Birthing and Being Birthed: Exploring How the Experience of Birth Trauma Impacts Birthing People in Their Postpartum Lives

by

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To Connor,

Whose birth was the start of where and who I am today

Love, Mama.

Table of Contents

ABSTRACT

Birth trauma is experienced by up to 30% of childbearing people and has negative health consequences. Further, birth trauma is poorly understood by healthcare providers and childbearing people's embodied experiences of trauma are ignored or made light of, contributing to further harm. This research utilized feminist phenomenology to explore the impact of birth trauma in childbearing people's postpartum lives. Three themes were discovered: Continuously Processing, Searching for Answers in Others, and Experiences as a Body in the Healthcare System. Birthing parents felt that their trauma began in prenatal care, was perpetuated during birthing, and ignored postpartum. Mental health care was invisible and interactions with healthcare providers were, overall, ineffective and contributed further to birthing parents' embodied trauma. This research brought forth findings for how childbearing people can be better supported during childbearing including recommendations for resolving embodied trauma and strengthening the healthcare system in terms of mental health support.

LIST OF ABBREVIATIONS USED

CBT	Cognitive Behavioural Therapy
DSM	Diagnostic Statistical Manual
EMDR	Eye Movement Desensitization Reprocessing
EPDS	Edinburgh Postnatal Depression Screen
PMI	Perinatal Mental Illness
PTSD	Post-traumatic Stress Disorder
VBAC	Vaginal Birth After Caesarean

GLOSSARY

Birthing Parent	A gender inclusive term for the participants in this research.
Childbearing Person	A gender-inclusive term for people who have carried a pregnancy and/or birthed a baby
Pregnant Person	A gender inclusive term for a person who is pregnant
Parent	A non-birthing biological parent
Perinatal	The period before and after birth

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CHAPTER 1: INTRODUCTION

Background

Perinatal mental illness (PMI) is one of the most common complications of pregnancy and one of the top three causes of death in the perinatal period (Clevesy et al., 2019; World Health Organization [WHO], 2008). Approximately 20 percent of childbearing people[1] experience a mental illness (Beck & Driscoll, 2006; Woody et al., 2017) and this has implications not only for their health, but for the health of their infants and families. While perinatal depression is the best known and most-researched PMI, recent studies have shown that anxiety is also prevalent (Dennis et al., 2017) and that birth trauma, a term for a spectrum of traumatic stress symptoms experienced as a result of events during childbirth, is present in up to 30 percent of the childbearing population (Anderson, 2017; Beck, 2004a; Beck et al., 2013; Cook et al., 2018).

Although birth trauma is one of the more common PMIs, it remains misunderstood by healthcare professionals. Thus, birth trauma is often misdiagnosed as anxiety or depression (Beck & Driscoll, 2006) and consequently treated inappropriately, or it remains undiagnosed and goes untreated. Furthermore, birth trauma is confused with the clinical diagnosis of post-traumatic stress disorder (PTSD). PTSD is a narrowly-defined clinical disorder (American Psychological Association [APA], 2013) as compared with the broader spectrum of symptoms that the term birth trauma encompasses (Beck, 2004a, 2004b; Beck et al., 2013). The consequences of untreated birth trauma are profound and people who do not get help often feel that they are alone in their experience (Moyzakitis, 2009; Taghizadeh et al., 2013) as friends and family are

[1] Childbearing person/people is a gender inclusive term to describe an individual who carries a pregnancy and births an infant.

commonly unwilling to talk about the trauma or they simply believe the childbearing person has experienced nothing to be traumatized over (Taghizadeh et al., 2013). This is especially the case for childbearing people who from outsider perspectives had a birth that is situated within the realm of 'normal', i.e. no major medical complications for birthing person or infant, yet for them, was a traumatic event. Perception is key in any trauma (Crawley et al., 2018; Sperlich et al., 2017; Van der Kolk, 2015), and it is the perception of a traumatic birth that this proposed study seeks to explore. The voices of people experiencing birth trauma are underrepresented and I aim to bring these forward through the question: How does the experience of birth trauma impact the childbearing people in their postpartum lives?

Coming to the Question

Birth trauma is an experience that is personal to me and seemed like an obvious choice for my thesis research topic. In the 1990s, New Zealand (my country of origin) amended its Nurses Act to make midwifery a profession distinct from nursing. This meant that midwives no longer needed to train as nurses first and that they could provide autonomous care to childbearing people. Although I was a teenager at this time who was not thinking about childbearing at all, my ideas about how I would birth were heavily influenced by this resurgence of a midwifery model of care. I grew up with a culture of physiologic birth where women were supported by care providers and their communities and I expected that this would be the case should I ever have children.

So, in 2008 when I discovered I was pregnant, I was shocked and disappointed to discover that Canada, where I had been living for a few years, did not have ready access to midwifery care. Unable to access midwifery services due to demand exceeding supply,

my pregnancy care was excellent medically-oriented care, but it lacked in psychosocial and emotional aspects. When it came time to birth, I was let down by the care providers present and a system that neglects childbearing people's autonomy, both of which contributed to the development of my birth trauma. This experience affected my postpartum transition to motherhood and went untreated for years.

In 2011 I became a doula so I could support childbearing people through their pregnancies, births, and postpartum periods and while there were wonderful births, there was also more trauma – for the people I supported and for me. I saw care providers perform procedures without consent of any kind. I saw birthing people yelled at, spoken down to, and sternly told to do as the care provider wished them to do. More recently, as a nursing student, I attended placement on birth units and again saw the type of care I had experienced as a birthing person and witnessed as a doula. Although this project focused on childbearing people, acknowledging that trauma happens to care providers too is important. Doulas and nurses have reported witnessing obstetric violence (Morton et al., 2018). My experiences with birth trauma make me steadfast in my goal to bring birth trauma out of the darkness of postpartum minds and into a forum where we can make change.

During my initial foray into the literature on this topic, I fairly quickly discovered that there is a plethora of research about events that cause birth trauma and examinations of labour and delivery's role in contributing to birth trauma. I found this a bit disappointing as my first thoughts were to look at experiences of the traumatic events themselves; however, this would likely contribute no new information to the existing body of literature. What did become clear is that the impact and/or effects of birth trauma

on postpartum life and early parenting are not so well understood and of note, there is limited knowledge about people's experiences of life with birth trauma. This gap, combined with my interest in postpartum transitions and early parenting, made the topic I eventually decided on a logical next step. There are people living in the world at this moment experiencing birth trauma, who may or may not know what is happening to them. Birth trauma, because it is a mental illness, is socially and institutionally invisible due to stigma regarding mental illness and the questions asked in this research aimed to shed some light on the experience of living with birth trauma in the postpartum period.

Purpose of the Study

The purpose of the proposed study was to explore the postpartum experiences of people living with birth trauma. Qualitative data garnered through storied experiences offered critical insight into the phenomenon of living with birth trauma, a perinatal mental illness that remains underdiagnosed, undertreated, misunderstood, and rendered invisible through stigmatizing practices that normalize taken-for-granted and everyday meanings of childbirth and parenting. Understanding how birth trauma impacted the lives of birthing people and their families offered new insights into how and why trauma-informed care practices not only align with best evidence, but are critical to ensure perinatal care is ethically and culturally safe and respects the autonomy and human rights of childbearing people.

Through the lens of a feminist phenomenological methodology, this study identified what it is like to live with birth trauma and in the process of discovering this, uncovered power inequities and structural barriers inherent in institutionalized care that

affected the birthing parents as they negotiated their postpartum life-world of embodied trauma.

Research Questions

This research gives a voice to those who are living with birth trauma, making visible psychological distress that was acknowledged neither by family and friends, nor in healthcare. Thus, the primary research question was: How does the experience of birth trauma impact birthing people in their postpartum lives? Sub-questions to further explore this phenomenon were:

1) What are the psychosocial implications of living with birth trauma?
2) How can the psychological distress associated with birth trauma be made visible in healthcare and in society in general?
3) What do people experiencing birth trauma think will help them in their recovery?

Significance of the Research

This research was the first of its kind in Canada and also the first to use feminist phenomenology, thus it brings forth findings unique to the Canadian health context, with a specific focus on the structures, institutions, and social norms around childbearing and parenting in Nova Scotia. The study has helped participants feel validated in their experiences, and further raises awareness of birth trauma's existence, thereby contributing to changes in perinatal care and reducing birth trauma, as well as enhancing postpartum supports. Finally, when considered within existing birth trauma literature and the broader body of evidence on PMI, the project also has the potential to inform curricula in healthcare education and provider training, influencing current and future

healthcare providers through reducing the stigma around birth trauma, thereby improving the mental health of new parents.

CHAPTER 2: LITERATURE REVIEW

Perinatal Mental Illness

Perinatal mental illness (PMI) is mental illness that occurs during childbearing. This term is used throughout to describe the experience of illness that negatively impacts the day-to-day functioning of an individual. Mental illness differs from 'mental health' in that health refers to the everyday ups and downs of our patterns of thinking. This is a baseline state that does not negatively affect our lives (Kutcher et al., 2016). For example, one might feel apprehension about going to get a pap test because it is awkward and uncomfortable, but this feeling does not mean the person has an anxiety disorder.

PMI includes all the usual clinically-defined illnesses such as anxiety, bipolar disorder, depression, obsessive compulsive disorder, and post-traumatic stress disorder (PTSD) (Misri & Kendrick, 2007; Postpartum Support International, 2018), as well as the non-clinical spectrum of birth trauma. For some people, their mental illness is pre-existing, i.e. they already lived with depression or anxiety and are now pregnant. For others, PMI is a new occurrence during pregnancy or postpartum as they previously did not live with mental illness. Although PMI can differ in its time of onset, when it starts it does not change the effects on childbearing people. PMI is an experience that falls outside the realm of normal adjustment to pregnancy or parenthood, negatively affecting the day-to-day functioning of childbearing people and as such, birth trauma is one type of PMI.

Birth Trauma

Definitions

Definitions of birth trauma vary depending on the study and have changed over time. Some quantitative studies and some recent qualitative works have used the term 'birth trauma' to describe PTSD and this is shown in the PTSD screening tools used for participant inclusion even when titles and abstracts use birth trauma as a descriptor (Anderson, 2017; S. Ayers et al., 2016; Reed et al., 2017; Taghizadeh et al., 2013). I would, however, propose that these terms are not interchangeable, and that birth trauma is an umbrella term that describes variations of traumatic experience, of which PTSD is one and this is supported in the early literature on birth trauma (Beck, 2004a, 2004b).

The Diagnostic Statistical Manual (DSM) of Mental Disorders is the preferred clinical tool for diagnosing mental disorders, including PTSD. In 1994, the DSM-IV (APA) included birth-related trauma in its diagnostic criteria for PTSD. Conversely, the current version of the DSM, DSM-5, does not specify childbirth as contributing event for PTSD. It does, however, define trauma as "Exposure to actual or threatened death, serious injury, or sexual violence through directly experiencing or witnessing in person the [traumatic] event" (APA, 2013). In addition to a precipitating event, the DSM has further criteria that must be met for PTSD diagnosis. These criteria include intrusive symptoms like recurrent involuntary memories or dreams of the event, dissociative reactions during which an individual re-experiences the event, and intense or prolonged distress or physiological reactions to exposure or cues that symbolize or resemble the event. Further, there must be persistent avoidance of stimuli associated with the event, negative alterations in mood and cognition and changes in arousal and reactivity beginning after the event occurs, and that are related to the event. These symptoms must last longer than one month and cause significant impairment in everyday functioning that

cannot be attributed to substance use or a physical condition. For about 4-7% of childbearing people, childbirth results in PTSD (Anderson, 2017; Verreault et al., 2012; Yildiz et al., 2017b).

Frequently, qualitative studies use a more generous definition for birth trauma such as "An event during labour and birth that involved threatened or actual serious injury or death to the mother and/or infant"(Anderson, 2017, p. 999). Moyzakitis (2004) offers the following:

> A woman who has suffered distress as a result of injury to her body, or pain and sorrow, which is of such a magnitude that it may lead to a traumatic condition, which can have a prolonged psychological and/or physical effect upon that woman." (p. 2)

Beck et al., (2013) suggest a broad definition: "[birth trauma] is an event during labour and delivery where the woman perceives she is stripped of her dignity" (p. 8) and Beck, (2004a) in her foundational work on birth trauma refers to it as "in the eye of the beholder" (p. 33) These definitions acknowledge individuals' perceptions of childbirth and ignore diagnostic criteria, which is why they are the preferred basis for the definition to be used in this proposed research. Thus, for the purposes of this proposed study, birth trauma is defined as 'psychological distress experienced as a result of events that occurred during childbirth' and symptomology includes the DSM (APA, 2013) list: re-experiencing the events through flashbacks; nightmares; intrusive thoughts; avoidance behaviours, feelings of guilt, hopelessness, powerlessness, and failure; anxiety; depression; hyperarousal; and physical symptoms such as sweating, stomach cramps, and muscle tension.

Risk Factors

Risk factors for birth trauma include personal characteristics such as personality and social circumstances as well as events from labour and delivery that contribute to its development (Anderson, 2017; Yildiz et al., 2017a). People who are at higher risk of developing birth trauma are those who have pre-existing trauma or mental illness (Anderson, 2017; S. Ayers et al., 2016; Verreault et al., 2012), high anxiety sensitivity (Verreault et al., 2012), with higher risk events being pregnancy or delivery complications (Anderson, 2017; S. Ayers et al., 2016) and, poor interactions with caregivers (Anderson, 2017; Verreault et al., 2012), expectations for birth not being met (S. Ayers et al., 2016; Verreault et al., 2012), preterm birth (Verreault et al., 2012), and a NICU stay for the infant (Anderson, 2017). Moderate risk factors include fear of childbirth (Anderson, 2017; Ayers et al., 2016), inadequate prenatal care (Anderson, 2017), and unplanned caesarean birth (S. Ayers et al., 2016; Verreault et al., 2012). An individual who does not have or experience these factors is at low risk for developing birth trauma. It is unclear from current literature how birth location, parity, and demographics affect risk of developing birth trauma (Anderson, 2017; Verreault et al., 2012), although we do know from childbirth research that people who are from marginalized communities, those who live in poverty, and younger birthing people have worse birth-related health outcomes than the general population (Grobman et al., 2015).

Incidence

There is no singular tool used for screening or diagnosis of birth trauma, and while the incidence is well-documented in the literature, studies use a variety of standardized measures to determine the presence of either PTSD (Yildiz et al., 2017b) or

the broader condition of birth trauma. A recent meta-analysis of global data determined that 4% of low risk populations and 18.5% of high-risk populations (risk as defined by above risk factors) will be diagnosed with PTSD following childbirth (Yildiz et al., 2017b). One Canadian study has investigated the incidence and risk factors for PTSD, and found that at one month postpartum, 7.6% of participants met diagnostic criteria for full PTSD while 16.6% of participants met criteria for partial PTSD (Verreault et al., 2012). Participants were further screened at 3 and 6 months postpartum and found that rates declined over time to 4.9% and 3% respectively. PTSD is the most severe presentation of birth trauma, but by no means the only one. Between 20% and 48% of childbearing people do not meet the criteria for a formal PTSD diagnosis but do report symptoms of PTSD from at least one diagnostic criterion category (Anderson, 2017). Further, Beck et al., (2013) estimate that 30% of birthing people perceive their birth as traumatic, subsequently experiencing stress reactions, yet do not meet any diagnostic criteria for PTSD. These statistics show that birth trauma is a common experience in the childbearing period, and that more needs to be known about this phenomenon.

Treatment

In the literature, various treatments have been evaluated including post-birth debriefing, cognitive behavior therapy (CBT), eye movement desensitization and reprocessing (EMDR), and medications. Post birth debriefing is a widespread practice in some countries, although there is variation in the timing, content, availability, and care provider delivering the debriefing (Bastos et al., 2015; Baxter et al., 2014). Inconsistencies in the way debriefing is administered contribute to a low quality body of evidence (Bastos et al., 2015) and contradictory results on effectiveness. Some

childbearing people do report that debriefing is helpful, yet others do not; therefore, current recommendations are to offer it to those who express interest, rather than as a universal treatment (Bastos et al., 2015; Cunen et al., 2014).

CBT is a talk therapy that helps people examine their patterns of thinking, in order to change habitual and distorted ways of interpreting the world (Beck Institute, 2016). CBT has long been the recommended psychotherapy for birth trauma and it remains an effective treatment (Beck et al., 2013; Beck & Driscoll, 2006).

EMDR is an integrative psychotherapy, or form of recoding for the brain that reduces reactions to thoughts about previous trauma (EMDR Canada, 2019). This technique requires the person living with trauma to think about the traumatic event while the clinician facilitates lateral eye movements, tapping, or uses an audio stimulus. This reprograms the brain to think about the traumatic event in a different way and the person's behaviour adapts as a result. EMDR is effective for birth trauma because it helps people to process distressing thoughts, alleviating trauma symptoms and allowing them to readapt their thought processes for an improved view of self and relief from physical manifestations of trauma (Beck et al., 2013; EMDR Canada, 2019).

Medications are used to offset the effects of anxiety and depression associated with birth trauma rather than to treat the trauma itself. Antidepressants and anti-anxiety medications are popular, and sedatives are sometimes prescribed for sleeping difficulties (Beck et al., 2013). Medications are best used in conjunction with psychotherapy (APA, 2013; Beck et al., 2013) rather than as a stand alone treatment.

Support groups are another form of treatment that have been helpful for people who have experienced birth trauma. Evidence assessing the effectiveness of these groups

on birth trauma specifically is unavailable, yet the consensus from online groups and forums as well as perinatal mental health advocacy organizations like the Maternal Mental Health Research Collaborative and Postpartum Support International is that peer support is invaluable. Further, the positive outcomes of peer support have been documented in other contexts, including in healthcare workers who experience vicarious trauma (Putnam, 2016), in reducing hospital readmissions in people with psychiatric diagnoses (Sledge et al., 2011), and in populations that traditionally are hard to reach and have issues accessing healthcare services (Sokol & Fisher, 2016). Participants in these studies report improved health literacy, a sense of connectedness, and were better able to access supports than those who did not attend peer support groups.

While not formally recognized in scientific literature, there is evidence in online birth trauma support groups that people who experience birth trauma are firstly, unable to access health interventions due to problems with diagnosis and limited resources, and secondly, those who are accessing health interventions report that the interventions are not effective (Birth Trauma Association, personal communication, November 20, 2018). The body of literature on treating birth trauma does not specify whether or not childbearing people were consulted at the outset. Rather, existing treatments are interventions that have been shown to be effective for PMIs like depression and adapted for use in birth trauma. Further, an identified priority for future research has been to include childbearing people in the development of interventions, to ensure that treatment is appropriate and effective as there are differences between the empirically measured effectiveness of treatments and childbearing people's experiences of intervention effectiveness (Baxter et al., 2014). Moreover, studies often do not report participant

demographics, so knowing who is or is not accessing these treatments is difficult to ascertain. Including childbearing people from all backgrounds in planning and development of future treatments is important and thus the proposed research will explore participants' ideas on recovery and treatment options, with the goal of making suggestions for postpartum supports. This form of patient-oriented research ensures that client-identified needs can be prioritized in health decision-making, leading to better client outcomes (Canadian Institutes of Health Research, 2011).

Experiences of Birth Trauma

To date, research on experiences of trauma related to pregnancy and/or birth has focused on the events during labour that birthing people perceive as the cause of their trauma (Anderson, 2017; S. Ayers et al., 2016; Byrne et al., 2017). Accounts of birth trauma during labour and delivery describe the feeling of being objectified, passive, and dissociated from one's body, out of control and ignored (Cook et al., 2018), all of which describe the disempowerment of birthing people and the concept that healthcare providers who were present could not see what was happening: birth trauma is invisible. The labour and delivery literature on birth trauma is extensive and has contributed much to understanding its symptoms (re-experiencing events through flashbacks; nightmares; intrusive thoughts; avoidance behaviours, feelings of guilt, hopelessness, powerlessness, and failure; anxiety; depression; hyperarousal; and physical symptoms such as sweating, stomach cramps, and muscle tension) and events that contribute to its development.

Research into experiences in the postpartum period is less common and current studies are primarily centred around PTSD and how that affects people in the postpartum period.

A qualitative Iranian study of 23 women (Taghizadeh et al., 2013) explored the effects of birth trauma in the postpartum period. Women described feeling alienated from their infants; in one case a participant offered her child to an aunt because she felt hollow as a mother. Women did not want to engage in sex with their husbands and referred to anxiety and feeling damaged as reasons their relationships suffered. Social conflicts were present with relatives, who did not understand women's emotions or changes in their affect and women reported feeling dread, fear, and anxiety about getting pregnant in the future and having to go through childbirth again. This study offers insight into how heterosexual women cope with birth trauma postpartum. While there may be cultural differences when translating findings to Canadian parents, this study begins to describe the social impact of birth trauma and how negative thought patterns can cause issues in relationships with infants, families, and intimate partners. The women in this study felt that their experience was not normal and that no one understood what they were going through, themes that this proposed research hopes to build on.

Peeler et al., (2018) aimed to explore how women are affected by memories of their traumatic birth. They used the Impact of Events Scale (IES) to determine if their seven participants had PTSD, although they were not formally diagnosed. Findings showed that women were disappointed with limited postpartum supports and wanted to share their stories but their PTSD affected their ability to do so. Complicating factors such as pre-existing mental or physical illnesses, relationship breakdown, and work affected women's perceptions of themselves postpartum and this study uncovered the importance of social support. Women who had family and friends to help them with practical tasks as well as emotional support felt better about themselves than those who

did not. This shows that when women perceive their birth does not fall into societal norms, they are reluctant to discuss it, further brooding on what went wrong and exacerbating their PTSD. Peeler et al.'s, (2018) work was the only study thus far to put forth the idea that the social contexts of women's lives affect their recovery from PTSD and these findings can be extended to birth trauma. The proposed research will add to the understanding of the psychosocial implications of birth trauma by delving in to how birth trauma impacts birthing people's relationships and social lifeworlds.

