a ‘Catch-22’ situation… I really want another baby, and you know I just don’t feel that I can.,” | 475-479

| Dilemma of wanting another baby | 526-527

| Panic | “It got to the stage where I couldn’t even go out, if I was with someone, I would start to erm really you know panic attacks”

“I wasn’t going out I couldn’t, I felt that I couldn’t cope with anything” | 371-373

| Dilemma of wanting another baby | 422-423

| Feeling of helplessness | “[sighs] but even now, I still find it really difficult to, go into new situations” | 401-402

| Feeling of helplessness | 440-441

<p>| Anxiety | “...she [psychologist] said that I was suffering from Post-Traumatic Stress Disorder from the birth” |</p>
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<td></td>
<td>“I’ve started having erm bad dreams again”</td>
<td>472</td>
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<td></td>
<td>“I can’t, can’t go back to that hospital again… I’ve drove past it a couple of times… that’s quite difficult, I just can’t, face going back really”</td>
<td>548-550</td>
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<tr>
<td>Difficulty talking about the birth</td>
<td>“I didn’t tell anyone how I felt about the birth, it was just, thought that I’d got post-natal depression”</td>
<td>202-203</td>
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<tr>
<td></td>
<td>“…gradually then that I started to, tell my husband, how I was”</td>
<td>203-205</td>
</tr>
<tr>
<td>Family life</td>
<td>Relationship with husband</td>
<td>“I feel quite guilty, and for my husband because, we’d always planned together you know, that we’d have, you know three children”</td>
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<td></td>
<td>Unable to go to work</td>
<td>“I haven’t been able to go to work”</td>
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<td></td>
<td>Relationships with family and friends</td>
<td>“I don’t feel able to work on my own without anyone else, without someone else who I’m really, familiar with and I feel confident with”</td>
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<tr>
<td>Implications for self</td>
<td>Loss of self</td>
<td>“I just lay there then afterwards and I felt different, like a different person, [holding back tears]”</td>
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<td></td>
<td>Detachment</td>
<td>“I just wasn’t me anymore”</td>
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<td></td>
<td>Disconnected from emotions</td>
<td>“I sort of felt, like I was less of a woman really”</td>
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<td></td>
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<td>“I just remember, feeling like... erm, I suppose like my body wasn’t my own anymore”</td>
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<td>“I sort of knew something wasn’t right, I didn’t feel right”</td>
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<td>“I remember her being born, and I just, you know I just looked down and I just felt really numb”</td>
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<td>“I felt, as though every... things weren’t real”</td>
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<td>“...one morning I just couldn’t get out of bed I just couldn’t, felt like, the only way I could describe it was that I felt flat”</td>
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<td></td>
<td></td>
<td>“I just felt like a shell”</td>
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<td></td>
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<td>“I just remember lying there, I just felt quite empty afterwards”</td>
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<tr>
<td>Objectification</td>
<td>“I just felt really excluded from everything you know like it wasn’t my body and it wasn’t my baby, [tearful]”</td>
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<tr>
<td>Negative self-concept</td>
<td>“It wasn’t you know just wasn’t my, my body, you know it was all their decisions and that was it”</td>
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<tr>
<td>Lacks confidence in her own ability to be a mother</td>
<td>“I thought you know that I was weak, and, you know, I wasn’t a woman, ‘How can I be a proper woman if I can’t cope with something as natural, as childbirth?’ “</td>
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<td></td>
<td>“I just felt, so ashamed”</td>
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<td></td>
<td>“I started to I saw the other moms that were washing and dressing their babies so I did the same”</td>
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<td>“…she wouldn’t feed properly wanted to breastfeed her and she wouldn’t feed… so I just gave up”</td>
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<td></td>
<td>“I’ve never really, been on my own with her, in the house with her”</td>
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<td></td>
<td>“…and now that you know some days I do stay in on my own with her and she just hates it”</td>
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<td></td>
<td>“I think my confidence grew as well then, in my ability to be a mom because, before that I felt that because of how I was feeling, I couldn’t look after myself let alone my daughter”</td>
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<tr>
<td></td>
<td>“It made me feel that my body was failing my baby, that my my own body couldn’t look after my own baby”</td>
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<tr>
<th>Feeling a sense of failure</th>
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<td>589-590</td>
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Appendix 20: Themes from Individual Tables

1) Lynn
   Control
   Thoughts about nearly dying
   Need to be acknowledged
   Expectations
   Need for explanation
   Physical distress
   Enduring distress
   Implications for self
   In relation to others

2) Jill
   Control
   Unexpectedness
   Expectations
   Physical and mental distress
   Need to be acknowledged
   Change
   Sense of self
   In relation to others
   Enduring distress
   Family life
3) **Heather**

Control

Expectations

Physical and mental distress

Baby as alien to self

Detachment

Continuing anguish

Pretence and duplicity

Need for acknowledgement

Life changes

Sense of self

4) **Alex**

Control

Feeling not ‘grown-up’ enough

Physical and mental distress

Negative experiences in hospital

Need to be acknowledged

Need for explanation

Validation from ‘outside’ of the hospital

Continuing anguish

Family life

Implications for self

5) **Nadine**

Pain

Fear

330
Abandonment
Lack of control
Experience of childbirth was not how she had imagined
Enduring distress
Detachment

6) Tina

Control
Abandonment
Humiliation
Physical and mental distress
Negative experiences in hospital
Need for explanation
Need to be acknowledged
Continuing anguish
Family life
Implications for self
Appendix 21: Superordinate Themes Integrated from Participant’s Tables of Themes

Control
Loss of control, others having control, the need to be in control, feeling of helplessness, being taken over, need to restrain oneself, attempts to gain control, being unable to move, feeling overpowered.

Physical and mental distress
Pain, dying, physical discomfort and distress, lack of explanation, negative experience of hospital, emotional distress, loss of blood, physical invasiveness, sickness, shock, struggling to cope with pain, fear of unknown, struggle to communicate, lack of dignity, want to escape, feeling trapped, ordeal of stitches, despair, hostility from staff, denial of pain relief, abandonment, lack of support, lack of consistency of care, feeling disregarded, need partner, lack of privacy, fear of humiliation, fear of being left alone, not being informed.

Expectations
Societal expectations of childbirth and motherhood, expectations not matching reality, disbelief at nature of experience, being unprepared, childbirth not as portrayed in media.
Need for acknowledgement
Lack of acknowledgement, dismissal of fears – validation denied, implications of being dismissed, need for validation, not being listened to, feeling misunderstood, feeling ignored, plea for help / recognition, frustration at not being believed.

Enduring distress
Negative memories of childbirth, fear and avoidance of childbirth, finding it difficult to talk about experiences, fear, depression, dilemma around feelings of wanting another child, need to escape, anxiety, feelings of anger, reminders of childbirth trauma, being denied a Caesarean Section, experience of flashbacks, numbed feelings, nightmares, panic, feelings of helplessness, fear of being left alone, feeling unsafe, self-harming, intrusive memories of the birth, hypervigilance, feelings of envy.

Implications for self
Loss of self, negative self-perception and appraisal, feeling bad about own feelings, questioning own self-concept, detachment, disconnected from emotions, feeling a sense of failure, lack confidence.

Implications for family life and relations with others
Marital discord, tension, isolation, difference of perception, feeling of being duped, perceived lack of empathy from others, feeling unsupported, intense relationship with child, change in relationship with partner, inability to continue with work, life-changes - sadness at loss, husband’s distress, affect upon relationships with extended family and friends.
Appendix 22: Seven-phase Model of Stages Accompanying Transition

(Sugarman, 2001: 144)