“I was just robbed of joy.”

An Interpretative Phenomenological Analysis of Women’s Lived Experiences of a Distressing Childbirth in Ireland: Perceived Impacts and Meaning-Making

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of DPsych is entirely my own work, and that I have exercised reasonable care to ensure that the work is original and have conformed to the regulations on the use and declaration of Generative AI, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work. I hereby certify that no Generative Artificial Intelligence (Gen AI) tools have been used in the creation of the thesis.

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A doctoral thesis is undoubtedly a journey of discovery. Like many journeys, what happens along the route, the people met, the challenges encountered, and the learnings gleaned have all influenced my final destination in the crafting of this submission.

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Key Terms Used

The term **Active Management of Labour** describes the knowledgeable management of labour that influences progressive uterine activity, a woman's physiological response to it and her sense of well-being during it.

The term **Apgar Score** describes the medical assessment of the baby which takes places at one minute and five minutes following birth, recording the baby's overall colouring, muscle tone, reflexes, heart and respiratory rate.

The term **Assisted Vaginal Delivery (AVD)** refers to the use and application of medical instruments, such as a forceps or ventouse (vacuum), to a baby's head during the second stage of labour, in order to progress to the final stages of a vaginal delivery. The term **Operative Vaginal Delivery (OVD)** may also be used interchangeably.

The term **Cephalic** describes the position of the baby, when their head is presented downwards in-utero and comes first.

The term **Caesarean Section (C-section)** refers to the surgical procedure, where a baby is delivered through an incision in the mother's lower abdomen.

The term **CPAP (Continuous Positive Airway Pressure)** refers to the delivery of constant airway pressure into the lungs, supporting individuals who may experience breathing difficulties.

The term **Expert by Experience** describes someone who has gained the required knowledge in a particular subject or topic through their lived experience.

The term **Gerunds** refers to the changing of verbs into nouns, when creating personal experiential statements (PES) during data analysis, that align with the participants' languaging of their experiences.

The term **Heel-Prick Test (Guthrie test)** describes when a small sample of blood is taken from a needle prick made in the baby's heel, between three- and five-days following birth. It tests for 9 conditions: Adenosine Deaminase Deficiency Severe Combined

Immunodeficiency (ADA-SCID); Classical Galactosaemia; Congenital Hypothyroidism (CHT); Cystic Fibrosis (CF); GluaricAciduria type 1 (GA1); Homocystinuria (HCU); Maple Syrup Urine Disease; Medium-chain acyl-CoA dehydrogenase deficiency (MCADD); Phenylketonuria.

The term **Health Service Executive (HSE)** refers to the publicly funded, state provider of health care in Ireland.

The term **Hyperemesis Gravidarum** describes the severe state of nausea, vomiting, and dehydration accompanied by weight loss, specifically experienced during pregnancy.

During physiological childbirth, the term **Masterly Inactivity** describes the close, and skilful monitoring of a woman's ability to naturally progress through the symbiotic process of childbirth, with the aim of avoiding unnecessary medical interventions where possible.

The term **Neuraxial Block** refers to the inclusive phrase used for an epidural or spinal anaesthesia.

The **Partogram** is a graphical record that maps the active management of labour's protocols and progress.

The term **Perinatal** describes the period from the 24th week of gestation up to the first 28 days following childbirth.

Abstract

"I was just robbed of joy." An IPA Study of Women's Lived Experiences of a Distressing Childbirth in Ireland: Perceived Impacts and Meaning-Making

Recent childbirth research focuses on evidence-based practice that is striving to facilitate a move from a pathogenic (dis-ease) to a salutogenic (health-ease) approach to maternity care. A salutogenic approach aims for events to be understood, manageable and meaningful, thus enabling perinatal women and their families to flourish. It is further recognised that perinatal mental health research requires a more inclusive approach where maternal stress, anxiety and depression are all explored within the broader context of perinatal maternal distress. Moreover, women's experiences of distress during childbirth are found to have negative consequences postpartum for the woman and her family. As a result of this salutogenic drive, worldwide childbirth research, including Irish childbirth research, continues to value and investigate women's psychological lived experiences of childbirth. However, women's voices and how they navigated their way through the stresses and distress of childbirth in Ireland, including what therapeutic supports or interventions they found helpful, are underrepresented within the research literature.

This study qualitatively explored the subjective lived experience of women who self-identified as having experienced distress during childbirth in Ireland, including their perceived impact and meaning-making. Employing a qualitative Interpretative Phenomenological Analysis (IPA) methodology, rich, detailed data were gathered from 12 participants, using one-on-one, in-depth semi-structured interviews, which were recorded, transcribed, and analysed. Three key interconnecting Group Experiential Themes (GETs) were identified: 1. *Suffering Unimaginably,* 2. *Having to Capitulate* and 3. *Regaining Coherence.* These themes give voice to the shared horizon of understanding amongst the participants, highlighting their unique experiences of their distressing childbirth. Furthermore, they illuminate the depth of the participants' distressing childbirth experiences, the impact it has had on the women's sense of self, their relationship with their baby, their partner, their family and their subsequent efforts to make meaning. It elucidates how the tensions between a perinatal woman's internal and external environments contribute to a distressing childbirth. These tensions need to be more openly acknowledged among all stakeholders, so they can be addressed in antenatal classes and informed, as well as worked through in a psychotherapy session.

Chapter 1: Introduction

1.1 Introduction

Childbirth is a universally lived experience for everyone who moves from womb to world and, arguably, can be considered a life-altering event (Larkin et al., 2017; Lorén et al., 2024). The process of childbirth is a complex, individual, lived experience for every woman who gives birth (Larkin et al., 2009), meaning that a fundamental focus of contemporary childbirth research encompasses the postpartum psychological developmental trajectory and well-being of both mother and child (Karlström et al., 2015; O'Reilly & Hanafin, 2016; Walsh & Devane., 2012). Moreover, global, European, and national (Irish) changing epidemiology, demographics, and ethnographies, including medical expertise and advancements, are prompting a more collaborative, deliberated and empirical evidenced based approach to childbirth (Betran et al., 2016). Furthermore, a multidisciplinary approach to the care of women's perinatal wellbeing is being called for by frontline healthcare professionals, healthcare policymakers, women themselves and their partners (Bohren et al., 2015), as it is now well recognised that childbirth outcomes are heavily influenced by social context (Basile-Ibrahim et al., 2024). Therefore, this in-depth study will focus on maternal distress in childbirth, including its impact and how women who gave birth in Ireland later made sense of their distressing experiences.

This chapter delineates the background to the research, the identified research gap which led to the rationale for this study, and, in brief, the methodology and methodological approach used, which will be returned to in Chapter 3. Moreover, it outlines the aims and objectives of the study to best answer the research question in support of the research gap

identified. Finally, it briefly outlines each of the study's chapters, ending with a reflexive overview of this researcher's interest in the phenomenon being explored.

1.2 Background and Rationale

1.2.1 Childbirth: A subjective, enduring experience

Annually, up to 60,000 women in Ireland successfully maintain their pregnancy and give birth to a liveborn or stillborn baby, weighing greater than or equal to 500 grams (O'Reilly & Hanafin, 2016). Each of these women must navigate their individual lived experience of childbirth, with or without assistance, either in a hospital or at home (HSE, 2019). Such experiences may be seen in a mixed methods study of 531 postpartum women who gave birth in Ireland, which found that the postpartum well-being of a mother, her baby, her partner, and her family are all influenced by a woman's childbirth experience (Larkin et al., 2012). Women's subjective experiences of childbirth, as either positive or negative, have been found to endure over time. 584 of 1,168 postpartum women in a Japanese prospective study, who completed the Childbirth Experience Scale (CES) in the first few days postpartum and five years later, were found to have statistically significant accurate recall of their childbirth experiences (Takehara et al., 2014). Others, such as Bossano et al. (2017) in their longitudinal study of 576 women, investigating women's outcomes after childbirth, found that women's fulfilment, distress, or difficulty with their childbirth experience (Salmon et al., 1990) was still evident between 10 and 17.5 years later. In this way, the present, as well as the future health and well-being of society, is, to an extent, dependent on women receiving optimal physical, psychological, emotional and socio-culturally sensitive care during the perinatal period.

For the majority of women, childbirth is a positive experience (Dahlberg et al., 2016), offering them the possibility to experience a growth-enhancing process into motherhood.

This is evident in Daly et al. (2022) qualitative thematic analysis sub-study, conducted within the Maternal Health and Maternal Morbidity in Ireland's (MAMMI) longitudinal study of 3,047 first-time mothers. Using open-ended questions, 24 women, who gave birth in one of three Irish maternity hospitals, were interviewed about their transition to motherhood. They identified their transition to motherhood as an intense period which was positively or negatively impacted by the quality of care and support received from healthcare professionals, along with family and peers. Kwee and McBride (2016) further argue that women who more easily transition and individuate into their new role as mothers, are more likely to support their child's psychosocial development. Meanwhile, it is the enduring nature of distress that has the potential for psychological morbidity for mothers, their partners, their babies and future partners (Johansson et al., 2020). Psychological distress is found to occur when there is emotional suffering with associated symptoms of depression, anxiety, loss of interest, unhappiness, desperation, restlessness, insomnia, headaches, and reduced energy, where symptoms may vary across cultures. Events causing distress threaten a person's physical or mental health and capacity to cope, resulting in emotional turmoil. Distress may be transient or, if prolonged, lead to a diagnosis of a psychiatric disorder (Drapeau et al., 2012). Therefore, the positive mental health and well-being of mothers, perinatally, directly impact the health and well-being of their children and families (Fenech & Thomson, 2014; Glover, 2014).

1.2.2 Childbirth: A Time of Increased Vulnerability

The Irish Department of Health's (DoH), 10-year National Maternity Strategy (2016) and the Health Service Executive (HSE) 'Mind Mothers study' (2017) of perinatal mental health identified and established the need for a more integrated, multi-disciplinary, and adapted approach to meet the mental health and well-being needs of women pre-, peri and postnatally. Women who have experienced a wide range of adversities (inter-partner abuse,

sexual abuse, self-injury, suicidal ideation, eating disorders and psychosis) are currently acknowledged as receiving insufficient care due to inadequate knowledge and expertise within the care teams (Carroll et al., 2018; DoH., 2016; Higgins., et al., 2018).

The National Institute for Health and Care Excellence [(NICE), 2014] identified that 15-20% of women are known to experience mental health issues in pregnancy and up to a year postpartum. However, over half of the women who experience prenatal mental health issues may go unnoticed, despite attending healthcare services and medical personnel at predictable, regular intervals during their pregnancy and into the early postnatal period (Rallis et al., 2014a). When given the time and continuity of care, women with significant mental health histories did engage with perinatal mental health services. Barriers to women taking up these services included perceptions of staff being time poor, and a sense of stigma/shame attached to being labelled as having a mental health problem. Therefore, women who had known mental health issues often preferred not to be offered mental health support unless they asked, while for some, their baby was a motivational factor in seeking help (Nagle & Farrelly, 2018).

A scoping review of 29 publications on perinatal mental health in Ireland, using thematic analysis, identified that Irish mental health services are overly medicalised and are deficient in meeting the needs of perinatal mothers (Huschke et al., 2020). They found that women who already experience mental health issues and lack social support are the most vulnerable during the perinatal period. They further found that prevalence rates of maternal ill-health vary across studies, while there is a dearth in qualitative studies where women's voices and experiences can be valued and heard (Huschke et al., 2020). Rallis et al. (2014b), in a review of literature on maternal stress, argue that future perinatal mental health research should adopt a more inclusive approach, where maternal stress, anxiety,

and depression are all explored under the umbrella of perinatal maternal distress. Research exploring the enduring nature of women's negative childbirth experience with its protracted impact on the well-being and development of the mother, her baby and other family members, where there is a multi-disciplinary approach to women's mental health perinatally, is equally being called for (Smythe et al., 2016).

Dr. Krysia Lynch, chair of the voluntary Association for Improvement in Maternity Services in Ireland (AIMSI), welcomed the national public airing, on Joe Duffy's live-line programme (RTE, 2019), of over 1,000 women's difficult childbirth experiences. She argued that women are consistently asking to be listened to. They long to receive care from a "compassionate, dignified, kind, consensual and respectful maternity service that genuinely puts the pregnant person at the centre of care" (AIMSI, 2019). Daly et al. (2022), further argue that women's voices evaluating their Irish childbirth experiences must be heard and included in research to provide a more comprehensive picture of their perinatal physical, psychological and emotional needs, including how these were met or not.

The research question to be explored in this study is certainly justified, given the above arguments. The qualitative nature of this current study will add to the existing qualitative literature on childbirth. Moreover, it aims to capture and explore the rich descriptions, interpretations and meanings which women who gave birth in Ireland attribute to their distressing childbirth experiences. It is hoped this research study will add to our understanding of how these women's quality of life has been impacted. In turn, this research hopes to elicit how psychotherapists can better support these women and their families in the future.

1.3 Research Question and Objectives

The research question devised for this qualitative study exploring women's experiences of their distressing childbirth in Ireland is as follows:

> *"How do women who self-identify as having had a distressing childbirth in Ireland make sense of the experience and its impact?"*

The following objectives are employed:

1. Explore the perceived impact of a distressing childbirth on women's sense of self, their relationship with their baby, their partner and their family.
2. Understand the intersubjective nature of women's lived experiences of their distressing childbirth in Ireland.
3. Illuminate how women navigated their way through this distressing childbirth experience and made sense of it.
4. Inform how psychotherapists and other healthcare professionals can support women following their experience of this phenomenon, including the type and timing of these supports.

1.4 Methodology

An Interpretative Phenomenological Analysis (IPA) qualitative methodology was chosen for this research study. One-on-one semi-structured interviews were conducted with 12 participants, who self-identified as experiencing a distressing childbirth between one and 10 years postpartum. Participants had the opportunity to voice their concerns, their complex understandings and sense-making of their childbirth experiences, including its influence on their subsequent lived life (Smith & Osborn, 2015). All participant interviews

were recorded, transcribed and analysed using Smith et al. (2009; 2022) rigorous and detailed seven-step data analysis process.

1.5 Outline of Thesis Chapters

Chapter one outlines the background, the rationale, the aims and objectives of the study. It provides a summary of the qualitative methodology used, which supported the exploration of this research study's topic, which is emotive and multi-layered. A reflexive account of this researcher's motivation for conducting the study is included. Similarly, a reflexive account of the researcher's experience and challenges while carrying out this study is found at the end of each chapter.

Chapter two offers an overview of the relevant literature, including the notion of childbirth as a natural, normal and mostly positive physiological event. It further explores the bio-psycho-social uncertainties and the challenges that can present, impacting women's experiences of childbirth. It illuminates the interrelating factors which result in the complex phenomenon of childbirth, as a distressing experience for a mother, her baby, and her partner. It concludes by examining the efficacy of trauma-focused psychological therapeutic interventions (TFPT) for postnatal women.

Chapter three presents the aim and objectives for this study and argues for the goodness of fit of a qualitative, interpretative phenomenological methodology to explore this research study's topic of inquiry. It further asserts that the philosophical underpinnings of an IPA methodology, i.e. phenomenology, hermeneutics and ideography, support the understanding and sense-making of real life, emotive human experiences. Thereafter, it delineates the research design and methods, including participant sampling, participant recruitment, data collection, and data analysis. It discusses the key ethical and data

protection considerations associated with investigating this study’s recognised, vulnerable population.

Chapter four presents the study’s findings through three key interconnecting group experiential themes (GETs), including each of their three sub-themes. These themes give voice to the shared horizons of understanding among the participants, as well as their unique and collective experiences of the phenomena under investigation.

Chapter five discusses the findings, situating them within the context of the selected, relevant literature and the methodology’s philosophical underpinnings. It offers this researcher’s novel perspectives and insights to support a greater understanding amongst relevant healthcare practitioners, in particular psychotherapists.

Chapter six concludes with the implications of this study for healthcare practitioners, including psychotherapists. It explores the strengths and limitations of the study, supporting the extant literature on distressing childbirth in Ireland and internationally. It concludes with recommendations and directions for further research.

1.6 Personal Motivation for this Research Study

My interest in psychologically supportive perinatal care extends back to my training as a midwife in the United Kingdom (UK) during the late 1980s and later as I trained in psychology and psychotherapy. The belief in the self-efficacy of the mother to achieve a physiological childbirth was deeply rooted and well supported during pregnancy and labour by all staff members where I trained and worked in the UK. The philosophy was respectful and supported minimal intervention. In contrast, I worked in a busy urban maternity hospital on my return to Ireland in the early 1990’s where the active

management of labour was still practised, and where higher levels of intervention were the norm. Despite my best efforts to resist the active management of my first labour, my daughter was born by forceps, where my informed consent wasn't even sought. A few hours later, I experienced a medical emergency due to severe postpartum haemorrhage, necessitating further medical and surgical interventions. I believe I recovered well because, as an insider, I understood what was happening and, to some extent, advocated successfully on my behalf. This study was conceived to support clients who experienced a distressing childbirth in my psychotherapy practice, as well as support other therapists as a psychotherapy supervisor in their work with perinatal clients, using evidence-based practice.

Chapter 2: Literature Review

This chapter reviews the relevant literature, including the notion of childbirth as a natural, normal, and, mostly, positive physiological event. It further explores the uncertainties and the challenges that exist for women and their babies in childbirth. Moreover, it contextualises and illuminates the interrelating physical, psychological, emotional, socio-cultural and political influencing factors which result in the complex phenomenon of childbirth, as a distressing experience for a mother, her baby and her partner.

2.1 Literature Search Strategy

A search for relevant articles to this study of the following databases was carried out using PubMed, Science Direct, EBSCO host, BioMedical Central, Taylor & Francis, Google Scholar and Cochrane Library. The following key search terms were used: childbirth, phenomenology of childbirth, perinatal, intrapartum, mode of delivery, instrumental delivery, assisted delivery, birth injury, birth complications, psychological impact, psychological outcomes, psychotherapy implications, well-being, maternal well-being and foetal well-being. Key seminal texts were also included. Reference lists of retrieved articles and seminal texts were further searched to source additional relevant literature.

2.2 Childbirth: A Symbiotic Journey

2.2.1 Distress: An Embodied Experience

Bessel Van Der Kolk (2015), in his well-known classic '*The body keeps the score'* describes how the experience of trauma results from a sense of being overwhelmed by events which cannot be escaped from. Childbirth, when considered from this perspective,

has the potential to be experienced as traumatic and a threat to a woman's safety. Although a woman can be medically assisted to deliver her baby, women recognise there is no turning back from the prospect of childbirth, once their pregnancy is established (Brosschot et al., 2018). As research practitioners and health care professionals we are tasked with understanding the inter-subjective embodied lived experiences and the meanings women attribute (Pringle., et al 2011; Finlay, 2009) to their distressing or negative childbirth experience, in order to influence more positive outcomes.

Psychotherapy, and more specifically psychoanalysis, have been concerned with the process of childbirth and its outcomes, since Otto Rank first published his book in 1924 on the "Trauma of Birth". Through his clinical reflections and introspections, Rank identified that his patients, often in languaging their lived experiences, symbolically represented pregnancy and childbirth during the therapeutic process. He believed his task as an analyst was to empower his patients work through the trauma of their childbirth, supporting them to achieve a more successful and intentional psychological separation from their mother object, than they achieved during their actual childbirth. Moreover, Rank's patients frequently languaged their sense of feeling reborn as they individuated, healed and recovered, which he believed signalled the end of the therapeutic process (Rank, 2010). Rank therefore, in contrast to Freud's earlier theorizing placed the mother, rather than the father, as the central figure in the child's developmental process.

Elements of Rank's psychoanalytic concepts were welcomed by several theorists who were later influential in their own right. His emphasis on the importance of emotions within the here and now of the therapeutic relationship, his prioritizing of the mother in the child's psychological development, including the impact of childbirth trauma on the separation and individuation process, his concept of our creative will as our greatest life motivator, all

found favour and were later expanded upon (Stein, 2010). Bowlby et al. (1952) expanded Rank's concept of the centrality of the mothers role as a primary caregiver, in his ethological theory on secure and insecure attachment. Bowlby illuminated how a child develops an internal working model based on the characteristics of their first care seeking relational bond with their care giving mother. This first mother-child relational attachment framework forms the foundation of either a secure or insecure attachment bond. This secure or insecure attachment style determines how a person engages in relationship as they move out and explore the uncertain world of other relationships (Bowlby, 2005; Heard et al., 2018). Mary Ainsworth went on to devise 'the strange situation task' to empirically investigate and elaborate on Bowlby's secure and insecure attachment findings. She discerned two types of insecure attachment styles; 1. insecure ambivalent and 2. insecure avoidant. In both these instances of insecure attachment a child's early relational world is unreliable, not dependable and unpredictable resulting in a child that is anxious and fearful in an ever-changing precarious world (Bowlby, 1997; Bowlby, 1980; Salter Ainsworth et al., 2015).

Ayers et al. (2014), longitudinal study of 57 perinatal women, demonstrates the importance of these early researchers work and findings when caring for women in childbirth. They found there was a negative corelation on childbirth outcomes and a woman's insecure adult attachment style. Furthermore women with an insecure avoidant attachment style, who also experience an operative delivery were found to be at the greater risk of developing later PP-PTSD. While, Taghizadeh et al. (2013), in their research further explored the impact of a mother's attachment history, previous history of childhood and early adult physical or emotional adversity on childbirth outcomes. They found a perinatal woman's perception of her environment, and in turn her decision-making capacity as well as her sense of personal agency, were all negatively impacted by their experiences of earlier adversity.

However, existentialists, take the philosophical position that adversity is part of our human condition, as we live in the thrownness of an evolving relational world with self (Eigenwelt), with others (Mittwelt), and within our environment (Umwelt) which are all situated within the context of the universe (Uberwelt). From this existential perspective adverse experiences are an inevitable possibility within our given lifeworld (Van Deursen & Arnold-Baker 2018; Van Deurzen, 2004) that are to be expected, rather than something that appears out of the blue and unexpected. Therefore, it can be argued that some mothers and their baby will inevitably have an adverse perinatal lived experience resulting in psychological distress (Van den Bergh et al., 2005). Furthermore, existentialists consider meaning-making as a dialogical process which seeks a resolution between our internal and external conflicting life-worlds, offering a unifying, pluralistic converging directionality (Cooper & McLeod, 2007) from which the various modalities of psychotherapy may approach issues arising from a distressing childbirth.

It is when we draw our epistemology from the more recent and rapidly growing field of Neuroscience and interpersonal neurobiology that we achieve a more integrated understanding of the significant contributions from all domains (Siegal, 2014), thus supporting a more comprehensive understanding of the phenomenon of a distressing childbirth. Women's sense of safety, risk, danger, or even life-threat, including during childbirth, is evaluated through the integrative processing of their phylogenetically or evolutionary developed nervous system, involving the cerebral cortex, the limbic region and the brain stem, which together Siegel (2011), termed as the triune brain. The cerebral cortex supports the higher cognitive functions of perception, thinking and reasoning, while the limbic region, more specifically, the hippocampus and the amygdala, are responsible for the processing of emotions, motivation, memory and meaning. The more primitive

brain stem is concerned with the activation of survival responses, fight/flight/freeze as well as supporting the regulation of body temperature, respiration and heart rate.