Elmir et al.'s, (2010) meta-ethnography compiled findings from 10 qualitative studies on experiences of birth trauma or birth-related PTSD. Findings for both intrapartum and postpartum experiences are detailed, with the 4 themes related to postpartum experiences findings described here. Theme 1: Women felt trapped by memories of their traumatic births. Even when years had passed, women describe having vivid flashbacks and intrusive thoughts that interrupted their lives, for some on a daily basis. Avoiding situations that caused these flashbacks and pushing the thoughts away were strategies women used to cope. Theme 2: A rollercoaster of emotions. Women experienced a variety of emotions ranging from anxiety to suicidal thoughts to anger. They report feeling guilty about having not done anything to prevent the trauma, particularly if interventions happened during the birth, and expressed a desire to have someone acknowledge their trauma. Theme 3: Relationships were disrupted. Women felt unattached to their infants and had to work hard to maintain a 'normal' maternal bond. They also did not want to be touched by their intimate partners, avoiding sex in fear of becoming pregnant again or because it reminded them of birth. Further, women felt that their partners did not understand what they were going through, even though that same

partner was present at the birth. Theme 4: Women found strength in their mothering. This was a theme that described breastfeeding and how some women felt they were 'making up' for their failure during birth by breastfeeding, and others felt like further failures because breastfeeding was not successful. This meta-ethnography considered both PTSD and birth trauma in its findings. It highlights the idea that birthing people know when their birth is not normal and they are hesitant to discuss it because people do not understand, but also because they lack spaces to share their stories. This proposed study aims to give people a forum to share their stories and to have their birth trauma acknowledged further in academic literature and in healthcare environments.

There are limited data about how birth trauma, rather than PTSD, affects people in the postpartum period. Beck (2004a) completed a descriptive phenomenological study using 38 women's written accounts of their experiences in living with birth trauma. Women were from New Zealand and Australia and findings were that relationships were negatively impacted, women felt isolated and unable to share their experiences with their social groups, and that they felt inadequate as mothers. This is the earliest study on birth trauma, and it uses the broad definition of spectrum rather than PTSD as its premise.

Moyzakitis (2009) conducted an exploratory and descriptive study of six women in England who experienced traumatic birth using a feminist lens to interpret data. Women described feeling detached from their babies, some over a period of two years. Women also reported relationship issues with partners, especially around sexual intimacy. Further, women felt isolated in relation to other mothers and felt that they could not talk about their experiences as others did not relate to their experience. Women in this study shared that their participation was therapeutic, as the researcher's professional

knowledge as a midwife helped them understand some of the events that happened during their births.

Canadian Context

Canadian research on birth trauma is extremely limited. Cohen et al., (2004) interviewed 253 mothers on postpartum wards in Toronto and again by phone at 8-10 weeks postpartum. These authors found that the only birth event correlated with PTSD was two or more maternal complications; however, depression during pregnancy, a higher socioeconomic status, being Canadian-born, and a history of trauma resulted in higher PTSD scores. Verreault et al., (2012) conducted a prospective study in Montreal on the incidence of PTSD after birth and found rates of 7.6%, similar to studies using global data. A study of Canadian and American nurses and doulas found that two thirds of participants had witnessed care that did not meet professional standards and they perceived that this contributed to women's birth trauma (Morton et al., 2018). Currently, no Canadian studies have explored birth trauma from the perspective of the individuals experiencing it. Thus, the proposed research will build on themes developed from existing literature, adding a Canadian perspective and exploring ways people are balancing parenting and their other responsibilities while coping with trauma, adding new insights into what they think would help them be their best selves and aid their recovery.

To summarize, birth trauma is a PMI that has profound consequences for childbearing people, their infants, and their families. Up to 30% of childbearing people experience birth trauma, symptoms of which include re-experiencing events through flashbacks; nightmares; intrusive thoughts; avoidance behaviours, feelings of guilt, hopelessness, powerlessness, and failure; anxiety; depression; hyperarousal; and physical

symptoms such as sweating, stomach cramps, and muscle tension. Risk factors fall into categories of personal and social attributes as well as contributing events. Treatments are available although childbearing people experience barriers in access and there are mixed reviews around effectiveness. Canadian data on birth trauma are limited and there are currently no studies about Canadian experiences in living with birth trauma. Childbearing people's experiences of birth trauma are represented in terms of PTSD for the most part, which neglects the broader experience of birth trauma, defined for the purposes of this proposed research as "psychological distress experienced as a result of events that occurred during childbirth." This is a purposefully broad definition to acknowledge the variation in individual experiences, which aligns with the underpinnings of feminist phenomenology, the methodology chosen for this proposed study.

CHAPTER 3: METHODOLOGY AND METHODS

Methodology

Feminist Phenomenology

This research aimed to uncover experiences of birth trauma in a population whose birth and postpartum experiences are typically situated within the realm of 'normal', as both birthing parent and baby were perceived by others as healthy. The population of interest for this research was birthing parents who had given birth within the last five years and self-identified as having experienced a traumatic birth. Additional inclusion and exclusion criteria are detailed below in the methods section. Feminist phenomenology offered the methodologic tools to explore this population's experiences in living with birth trauma. With roots in existential philosophy, phenomenology attempts to capture the 'what' and 'how' of lived experiences, making collective meaning from individuals' accounts of a given phenomenon (Creswell & Poth, 2018; Moran, 2000). Feminist theory traditionally situates itself within female embodiment; however, in its modern iterations focuses more on social inequities for all people, not just women (Freeman, 2018; Goldberg et al., 2009; Zeiler & Käll, 2014). A feminist lens provided a juxtaposition to phenomenology in that it seeks to expose experiences that are outside of norms, or deviant, to uncover power imbalances as well as structural, institutional, and societal rules that oppress with the goal of promoting change (Zeiler & Käll, 2014). For this research, Merleau-Ponty's, (1962/2017) interpretation of the four existential pillars: embodiment, spatiality, temporality, and relationality, were used in conjunction with a feminist lens to uncover themes related to the experience of living with birth trauma.

Lifeworld. The lifeworld refers to the world, a set of conditions, or the context in which we live our lives (Moran, 2000). Merleau-Ponty (1962/2017), emphasizes that living means being in the world. Humans are in a reciprocal relationship with their lifeworlds, meaning that we influence our world and the world influences us. Further, humans act with intention in their relationship with their lifeworld (Moran, 2000), which implies that we have agency in our interactions.

Embodiment. Merleau-Ponty (1962/2017) rejects the Cartesian dualism of mind-body separation, in which we can separate our minds from our bodies. Instead, he suggests that rather than having a body, we are our bodies. This is to say that our body is our self, and we perceive everything through the window of our body. Bodies that have recently been pregnant and are now postpartum have experienced a transformation, which affects people's perceptions of themselves and their interactions with their lifeworld.

Spatiality. Space is perceived in relation to the body and consists of external space, in which the body is an object (körper) and embodied space, where the lived body (leib) exists (Merleau-Ponty, 1962/2017). The experience of birth trauma is a meeting of the body of object and the lived body. Accounts of birth trauma describe the feeling of being objectified, passive, and dissociated from one's body, yet the postpartum body is lived. It changes shape, nourishes a baby, and experiences desires. Feminist phenomenology gives us a way to uncover the ways in which these two perceptions of space interact.

Temporality. Time is non-linear and our perception of time is in relation to our current lifeworld (Moran, 2000). The memories of birth trauma transcend time, intruding on the present in unwanted ways in the form of thoughts and physical sensations. Often,

people with birth trauma describe themselves as 'stuck', unable to let go of the trauma, yet wanting to move forward and feminist phenomenology can explore some of the reasons why this might occur.

Relationality. People are not objects we interact with; they are fellow subjects within the material of our lifeworld (Merleau-Ponty, 1962/2017). We co-construct our reality with our fellow subjects and our perceptions of them and of ourselves are influenced through our relations (Moran, 2000). Postpartum life is filled with relationality and this experience is complicated by birth trauma and well-represented in the literature. Feminist phenomenology delves into the relations themselves, giving insight into the material and non-material perceptions and processes that inform relationships (Freeman, 2018; Zeiler & Käll, 2014).

In summary, feminist phenomenology provided opportunities to broaden understandings of marginalization, invisibility, non-normativity, and oppressions (Goldberg et al., 2009; Zeiler & Käll, 2014) that were present during life after birth trauma. This gave a foundation from which to question, or perhaps even dismantle, assumptions around the experience of birth trauma. Further, feminist phenomenology was necessary for understanding the way postpartum people interpreted their world, how they understood themselves, and how others understood them (Goldberg et al., 2009). Therefore, feminist phenomenology was the right choice for this research.

Researcher Positionality/Reflexivity

While early phenomenologists emphasized 'bracketing' (Moran, 2000), or the process of researchers putting their experiences, opinions, and ideas aside so their subjectivity does not influence their data collection, later phenomenologists suggest that

this is firstly, not possible, because we always see ourselves in relation to the world, and secondly, that because the researcher and participant are in relation, there is no escaping the influence of one on the other (Merleau-Ponty, 1962/2017; Moran, 2000). As I have personal experiences with birth trauma, I engaged with my supervisor frequently to examine how my own perspective and potential blind spots (Creswell & Poth, 2018) might have affected the data collection. Before beginning interviews. I worried about my experiences 'taking over' and not seeing what birthing parents were experiencing. This turned out to be unwarranted as while aspects of individuals' experiences were familiar to me, there were also aspects that were unfamiliar.

In talking with birthing parents, I experienced the phenomenological nod (Van Manen, 1997) and recognized myself in the birthing parents. I hope that others reading this research experience it too. Ultimately, any research is interpreted through the researcher's point of view and this is recognized in feminist phenomenology, which embraces the subjectivity of experiences and the co-creation of knowledge (Freeman, 2018; Goldberg et al., 2009; Zeiler & Käll, 2014). As the researcher, I identified myself to participants as a graduate student, a registered nurse, and also as a mother who experienced birth trauma following her child's birth. In so doing, I became both similar to and dissimilar from the participant (Goldberg, 2008), while approaching the relation with authenticity and honesty. The birthing parents were curious about my experiences and we fostered trusting relationships as we conversed about how they were doing postpartum. I was surprised to feel quite attached to birthing parents and I often find myself wondering what they are up to, how far they have come in their birth trauma journey, and whether or not their participation in this research continues to provide positive effects.

Methods

Inclusion/Exclusion Criteria

Birth trauma occurs in all kinds of births although it has been identified as more prevalent in births where birthing parent and/or baby experience morbidity or mortality, for example a stillbirth or a preterm birth. Experiencing birth trauma, however, is not limited to these higher risk situations, and those whose birth experiences appear from the outside to be within medical and societal norms, i.e. a medically uncomplicated birth with a physically healthy parent and a healthy baby, develop birth trauma as well. Thus, the inclusion criteria were as follows:

1) Birthed at term (37-42 weeks' gestation) to a live baby within the past five years and currently were parenting this baby.

There were no age restrictions for this study except for being the age of majority in Nova Scotia. There is evidence that preterm birth puts people at increased risk of trauma (Kraljevic & Warnock, 2013) and that post term births are subject to higher rates of medical intervention such as induction (Akuamoah-Boateng & Spencer, 2018), which also contributes to higher rates of birth trauma. The proposed research aimed to capture medically and socially normative births and these parameters were in place to ensure this happens. Initially, the first year post birth was necessary for inclusion; however, this became problematic during recruitment as I was overwhelmed with responses but very few people had birthed in the last year. The decision to broaden the timeframe from birthing to within the last five years was made. Moreover, this broadened timeframe provided opportunities to understand ways in which birth trauma changes over time and how birthing parents were coping longer term.

2) Had a ‘low’ or ‘normal’ risk pregnancy.

Again, this research aimed to capture medically and socially normative births. Pregnancies that were classified as low or normal risk fell within norms and childbearing people who experienced these pregnancies were eligible for inclusion.

3) Perceived the birth of their baby as traumatic.

Currently, neither PTSD nor birth trauma is commonly diagnosed (Long et al., 2019; Tenenbaum Potter, 2017), therefore, there was no requirement for participants to have a formal diagnosis. Moreover, this was a phenomenological study that aimed to explore ‘postpartum life with birth trauma’ and as such a definition of what this phenomenon is and how it is experienced was gleaned from participant data. In the interest of recruiting participants who perhaps did not know what is happening to them, some symptoms of birth trauma and contributing events were described on promotional materials (Appendix A).

4) Could meet for an interview in Halifax or online.

5) Willing to share experiences openly in English.

6) Able to give informed consent for participation.

Exclusion criteria:

1) Had a ‘high risk’ pregnancy.

This means that the childbearing person experienced pregnancy complications such as (but not limited to) pregnancy-induced hypertension, gestational diabetes, or pre-eclampsia. Further, a high risk pregnancy is one during which the fetus had medical issues diagnosed during pregnancy such as cardiac problems of genetic conditions.

2) NICU stay for baby.

3) Cognitive status does not allow person to give informed consent.

Sampling and Participant Recruitment

Sampling Strategies

A purposive sample was used (Creswell & Poth, 2018); this means that participants met all inclusion criteria for participation. I conducted a brief conversation with potential participants via email to confirm eligibility (Appendix B). Further, snowball sampling (Creswell & Poth, 2018) was utilized. I have strong connections to birthing and mental health communities in Halifax and I encouraged my professional and social network to give potential participants information about the study. This network shared social media posts, referred potential participants to the research's website, and spread word of mouth. To be clear, I did not solicit participants directly myself, I made use of my network to bring interested parties to me.

Recruitment Methods

Birthing parents defined their birth trauma themselves. To assist potential participants in determining their eligibility, some of the common symptoms of birth trauma identified in the literature were listed on recruitment materials. These include symptoms like flashbacks, intrusive thoughts, panic attacks, and avoiding healthcare or the place where the birth occurred. A website (birthtraumanovascotia.ca) was set up for the research where potential participants could gather information to inform their decision to participate. Social media platforms, community-based health organizations, and parenting-oriented websites were used to share the research's website and promote the study to potential participants. Further, recruitment posters were placed in family resource centres, physician offices, mental health clinics, public libraries, and on other

publicly-accessible community bulletin boards. I also emailed my contacts information about the research to help spread word of mouth.

Sample Size

In keeping with the phenomenological tradition, the sample size for this study was small (Creswell & Poth, 2018; Moran, 2000). 6 birthing people were recruited, allowing for an in-depth exploration of their experiences.

Data Collection

Privacy and Confidentiality

I corresponded with potential participants via email. I was the only person with access to this email and participants' personal and/or identifying information was kept confidential. I was willing to provide my phone number to potential participants who prefer to communicate via phone, but all preferred email.

Nova Scotia is small. As with any research that involves personal experience, there is the potential for participants to be identified by those who know their stories (Creswell & Poth, 2018). To mitigate this, participants were assigned a pseudonym that subsequently appeared on all documents. As many potentially identifiable data as possible have been removed (Creswell & Poth, 2018; Van Manen, 1997) or will be reported as group data, e.g. demographics.

Conversations were audio recorded and transferred immediately following the conclusion of interviews to an encrypted, password-protected external storage drive that only I had access to. Once safely downloaded, recordings were deleted from the voice recorder. Interviews were transcribed verbatim by a professional transcriptionist. Electronic transcripts will be kept for 3 years on the external drive before being deleted.

Paper copies of transcripts were stored in a locked storage box in my home office before being shredded and destroyed at the conclusion of the research.

Individual Interviews

Individual interviews took place between October 2019 and March 2020. Consent forms (Appendix C) were accessible on the website for potential participants to view as part of their decision to participate and a copy was emailed to birthing parents when they were found to be eligible. The informed consent process involved the birthing parents reading the consent form in my presence, having the opportunity to ask questions, and then answering 2-3 brief questions from me to ensure they understood what they read and the implications of their participation. Birthing parents were reminded that they were able to stop participation at any time during the interview or up to two weeks post interview and given a copy of the consent form to sign.

Birthing parents were the final decision makers on date, place, and time for interviews. I met with them in Dalhousie meeting rooms and in their homes. Interviews lasted 60-90 minutes. Demographic information including, gender, relationship status, sexuality, education, and income was gathered after our conversations; this information provides a snapshot of who the birthing parents were, the experiences they bring, and may further offer future researchers a rationale for inclusion criteria based on who was or was not present in this research. While there was an interview guide (Appendix E), I followed the lead of participants to allow for exploration of the individual's perception of their experience (Creswell & Poth, 2018; Van Manen, 1997). Information garnered from birthing parents was incorporated into discussions with the next birthing parents so I could determine what was common between experiences. While birthing parents were

asked to talk about their experiences living with birth trauma, i.e. life after the birth of their baby, they all spontaneously brought up their birthing. This was an expected event as opportunities to talk about traumatic birth are rare and childbearing people often feel isolated in their experience (Beck et al., 2013). As it became clear that the way birthing parents birthed affected their postpartum lives, their stories became part of the data and were used in analysis. This broadened perspective provided more insight into life with birth trauma. Birthing parents received a $30 gift card for participating in the individual session and each was offered a copy of their transcribed interview, giving them the opportunity to make additional comments. Five birthing parents opted to receive their transcript.

Individual Vignette

One of the knowledge translation strategies for this research was the creation of a video that highlights participants' stories using their voices. Participants were invited to contribute an audio response to the question: *How do I live this trauma?* At the conclusion of the individual interview, birthing parents were asked if they wanted to contribute their voice in a vignette. All participants did so and recorded a 30 second to 2 minute audio response to the above question. These responses were used as part of a video containing participant voices that will be available on this study's website.

Focus Group Session

Following their individual interview, participants were invited to express their interest in a focus group session. The focus group session involved participants in collaborative analysis (Van Manen, 1997), a process that makes use of group dynamics to

further examine a phenomenon. The focus group session was audio recorded and transcribed verbatim.

The focus group took place in March 2020, on the first day that initial COVID-19 restrictions were put in place. While five birthing parents expressed interest in this group, in the end two participants were present. Birthing parents were given time to read the consent form and had opportunities to ask questions or obtain clarification. I reminded birthing parents that the proceedings were to be kept confidential to protect their privacy and that their informed that consent could be withdrawn for the focus group session up until recording began, but as it can be difficult to know which voice is whose on an audio recording, their contribution could not be redacted after that point. Consent forms were signed before the focus group session proceeded.

This two hour session took place in a Dalhousie classroom. I shared preliminary findings and birthing parents shared their thoughts on these. This session was very interactive with lots of back and forth conversation, phenomenological nods (Van Manen, 1997), and discussion around understanding. Birthing parents felt that my interpretation of their individual interviews was "spot on" and they added a few suggestions for me to add. This session, although small, was a positive experience for all of us and further was a sort of pilot for me to see how in a facilitated peer support group might work as an intervention for birth trauma recovery.

Data Analysis

Thematic Analysis

Phenomenological analysis is an iterative process of reading and categorizing that leads to the development of themes for the phenomenon in question (Creswell & Poth,

2018; Van Manen, 1997). The four existentials (embodiment, spatiality, temporality, relationality) were kept as categories through which themes developed from the data. Feminist phenomenology provided a critical lens for data analysis; one that offered an opportunity to question structural, institutional, and societal processes that influenced the birthing parents' lives. Thus, analysis looked at aspects of childbearing and how embodied trauma affected birthing parents postpartum.

I analysed transcripts from individual interviews as soon as they were available as analysis informed subsequent interviews and future analyses (Van Manen, 1997). Analysis required reading transcripts multiple times, becoming familiar enough with each one to begin assembling themes out of participants' words. Approaches to the practicalities of this included taking the text as a whole, taking sections of text and asking what stands out, or going line-by line asking what the line reveals (Van Manen, 1997). I used a combination of these approaches as each felt right at given times. I also asked myself what was missing from the transcripts based on knowledge from the existing literature to understand how birthing parents' experiences were different from what was already known. Once themes were pulled from the data, I used the free imaginative variation process (Van Manen, 1997) to decipher themes. to do this, I asked myself 'will this phenomenon be the same if I imagine it without this theme?' and if the answer was yes, then the theme and could potentially be discarded or re-envisioned (Van Manen, 1997). I used this process with each transcript and then in considering the transcripts together as each birthing parent had different prominent themes. This was not a straight forward process. The data were filled with insight and there were so many aspects of life with birth trauma that were relevant to individuals yet did not reflect the phenomenon as

a whole. Capturing every facet of this phenomenon is not possible in this short masters thesis and this I find disappointing on one hand. On the other hand, the final themes were a merging of each birthing parent's experience the context of all their experiences and existing knowledge on life with birth trauma. Insofar as phenomenology is an exercise in finding commonalities in a given experience, the thematic analysis resulted in a description of what was common among birthing parents.

Credibility and Rigour

Credibility in qualitative research is the preservation of participant voices in the researcher's interpretation and representation of data (Polit & Beck, 2017). In phenomenology, this means that the themes, which emerge from data analysis, are truly representative of participants' experiences of the phenomenon in question. Credibility can be enhanced by researchers disclosing their experiences and also by verifying research findings with participants (Cope, 2014). Additionally, feminist phenomenology uses an interpretive, critical perspective to bring understandings of a phenomenon, and credibility can be enhanced through the notion of the "phenomenological nod" (Van Manen, 1997, p. 27). This refers to the recognition one feels upon hearing the stories and experiences elucidated from the research; the ways in which the description resonates with one's own experience of birth trauma and how this feels 'true' to one's embodied understandings of this phenomenon. The focus group was an opportunity to validate initial findings with birthing parents, thereby improving credibility, and moreover provided an additional occasion for researcher-participant collaboration, adding to the credibility of this research (Mays & Pope, 2000).