The Polyvagal theory, developed by Porges, further informs our understanding of the complex bio-psycho-social and neurological processes involved in our subjective experiencing of our intersubjective world. Porges termed our ability to perceive safety within our lifeworld or lack of as *"neuroception"* (Porges & Dana, 2018). Accordingly when we have a perception of safety, our ventral vagal social engagement system is activated. When we perceive danger, we disconnect, move out of awareness, and move into a self-protective state. Neurobiologically our Pre-Frontal Cortex (PFC) social engagement system is deactivated, and the fight-or-flight responses of our sympathetic nervous system are mobilised. Furthermore, if this fight/flight response is insufficient and or our life feels further threatened, our Dorsal-Vagal system is activated, resulting in immobilisation and freeze of all ventral-vagal and sympathetic nervous system responses. This immobilised state is known as death-feigning and is one of our adaptive responses to threat (Porges & Dana, 2018).

Hammond et al. (2013), in their paper, explore the interdependent relationship between the birth environment, neurobiology and midwifery practice. They argue that spaces and places are permeated by ever-evolving social, political, and ideological influences, both past and present, thereby impacting the neurobiology of both midwives and mothers. They further assert that midwives' capacity to empathically be with women in their maternity space and place is influenced by how the environment positively or negatively impacts them, and in turn their levels of oxytocin production. Moreover during childbirth, the release of the hormone oxytocin supports a mother's increased sociability and agreeableness with her care provider.

However, neurological feedback, as a result of facial expression, prosody of voice, and a scan of the environment, allows a mother to decide if she feels safe or unsafe. Therefore, a safe care environment with supportive midwifery care practices, increases the mother's sense of trust in herself and those around her, reducing stress levels and increasing empathy, reciprocity and generosity (Hammond et al., 2013). Siegel (2011), further explains individuals move towards what they perceive as good, while alternatively will fight, withdraw or helplessly freeze and collapse when they perceive a situation as bad or dangerous.

Moreover, the patterns created by how an individual's brain, wire's, fire's and makes meaning in distressing situations are based on their unique lived experiences, particularly the mental, representational attachment patterns or schemas formed and developed through their successes or failures in their early interactions with their main caregivers, which Bowlby termed, internal working models (Bowlby, 1997). The more attuned, trustworthy and secure early attachment bonds were, the greater the sense of safety and capacity for achieving emotional regulation when an individual finds themselves in distressing situations. In contrast, an individual's brain is unable to forget, is biased towards anxiety and fear when attachment bonds are less than trustworthy, insecure and or they experience traumatic and painful life events. As a result of the synaptic meaning-making brain connections made in order for the individual to survive, maladaptive anxious ambivalent, avoidant or disorganised patterns of relating develop (Cozolino, 2017).
Therefore, perinatal women's perceptions of feeling safe or feeling unsafe in childbirth are uniquely and unconsciously evaluated based on their lived experiences of secure or insecure early relationship and or later distressing life events.

Herman et al. (1989), argue that vulnerable adults who have experienced an accumulation of adverse childhood events are more susceptible to being victims of further adverse events. Therefore, how a mother perceives her childbirth environment is evaluated through the lens of her historical accumulated lifespan developmental experiences known as allostatic load. It has been further argued by Reed et al. (2017), women who perceive their childbirth environment as hostile and have previously experienced adversity in their earlier life, may be activated and re-activated into previous emotionally distressing and fearful situations. Accordingly, Loughnan et al. (2018), found 9-23% of women experience anxiety antenatally. 11-21% experience anxiety post-natally, with 8.5% of those being diagnosed with an anxiety disorder. Moreover, the Women's Health Taskforce (2019), reports 16% of Irish women experience depression during pregnancy, where 1:4 Irish women have experienced physical and or sexual violence Memories of sexual abuse experiences were evoked for some women following their adverse childbirth experiences (Alvarez-Segura et al., 2014; DoH 2019). Regrettably, within Ireland and the UK, suicide accounts for the highest proportion of maternal deaths, in the first year postpartum, among perinatal women (Knight et al., 2020).

The above arguments offer some insight into the psychological processes of how psyche conflicts that develop in the early years, influence an individual's ability to navigate positively or negatively their later psycho-socio lived life. Perinatal women are required to successfully navigate and adapt to the many complex demands of childbirth, regardless of the allostatic load they carry into their childbirth experience. As childbirth does not take place in a vacuum, the situated context of childbirth, which has the potential to result in enduring distress and trauma are explored below. The efficacy of trauma-focused psychological therapeutic interventions (TFPT) for distressing and traumatic childbirth are also examined.

2.2.2 Physiological Childbirth: Defined

Physiological childbirth can be considered a complex phenomenon, as there is no single accepted definition of what constitutes a physiological childbirth. The World Health Organization (WHO, 1997) defines the experience of a physiological birth as the spontaneous onset of a mother's labour between the 37th and 42nd week of her pregnancy where the mother and baby's well-being are both maintained throughout the labouring process, so the desired spontaneous vertex delivery of the infant is achieved (White, 2022). Alternatively, the United Kingdom's (UK) Maternity Care Working Party defines physiological childbirth as one where there is no induction of labour, no instrumental or surgical intervention to augment delivery and no epidural, spinal, or general anaesthetic administered during labour or childbirth (Avery et al., 2014). This definition elucidates how physiological childbirth is interrupted once medical interventions are employed. The United States of America's (USA) task force of three midwifery bodies [Midwives Alliance of North America (MANA), American College of Nurse Midwives (ACNM) and the National Association of Certified Professional Midwives (NACPM), 2013] define a physiological childbirth as one which is powered by a woman and her foetus' innate human capacity. This definition firmly keeps the focus on the innate efficacy of a mother and her baby to successfully navigate the birth process, rather than maintaining a focus on the parameters of normal or abnormal, and or pre-determined timelines.

2.2.3 Navigating Symbiotic Flow Disruptions

Although the experience of pregnancy and childbirth is mostly a natural phenomenon, the uncertainty of childbirth dictates that the safe movement of the mother and her foetus through the perinatal period is not guaranteed. It was in 1974 that LeBoyer first described a foetus' progression through the birth canal as the most dangerous journey one will ever

make (LeBoyer & Fitzgerald, 1991). Labour, as it is aptly termed, requires considerable energy from a mother and her baby to execute uninterrupted. Once labour commences, facilitated by maternal hormone production, there is a symbiosis between the mother's and baby's joint efforts and skill to safely execute the birthing process. Where a baby's passage down the birth canal becomes obstructed, medical intervention and or a C-section is often required to expedite a safe delivery of the mother and her baby (Pavličev et al., 2020).

In 2022 only 61.5% of women giving birth in Ireland had a vaginal delivery, 37.5% of women's labour were induced, 41.6% had an epidural, 26.8% had episiotomies, 1.6% had 3rd and 4th degree perineal tears, 13.5% had an operative vaginal delivery, 38.3% had a C-section, only 17% had a vaginal birth following a C-section, 4.7% had a postpartum haemorrhage (PPH) following a vaginal delivery before leaving the labour ward, while 7.0% had a PPH following a C-section prior to leaving the labour ward, and 1.8% required a general anaesthetic (HSE, 2024). These statistics reflect the predominance of the bio-medical model of care and show a year-on-year increase.

The obstetrical term "dystocia" is frequently used to denote a difficult childbirth, where the word dystocia originates from the Greek word "dystokia" where "dys" means "difficult" and "tokos" means childbirth. Birth dystocia is deemed to be the most common reason why women's labour and childbirth experiences are interrupted (Neal et al., 2015). A difficult childbirth experience, although a complex phenomenon, can be generalised as one that is either slow or prolonged (Algovik et al., 2010). More specifically, a difficult childbirth is classified across the literature using several and often interchangeable terms. Terminology used is relative to: (1) the stages of labour where the difficulty arises or (2) describes the physical (arrested, complicated) or psychological (negative, difficult or traumatic) character of the difficulty (Algovik et al., 2010; Boorman et al., 2014; Gough & Giannouli,

2021; Henriksen et al., 2017; Neal et al., 2015). With the above in mind, we can see that childbirth, similar to any other human life-span developmental stage, can leave women vulnerable to adversity, with the potential for exposure to harm (Huschke, 2021). Together, a mother and her baby must navigate the presenting complex internal bio-psycho-socio-cultural factors and external environmental factors that recognisably influence the birthing process (Smythe et al., 2016).

2.3 Epidemiological Trends in Childbirth

In Ireland, prior to the Irish Government setting up the National Hospital Advisory Council in 1947, within the new Department of Health (DoH), the majority of women chose to give birth at home. By 1957, the Irish Department of Health (DoH) promoted hospitals as the safest place for a pregnant woman to give birth, similar to other European countries as well as the UK, Canada, New Zealand and Australia. Pregnancy and childbirth now account for the largest number of hospital admissions in Ireland today (National Maternity Strategy 2016-2026), as 99% of women choose to give birth in hospital, in consultant-led units (DoH, 2016; O' Reilly & Hanafin, 2016). Women desiring home births in Ireland between 2012 and 2022 were only 0.5% of all childbirths. However, this trend is reversing, where in 2022, 432 women desired a homebirth, representing 0.8% of childbirths in Ireland (San Lazaro Campillo et al., 2024). Since 2004, the USA has also seen an increase in home birth rates, where MacDorman and Declercq (2018), report out-of-hospital births accounted for almost 2% of childbirths in 2023, up from 1.61% in 2017. The authors further report that American women who choose a home or birth centre for childbirth are doing so despite it costing them more financially. They believe it is safer, reduces the risk of medical interventions, and gives them a greater sense of autonomy around their childbirth experiences.

2.4 The Bio-Medical Model of Childbirth: Psychological Impacts

2.4.1 Active Management of Labour: Taking Over Control

In 1972, following on from the Irish DoH promotion of hospital childbirth, a pioneering, biomedical, technocratic maternity care approach was introduced by O'Driscoll, a Dublin-based Obstetrician. Women's labouring processes were observed, monitored and skilfully managed in this transformative active management of labour. Once they exceeded 12 hours, their labours were augmented with intravenous syntocin and or an operative delivery (Grigg et al., 2014; Liston, 1995; O'Driscoll et al., 1973). O'Driscoll believed the active management of labour, which progressed women faster through childbirth, was vital to achieving a safe and successful delivery for a mother and her baby. He further contended, this accelerated bio-medical approach to labour would allow midwives to give more intensive care to mothers. However, in practice, Irish midwives' work output tripled that of their UK colleagues, as they kept up with the accelerated demands of the active management protocols. Begley et al. (2011), argued that this overfocus on the monitoring and control of women's physical progress during childbirth left midwives with little time to address the psychological impact of this activity on a mother and her baby. Nonetheless, the active management of labour subsequently spread across most of the English-speaking world. Only where women's labouring was less than 12 hours, thereby exceeding expectations, were previous practices of skilled observation known as masterly inactivity permitted, with the alleviation of a woman's pain being the main concern.

It has undoubtedly contributed to the steady reduction of mortality rates for both mothers and their babies (Liston, 1995). Maternal deaths related to pregnancy or childbirth in Ireland were 4.69 per 1000 live births in 1938, reducing to 2.15 per 1000 live births in 1947 (DoH, 1947), 1.88 per 1000 live births in 2016, and zero in 2019. The perinatal infant mortality rate in Ireland was 29 per 1,000 live births in 1947, reducing to 7.3 per 1,000 in

2007, 5.8 per 1,000 in 2016 (CSO, 2016), 5.64 per 1,000 in 2019 (CSO, 2019), and 3.0 per 1,000 in 2023 (CSO, 2023).

2.4.2 Unintended Outcomes: A Conflict of Needs

Murphy-Lawless (1998), in her book *Reading Birth and Death* argues that Midwife-led care sharply declined with the introduction of consultant-led biomedical-technocratic childbirth care. Murphy-Lawless further asserts that the unintended cost to women has been the reduction in their sense of agency, knowledge and skills around childbirth, as well as the expectation for more perfect outcomes. Death in birth now goes largely unspoken about, including when a baby is born with a malformation (Murphy-Lawless, 1998). Seibold et al. (2010), in an exploratory descriptive study using a modified participatory approach, observations, and focus groups, with 18 Australian midwives, from across care disciplines, found midwives perceived themselves to be the gatekeepers of the ideal birth space. However, they experienced that their practice and care were hindered by the risk perspective of the bio-medical discourse, thereby interrupting the essential symbiotic flow between mother and midwife needed to craft a positive childbirth outcome. In a qualitative study across locations, Butler (2017b), subsequently used thematic network analysis to explore the experiences of 14 midwives and the strategies they used to support a normal birth in British Columbia, Canada. Midwives actively created a conducive home or low-tech birth environment to support optimum childbirth outcomes. They provided vital continuity of care ensuring the expectant mothers were informed in their choices. Providing masterly inactivity, they carefully watched and waited as they prepared the women to manage their expectations in early labour. Later, they supported them to cope when in active labour, using their accumulated midwifery skills.

Consequently, the WHO no longer recommends the active management of labour as an appropriate childbirth care option. They recognise, albeit an unintended outcome, that women are dissuaded of their right to exercise choice and autonomy around their childbirth process (WHO, 2018). Despite this WHO directive, the active management of labour continues to be practised today. including where normal-risk women are now offered an elective induction at 39 weeks' gestation, on request. The increased prevalence of women seeking to be induced at 39 weeks indicates this expectation has become embedded as a bioecological norm for both service users and service providers. This notion is reflected in the findings review of Downe et al. (2018), which demonstrates that current childbirth practices have changed little since O'Driscoll pioneered the active management of labour. They continue to centre around the management of risk, the accessibility to available interventions, and the efficiency of the service, depending on budgetary constraints. Nicholson et al. (2024), in their recent Irish trial study explored the safety for women to be induced at 39 weeks as an outpatient, alleviating some of the pressures on an already challenged in-patient maternity care system. They found vaginal deliveries increased, while perineal injuries, instrumental deliveries and operative deliveries also all reduced. These findings indicated it was safe to electively induce women at 39 weeks' gestation as an outpatient. Grobman and Caughey (2020), meta-analysis concurred with these findings and also found neonatal unit admissions were reduced, as was respiratory morbidity for these women's babies.

However, a United Kingdom study showed these benefits were minimal, as only one adverse outcome was eliminated for every 360 women induced at 39 weeks (Muller et al., 2023). Furthermore, little appears to have been discussed with the women around the hoped for outcome of alleviating pressure on busy Irish hospital maternity care services by routinely offering induction at 39 weeks. Nicholson et al. (2024), also offered the women

who participated in this trial study targeted, individual, ongoing assessment, support, guidance and regular reassurance. Many studies evidence the positive influence on childbirth outcomes of this high level of supportive maternity care (Bohren et al., 2015; Downe et al., 2018; Hammond et al., 2013; MacLellan, 2020; Smythe et al., 2016), potentially influencing the high rates of vaginal deliveries at 76%. Therefore, measuring the care received in childbirth outcomes is becoming more critical, particularly as induction of childbirth as an outpatient at 39 weeks' gestation for normal/low risk first-time mothers is more recently promoted in Ireland, UK and USA, as providing greater choice, safe and effective outcomes for mother and baby, thereby providing an optimal care experience (Nicholson et al., 2024).

2.4.3 The Invisible Expectation: Unsupported, Unseen & Unheard

The overuse of technology and medical interventions was however found by Sadler et al. (2016), to be frequently in divergence from women's care needs, respect for their autonomy, and right to informed consent. Moreover, the WHO in 2018 acknowledged the increasing disparities found among the maternity care systems across the world, resulting in what Miller et al. (2016), termed medical interventions which are either too little, too late or too much too soon, leading to adverse childbirth outcomes.

Women's distressing childbirth experiences are, alternatively and or interchangeably, categorised as negative, difficult, and even traumatic, with prevalence rates varying widely across studies and countries from 6% to 45% (Algovik et al., 2010; Boorman et al., 2014; Gough & Giannouli, 2021; Henriksen et al., 2017; Neal et al., 2015). Henriksen et al. (2017), in their Norwegian mixed methods study of 1352 multiparous women, using thematic analysis, found that 21.1% reported their childbirth as a negative experience. Contributing factors identified included fear of childbirth, a history of abuse, dramatic and

unexpected childbirth complications arising, pain leading to loss of control, women feeling unsupported, unseen or unheard by their midwife; and women not being involved in decision making around their care.

Nagle et al. (2022), Irish quantitative study of 1154 women between one- and five-days postpartum shows similar findings, where 209 (18%) reported their childbirth as traumatic. Contributing factors reported were a history of depression, induction of labour, combined ventouse/forceps assisted birth, and PPH. 134 of these women completed the birth trauma scale when followed up six to twelve weeks later. Of this cohort, 4% were considered to have reached the criteria for PP-PTSD. A larger percentage of these women displayed symptoms of functional impairment, which was considered evident of sub-clinical PP-PTSD

Dekel et al. (2017), systematic review of 36 quantitative studies of a predominantly community cohort also found that a negative personal experience of childbirth was a predictive factor of postpartum post-traumatic stress disorder (PP-PTSD). They identified PP-PTSD rates in 4.6-6.3% of women who described their childbirth experiences as negative, while symptomatology was seen in 16.8%. Furthermore, a negative childbirth experience may be re-experienced in a subsequent pregnancy (Thomson & Downe, 2016), with more recent studies affirming there is an increased incidence of maternal and foetal birth trauma associated with an instrumental delivery (Muraca et al., 2017), PPH and 4th degree perineal tears (Ducarme et al., 2015; Rane et al., 2017).

2.5 Managing the Perception of Risk

It has long been recognised that women’s perception of their childbirth experience is acknowledged as subjective, as others who are present at the time of the birth may not share the same perception (Beck, 2004). Larkin et al. (2012), study of focus group

interviews with 25 women at three months postpartum showed similar findings. While women perceive their individual expectations of childbirth differently, the health and safety of their baby was their first priority, rather than the type of birth they experienced (Downe et al., 2018). Gallagher et al. (2022), in their recent Irish qualitative study corroborated these earlier findings, where they interviewed 30 clinicians, 15 pregnant women and two of their partners in three focus groups, and a further two women individually for their views on rising C-section rates. Results revealed that women, their partners, and clinicians all similarly perceive C-sections as a normal mode of birth in Ireland. However they differ in that the women perceived a vaginal birth as riskier, while clinicians were concerned that the risks from a C-section are now underestimated. Clinicians also felt increased pressure to perform a C-section on women where they perceived their inductions of labours as failing, or taking too long, further negatively influencing C-section rates.

The various elements influencing a woman's perception of their childbirth experience one month postpartum were also identified in a quantitative study of 920 first-time mothers, who gave birth in Sweden, had a normal pregnancy and a spontaneous onset of labour. The four major dimensions that emerged from this study were: 1. Women's sense of their own capacity, which was based on their perceived control, sense of self-efficacy, level of pain, and ability to cope well; 2. Their perceived sense of safety was based on their sense of security and either positive or negative memories of their childbirth experience; 3. The level of professional support experienced was based on information and care given by the midwife during childbirth, and 4. Participation was evaluated on the choices women were able to make in order to influence their individual childbirth experience (Dencker et al., 2010).

The WHO similarly argues that “most women want a physiological labour and birth, and to have a sense of personal achievement and control through involvement in decision making”, even where medical interventions are needed or wanted (WHO, 2018, p.1). Encouragingly, women who experienced childbirth complications, yet received quality care from their midwife, more often reported a positive childbirth experience (Henriksen et al., 2017). Accordingly, the women who give birth in Ireland and the maternity care service providers both recognise, it is neither realistic nor useful to hold an either/or position on physiological childbirth over the biomedical childbirth approach. Therefore, the National Maternity Strategy 2016-2026 identified three childbirth care pathways: supported care, assisted care and specialised care, based on normal, medium or high-risk care needs (DoH, 2016).

2.5.1 Women-Centred Care: Respect and Choice, Preserving Basic Human Rights

The disquiet among women, their partners, and childbirth advocates, despite advancements in childbirth care outlined above, has prompted the emergence of an evolving third approach, the person-centred approach to midwifery care and childbirth. This is a holistic, respectful human rights, evidence-based women-centred care approach, which neither undermines the medical model of care nor overly relies on the natural physiological childbirth processes (Rane et al., 2017). Several studies show that when these core conditions are present to meet a woman’s individual care needs in childbirth, outcomes are improved, women feel satisfied and empowered, with the potential for birth trauma reduced (Bohren et al., 2015; Downe et al., 2018; MacLellan, 2020; Smythe et al., 2016). Many benefits are emerging from their findings. The length of labours are reduced; spontaneous vaginal deliveries are increased; less pain relief is required; C-section rates are reduced; and maternal fulfilment is increased. Physical health outcomes for the baby are also improved, as evidenced by better Apgar scores at 5 minutes postpartum (Bohren et

al., 2015). In this way, the person-centred approach to respectful maternity care recognises and facilitates the need for flexibility in all childbirth situations, as one size does not fit all. It offers some protection against the oppression and disservice resulting from the mistreatment of perinatal mothers and their babies (McGarry et al., 2017).

Person-centred, respectful midwifery care aims to find a balance between the physical, psychological and interpersonal care needs of pregnant and labouring women to optimise the safe delivery of both the mother and her baby (Fontein-Kuipers et al., 2018; Sposato & Miller, 2024). Turner et al. (2020), corroborated these findings in their systematic scoping review of 21 studies from 10 countries, where 17 were multicentre and nine had over 30,000 participants. They explored the associations between midwifery and nurse staffing of inpatient maternity services, with outcomes and quality of care. Findings revealed, childbirth biomedical interventions reduced, and outcomes improved with increased midwifery staffing levels as there was a reduction in the use of epidurals, augmentation of childbirth, perineal damage at birth, postpartum haemorrhage, maternal readmission and neonatal resuscitation.

As far as possible, a collaborative responsive approach to supporting the mother's desires and choices, regardless of care pathway, is encouraged, including the seeking of informed consent where and when a change in her care pathway is recommended. The WHO acknowledges that the specific care approach taken to women's childbirth determines the extent to which labouring women perceive their ability to stay within their own internal control, or are being externally controlled, by environments, events, and personnel around them (WHO, 2018).

Therefore, positive childbirth experiences have been consistently identified with respectful care, a trusting relationship, choice, control and participation in decision making (MacLellan, 2020). It is evident from this current review that the type of care women receives during childbirth, the quality of the clinical environment they give birth, the social norms and cultural beliefs they adopt, as well as the personal attributes they develop, all influence the quality of women's individual childbirth experiences (Smythe et al., 2016).

2.6 Women's Lived Childbirth Experiences

2.6.1 A Positive Experience: Defined and Elucidated

In a Swedish longitudinal qualitative study, Karlström et al. (2015), explored women's experiences of a positive hospital childbirth. Using a Likert scale, which ranged from a very positive to very negative rating, 26 women self-assessed their childbirth experience at two months, and again at 12 months postpartum. Six to seven years after the initial study, the women participated in focus groups of 2-5 participants. This time lapse was specifically chosen to give women the space to process their experience. The collected data was then analysed using thematic analysis, where two major themes emerged. A positive childbirth experience was had when: 1. The women experienced their individual strengths and abilities, and 2. experienced a supportive, trustful relationship. Six sub-themes were further identified: (a) Having positive expectations with a feeling of confidence; (b) Being physically and mentally prepared; (c) Having a sense of control to relax and be able to let go into the process of giving birth; (d) Feeling safe, seen and heard; (e) Being guided through the process of childbirth by the midwife; (f) Staff and parents working together as a team (Karlström et al., 2015). These necessary conditions reflect the dynamic capacities that women require as they give birth. Undoubtedly, they contribute to women's empowerment, or their lack to their disempowerment in pregnancy and childbirth, impacting their level of satisfaction with their childbirth experience. In this next section, a

health-ease or salutogenic childbirth will be explored, alongside how satisfaction in childbirth is influenced.