Rigour requires that the research process is thorough and accurate, and that the research design is appropriate for answering the research questions (Creswell & Poth, 2018; Cypress, 2017). No form of rigour can compare to the sense of belonging to a broader understanding of experience that is shared, as described by the phenomenological nod, and in realizing one is not alone in living with birth trauma. Birthing parents came to realize through their participation in this research that they were experiencing something that is recognized, albeit infrequently, and common. They commented on feeling validated in their reactions and experienced a sense of belonging as they learned that their embodied trauma could be explained by what happened to them during birthing. Making the methods, data collection, and analysis processes clear in writing up the study further adds to rigour as transparency helps readers and future researchers determine how feminist phenomenology contributed to furthering understandings of birth trauma.

Ethical Considerations

Due to the personal nature of birth trauma, there is a risk of psychological harm to participants in that troubling memories and thoughts may be triggered. Participants were provided with a list of local mental health supports including psychologists, counsellors, therapists, and health teams that they could access for support (Appendix G). Although our conversations were at times upsetting and birthing parents were emotional, no birthing parents reported lasting adverse effects from their participation in this research. In fact, as Moyzakitis (2009) found, sharing experiences can be therapeutic and birthing parents benefitted from verbalising what they were going through and learning that they were not alone in their experience. In addition to benefits for individual birthing parents, this study has the potential to help others who experience birth trauma and also healthcare

professionals by raising awareness of birth trauma's existence, contributing to changes in birth practices and reducing birth trauma, as well as enhancing postpartum supports including education.

Ethics approval #2019-4833 was obtained from the Dalhousie University Research Ethics Board in August 2019 after one round of revisions.

Knowledge Translation

Results of this research will be disseminated in the usual academic manner, including publications in academic journals, provincial and national conference presentations and posters, and at university seminars. Because healthcare professionals commonly misunderstand birth trauma, it is important to me that study findings are presented in non-academic forums that reach frontline clinicians, in order to influence behaviour change. I will present the findings at various health-related events in the Halifax community. Such events include health professional development days, research rounds, and mental health-specific seminars.

Further, I plan to use findings to develop educational sessions and an evidence-informed group peer support curriculum for pregnant people and families, as part of a larger project on perinatal mental health.

Lastly, participant voices will be showcased in a video that is created out of the individual vignettes recorded and images related to findings of the proposed study. This video will be available on the study's website as well as on social media to facilitate sharing. These knowledge translation strategies ensure that this research reaches the audiences intended to benefit from it and that participants' voices are heard.

Participants

There were 6 participants in this research. I have chosen to call the participants 'birthing parents', as they were the people who carried and birthed their babies. This term distinguishes them from their non-birthing partners and their own parents. Each birthing parent was given a pseudonym and they were named: Jordan, Laura, Sylvie, Elizabeth, Allison, and Emily. The birthing parents were between 27 and 35 years old at the time of the interviews. They were 10 months to 3 years post-birth. Some had high school educations and others had university graduate degrees. All were white, female gendered, and in heterosexual relationships with a male partner. Some were married. Household incomes ranged from $60,000 to $100,000+ per year.

Summary

This research was an exploration of how the experience of birth trauma affects the postpartum lives of birthing people using feminist phenomenology as a methodology. It builds on existing literature about postpartum experiences with birth trauma, exploring ways that birth trauma can be made visible. The next chapters will present the findings of this research, as interpreted through the lens of feminist phenomenology.

CHAPTER 4: CONTINUOUSLY PROCESSING

'In' my present, if I grasp it while it is still living and with all that it implies, there is an *ek-stase* towards the future and towards the past which reveals the dimensions of time not as conflicting, but as inseparable. To be now is to be from always and for ever.
- Maurice Merleau-Ponty

Back and Forth to the Present

As human beings move through their lives, their sense of time changes. Stoller (2011) suggests waiting in pregnancy gives women an altered sense of time; waiting is a fundamental element of temporality, and therefore time quality for childbearing people becomes altered. Pregnancy is a period of waiting - for birth, for a baby, and for the transition to the next phase of life. Thusly childbearing bodies experience time differently than bodies who do not bear children - whether by choice or by biology. Our perception of time is further altered through our experiences. The present self is distinct from the previous self and will be forever changed from the self of tomorrow (Merleau-Ponty, 1962/2017).

Birthing parents experienced changes in their perceptions of themselves and noticed that time was a back and forth process through which they tried to make sense of what happened to them during birthing. This chapter is a discussion of the second theme explored in the research: one in which birthing parents attempted to make sense of their birthing experience, work through their embodied trauma, and understand the feelings they experienced after birthing their babies. The birthing parents' awareness of their trauma was brought to light through our conversations and it became clear that they were *continually processing.*

Something's Wrong but I Don't Know What

The birthing parents lived in worlds that are influenced by their embodied

experiences as well as social forces (Stoller, 2011). To be embodied is to gain knowledge by experiencing the world through the body (Merleau-Ponty, 1962/2017; Stoller, 2011). The philosophical underpinnings of this research take the stance that one does not *have* a body, one *is* a body (Merleau-Ponty, 1962/2017). This is to say that the self is inseparable from the body and thusly all knowledge gained and meaning interpreted occurs through the body. Birthing parents experienced birthing as traumatic and this experience is embodied in different forms. Social discourses on childbearing state that pregnancy is a happy time, good parents are happy and love parenting, and that the transition to parenting is smooth (Bruijn & Gould, 2016; Young, 2005). Further, birth is seen as a standardized medical process that childbearing people take part in and once the baby is born if both parents and baby are healthy, then there are no problems (Beck, 2004b; Bruijn & Gould, 2016). A common refrain from birthing parents was that they felt something was 'wrong' or 'off' with the way they were feeling postpartum, but they could not quite work out what was going on, nor could they understand how their experience fit with their knowledge on childbearing. Even though all birthing parents volunteered for this study with an awareness it was a project about living with birth trauma, only one parent suspected before seeing recruitment materials that they were experiencing a traumatic reaction to childbirth. This parent had sought therapy for debilitating symptoms and had an awareness of their trauma that had been raised in part by their therapist. Other birthing parents commented on the fact that they saw themselves in the advertisements for this study in a way they had not seen themselves in representations of more commonly known perinatal mental illnesses (PMIs) like depression and anxiety. Emily shares how she saw herself reflected in this research:

> At mom and baby club someone came to speak about postnatal depression. It's really easy to find books at the library about postnatal depression. I was very aware that maybe sometimes I was depressed, but I didn't see myself in the descriptions of postnatal depression in the same way that I saw myself in the poster for your research. When I saw on your poster about, "do you get flashbacks", that's the moment that I think I knew what I was experiencing was something different.

Emily's description that they were experiencing "something different" was shared by other birthing parents. Throughout the conversations I had with them, all birthing parents mentioned that they were aware of postpartum depression and some knew about perinatal anxiety, and they were able to describe symptoms of these mental states; however, that was the limit of their knowledge on PMI and they felt that depression and/or anxiety did not fit with what they were feeling: "I didn't stay shut in my house. I wasn't wearing the same clothes for days. You're dressed and you look good" (Elizabeth). The fact that they were able to look after their babies and function, from the outside at least, as expected, caused them to doubt the feelings they experienced and thus they kept their thoughts and feelings to themselves. In part, birthing parents experienced doubt about the way they felt, because their narratives of their birthing did not fit what they thought of as traumatic.

Bruijn & Gould (2016) founders of birthtalk.org, an Australian organization dedicated to peer support for birth trauma, describe the dichotomy of social discourse on birth and the embodied experience of traumatic birth. They suggest that the general population, due to media, television, and personal experiences think of birth as painful, dramatic, and an event that requires medical intervention. So, in popular discourses, a

birthing person who experiences any of these things thusly had a 'normal' birth and there is an assumption that this person will have a 'normal' transition to parenthood (Bruijn & Gould, 2016). Therefore, birth trauma is not visible because events that contribute to it, like obstetrical intervention and lack of communication from care providers, are commonplace. When these events are normalized, society makes the assumption that birthing people openly accepted what happened and have moved on from birthing unscathed. This, however, is not the case and up to 30% of childbearing people are traumatized by birthing (Beck et al., 2013). Birke (2000) offers opportunity for further thought when she points out that typically, bodies are thought of as either biological or socially constructed beings, but not both. Much analysis on social constructs like power, gender, and language has been done in relation to childbearing; however, biological bodies in terms of childbearing cannot be left out of the discussion as childbearing is in part, a process of biology. This is not to suggest that birth trauma is either biological or socially constructed, but rather to say that it is experienced due to both. "The body is affected by discourse, but we get little sense of the body reacting back and affecting discourse" (Birke, 2000, p.137). In the sections to follow, the bodies of the birthing parents in the context of this research are deeply affected by discourse. Specifically, their bodies were connected to social discourse in the symptoms of trauma they embodied and the feelings they were working to understand.

Embodied Trauma

Birthing parents wanted me to share traumatic symptoms they experienced as they felt that these were indicators of a problem and they wanted others to understand what birth trauma could look like. This is not to imply that every person living with birth

trauma will experience all of these symptoms, but rather to make visible embodied trauma so it can be recognized in ourselves and in others. The experience of birth trauma is broad and differs not only between individuals, but over time within individuals and thus an important consideration is that for some birthing parents, these symptoms dissipated or changed as time passed since birthing and for some, new symptoms appeared. Of note is the language birthing parents used to describe what they experienced - for the most part, it did not match what healthcare professionals might use when referring to post-traumatic stress, nor was it the same as the DSM (APA, 2013) terminology. I suggest this disconnect may contribute to difficulties in diagnosis, which in turn affects the course of treatment and recovery. To honour birthing parents' wishes and to aid in translating language, birthing parents' words are reflected in the first part of each heading in this section, with the corresponding DSM terminology in parentheses.

Replaying the Birth (Flashbacks)

Birthing parents talked about how they would "replay the birth" in their minds and, when I clarified, shared that these replays were not a conscious choice and most of the time, they were unwanted and distressing. These birth replays typically came at times when birthing parents had a brief break from their parenting responsibilities, such as when their baby was sleeping, or when they were in the shower. For some, the replaying was purely visual. Mental images of the birth would "pop into" their heads, with specific recollections of certain things like faces, machines, or posters on walls: "Every time I would shower, I would like, replay my birth. I would relive the experience. For a few months, off and on. I remember seeing this one certain RT's face" (Elizabeth).

Others experienced auditory replaying, which involved hearing over and again

specific phrases people said, music that was playing, or sounds from the birth room. For Jordan, it was a phone ringing: “The doctor’s phone just keeps ringing tilililing tilililing [ringtone] and I keep hearing that”. Emily heard “minimal maternal effort” due to a conversation in the room of which she was the subject, but not included:

> There was one point that I heard someone come in and was like, "I thought she started pushing at five. I thought this was going to be a done deal by now." Somebody said to the woman, "Yes, but the first few hours with minimal maternal effort." I was like, Excuse me [laughs]? (Emily)

Smells were another way birthing parents re-experienced birthing in the present. Elizabeth describes their memory of cranberry juice:

> As I was pushing he [partner] would give me sips of this cranberry juice and I haven't drunk cranberry juice since. I don't think I could 'cause I feel like anytime I ever see or smell cranberry juice again that I'll always remember it [birthing].

Hellawell and Brewin (2004) describe flashbacks as a form of situationally accessible memory, which is accessed outside of an individual’s control. Narratives of a traumatic event, or a person’s memories, are known as verbally accessible memory, and can be accessed at will. Flashbacks commonly come in the form of ‘reliving’ episodes and dreams, both of which the birthing parents in this research experienced. Emily describes this:

> I couldn't understand why when my baby was sleeping peacefully beside me I would still be up and super alert, super awake and racing heart like as soon as I close my eyes I was back in a hospital room. I guess they weren't nightmares, they were flashbacks, but sometimes I would eventually fall asleep and I would wake

up with nightmares.

In addition to the replaying, birthing parents shared how their recollection of birthing was not as clear as they would have liked, in that they could not remember certain periods of time, sequences of events, or some of the things that happened to them. This inability to recall their birthing narratives was distressing as it felt to the birthing parents like a part of themselves was missing. Memories of events during birthing change over time (Garthus-Niegel et al., 2015) and are modifiable through cognitive processes (Santoro et al., 2018). In contrast to their narrative memories with which they could not recall details, birthing parents who had flashbacks, could recall in great detail what was happening, as described in the visual, auditory, and olfactory replaying above. So, embodied trauma for the birthing parents was not only flashbacks, but also difficulties remembering what happened and a desire to align these narratives in order to move forward.

Birth trauma was also embedded in bodily positioning. Some birthing parents experienced replaying due to positioning of their bodies that reminds them of birthing "I cannot be on my back looking between my knees without having flashbacks" (Emily). Others re-played birthing moments when they were trying to get to sleep, or as dreams when they are asleep:

> For months, every single night. Every single time I would get up and I'd go back to sleep and it started and I was like, "I just don't want to go to sleep, 'cause I just - I'm so tired of dreaming about this [birthing]". Every night for months that's what I thought. This is like extra not normal this is not expected. I don't think this is a thing that other parents go through. Nobody talked about the lingering

thoughts and dreams and feelings. (Sylvie)

Here Sylvie offers a glimpse into how birth trauma is infiltrating postpartum life and how she has trouble sleeping due to replaying the birthing. (Merleau-Ponty, 1962/2017), in discussing temporality, suggests that time is not a linear succession of events, but rather a concentric relationship in which perceptions of the past arrive in the present and projections for the future come to us in the now. Their past birthing experience is woven into birthing parents' postpartum experiences and is inseparable from their current experiences and perception of their selves. Further, (Merleau-Ponty, 1962/2017) suggests that temporality is a process that arises from our relation to things (p. 412), and for the birthing parents, the 'thing' is their birth trauma. Thus, the parent's relation to their birth trauma creates a temporality in which their birthing experience is continuously present, and this ongoing presence creates worry.

Worry/Nervousness (Anxiety)

Birthing parents described feeling worried and/or nervous in multiple ways. For some, this was associated with their abilities to parent their babies or on the health of their babies: "At one point he spit up like a bunch of, um, mucus and I like lost my mind because I thought he was gonna choke and so I was panicking" (Laura). "I was just really overly concerned about everything, I think. Just, like, every little detail, about my baby. And I had a really hard time, like, letting anyone else do anything or help me" (Elizabeth). Some birthing parents experienced anxiety when they thought about birthing: "I hated when I started thinking about it [birthing] 'cause then I just got upset. Um, and like I would have-- like a lot of anxiety over it" (Jordan). "Well, this happened with this, so this could happen with that. You don't know, your body's different. Like, it's just that

anxiety that keeps spinning" (Allison). Other birthing parents found that their baby crying was the cause of their panic:

> I was at the grocery store with [baby] once and [baby] started crying - just normal 'cause babies cry. I would get a little bit anxious about it when he cried. I remember a woman came up to me and was like "Oh, he's hungry, you need to feed him" and was kind of like, you know, when they get really close to you and stuff and was trying to kind of touch him and I got, that made me really anxious and I left the grocery store because that made me so anxious. (Elizabeth)

Birthing parents described feeling tense, flushed, and hyper alert when they saw reminders of the birth and these reminders ranged from seemingly benign items like exercise balls to more stressful stimuli like going to a doctor's office and positioning during physical examinations. Emily experienced panic when walking past the place of birth:

> I had pervasive feelings of panic for no real reason. Which I still get sometimes but I don't know if this is thesis-related stress, but heart racing, hand sweating and still to this day I get this intense from walking past [birthing location]. (Emily)

Birthing parents spent a large amount of their time planning to avoid these reminders or trying to regulate their thoughts when they knew they had to be exposed to one.

Birthing parents also shared that they avoided previously loved activities, like birth-related social media accounts, looking at photos of their newborns, or any videos or photos taken during the birth because these activities were steeped in anxiety. "I have never watched the video because I do not want to be back in that place and even looking at pictures of him as a tiny infant -- it just makes me, um, stressed out. (Laura). "I don't

want to look at photos and, you know, not knowing why" (Allison). Jordan connected viewing birthing-related images of any kind with their traumatic birthing and disconnected themself from things they had previously loved:

> I love everything about birth and watching videos and seeing pictures. On Instagram, I follow all these birthing things and I couldn't even look at them. I had to unfollow a lot of them because they were just kind of like triggers I guess. So that was kind of upsetting 'cause that's something that I love and I'm not even able to you know, enjoy it or see it.

Anxiety was often associated with birthing parents' thoughts on the way they gave birth in that they feel if they failed at birth, they might fail at parenting too. An argument could be made that anxiety is a tenet of the transition to parenting and within the realm of expected as part of their new role; however, I would suggest that the amount, frequency, and duration of birthing parents' anxiety shows something more. Birthing parents were living with their anxiety at moderate to high levels every day, for months and in some cases over a year and this is a way in which their body affects discourse - when they experience these symptoms, their narrative of their parenting capabilities changes. In turn, this affects their behaviour.

I Had to Get Away (Panic Reactions)

One such impact on birthing parents' behaviours was their need to escape situations. Panic is a sudden onset of uncontrollable anxiety, which sometimes causes unthinking behaviour (APA, 2013). In part, this response is a biological mechanism that protects us from danger, but in our relatively-safe-from-danger lives, panic is commonly a maladaptive response to chronic stressors (Kutcher et al., 2016). Laura experienced a

generalized feeling of panic and an overall heightened stress response, saying she felt "Just tense and panicked" in response to her baby crying. Panic is not well described in literature on birth trauma, yet the birthing parents in this research experienced it often. Usually, the panic was an escalation of anxiety states or related to flashbacks. Birthing parents described times where their nervousness and worry would get so bad that they experienced an urge to escape the situation or physical location they were in.

For Emily, the panic began during pregnancy: "No one else seemed to understand the sheer sense of panic that I carried around for those nine months, because the midwife was like, "This is a perfectly normal experience. You're perfectly healthy…"" Emily's embodied trauma meant that panic continued into parenting, particularly in her relationship with her partner:

> I completely panic. There is no taking it slow because as soon as he lays any type of hand on me, we basically don't have physical contact, because as soon as he touches me or goes to kiss or anything I'm like, oh, but this is going to lead - my brain is just like, I know where this is going and I can't. It's going to be painful and I freak out.

Emily knew on a logical level that touching is okay; however, her panic was so well embodied it was inseparable from her own sense of self - in other words, she is her panic. Thus, she continued to seek understanding about why she feels the way she does and until this is resolved, she cannot see herself without anxiety and panic. Emily was not the only birthing parent who avoided the attentions of her partner. Others felt that any attention their partner gave them, no matter how platonic in nature, led to thoughts of intimacy and thus to pregnancy and then birthing again, so they decided to shut down any physical

contact as a pre-emptive strike to panic. For many birthing parents, not being able to let the panic go has caused difficulties in their relationships with their partners. Research on panic in non-birthing trauma contexts suggests that 53% of acute trauma (Bryant, R. A., & Panasetis, 2001) and 90% of sexual assault survivors (Falsetti & Resnick, 1997) experience panic attacks. There is no reason that birth trauma survivors would not have similar rates. Some birthing parents experienced trauma embodied in dissociative episodes. Allison shares an experience with dissociation:

> I check in, it's fine. I go back to the room, it's fine. I talk to the doctor a bit and then if something comes up like "you know what, I think we're going to do an exam" - I think it's those words that initiate it like it really sinks in… No, this is happening, this is actually going to happen. Someone's going to touch you in a place that's very sensitive and very vulnerable and was directly linked to what happened. So that's usually when the body takes over. I'll even sometimes keep talking… I remember the last time I kept talking and it was like, no this is OK. Yeah, I want to do this - tears flooding down my face, body shaking… I find a spot on the ceiling and kind of send myself out , you know, and I say that like I planned to do it - it absolutely isn't part of the plan but from experience that's typically what happens so I just kind of let it happen. I don't kick and scream, I don't, you know, fight physically like something is attacking me. (Allison)

This kind of dissociation was an extreme reaction to emotional stress brought on by setting, people, and positioning that were similar to the birthing experience. Allison was dysregulated by her dissociation, yet had trouble explaining to the staff at the clinic what she needed and her reactions in these situations. The staff at the clinic were

unprepared to treat panic attacks and instead of offering Allison support and time, they asked her if she wanted to calm down in the waiting room full of people. In these moments, Allison was back in the birthing room and she was the only one aware of that because her body was not able to communicate verbally. Consequently, the people around Allison were not aware of where in time she is and how her birthing experience keeps coming up in the present.

Bodily Sensations

Physical pain was present for many birthing parents and there was typically no physical explanation for it. Laura shares her challenges with pain:

> After giving birth I had extreme pain in all my joints, which the doctors had no explanation for and I saw several medical professionals. I saw my family doctor and I had been seeing a chiropractor and an athletic therapist prior to giving birth so I continued with them and massage therapy and nobody had any explanation as to what was causing the pain but it was severe so when I would get up in the mornings, I could barely walk, in my feet and my knees, so even going down the stairs was excruciating and then it would sort of dissipate a bit as the day went on but, it was also in my hands and my elbows. it disappeared from my hands and elbows first.

According to Laura, there was no explanation from professionals about the cause of the pain. She spent time, money, and effort to reduce her pain and had to forgo social opportunities because she could not leave the house easily. Sylvie suffered from unexplained headaches for months postpartum and no physician was able to discover any physical cause. Women's pain has long been overlooked by medical professionals

(Samulowitz et al., 2018). Women are less likely to receive pain medications and more likely to receive sedatives than men, implying that women are anxious or hysterical rather than in pain. Elizabeth's pain came from physical reactions she had when her baby cried, "In my head I still might be "Okay, hey now, this is okay, he's just crying." But I'd be tense through my shoulders and in my jaw. Emily experienced pain with touch and sought professional advice to rule out any physical trauma. When no physical cause could be found, the physician told Emily she seemed to be experiencing "exquisite tenderness", a non-specific term that was not helpful for Emily's recovery. Because Emily did not get the answers she needed, she coped with her pain by disconnecting her genital area from the rest of her body and continued to have difficulty acknowledging that this part of her body exists. The birthing parents' experiences with pain show that, contrary to the focus in research (Samulowitz et al., 2018), there is a psychological aspect to the birthing parents' pain.

Van der Kolk (2015) suggests that pain reactions in trauma occur due to traumatic memory encoding in the brain. This process leads to hyperarousal of the nervous system and consequently perception of bodily sensations, including pain, when exposed to stimuli associated with the trauma. For birthing parents, these stimuli include their baby crying, bodily positioning, and thinking about birthing. Their responses to these stimuli led to pain sensations that went untreated by healthcare professionals. In this sense, the birthing parents were let down not only by not being given medication, but also in not being referred for mental health assessment.

The biological body has reason to experience pain; however, there are social aspects too. Birthing parents are constantly reminded through comments from family and

media images that their reaction to their birthing experience is abnormal and they have no reason to feel the way they do. This topic is explored further in Chapter 5.

Birthing parents in this study are waiting - to understand, to recover, to move forward from their birth trauma. For most, this study's recruitment materials represented the first time they had seen themselves and the way they were feeling reflected outside their own bodies. By seeing common reactions to traumatic birth on a poster, they were connected to me, as the researcher, and also to the experiences of others through the focus group. They recognized their own experiences in the experiences of others, creating connection and a new perspective on themselves. This recognition is in phenomenological terms referred to as the 'phenomenological nod' (Van Manen, 1997), which refers to the nod one gives when a description of an experience resonates as something one has experienced or could experience themselves. That a poster resulted in a phenomenological nod from the birthing parents speaks to how simple connecting to the birth trauma population might be and also to how invisible birth trauma is in circles of care. Birthing parents all saw healthcare providers at one point or another in their postpartum journey, yet none were engaged in conversation around the way they were feeling. In the following section, we will work through some of the shared feelings birthing parents experienced.

All the Feelings

The birth of an infant and the subsequent foray into parenting is filled with emotion. The common social discourse around pregnancy and childbearing is one of a happy, positive time and these feelings are thus expected to continue into parenting (Beck et al., 2013; Bruijn & Gould, 2016). For birthing parents, *becoming* a parent in terms of

birthing was neither what they expected nor what they had hoped for. As a consequence, their experience of *being* a parent was altered as they worked through the emotions associated with a traumatic birth.

Failure was a universal feeling among the birthing parents. Their perceived failures included their bodies not working the way they should to breastfeed, not being able to let go of what happened, not giving their babies the entrance to the world they had hoped for, and not standing up for themselves. Sylvie describes how her perceived failures during birth led to additional feelings of failure when breastfeeding did not work out, “I really bought into the 'breast is best' and somehow, felt like a failure for not breastfeeding. I kind of feel like I've made poor choices that then resulted in a failure somehow for [baby].” Stressful labour and delivery, unexpected caesarean birth, and psychosocial stress and pain in childbirth are risk factors for breastfeeding difficulties (Beck & Watson, 2008). None of these factors were mentioned to Sylvie during their interactions with healthcare providers and thus Sylvie bore the weight of her failure entirely on her own. Emily also embodied failure and shared her thoughts in more general terms:

> Having been fed all that rhetoric about how I was strong and it was going to be, not easy, but that I was capable of doing it to then not being capable, came with “what other things am I going to fail at now?”

The circumstances of Emily’s birthing caused them to question their capabilities as a parent. Over time, Emily embodied their failure and although their present self was not embroiled in any meaningful action of failing, Emily continued to look for failure on the horizon. Embodied experiences exert influence over individuals and their perception of

time (Stoller, 2011) and the aforementioned embodied trauma is one such experience. The birthing parents saw themselves as changed due to their birth trauma; however, the birth trauma was present throughout time. The birthing parents' present selves were unable to envision a future, or horizon (Merleau-Ponty, 1962/2017), without their embodied trauma. Thusly, Emily spent time thinking about what else could go wrong and ways that they might be responsible for further failures while also trying to make sense of what happened. For Emily, there was no foreseeable end to concerns about failure. Jordan too felt like they failed and struggled with thoughts of all the things they should have done, "You know, that experience that I should have had and I wanted… I just feel - still, I feel like- [sighs] a bit of like a failure for not doing what I wanted, fighting for what I wanted."

While Jordan, along with other birthing parents, expressed a sense of loss for an experience she did not have and one she held herself responsible for , she felt her care team had failed her too. This meant that Jordan moved into parenting with a large amount of anger and resentment:

> I have like a lot of anger [chuckles]. I'm not a crazy person, but- I said to my sister, seriously, that doctor. I'm like, I would go to his house and like slash his tires and egg his house it's kind of like mad, you know what I mean? I hate you [doctor] for ruining that experience and for thinking nothing of it too.

Anger was present for many birthing parents as they moved forward in raising their babies. This is an emotion that has been identified as prevalent in birth trauma (Beck, 2004a; Beck et al., 2013; Reed et al., 2017) and one that was difficult for birthing parents to find an outlet for. Birthing parents directed their anger at care providers, mainly those

who were in attendance at the birth. They blamed care providers for treating birthing like an everyday event and not supporting them in ways they would have liked. Birthing parents were also angry with themselves, for "letting" things happen the way they did, and now having to live with the consequences. Others were angry at their partners, because partners did not or could not understand what birthing parents went through. Or, if partners were aware of birthing parents' difficulties, they lacked understanding and empathy for the situation, and made unhelpful or inappropriate comments.

Sylvie recalled some specific moments of anger at different times in her parenting journey. The first was after Sylvie asked nursing staff at the hospital for a nipple shield at the recommendation of her physician sibling and the nurses were not willing to supply a shield. "Um, angry would be mild. I felt so let-down by them". The second happened when Sylvie met with an obstetrician around 10 months postpartum to discuss what her options were for future births - Sylvie was told immediately after birthing that surgical births would be necessary in future. When the obstetrician asked Sylvie about her feelings related to their birthing, Sylvie found herself filled with rage, "'My feelings are litigious. I feel pretty frickin' legal about this, if I'm being honest with you', and I don't think he liked when I said that, but that's how I felt. I just- I was just angry." The third was during a reunion of the prenatal group Sylvie was a part of:

> A few other women were telling their stories, and one of them wasn't progressing in her labor, and I think a lot of them, like, they just didn't get as far dilated as I had, and one of them expressed remorse for starting to have the waterfall of interventions, and that's when I-I really got a little angry, I was like, "That's a really hurtful turn of phrase to use." That, like, you didn't dilate, like, your body

> was not doing something despite medical interventions, like, this is not your fault… She was holding herself accountable for something that was not her fault or her problem, and the instructor was, uh, she expressed no remorse, or no accountability, or accepted no responsibility, and kind of didn't react to any of us… I think, if anything, she probably internalized our experiences as validation of the point that she was making. Like, "Yup, you started it by having that nitrous, and you just shouldn't have."

Sylvie, during prenatal classes, interpreted, as many pregnant people do, that interventions like pain management, intravenous lines (IVs), assisted deliveries, and caesarean births were to be utilized only if one was not able to get through childbirth the 'normal' way, meaning an unmedicated, physiological birth. Stoller (2011) points out that in addition to embodied experiences, there are cultural elements that influence individuals' perceptions. Sylvie, Jordan, Allison, and Emily all planned for unmedicated birthing. Laura and Elizabeth planned to wait for labour and see how they felt and were open to pharmacological pain management. These plans were based in part on previous birthing experiences and in part on information garnered from their care providers, family, and friends. Each birthing parent's decision-making was affected by social and cultural discourse and the lens through which they see their world. I, for example, due to my family's experiences with birthing and the cultural norms of my country of birth, assumed I would be able to access midwifery care. I never thought to question this until I became pregnant and discovered it to not be the case in my adopted home.

Pregnant bodies are subject to control in a system that relies heavily on medical direction for care of them. In Canada, most birth occurs in hospitals and the majority of

births are physician-directed (Canadian Association of Midwives, 2018). Historically, and presently as a result of the way perinatal care is structured, many see birth not as a normal life event but as a process that needs to be medically managed (Cahill, 2001; Lorentzen, 2008). Hence, childbearing is a process entrenched in meaning made not only from embodied experience, but also from social experiences. While some birthing parents did recognize the broader pressures exerted on them, most put the onus of responsibility for what happened during birthing within themselves and carried this embodied weight with them into their lives as new parents.

Guilt and regret were feelings expressed by the birthing parents and these were brought forth in further variations of the "should have" thoughts expressed by Jordan above. A number of such thoughts were related to the birthing experience and held a sense of regret for things that in hindsight, birthing parents felt they needed or would have done: "I would have ordered more food from the cafeteria 'cause I was so hungry.", "I wish they had kind of like held my hand a bit more through this process", "I wish I had called my parents" (Sylvie). "I wish we could've done that [vacuum] earlier", "I wish I would have prepared better for the birthing experience", "I wish could remember. Everything is such a blur" (Elizabeth). "I wish someone had just asked me [how I feel]" (Allison). "I wish someone told me why they had done what they done [sic]. Why I had to have a vacuum, why they put me on oxytocin, why they cut an episiotomy pre-emptively, etc." "I wish they would have told me what I could have expected in my recovery process" (Emily). "I would have liked to have been offered the opportunity to ask more questions", "I would have liked to have known, like, what would happen if you didn't. Um, what are my options here" (Laura). "I wish somebody would've said

something then because if I would have thought, okay that might be one hour instead of four, I would have waited [for epidural], you know what I mean?", "I just wish like that he [doctor] would have not made it in. You know? I wish the nurse would have just delivered the baby", "Oh, I wish that would have been me [having a beautiful birth]" (Jordan).

These thoughts of things that the birthing parents would change show how embodied trauma causes them to view their birthing experiences. Merleau-Ponty (1962/2017) suggests that the present self has its unique perspective due to its embodied experiences. When I asked if birthing parents thought of these wishes in the moments during birthing, they all responded that they did not. These "should haves" and "I wish" thoughts and the feelings of guilt and regret came to the birthing parents after birthing and continued to permeate their worlds. They knew they could not go back and change what happened, yet they were unable to move forward until they developed understanding.

In addition to the thoughts of wanting to change what happened, some "should haves" are in the present and these thoughts centred on birthing parents wanting to feel better or get some relief from the intrusive memories of their traumatic births: "I just wish there was something that like, would make a difference" (Jordan). "I remember at the midwives counting the tiles on the ceiling and wishing that I could, like I wish I could disassociate, but it was like just hypersensitivity" (Emily). "I think I would have benefited from some medication [for anxiety] (Elizabeth). "I think just acknowledgement would have really helped", "If someone had actually said, "How are you?," then, yeah, I think I would have-I think I would have gotten help earlier" (Allison). Birthing parents

were often ashamed and embarrassed about the ways they were feeling as they worked to recover from birth and embody their new roles as parents. They needed to understand their experience, yet were reluctant to proactively share how they felt. Birthing parents described feeling overwhelmed with emotions, specifically emotions that were unexpected as part of their postpartum journey. Social discourse of early parenting focuses on this time as happy, one in which you will love your baby and parenthood. Birthing parents did feel these emotions too, but more 'negative' ones pervaded their experiences.

Chapter Conclusion

Time for the birthing parents was non-linear; they lived in a back and forth world where their birthing experience was present in the form of symptoms and emotions, which are embodied as birth trauma. While this study was focused on post-birth experiences, during our conversations all but one of the birthing parents spontaneously spoke of events during birth; things that happened to them became present. I know from my own experience of birth trauma that what happened during birthing is not easily separated from the present as I experienced my own unwanted and seemingly uncontrollable memories, which sometimes were very inconvenient. I further know from my own journey of recovery that the threads eventually unravel and that we find capabilities and strengths in the messiness of the way we gave birth. I had the privilege of being with birthing parents as they verbalized their experiences for the first time and to see their flickers of recognition and hope as they began to shift their perspective to one of understanding and eventual healing. Their waiting was at an end, and they could begin to develop new ways of seeing themselves - as people capable of healing and as part of an

experience bigger than themselves. Birthing parents can now see themselves as people living with birth trauma, and their experience is no longer invisible.

CHAPTER 5: SEARCHING FOR ANSWERS IN OTHERS: RELATIONSHIPS IN BIRTH TRAUMA

No one exists alone in the world. As the perception of the self is understood through the body, so too are interactions with others. Rather than being objects to interact with, other people are the fundamental material of our lifeworld (Merleau-Ponty, 1962/2017). These are not solitary relationships, but rather, they are a co-construction of our reality with others. Postpartum life requires the formation of new relationships and a navigation of old relationships in new ways. For example, co-parents must navigate their new roles as parents while also maintaining their existing roles as partners.

Birth trauma has been shown to negatively affect relationships (S. Ayers et al., 2016; Beck et al., 2013; Moyzakitis, 2009; Taghizadeh et al., 2013), although exactly how they are affected is unclear. Feminist phenomenology offers a framework to explore perceptions and processes that inform our relationships (Freeman, 2018; Zeiler & Käll, 2014). Birthing parents offer insights into the ways their relationships with others were affected by their birth trauma and their thoughts and feelings about their interactions with their babies, family, and friends.

In this chapter, parents shared their experiences in relating to others who were critical to their lives postpartum. Through their interactions with their babies, partners, mothers, and extended social circles, the parents tried to find answers for what was happening to them and uncover themselves in the process.

Parenting Extremes: Relationships with Babies

Attachment and Bonding

The Lovable Potato: Challenges in Baby Bonding

Attachment and bonding are important in the birthing parent-baby relationship. Much emphasis has been placed on this in recent years due to research findings that early attachments with caregivers affect long-term emotional and behavioral characteristics (Boivin, 2012; Dekel et al., 2019). Attachment and bonding for the birthing parents existed as extremes: some were disconnected from their babies, and others were overprotective. Birthing parents who felt disconnected put extra work into bonding with their babies. Jordan had an older child and used comparison when describing bonding:

> I had to work to [sighs] it's hard to explain, but with skin to skin with her [older child], I just automatically was like - Oh, I'll have skin to skin all the time. And with him [current child], I had to really be like, okay, you need to do skin to skin with him 'cause he needs that. It wasn't, I want to do that because I want him close. I felt kind of disconnected from him. I felt bad as a mom, a horrible mom because you shouldn't feel like this about your baby… You already had this amazing experience with your first and now you're not doing the same with your second.

Jordan experienced a disconnection in her relationship with her baby and had to work to overcome the way she felt. She felt that bonding was not as intuitive as with her first baby and concluded that the issue lay within herself, when in fact Jordan's embodied trauma was a contributor to her difficulties. Young (2005) describes how in male-dominated societies, women are alienated from their bodies. Female bodies are vulnerable, in danger of being violated, and thusly closed off in a perpetual dichotomy of "I can" and "I cannot" (p. 148). Young goes on to describe ways in which women enact this dichotomy by projecting aims while at the same time resisting the task. Jordan, in

wanting to be the ‘good’ birthing parent and knowing she must bond with her baby, convinced herself that because she did not feel attached, she was not meeting these self-imposed goals of ‘good’ parenting. Further to her own ideas of parenting, Jordan’s use of value-laden language when she referred to herself as ‘horrible’ and ‘bad’ suggests she felt she was not measuring up to a pre-conceived standard. Notions of what successful parenting is are formed by personal ideologies and broader social and cultural influences. Henderson et al. (2016) argue that the “perfect mother” (p. 523) ideology is inescapable and found that even birthing parents who do not subscribe to this ideology are negatively affected by societal discourses on successful parenting. Birthing parents felt pressure to be perfect and this internalized ideology combined with their embodied trauma created challenges in bonding.

Similarly to Jordan, Sylvie felt disconnected from her baby and was uncertain about what to do with him:

> I had some anxiety about like, what do I do with this basically like a potato, a very, very lovable potato? But he's just-he's sitting there and I didn't know if holding him and cuddling him was enough, if I needed to do more things to stimulate him and nurture his development.

Sylvie’s reference to her baby as a vegetable demonstrates how disconnected she felt. Sylvie’s baby was an object in need of her nurture, yet she was unsure if she was doing enough and how she could do more. Sylvie felt the weight of the ‘perfect mother’ ideology (Henderson et al., 2016) and felt she needed to do more. Thus, she took on the ‘I can’ of Young's (2005) dichotomy when she did more to stimulate her baby’s development. In hindsight, Sylvie came to the conclusion that newborns are satisfied with

feeding, cuddling, and human interaction. She felt that interactions in the form of play, music, and academic pursuits could wait until the baby was older. She did, however, say that knowing this beforehand would have saved her some stress and relieved her of her feelings of inadequacy. Thus, accurate representations of parenting may be required to put birthing parents at ease. These could come from social discourse, but also from healthcare providers interacting with childbearing people.

In terms of bonding and birth trauma, Sylvie's and Jordan's experiences align with existing literature which shows that when birth trauma is present, attachment and bonding with babies is more challenging than when birthing parents are not traumatized (Anderson, 2017; S. Ayers et al., 2016; Beck, 2004a; Beck et al., 2013). Although long term effects of birth trauma on children have not yet been studied, evidence on adverse childhood events suggests early experiences do affect behaviour long term (Boivin, 2012). Thus, birthing parents have cause for concern when they have difficulties with bonding and further exploration of this phenomenon is warranted.

Birthing Parents' Bodies as Baby's Home: Overprotective Bonds

While Jordan and Sylvie felt disconnected from their infants, Laura, Allison, Elizabeth, and Emily felt extremely attached to their babies. These birthing parents showed their attachment through bed-sharing, exclusive breastfeeding, not putting their babies down, and refusing to let others help them. Mothers with PTSD tend to be controlling in their interactions with their babies (Anderson, 2017). These mothers are hypervigilant, not allowing their babies to self soothe or be out of their sight and tend to discourage other people from providing care for their babies.

Interestingly, the birthing parents in this research did not describe their interactions with their babies as controlling. Rather, they perceived themselves as protective. However, some of their behaviours could be interpreted as attempts to gain control. Elizabeth's partner was away for weeks at a time due to work and thus she spent long periods of time alone with her baby. Although Elizabeth had family around to help her, she rarely took them up on their offers and preferred to go it alone:

> I always had a really hard time letting go. I think it was hard 'cause I didn't let myself have a break. Looking back, I could have taken up people's offers to help and I could have taken a break, but I didn't feel like I could. I just felt I had to be with him, like, all the time and, like I was the thing keeping him alive. You know what I mean?

Elizabeth felt in control when she was the one caring for her baby and so she took on all aspects of the baby's care herself. Likewise, other birthing parents felt they knew their baby the best and that they were therefore the only person who could look after their baby. This meant forgoing sleep, exercise, and social interaction in order to care for their infant 24/7.

These perceptions of what parenting, and in particular, mothering, means, change across time and culture (Barnes, 2014). Myths surrounding motherhood, such as mothering being intuitive, mothers being attuned to babies' needs, and expectations that women will become mothers (Barnes, 2014) frame alternative experiences as deviant or less-than. The birthing parents perceived that they needed to be everything for their babies in part because of societal expectations that promote this expectation. Emily

determined that her baby needed to be held and she figured out how to ensure that happened:

> It's a joke in my extended family that my baby wasn't laid down at all for the first five days of his life, either I was holding him, my husband was holding him, or my sister was holding him. That was something I determined - this baby cannot be out of people's arms. I coordinated that effort and made sure that that never happened to him.

Birthing parents reported feelings of guilt, shame, and embarrassment for failing their babies and this meant they needed to do everything for their babies postpartum. Emily determined her baby would not be put down as she felt he was abandoned during birth. Thus, even when birthing parents did have support, they controlled the ways their babies would be cared for and who was involved in care.

Laura's way to control her baby's care was a bit different from Emily's. Laura experienced high levels of anxiety most of the time and described feeling "a heightened stress response" when her baby cried. This response led to her feeling "tense and panicked". Laura had trouble sleeping after birthing and shared a moment from the hospital:

> I heard babies crying which I thought was him [baby]. So I got myself out of bed and took my IV cart with me down the hall, barely mobile, to find them and found them in the family lounge and he [partner] went "You're ridiculous. Go back to bed and go to sleep." But I was just so anxious. I was thinking about things and every sound that I heard I- yeah, I was just like hyper-vigilant.

Hypervigilance is a criterion for PTSD diagnosis (APA, 2013) and the scenario Laura described is one that might have been recognized as an early sign of birth trauma. Laura needed to know where her baby was at all times and when he disappeared, she became panicked and consumed with knowing his whereabouts. Beck et al. (2013) suggest that healthcare providers explore the birthing experience with birthing parents and screen for post-traumatic stress in order to facilitate referral to a mental health provider. None of the parents in this study had conversations with healthcare providers about birth trauma and thusly the parents entered into parenting without information that may have benefitted them.

Breastfeeding

Similar to their actions with caring for their babies, birthing parents were the primary decision makers on how to feed their babies. Beck & Watson (2008) in their foundational work on birth trauma and breastfeeding, which remains relevant today, found that when bodies fail in birth, birthing people try to prevent further failure through breastfeeding. Beck and Watson (2008) discovered that these outcomes are connected to a complex interplay of birth trauma symptoms and individual factors. For some birthing parents, this interplay will promote breastfeeding and for others it will impede breastfeeding. When Sylvie's birth ended in an unplanned c-section, she embodied her failure as discussed in Chapter 4. Unfortunately, Sylvie also struggled with breastfeeding. Her challenges with low milk supply eventually led to cessation of breastfeeding which exacerbated her perception of bodily failure. Having commented on being unsupported from the outset, Sylvie felt let down by her care providers and further felt hat her body had failed - again. Sylvie's experience is one that shows how breastfeeding can

undermine parents' confidence and cause more feelings of failure when it does not work out (Beck & Watson, 2008).