Furthermore, The WHO (2018, p.1) defined "a positive childbirth experience as one that fulfils or exceeds a woman's prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment, with continuity of practical and emotional support from a birth companion(s) and kind, technically competent clinical staff". In a recent systematic review of 37 studies involving 19 countries investigating what matters to women during childbirth, Downe et al. (2018), findings corroborate the WHO's definition of a positive, fulfilling birth experience.

2.6.2 Childbirth: A Salutogenic Perspective

Recent childbirth research focuses on evidence-based practice that is striving to move from a pathogenic (dis-ease) to a salutogenic (health-ease) approach to maternity care, where perinatal events are understood, managed and meaningful for perinatal women. This enables women and families to flourish from a psychological, social and spiritual perspective and not just physically (Ayers, 2017). A Salutogenic approach is a biopsychosocial approach to health and disease developed by Antonovsky in 1996. In his Salutogenic Model of Health (SMH), he asserts that salutogenesis or the genesis of health, is not about the absence of pathogenesis or disease; rather, they both exist on a continuum with each other. Therefore, as we all exist within various degrees of tension between health and illness, the focus needs to be on promoting low-risk behaviours, rather than risk reduction. This moves our perspective from dis-ease to health-ease (Antonovsky, 1996).

2.6.3 Satisfying Childbirth: Understandable, Manageable, and Meaningful

Salutogenic maternity care theory promotes a health and wellness approach to maternity care provision. Comprehensibility, manageability, and meaningfulness were three key salutogenic concepts used in the best-fit framework analysis of 31 qualitative studies from ten high-income countries (Mathias et al., 2021). Comprehensibility related to women being predictably supported by a midwife, in a predictable system, to prepare for the unpredictability of their lived childbirth experience. Manageability refers to midwives providing sufficient care, which supports a woman's internal and external resilient capability, through increased family and community supports. Meaningfulness required midwives to build a supportive relationship with perinatal women, so they autonomously engaged and committed to their childbirth process. These three concepts are also commonly referred to as 'Sense of Coherence' (SOC).

Antonovsky's SOC was found to be a predictive factor in women's health and resilience to childbirth stressors in an Australian longitudinal study exploring the association between Women's SOC, childbirth outcomes and factors influencing SOC changes (Ferguson et al., 2016). Women's SOC was found to be increased at eight weeks postpartum, when they were satisfied with their childbirth experience. Correspondingly, it was decreased with their dissatisfaction, because of an assisted delivery and or receiving an epidural. C-section rates were 50% lower in women who had a high SOC antenatally. High antenatal SOC scores were found to be associated with older pregnant women who had high social support levels and a low incidence of depression antenatally (Ferguson et al., 2016).

Bossano et al. (2017), in an American longitudinal study, substantiated that women's mode of delivery influenced their perception and satisfaction with their childbirth experience, using the Salmon satisfaction scale. In this study, the differential scores of fulfilment, distress, and difficulty were measured. Their study assessed 576 mothers between 10 and

17.5 years later, on childbirth satisfaction in relation to their first childbirth when compared with their mode of delivery, Women who delivered vaginally reported greater satisfaction and less distress than those who delivered by C-section, while women who delivered by C-section and had not laboured, reported the highest rates of median fulfilment and lowest median difficulty scores. Women who experienced a spontaneous vaginal delivery had the lowest median distress scores. Higher difficulty scores were noted for women who had an induction of labour, a prolonged second stage of labour and a C-section, but not when they had a vaginal delivery. Correspondingly, all 3 scores were negatively impacted for women who had an operative vaginal delivery.

2.6.4 Empowering childbirth: Confidence Matters

For women to experience physiological childbirth as a psychologically empowering journey, they need to receive the necessary internal and external physical, psychological, and social supports. Many recent studies demonstrate comparable findings to support this view.

In their concept analysis of 97 papers ranging across all continents, Nieuwenhuijze and Leahy-Warren (2019), explored women's perinatal empowerment. The external factors identified were gender equality, access to and control over resources, meaningful interconnections with care providers, and facilitation of women's choices and decisions. Internal factors included: women's belief in their ability to achieve meaningful goals, having control over their situational context, as well as the behaviours of those around them, in addition to themselves. Furthermore, Olza et al. (2018), in their meta synthesis of eight qualitative studies involving 94 women, concluded that by fulfilling these needs, women enhanced their belief in their capacity to give birth, and in turn, prevent interruptions to physiological childbirth. Moreover, Neerland (2018), had similar findings

in a concept analysis of 24 articles across 11 countries, relating to labour and childbirth. She found women's confidence to achieve a physiologic birth was grounded in their belief that childbirth is a normal process, which they have an innate capacity to achieve. She further argues that women's self-belief and confidence are fostered by 1) ascertaining information that increases their knowledge around physiological childbirth and, 2) with the social support from a trusted maternity care provider, situated within a safe environment. Neerland (2018), has also sought to define a woman's confidence in relation to her internal capacity to achieve a physiologic labour and childbirth as she navigates her external world.

Comparably, a qualitative content analysis study completed in Sweden by Ronnerhag et al. (2018), demonstrated that women's sense of safety in childbirth is enhanced when they are involved, informed, and guided in the process of childbirth. 16 new mothers, who had given birth within the previous 12 months at a regional hospital, participated in one-on-one interviews. They found that safety is achieved through the shared experience of giving and receiving trustworthy information, rather than information that has little meaning, is misleading, and lulls them into a false sense of security. Alternatively, when the mothers were left uninvolved, they felt ignored.

2.6.5 Childbirth Satisfaction: Influence of Space and Place

As noted by Nieuwenhuijze and Leahy-Warren (2019), Olza et al. (2018), and Neerland (2018), the importance of space and place is gaining more significance, particularly from a psychological perspective for those involved in the achievement of optimum childbirth outcomes. Positive and successful childbirth outcomes from midwife-led care units are well documented for low-risk pregnant women. Multiple international studies demonstrate that the safe care of low-risk mothers and their babies is not compromised in midwife-led units, as opposed to consultant-led units (Begley et al,. 2011; Dencker et al., 2017;

Hundley et al., 1994; Sutcliffe et al., 2012; Tian et al., 2017; Walsh & Devane, 2012). Ireland is no exception as an unblinded Irish randomised trial study comparing 1,653 low-risk pregnant women attending consultant-led units versus midwife-led care units, at a 1:2 ratio, demonstrated that up to 40% of the women booked into consultant-led units were suitable to be cared for in midwife-led units. A reduction in all areas of medical intervention was noted, where continuous electronic foetal monitoring and augmentation of labour were found to be statistically significant between groups (Begley et al., 2011).

Similarly, Gregory et al. (2023), in their mixed-method survey comparing the childbirth experiences of 141 women who had the dual experience of a home and a hospital childbirth between 2011 and 2021, found that women's satisfaction for homebirths over hospital births was higher. They were also higher for midwifery-led care over consultant-led care. Their qualitative analysis found that what mattered to their participants was to be able to: give informed consent that was informed, regulating their childbirth experiences through shared decision making; the absence of unwanted or unwarranted interventions, ensuring their bodily integrity was respected; to have a continuity of carers and establish a rapport with them. All of the study's participants motivatingly wanted others to have a similar opportunity and experience a homebirth.

Smythe et al. (2016), in their philosophical hermeneutic analysis of a New Zealand community based childbirth, case study exploring the notion of a good birth, found it was the coming together of many elements, not just place and space, that supported a sufficient collective confidence, and oneness between place, space, mother with midwife, and other, to achieve a good birth. In taking Heidegger's notion of the fourfold (earth and sky, divinities and mortals), they found that a particular woman with all her individual history, is in a particular place and space, at a particular time, instinctually attuned in her decision

making, including to the behaviours of the midwife. It is the melodic tone of the midwife's voice that inspires trust, that together they can meet and surmount the risk of death in birth to achieve a good birth.

The next section describes the poor outcomes that may occur when childbirth is interrupted.

2.7 Dissatisfaction in Childbirth

Despite the ongoing focus on maternity care improvements, the Irish National Maternity Experience Survey conducted in 2020 found that 15.3% of women giving birth in Ireland continue to describe their overall maternity care experience as fair to poor (HSE, 2020).

This is in spite of the WHO (2018) stipulating that it is all women's human right to receive respectful, holistic midwifery care while giving birth, so that mothers and their babies thrive and fully realise their potential for well-being. These findings importantly support and contribute to the rationale for this qualitative research study. Just as women's positive experiences of childbirth have been found to positively influence the later well-being of a mother, her baby and their immediate family (Fenech & Thomson, 2014; Glover, 2014). The alternative is also true as French & Thomson, (2014) found that women's experiences of a distressing childbirth are found to have negative consequences postpartum for a woman and her family.

Furthermore, Wigert et al. (2019), in their meta-synthesis of 14 qualitative papers, across three continents, Australia, Northern Europe and the USA, found women who experience a traumatic childbirth go on to develop an intense fear of childbirth, despite having no previous fear of childbirth. Women reported they had no choice but to suffer the

consequences of their traumatic childbirth and face their fears, as they were often met with little understanding of their circumstances. Their intense fear negatively impacted their future pregnancies and childbirth. Therefore, women strategised and managed their fear by having fewer children than they wanted, chose to give themselves an exit through a C-section, or sought support from their partners, their family or a supportive midwife. Fear of childbirth may go on to vicariously impact other women who hear of their terrible childbirth experiences. Moreover, the well-being of the father can be adversely impacted when their partner experiences a traumatic childbirth, which in turn, was found to negatively affect a couple's relationship with each other, their relationship with their child, and their child's ongoing development (Johansson et al., 2020).

A mixed-methods systematic review of 42 studies found the least positive outcomes involved obstetric interventions, in the form of an assisted vaginal delivery (AVD) or emergency C-section, when compared to an elective C-section. Equally, an AVD following a previous C-section tended to have a similar negative outcome. Participants identified that an AVD was an inconceivable option for them prenatally. Instead, they had focused on imagining either a physiological birth or a C-section. Comparably, fathers in the same study found themselves unprepared for an AVD, as they believed there were just too many variable outcomes for it to be realistically considered from the outset (Crossland et al., 2020). Gamble and Creedy (2005), illuminated in their study the comorbid interplay between maternal and foetal birth complications. They used the American Psychiatric Association's DSM-1V criteria to assess maternal symptoms of trauma and or Post Traumatic Stress disorder, associated with each woman's childbirth experience and specific mode of delivery. Their study involved 400 Australian women attending three public ante-natal clinics. All 400 women were assessed for trauma symptomatology at 72 hours and 4-6 weeks postnatally. Their findings showed a highly significant co-relation between operative delivery and

trauma symptomatology, both for instrumental deliveries and emergency C-sections. Seventy-three per cent of women who delivered by emergency C-section developed trauma symptoms, while 33% went on to experience acute PTSD, and 79.3% of women who had an instrumental delivery developed trauma symptoms.

2.8 Distressing Childbirth: Traumatic Childbirth Outcomes

2.8.1 Distress: An Omnipresent Concern

O'Donoghue et al. (2025), in their integrative review found healthcare professionals felt deficient in the skills, knowledge and referral resources needed to give optimum psychological care to impacted perinatal women, who experienced psychological childbirth trauma or CB-PTSD. Healthcare staff were further frustrated by the fragmented mental health care system that was available, with its poor communication strategies. Furthermore, Horesh et al. (2021), argue for CB-PTSD to be treated as a unique sub-type of PTSD, as it is the only mental health disorder that develops out of a life event that is considered socially positive. For some, childbirth is frightening and anxiety provoking resulting in a PTSD diagnoses for 3% amongst low risk and up to 16% for high risk perinatal women (Furuta et al., 2018), with a prevalence of 1.2% amongst their partners (Heyne et al., 2022; Kranenburg et al., 2023) However, the acknowledged subjective, stigmatising and shaming impact on predominantly females, means CB-PTSD is often under acknowledged by society as well as being underreported by the women themselves (Horesh et al., 2021).

Encouragingly, Arora et al. (2025), in their very recent validation study of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) frequently used Posttraumatic Stress Disorder Checklist assessing 20 symptoms for CB- PTSD, strongly

corelated with the findings from a clinician-administered PTSD scale for the DSM 5. In a sample of 59 perinatal women who reported a traumatic birth experience (median 4.6 months) 35.59% met the DSM 5 criteria A for PTSD, where there was an actual or perceived threat or potential threat to the life of the mother or her baby or physical injury. Using a cut-off point of 28 rather than 32, correctly diagnosed 86% of perinatal women experiencing CB-PTSD. While the cut-off point of 32 was diagnostic of perinatal women with more severe CB-PTSD. This suggests the DSM 5 PTSD checklist is a potentially reliable screening tool to be used by healthcare professionals for the early diagnosis of CB-PTSD amongst perinatal women who report a traumatic childbirth experience. This would in turn allow for early and targeted psychotherapeutic interventions to be offered. However, further validation of these findings is needed amongst a larger cohort of perinatal women.

Bartal et al. (2023), analysed 995 women's narrative accounts of the most distressing aspect of their childbirth experience, using a natural language processing model and machine learning algorithms to identify CB-PTSD. They found narratives were longer, emotional language used was more negative, particularly including more references to death, amongst the women who experienced PTSD in comparison to those who had no CB-PTSD. Diagnosis of CB-PTSD was 80% accurate. Therefore childbirth narratives, have the potential to be used as an early screening tool for accurately identifying CB-trauma with the support of machine learning algorithms. Furthermore women who have the opportunity to tell their story and construct their narrative during the early postnatal period, have a greater capacity to psychologically adapt to what happened to them.

Therefore, this qualitative study will also add to the growing literature on the converging factors in women's language use following a distressing childbirth. Thus supporting

psychotherapists to more easily identify perinatal women who are experiencing CB-PTSS, or CB-PTSD.

2.8.2 Childbirth trauma: Woman-Centred Definition

Reed et al. (2017), in their mixed-method online study of 943 women from around the world, used thematic analysis to analyse 748 participants' answers to the question about their traumatic childbirth. Two-thirds of the participants reported their traumatic childbirth experience resulted from care providers' actions and interactions, while the remaining third described a complication of their childbirth, or their baby being admitted to the neonatal special care, as the issue.

Therefore, Leinweber et al. (2022), developed a woman-centred inclusive definition for childbirth trauma in their efforts to guide practice, education and research. They consulted widely with both experts and stakeholders, as no clear definition of childbirth trauma existed. They defined a traumatic childbirth as one where, *"women experience their interactions or events relating directly to childbirth as causing them overwhelming, distressing emotions, and reactions, which lead to a short and or a long-term impact on a woman's health and well-being"* (Leinweber et al., 2022b, p1). This definition further recognises the traumatic impact of poor healthcare provider interactions and obstetric violence.

2.8.3 Obstetric Violence: A growing Phenomenon

It was in Latin America, the term obstetric violence was first used, and is now legislated, to highlight the growing concern there, for women's wellbeing postpartum (McGarry et al., 2017). Obstetric violence in Venezuela is understood to occur when the natural phenomenon of pregnancy is pathologised, medication use is abused, women are dehumanised and disempowered through the loss of autonomy and choice around their

decision making, thereby adversely affecting their future well-being (McGarry et al., 2017). Elsewhere, Keedle et al. (2022), carried out a content analysis of 626 open-text comments from a 2021 Australian national survey of women who gave birth over the previous five years. Three main categories were generated, showing similar results to Venezuela's understanding of obstetric violence (OV). Women felt dehumanised, violated, and powerless. They reported incidences of bullying, coercion, non-empathic care, and physical and sexual assault. While, disrespect, abuse and non-consented vaginal examinations were the sub-categories that received the most comments. Martín-Badia et al. (2021), in a qualitative phenomenological study of 24 midwives, in three focus groups, explored their experiences of obstetric violence from an ethical perspective. The study revealed that obstetric violence negatively impacted midwives' bioethical principles of non-maleficence, beneficence, autonomy, justice, vulnerability, dignity and integrity. This is regardless of it being subjectively called obstetric violence or not. Therefore, Martín-Badia et al. (2021, p1), argue that obstetric care needs *"better humanising"* considering the ongoing extent of the women's negative experiences of childbirth.

Feelings of dehumanisation and disempowerment were equally evident in an Irish mixed-methods study of 531 participants. Women who participated in the study. involving four maternity hospitals and a pilot hospital in Ireland, evaluated their childbirth preferences using a discrete choice experiment (DCE). Women prioritised their access to pain relief, followed by partnership with their midwife and then receipt of individualised care. They placed less priority on shared decision making, the presence of a consultant obstetrician, or the use of childbirth interventions (Larkin et al., 2017). Although not termed obstetric violence, these feelings of dehumanisation and disempowerment caused distress through the loss of women's sense of self. Women's dehumanisation was evident in their doubt of their ability to hold onto their own desires for their childbirth experience, within an

intensely medicalised and hierarchical system. As a result, Irish women's access to pain relief superseded all other desires. Consequently, feelings of terror and horror at the thought of not having access to pain relief were experienced by the labouring women (Larkin et al., 2017). A mixed-method online study of 748 women, which focused on the impact of both the actions and inactions of the maternity care centre, identified that women's needs were often detrimentally dismissed through coercion and aggression. Participants reported staff often used the foetus' risk of morbidity to gain maternal agreement for medical interventions (Reed et al., 2017).

Bohren et al. (2015), in their mixed methods systematic review identify that maternity care failures, which result in practices that are neglectful, disrespectful, and or abusive, must be addressed from an integrated multidisciplinary level by healthcare providers, healthcare systems and healthcare policy makers. Recent studies are beginning to focus on timely interventions for women who experience a distressing childbirth, as well as on what happened to them. Studies exploring various forms of therapeutic interventions are discussed in the next section.

2.8.4 Childbirth Trauma Interventions

Little has been explored around the efficacy of therapeutic interventions, including in-depth holistic psychotherapy care models. In a randomised controlled trial study of 2,419 postnatal women in the northwest of England, Slade et al. (2020), document a 28.1% incidence rate of traumatic childbirth experiences when screened at 6-12 weeks postnatally. Similar to other studies, eligible participating women were more likely to have experienced an induction of labour, childbirth in an operating theatre, an instrumental birth, an emergency C-section, blood loss exceeding 1,000 mls, or their baby's Apgar score was less than seven at five minutes. 336 out of 678 participants were assigned to a group

receiving postnatal maternity care. This included a self-help leaflet and an online video outlining how to support their own psychological responses postpartum, in an effort to prevent the development of PTSD following their traumatic childbirth experience. 342 other participants received the usual available postpartum care. The self-help group showed no significant difference in the later incidence of PTSD development versus the usual care group. Therefore, Slade et al. (2020), concluded that self-help literature without sufficient professional support, for postnatal women who experience a traumatic childbirth, is inadequate and therefore inadvisable in the prevention of later PTSD. In contrast, Loughnan et al. (2018), systematic review investigating the efficacy of perinatal anxiety-based interventions showed significant reductions in participant symptoms following an online group or pharma-psychological treatment intervention.

Furuta et al. (2018), in their systematic review and meta-synthesis examining the efficacy of trauma-focused psychological therapeutic interventions (TFPT) for postnatal women of all clinical trials reporting post-traumatic stress symptoms for the intervention and control groups or two time points of pre- and post-intervention involving 2,677 postnatal women found TFPT regardless of modality had a positive effect in the short to medium aftermath between 3 and 6 months postpartum. However, there was insufficient evidence to assess the efficacy of TFPT beyond 6 months postpartum. Nonetheless, the National Institute for Health and Care Excellence Guidelines (2014; 2020) recommends the use of Trauma-focused Cognitive Behaviour Therapy (TF-CBT) or Eye Movement Desensitisation and Reprocessing (EMDR) as effective high intensity psychotherapeutic intervention for Childbirth PTSD, offered individually or as a group by a qualified therapist.

However, Dekel et al. (2024), argued that there is no recommended treatment to mitigate against childbirth-related post-traumatic stress disorder (CB-PTSD). In their review of 41

clinical trials, they evaluated brief psychological therapies and trauma-focused therapies, such as cognitive behaviour therapy and expressive writing. They also reviewed memory consolidation and reconsolidation blockage, mother-infant-focused therapies and educational interventions. Of the 41 studies, 24 related to interventions alleviating the impact of PTSD following a traumatic childbirth. 14 studies were aimed at interventions to alleviate possible CB-PTSD, and 3 were aimed at preventing PTSD during pregnancy. Interventions had a moderate impact on PTSD following childbirth. A single therapy session within 96 hours of childbirth proved helpful. However, it was brief, structured, trauma-focused therapies and semi-structured, midwife-led, dialogue-based psychological counselling that proved the most beneficial. Their review yielded insufficient evidence to evaluate the efficacy of antenatal programmes on women who had developed PTSD symptomatology.

Jomeen et al. (2025), in their scoping review for effective health treatment practices of birth trauma, similarly, argue there is still no consensus on the most effective healthcare practice for childbirth trauma and or CB-PTSD. However, they suggest considerable progress has been made in the use of evidence-based interventions. Their review found a single session, delivered early face-to-face by a qualified practitioner, within 72 hours of childbirth was most effective, with no variation between a trauma or non-trauma focused intervention noted. Where therapeutic interventions occurred later, more sessions were required to elicit a positive effect. Digital delivery of sessions was also shown to be effective. However, feeling cared for, listened to and understood while perinatal women made sense of their traumatic experience evidently played a key role in the women's recovery. This is not new, as the quality of the therapist-client relationship has long been recognised as significant to the success of the therapeutic process regardless of the modality of therapy practiced (Cozolino, 2017). Accordingly, in brief interventions where

a supportive relationship was not established and or deemed necessary, little positive impact was achieved (Jomeen et al., 2025).

Kranenburg et al. (2023), in their recent interdisciplinary overview of CB-PTSD considered relevant literature alongside their clinical practice experiences in obstetrics, psychiatry and medical psychology. They advocate similarly to Horesh et al. (2021), for childbirth trauma to be given a unique position, considering its aetiology is acknowledged as rooted in what is generally perceived within society as a positive event. Furthermore, for some their socio-cultural norms situate childbirth's intensity, pain and unpredictability as stressful rather than have the potential to be traumatic and harmful. Therefore, focusing resources on the prevention in the early perinatal period alongside early intervention is key to reducing women's experiences of traumatic childbirth. Using PTSD checklists perinatally as a supportive early intervention tool, as well as giving time to discuss a woman's perception of her childbirth before discharge is warranted. They also argue the benefit to offering timely psychoeducation to women to help them understand their childbirth experience to offset PTSS.

Similarly Gough and Giannouli (2020), in their qualitative IPA study exploring six psychotherapists experiences of working with childbirth trauma argue for the unique nature of childbirth trauma within the context of its occurrence. They found perinatal women frequently lacked a space to tell their distressing childbirth story and work through their experience of loss, failure and misplaced self-blame. Some women were misdiagnosed as experiencing postnatal depression rather than childbirth trauma. The therapists were keenly aware the women needed to function sufficiently to care for themselves and their baby as they processed their childbirth trauma within the therapeutic space. They questioned if women are set up to fail where they develop unrealistic expectations of childbirth pre-

natally, rather than hold more realistic expectations, supporting them to have a greater flexibility in its unpredictability. All identified the need to explore previous adverse experiences, particularly in relation to what did happen that shouldn't have happened. As a result 5 of the 6 therapists took an integrative approach to their therapy sessions, recognising CBT does not work for everyone, despite NICE (2020) guidelines. All of the therapists agreed that the length of sessions needed was frequently dictated by the presence of other issues outside of the traumatic childbirth. While most of the therapist participants had a background in midwifery practice or as Doulas, which they felt was generally beneficial to their work, they refrained from discussing any organisational issues that may have impacted the woman's childbirth experience. This was despite recognising that the 'how' and 'what' of a woman's distressing childbirth needed to be explored.