While Sylvie's embodied trauma impeded breastfeeding, the other birthing parents found that their birth trauma promoted breastfeeding. Breastfeeding became a way they could ensure their babies were looked after optimally and helped assuage some of the guilt they felt over the way their babies were birthed. During our conversation, Emily described how breastfeeding was a decision she made on her own while she was pregnant; her partner had no say in how they would feed their baby. This decision came with contention, which Emily describes:

> I have been feeding on demand this whole time [one year]. It's been a contentious issue because my husband thinks that because I'll feed him [baby] and it doesn't matter to me whether he's hungry or he just wants comfort, like if he looks like if he wants to feed, I'll feed him and my husband says that means we can't read his cues to know whether he's hungry or in need of comfort or something else, which means that when my husband is by himself he doesn't know what it is that [baby] actually means. But in my mind, he just needs me. That's the solution.

Following her traumatic birthing, Emily felt that breastfeeding was something that was within her control. Emily felt guilt and shame around the circumstances of her baby's birth and breastfeeding formed a relationship with her baby that in part 'made up' for the traumatic birth.

Benoit et al. (2016) discuss guilt related to infant feeding decisions and offer insight into how breastfeeding promotion practices in perinatal care settings cause mothers to feel guilt related to how they feed their babies. Benoit et al. (2016) posit that

breastfeeding promotion as currently delivered focuses on the benefits of breastmilk and neglects to describe the embodied experience of breastfeeding. Emily's experience above highlights her embodied experience of breastfeeding. She was unconcerned with whether or not her baby needed the nutritional value of breastmilk and instead concerned with her baby's emotional well-being. This is in contrast to Emily's husband, who saw breastfeeding as valuable only for nutrition. Emily knew that her body was comforting for her baby and that breastfeeding made him feel safe. Further, Emily's successful breastfeeding experience helped her regain control over her body and contributed to her feeling confident in knowing how to care for her baby.

Some birthing parents had initial difficulties with breastfeeding yet were successful long term. Beck and Watson (2008) suggest that birthing parents who experience a traumatic birth could benefit from intensive one-on-one support for breastfeeding. Embodied trauma can contribute to feelings of violation and can make birthing parents feel disconnected from their babies, as Jordan and Sylvie described above.

Breastfeeding support in hospital was limited and most parents received one visit from a public health nurse at home. Specialized lactation support typically requires out-of-pocket expenses or a trip back to the hospital clinic, both of which have barriers for birthing parents. Laura had some initial difficulties with breastfeeding and sought out a lactation consultant. Rather than being reassured, she became more anxious:

> I was just so paranoid about breastfeeding. The lactation specialist had me so stressed out because every time my son would latch, he would fall asleep. And so then she was telling me that he needed a certain amount of drops every however

many hours and if he hadn't eaten then I had to wake him up. And she was showing me like how to express onto a finger that I had to put into his mouth… I was worried that he wasn't getting enough to eat and that I constantly had to be waking and doing that. And I was just worried about everything else like, you know, is he- is he breathing? Is he all right? Is he too cold? Is he too hot? What if I fall asleep with him while I'm holding him. [chuckles] Like it was just constant.

Laura's anxiety carried over from her birthing into her breastfeeding. The lactation specialist overwhelmed Laura with information about how to breastfeed. Benoit et al. (2016) suggest that a collaborative approach to breastfeeding education in which mothers and professionals work together to uncover needs may optimize birthing parents' voices and minimize guilt. I suggest that such a collaborative relationship would be beneficial with embodied trauma as professionals could see that birthing parents are struggling. Acknowledgement that birth trauma affects breastfeeding could help birthing parents understand why their bodies are reacting in given ways and allow them to overcome embodied experiences that hinder breastfeeding. This requires that healthcare providers become educated on birth trauma - one of the goals for this research.

Armed with knowledge, Laura might have known that her anxiety and excessive worry about feeding are signs of trauma (Beck & Watson, 2008). Sylvie would have learned that people who birth via cesarean have lower levels of oxytocin and prolactin (Nissen et al., 1996), both of which are important for lactation. Jordan and Sylvie could then have been aware of the potential challenges they might face in relation to infant bonding (Anderson, 2017; S. Ayers et al., 2016; Beck, 2004a).

Throughout our conversations, birthing parents expressed that they wanted information about what was happening to them and stated they thought that knowledge would have helped them in their recovery process. As the birthing parents tried to work out how to care for their babies, they also learned to navigate co-parenting and changes in their relationships with their significant others. All of the birthing parents had partners who were supportive of their pregnancies and who attended their birthing . As they moved forward in parenting together, some tensions arose.

Seeking Support from Significant Others

There is conflicting evidence around the effects of birth trauma on co-parents' relationships. Sometimes relationships are negatively affected (Beck et al., 2013) and other times there is no effect from birth trauma (Yildiz et al., 2017b). There is currently no information on the long-term effects of birth trauma on co-parenting relationships (Anderson, 2017). This research aimed to contribute detail on how relationships are affected due to birth trauma.

Elizabeth and Sylvie felt that their relationships with their partners were positive and they had few issues postpartum. Their partners listened to their stories and validated the way they were feeling while trying to make sense of the birth trauma with them. Elizabeth's partner is a healthcare professional and "normalized" her reaction to the traumatic birth, telling her "That's probably a normal reaction". Likewise, Elizabeth knew that the birthing was a significant event for her husband: "I know that he also thinks about that day as being not only the most important, but also a traumatizing day and an amazing day all in one".

Similarly, Sylvie's partner recognized that she was not herself after the birth and he did support her as best he could. At the same time, Sylvie recognized that her partner likely had his own feelings about the birthing:

> I'm so thankful for my husband's efforts to try to understand what I'm going through and I wish that he had some way to, relay his experiences too because it was terrible for him. He was asleep in the-the lazy boy beside me and all these things were going on and fortunately for him he is a very deep sleeper, but he was woken up by a nurse saying, "Your wife is having an emergency C-section you need to put these scrubs on." And so, he was like, "What the f is happening?"

Birthing people are not the only people who are affected by birth trauma. For example, fathers' experiences of traumatic birth have been described in great detail (Elmir & Schmied, 2016). Men reported being afraid that their partner or baby will die, trying to 'keep it together' while watching events unfold, being abandoned by healthcare providers, (Etheridge & Slade, 2017), wanting information but not being given it, and not wanting to talk about the birthing with their partners (Elmir & Schmied, 2016). Thus, Sylvie's partner is not alone in having difficulty processing what happened during their child's birth.

Birthing parents were all in heterosexual relationships and thus Elmir & Schmied's (2016) findings may apply to them. There are, however, no studies to date on how same-sex parents are affected by traumatic birth. Further conversations would be valuable in developing understandings of how families in the LGBTQ2S+ communities live with birth trauma.

While neither partners nor the birthing itself were the focus of this research, both came up spontaneously in conversations with the birthing parents. The birthing parents' relationships with partners changed postpartum in many ways. Jordan wanted to talk with her spouse about her feelings, but her initial attempts to do so were not well received; she therefore stopped attempting to talk to him about it. She perceived that her husband let her down:

> He [spouse] never would, uh, do a lot. He never was like, "Are you sure you want to do that?" He would never be like, "Okay. You remember what you wrote on your birth plan? You know the risk. Do you want to do this? Do you want us to take a minute?" He was never like, "Okay, let's talk about this, figure it out. You said this is what you wanted, but now, you're…" And I just feel like he should have protected me more, I guess. Which, I never told him that before but… Yeah. So, I think I have a little bit of ill feelings towards him not protecting me. Because I feel like that's his job… and there's probably some more affecting our relationship from that than I thought.

Jordan shared during our conversation that she and her spouse were living apart due to ongoing challenges in their relationship. She felt that she was, due to her birth trauma, unable to cope with her husband's "stuff" and they took a break to both work on their mental health. At the focus group five months after our initial conversation, Jordan and her husband were again living together and doing well in their relationship. On a logical level, Jordan knew her expectations that her husband protect her in labour were unrealistic, because he did not have the knowledge required to understand what was happening during birthing. Further, his main concern was that Jordan and the baby were

safe. Jordan mentioned to her husband only the morning of our conversation that she was taking part in this research because she wanted to avoid having to field his questions:

> He [spouse] kind of was just like "What do you mean?" Because I just told him today… Yeah, and he was like, "Well, traumatic? How was it traumatic?" He's gonna ask me afterwards, "Well, what were you two talking about? What was upsetting? I was there and the baby was healthy and nothing was wrong. It was okay. You know, you weren't cut open and you didn't have tough surgery." I know it wasn't traumatic to him, you know? He has no idea to me it was such a big part of my life for so long that it was so upsetting and like.

There is a significant difference in the way Jordan perceived her birthing and the way her husband perceived it. Jordan remained angry about how she was treated and experienced grief over the birth she did not get to have. Merleau-Ponty (1962/2017) offers perspective on how different people can come to embody different experiences, even though they were present at the same birth: "The grief and the anger of another have never quite the same significance for him as they have for me; for him their situations are lived through, for me they are displayed" (p. 356). Although Merleau-Ponty's language is universally masculine and he is referring to grief and anger, this insight can be applied to birth trauma.

Jordan's body experienced the violence that resulted in her embodied. Although Jordan's spouse was at the birth too, his body did not experience the trauma. He saw the trauma, but because it was displayed and not experienced directly by him, he did not experience the birth as traumatic. Thusly, the significance of the event differed for Jordan and her spouse and they had difficulty reconciling the birthing as the same event, even

though they were both present. This difference in the way the birthing was experienced occurred with all parents in this study and is a well-documented phenomenon in research on partners' experiences of birth trauma (Elmir & Schmied, 2016).

Emily had a similar experience to Jordan in trying to get understanding from her husband:

> He [husband] listens and he's like, "Okay", but then it doesn't really feel like there's any resolution although I'm not sure what resolution he can give me or he'll be like, "Really? This again, we talked about this last week, I thought we were over this." He can't seem to understand that I don't know how to move past it. It's a recurring problem for me and he's like, "But we've had this conversation 100 times. What can I say to you that's going to make you be like, okay, now I'm good?" I can't give him the answer, as though it's this circular thing where I'm like, "I need help." He's like, "What do you want me to do to help you?"

Birthing parents and their partners were participants in the same world (Merleau-Ponty, 1962), yet their perception of the birthing was not the same. Emily's husband wanted to help, but did not have knowledge about birth trauma, nor did he have the skills to assist Emily in processing what happened. Further, he does not remember the birthing as traumatic and was unable to reconcile his version of events with the one Emily told him about. Thus, when Emily reached out to her husband in attempts to make sense of her experiences, she was unable to get what she needed. Nevertheless, Emily continued to bring her birth trauma up with her husband, showing a strong desire to gain understanding of what happened and to heal.

Perception of trauma varies between individuals and of those present during birthing, only some develop trauma symptoms (Beck et al., 2013; Fenech & Thomson, 2014). A majority of partners in this research could not understand birthing parents' reactions to their experiences of birth. Partners did not have access to information and support as these resources are rare and difficult to find. Thus, birthing parents perceived their partners as unsupportive and most ceased attempts to talk about what was going on.

Lack of communication between birthing parents and their partners further contributed to postpartum challenges in intimacy. Birthing parents experienced challenges in their sexual relationships with their partners. Emily lived with some debilitating symptoms that led to intimacy issues in her relationship with her husband:

> Yes, my baby is almost a year old and I've probably slept with my husband three times and hated every second of each of those times. I'm very conscious of a huge feeling of guilt, like that I'm letting him down, that this is going to be the dissolution of our marriage.

Sexual intimacy was challenging for some birthing parents, particularly those who were living with somatic symptoms of trauma like pain and re-experiencing due to bodily positioning. Sex reminded birthing parents of the birth and can trigger flashbacks and panic attacks as well as contribute to relationship tension (Fenech & Thomson, 2014). During our conversation, Emily talked about how sex was an enjoyable part of her relationship before birthing and she knew that her fear of sex was affecting her marriage. She wanted to rekindle her desire for intimacy, but this desire had been influenced negatively by her inability to be touched. While Emily expressed a desire to enjoy sex with her husband again, she could not foresee a future in which this would happen.

Allison too struggled with being touched by her partner and made efforts to avoid any hint of sexual behaviour because even the slightest inkling would lead to sex, then pregnancy, then birthing, then more trauma. Allison describes her thinking on this:

> My brain told me that if I got changed in front of him [husband], or he saw my body, he would be attracted. He would want to have sex. I would get pregnant and I would go through trauma again… So my brain convinced me that, well, my guaranteed way of not having that trauma happen again is to cover myself up so that he doesn't… You know, he's not enticed. And so we don't, like it, it was so traumatic that I was thinking like six, seven steps ahead in order to prevent that from happening.

Allison's fear of intimacy had her pre-planning to avoid any contact with her husband whatsoever, including holding hands or hugging. Additionally, Allison felt uncomfortable if she and her husband were watching a show and scenes containing sex appeared. She shared that she would either change the show to get up and leave the room. Allison and Emily's experiences align with the current literature in that birth trauma has a negative effect on intimacy (S. Ayers et al., 2016; Beck et al., 2013). However, this may be temporary. Allison shared that her participation in therapy helped her come to terms with her fear and while she was not back to her pre-birthing self in terms of sexual desire, she was sometimes able to have enjoyable sex with her husband.

Interestingly, none of the other parents described issues in intimacy with their partners. This suggests that avoiding intimacy, while common, may be temporary or perhaps simply an expected part of the transition to parenting. Either way, further exploration is needed to determine what is related to birth trauma and what is not. In

summary, partners were a source of contention and problems, but also support in the postpartum period. The birthing parents' relationships also included their own parents, who were present in various ways.

Reaching Out: Relationships with Mothers

For Allison, Laura, and Emily, support from their parents came in the form of short visits due to geographical distance. Their parents would visit for days or weeks and then leave. Jordan, Sylvie, and Elizabeth had their parents nearby and saw them more frequently than the other participants. Mothers[2], in particular, came up throughout my conversations with the birthing parents. Birthing parents received little information from their mothers about birthing, and certainly no knowledge related to birth trauma.

Porter and Gustafson (2012) explored how knowledge about reproductive health is passed from one family generation to the next. They discovered that while information transfer varies within and between families and generations, often embodied knowledge is not shared between mothers and daughters. The role mothers played in the postpartum lives of the birthing parents may have been reflective of ongoing relationships. Jordan took an indirect approach with her mother, hinting that she needed help:

> I've kind of tried to reach out to my mom a little bit, but then I'm one of those people that don't like to ask for help or admit you know, failure or defeat or whatever. So I'll be like, "Yeah, it would just be kind of nice if I had some time to like try to bond- like to bond with him a bit more, you know"… But she never took the bait.

Jordan liked to keep her emotions hidden from her mother, but at the same time wanted her mother's help. Rather than sharing how she felt and offering ways in which her

[2] 'Mothers' in the context of this section refers to the birthing parents' own mothers.

mother could assist her, Jordan only alluded to needing help. Thus, Jordan's embodied trauma was not effectively communicated. When her mother did not understand her request, Jordan continued on her own.

While Jordan had an aloof relationship with her mother, Sylvie described her relationship with her mother as 'close'. Sylvie shared that her mother is "super great with kids and she does a good job raising kids. So, she was there to help". Thus, Sylvie was surprised when her mother reacted to the way she was feeling: "My mom was like, "You shouldn't cry. You should be thankful that he's here and he's safe and he's fine.""

As aforementioned, birth trauma is often misunderstood (Beck et al., 2013; Bruijn & Gould, 2016) and birthing parents had trouble coming to terms with their embodied trauma. Therefore, it was unsurprising that birthing parents' mothers were either unaware or misunderstood what birthing parents were going through. Expectations for childbearing vary between generations of families (Porter & Gustafson, 2012) and birthing parents' mothers expected them to be happy that they and their babies were physically healthy. This is not an uncommon refrain and typically such beliefs come from mothers' own experiences of early parenting, or from the messaging they themselves received from their own mothers. Many birthing parents heard similar messages from their loved ones and social circles.

These expectations to be happy because the baby was healthy contribute to myths of mothering (Adams, 2015; Barnes, 2014; Wolf, 2013) and increased feelings of inadequacy and failure for birthing parents who did not meet societal expectations of what is a 'good' parent (Adams, 2015; Wolf, 2013). Parenting does not occur in isolation; it is intertwined with social and cultural contexts including those of the family. Birthing

parents took their mothers' reactions as a sign that their postpartum adjustment was 'different' than what was expected and consequently that they should not have been feeling the way they were. This awareness of being different created emotional pain that was further embodied as trauma. At times, the embodied trauma created unexpected reactions, as Elizabeth elaborated on:

> My mother in law held him when he was like three days old. He was all snuggled up on me. I had just finished nursing him and we were having a moment. And she came and just, picked him up abruptly from me and… I hit her. My reaction was, it was like somebody was stealing my baby. It was a horrible reaction. And I know she was just trying… she was excited and trying to see him. But I think it was because she didn't ask or I didn't hand him into her. She just grabbed him from me. And I just remember, like, it just didn't feel-- it didn't feel right that I was sitting there not holding him. Like, I felt like he needed to be with me.

Relational moments enhance or uncover deficiencies in familial relations (Porter & Gustafson, 2012). This physical response to another person taking her baby created distress for Elizabeth. She worked to understand her reaction for months but could not come to terms with how she had behaved and continued to feel embarrassed and ashamed. Elizabeth's reaction showed a mistrust between her and her mother in law, but also Elizabeth's deeply embedded protective instinct towards her baby.

Birthing parents sought understanding of themselves in others, yet most birthing parents were not forthcoming about what they were feeling. This withholding of their experience made it difficult for others to empathize and understand of what was happening. Birthing parents' mothers could not provide the emotional support birthing

parents needed and this theme extended into birthing parents' relationships in their social circles.

Relationships with Friends and Acquaintances

Socializing is an essential part of postpartum life as social networks help birthing parents find information, validation, and encouragement (Price et al., 2018). Friends played a part in the birthing parents' lives although for some having a baby changed their social circles. Elizabeth had a solid network of peers who gave her information about child rearing and postpartum health. Elizabeth talked about the few times she was honest about how she was feeling and the responses she got were: "Oh. You're just tired. You just need sleep." Elizabeth admitted that this was true, birthing parents almost always need more sleep, but the response also deflected her attempt to tell her friend how she was feeling. The information birthing parents give each other is not always accurate and comes less from evidence-informed practices and more from personal experiences. (Beck, 2004a). Elizabeth's friend based her response on her own experience, in which she had not embodied trauma. Thusly, the information was not accurate for Elizabeth's situation.

Price et al. (2018) found that sharing experiences with those in similar situations helped first time mothers realize that although their experiences did not fit with representations of mothering as depicted in social discourse, what they were experiencing was 'normal'. While I am reluctant to categorize birth trauma as 'normal', there is opportunity for those experiencing birth trauma to find solace in hearing that others go through something similar. Further, a sense of what is an expected reaction to a traumatic birth could be made from birthing parents sharing their experiences. Most birthing

parents did not talk to their friends about what was happening to them as they did not want to field questions about the birth or have to justify the way they were feeling. As aforementioned, when they did make efforts to talk about their embodied trauma, they were met with unhelpful comments about being physically healthy. Thus, birthing parents continued to see themselves as living through something that was a deviance from the expected journey into parenting.

Jordan, instead of talking to those close to her, told her hairdresser how she was feeling. Fortunately, this person knew Jordan well enough to recognize something was off and suggested Jordan talk to someone. This led to Jordan making an appointment with a psychologist whom she was to see shortly after our conversation. Jordan jokingly shared this interaction with me during our conversation as she recognized that the hairdresser was the least likely of all her social network to help, yet this person turned out to be the most helpful. Not only because of the recommendation to see a mental health professional, but because she listened without judgement, and validated for Jordan that her feelings were real and appropriate.

Allison did not share her feelings with anyone other than her therapist who helped her work through her birth trauma. Allison had difficulty expressing herself as she would be triggered by talking about the birth. So, when Allison's neighbour once asked her what her birthing was like, she struggled with words:

> I had to make a very conscious effort to form sentences and words and, um, just not to make it seem like I was struggling, I guess. It was taking all of my physical and mental effort to hold back my panic. It was very terrifying. I remember telling the story and leaving out some, uh, I mean, definitely, there were holes, there

were lots of holes. But I skipped over some details and told something that's still related to the story and then skipped over something else and got to some hard stuff but didn't touch a whole bunch of other sort of stuff because it was too much, and then wrapped it up at the end with a little bow and said, "Yeah, and then she spent a great day."

She did the same when her therapist first asked her to describe birthing:

> I kind of rushed, talked about a little bit and I was like, "Yeah, it was really traumatic and horrible." Um, but we were really blessed with a great baby and she's so funny and she's great and I love my husband and we have a great family. And she was like, "Well, then, you just put a little bow on that and tie it off and be done with it," you know?

This tendency to downplay birth trauma and gloss over details of the birth was a reoccurring experience for Allison and something that other birthing parents described as well.

Rather than talk about birthing, Jordan would tell people how much her baby weighed, Laura and Elizabeth simply did not talk about it at all. Sylvie shares her thoughts on why she declined to share her story with others, "I wasn't prepared and still am not really willing to get into the intellectual exercise of explaining to them that just because the outcome was correct, the process was not ideal." By outcome, Sylvie is referring to the 'healthy baby healthy parent, no problem' rhetoric that is prevalent in social discourse. The way people birth matters and even though the parents are happy to have their baby and to have physically recovered from birthing, they are mentally scarred and trying to understand how they can get better.

Chapter Conclusion

The parents' birth trauma influenced their postpartum relationships. Parents are keeping their experience from their social networks in order to avoid emotional reactions or unwanted comments from others. They receive unhelpful advice but also support from their mothers. Partners have difficulty understanding the parents' experiences and while some are able to help, most are unable to provide the support and encouragement parents need. The parents relationships with their babies exist as either detached or overprotective, contributing to feelings of guilt and inadequacy. Parents are doing their best to maintain and develop their relationships with others; however, they are left wanting when others are unable to fulfil their needs. The parents look for answers in others and when none are found, they are left alone to work through their feelings. Thus, birth trauma remains invisible and birthing parents are unable to find the supports they need.

CHAPTER 6: EXPERIENCES AS A BODY IN THE HEALTHCARE SYSTEM

The most common way people give up their power

is by thinking they don't have any - Alice Walker

A customary part of childbearing is seeking care for pregnancy, birth, and postpartum. All birthing parents in this research sought prenatal care upon discovering their pregnancies. They saw a mix of practitioners, including obstetricians, family physicians, midwives, and nurses. These care providers practice in the context of Nova Scotia's (NS) healthcare system, which is a physician-dominated model in terms of pregnancy care.

This research focused on the postpartum experience of birth trauma; however, during our conversations the birthing parents suggested that their trauma began before they gave birth. Their interactions during prenatal and intrapartum care contributed to the embodiment of their trauma. Henceforth, interactions with the healthcare system are described across the childbearing continuum. I use feminist phenomenological analyses of metaphysical and obstetric violence as the theoretical underpinning to showcase how the healthcare system contributed to the birthing parents' birth trauma.

Metaphysical Violence

Wolf (2013) frames metaphysical violence as an objective type of symbolic violence, which is violence embodied in language. Further, Wolf (2013) maintains that metaphysical violence can occur due to a lack of language or words to describe one's circumstances and thusly, an inability to understand one's world. Wolf goes on to propose that various acts which occur during labour, like continuous electronic fetal monitoring; vaginal exams; routine use of IVs and epidurals; and coached pushing are examples of ways in which the healthcare system perpetuates metaphysical violence.

In addition to intrapartum events, Wolf (2013) contends that the routinization of perinatal care through standardized practices creates conditions for violence. By this, Wolf means that the standardization of protocols, procedures, and policies results in childbearing people being seen as one of many, simply a body that is pregnant, rather than the powerful pregnant or birthing person they are. In such a system, individuals' needs are not unique and childbearing people are seen as "vessels that the system must attend to in order to produce healthy babies" (p. 104).

The birthing parents experienced some of these acts of violence during their labours. This research was not intended to be a study of the intrapartum experience. Yet, for the birthing parents, there was no clear distinction or point at which they were able to separate themselves from their birthing experience. As discussed in Chapter 4, they were back and forth between their birthing and postpartum worlds and there was no doubt that birthing influenced their embodiment as postpartum people. They did, however, all spontaneously discuss their experiences with prenatal and intrapartum care and these discussions brought forth some important insights into where and how metaphysical violence and subsequent birth trauma occur.

Navigating the Pregnancy Care World

All birthing parents in this research had medically 'normal' pregnancies. Across Canada, physicians attend 90 percent of births (Canadian Institute for Health Information, 2004). A 2018 report from the Canadian Association of Midwives (CAM) shows that this percentage has not changed much in the last decade, with midwives attending 10.4 percent of birth across Canada in 2017. In NS, physicians are the main providers of pregnancy care (Koto et al., 2019), with midwives attending 2.9 percent of births

(Canadian Association of Midwives, 2018). Family physicians and obstetricians provide primary care during childbearing and the birthing parents saw at least one and sometimes more than one of these providers.

The birthing parents' experiences suggest that prenatal care marks the beginning of the metaphysical violence (Wolf, 2013). Pregnant people have limited choice in care providers and their preferences are frequently denied by the healthcare system. Birthing parents described feeling confused about the way their care worked and they felt they could not advocate for themselves in order to get the care they desired. Sylvie saw her family physician up until 24 weeks gestation, but her physician did not attend births, so her care was then transferred to an obstetrician. This is one way in which metaphysical violence is enacted, as the norm in perinatal care is for people to see an obstetrician, who is a 'high-risk'[3] surgical specialist - for their 'low risk' pregnancies.

Laura and Elizabeth went to their family physicians upon discovering pregnancy. These two birthing parents, rather than seeing their usual physician for some of their care, were instead referred immediately to an obstetrician. As it turns out, this process of referral is less than clear as Laura describes:

> It was very confusing to me. If I had have stayed with my family doctor, how that would have looked as far as the referral process? I missed out on one of the tests, 'cause I had no idea that was something that you had an option to do. If I had to stay with my family doctor, would I have been referred to one particular obstetrician? It was just a lot of confusing questions about how that worked.

[3] Risk is a term used in medicine to label pregnant people based upon physical characteristics that contribute to potential issues in the perinatal period. Such terms are used in decision-making on type of care provider and to suggest interventions. Being labelled a given risk level does not equate to perceiving one's pregnancy as risky.

It would seem that for birthing parents, confusion came at the outset of their pregnancy care. They did not have the language or knowledge to effectively advocate for the care they wanted. Referring providers gave limited information about the course of care and further, they showed a bias in the type of provider they referred the birthing parents to: obstetricians. None of the birthing parents were told about midwives and this is hardly surprising given the lack of investment in midwifery in NS. Development of the province's midwifery program has been stalled since regulation in 2009 (Taylor, 2012). Midwives remain available in only three geographical regions of the province, which means limited access. Further, demand for midwifery exceeds the supply of midwives. Thus, more pregnant people are denied access than are accepted into care (Personal Communication, November 18, 2018).

Physician referrals notwithstanding, birthing parents did seek midwifery care. Those who accessed midwives did so on their own, based on recommendations from their social networks. Laura sought midwifery care for her pregnancy and she eloquently explained how she felt about this care:

> The midwife clinic was very well laid out and you knew what the process was and what weeks to go and I liked it because it wasn't so, um, medicalized. For the most part, I was with the same person the whole time and you could have conversations. When you go for your appointments we would just sit at the table and have a conversation and it was just… more relaxed feeling and less invasive.

Laura experienced these feelings of relaxation and clarity in contrast to her confusion in the beginning with her physician. She brings up a wonderful point about continuity of care, which is a care delivery model in which pregnant people see the same one or small

number of providers for their entire pregnancy (Sandall et al., 2016). In this model, the care provider who attends the birth is familiar to the birthing person and acquainted with their preferences. Midwife-led continuity of care has been shown to improve satisfaction with birthing and decrease the use of interventions in birthing (Sandall et al., 2016).

Birth trauma often occurs due to ineffective or absent communications from healthcare providers (S. Ayers et al., 2016; Reed et al., 2017; Verreault et al., 2012). Continuity of care has potential for decreasing birth trauma, as relational care develops trust throughout pregnancy. The pregnant person is at the centre of their care, informed on their options, and given autonomy to make decisions that are best for them. When this relationship continues into the birthing space, birthing people feel in control of their bodies and what is happening to them and this decreases the likelihood of developing birth trauma.

The standard physician-pregnant person relationship relies on a more top down power relationship than midwifery models. Women have described feeling powerless, like a piece of meat, as an object during birthing (Allen et al., 2018; Beck, 2004a; Moyzakitis, 2009). Jordan experienced this sense of disembodiment in her pregnancy care. She started out with a midwife, but required an obstetrical consult due to ‘failing’ her gestational diabetes screen. The physician Jordan saw recommended obstetrical care and although Jordan’s subsequent testing was normal, guidelines require further monitoring in pregnancy. Jordan felt discouraged:

> I tried to say I wanted the midwife you know, I had them, but they're [midwife] like, "Well, this doctor is recommending you go over there." And I'm like, "I don't want to," and they're like, "Well, they're recommending it so we technically can't

say you can stay here". Okay, well, there goes my midwife and there goes my home birth.

Although presented to Jordan as necessary for safety, this transfer of care from her provider of choice to another is an act of violence. Here, Jordan is seen not as an individual with unique needs, but as a pregnant body in need of close monitoring that must be overseen by an obstetrician. Despite Jordan's wishes to stay with midwifery care, the system uses metaphysical violence (Wolf, 2013) to control her. Jordan's body, due to the failed diabetes screen, was no longer her own. Rather, Jordan's body was an object that required monitoring according to standardized guidelines. She felt powerless to influence the trajectory her bodily failure sent her on. Jordan identified this moment as the beginning of her birth trauma, even though she was further traumatized during birthing.

Birthing Bodies as Objects for Control

Cohen Shabot (2016), proposes that labouring bodies are "active, creative, powerful, open body in labor, which is not shy or weak but loud and almost irreverent at its core" (p. 243). This strong laboring body is in contrast to normative views of female embodiment, which situates female bodies as weak, shy, and as alienated from women themselves (Cohen Shabot, 2016). Thus, when birthing people show their power, the healthcare system, through individuals such as midwives, physicians, and nurses, and through institutional means like policies, procedures, and funding, exerts control over pregnant bodies. Intrapartum care was the main contributor to the birthing parents' trauma.

Commonly, birth trauma is framed as a phenomenon resulting from events during labour and increasingly the term ‘obstetric violence’ is used to describe events that contribute to birth trauma (Kukura, 2018; Morton et al., 2018). The birthing parents shared some challenges they had in their interactions with their intrapartum care providers. Laura’s primary midwife was not there during her birth. Instead, Laura’s birth was managed by the hospital’s on-call obstetrician:

> The obstetrician was going off shift and she had her jacket and purse. She put her purse down on the bed and was signing off on the induction. And you know, "So-and-so is coming on shift and they will take care of you." The midwife that I had was not the one that I had regularly seen. So, it's somebody I didn't know. I didn't really feel like there was anybody that I could ask questions.

This interruption in continuity upset Laura. She had developed a trusting relationship with her primary midwife and due to the nature of her induction, could have used extra support. Further, Laura felt that procedures were not explained:

> Explaining things to me in detail would have been helpful at times and that's their [physicians’] job. They communicate to the nurses and to whoever else. They administer the medications. I felt a lack of inclusivity of me in the process. It was more like this is being done to me instead of with me.

These feelings of being a passive part of the birthing process are described in existing birth trauma literature where participants report feeling objectified and not involved in their care (Anderson, 2017; S. Ayers et al., 2016; Beck, 2004a; Moyzakitis, 2009). Metaphysical violence is possible because it involves practices that are normalized (Wolf, 2013). Not being actively involved in care during birthing is a continuation of the

violence experienced during prenatal care. Laura's care providers withheld information from her while also ignoring that she likely had questions about what was happening. Things that are taken-for-granted to care providers are not experienced the same way by birthing people. Care providers become accustomed to practices that occur during their everyday work and forget that explanations might be required. When this gap in knowledge or expectation is not bridged with communication, the potential for trauma grows.

Uncertainty about induction was something Jordan experienced too. She had trouble getting her obstetrician to explain the process to her:

> I tried to ask my doctor so many times, "what do you do for induction? What do you mean by induction?" He was like, "We'll talk about it when it comes up." I finally got an answer from a different doctor when he wasn't there: "We do the gel or the ball or whatever, the catheter."

Jordan's use of 'tried', almost a year post-birthing, suggests that she never really got the understanding she was looking for. This withholding of information is a means of controlling birthing people. Wolf (2013) contends that normalization of medicalized childbirth practices perpetuates metaphysical violence. Jordan's attempts to gather information were perceived as challenging the order of things in that the physician wanted to decide when and if a discussion about induction would have occurred. Consequently, Jordan was silenced. And thus, the violence inflicted upon Jordan contributed to her birth trauma.

Sylvie's baby was born via caesarean section (c-section), an experience which was the main contributor to her birth trauma. She felt that the communication during the emergency was adequate; however, she describes a brief interaction postpartum:

> The doctor came in who had done the c-section and I was kinda bleary-eyed. I was asleep when she came in and she quickly said, "Glad to see you're doing well and your baby's doing well. It was a really bad c-section, so all your future children will also be c-sections. Do you have any questions?" And we're like, "This is crazy" And then she said, "Okay, have a good day," and she left. And we didn't see her again for the rest of our stay there. So I thought, maybe I'm recalling these things incorrectly. And I asked my husband (he was considerably better rested than I at that point) and he said, "No, it really was under a 60 second encounter." And that was that. I mean, she was just gone.

This inadequate interaction caused a lot of stress for Sylvie. She did not understand why the physician said these things and spent months mourning not only the loss of the birth she had wanted but not experienced, but also the loss of future vaginal births. Sylvie got answers about her body when she saw another obstetrician at 10 months postpartum to discuss options as she was considering another pregnancy. This obstetrician answered her questions and informed her in fact she may try for a vaginal birth after caesarean (VBAC).

Spending short periods of time with patients is both standard and expected of physicians working in perinatal care. Constraints such as these are not the fault of individuals, but rather the result of a complex mix of funding, policies, rules and regulations. The more patients physicians see, the more they are able to bill (Koto et al.,

2019). Interactions are medically focused and do not explore topics such as mental health and social needs. Interestingly, Sylvie's experience with these two physicians is an example in which the system has done away with standardized care. These physicians have interpreted guidelines differently and each interpretation has an effect on Sylvie, whose body will be pregnant again. Ultimately, the way this interaction played out harmed Sylvie, and she is not alone in being damaged by the healthcare system.

Emily had an interaction with her midwife that shows how commonplace intervention and the subsequent embodied trauma have become:

> The midwife came to our house maybe four or five days after [baby] was born. She literally said, "Tell me about how that was for you?" I couldn't tell her what happened to me. She'd been there so she knew. I couldn't tell that story without bursting into tears and I just sobbed and sobbed. She said, "Don't worry. Women often find it hard to process and it'll go away with time." That's all she said. That was difficult for me because I had some questions about why certain measures had been taken. She didn't seem to realize or maybe I was unable to convey in my sobbing state that I need answers to understand why certain things had happened and she wasn't willing or able to give me those answers. I was thankful she'd asked but then it didn't have the resolution that I wanted to.

This was a missed opportunity for the midwife to give Emily the understanding she craved. The midwife's assertion that Emily's distress around birthing would go away with time is a sign that difficult births are normalized in the current system. While some childbearing people do get relief from their traumatic symptoms with time, the majority require treatment. Moreover, everyone can benefit from understanding what happened to

them and why they feel the way they do postpartum. Wolf (2013) beautifully explains this phenomenon of not understanding and proposes that birthing people who are damaged by birth experience multiple traumas. The first trauma comes from the nature of their birth and the second because they do not have the language or conceptual framework to make sense of their experience. Thus, they embody their trauma but cannot work out why.

Emily did not have the language to describe what happened to her and she was so overwhelmed with emotion when she thought about the birth that she was unable to articulate how she was feeling. The midwife understood what occurred during Emily's birthing and also had a broader understanding of how birth works and why given interventions became necessary. Unfortunately, the midwife chose not to share this information and brushed Emily's reaction off as common. This was an example of metaphysical violence (Wolf, 2013) at work. Emily was seen as another childbearing person who just needs time rather than an individual who is searching for answers in order to make sense of her feelings. Even a short discussion post-birth with a care provider can improve (di Blasio et al., 2015) the severity of embodied trauma. The birthing parents expressed that they wanted acknowledgement of their difficult births, validation of their experiences, and a short primer on what they might expect in the coming days and weeks in terms of their mental health. However, none of them received this from care providers.

Participation in this research was the first time most of the birthing parents had a dedicated moment to talk about their experiences. At the focus group, they shared that the time we spent together was helpful and they were moving forward in their healing due to

our discussions. Thus, having therapeutic interactions with care providers as soon as desired post birth would be beneficial for recovery.

Perceptions of Nursing Care

Thus far I have focused on interactions with physicians. There were, however, many interactions with nurses across the birthing parents' childbearing journeys. As a registered nurse myself and because this is a nursing research-based project, part of my conversations with the birthing parents involved interactions with nurses. I wanted to understand how birthing parents perceived nursing care and how interactions with nurses related to birth trauma.

The information that came out of these discussions was difficult. Working in a hospital environment means nurses are constrained by their scope of practice, employers, the healthcare system, and government policies (Khamisa et al., 2013). Professional practice standards must be met while concurrently meeting the demands of childbearing people. In nursing, moral distress is prevalent and burnout is a frequent phenomenon (Khamisa et al., 2013; Morton et al., 2018) The intention here is not to discount the role that nurses play in perinatal care and the important work perinatal nurses undertake. Rather, I present these findings to help show where birthing parents felt improvements were needed. As aforementioned, health systems standardize care at the expense of valuing individuals' needs. This standardization affects nurses' interactions with childbearing people.

Initiating Relations Oneself: Reactive Nurses

Overall, birthing parents shared that the nursing care they received was reactive rather than proactive. By this, they meant that nurses responded to their requests, but the

onus was on them to ask questions about themselves or their babies. Sylvie describes an interaction that occurred at the beginning of her induced labour:

> A nurse at the beginning of the induction sat in the chair I had asked to sit in. I should have just had the chutzpah to call her out and in other circumstances, I probably would've been like, "Actually being in labor, can I please just sit there for a few minutes?

Cohen Shabot (2016) reminds us that the labouring body is an active, productive, sexual body that is highly valuable in society. Cohen Shabot (2016) also points out the contrast of this powerful body in that labouring bodies are also vulnerable, making them open to violation and exploitation. In allowing the nurse to continue to sit in the comfortable chair, Sylvie takes on the role of the vulnerable birthing person. This role is not her usual one and as her labour progressed, she was violated further with her labour ending in a c-section. In reflecting on her birthing experience, Sylvie felt that she could have had more support from the nursing team:

> I had this side thought of, "Where were you guys five hours ago when I needed somebody to like give my husband a break and rub my back?" Or to say that, "Yeah, I'll hold your hand as you go for a walk around the room." It has made me think if we are ever fortunate enough to have another child that I would probably hire doula - who is paid out of my pocket, to support me through labour.

In increasingly technological birth environments, nurses struggle to keep up with face-to-face care such as hand holding and physical support like counter pressure, hip squeezes, and repositioning (Morton et al., 2018). Continuous labour support has been shown to decrease obstetric intervention and result in better perceptions of birth (Hodnett et al.,

2017). The best outcomes come when the support person is not hospital staff or a member of the birthing person's social networks. Thus, a doula is the obvious choice for continuous support.

Doulas are trained professionals who provide continuous support to a childbearing person and/or family before, during and shortly after childbirth (Doulas of North America International, 2020). While some private insurance companies reimburse for doula services, typically families pay for doula services themselves. This creates issues for people who do not have the budget for this service and privileges people of higher socioeconomic class. None of the birthing parents had doulas present at their births, yet most of them said they would consider one for any future births and some were making plans for this by researching how to find one, what they do, and how much they cost.

In a sense, the absence of system-based funding for doulas creates a world in which exploitation is the norm. With only their partner there to advocate for their preferences, the birthing parents were left in the care of a system that does not have their best interests in mind. In fact, this system created the conditions for the birthing parents' traumatic births and the subsequent embodied trauma. In addition to wanting proactive care, the birthing parents brought up that they felt communication was very important and there were some wonderful insights into how nurses communicated.

Uncertainty Over Bodily Experiences: Communicating with Nurses

Overall, birthing parents felt that nurses communicated to them when other care providers did not. Nurses were the most frequently present care providers and offered the most support in the hospital birthing environment. Often, routine procedures that happen during birthing are normalized by care providers but unusual to birthing people. As a

result, care providers did not always inform birthing people of what to expect. Laura experienced shaking from her epidural, a common side effect, and brought it to her nurse's attention. Laura was reassured when her nurse explained: "Oh, that's just the medication, and that's a normal side effect." A discussion beforehand preparing Laura for this side effect may have helped her feel more confident.

Elizabeth had limited knowledge around the second stage of labour. This is the stage where the cervix is fully open and the birthing person helps their baby descend by pushing. Elizabeth felt the nurses communicated very well, although they did not explain the course of a typical labour:

> The birth unit nurse was great. I still remember her perfectly. I wish she had told me that I could push for hours. No one had told me that. I started pushing and I expected to have the baby.

For a first time birthing parent, two hours for the second stage of labour is not unusual. Elizabeth felt her body took too long to push her baby out and that the care providers continuously referred to how long she was taking to birth her baby. Birthing parents, often influenced by television births where babies appear minutes after the first contraction (Luce et al., 2016) sometimes have limited knowledge of how long birthing can take. Elizabeth's expectations for pushing were an example of how something routine for care providers is out of the ordinary for birthing people and is a gap in communication that needs to be bridged. Further, Cohen Shabot (2016) suggests that while labouring bodies are turned into objects because this makes staff comfortable, the main reason for objectification is that labouring bodies are acting from immanence (Beauvoir, 1948/2011) and thus challenging medical power. In other words, the strength and beauty of a birthing

body acting in all its physiological glory is disturbing to the system, which sees pregnancy and birth as a risk that must be managed to ensure safety. Elizabeth allowed her body to open as it felt right for her, yet the care providers, through comments about how long she was taking, placed a time limit on her. As a result of this communication, Elizabeth began to feel inadequate and attempted to push 'harder', which in turn meant she was not breathing as well. This led to fetal heart decelerations and a suggestion for assisted delivery. Information was again not communicated to Elizabeth:

> So she's [physician] like, "We're going to have to do a vacuum." And for some reason I was like, "No, no," because I didn't understand what a vacuum was. I was thinking she meant forceps.

Elizabeth consented to the vacuum without understanding what it was. The way the physician broached the topic of the vacuum was less of a discussion and more of a requirement. The nursing staff went along with this recommendation and did not take the time to inquire about Elizabeth's knowledge and consequently, metaphysical violence occurred. Given that Elizabeth did not have an opportunity to ask questions and the procedure was not explained, informed consent was not properly obtained. This is an important ethical aspect of healthcare and violations are unfortunately frequently reported in perinatal care (Flanigan, 2016), not only by birthing people, but also by health care providers.