Evident in this review is decades of childbirth research, carried out across all continents, inclusive of Ireland (Avery et al., 2014; Ayers, 2014; Basile-Ibrahim et al., 2024; Begley et al., 2011; Bohren et al., 2015; Boorman et al., 2014; Butler, 2017b; Daly et al., 2022; Keedle et al., 2022; Kitzinger, 2012; Kwee & McBride, 2016; Larkin et al., 2009; Leinweber et al., 2022a; Nieuwenhuijze et al., 2024). Yet, childbirth distress, its consequences on perinatal women and their families, remains an omnipresent concern worldwide. Childbirth as a psychological experience, demands an integrated, responsive, innovative and adaptive approach to the many emerging, challenging and unexpected perinatal care situations that present themselves. Despite The Irish National Maternity Strategy's (2016-2026) alignment with the WHO (2018), on respectful person-centred midwifery care, the recent restrictions imposed as a result of COVID-19 saw over 52,000 women and their partners sign a petition in December 2020 in Ireland (RTE, 2020). They demanded that Irish maternity hospitals meet their basic human right to have their birth partner present at the birth of their baby. Birth partners stressed they were already in the

same safety bubble as the expectant mothers and therefore hospitals could not legitimately exclude them from the birth. Restrictions were only lifted in May & June 2021, following a Health Service Executive (HSE) directive to maternity care hospitals not to cause any further psychological or physical distress to women and their partners by restricting access (HSE, 2021).

Therefore, we are required to consider perinatal women to be experts of their own experiences (Smythe et al., 2016). Women's evaluations of their own distressing childbirth experience need to be heard and included in research. This will provide a more comprehensive picture of the physical, psychological and emotional needs, including how these were met or not during pregnancy, childbirth and post-childbirth. However, a distressing childbirth does not happen in an isolated vacuum, rather it is co-created as a result of how women and those with women engage with themselves and each other perinatally (Murphy-Lawless, 1998; Neerland, 2018). Thus, the in-depth exploration of women's multifaceted, inter-subjective lived experiences of a distressing childbirth, including how they later make sense of it, is well served using a qualitative methodological approach.

Using an IPA methodological approach allows for the enrichment of our understanding of a phenomenon to be revealed (Smith et al., 2022), which, for this study, is a distressing childbirth, with its perceived impact among Irish women, their baby, their partner, and their family. Moreover, it supports the investigation of the enduring phenomenon of a distressing childbirth at a specific moment in time and over a cross-section of time (Ayers et al., 2016; Bossano et al., 2017; Maimburg et al., 2016; Takehara et al., 2014; Yawn et al., 1998) in Ireland after one year postpartum and up to ten years later. Privileging the individual unique perspective in this qualitative research study is distinguishable from the

privileging of a wider group perspective that is the focus of quantitative childbirth studies (Smith et al., 2022). Consequently, taking a qualitative IPA approach to this research study aligns with recent childbirth research where there is an emphasis on taking a salutogenic approach to care (Ayers, 2017; Mathias et al., 2021) to ensure that perinatal women receive evidence-based care that they can understand, is manageable and meaningful (Antonovsky, 1996). Therefore, continuing to add to the extant literature on women's perinatal experiences of childbirth distress is still a major concern.

2.9 Conclusion

This chapter has delineated the epidemiological factors that have influenced the trajectory of childbirth policies, processes and practices in Ireland. It further outlines how these were influenced by international guidelines and practices internationally, in particular the active management of Labour and respectful, person-centred care. Specific consideration was given to exploring the benefits of taking a biopsychosocial salutogenic approach to childbirth that supports it to be understandable, manageable and makes sense for all those involved. This is in contrast to the biomedical model and pathogenic approach to childbirth, that is often detrimentally influenced by external institutional and political policies and practices, leading to the possibility of harm. Therefore, examining the impact for perinatal women of a distressing childbirth in Ireland in this qualitative study will further inform healthcare professionals capacity to recognise and make worthwhile psychotherapeutic interventions in their care.

2.10 Reflexive Comment

In reviewing the literature for this study, I became familiar with the many research studies with a focus on childbirth, which have already been carried out. This focus varied, and

several interchangeable terms were used, from positive to negative, to traumatic to difficult. The term complicated appeared to be the umbrella term of choice where studies went across experiences. As I progressed through the review of the many studies, a pattern started to emerge. Many of the earlier studies were quantitative. Some were mixed methods, and more recently, qualitative studies have been equally the focus and are being called for to add to the perinatal women's experience of childbirth. Discovering the notion of a salutogenic versus a pathogenic childbirth was significant in my search for deciding where research needed to go and where I could identify a gap in the Literature. Next, coming across the call for qualitative childbirth research with a focus on the more inclusive umbrella term of distress left me feeling hopeful and relieved that I had at last found my direction. Thereafter, as I focused more specifically on qualitative studies and the notion of distress, I became aware of the terminology and language used by the various researchers to articulate perinatal women's salutogenic or pathogenic experiences of childbirth. While somewhat unconscious, this may have ensured that IPA as a methodology went on to be my chosen methodology for this study. Language used by the participants has a significant role and contribution to make, throughout data gathering, data analysis and in the writing up of the study. This ensured the privileging of the participants' individual experiences and voices as well as the commonalities across all participants.

Chapter 3: Methodology

This chapter outlines the aims and objectives for this study, exploring women's experiences of a distressing childbirth in Ireland. It examines the rationale for choosing an IPA methodology as an approach to answer the research question. Moreover, it illuminates how IPA's philosophical underpinnings further support an in-depth exploration of the research question. It delineates the processes used for participant recruitment, data gathering and data analysis, where IPA's 7-step methodological approach was closely followed, promoting this researcher's deep, reflexive engagement with the text during data analysis. Adhering and committing to IPA's rigorous processes, which were closely supervised, ensured the integrity of the study was figure throughout. Lastly, it discusses the careful consideration given to this current study's potentially vulnerable participants to ensure their ethical needs were met throughout the research process.

3.1 Research Question and Objectives

The research question devised for this qualitative study exploring women's experiences of their distressing childbirth in Ireland is as follows:

> *"How do women who self-identify as having had a distressing childbirth in Ireland make sense of the experience and its impact?"*

Accordingly, the objectives of the study are:

1. Explore the perceived impact of a distressing childbirth on women's sense of self, their relationship with their baby, their partner and their family.
2. Understand the intersubjective nature of women's lived experiences of their distressing childbirth in Ireland.

3. Illuminate how women navigated their way through this distressing childbirth experience and made sense of it.
4. Inform how women can be supported by psychotherapists and other healthcare professionals following their experience of this phenomenon, including the type and timing of these supports.

3.2 Rationale for Choosing a Qualitative Research Approach

A qualitative methodology was chosen for this study since it aimed to sensitively explore the multifaceted, rich nature of a given lived experience (Creswell et al., 2007; Yardley, 2000). It is a particularly useful methodology to use when carrying out a research study that involves an in-depth investigation of the subjective experience of health or even ill-health as a subject matter. This is in contrast to the isolating of observable, objective, influencing variables on health and illness that can be identified and generalised across a much larger participant group when using a quantitative methodology (Yardley, 2000). Therefore, how participants perceive their lived experience is prioritised in a qualitative research study over the incidence of an experience in a quantitative study (Smith et al., 2022). Consequently, a qualitative methodology has a goodness of fit with the aims of this research study, which are to explore in-depth women's lived experiences of a distressing childbirth in Ireland at a specific moment in time, over a cross-section of time.

Equally to be considered when choosing a methodology for this study was that women who experience distress perinatally are not always identified by the healthcare providers, despite frequent and regular contact (Rallis et al., 2014b). Some women who are known to healthcare providers to experience mental health issues prior to giving birth prefer to choose when, where, and if they require additional supports perinatally, rather than it be assumed they will want to avail of the supports offered to them (Nagle & Farrelly, 2018).

This reinforces the value of choosing a qualitative methodology for this study. Women get to exercise their personal agency when choosing to participate, as they are asked to self-identify as experiencing a distressing childbirth in Ireland. This is in contrast to having to respond to, often a predetermined definition of distress, which they must choose to fit into and subscribe to in order to participate. Choosing a qualitative methodology is therefore particularly considerate of sensitive topics, which involves unique and varied interpersonal processes, while taking into account the socio-cultural context of the study's participants.

Qualitative methodologies all have the potential to generate valid, flexible notions of truth, knowledge and reality, which are negotiated and co-constructed within participants' inter-subjective, bio-socio-political and cultural situatedness (Creswell et al., 2007; Yardley, 2000). Equally, a rigorous qualitative study demands a knowledgeable, skilled researcher in both the methodology and the topic area under inquiry in order that an opportunity to expand on earlier findings and insights is created (Creswell et al., 2007; Silverman, 2013; Yardley, 2000). Thus, in choosing a qualitative methodological approach there is an appreciation of the knowledge and the clinical experience brought by this researcher to exploring in-depth, the subjective descriptions, understandings and meanings of self-identified participants' lived experience of a distressing childbirth in Ireland. Furthermore, it supports a coherent, transparent and trustworthy research process and findings (Braun & Clarke, 2014) while demonstrating its capacity to be women-centred, as called for by Smythe et al. (2016).

3.3 Rationale for a Phenomenological Approach

A qualitative phenomenological approach was suitably chosen because its philosophy attends to our experiences of being human (Smith et al., 2022). It is through our use of language that what is concealed is revealed; thus, taking a phenomenological attitude

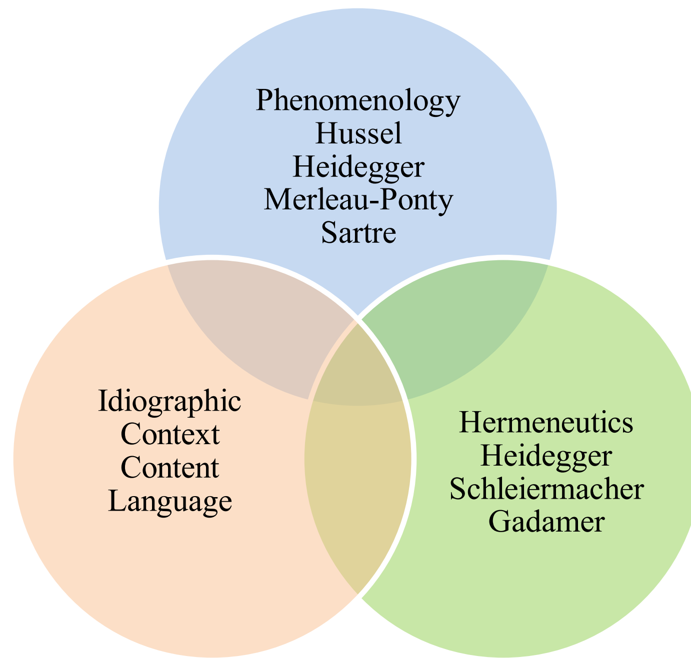
allows for careful consideration of what matters, the taken for granted, the overlooked, the individual diverging, as well as shared viewpoints (Finlay, 2009; Van Manen, 2017) of women's experiences of a distressing childbirth. A qualitative phenomenological approach sensitively guides the researcher towards a deep examination of participants' understanding and sense-making of their lived life (Finlay, 2009; Larkin & Thompson, 2011; Van Manen, 2017) due to their distressing childbirth. Moreover, a qualitative phenomenological methodology amplifies participants' descriptions of their subjective thoughts, feelings, behaviours, language, and social relationships. Its flexibility allows participants' descriptive voices to be valued and the unknown to be revealed (Biggerstaff & Thompson, 2008; Creswell et al., 2007; Willig, 2007), with its interpretative stance acknowledging the inter-subjective, co-construction of human experience that is uncovered during qualitative data analysis (Creswell et al., 2007; Finlay, 2009; Larkin & Thompson, 2011; Smith et al., 2009; Yardley, 2000).

3.4 Rationale for the Use of an IPA Approach

Deciding a study's methodological approach requires a goodness of fit between the process and the product that is desired by this researcher (Creswell et al., 2007; Sandelowski & Barroso, 2003; Starks & Brown-Trinidad, 2007). Qualitative data gathering can be perceived as a shared ethical undertaking between the researcher and their study's participants. Therefore, a researcher's commitment to and a personal experience of engagement with the topic being researched, inclusive of suffering, is seen as beneficial for this ethical endeavour (Yardley, 2000). Moreover, consideration must be given to the time and resources available for carrying out a qualitative research study (Silverman, 2013). As a result, three methodologies were considered for this study. A mixed-method inquiry combining a qualitative and quantitative approach was initially considered. However, it was precluded by the time limits of this doctoral programme. Discourse Analysis and IPA

were both considered for their focus on understanding how language shapes and reflects the inter-subjective, co-constructions and context of participant's psychosocial and political lived realities (Johnson et al., 2004; Starks & Brown Trinidad, 2007; Smith et al., 2009; Willig, 2007) Discourse Analysis was not chosen, as IPA's idiographic focus allows for some linguistic analysis. This went some way towards fulfilling this desire. IPA was chosen, as it is a qualitative, interpretative phenomenological approach that privileges the individual and thereafter the collective. While it was first situated within the discipline of psychology, and in particular health psychology, it has now grown and developed beyond the discipline of psychology into other areas of healthcare (Finlay, 2011), including maternity care. It aims to investigate how a particular group of participants make sense of their lived experience (Larkin & Thompson, 2012), comprehensively addressing their described, lived, individual experiences for content, context, and language (Larkin et al., 2006; Smith et al., 2009; Shaw, 2011; Smith et al., 2022). (Yardley, 2000; Eatough & Smith, 2017). Thus giving this study's participants the opportunity to voice their concerns, their complex understandings and sense-making of their distressing childbirth experiences. Equally, IPA's inquiry demands rigour and skill from the researcher, as it draws from the three core principles of: (1) Phenomenology, (2) Hermeneutics and (3) Ideography (Finlay, 2009; Smith et al., 2009; Smith et al., 2022). In this way, IPA as a methodology aligns with this current researcher's core training in humanistic and integrative psychotherapy, where the emphasis was on existential and Gestalt psychotherapy. Equally, its value of the idiographic supports her own value system and her many years spent working as a nurse and midwife, where every patient, mother, and family she cared for mattered.

Figure 1: *3 Pillars of IPA*



3.4.1 The Phenomenology of IPA

IPA is underpinned by several philosophies (Smith et al., 2022) and thus advances a pluralist view. Combined, they illuminate a collective appreciation of everyday human experiences that are individually lived (Yardley, 2000; Smith et al., 2009; Smith et al., 2022). Moreover, IPA philosophical underpinnings offer individual, converging and diverging viewpoints (Finlay, 2009). Husserl (Moran, 2000) argued that all scientific data is rooted in and drawn from our experiences of living within our lifeworld. To understand and make sense of our experiences, we must reflect on how we experience our experiences by intentionally focusing on the experience to be explored and understood. This is achieved, he believed, by the taking on of a phenomenological attitude when exploring real-life human experience (Van Manen, 2017). Researchers aim to suspend their natural attitude to adopt an open or phenomenological attitude to allow the essence of an experience to be uncovered (Finlay, 2009; Smith et al., 2009; Larkin & Thompson, 2011). Through reflective questioning, engagement and eidetic reduction, it is proposed that the essence of the lived experience as it is perceived unfolds (Smith et al., 2009). Thus, our

intuitive awareness and consciousness of the thing for itself are increased, and we arrive at a greater clarity or insight (Smith et al., 2022). Therefore, Husserl demands that, as researchers, we engage with our participants and their data with an open curiosity, which necessitates a setting aside of any held preconceptions around our participants or our area of investigation and study.

Heidegger, Merleau-Ponty, and Sartre all contribute an existential philosophical view where they emphasise a shared inter-subjective worldview. Heidegger (Moran, 2000) asserts that we are temporally situated in our lifeworld, which we are thrown into at birth and will end with our death. Our meaning and sense of self are created in response to how we engage with our lived experiences of being-in, and being-with our given world of people, culture, language and objects. Therefore, diverging from Husserl, Heidegger argues that the bracketing of our presuppositions is limited. (Finlay, 2009; Larkin & Thompson, 2011; Smith et al., 2009; Smith et al., 2022; Yardley, 2000).

Merleau-Ponty contributes a subjective, embodied, and symbiotic perspective where we experience our world through our body sensations, emotions and feelings. We reach out to meet, touch and feel ourselves and then the other, giving us a unique, subjective, corporeal way of relating within our lifeworld (Smith et al., 2009). The intention we ascribe to our corporeal experiencing of our lifeworld shapes the meaning we create from these experiences. Interruptions to our corporeal experiencing of the world through our body sensations, emotions and feelings force us into an eidetic reduction of our understanding of our perceptions. As a result, while we can observe and have empathy for another’s experiencing of their intersubjective lifeworld, we cannot be their body and so can never fully know their experience (Smith et al., 2009; Smith et al., 2022).

Correspondingly, Sartre suggests our existence precedes our essence, and therefore, we are always caught in the striving to become something or someone in our lifeworld. Our unique, individual meanings and understandings are created through our inter-subjective actions, inactions, presence or absence with others. How we experience our beingness within our lifeworld may be influenced and or interrupted when others are also present. (Smith et al., 2022). Hence, Sartre saw *"hell as other people"* (Moran, 2000, p 372). He elaborates how the absence of another that we expect to meet can leave us with a sense of nothingness. Alternatively, the unexpected presence and gaze of another watching us can increase our self-consciousness. Ultimately, we are situated in a biological, social, cultural, economic and political world of finite resources, which we must compete for. Sartre argues freedom comes from taking responsibility to engage with these imposed limits and restrictions, as a result of being in the world (Van Deurzen, 2004) Therefore, the embodied and moral impact as a result of the presence and or absence of others within our lifeworld brings their individual challenges (Smith et al., 2009; Smith et al., 2022), including during childbirth. Engaging with our lifeworld in this embodied way, where we touch and are touched by our world, including with others, is what gives us our unique perceptive and interpretations of our experiences.

3.4.2 The Hermeneutics of IPA

Hermeneutics' key focus is interpretation. It explores how and why we come to the interpretations that we arrive at, including our interpretation of past writings or events in the current time (Smith et al., 2022). Heidegger, although concerned with the phenomenological perspective of our existence and being-in-the-world (Dasein), argued that making sense of how we experience our experiences of Dasein can only be accessed through interpretation. In this way, he shared the perspective with other interpretative phenomenologists that we can never fully bracket our preconceptions and diverged from

Husserl's descriptive phenomenological perspective of adopting a phenomenological attitude. Heidegger believed that through interpretation, we can bring to light meanings that are easily available and visible, as well as meanings that are deeper, less available, and which must be uncovered. We can best support this interpretative stance as researchers by having an awareness of the influence of our prior experiences, our assumptions and our preconceptions, where they are informative but not interruptive and disruptive to our emerging, new interpretations of the available research data (Smith et al., 2022). In this way, Heidegger's writings underpin an IPA methodology where participants' experiences are privileged, as they are perceived as being the experts of their own experiences.

Schleiermacher according to Smith et al. (2009), further emphasizes the inter-subjectivity of language as central to how we are heard, understood, and interpreted, thereby increasing the value and richness of any analysed data He stressed the influence of our collective community on how we first gain and then use language, while equally significant is how we as individuals go on to shape our utterances of that language. Therefore, he saw the interpretation of a text or available data as a craft that is intuitively led. A skilled researcher may come to know the participant better than they know themselves and go on to offer a perspective beyond that of the participant that is both meaningful and insightful (Smith et al., 2022).

Gadamer also privileges the intersubjectivity of the interpretative process and views the process of interpretation as a fusion of horizons. Smith et al. (2009), assert that they question Schleiermacher's perspective of the skilled researcher coming to understand the author/study participant better than they understand themselves. Rather, he sees it as a dialogical engagement in the context of the present, with the happenings of the past, so that something novel can be uncovered. Like Heidegger, he suggests that we must take care to

consistently evaluate what our preconceptions are, as we move through the process of data analysis. Our pre-conceptions may only come more fully into the foreground of our awareness as a result of our exposure to the participants' data after it is collected (Smith et al., 2022).

To stay true to the participants' voices, IPA's data analysis demanded an open, fluid, iterative and reflexive interpretative engagement from this researcher. This reflexive, dialogical and circular interpretative engagement is known as the hermeneutic circle (Smith et al., 2022). It considers both the content and the context of our lived experiences and the significance of coming to an understanding of the dynamic interplay that occurs between them. Namely, that the part (content and descriptive language used) can be best understood as part of the whole (context), and the whole can best be understood when viewed from the part, which is known as the hermeneutic circle. Thus, IPA's hermeneutic approach to data collection and analysis facilitated this researcher to empathically question and interpret participants' own interpretations of their described lived experiences, which is known as 'double hermeneutics' (Smith et al., 2022). Double hermeneutics ensured the researcher' and the participant's interpretations of these experiences were equally valued (Biggerstaff & Thompson, 2008; Pringle et al., 2011). This rigorous process creatively formed, reformed and transformed the meaning-making of the data throughout analysis and write-up (Larkin & Thompson, 2011; Smith et al, 2009; Yardley, 2000).

3.4.3 The Ideography of IPA

IPA's idiographic approach appreciates the reflective, unique, individual and contextual contribution that investigating research participants' personal lived experience brings to our knowledge base (Pringle et al., 2011). IPA's purposive sampling, where participants are sought among a particular group of people who have a particular lived experience

within their lifeworld, acknowledges the paradoxical nature of our experiences where they are simultaneously individual and with others (Smith et al., 2022). IPA's small participant numbers allow time for a deep, detailed, rich understanding through systematic data analysis of each individual's research data, including how they use language to describe their lived experiences (Eatough & Smith, 2017; Larkin & Thompson, 2011; Smith & Osborn, 2015). This level of methodological rigour supports rich, credible, and dependable findings (Biggerstaff & Thompson, 2008; Yardley, 2000). Therefore, transferability of findings is only considered in the final exploration of convergence and divergence across all participants' data (Eatough & Smith, 2017), allowing for patterns of similarity and difference to be uncovered. Privileging this idiographic perspective is distinguishable from the privileging of the nomothetic perspective that occurs in the generalizability of quantitative psychological studies (Smith et al., 2022). Consequently, taking a qualitative IPA approach to this research study aligns with recent childbirth research where there is an emphasis on taking a salutogenic approach to care (Ayers, 2017) to ensure that perinatal women receive evidence-based care that they can understand, is manageable and meaningful (Antonovsky, 1996).

3.4.4 IPA Critiqued

Nevertheless, IPA has its critics. Van Manen (2017), argues that IPA is more accurately represented as a psychological inquiry and analysis of a participant's psychological experience rather than it being a phenomenological analysis of a phenomenon for and of itself. He further argues that achieving a phenomenological understanding of human experience by seeking to reveal the structures of lived experiences through eidetic reduction in order to gain insights is extremely challenging for the novice researcher. Furthermore, Van Manen suggests IPA's and other qualitative methodologies popularity have flourished as a result of their step-by-step guidance in support of the novice

researcher. This results in the generation of emotional, psychological, superficial themes rather than original and genuine phenomenologically generated meaningful insights. Zahavi (2019), agrees with Van Manen's perspective, where a less than discerning use of the term phenomenological will impact and reduce its significance. However, he further argues that Van Manen and Smith are both moving away from a philosophical phenomenology perspective, yet each individually claims their research approaches are phenomenological in nature. Zahavi emphasises that philosophers' phenomenological approaches are situated and developed within a context. Therefore, he suggests we must consider them in the context they were developed within, while carrying out a phenomenological analysis of participants' data. Smith (2018), in his rebuttal of Van Manen, argues that phenomenology is not owned by philosophy and that, to some extent, philosophers are only validating what we as humans are already doing in our interpretations of our lifeworld, including in health and illness. Furthermore, Smith et al. (2022), stress that IPA as a methodological approach is not aiming to operationalise a specific philosophical idea, but rather support consistent, sophisticated and nuanced data analysis and findings, supporting its relevance for this study.