Nurses report seeing violations in informed consent procedures often. According to Morton et al. (2018), this may happen in up to 65% of births at which nurses are present. Elizabeth recalls this moment of knowing the vacuum would be used in great detail. She realized her body was not doing what it should. This led to a decrease in

confidence around her abilities and postpartum moments of panic when she recalled not understanding the vacuum. Elizabeth's birth trauma was born in this moment and she embodied it as she moved into parenting. Communicating with more detail and empathy may have helped Elizabeth have a better experience.

For Elizabeth the fetal heart rate (FHR) was not a difficult part of her experience; however, FHR issues were mentioned by most birthing parents. This was an aspect of birth that care providers were particularly concerned about, yet one they did not communicate well about. The birthing parents perceived that nurses reacted well to emergent events as measured by FHR monitors and that they were technically qualified to do their job. When her baby's heart rate began having issues, Sylvie recalls an excellent response from the care team:

> Nurses and doctors just came out of the walls. They were there very quickly. They were very good in that crisis moment and they were very gentle. Nobody was raising their voice or talking over anybody else. It was as calm, cool, and collected as an emergency could be.

These kinds of emergencies are frequent in hospital birthing environments and care providers have standardized actions in response to FHR problems (Morton et al., 2018). Unfortunately, often the birthing person is left out of these actions as the focus is on the fetus. Sylvie knew there was a problem but did not understand the scope until she was being wheeled down a hallway to the operating room. She had become a body in the system, one whose autonomy had been taken. As she was being prepared for emergency surgery, a nurse said to her: "And remember, you got to nine-and-half centimeters." While it is possible the nurse said this as a way to emphasize to Sylvie how strong she

was, Sylvie perceived it as another checkbox on her list of bodily failures and ruminated on it for months postpartum. This highlights how communication can become violence and perpetuate birthing parents' perceptions of bodily failure. In hindsight, Sylvie thought that all the suffering could perhaps have been avoided if she had just been able to have a c-section earlier.

Invisible Nurses: Care in the Postpartum Unit

As all birthing parents birthed in hospital, they were at some point post-birth moved to a different physical location for postpartum care. Jordan felt that nursing care was a comforting presence, saying: "They were all fantastic. They were very caring people. The nurses that I had really stood out, and that was sort of the one comforting thing about it." Other birthing parents felt that nurses saw them as a burden or inconvenience and described moments where nurses seemed less than impressed at the reason the they called. Elizabeth, a nurse herself, felt that her requests for help were ignored:

> The postpartum nurses did nothing for me. I don't even know if I had a nurse assigned to me… I didn't pee for a really long time and one nurse told me if I don't pee within an hour or whatever, you need to tell them because they need to cath you. I had a bunch of IV fluids and stuff and I couldn't pee and I couldn't pee and I kept ringing the buzzer and they kept saying they'd send someone down. They didn't and it was like three hours later and finally I peed almost two liters -- a bladder can actually like rupture at two liters.

Elizabeth's concerns were also not addressed when she passed a large blood clot. Rather than coming to reassure her, nurses made her feel like she was exaggerating her

experience. By not coming to see her, nurses gave the message that nothing was wrong. Further, it sent the message that Elizabeth's experience was the norm and not worthy of nursing attention.

Sylvie also felt nursing care was not present. When the nurses did not come to her room, she went to the nurses' station:

> I didn't feel like we had as much help from nurses as I wish we had. We had to go ask for some more [diapers/wipes] after we had run out and we were still in hospital days later. And they were like, "Oh, here you go." And I guess I wish they had kind of like held my hand a bit more through this process

Sylvie wanted more support and someone to guide her. She felt let down by the nurses and wished that they would have been more present to help her. Elizabeth experienced absent nursing care for a slightly different reason than Sylvie. During her stay in hospital postpartum, Elizabeth's professional designation as a nurse worked against her as the postpartum nurses assumed her knowledge:

> I had trouble getting him latched and no one helped me with breastfeeding. Someone had told them that I was a nurse. I feel like they thought because I was a nurse that we were not high-risk parents. I don't breastfeed my patients... So, I don't know how to breastfeed. I don't know how to take care of my own newborn baby.

Guiding new parents through the early postpartum hours and days is the role of the postpartum nurse. It seems though, from the birthing parents' experiences, that this is not what happens in the current healthcare system. Nurses were perceived by birthing parents as having more non-patient-focused tasks and prioritizing these over direct patient care.

Nurses in hospital environments face pressure from employers to complete documentation, screening, and to do more with less staff and less time. The system oppresses nurse too, asking them to choose between doing what their employers mandates and caring for childbearing people in the way they prefer. In short, metaphysical violence affects nurses too.

Traditionally, nursing care is siloed. Perinatal nurses receive only basic education on mental health issues and mental health nurses frequently have limited knowledge on childbearing. Anecdotally, perinatal nurses comment on being hesitant to check in on mental health because they have limited time to explore such concerns with their patients. Similarly, in my psychiatric nursing practice, I am often asked to take on perinatal patients admitted for illness because my colleagues know I am informed on childbearing.

The birthing parents astutely commented on the absence of anything mental health related in birthing and postpartum spaces. Metaphysical violence occurs in the absence of information (Wolf, 2013). Birthing parents saw no posters, brochures, or other media about perinatal mental illness (PMI). Further, there were no mental health practitioners present in the hospital. Birthing parents felt that this was problematic. They wanted someone to ask the right questions to uncover their feelings. Noticing signs of trauma or other PMI can be challenging; however, mental health professionals are well equipped to see these signs. Thus, the addition of a specialized nurse or other mental health clinician would benefit birthing parents.

Abandoned by the System: Absence of Community-Based Mental Health Care

As birthing parents were discharged from hospital and went home, their interactions with the healthcare system became almost non-existent. Consistent with

other research on birth trauma, many of the birthing parents avoided their six week postpartum check up (Akuamoah-Boateng et al., 2014; Beck, 2004a). The consistent theme behind this decision was that they had been harmed by physicians enough and did not want to engage with that profession further.

Some birthing parents received a visit from public health nurses. They found these nurses to be well versed in physical concerns, like breastfeeding and breast health, pelvic floor issues, and postpartum bleeding. However, there was no mention of mental health during these visits. Jordan recalls trying to explain how she was feeling to the public health nurse who visited her:

> I said something to the public health nurse when she came. I was like, "Well, you know, I just feel a bit different. I don't have that same overwhelming feeling like when I had [prior baby] as with [current baby] and I don't know, maybe it's a second baby kind of thing." And she's like, "Well, no, I think that can be normal." Looking back now, I know [it wasn't].

Jordan does not have the words to describe what is happening and is unable to get across to the nurse that she thinks her experience is not 'normal'. Jordan discovered over months that she was experiencing birth trauma and at the time of the focus group, 18 months postpartum for her, she was still struggling. In terms of language to describe their experiences, birthing parents at the focus group thought that 'birth trauma' as used in this research was a good choice. They liked that this term represents a broad range of experiences and is less medical-sounding than post-traumatic stress disorder (PTSD). In phenomenological research, 'birth trauma' works well as it offers opportunities to recognize many experiences.

Wolf's (2013) work is in part to provide a foundation for childbearing people to understand their experiences and this research was an opportunity for that too. I discovered early in the individual interviews process that the birthing parents did not have the language to describe their birth trauma. This discovery is discussed more in Chapter 4; however, important to note is that the system does not provide opportunities for childbearing people to understand what is happening. Sense-making is an important aspect of trauma recovery (Baxter et al., 2014; Dancy, 2020) and insofar as no providers discussed traumatic birth with childbearing people, the system ignored opportunities for early recovery.

Mental health care in primary care locations was insufficient at best and non-existent at worst. On a positive note, Sylvie's primary care provider screened her for PMI. Specifically, her physician asked about postpartum depression and used the Edinburgh Postnatal Depression Scale (EPDS) on multiple occasions. The EPDS is a self-administered, validated tool used across the globe (Long et al., 2019). Acknowledgement of difficult births and the consequent birth trauma helps birthing parents recover and more importantly, it makes birth trauma visible. Sylvie appreciated the open discussions her physician had and that he normalized PMI. While she felt that depression did not fit with her experience she knew something was not right. Yet Sylvie did not get into how she was feeling with her physician because he did not ask.

Elizabeth recalls her primary care provider asking about mood, but Elizabeth felt her mood was fine. She was, however, experiencing moderate anxiety, flashbacks, and intrusive thoughts. She felt that had these topics been broached in a specific, targeted manner by her provider, she would have been able to understand her experience sooner.

Birthing parents sought acknowledgment and validation postpartum. They wanted care providers to acknowledge that trauma occurs not only due to interventions that *did* happen, but also due to interventions that *did not*. In addition, birthing parents thought that they could have benefitted from knowing that trauma happens even when there are no physical injuries sustained. Birthing parents were often told that nothing was wrong, that they were exaggerating their distress, or that they would be fine, similar to Emily's experience with her midwife. In hindsight, birthing parents thought that prenatal preparation for potential PTSD and other mental illnesses would be valuable and given the prevalence of PMIs, I agree.

I want to be careful to note that the birthing parents I spoke with did not refer to the practices they experienced as violence. However, just because violence was not perceived does not mean it did not exist. As Wolf (2013) asserts, metaphysical violence is often invisible because it has been normalized. Further, Wolf (2013) suggests that "destruction to the self is not a deviation from "normal" but a logical and inherent consequence of the "normal" "(p. 103). Therefore, if metaphysical violence is a result of childbirth working properly in terms of medical and social norms, hospital policies, and standardized procedures, then birth trauma is the obvious consequence of childbirth.

Chapter Conclusion

Metaphysical violence (Wolf, 2013) and obstetric violence (Cohen Shabot, 2016) are present in systems that standardize care and ignore the individuality of bodies. This violence is perpetuated in the system through individuals' actions with childbearing people, guidelines for care, and institutional policies. Birthing parents noticed the invisibility of their birth trauma in their interactions with the healthcare system. Care

providers in hospital settings were focused on physical health and there were missed opportunities to provide adequate mental health care to birthing parents. Further, mental health care in hospital environments and in community-based primary care was insufficient. Birthing parents perceived the absence of discussions about their mental wellness as a cue that what they were experiencing must be 'normal'. Their thought processes were along the lines of: if no care provider asks, then surely this is just what being a parent is like. Thusly, the birthing parents kept their embodied trauma to themselves.

Recognizing birthing people's individual stories as well as how they fit within the broader context of birth trauma is important for both the healing of individuals as realizing the scope of this illness in the postpartum population. When our health care system recognizes the phenomenon of birth trauma as a real part of postpartum life, childbearing people will experience faster and easier recoveries and health care providers, including nurses, will have better tools to assist childbearing people in the postpartum period and beyond. Now, we can move to discussing the supports birthing parents said they needed and practical ways we can support recovery from birth trauma.

CHAPTER 7: CONCLUSION

Education is the most powerful weapon which you can use to change the world - Nelson Mandela

Summarizing the Findings

This research aimed to explore the experience of living with birth trauma from a feminist phenomenological perspective. Voices of birthing parents provided insight into embodied trauma, postpartum relationships, and how healthcare practices work to enact violence. In this research, three themes were revealed through participant narratives and researcher interpretation. They included: continuously processing, searching for answers in others, and experiences as a body in the health care system.

Chapter 4, *Continuously Processing*, explored birthing parents' embodied trauma and the ways in which they worked to understand what was happening to them. Birthing parents felt they needed language to describe their lived experiences as well as acknowledgement and validation for what they embodied. They lived with their birthing experience in the present and experienced difficulties in moving forward.

Chapter 5, *Searching for Answers in Others*, discussed birthing parents' relationships with others in their worlds. These others included their babies, partners, their own parents, friends and acquaintances. There were extremes in bonding with babies as parents described being either disconnected from or overprotective of their infants. Birthing parents sought understanding from their partners, but as partners had trouble understanding birthing parents' experiences, there was no support to be found. Intimacy was difficult and birthing parents were concerned that their birth trauma would result in the end of their relationships with partners. Birthing parents also received mixed messages from their own parents, friends, and acquaintances and found that while understanding was low in those close to them, support was found in surprising places.

Chapter 6, *Experiences as a Body in the Healthcare System*, posits that the healthcare system enacted metaphysical violence on birthing parents. Birthing parents felt that their trauma began in prenatal care, was perpetuated during birthing, and ignored postpartum. Mental health care was invisible and interactions with healthcare providers were, overall, ineffective and contributed further to birthing parents' embodied trauma.

The birthing parents' experiences fit well with Rubin's (1967a) theory of maternal role attainment. Rubin (1967a) describes the processes of taking in, taking on, and letting go as fundamental parts of becoming a mother. According to Rubin (1967a), a childbearing person moves through stages within each of these processes as they engage in different phases of childbearing. The eventual conclusion is seeing oneself as a mother. Many of the birthing parents went through these processes as they moved forward in their parenting journeys. Birthing parents engaged in mimicry (Rubin, 1967a) as they attempted to emulate the parenting they had experienced themselves or observed in their peers. When birthing parents attempted to make sense of their embodied trauma, they engaged in fantasy (Rubin, 1967a) as they directly tried to obtain information about what happened to them and why. Further, birthing parents involved themselves in introspection-projection-rejection (IPR) (Rubin, 1967a). IPR as a circular process in which birthing parents examine each object, in this case events that occurred during birth, and deciding what to do with it. Birthing parents took these events and determined them as traumatic, events that contributed to their difficulties in their postpartum lives. While Rubin (1967a) describes the processes in her theory as existing as a spherical model through which birthing parents move from outer to inner, the paths the birthing parents in this research took were less than linear. Birthing parents moved back and forth between

processes, attempting to take in what had happened to them, but ultimately were unable to do so on their own. Birthing parents did attempt to reach out to others; however, when similarity with those others was not found (Rubin, 1967b), birthing parents continued to seek resolution within themselves.

Implications for Practice

As part of this research, birthing parents were asked what they would change about their care to prevent birth trauma and also what they thought would have helped them recover. These recommendations have been sprinkled throughout the previous chapters as solutions for resolving birthing parents' embodied trauma and strengthening the healthcare system in terms of mental health support. This research has brought forth findings for how birthing people can be better supported during childbearing.

Education

Birthing parents commented frequently that they were not informed about birth trauma and that they wanted information. In fact, even when they went searching for information about their experiences, they were unable to find reliable sources. Some even commented that the brief description on this study's website was the first time they had seen themselves represented. This shows that birth trauma is not visible to birthing parents, their families and friends, or to healthcare providers.

Canadian-Specific Birth Trauma Resources

While a few resources exist, they tend to be piecemeal, i.e. focused on story sharing or on obstetric justice. A comprehensive website with Canadian content including an overview of birth trauma, treatments, and experiences birthing people may have postpartum would

be beneficial as a place to find information. Childbearing people, family and friends, and healthcare professionals could all benefit from this.

Healthcare Professionals

Birthing parents were clear that their care providers did not check in on their mental health, nor did they recognize signs of birth trauma. Education sessions facilitated by experts in perinatal mental health are urgently required. Schaar & Hall (2013) initiated education for obstetricians about routine screening for postpartum depression. They contacted the physicians' offices and explained the prevalence of PPD, its adverse effects, and the EPDS that is used to screen. These physicians then took part in a pilot project in which they screened all their patients for PPD. Office staff were also engaged in the initiative, as these professionals have the first and last engagements with patients and can play a vital role in identifying PPD. The physicians overall reported that they liked the screening tool and found screening to be effective. Thus, a similar initiative could be trialled in Nova Scotia for birth trauma screening. Further, infographics and posters about birth trauma can raise awareness in workplaces and ensure birth trauma is visible in healthcare.

Care providers, and particularly nurses who are interacting with childbearing people across the care continuum, must remain open-minded and reflective in their practice. Doing so offers opportunities to identify areas for improvement in practice, which is an ongoing process for care providers. Care providers who are educated about birth trauma can share their knowledge with childbearing people. This creates an open, welcoming environment for birthing parents to talk about their birth trauma and one that can eventually decrease traumatic births through changes in obstetrical practice.

Mental Health Supports

Birthing parents were acutely aware of the absence of mental health supports and resources throughout their childbearing. They suggested the following would have helped them identify what was happening so they could get treatment and recover faster.

Mental Health Professionals in Perinatal Practice

There were no mental health specialists involved with the birthing parents' care and they felt that this was detrimental. Nova Scotia does have one specialty Reproductive Mental Health Team; however, it is based in one location and due to funding restrictions and its small size, the team can see only those who are severely affected. Having a psychiatric/mental health nurse, clinical social worker, psychologist, counsellor, or other trained mental health professional present in perinatal environments is paramount. These professionals have specialty knowledge on mental illness, screening, diagnostic criteria, psychotherapy, and other treatments that perinatal nurses were perceived by birthing parents to not have. Birthing parents *want* their care providers to initiate conversations about mental health and having these professionals present will facilitate this.

Screening

Screening is an important part of identifying the presence of mental illness and also in discovering how it is affecting birthing parents. Many screening tools exist for birth trauma, yet none are routinely used in practice. The City Birth Trauma Scale (Susan Ayers et al., 2018) was developed for PTSD following birth, but also measures partial symptoms of birth trauma. This scale has been validated in European contexts (Nakić Radoš et al., 2020). Simkin & Klaus (2011) developed a short self-assessment of distress following childbirth that birthing parents can use to determine their embodied trauma and

(Bruijn & Gould, 2016) have a similar self-completed questionnaire available. These self-assessments are designed to be used multiple times so birthing parents can assess changes in their birth trauma. Birthing parents commented that they would have liked to have been asked specific questions related to their embodied experiences, rather than general questions about their mood. Thus, there is a need for the use of appropriate screening tools and this is a practice that needs to be routinized.

Critics of universal screening often cite the fact that there are not enough resources to follow up on people who screen positive and thusly universal screening is not feasible. However, this critique does not hold given the amount of literature available for implementing universal screening. While follow up is challenging due to a dearth of mental health resources, universal screening is necessary to bring forth the scope of this issue. As metaphysical violence is present whether it is seen or not, so too does birth trauma exist whether we see it or not. Turning away from the problem by not universally screening does not negate birth trauma's existence and if the lives of birthing people are to be improved, the system must acknowledge the scope of the problem as a first step in planning for recovery.

Peer support groups

Birthing parents expressed a desire to meet and talk with others who experienced birth trauma. They felt that these connections would give them some validation and remind them they are not alone in their experience. Peer support is valued by childbearing people for its opportunities to make in-person connections (Price et al., 2018) and has been shown to be effective for vulnerable and/or marginalized populations that are difficult to reach (Sokol & Fisher, 2016). Setting up an in person or online

facilitated group would be beneficial for birthing parents as they can learn what their embodied trauma is from, discover strategies for coping with their trauma, and follow a path to recovery. Peer support is effective in other contexts, such as in schizophrenia (Sledge et al., 2011) and postpartum depression (Prevatt et al., 2018), so there is no reason why the same cannot be true for birth trauma.

Vignette Video

The knowledge translation planned for this research includes the vignette video. This is an animated short video that uses excerpts from birthing parents' recorded vignettes to show what life with birth trauma can be like. This video will be available online and can be a source of education for all on how people are living with their birth trauma and ways in which support is needed.

Limitations and Strengths

The findings from this study are not generalizable (Creswell & Poth, 2018). This was never the intention for this work, as birth trauma is a subjective experience that will be different for each person who experiences it. There are commonalities across this experience, and this research has provided insight into what those are; the small sample size allowed for in depth exploration. Findings from this work can be interpreted within the context of existing literature on birth trauma to provide a broader understanding of postpartum life with birth trauma. Although there was variation in education levels and income, birthing parents were all white, heterosexual women. Their demographics represent a certain view of the world and future research should aim to recruit birthing people from more diverse backgrounds.

For some, a researcher positioning herself could be seen as a limitation in that the researcher's experience with the phenomenon could cloud the relations, and therefore data collection, with birthing parents. In this case, however, this was a strength, as I was seen by birthing parents as someone who had something in common with them. This made them feel more comfortable in sharing their experiences. Additionally, because of my lived experience with birth trauma, I identified areas for further exploration and opened up conversations to new perceptions that participants may not have brought up on their own.

Conclusion

My conversations with birthing parents have led to insights into how birthing parents live with birth trauma including its embodiment, relationships, and systemic violence. This research has been a personal and professional journey for me as I moved from having my own embodied trauma to validating and encouraging others to talk about their experiences. The strength of the birthing parents was immense and we have all contributed to something bigger than ourselves in this research. Birth trauma has been brought into the light through this work. Perinatal mental illness is an important and current issue in Canadian society, and this research will make a meaningful contribution to improving the mental health of birthing people.

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APPENDIX A: RECRUITMENT POSTER

APPENDIX B: PARTICIPANT SCREENING QUESTIONNAIRE

Thank you for your interest in participating in this study. To make sure you are eligible, I have a few questions to ask you. This should take around 5 minutes of your time.

I'd like to know a little bit about you:		
Are you able to meet in the Halifax area for an interview?	If YES **CONTINUE**	If NO **NOT ELIGIBLE**
Were you considered to be high risk?	If NO **CONTINUE**	If YES **NOT ELIGIBLE**
Did you experience pregnancy-induced hypertension, gestational diabetes, or pre-eclampsia, or any other complication during pregnancy?	If NO **CONTINUE**	If condition associated with higher risk pregnancy **NOT ELIGIBLE**
How many weeks' gestation were you when your baby was born?	Between 37 and 42 weeks at time of birth **CONTINUE**	If </=36+6 or >=42+1 **NOT ELIGIBLE**
These next questions are about the time following your baby's birth:		
Did your baby stay in the Neonatal Intensive Care Unit (NICU)?	If NO **CONTINUE**	If YES **NOT ELIGIBLE**
Please briefly describe why you are interested in participating in this study	If evidence of perceived birth trauma **ELIGIBLE**	If no evidence of perceived birth trauma **NOT ELIGIBLE**

Not Eligible Script: Thank you so much for your interest in participating in this study. At this time, you do not meet the eligibility criteria, so we will not proceed to an interview. I can send you a list of resources for mental health supports if you would find that helpful and I encourage you to keep talking about your experience.