3.5 IPA Methods

This section discusses in detail the processes used for participant recruitment, data gathering, and data analysis, which closely adhered to IPA's 7step methodological approach (Smith et al., 2009). A minimum of 6 with a maximum of 12 participants is recommended for an IPA study (Smith et al., 2009; Smith et al., 2022). Collected data is detailed, and a first-person account within the specified context of the research study and thereby is representative of a particular perspective rather than a population (Larkin & Thompson, 2011; Smith et al., 2022). This section will discuss the careful consideration given to this current study's potentially vulnerable participants. Therefore, women's

capacity and right to self-determine their participation, including how they participated, was factored in throughout this IPA methodological process. Their emotive voices and individual perspectives of their experiences of a distressing childbirth was valued, listened to, and heard.

3.5.1 Participant Sampling

Participant sampling adhered to IPA guidelines (Larkin & Thompson, 2011; Smith et al., 2009; Smith et al., 2022). Consequently, sampling was relatively small, purposive and reasonably homogeneous. Therefore, the maximum recommended number of 12 participants was sought for this study to best support rich, credible and dependable findings (Biggerstaff & Thompson, 2008; Yardley, 2000). Each participant was required to meet the study's inclusion criteria before they were accepted as a participant in the research study. Furthermore, this researcher, while developing the inclusion and exclusion criteria, sought to attend to potential ethical concerns of informed consent, as well as participants' psychological and emotional capacity and safety at this early stage of participant recruitment (Smith et al., 2022). At the forefront and from the beginning of the study, she held the intentionality that the needs of the participants at all times superseded those of the research topic (Greaney et al., 2012). The inclusion and exclusion criteria were as follows:

Participants:

1. Must have given birth in Ireland and self-identified as having experienced a distressing childbirth.
2. Must be living in Ireland, preferably within the Leinster area, so they are within a reasonable driving distance of this researcher.
3. Must be over the age of 18 years to give their informed consent to participate in the study.

4 Must be at least one year and no greater than 10 years following their distressing childbirth experience in Ireland. One year allows women time to recover from their distressing childbirth experience (Ayers, 2017) and gives them time to process and make sense of it (Karlström et al., 2015). While 10 years ensures women's recall of their distressing childbirth experience is still credible (Bossano et al., 2017; Takehara et al., 2014; Yawn et al., 1998).

5 Child, whose distressing birth is the subject of this study, must be living and generally well at the time of the study. This is to maintain the reasonably homogeneous sampling criteria.

6 Must be registered with a general practitioner (GP) practice in Ireland, to support their safe participation in this study, where they can gain access to the Counselling in Primary Care (CIPC) services or be referred to the perinatal Mental Health services or the Community Mental Health services if further support is required following the debriefing process.

7 Must have fluent English to ensure they fully understand the process to give informed consent and can give a detailed, rich, and reflective account through English of their distressing childbirth experience.

Participants were not included in the study if:

1. They were not fluent English speakers and therefore were unable to give informed consent or a detailed, rich, first-person account of their distressing childbirth experience.
2. They experienced a stillbirth, neonatal, infant or child death postpartum following their distressing childbirth experience. These women may be working through the grief process, are psychologically vulnerable and do not fit the homogenous sample required for this study.

3. They fit the inclusion criteria but are personally known to the researcher. This minimises researcher bias and the potential that participants feel overly influenced or coerced to participate in the study.
4. They were currently experiencing obvious and undue distress, as a result of their childbirth experience, thus increasing their risk of future and or ongoing mental health issues.
5. They were not registered with a GP.

3.5.2 Participant Recruitment

Participant recruitment only commenced once DCU's ethical approval was granted by Dublin City University (Appendix A). Ten participants for this study were accessed and recruited through healthcare practitioners, within the Leinster region, whose contact details were available on their relevant, publicly available, professional bodies' websites and whose client population included perinatal women. Therefore, permission was not needed before contacting them. Two of the recruited participants also informed three other participants about the study, who wished to participate. This is a well-recognised research recruitment process known as snowballing,

The following healthcare professionals' contact details were accessed via their professional bodies' websites, as outlined below:

- Accredited psychotherapists and accredited psychotherapy supervisors were accessed via the Irish Association for Humanistic and Integrative Psychotherapists (IAHIP) and the Irish Association for Counselling and Psychotherapy (IACP).
- Doulas were accessed via the Doula Association of Ireland (DAI), Doula Care Ireland and the Irish Doula Directory.

- General practitioners (GPs) were accessed via the Irish College of General Practitioners (ICGP).
- GP practice nurses were accessed via the Irish General Practice Nurses Educational Association (IGPNEA).
- Physiotherapists were accessed via the Irish Society of Chartered Physiotherapists (ISCP).

Professional practitioners who were contacted, as outlined above, were sent an email (Appendix B) introducing this researcher, this research study and how they could support the participant recruitment process. Included as attachments in the email were: a classified advertisement (Appendix C); a participant information sheet (Appendix D) in the form of a plain language statement (PLS) and the interview schedule (Appendix E); all of which supported an open and transparent recruitment process that was clear, detailed and easily understood. It ensured self-identified potential participants were sufficiently informed about the study when they initially contacted this researcher, through this study's secure designated phone number, via a password-protected iPhone XR, or DCU email address as provided.

All potential participants, once they contacted this researcher, were invited to engage in a more in-depth conversation. This allowed this researcher to determine if they had received the detailed written information about the study (Appendices C & D), fit the inclusion criteria, and their agreement to participate in the study was well informed. All participants were emailed a copy of the consent form (Appendix F) and, where requested, a copy of the interview schedule (Appendix E) following our phone conversation. This gave them time to familiarise themselves further with the study, prior to attending for their one-on-one interview. This ensured their consent was fully informed and ongoing. Only one potential

participant who made contact with this researcher was considered unsuitable to take part in the study at the time of the recruitment process. Her baby was only six months old at the time of making contact, and therefore she did not meet the inclusion criteria. She was advised of relevant, available support services during our brief conversation and had the details sent to her by email as requested (Appendix G). She was thanked for her time and interest at the end of our conversation.

Written informed consent was obtained prior to commencing each of the one-on-one semi-structured interviews (Appendix F). Participants were interviewed as they presented. Once 12 participants had been interviewed, all relevant healthcare professionals who had supported the recruitment process were sent an email to let them know the study was closed to any further participants, as the required number had been reached. They were thanked for their time and the support they had given to the recruitment process for this study.

Participants' demographic details obtained are outlined below:

Table 1: *Participants' key demographic details*

Participants' age range at interview	30-45
Participants' age range at the time of distressing childbirth	29-38
Chosen Maternity Care option	6 Public hospital with public consultant-led maternity care 5 Public hospitals with private consultant-led maternity care 1 Home Birth with private midwife, transferred to public hospital with public consultant-led maternity care for prolonged labour.
Participants' delivery outcomes	1 spontaneous onset and delivery + episiotomy 1 spontaneous onset +forceps + episiotomy 1 spontaneous onset + epidural + forceps + episiotomy 1 Spontaneous onset + epidural + emergency C-section. 1 Induced + spontaneous vaginal delivery 1 Induced + spontaneous vaginal delivery + tear 1 induced + emergency C-section 3 Induced + epidural +emergency C-sections 2 Elective C-sections
Participants impacted by Covid-19 restrictions	5 experienced childbirths under Covid-19 restrictions. 7 experienced childbirths prior to Covid-19 restrictions.

Baby outcomes	9 accompanied their mother to the postnatal ward. 3 admitted to Neonatal Intensive Care Unit (NICU) after C-section. 2 discharged to mother on postnatal ward. I discharged directly to home with mother.
Relationship Status	10 married at the time of childbirth and in the same relationship. 2 engaged at time of their childbirth. No longer in a relationship.
Fathers' age range at time of interview	32-52
Fathers' age range at time of childbirth	31-42
Participants' highest educational attainment	All 12 have 3rd level qualifications Ranging from Bachelor's degrees to PHD
Fathers' highest educational attainment	9 have 3rd level & 3 have 2nd level qualifications Ranging from Leaving Certificate to Masters
Children's age ranges at the time of interview. Equivalent to length of time since distressing childbirth	5 were 1-2 years 3 were 3-5 years 2 were 6-8 years 2 were 9-10 years

Children's Gender assigned at birth	9 male and 3 female
Family structure	5 participants have one child 4 participants have two children 3 participants have three children
Place of child within family, whose childbirth was distressing	9 were first-born 2 were second born 1 was third-born

3.5.3 Data gathering

Data was gathered using one-on-one in-depth semi-structured interviews. Where requested, participants were given a copy of the interview questions (Appendix E) in advance to alleviate concerns they may have had. This was in addition to the information on the likely content of the interview that was outlined in the plain language statement (Appendix D). Keeping with good ethical practice, participants chose the timing of their interview, as well as an appropriate, convenient venue that was as free far as possible from interruptions. Six participants were interviewed at this researcher's professional private practice, two chose to be interviewed at their professional offices, one chose to be interviewed in her home, and three chose to be interviewed at a convenient hotel.

Smith et al. (2022, p54), describe one-on-one in-depth semi-structured interviews as "a conversation with a purpose". Six to ten open-ended questions to generate a constructive and expansive conversation around participants' experiences were used (Biggerstaff & Thompson, 2008), allowing the participant the autonomy to lead and for a trustful rapport to build between the researcher and the participant (Smith et al., 2022). A pilot interview

was conducted with a professional colleague to ascertain the efficacy of the interview questions and to support this researcher's general preparation for participant interviews. During this pilot interview, the participant noted how having the option to avail of food and beverages during the interview was in stark contrast to the fasting imposed on her during labour and delivery. Consequently, this researcher factored in the availability of food and beverages, promoting further comfort, ease and agency for all 12 of the interview participants thereafter, where similar comments to the pilot participant were often made.

All interviews were audio recorded. Questions were asked: only where and when needed; sensitively and respectfully; one at a time. Questions moved from the general to the specific; in order to provide a caring and yet contained environment, for participants to talk freely about their distressing childbirth experience. Equally, gentle prompts, only where and when needed, kept the conversation focused, relevant, responsive to participants' answers and sufficiently flexible to follow interesting information (Ryan et al., 2009). Participants were given the time they needed and chose to take to complete their accounts. As a result, interviews ranged from one to three hours long. Therefore, the data obtained was detailed, rich and a first-person account of women's lived experiences (Larkin & Thompson, 2011). Due to the length of the interviews and the outpouring of information from the participants, a break was frequently requested and taken during the interview, where they also took the opportunity to avail of food and fluids.

This researcher wrote up field notes immediately after the interview of her informal observations, thoughts, and feelings, based on verbal and non-verbal responses or possible omissions, during the interview, to support data analysis. Interviews were transcribed verbatim, paying particular attention to repetition, hesitations and emotive expressions.

Transcripts were anonymised by using pseudonyms outlined and removing specific identifying information, such as maternity hospital names.

Research procedures and data analyses were all overseen and reviewed regularly with this researcher's academic supervisors and twice yearly by the independent panel member. Changes were made where necessary following these consultations (Smith et al., 2013). Therefore, after the completion of all 12 interviews and following a scheduled interim supervision panel meeting, it was decided that the support of an experienced transcriber was an appropriate intervention, given the very large amount of data still to be transcribed and the ever-creeping timeline in which to complete this study. An amended application was submitted to DCU's Ethics Application Board following a further consultation with DCU's data protection unit (DPU) and granted. All required ethical procedures were followed. This researcher edited all transcribed transcripts, once returned by the transcriber, for accuracy as well as for the inclusion of linguistic repetitions, hesitations and emotive expressions. All of which make an important linguistic contribution to data analysis in any IPA study (Smith & Nizza, 2022).

3.5.4 Data Analysis: Methods and Stages

Smith et al. (2013), iterative and inductive seven-step linear data analysis process supports a dynamic, organised, competent and creative analysis of data. Therefore, data analysis is a more complex process than just following Smith et al. (2009), seven-step approach, step by step. IPA's data analysis demands that the researcher dwell in and embody the data. Therefore, time and patient acceptance were required as this researcher built up the skill required to preserve both the idiopathic individual participant voices alongside the identified similarities and differences across all voices (Smith et al., 2009). However, the seven steps are particularly useful and undoubtedly supportive of the researcher, and

especially for a novice researcher's progress through the in-depth, complex process of data analysis. Therefore, the seven steps outlined below were followed during data analysis, supporting a rigorous and comprehensive exploration of each participant's accounts and revealing their in-depth experiencing:

1. *Reading and re-reading:* By reading and re-reading the participant's transcript, this researcher actively engaged, familiarised, and immersed herself within the data, keeping the individual participant's lived experience as the focus. Initial observations, thoughts or judgements were captured, noted in the margins and then bracketed. The tone, rhythm and structure of the participant's individual account were also noted, in order to evaluate the overall flow, location of richer data, and illuminate obvious gems (Eatough & Smith, 2017). Thus, this researcher attended to both the parts and the transcript as a whole.

2. *Exploratory noting:* Following reading and re-reading, each transcript was in turn uploaded onto an Excel spreadsheet to facilitate the rigorous, lengthy, in-depth, IPA data analysis process. Only when steps one to five were followed and completed was the next transcript uploaded onto a subsequent Excel sheet, within the same Excel file. This supported the researcher to closely and systematically examine in-depth, each of the participants' individual accounts line by line and one by one, as suggested by Smith et al. (2009; 2022). Furthermore, it allowed for the iterative movement back and forth within the transcript and eventually across transcripts as delineated in step six. In this exploratory, open-minded notetaking, this researcher examined the language, thoughts, understandings, concerns and meanings which individual participants attributed to their experiences. Notes were detailed across three columns and were in-depth, interpretative descriptions of the

context and linguistic content of the participants' accounts, as well as a conceptual understanding of the participants' lived experiences. Smith et al. (2009) caution the researcher during this lengthy and challenging process to keep the participants' sense-making to the fore by stopping the process for a time or by reading the text backwards, thereby deconstructing already formed concepts. This researcher frequently felt compelled to stop and reflect on the agonising experiences recounted by each participant, as she dwelt in the agonising embodiment of their data during this sense-making process.

3. *Formulating Personal Experiential Statements (PES):* Following the in-depth exploratory noting, this researcher formulated experiential statements by working with, analysing and interpreting the exploratory notes, while still staying close to the participants' experiences. Smith et al. (2022) suggest that participants' whole narratives be broken down into meaningful parts, reorganised and reformed into a new whole as the study progresses through these next stages. The researcher's interpretation becomes more central to their understanding, while remaining true to the participants' experiences, indicating the importance of using *"gerunds",* supporting this researcher to interpret the sense-making of the participant, yet remaining close and true to the participants' voices, thereby minimising the potential for preconceptions to interrupt the data analysis process. Dynamic inter-connections, patterns and relationships were made, aided by the earlier notes (Smith & Nizza, 2022).

4. *Searching for connections across Personal Experiential Statements (PES):* The identified experiential statements were printed, cut out into individual statements and organised chronologically on a large table. This equalises the significance of all

personal statements at this beginning stage of the clustering process (Smith & Nizza, 2022). Next, the statements were moved around, grouped and regrouped until a pattern of relating and converging experiential statements was identifiable and clustered together. Equally, other diverging patterns were also noted and grouped into clusters, but separately. Some of the experiential statements, although interesting, were not relevant to this research study's aims and objectives, so were precluded beyond this stage of the data analysis process. Next, clusters of related statements were mapped and merged into other clusters and organised based on their relevance to each other, rather than the context or frequency of use or function. Personal statements that reflected the particular experience of the participant best were retained, while statements not relevant to this study were discarded. Alternatively, some personal statements were altered slightly to better reflect the experience within their particular cluster, within their larger cluster. This researcher returned to the relevant sections of the participant accounts, if and where she needed further clarity on any ambiguity within the personal statements while carrying out this iterative, clustering process. Eventually, a number of statements figured as best representing the participant's experiences. When these were selected, a number of similarly relevant personal statements were also retained in support of the cluster. Smith and Nizza (2022) suggest this pattern of clustering is in itself an interpretative endeavour. Furthermore, Smith et al. (2022) suggest that in this creative individual process, there is no predetermined way to group these statements. The overall purpose being to seek out the best way to demonstrate their interconnectedness and relevance to the experiences of the participants, which are supportive of the purpose of the research study.

5. *Naming the Personal Experiential Themes (PETS) and consolidating them and organising them in a table:* Once the clustering and re-clustering process was carried out and completed as above, this researcher chose a title, closely matching the experience which figured most prominently within each of the identifiable clusters. This title is known as a Personal Experiential Theme (PET). Due to the large volume of participant data collected from all 12 individual participants, which generated a large volume of personal experiential statements, this researcher identified five PETs for many of the individual participants. Five experiential statements which best supported the characteristics of each of the five personal experiential themes were also selected for most of the participants. Smith and Nizza (2022), suggest that the optimal number of personal experiential themes is three to five in order to best reflect the three to five most important features of an individual participant's experience being explored. Therefore, these themes and relevant experiential statements strengthened and respected the idiographic contribution of each individual participant's horizons of understanding around their distressing childbirth, including its impact and meaning-making. Each participant's experiential themes and their relevant personal experiential statements were organised and presented in a table (See Appendix X). These tables of themes and their relevant statements were reviewed, discussed, and revised, as necessary, at monthly supervision meetings, ensuring they closely represented the participants' voices and experiences. Moreover, they were presented at this researcher's bi-annual panel review meetings, evidencing a transparent, rigorous and credible process of data analysis.

6. *Continuing the Individual Analysis of other Cases:* The next participant's data was only analysed once the previous participant's data was fully appraised, using the

dynamic, rigorous and iterative procedure as outlined above. This researcher aimed to bracket any pre-conceived notions formed during the previous participant's data analysis. This privileged the idiographic nature of each of the 12 participants' individual data (Smith et al., 2009).

7. *Working with Personal Experiential Themes to Develop GET's Across Cases:* Once all 12 participants' data had been analysed and carefully tabulated as above, attention was given over to exploring connections, similarities and differences across participants' personal experiential themes. To support the equality of all 12 participants in this process, their personal experiential themes were printed out, individually identified, cut out and laid out on a table, clustered and re-clustered similar to the process delineated above for the naming of personal experiential themes. As patterns of convergence and divergence across all 12 participants' personal experiential themes were illuminated, others were mapped, merged together and altered slightly to better reflect the personal experiential themes within their particular cluster, within their larger cluster. The purpose of this once more iterative, re-clustering process was to reveal and develop a table of GET's that gives a higher order critical relevance to the overall data analysis of the participants' experiences of their distressing childbirth (Smith et al., 2022). During this re-clustering and altering process, any doubts or ambiguities that arose for this researcher around personal experiential themes were easily checked and verified with the individual participant's data, as a result of the participant identification process that was carried out at the beginning. Therefore, the GET's continued to reflect closely the participants' experiences of their distressing childbirth, albeit at a higher conceptual level (Smith et al., 2022; Smith & Nizza, 2022). Bin Md Syed and Wilson (2024), further explain that these GET's which are illustrative of the

group's horizons of understanding of their distressing childbirth experience, may equally reveal an obvious theoretical or philosophical underpinning.

3.5.5 Researcher Reflexivity

Researcher reflexivity is an essential aspect of any qualitative Interpretative Phenomenological study (Smith & Nizza, 2022). Smith et al. (2022), acknowledge that many aspects of IPA as a methodological approach appear deceptively easy. In reality, it is much more difficult than appears to do it well. This researcher was aware she was considered an insider to this research study, having qualified as a midwife and experienced a distressing childbirth. She subscribed to the notion that a rigorous qualitative study demands a knowledgeable, skilled researcher in both the topic area as well as the methodology under inquiry in order that an opportunity to expand on earlier findings and insights is created (Yardley, 2000; Creswell et al., 2007; Nizza & Smith, 2022; Silverman, 2013). Therefore, as suggested by Smith and Nizza (2022), this researcher recorded a reflexive interview with a psychotherapist colleague to illuminate some of her preconceptions. This interview revealed that a predominantly non-interventionist, bio-medical perspective of childbirth was held by this researcher. This perspective was largely influenced by her midwifery training in a medium-sized, consultant-led unit in the United Kingdom (UK), where the midwives were autonomous practitioners. This culture was openly supportive and empowering of women towards achieving a normal childbirth.

Staying aware of the influence of prior experiences and preconceptions in order that they were informative rather than interruptive to the uncovering of new interpretations of the available research data continued to challenge (Smith et al., 2022) throughout this study. I successfully learned to use gerunds, where I changed a verb used by the participant to describe their experience into a noun, when I crafted each participant's personal

experiential statements and themes. This ensured that as a researcher, I stayed true to the participants' experiences during data analysis (Bin Md Syed & Wilson, 2024). As challenges arose, further time was given to discuss and reflect on interruptions to the data analysis process and progress with my academic supervisors and clinical practice supervisors. Having no opportunity to work with the participants outside of their interview left me struggling to shake off the deep sadness and unexpressed rage of one participant. I was already attuned to the grief of another, as I dressed for the interview and could only wear black. I felt the urgency to be early for another and heard the unsettling consequences of her anxiety as she lived with the result of her slightly premature childbirth during Covid-19. I wondered about the burden another carried, as I walked up four flights of stairs to her office with my hands full and heard the burdens she continues to work through, 10 years later. I worried about another finding her way through a long, winding corridor to the meeting room and learned that this paralleled her experience of visiting her baby in the NICU.

3.6 Ethical Considerations

Smith et al. (2009), view good ethical research practice as an active and continuous process, requiring ongoing monitoring throughout the research study, while Beauchamp (2003), asserts that we can never fully know what an experience is like for others; rather we need to consider many eventualities. Therefore, close attention was paid to this study's design and recruitment process, as a result of the research topic being a personally sensitive subject for those involved. Consequently, Smith et al. (2009), highlight five ethical principles which were considered while undertaking this IPA study in order to support participants' safety and well-being. These are non-maleficence, autonomy, veracity, beneficence and justice. While Corey et al. (2011), add trust as a sixth. Therefore, to minimise the potential for overwhelm, distress or harm among this research study's

vulnerable participants, the following ethical principles were considered and adhered to, as delineated below:

Non-maleficence

A full ethics committee review was required for this research study, in order to navigate the competing needs of the research participants with the research topic (Bond, 2004), thereby ensuring the participants' rights superseded those of the research topic (Greaney et al., 2011). Recruitment and interviewing of participants were only carried out following ethics approval. Participants were accessed and recruited through healthcare practitioners (accredited psychotherapists, accredited psychotherapy supervisors, doulas, GPs, GP practice nurses and physiotherapists) where initial contact was sensitively made by someone who was known to them and with whom they had already self-identified as experiencing a distressing childbirth. This supported potential participants against unsolicited intrusions and minimised their vulnerability to further upset. Healthcare professionals who acted as gatekeepers were given guidance via email to support an open and transparent recruitment process that was clear, detailed and easily understood. Careful balancing of the benefits and risks of using other professionals to filter access to and recruitment of participants was closely considered, as it risked a sampling bias by inadvertently eliminating people who were eligible and willing to participate. Therefore, participants' recruitment was supported by clear, detailed inclusion and exclusion criteria.

Autonomy

Using an IPA methodology allowed participants the opportunity for their individual voices to be empathically listened to and their experiences privileged within the research process. Women participants' right to self-determination was facilitated where they self-identified to participate in the study, including the where and when of their one-on-one semi-

structured interviews. Participants were fully informed verbally and in writing of the nature, purpose and data collection process involved, to ensure their consent was fully informed. Semi-structured interview questions were asked sensitively and respectfully, one at a time, funnelled from the general to the specific, allowing participants further autonomy to lead the interview process (Biggerstaff & Thompson, 2008; Ryan et al., 2009; Smith & Osborn, 2007). This minimised the potential for a participant to experience an imbalance in the power relationship between themselves and this researcher. Participants' verbal and non-verbal behaviour was carefully monitored for ongoing consent and any deleterious effects throughout their semi-structured interview. Participants' data will only be used for its intended purpose and safely stored for the designated period as detailed in the ethics application form. Participants were given the option to opt out of the study at any point up until its completion.

Beneficence:

While there were no immediate participants' benefits, indirect benefits included the opportunity to voice and have their often emotive, lived experiences of a distressing childbirth in Ireland heard. Moreover, benefits may be enhanced where participants believe others will benefit from the subsequent research findings of the study. Accordingly, participants were informed that this research study will be presented as a thesis for a doctorate in psychotherapy award and, on satisfactory completion, will be available through the university's library via their open-access database. Thereafter, participants can request a summary of the findings, in respect to their willingness to participate. Findings will be presented to interested stakeholders and presented at relevant conferences and or written up as a research article for suitable peer-reviewed publications. If accepted for presentation and or publication, the findings will be widely available within the public domain.

Trust

Trust requires this researcher to build a positive rapport, maintain and manage appropriate professional boundaries, anonymity, cultural diversity, power differences and disclosures of abuse (Corey et al., 2011). Therefore, participants were informed verbally and in writing of the limitations to confidentiality, in accordance with the law, the university's research integrity requirements, and the researcher's accrediting bodies' Code of Professional Ethics prior to agreeing to participate. Furthermore, they were given a pseudonym and were informed that anonymity was limited, due to some use of direct participant quotes in the writing up of the study's findings. However, this researcher, as far as possible, ensured data was further pseudo-anonymised to reduce participant recognition by removing other potentially identifying information. Neither was participants' potentially identifying demographic information collected regarding their: Racial or ethnic origins; Genetic or biometric data; Sexual orientation or sex life; Political opinions; Religious or philosophical beliefs; or Trade union membership.

Veracity:

As an insider, this researcher was aware of upholding the boundaries across multiple roles as a researcher, nurse, midwife, psychologist and psychotherapist throughout this study. An interview was recorded with a professional colleague to reveal her pre-conceptions, to pilot interview questions and practice interview skills. Furthermore, frequent use was made of clinical supervision as well as academic supervision throughout the research process and in particular during data analysis and the writing up of findings, to minimise the interruptions that stemmed from the researchers' professional and personal experiences. All data protection and confidentiality conditions set out by DCU and as laid out in my initial and amended ethics applications, were fully adhered to. Therefore, the transcriber was

briefed on the nature of the study and the emotive content of the interviews, so consent was informed prior to agreeing to undertake the work of transcribing the interviews. They were further briefed on the requirements of the transcription process and the transfer of audio recordings in line with DCU policy. Recordings and transcriptions were only shared through a secure DCU Google Drive Folder. The transcriber signed the data processing and sharing agreements, as provided by DCU's Data Protection Unit, before commencing transcription of the interview data. This researcher was available by phone and email to the transcriber during the transcription process to deal promptly with any questions or issues that arose for the transcriber. The transcriber was given the opportunity to debrief at the end of the transcription process and at any time during the process as requested. This researcher edited all transcribed transcripts, once returned by the transcriber, for accuracy as well as for the inclusion of linguistic repetitions, hesitations and emotive expressions. All of which make an important linguistic contribution to data analysis in any IPA study (Smith & Nizza, 2022).

Justice:

The study design and implementation closely considered the participants' and researcher's safety and well-being. Any undue distress caused by the research process was addressed quickly and alleviated as far as possible. Recruitment of participants was confirmed, and interviews were organised only when participants made contact by phone, demonstrated a clear understanding of the purpose of this research study during our conversation, fit the inclusion criteria, and freely gave their consent to participate. Upon request, participants were provided with a copy of the interview questions in advance, helping to alleviate any previously encountered concerns. Interviews were held in quiet locations, agreed in advance with the participants, ensuring they were as free as possible from unintended interruptions. Consent was obtained in writing before the interview and ascertained again

where necessary during participant interviews, particularly where participants asked for the recording to be temporarily paused. All participants were debriefed following their one-on-one interview and asked if they wished to have a follow-up call a week later to ascertain their well-being. All participants availed of the call and assured me of their well-being when we spoke. Most participants expressed experiencing the benefit of having their voice heard, at the end of their interview, often again during the debriefing session and or during their follow-up phone call. As a result of employing the above measures, the potential for distress of the participant, before, during and after the interview process was minimised.

3.6.1 Research Rigour

The following four markers are recognised by Nizza et al. (2021), as supporting excellence in the quality, validity, trustworthiness, and reliability of an IPA research study. These markers are as follows: constructing a compelling unfolding narrative, developing a vigorous experiential and or existential account, close analytic reading of participants' words and attending to convergence and divergence. Yardley (2000), further suggests a credible qualitative research study requires a sensitivity to context, commitment and rigour, transparency and coherence, impact and importance. To achieve the above, the full conduct of this research study (research procedures, data and analyses) was overseen during monthly academic supervision meetings and biannual panel reviews with two experienced research supervisors and a third experienced panel member at DCU. Throughout the process of data analysis and the write-up of findings, this researcher's supervisors reviewed her work for balance between description, interpretation and ongoing researcher bias. (Smith et al., 2009; Larkin & Thompson, 2011). Furthermore, this researcher's use of 12 individual Excel sheets within a single Excel file supported an audit trail capturing her actions, decisions, changes and progression for all 12 participants from data gathered through to completion of data analysis. Equally, keeping a reflexive journal

supported the crafting of sections on this researcher's reflexive comments and the significance of reflexivity during data analysis.

During data analysis, this researcher moved iteratively from the parts to the whole and then from the whole back to the parts, until sufficient depth of analysis and interpretation was achieved. The iterative process deepened ever further through levels, as the current data's descriptive content, context and language were analysed, presenting metaphors were interpreted and a micro-analysis of the data for temporality, concepts, paradoxes, and possible unconscious or coming into consciousness processes which took place were uncovered and examined (Smith & Osborn, 2007). The writing and rewriting of the findings allowed for the final analysis and interpretations to be captured. (Smith et al., 2009) Findings and themes were presented narratively, graphically and discursively in a coherent new whole. Original data extracts were used to support transparent and true representations of the participants' accounts of their lived experiences (Smith & Osborn, 2015).

3.7 Conclusion

This methodological section demonstrated the suitability of a qualitative IPA methodology to comprehensively provide an in-depth understanding of women's experience of a distressing childbirth in Ireland: its perceived impacts and meaning-making. Its capacity to prioritise the lived, inter-subjective co-construction of experience and interpretation at data collection, analysis and write-up stages for this research study is clearly detailed. The relevance of IPA's philosophical underpinnings to further support our in-depth understanding of the complex intersectional layers that contribute to a distressing childbirth is outlined. Conditions for good ethical practice, as well as the sourcing and recruiting of participants, were delineated for this particular study. Ensuring I sought out

adequate supervision, as I completed the many emotive aspects of this study, was equally a significant ethical responsibility.

3.8 Researcher's Reflexive Comment

Despite being an insider as a midwife and an expert by experience of a distressing childbirth, my naivety as a novice researcher was stark. As a result, the interruptions and disruptions were frequent and many. I regularly, in parallel to the participants' experiences within the Irish childbirth hospital system, felt the doubt, terror and emotional crippling of not knowing how the professional doctorate research system and IPA processes, in particular, operated in practice. I lacked insider knowledge. Like the research participants, I was acutely aware of my lack of knowledge and how disadvantaged I felt in this vulnerability. Often, I felt nauseated and regularly braced myself to just think about sitting down to transcribe, read, reread and analyse their agonising, distressing accounts. I felt the shame of being a midwife, yet I carried the responsibility of my participants' trust to do justice to their voices, which pushed me forward.

During my search to understand, Engward and Goldspink (2020), spoke to my experience, where they described dwelling with their participants' data, as similar to sharing space with lodgers. Goldspink speaks about learning to live with the embodied daily uneasiness, uncomfortableness, and uncertainty of being absorbed in the experiencing of her participants' data, as she was both instrumental in its interpretation and the instrument through which it was interpreted during data analysis. Their normalising of my experience somewhat supported a more salutogenic progress through the data analysis process, albeit slow right through to completion.

Chapter 4: Findings

This chapter presents findings following an in-depth data analysis of 12 participants' semi-structured interviews using an IPA methodological approach. A brief summary of each participants' journey through childbirth is presented in Table three below. All data has been anonymised. Pseudonyms were allocated as outlined, and specific identifying information and background details are not included. Thereafter, each of the three GETs is illustrated, utilising data from nine of the 12 participants, that best represents the experiencing and languaging of that particular theme. For balance, each sub-theme is represented by three of those nine participants, where no participant is utilised twice within the same set of sub-themes. Although all participants are represented and duly considered for their converging commonalities, as well as their diverging differences across the themes and sub-themes, some are more figure in the writing-up of this findings section, as a result. The participants' voices will be reflected through direct quotations and therefore provide further support for the researcher's in-depth analysis and hermeneutic engagement with their unique, individual accounts. Speech hesitations, repetitions, and false starts are included, which provide an acknowledged supportive linguistic context to the researcher's hermeneutic engagement with the participants' accounts, characteristic of an IPA methodology. This supports clarity as well as flow, thus maintaining the quality of the reader's experience, while staying close to the participants' experiences.

Table 2: *12 Participants' demographic and childbirth summaries*

Participant: 1 Birth outcome: Spontaneous labour followed by Forceps delivery with the aid of an episiotomy.	Sarah and her partner chose a home birth. After 23 hours of labouring with insufficient progress, she consented to a transfer to a maternity hospital. Her transfer by ambulance felt chaotic as her nitrous oxide was running low, her homebirth midwife was travel-sick in the ambulance, and the ambulance personnel were reluctant to deliver a baby. Shortly after arrival at the hospital, her baby went into distress and was delivered by forceps, with the aid of an episiotomy. Sarah remembers little of the delivery, only that she *"let the river take" (Ln218)* her as she became overwhelmed by the volume of people in the room and a midwife shouting at her. Following discharge home, her episiotomy site became infected, and her wound reopened. Despite a course of antibiotics, there was little improvement. The doctors eventually agreed to re-suturing her perineum, but only after she threatened to handcuff herself to a bed. This proved a game-changer. However, she was angry for a long time afterwards over what happened to her. This caused friction between her and her partner, who was unable to support and attune to her needs. Just over a year later, she separated from her partner as their relationship broke down. She returned home to live with her parents, who were glad to be able to support her, having worried she had been living so far away from them.

Participant: 2 Birth outcome: Induced followed by an Emergency C-section at 36+2 weeks' gestation. Baby to NICU. Discharged home together	Page was unexpectedly admitted for induction at 36 weeks' gestation during COVID-19 for oligohydramnios. It was diagnosed on a scan during her routine antenatal consultant visit. Following induction, she underwent an emergency C-section for an unengaged cephalic presentation, failure to progress, and foetal distress. Her husband, delayed by hospital security, arrived at the theatre within minutes of their baby's birth. Subsequently, their baby was admitted to the NICU for CPAP, having been ventilated briefly while in theatre. Page describes being on the postnatal ward alone, without her baby as 'shit', where midwives were too busy to ask any questions of her and she turned to another mother for information and support who had been through it all before. She and her baby were discharged five days later, having spent only their final night together on the postnatal ward. She breastfed for 6/52 with a lot of difficulty, which she felt was compounded by their initial separation. The smell of overnight oats and the noise of a breast pump retriggered her distressing memories of breastfeeding up to six months later. She still experiences anxiety since childbirth, in a way she never had before, although it has improved.
Participant: 3 Birth outcome:	Louise was 12 weeks pregnant with her second child when she experienced a near-fatal medical episode. She was admitted for a week to a special care unit in a tertiary care hospital, as COVID-19 came in. Thereafter, her whole

Elective C-section at 33 weeks' gestation. Baby to NICU. Discharged home together.	pregnancy was closely monitored as she was immediately categorised as high risk. By 30 weeks' gestation, she was given the option and agreed to be admitted to hospital for closer monitoring, as she was experiencing placental insufficiency, reducing amniotic fluid, foetal growth retardation, reduced foetal movements and her blood pressure was more difficult to stabilise. At 33 weeks, a decision was taken by her medical team to carry out a planned C-section with her specialist medical team also present. Her baby was transferred immediately to the NICU. She worked tirelessly to be there to feed him in the NICU, to ensure he came home with her a week later. She is keenly aware that her second child has gone uncelebrated, and feeding time in their house remains a battleground. Being premature babies, their food intake was consistently monitored, it now holds no joy for both her children. She openly acknowledges the toll of her childbirth on her husband and extended family, which she feels guilty about, as they were very supportive throughout. Yet, she is happy that she and her baby got out alive.
Participant: 4 Birth outcome: Induced followed by vaginal delivery.	Mia, being pregnant at an advanced maternal age, was astounded when she was categorised as a geriatric pregnancy. She had a lot of pains during her pregnancy that felt nothing close to normal for her and found herself educating one of the many doctors she met at the antenatal clinic about her symptoms. Her doctors, as a result, wanted

	her induced for advanced maternal age at 40 weeks' gestation. She knew little about the induction process, although she did attend antenatal classes, knowing she feared the prospect of childbirth. Her labour was rapid and intense, leaving no time for an epidural to happen. Her perineum tore as her baby was born and required suturing. She felt each suture as it went in. Yet no additional pain relief was given. Afterwards, she found breastfeeding very difficult and accessed the services she needed privately. She subsequently went on to breastfeed her baby for 13 months, although she still experiences high levels of anxiety. She recognises her childbirth experience left her anxious with a hyper focus on risk, which has improved somewhat.
Participant: 5 . Birth Outcome: Spontaneous vaginal delivery with the aid of an episiotomy	Sadie became pregnant shortly after having major surgery, where her wounds became infected, necessitating an extended course of antibiotics. Once her infection cleared, she intentionally became pregnant. She had no fear of the pain yet, but always feared the actual giving birth. Although she attended antenatal classes, she still felt she had not educated herself enough and was very tense throughout the labour, which had started spontaneously. After a prolonged labour and with the aid of an episiotomy, she gave birth to her baby, who had an obvious deformity, which went undiagnosed during the antenatal period. Not knowing and finding out after the birth leaves her feeling guilty and blaming herself for having done a bad job, although no

	genetic factors were found to have contributed. Ever since, she has wondered if she gave herself enough recovery time before becoming pregnant. Sadie was devastated when the midwives took her baby so she could have a rest, having just arrived on the postnatal ward. She interpreted this as she couldn't be a mum, was unable to cope, was too fragile to do the job she was programmed to do and had failed. In contrast, breastfeeding successfully allowed her to feel she was doing a good mum job and not inducing further injury. She overcompensates ever since, to ensure her child is happy, a legacy burden she carries from her childhood, as she was never allowed to feel anything other than happy. She went on to have another child two and a half years later, educated herself, ensuring she had a different experience. In contrast, she describes it as a warrior childbirth, as she confidently ignored all those around her and did what she needed to do.
Participant: 6 Birth Outcome: Spontaneous labour, epidural followed by forceps delivery with aid of an episiotomy.	Eva went into spontaneous labour on her first pregnancy, albeit overdue. This followed several stressful weeks at the end of her pregnancy, where a family member was hospitalised after a serious accident. She reluctantly accepted an epidural after many hours of intense, painful contractions, not knowing how much longer she could sustain the level of pain she was experiencing. She wished there was more guidance from the midwives. Her husband later affirmed, they did tell her to take the epidural. Not

	having any sensations of labour, thereafter, left her derealizing, as well as her labour slowing down, and her baby eventually showed a lack of oxygen. A decision was taken to do a forceps delivery with the aid of an episiotomy. Her baby took four minutes to cry, as he had poor Apgar scores. Hearing him cry was the best moment of her life. However, Eva believes having an epidural, an assisted delivery and an episiotomy during her first childbirth set off a cascade of events for her subsequent two childbirths. She blames herself for the circumstances that ensued and holds deep regrets around them. Each childbirth was impacted differently. Hoping for a chance to do it right on her third childbirth, she describes wanting to give birth the Amazonian way. However, she felt compelled to agree to a C-section. If she had chosen to deliver vaginally, she was advised by her doctor that she risked developing a vaginal fistula and potentially would require a colostomy bag. This was a risk she decided not to take. Her third child was born by a planned C-section.
Participant: 7 Birth outcome: Induced followed by vaginal delivery.	Mary booked privately under a consultant for her 3rd childbirth in the hope of receiving better care, having received less than satisfactory care on her previous two pregnancies. Although Mary undoubtedly believed that who cared for you at the hospital was a lottery, she was still somewhat ambivalent about using private care services, as she had worked in a state service all of her career and was

	passionate about the benefits of the public system. However, her husband was clear that this was a necessary decision, and she was deserving of it. Mary found herself agreeing to the consultant's suggestion to opt to be induced, a week early during Covid-19, so she could control the timing and thus the speed of her childbirth, as Mary's two children had been born very quickly. While she had some reservations, Mary arrived at the hospital having already started her labouring. She assumed she would be allowed to progress at her own pace, having sent her husband home to bring their children to school. However, the consultant rushed her to a bed, so her induction could begin. Mary was uneasy from the beginning with so much intervention. Despite protesting, even offering to return her bed, Mary found herself unable to stop the process. She worried the destiny of her child was being decided by the hospital system, rather than by the readiness of her baby. Mary described herself as meaning little more than a fiscal unit, a private perinatal woman, within this hospital system. She was determined to voice her concern and be heard by the consultant before leaving the hospital, motivated by the amount of money she was paying for her care. Afterwards, she felt her experience brought her to a dark place, although she felt grateful she and her baby got out alive.
Participant: 8	Lyndsay approached her second childbirth as routine, having previously prepared for her first childbirth, which had a

Birth outcome: Elective C-section	positive outcome, although it was an emergency C-section. Having had a very busy and stressful work year, she was looking forward to her childbirth and was booked for an elective C-section. On hindsight, she recognises a number of red flags were apparent after her arrival at the hospital. She was not on the scheduled theatre list, was then listed, only for the time to be changed without consultation, leaving it all a bit rushed. Having had a previous C-section and coming from an allied healthcare background, she knew she needed to stay alert during her spinal anaesthetic. She was equally alert to the distraction techniques often employed by the medics, asking her necessary questions, but all of it was happening concurrently. At the time and even on reflection, she felt she had clearly let the anaesthetist know that she was not sufficiently numbed by her spinal anaesthetic. It was her husband who realised very quickly she wasn't okay. He quickly alerted the anaesthetist to her pain, which she expressed as 10 out of 10 on the pain scale. She refused the general anaesthetic offered by the anaesthetist, wanting to see her baby being born. It all became just a blur after the anaesthetist administered enough opioids to make her comfortable yet failed to alert the team around him. It was only close to the end, her consultant became aware she was feeling what he was doing. While he visited her and attended to what happened the next day, and during a subsequent follow-up a number of months later, she felt he never owned

	or took responsibility for what had happened. She is still conflicted and questions herself if she was just a passive bystander in what happened. Alternatively, she feels that as a professional and an expert by experience, she had alerted the anaesthetist sufficiently. Yet he dismissed her feedback, only to carry out further checks that proved inaccurate. As a result, Lindsay remembers very little of that year, yet is very grateful for the support of her extended family, having got very ill a number of months later.
Participant: 9 Birth Outcome: Spontaneous labour, epidural, followed by Emergency C-section	Grace was keenly aware she carried little sense of her own worth. Fearing rejection, she always felt she needed to be the good girl. She saw her pregnancy and childbirth as a result, a rite of passage. Grace had engaged in many years of therapy and transpersonal work and attended hospital antenatal classes, which she believes only primed her for the active management of labour. While she read the various pregnancy books of the time, she felt she let all the information pass her by, having only passively engaged in the process. She regrets not doing more, particularly around advice given by a midwife in her outreach clinic, who suggested trying to get her baby into a better position for her childbirth. Grace went into spontaneous labour and, after many hours of painful labouring, accepted an epidural. Exhausted, she had an emergency C-section, having failed to progress in the second stage of labour and for foetal distress. Grace found the isolation and the challenges of

	breastfeeding very difficult when she returned home. She developed two breast abscesses that necessitated surgical drainage. Despite her determination and perseverance, she was unable to continue breastfeeding. Several years later, having attended a gentle birthing weekend and subsequently training as a Doula, she realised all she didn't know and hadn't followed through on. She is keenly aware of the enduring impact of her childbirth on her relationship with her partner and its ongoing imprint on her baby. All of which she continues to manage, grow and develop from.
Participant 10 Birth outcome: Spontaneous rupture of membranes, induced, followed by emergency C-section.	Alice discovered she was pregnant at the beginning of the pandemic. Despite being very sick for the first 12 weeks of her pregnancy, she describes having a good pregnancy. She researched a lot about childbirth during that time and attended antenatal classes online. She booked privately under a consultant, as that was the maternity care system she was familiar with back in her own EU country. While she had no fear of childbirth, she was very worried about being on her own in the hospital, due to Covid-19 restrictions. She was equally aware that if she were giving birth back in her own country, they had no restrictions on partners, and her husband would have been able to stay with her while she was in the hospital. Alice's consultant told her on her final visit, all would be fine. However, it was not fine as Alice's waters ruptured, no contractions followed, and after many hours with no contractions, she had to return to the hospital,

	with meconium-stained liquor. She was given the choice to stay overnight on the pre-labour ward or opt for an induction of labour and be admitted to the labour ward. Terrified of being left on her own without her husband, she chose to be admitted for induction. After many hours of intense labouring and her syntocinon drip consistently increasing, she agreed to an epidural, despite wanting to have as natural a childbirth as possible. Her consultant was called when her progress was insufficient, and her baby was becoming distressed. She advised a C-section. Alice felt her organs were exploding inside her, and her heart was in excruciating pain as her C-section progressed. When she started to scream in pain, her husband later told her the anaesthetist continued to syringe medication into her drip, despite telling her it was normal. As a result, she could barely see her baby through the fog of sedation and dissociation, getting to only touch his toes. Postnatally, she found it very difficult to cope with her baby and her painful C-section scar without her husband being present to support her. She feared falling asleep without her husband present to watch over their baby. He was only allowed in for one hour each day to visit. When she returned home, her blood pressure increased, and she was readmitted to the hospital, while her husband waited outside on the street with their baby. He was eventually allowed in during visiting hours, but was left caring for their baby at home until she was discharged home. Once home,

	she got in touch with her midwife, whom she had done her antenatal classes with, as well as a private lactation consultant. She found both very helpful and eventually went on to breastfeed successfully, without which she would have felt nothing but a failure. However, in the first few weeks, she rarely slept, and eventually this took its toll, where she agreed to start on antidepressant medication. She has returned for a number of visits to her consultant to talk about her childbirth experience, which she found somewhat helpful. Having returned to work, she continues to be triggered over a year later by the road she walked down while she was awaiting contractions and more recently as she passes the hospital on her way to work. The pain of her scar, although diminished, is a constant reminder of her childbirth, which she continues to have nightmares about. Her husband equally worries that her childbirth experience and subsequent suffering will destroy her.
Participant: 11 Birth outcome: Induced followed by emergency C-section.	Ruby became pregnant after many years of failed in vitro fertilisation (IVF) cycles. She was initially pregnant with twins but miscarried one twin during the early weeks of her pregnancy, which she has rarely spoken about since and couldn't believe she brought it up towards the end of her interview. Ruby, at the time, just moved on, knowing she still had one. She was used to just moving on when her IVF cycles failed, including after two other miscarriages. Ruby really wanted a natural childbirth, feeling she deserved an

	easy childbirth after all she had been through. Therefore, she went to yoga and hypnobirthing classes. She never considered another alternative and was confident she could do natural childbirth. However, she was admitted to hospital at 42 weeks' gestation for induction, as her consultant, whom she describes as a lovely man, left her try for a spontaneous labour for as long as he could. Despite diligently attending her antenatal classes, Ruby knew little about the induction process, later feeling she had been misled in the classes. She had friends who were induced and, within 24 hours, had their babies. This was her expectation for herself as a result. However, after five days of induction, she was showing little signs of progress, and her consultant decided to augment her labour with a syntocinon drip. Going from no pain to intensely painful contractions was challenging for Ruby, although manageable. Her husband found it even more challenging to watch her in this much pain. However, after many hours of labouring with little progress, her baby began to show signs of distress, and the consultant recommended an emergency C-section. Ruby became hysterically emotional and pleaded for a different solution. However, seeing him after he was born made everything worthwhile. Following her C-section, she shook uncontrollably, as if all her organs were shaking. She was not allowed to have her baby until the shaking stopped. The following morning, it was like a new dawn and a new day.