Eligible Script: Thank you so much for your interest in participating in this study. I would like to invite you to attend an individual interview. This can take place at a time and place that is convenient for you. During this interview, you will be asked to tell us about what your life is like since you gave birth and the ways that you feel your birth trauma has affected you. I'd like to send you a copy of the consent forms for our individual interviews as well as something called an individual vignette so you know about what we will be doing and what some of the risks and benefits for you might be. Let's talk about when and where would work for you….

APPENDIX C: CONSENT FORMS

CONSENT FORM
for INDIVIDUAL SESSIONS

Project Title
Exploring how the experience of birth trauma impacts childbearing people in their first five postpartum years.

Principal Investigator
Sandra Murphy BScN, RN
Master of Science in Nursing Student, Dalhousie University School of Nursing
5869 University Avenue
Halifax, NS B3H 4R2
Tel: 902-412-3531
Email: sandram@dal.ca

Graduate Supervisor
Lisa Goldberg, RN, PhD, Caritas Coach
Associate Professor, Dalhousie University School of Nursing
5869 University Avenue, Halifax, NS B3H 4R2
Tel: (902) 494-2988
Email: lisa.goldberg@dal.ca

Funding for this study is provided by the Nursing Research Fund from the Dalhousie University School of Nursing.

Invitation to Participate
You are invited to take part in a research study being conducted by Sandra Murphy, a student at Dalhousie University, as part of the requirements for the Master of Science in Nursing degree program. Sandra is also a registered nurse. Taking part in this research is voluntary and participating or not participating is entirely your choice. There will be no impact to you if you decide not to participate in this research. The information below tells you what is involved in participation, what you will be asked to do and about any benefit, risk, inconvenience, or discomfort that you might experience.

You should discuss any questions you have about this study with Sandra. Please ask as many questions as you like. If you have questions later, please do not hesitate to reach out.

Purpose and Outline of the Research Study
Birth trauma is postpartum psychological distress related to events that occurred during childbirth. There is no one event that causes trauma, and symptoms can vary but might include intrusive thoughts related to giving birth, flashbacks, nightmares, feeling on edge, anxiety, depression, feelings of guilt or failure, and avoiding situations that remind you of

birth. Up to 30% of people who have given birth perceive their birth as traumatic and this affects people their everyday lives. This study explores how the experience of birth trauma impacts the lives of people who have given birth within the last year. I am going to talk with 5-8 people about what life is like when living with birth trauma. This might include how you feel about parenting, your relationships, your mental health, supports you have found, and things you think might help you. Gathering this information might help people living with birth trauma in their recovery and also might contribute to education for healthcare professional and families.

Who Can Take Part in the Research Study?
You may participate in this study if you had a low or normal risk pregnancy, gave birth between 37 and 42 weeks' gestation within the last 5 years, experienced this birth as traumatic, your baby was born living, and you are currently parenting this same baby. Participants must be able to either meet in the Halifax area or be available via telephone or video call for an interview, and be willing to share their experiences openly in English. You are not eligible to participate in this study if you had a high risk pregnancy, gave birth before 37 weeks or after 42 weeks' gestation, your baby spent time in the Neonatal Intensive Care Unit (NICU), or you cannot provide informed consent for participation.

What You Will Be Asked to Do
You will be asked to meet with Sandra Murphy at a time and place that is convenient for you. There are two individual components that you may choose to participate in.

1) *Individual Interview.* You will be asked to talk about your experience in living with birth trauma and how that affects your everyday activities. Your conversation with Sandra will be audio recorded and later transcribed by a transcriptionist. You may still participate if you prefer your conversation is not audio recorded - in this case Sandra will record written notes. This individual interview will last 60-90 minutes.

   OPTIONAL ACTIVITY:
2) *Individual Vignette.* You will be asked to speak for 2-3 minutes, answering the question 'How do I live with this trauma?'. You can talk about anything that comes to mind when you hear that question. Your response will be audio recorded and then, along with other participants' recordings, edited into a video with images and/or video footage showcasing your voice along with other people living with birth trauma.

   You can choose to participate in the individual interview only and not participate in the vignette, but you must participate in an individual interview to participate in the individual vignette. This means you cannot participate only in the vignette.

3) *Focus Group Session.* You will be asked if you would like to participate in a focus group session at a future date and time, after all individual interviews are completed. The focus group brings together all willing participants. Sandra will present the preliminary findings of this study, based on the data collected from the individual interviews. You will be asked to provide feedback on these findings, add any

information you think is needed, and make any comments you would like. This group conversation will be audio recorded and later transcribed by a transcriptionist. This focus group session will last 60-90 minutes. If you would like to participate, you must consent to be contacted by Sandra about this session.

Possible Benefits, Risks and Discomforts

In other studies of birth trauma, some participants have reported that they find talking about their experience helpful while other participants have found talking about their trauma upsetting. You might experience troubling or upsetting thoughts or psychological distress and you may be affected emotionally by participation. You can take a break or stop the interview at any time without consequence. You will be encouraged to talk about your feelings and to seek professional support for your trauma. A list of providers will be given to you for this purpose.

Sometimes people living with trauma, particularly when they are talking about what happened to them or thinking or talking about how their life is affected by their trauma, enter a mental state where they are not able to regulate their thoughts and/or feelings by themselves. This could be a panic attack or a dissociative reaction. If something like this happens during this interview, you will be encouraged to call the mobile mental health crisis team for assistance. This service offers immediate telephone support from a mental health professional to help you.

There is the potential that people who know you and your story could identify you from a direct quote even though a pseudonym will be used. Also, as your voice will be used in its original form in the individual vignette, there is a risk that you may be identified by people you know. Your voice is not able to be modified for this video.

There are no anticipated risks related to your physical wellbeing. Participating in the study might not benefit you directly, but things that might benefit others may come out of this study.

Compensation / Reimbursement

To thank you for your time, you will receive a gift card, value $30, for this individual interview session. You will not be compensated for transport, childcare, or meal costs related to your participation.

How your information will be protected:

The primary investigator (Sandra Murphy) and her research supervisor, Dr. Lisa Goldberg. will be the only people who know you participated in this study. You will be assigned a pseudonym that will appear on all documents and any potentially identifiable data will be removed. Audio recordings will be kept in an encrypted format on a password-protected external storage device. Data will be described in terms of the group of participants, rather than individuals, with the exception of direct quotes.

Confidentiality:

Only Sandra will have access to your personal information, and this will be kept confidential. She will not tell others about your participation and your real name and assigned pseudonym will be kept in an encrypted format on a password-protected storage device. Your demographic information will not be reported individually to protect your

confidentiality. Any paper versions of transcripts used during data analysis will contain your pseudonym and these will be keep locked in a storage box when not in use. When this study is complete, paper versions will be destroyed securely and electronically stored data will be kept for 3-5 years before being deleted.

I will not disclose any information about your participation in this research to anyone. The only time I am required to share information with others is in the unlikely event that I witness or see evidence of child abuse or neglect and in this case I am required to contact authorities.

Sharing Your Data
Information that you provide to us will be kept private. Only Sandra Murphy and Dr. Lisa Goldberg at Dalhousie University will have access to this information. I will describe and share study findings in a thesis, presentations, public media, journal articles, and through a video made from an individual vignette. I will be very careful to only talk about group results so that no one will be identified. This means that you will not be identified in any way in our reports. The people who work with us have an obligation to keep all research information private. Also, I will use a pseudonym (not your real name) in our written and computer records. All your identifying information will be securely stored. All electronic records will be kept secure in an encrypted file on a password-protected computer and external storage device.

If You Decide to Stop Participating
You are free to leave the interview at any time. If you decide to stop participating at any point during the interview, you can decide whether you want any of the information that you have contributed up to that point to be withdrawn or if you will allow us to use that information. You can also decide for up to 2 weeks following your interview if you want to withdraw your data. After that time, withdrawing your data is not possible because it will be being analyzed.

How to Obtain Results
I can provide you with a digital or paper version of your interview transcript for your records; this can be emailed or mailed to you based on your preference.
The video created from the individual vignette will be available on the study's website, or you can opt to receive a version via email.
Preliminary findings will be shared at the focus group session planned for when individual interviews are completed. You can opt to receive an emailed summary of preliminary results whether you choose to attend the focus group or not.
Final results will be available on the study's website or you can opt to receive a version via email.

Questions
I am happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Sandra Murphy at sandram@dal.ca or at 902-412-3531 OR or Dr. Lisa Goldberg, supervisor, at lisa.goldberg@dal.ca or 902-494-2988 at any time with questions, comments, or concerns about the research study (if

you are calling long distance, please call collect). I will also tell you if any new information comes up that could affect your decision to participate."

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca and reference REB file # 20XX-XXXX.

SIGNATURE PAGE for INDIVIDUAL SESSIONS

Project Title: Exploring how the experience of birth trauma impacts childbearing people in their first five postpartum years.

Principal Investigator: Sandra Murphy BScN, RN
Master of Science in Nursing Student, Dalhousie University School of Nursing
5869 University Avenue
Halifax, NS B3H 4R2
Tel: 902-412-3531
Email: sandram@dal.ca

Individual Interview
I agree to take part in an individual interview ☐ Yes ☐ No
☐ I consent to audio recording ☐ I do not consent to audio recording (written notes will be taken)
I agree that direct quotes from my interview may be used in publications and presentations of this research study ☐Yes ☐No
I wish to receive a copy of my interview transcript ☐No ☐Yes - Specify email or mail:
_____
I would like an email version of the preliminary results ☐Yes ☐No

Individual Vignette (Optional)
I agree to take part in an individual vignette ☐Yes ☐No
☐ I consent to audio recording of the individual vignette and consent to my contribution and unaltered voice being used in a video
I would like an email version of the finished vignette video ☐Yes ☐No
I would like to be contacted about participating in the focus group session ☐Yes ☐No
I would like to receive an emailed summary of final results ☐Yes ☐No

I, _____, the research participant, have read the explanation about this study. I have been given the opportunity to discuss my participation and my questions have been answered to my satisfaction. My participation is voluntary, and I understand that I am free to withdraw from the study at any time, up until 2 weeks after my interview is completed.

_____ _____ _____

Printed Name Signature Date

CONSENT FORM
for FOCUS GROUP SESSION

Project Title
Exploring how the experience of birth trauma impacts childbearing people in their first five postpartum years.

Principal Investigator
Sandra Murphy BScN, RN
Master of Science in Nursing Student, Dalhousie University School of Nursing
5869 University Avenue
Halifax, NS B3H 4R2
Tel: 902-412-3531
Email: sandram@dal.ca

Graduate Supervisor
Lisa Goldberg, RN, PhD, Caritas Coach
Associate Professor, Dalhousie University School of Nursing
5869 University Avenue, Halifax, NS B3H 4R2
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Email: lisa.goldberg@dal.ca

Funding for this study is provided by the Nursing Research Fund from the Dalhousie University School of Nursing.

Invitation to Participate
You are invited to take part in a research study being conducted by Sandra Murphy, a student at Dalhousie University, as part of the requirements for the Master of Science in Nursing degree program. Sandra is also a registered nurse. Taking part in this research is voluntary and participating or not participating is entirely your choice. There will be no impact to you if you decide not to participate in this research. The information below tells you what is involved in participation, what you will be asked to do and about any benefit, risk, inconvenience, or discomfort that you might experience.

You should discuss any questions you have about this study with Sandra Murphy. Please ask as many questions as you like. If you have questions later, please do not hesitate to reach out.

Purpose and Outline of the Research Study
Birth trauma is postpartum psychological distress related to events that occurred during childbirth. There is no one event that causes trauma, and symptoms can vary but might include intrusive thoughts related to giving birth, flashbacks, nightmares, feeling on edge, anxiety, depression, feelings of guilt or failure, and avoiding situations that remind you of birth. Up to 30% of people who have given birth perceive their birth as traumatic and this affects people their everyday lives.. This study explores how the experience of birth trauma impacts the lives of people who have given birth within the last year. I am going

to talk with 5-8 people about what life is like when living with birth trauma. This might include how you feel about parenting, your relationships, your mental health, supports you have found, and things you think might help you. Gathering this information might help people living with birth trauma in their recovery and also might contribute to education for healthcare professional and families.

Who Can Take Part in the Research Study?

You may participate in this study if you had a low or normal risk pregnancy, gave birth between 37 and 42 weeks' gestation within the last 15 years, experienced this birth as traumatic, your baby was born living, and you are currently parenting this same baby. Participants must be willing to share their experiences openly in English.

You are not eligible to participate in this study if you had a high risk pregnancy, gave birth before 37 weeks or after 42 weeks, your baby spent time in the Neonatal Intensive Care Unit (NICU), or you are incapable of providing informed consent for participation.

What You Will Be Asked to Do

You will be asked to meet with Sandra Murphy and the other participants in this study for a focus group session. The time and place will accommodate as many participants as possible. Sandra will present the preliminary findings of this study, based on the data collected from the individual interviews. You will be asked to provide feedback on these findings, add any information you think is needed, and make any comments you would like. This group conversation will be audio recorded and later transcribed by a transcriptionist. If you do not want to be audio recorded, you may not participate in this session. This focus group session will last 60-90 minutes.

Possible Benefits, Risks and Discomforts

In other studies of birth trauma, some participants have reported that they find talking about their experience helpful while other participants have found talking about their trauma upsetting. This is the same with talking about your experience in a group of others who share a similar experience. You might experience troubling or upsetting thoughts or psychological distress and you may be affected emotionally by participation. You can take a break at any time without consequence. You will be encouraged to talk about your feelings and to seek professional support for your trauma. A list of providers will be given to you for this purpose.

Sometimes people living with trauma, particularly when they are talking about what happened to them or thinking or talking about how their life is affected by their trauma, enter a mental state where they are not able to regulate their thoughts and/or feelings by themselves. This could be a panic attack or a dissociative reaction. If something like this happens during this interview, you will be encouraged to call the mobile mental health crisis team for assistance. This service offers immediate telephone support from a mental health professional to help you.

There is the potential that people who know you and your story could identify you from a direct quote even though a pseudonym will be used.

There are no anticipated risks related to your physical wellbeing. Participating in the study might not benefit you directly, but things that might benefit others may come out of this study.

Compensation / Reimbursement
There will be no compensation for this focus group session; however, light refreshments will be served.

How your information will be protected:
The primary investigator (Sandra Murphy) and her research supervisor, Dr. Lisa Goldberg. will be the only people who know you participated in this study. You will be assigned a pseudonym that will appear on all documents and any potentially identifiable data will be removed. Audio recordings will be kept in an encrypted format on a password-protected external storage device. Your demographic data will be described in terms of the group of participants, rather than individuals, with the exception of direct quotes.

To protect your identity at this focus group session, you can use your assigned pseudonym instead of your real name if you prefer.

Confidentiality:
Researcher: Sandra will keep your personal information confidential. Only Sandra and her research supervisor, Dr. Lisa Goldberg. will know you participated in this study. They will not tell others about your participation and your real name and assigned pseudonym will be kept in an encrypted format on a password-protected storage device. Your demographic information will not be reported individually to protect your confidentiality. Any paper versions of transcripts used during data analysis will contain your pseudonym and these will be keep locked in a storage box when not in use. When this study is complete, paper versions will be destroyed securely, and electronically stored data will be kept for 3-5 years before being deleted. I will not disclose any information about your participation in this research to anyone unless compelled to do so by law. That is, in the unlikely event that I witness child abuse or neglect, or suspect it, I am required to contact authorities.

Co-Participants: This focus group session gathers willing participants together and this means that you will meet each other and hear each other's information. Taking part in this focus group session is voluntary and to participate, you must agree to keep information about others' identities and their experiences confidential. This means that you don't talk about what was said at the focus group session outside of the focus group session and that you do not take any photos, make lists of pseudonyms or names, or share other information with people not involved in this focus group session.

Sharing Your Data
Information that you provide to us will be kept private. Only Sandra Murphy and Dr. Lisa Goldberg at Dalhousie University will have access to this information. I will describe and share study findings in a thesis, presentations, public media, journal articles, and through a video made from an individual vignette. I will be very careful to only talk about group results so that no one will be identified. This means that you will not be identified in any way in our reports. The people who work with us have an obligation to keep all research

information private. Also, I will use a pseudonym (not your real name) in our written and computer records. All your identifying information will be securely stored. All electronic records will be kept secure in an encrypted file on a password-protected computer and external storage device.

If You Decide to Stop Participating
You are free to leave the focus group session at any time. If you decide to stop participating at any point during the session, we are unable to withdraw your contribution. There will be many voices on the recording and we cannot always tell who is whom.

How to Obtain Results
I will share preliminary findings based on data from the individual interviews with you at this focus group session. You can opt to receive an emailed summary of preliminary results whether you choose to attend the focus group or not.
Final results will be available on the study's website or you can opt to receive a version via email.

Questions
I am happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Sandra Murphy at sandram@dal.ca or at 902-412-3531OR or Dr. Lisa Goldberg, supervisor, at lisa.goldberg@dal.ca or 902-494-2988 at any time with questions, comments, or concerns about the research study (if you are calling long distance, please call collect). I will also tell you if any new information comes up that could affect your decision to participate."

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca and reference REB file # 2019-4833.

SIGNATURE PAGE for FOCUS GROUP SESSION

Project Title: Exploring how the experience of birth trauma impacts childbearing people in their first five postpartum years.

Principal Investigator: Sandra Murphy BScN, RN
Master of Science in Nursing Student, Dalhousie University School of Nursing
5869 University Avenue
Halifax, NS B3H 4R2
Tel: 902-412-3531
Email: sandram@dal.ca

I, _____, the research participant, have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in a **focus group session**, and that this session will be audio-recorded and then transcribed. My participation is voluntary, and I understand that I am free to leave the focus group session at any time.

I agree to take part in this focus group session ☐Yes ☐No

I agree that direct quotes from my contribution may be used ☐Yes ☐No

I will keep information about my co-participants private and confidential ☐Yes ☐No

I would like to receive an emailed summary of final results ☐Yes ☐No

_____	_____	_____
Printed Name	Signature	Date

APPENDIX D: INFORMED CONSENT FORM

Questions for Informed Consent Process

Part of the Informed consent process is being able to understand what you've read in the consent form and what is involved in participating. I have a few questions to ask you to make sure you're making an informed choice to participate. (Ask 2 questions)

What are two potential risks/benefits to you in participating in this research?

_____

How much time is this interview expected to take?

_____

What is this study about?

_____

_____

How would you let me know that you would like to stop participating?

_____

APPENDIX E: INTERVIEW PROTOCOL

Individual Interview Protocol

Phenomenological interviews do not use a formally-structured guide. Rather, the researcher follows the lead of participants to allow the underlying aspects of a phenomenon to come to light (Cresswell & Poth, 2018). Thus, these questions are broad with the purpose of stimulating discussion and this guide includes prompts to remind me to get more breadth and depth when necessary.

Interview Questions

Tell me what life has been like for you since the birth of your baby.
Describe when you realized that birth trauma was affecting you.
How do you feel that birth trauma affects your day-today life?
How have your ideas about what kind of parent you would be changed due to the trauma?
Tell me some things that you think will help you in your recovery?
What kind of support do you need to be the parent/person you want to be?

Clarification

What do you mean by that?
Describe that a bit more for me?

Probes

What's that like for you?
What does that feel like?/How does that feel?
How does that affect you?

Reminders for Researcher

What are you not hearing?

APPENDIX F: CONFIDENTIALITY AGREEMENT

Confidentiality Agreement

Research Study Title: Exploring How the Experience of Birth Trauma Impacts Childbearing People in their First Five Postpartum Years

1. I, _____ transcriptionist/video editor, agree to maintain full confidentiality of all research data received from the research team related to this research study.

2. I will hold in strictest confidence the identity of any individual that may be revealed during audio recordings or in any associated documents.

3. I will not make copies of any audio-recordings, video-recordings, or other research data.

4. I will not provide the research data to any third parties without the research team's consent.

5. I will store all study-related data in a safe, secure location as long as they are in my possession. All research data will be stored in an encrypted format.

6. All data provided or created for purposes of this agreement, including any back-up records, will be returned to the research team or permanently deleted. When I have received confirmation that the work I performed has been satisfactorily completed, any of the research data that remains with me will be returned to the research team or destroyed, pursuant to the instructions of the research team.

Name (printed) _____

Signature _____

Date _____

APPENDIX G: RESOURCE LIST

Mental Health Resources for Participants

Publicly Funded Counselling

IWK Reproductive Mental Health
902-470-8098
- Need referral from primary care provider
- Located in Halifax

NSHA Community Mental Health Teams
Central Intake 1-888-429-8167 (toll-free)
- Self referral or referral from primary care provider
- Locations throughou

Crisis Supports

Mobile Mental alth Crisis Team
902-429-8167 (H ifax) or 1-888-429 167 (toll free)
- Telephone supp in a crisis
- Referral for supp or help gettin acute care

911
If you have a nerg y

Community Resources

Family Re urce Cen es
- Locations roughou NS
- Parenting ograms, er support, social s orts

Online

Postpartum pport In rnational
- Information out perina ental illn and s orts
- Phone line fo pport

Birth Trauma Supp Center
- Evidence-informed in tion abou irth trau
- Online peer support group

Birth Trauma Association
- Evidence-informed information about birth trauma

Private Counselling

Psychologists/Counsellors/Therapists in Nova Scotia
- List of providers, can sort by perinatal