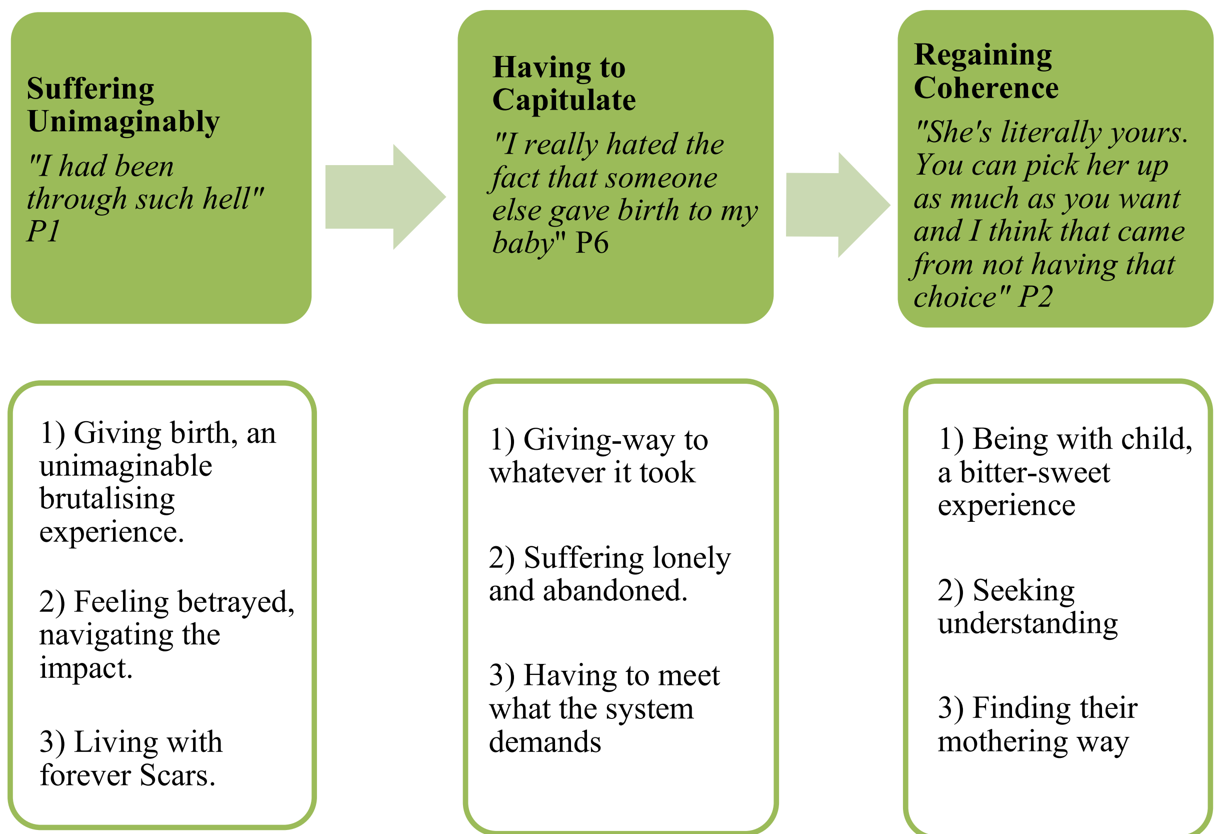
	Ruby was very grateful for all the care she got on the postnatal ward afterwards, despite the midwives being so busy. However, she opted for an elective C-section on her second baby, deciding she could not put herself through all that again. On hindsight, she feels this was a good decision.
Participant: 12 Birth Outcome: Induced, followed by emergency C-section and severe postpartum haemorrhage (PPH). Admitted to ICU and baby to NICU. Discharged home together.	Emily, being pregnant during COVID-19, found herself doing everything on her own and describes her pregnancy as a textbook pregnancy. This was despite bleeding at six weeks and having regular two-week scans until 12 weeks' gestation. Towards the end of her pregnancy, she mentioned at her routine hospital antenatal visit that she had a rash which itched really badly. She had bloods taken and was advised that if they were bad, then they would schedule her for a C-section. At the time, she didn't understand their significance. However, from her perspective, it all went pear-shaped at 38+2 when her waters spontaneously ruptured. She was diagnosed with a hind water leak, admitted to the prenatal ward and had further bloods taken. At 5 am, the staff came to bring her to the labour ward for induction. She only found out afterwards that they were panicking, as her bloods were so abnormal. She felt really lucky on arrival at the labour ward that the CNM was someone she knew from home and allowed her husband to come in. She actively engaged the support of the many staff she met and knew from then on. After a number of hours in labour, she requested and got an epidural. However, while

	she was progressing slowly, her consultant recommended a C-section by the early evening. She only remembered hearing her baby cry and then blacking out. She was quickly transferred to the ICU for severe pre-eclampsia and postpartum haemorrhage. She was unable to sleep with the noise of the ICU, which was very stressful. She pleaded with staff to get her out of there, so she could breastfeed her baby, and after three days, she was back on the postnatal ward with her baby. However, as they were measuring everything, she continued to get very little rest or sleep. The following day, she was panicking as she had all this information coming at her, her baby was back with her, she had two units of blood transfused, she could barely move following her surgery and as she still had a catheter in situ. She spent the week in the hospital and will never forget the horror of the isolation of the nighttime. In hindsight, she was left feeling like a failure and a bad mother, particularly if she rang the bell for help. She was exhausted following her return home despite extended family help. She combined feeding her baby for 5 weeks until she realised she wasn't well enough and weaned him fully onto bottle feeds. It proved a game-changer for her. She attended a debrief in the hospital after six weeks, where she learned more fully what had happened and why.

The three GETs identified were:

1. Suffering Unimaginably: “I had been through such hell”.
2. Having to Capitulate: “I really hated the fact that someone else gave birth to my baby”, and;
3. Regaining Coherence: "She's literally yours. You can pick her up as much as you want, and I think that came from not having that choice".

Figure 2 *illustrates three GETs and their three relevant sub-themes identified*



4.1 Suffering Unimaginably: "I had been through such hell"

The first group experiential theme is at the core of all participants’ distress. Most participants were open and prepared to expect the unexpected, as they navigated their hospital childbirth journey. However, they expected to at least feel safe. Yet, many of them

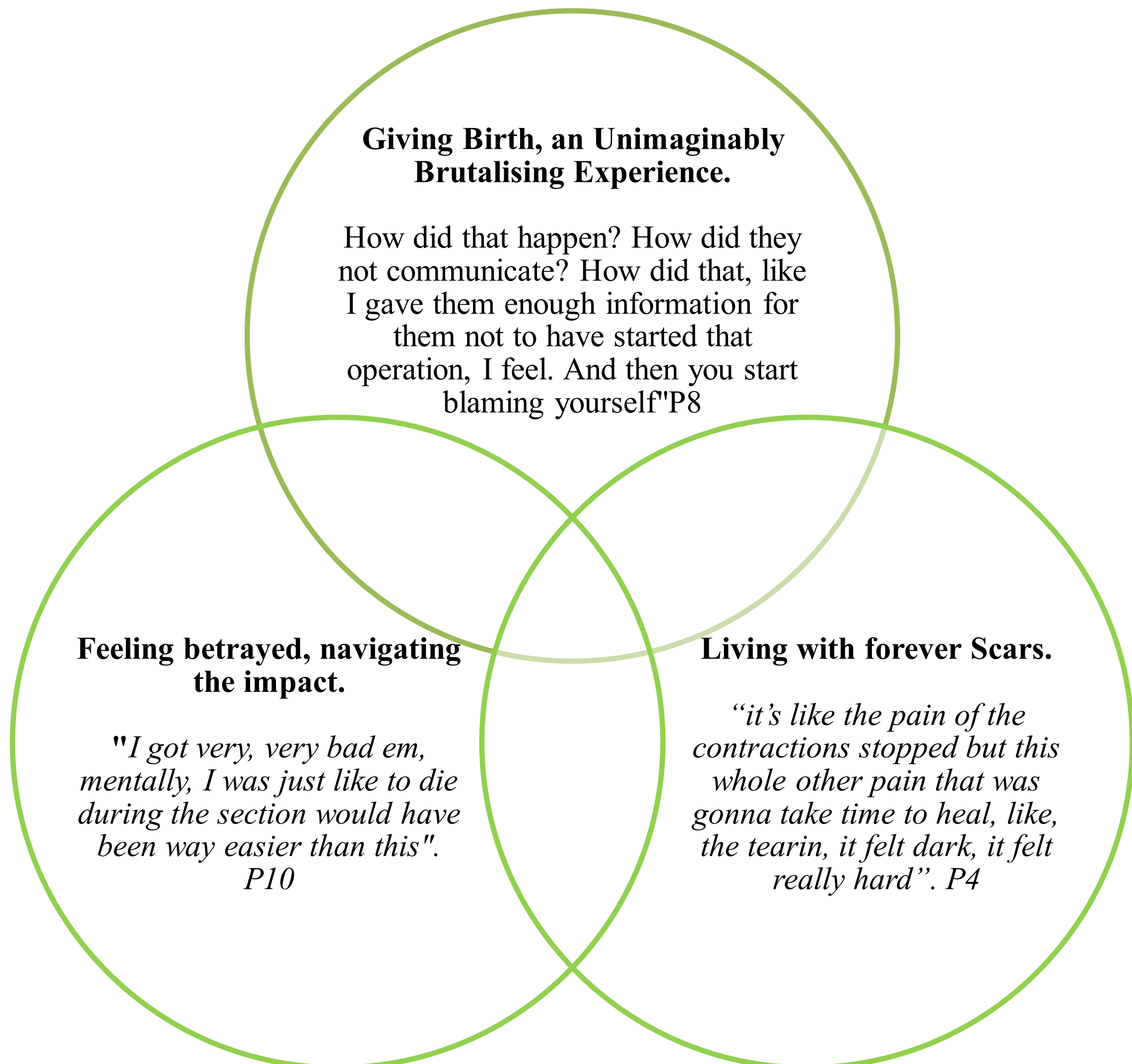
left the maternity hospital feeling harmed. Most of the participants spoke about experiencing levels of chaos, fear and excruciating pain during childbirth, beyond anything they had ever encountered before. Despite all of the participants preparing for childbirth: through extensive reading; by attending various modes of childbirth preparation classes; by having childbirth expertise via experience and or as professional insiders with knowledge of childbirth, healthcare or other public service systems; they still found themselves navigating distress and suffering on a magnitude that was previously unimaginable to them. However, the perceived source of the participants' suffering diverged, as did their responses to what was happening throughout their childbirth experiences and beyond.

Table 3: *GET 1 with sub-themes and their prevalence in the participants' experiences.*

GET 1: Suffering Unimaginably	P1 *	P2 *	P3 *	P4 *	P5 *	P6 *	P7 *	P8 *	P9 *	P10 *	P11 *	P12 *
1.1 Giving birth is an unimaginably brutal experience	*	*	*	*	*	*	*	*	*	*	*	*
1.2 Feeling betrayed, navigating the impact		*		*	*	*	*		*	*	*	*
1.3 Living with forever scars	*	*	*	*	*	*	*	*	*	*	*	*

Figure 3:

Three sub-themes from GET 1 with relevant participants' quotes



4.1.1 Giving Birth is an unimaginably brutalising experience

Participants articulated experiencing overwhelming levels of suffering that were accumulative, shocking, agonisingly painful, exhausting and eventually became uncontainable, for many regardless of their mode of childbirth. Most of the participants did not fully understand what happened during their childbirth, which left them so distressed. They frequently felt guilty and at fault because of their incapacity to cope with what had

happened to them and or with the pain of their contractions, despite pain relief being inadequate or not freely given when requested. Spontaneous recognition or acknowledgement by maternity care staff of their distressing experience did not happen. Consequently, participants defaulted into their defensive coping position of doubting and blaming themselves.

Sarah quickly became overwhelmed shortly after arriving at the hospital, with the speed and intensity with which the delivery room filled up with unfamiliar people for her assisted delivery. Her partner and homebirth midwife, the people chosen, familiar and thereby safe to her, faded into the background, as the hospital staff took over her care.

> *"one of the most distressing parts was at one point going, em, just kinda having this realisation going, oh shit, like I don't know what to do here, I feel like I have no power. I'm completely powerless, physically and just did not know where to pull strength from and everybody that was in the room, that was there to help me, what they were saying didn't matter, what was going on for me inside my body or what was happening and I was going shit, nobody knows what to do here to help me and I think some part of me went, just gone off somewhere. I was just screaming" (Ln 73-79).*

Sarah felt powerless and directionless with the lack of attuned guidance from the hospital midwives, in comparison to her homebirth midwife, vaguely knowing her baby was in distress. Her trust in those who were supposed to be there to help was further eroded when the midwife started to shout at her, and she started screaming out in responsive desperation. She quickly lost faith in herself to know what to do and felt those around her didn't know either. Unfortunately, Sarah's suffering didn't end with the delivery of her

baby by forceps. Sarah uses the metaphor of being "*through hell" (Ln102)* to describe her sense of being brutalised by her assisted childbirth experience. Subsequently, the doctor suturing her episiotomy, failed to adequately numb her perineum. Out of desperation and anger, Sarah dug deep into her resourcefulness shouting in protest at him "can you just wait" (Ln101) and asked him to relieve her pain. However, no acknowledgement of her pain or additional effort was made to relieve it by any hospital staff present. Consequently, while later trying to make sense of what didn't make sense to her, she could only conclude that the hospital's needs mattered more and superseded her own.

Lyndsay further affirms an ongoing, brutal view of her childbirth experience. She recognises there were shifting red flags and an absence of communication from the beginning, and everything felt *"quite rushed"* (Ln113), despite it being a planned C-section. Her name had been omitted from the theatre list, then added to the end of the day, only to be changed yet again to a mid-morning slot without any consultation.

> *"then on reflection, how did that happen? How did they not communicate? How did that, like I gave them enough information for them not to have started that operation, I feel. And then you start blaming yourself, did I not say enough, am I that passive patient lying there just saying yes doctor, no doctor" (Ln158-162).*

Despite the rush, as an allied health professional, she clearly remembered focusing her attention on noticing if her spinal anaesthetic was taking effect. She remembers reporting and physically showing the anaesthetist where she wasn't numb and "*could totally feel"* (Ln123) her right side. However, he continued with his assessment, leaving her feeling dismissed and disbelieved. It was her husband, rather than the midwives or doctors, who noticed and alerted him to her excruciating pain, as her C-section progressed. When she

refused a general anaesthetic (GA) wanting to see her baby being born, the anaesthetist responded by syringing in lots of opioids, similarly to Alice's experience. As a result, her baby's birth was a blur. She felt *"robbed"* (Ln412) at having the sense of *"amazingness"* (Ln91) she got with her first childbirth, stolen from her. No offer of a GA was given after her baby was born and therefore her right for ongoing consent or even the right to change her mind was not attended to. Neither did the anaesthetist alert her consultant or anyone else in the theatre to her pain.

Over four years later, having since achieved *"an incredible"* (Ln550) third childbirth, Lyndsay's distress is easily evoked and obvious during her interview, as she recounts the circumstances and blur of her second childbirth. Her tone is wistful as much as it is regretful for what could have been, should have been, yet wasn't. Lyndsay, like others, falls back into blaming herself when trying to make sense of what she believes shouldn't have happened but did anyway. She reasons she went into her elective C-section all wrong (Ln96) and with "*tunnel vision"* (Ln105). She felt no fear, believed it was all routine and was comfortable in the maternity care setting as an allied health professional with insider knowledge. While blaming herself may give her momentary cognitive relief and control, she continues to be tormented by her conflicting, knowledgeable and reflexive questioning of herself. She wonders if she is just one of these passive patients, saying yes to a paternalistic system. Constructively, her questioning tone holds a hint of anger. She reasons that as an insider; she had given the anaesthetist and her consultant obstetrician enough information to have paused what they were doing. Furthermore, she knew what numb felt like as an expert by experience, having had a previous childbirth by C-section.

Page, Mia, Mary, Grace, Alice, and Ruby, like Sarah and Lyndsay, equally describe unimagined excruciatingly painful experiences where their capacity to cope was eventually

exceeded, following the induction of their childbirths. Each of them identified and voiced their understandings of an early out-of-the-blue experience that felt shocking, as well as fear-inducing, and thereby threatening, shortly after arriving at the hospital. This was only the start of a catalogue of further distressing experiences as their labours progressed. Page, Grace, Alice, and Ruby all proceeded to an emergency C-section for a prolonged/protracted labour, significant foetal distress, and failure to progress to a spontaneous vaginal or instrumental delivery.

Diverging from other participants, Louise welcomed her care and admission at a high-risk tertiary maternity care unit, having had a near-death experience in early pregnancy, as a result of a medical condition. From then on, she lived with the constant uncertainty and worry of never knowing if she or her baby would survive the physical strain pregnancy and later childbirth placed on her body.

> *"it was my faith that got me through, that kept me sane through it all and I don't even know through all this interviewin conversation if I have disclosed how much of an impact it had on me but I mean every day, every night you're wakenin up not sure if your baby is going to survive the day, em if your heart is gonna keep ticking, if your child is goin to be left without a mother", (Ln1274-1276)*

By 30 weeks' gestation, she easily accepted her consultant's offer to be admitted, acknowledging the severe psychological toll her escalating risk was having on her and her extended family. Her trust in her knowing and her unwavering faith further supported her to accept her interdependence on her medical team, for her and her baby's life.

Unlike the other participants, she welcomed a packed operating theatre of medics for her planned C-section. She connected through her familiarity with them and their shared understanding that none of them really knew what to expect, despite Louise being an expert by experience and the medical team experts by profession. The only noticeable overwhelm and crack in her armour of reasoning and calm came when she dissociated as she attempted to put on a too-small theatre hat on her head, just before her surgery began. She recalled thinking *"we're going to need another boat, we're going to need a bigger boat"* (Ln532-533). However, she quickly recovered her composure, reclaiming her competency and adequacy in her time of crisis and unimaginable suffering. She took back control as she felt the tension in the operating theatre, witnessed the worry and vulnerability of the staff *"furrying around"* (Ln 534) and started to *"crack jokes"* (Ln539).

Louise's use of a boat metaphor and needing a bigger boat illuminates her awareness of having to be resourced to navigate the risky waters of childbirth. Similarly, Eva's metaphor reveals an awareness of the risk, danger and the potential for destruction in childbirth finding herself having to *"ride the waves"* (Ln450), like *" a stormy, stormy sea, with a ship in turmoil"* (Ln455). While for Alice she represents the inconceivable, as well as the invisible danger and destruction of childbirth in her *"Titantic"* (Ln 951) metaphor, *"sinking, like sinking like a ship sinking"*(Ln 951), as she tried to not drown in her suffering that is slow and sure. While Mary's metaphor of *"pushing against the tide"* (823-824) describes for her the unnaturalness and enormity of the effort needed to resist unwarranted and unwanted interventions. Sarah's metaphor of "*letting the river take"* (Ln218) her and Page's metaphor of going under water, where there was nothing to hear only the *"Whooooo"* (Ln127) sound of water, describes their dissociation into nothingness, free from pain and the chaos of their childbirth circumstances. Alice further emphasises that the sinking was slow, which is evidenced in her repetition of the word sinking, as

every time she thought she was getting better, she got worse. Despite coping with the pain by dissociating, during her emergency C-section, she concedes *"to die"* (Ln787) would have been preferable.

4.1.2 Feeling betrayed, navigating the impact

Many of the participants believed that the potential for suffering and distress was not communicated to them in any meaningful way during their childbirth preparation classes, regardless of their chosen model. Some participants felt misled by what they were told and led to believe by the facilitators and by what they researched. Others were left feeling betrayed by their bodies, for not doing what they were born programmed to do. Some acknowledged that this unimaginable level of suffering in childbirth went largely unspoken about within their relationship circles. Many regretted their own naivete, despite having professional or personal insider knowledge of childbirth, healthcare or other public service systems, thereby considered to be experts by experience and or by profession. This negative impact reverberated through to their partners, extended family and friends

Alice spent considerable time researching all her childbirth options and potential outcomes during pregnancy, so she was well informed and prepared. She attended ante-natal classes, despite Covid-19 restrictions, learning supportive visualisation and breathing techniques to allow her to support her body, yet stay open to all eventualities.

> *"my partner with this baby and I was just like shaking and like looking around, like, yeah, em, and yeah, he was trying to get my attention to the baby, look how beautiful he is. And I was, yeah, he's beautiful, and I was just screaming. Em, and then, yeah, I remember seeing this baby and thinking he is going to grow up, without a mum I will not see him grow up. And then nothing, they just put me out.*

So for me I was dying. I don't think they put general, I think they just sedated me, that's what I understood by, at the end woke up in the recovery room, there was my husband, very worried, with the baby in his hand" (163-165).

Her consultant's perception that she was the ideal candidate for childbirth and all would be fine also proved unfounded. She, like Sarah, uses the metaphor of *"hell"* no less than 10 times to describe various elements of this unspoken-about suffering, having found herself screaming from unbearable pain during her C-section and thinking her baby would have to grow up without her. Her husband was equally devastated. He watched her put so much effort into researching childbirth and yet suffer so much. Alice describes how he fears the impact of her distressing childbirth will *"destroy"* (Ln825) her.

"if you're not able to do the basic thing that women are supposed to be doing which is giving birth, like, I wasn't able to do and there was nothing. Like it was just, so going back to work was actually very difficult because I don't think I was able to do anything" (992-994.)

Thirteen months later, she admonishes herself for having ever thought she could have influenced a more positive outcome and is left feeling *"stupid"* (Ln802). She experiences an unbridgeable dissonant gap between what she learned, read, and was told about childbirth, in comparison to what she experienced, to such an extent that she is unable to say she gave birth. She acknowledges *"Mentally I was a mess"* (Ln464) and is left with *"being very afraid of dying"(*Ln978) She is tortured by her thoughts on what she could have done differently and the belief that she failed, using the word "*fail"* 27 times, demonstrating the impact her distressing childbirth experience has had on her sense of self, leaving her shamed by her body's inability to do childbirth naturally.

Ruby also prepared well for her childbirth, intentionally wanting to minimise the need for medical intervention. Therefore, she sought out childbirth classes in hypnobirthing and yoga, enthusiastically practising her breathing and all that was asked of her. She acknowledged her naivety in accepting the misconceived ideology of her chosen prenatal classes, that childbirth was mostly a spontaneous and natural event.

> *"[my husband has] never, ever seen me so upset, never so distressed. And I suppose for him to see me like that wouldn't have been pleasant. You know he said he didn't know what to do or what to say, I was just so distressed, when, when I was told it was a c-section he said I was just hysterical like and he said it was, yeah he said it was hard, it was really hard. Yeah, but then it's funny, then the next day you wake up and it's a brand new day and you've a baby and it's all over. Like, it's crazy. If you look back and you go, was, was that me? Did I go through, It's, it's crazy when you think back on it, crazy like" (284-290).*

Ruby, over seven years later, used the term *"crazy"* repeatedly and 22 times in all during her interview, while recounting her experience of her prolonged induction and distressing childbirth experience. The enduring use of the term *"crazy"* throughout her interview mirrors the enduring nature of her distress. Ruby and her husband felt misled into thinking all would be okay, so neither even considered other medically assisted childbirth possibilities. She was equally naïve about the induction process, finding herself completely unprepared. Her only knowledge came through friends who had their babies after 24 hours of going into the hospital, as well as her mother's words, *"you'll get through it, it is not that bad"* (Ln140). All of which, in hindsight, was of little benefit to her.

Her distress was compounded by the exhaustion of sleepless nights, spent overhearing the other women scream out while painfully labouring, with nothing but a curtain to shield each from the other. Yet she steadfastly held onto the hope that if she could remain calm, she would be able to achieve a normal birth. Despite approximately 10 hours of augmented, painful labouring and little progress, Ruby felt she was doing something wrong when she and her husband were excluded from the midwives and doctor's conversations. Her accumulated distress, like the other participants, eventually felt uncontainable, leaving her hysterical, pleading for an alternative when her doctor informed her of her baby's distress and the need for an emergency C-section.

Grace, like Alice and Ruby, as well as many of the other participants, acknowledged her naivety about the reality of childbirth within the Irish hospital maternity care system. She remembers the immediacy and now more fully understands the effectiveness of the challenge to her power and agency on walking through the doors of the hospital.

> *"as we went in, was, I had my lovely, very proud of my, and very protective of my birth plan because I wanted people to know as much as possible to, to honour this for Reubin's experience, and my own. But em, so we hadn't been told we need to kinda of see it beforehand or bring it to your midwife appointment you know and we'll just tick and do whatever. So as the head eh midwife that was on, on the day got it, she absolutely, you know, it was just that whole, pooh, poohed, what are you doing with this, Jesus, we're only seeing this now, well this is ridiculous, what do you expect us to do with this now (speaking crisp and fast)? This whole barrage" (Ln102-109)*

Grace started out celebrating pregnancy and childbirth as a *"rite of passage"* (Ln67) and was strong in her determination to give her baby a good birth experience, thus changing the legacy burden she carries around her own childbirth. She responsibly owns her part in how quickly she submitted to the system, allowing herself to be divested of her power. She uses the metaphor, *"wearing my heart on my sleeve"* (Ln50-51) to describe the open trust she walked through the hospital door with. Ten years later, she easily recalls the face of her admitting midwife for all the wrong reasons. She quickly shut down because of the *"disempowering, dismissive and cold"* reception she was given by the midwife, along with the "whole barrage" of criticism she directed towards her birth plan. She failed to protest, frozen by the shock of the unexpected cold environment she landed in.

Grace describes the hospital antenatal classes, facilitated by a midwife who undoubtedly *"held court"* (Ln82), as *"brilliant craic"* (Ln82), although she believes they primed her to be a passive recipient in the routine, active management of labour. 10 years later, the enduring emotive impact of Grace's childbirth experience is very evident in her countless false starts throughout her interview, although she appears very logically composed. In contrast, Grace described her husband as ready to *"burst"* (Ln111) and *"fuming"* (Ln111) with anger because of how she was being treated, yet he was no more outwardly vocal at the time. Although Grace described meeting some lovely midwives, thereafter, she was unable to shed the negative impact of her initial encounter. This was despite, like Mary, experiencing a glimmer of hope, as she recognised in the acknowledgement in the eyes of a student midwife, that she aligned with her birth plan. She felt worn down after many hours of *"battling"* (Ln201), the physical pain and the unsupportive environment. Her baby became distressed, and he was born by C-section.

4.1.3 Living with "forever scars"

Many of the participants spoke about their experiences of having to learn to live with enduring physical and or psychological scars, impacting their relationship with their partners and imprinting on their child(ren)'s developmental trajectory. Most had little awareness of the potential for suffering and harm as they journeyed through their unique childbirth experience. However, they felt the acute pain of their shame as they took on the blame while navigating their confusion. Some spoke about the darkness they experienced after the harsh reality of what they had suffered in childbirth had sunk in, often over time. Many of the participants displayed a limited capacity to navigate risk, fearfully and consistently watching out to avoid potential threats or at least mitigate the impact as far as possible within their everyday lives. This frequently left them anxious in their decision-making, their capacity to parent and subsequently questioning their ability, as they returned to work.

> *"it's like the pain of the contractions stopped but this whole other pain that was gonna take time to heal, like the, the tearin and the, it, it, just, it felt dark, it felt really hard" (Ln267 – 268).*

Mia succinctly describes her ongoing pain, suffering and darkness that extended well beyond the actual birth itself and is a constant reminder of her *"forever"* (Ln358) physical and psychological wounds. Like other participants, her request for additional pain relief was ignored, as her perineal tear was sutured without adequate local analgesia, despite her repeated protests. No acknowledgement was given that she was heard, and no interventions were made to alleviate her pain by any of the staff in the room. Over three years later, she is confronted many times a day in the toilet by her physical vulval deformity, which she terms her *"forever scar"* (Ln 358) as a labial stitch came out prematurely where she had

torn down to the bone, as she gave birth. She is left questioning what she did not know, was not told, or could have done differently, had she but known.

> *"my ex-partner, em, he'd be walking along the side* [of a river] *going oh look or they'd be all be like the baby ducks and the swans and everything would be there or whatever would be and I'd white knuckling the pram or the buggy on the far side as far away from the water edge as possible and I couldn't let him push her even close to it. I, Like, literally what if you let go and the wheels slip off into the water" (Ln397-401)"*

Mia acknowledges she experienced bouts of depression and marked anxiety, as her perception of the world as an unsafe place for her and her baby took over following her discharge from the hospital. Holding this perception caused her to consistently hesitate and feel challenged, having to step out and engage with the world around her. Adding to this perspective were the unhelpful, throwaway remarks of the midwife resounding in her ears, as she left the hospital, "*there's your baby, try keep her alive"* (Ln282). Deciding there and then that her baby was her utmost priority, although she herself felt like she was "*fallin apart below and I'm feeling in bits"* (Ln289), decided she was no longer the priority. The ongoing impact of her childbirth and the subsequent anxiety she experienced took its toll on their relationship, where her partner left their home when their baby was a year and a half old and has not returned.

Sarah, like Mia, was in unbearable pain and unable to urinate, following the breakdown of her episiotomy scar.

"I'm handcuffing myself to this bed until you sort me out. I'm not going back home. I can't peee. Like, I've got like got serious stuff going on here, and I'm not going home til you sort me out. So they did. (145-147)

Three weeks postnatal, Sarah refused to be sent home for her episiotomy to heal over time, as suggested by the hospital medical team, having just completed a course of antibiotics that made little difference. Her anger and upset were evident during her interview, where she recounted having to lie, just to be taken seriously enough to be reviewed by the maternity care team, on the advice of an allied health professional at the hospital. Her resolve to get the respectful care she needed is evident in her language of her threat of *"handcuffing herself"* to a bed, and in her repetition that she was *"not going home"* until something was done

"but I just couldn't, just, I couldn't kind of handle anything coming at me for a, awhile. I was just trying to cope, was just, felt very, the stress kinda continued on, or the stress response felt like it continued on" (Ln172-174)

Sarah is clear that getting her broken-down, episiotomy site re-sutured proved a game-changer, and her physical recovery was quick and uneventful thereafter. However, the psychological rupture she experienced because of her distressing childbirth experience took much longer to repair, and she was stressed and angry a lot of the time, leaving her feeling *"like a monster"* (Ln386). This rupturing seeped into her other relationships, where she was unavailable to extended family and friends, as taking care of her baby was all she had energy for. Most of all, the fear of how her vulval scarring felt left her too scared to look and *"too scared to see, em but, yes so sexually then as well, that, I just couldn't even consider it".* (Ln380-381). By the time that changed for her, the impact on their

relationship was irretrievable. Her partner *"just didn't want to be affectionate"* (Ln384), and they separated a few months later.

Sadie's episiotomy scar, unlike Mia's and Sarah's, both healed uneventfully. It is the enduring psychological scars that are still impacting 10 years later, as she watches over her son.

> *"I think the type of birth has probably made me want to wrap him up and em then I feel guilty about wrapping him up because I think I haven't exposed him to enough things for him to feel confident and to be able to live his life" (Ln230-233).*

Sadie got pregnant quickly and easily, which somewhat surprised her, having had extensive surgery just a few months earlier. She felt proud to be pregnant and able to carry her baby. Despite preparing well, attending hospital antenatal classes, and the midwives being lovely, 10 years later, she still believes she *"did a bad job"* (Ln62). She recalls her labour as being long, tense and not knowing what to do for most of it, as she experienced an absence of guidance. After 20 hours and a change of shift, she overheard a mature, confident midwife deciding with her less confident colleague that she would do an episiotomy to help deliver her baby. She thinks it *"probably did get it out"* (Ln79). Sadie, in speaking of her baby as an 'it', is attempting to maintain an emotional distance, yet like other participants, is already crying softly, as she remembers the elation of pushing her baby out, followed by the shock of finding out he had a birth defect. She further explains the shock stemmed from having no warning, as it was not picked up on scan, which is indicative of her expected sense to know that has come with modern technology. However, Sadie, like others, defaults into saying it must be her fault and blaming herself, despite a

genetic cause not being found. She declares she didn't wait long enough and wasn't well enough to hold a baby, following surgery.

> *"I think the whole element around feeding him and seeing that he was growing and that he was health and that I could make a healthy baby, em, postnatally healthy, probably helped us both a lot and connected us both" (Ln127-129)*

The psychological scars are only healing slowly, undoubtedly helped by the success and ease with, she achieved to breastfeed him, similarly to Alice and Mia. However, she has waited and watched her child all his life for signs of trauma, bringing him to play therapy from a young age. Sadie feels responsible and guilty that he is sensitive to other people's perception of him, just like her. Her guilt was compounded when he developed a stutter after she gave birth to his sibling, who had no birth defect. She openly acknowledges she prioritised her need not to have to continue to wallow in what she*" hadn't done right"* (Ln172).

4.2 Having to Capitulate

"*I really hated the fact that someone else gave birth to my baby", P6*

The second group experiential theme illustrates how many of the participants felt they had little or no choice but to go along with whatever it took to deliver or be delivered of their baby. Often, they found themselves alone, battling from the beginning to be heard, pleading for guidance and supportive care. Many of the participants, similar to Mary, described their experience of the *"rush"* (Ln191) once they unwittingly found themselves "*in the queue"* (Ln180) on the Irish childbirth induction *"conveyor belt"* (Ln190), where their pain, rapidly and with a force *"all of a sudden then, it went just, bang, out of control"* (Ln356). Moreover, participants felt they and their partners found themselves similar to

Mia alone, *"Just left"* (Ln117), regardless of choosing public or private care. Regardless of choosing the public or private system, Lyndsay described the chances of receiving quality care as actually a *"gamble"* (Ln557). Therefore, care received or not, resembled for Mary the *"luck of the draw"* (Ln19) as participants reported call bells endlessly hopping, with midwives running off their feet. Ultimately, their distressing experience highlighted to them that they, as individuals, mattered little within an oversubscribed and under-resourced maternity care system, where Louise describes the staff as having little time to "*gauge their audience"* (Ln254). As a result, participants were hyperaware of what got said, who said it, and the tone used to say it, with every interaction they had.

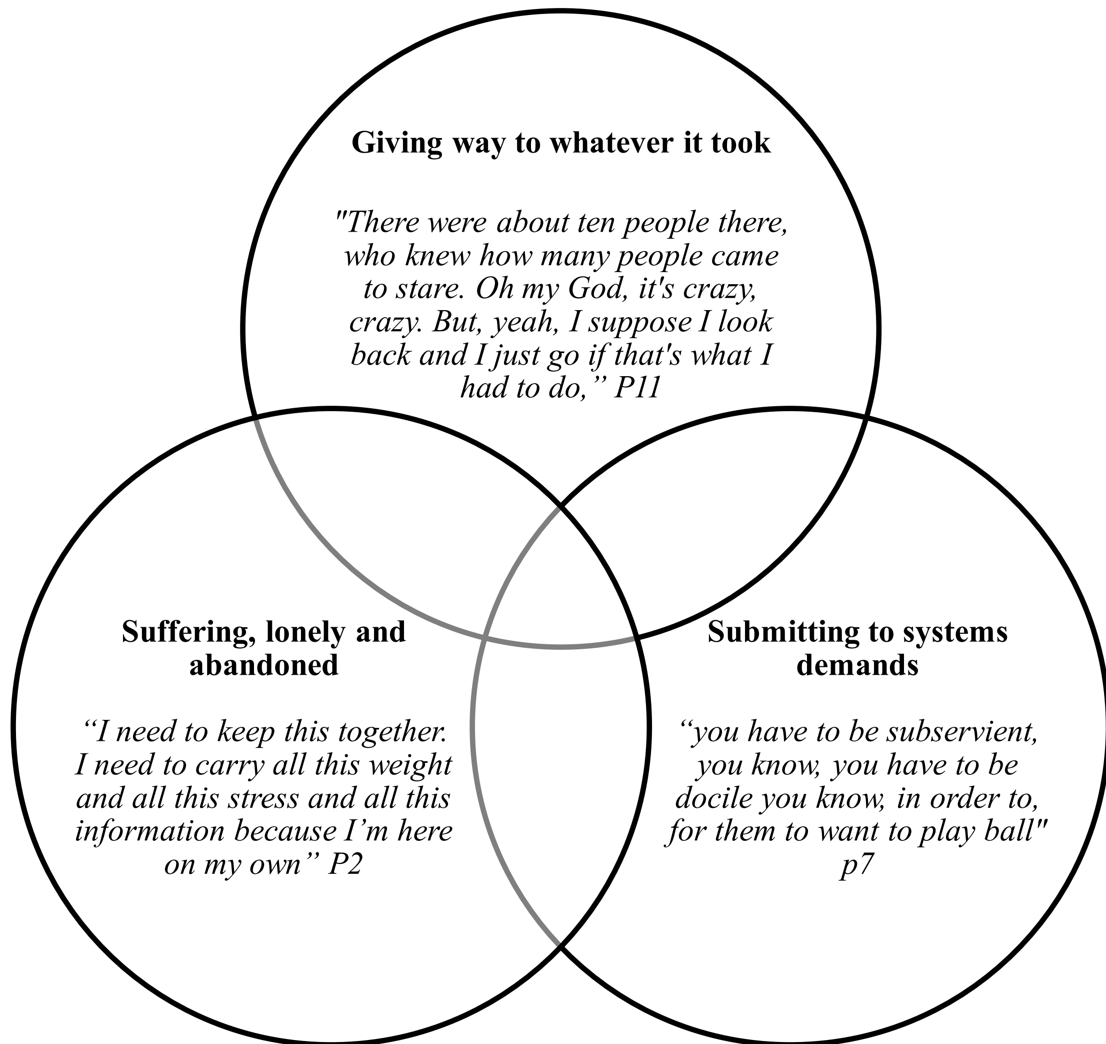
Table 4:

GET 2 with sub-themes and their prevalence in the participants' experiences.

GET 2: Having to Capitulate	P1 *	P2 *	P3 *	P4 *	P5 *	P6 *	P7 *	P8 *	P9 *	P10 *	P11 *	P12 *
2.1 Giving way to whatever it took	*	*	*	*	*	*	*	*		*	*	*
2.2 Suffering, lonely and abandoned	*	*		*	*		*		*	*	*	*
2.3. Submitting to systems demands	*	*	*	*	*	*	*	*	*	*	*	*

Figure 4:

Three sub-themes from GET 2 with relevant participants' quotes



4.2.1 Giving way to whatever it took

Participants spoke about being pressured and rushed into yielding to the maternity care system, where things felt wrong, throughout their childbirth experience. This was despite being open to and asking for guidance, having onboarded that nothing about childbirth goes to plan. Participants were often left feeling powerless, worthless, invalid and not mattering, as they moved through their childbirth journey. In their pain and vulnerability, push back was notably absent, even among those who had expertise by profession or

expertise through experience. Participants who managed to voice their protests were eventually worn down, as were their birth partners who came to their assistance and advocated on their behalf. Some participants notably derealised to cope and escape their suffering in the moment.

Eva is aware it was about doing and giving way to whatever was needed, knowing her baby showed obvious signs of distress at birth and took four minutes before she heard him cry. As a result, Eva describes hearing her baby cry as *"the best moment ever"* (Ln70).

> *"it was a storm. Like a stormy, stormy sea, a, with a ship in turmoil and then a then the clouds when the baby finally cried for the first time, baby cried, eh, some sun" (Ln455-456).*

She is catapulted back there again as she talks about her experience. Tearing up and crying softly, she voices how quickly she is transported back in time, place, and space, as she describes her experiences and as she outwardly reveals her vulnerability. As a knowledgeable allied health professional, she accurately presupposes she is not alone among my participants in the triggering of her emotions. All of the participants notably cried silently and softly as they described what happened to them in childbirth and the levels of unimaginable suffering they experienced. In her presupposition, she potentially preserves her autonomy and agency as a knowledgeable professional during the interview. This contrasts with her childbirth experience. She, like others, is drawn to metaphors of the sea to support her expression of the intensity of the effort and the depth of the turmoil she experienced during her distressing childbirth. She proffers that she loves water, loves surfing the waves, loves swimming, as the cold water supports her to feel present and alive in her body. Surfing the pain of her embodied contractions had a similar visceral impact,

allowing her body to productively use the pain, supporting the descent of her baby. She welcomed feeling alive, connected and present to her baby, doing childbirth *"the amazonian way" (*Ln411). This archetypal perspective supported her spiritual belief that her baby's soul enters its body through childbirth, where previously as *"one, you become two"* (Ln402). She concurrently transitioned from being the first in her life, to becoming the mother who puts herself last within a family of three.

> *"I hated the epidural, I hated the epidural, I hated the sensation of not feeling what was happening. I really hated the fact that someone else gave birth to my baby"* (347-348).

All this was taken from her, in the unfeeling sensation she got, once she acquiesced, accepting the epidural, which she will always *"deeply regret"* (Ln372). Yet she felt she had no choice but to give way to an epidural, to reduce the too-soon sensations of her body's urges to push. However, she remains conflicted, blaming herself for how this came about, despite her husband's clarity that she was told to take the epidural. She remains unsure if she *"just capitulated"* (Ln49) from exhaustion or shut down when the midwives failed to be forthcoming, offering little in the way of supportive guidance when she asked for it. Regardless, without the visceral sensation of pain, Eva was unable to stay present to her labouring and giving birth, drifting in and out of sleep. Her intense longing to have held out and *"have a natural birth"* (Ln54) is very evident throughout her interview, as is the magnitude of her loss in declaring, *"it ruined my giving birth"* (Ln351). Furthermore, she recalls it was following the epidural that her labour slowed, and her baby's condition deteriorated, resulting in a forceps delivery, with the aid of an episiotomy, leaving her vehemently asserting the impact this catalogue of events had on her. The strength of emotion is evident in her repetitive use of the word *'hated'.*

Sarah's baby, like Eva's, was delivered by forceps, which she has little memory of. She too derealised, feeling powerless to change her situation and withdrew inside herself, describing, *"some part of me went, just gone off somewhere"* (Ln79)

> *"I don't even probably remember this but they em, Rowan had to be pulled out by forceps an, an, and I don't think I actually remember that. I didn't even know he was born until he was already born. It was just a complete, kind of, don't even know what the word is, I was going to say, panic, just, just, all happened like as if I almost wasn't there. I was just in so much, I don't know whether to say pain or panic, eh I don't know what the word is. But then eh my partner was there and I looked over and Rowan was born. He was on the table over beside me and luckily he was OK" (Ln92-98)*

Sarah felt powerless to change her situation, recalling during her interview, screaming in frustration at the *"mismatch"* (Ln83) between her embodied experiencing, what was happening around her and what was being asked of her. She was unable to discern if she was experiencing pain or panic, fearing, like others, in the lack of guidance and confusion, *"something was very wrong"* (Ln64). Staff failed to attune to what she needed. Furthermore, by *"shouting"* (Ln88) at her, they failed through their interactions to create a safe space within which she could co-regulate. Neither did they provide a supportive environment, so that at the very least, she could self-regulate and stay in control. Therefore, she reluctantly gave way to the will of the hospital maternity care team, letting others take over, intimately intrude on her body, and pull her baby out by forceps, where she felt lucky, he was alive. Her emotionality was evident over four years later in her many

speech hesitations, repetitions, false starts, and panicked tone as she vividly recalled her experience during her interview.

Ruby acknowledges that, while her childbirth was a crazy experience and she was glad when it was all over, she, without doubt, like Eva and Sarah, would do whatever it took and go through it again if she had to.

> *"I don't even know who did the section, I couldn't tell you, there were about ten people there, who knew how many people came to stare. Oh my God it's crazy, crazy. But, yeah, I suppose I look back and I just go if that's what I had to do"* (Ln303-305).

Ruby, like some of the other participants, uses double digits to describe the volume of people who attended her C-section in the operating theatre. She very directly relays feeling objectified in the process, where it appears no one introduced themselves to her. The theatre staff's staring presence on the day came without any forewarning and thereby felt quite intrusive. Ruby very aptly articulated the impact of being objectified during her interview when she said, *"who knew so many came to stare"* (Ln 304). Over seven years later, she still does not know who delivered her baby, is baffled as to why it took so long for him to be born and cannot fully understand the uncontrollable shaking she experienced for an hour and a half following her C-section. None of her friends could relate to or understand her experience either. Her husband never talks about the whole birth now. The day following their child's birth, he told Ruby how petrified he was, as he had no idea it could end in an operation. While she acknowledges the midwives were doing the best they could, she would definitely have valued a bit more information, care and attention, so she knew what was happening.

4.2.2 Suffering, lonely and abandoned

All participants recognised that hospital maternity care staff were doing their best within this predominantly under-resourced and overburdened system, where the scope for person-centred, respectful care and connection was evidently limited. While five participants found themselves thrown into the quickly escalating, intensely stressful, partner and visitor restrictions imposed during Covid-19, this experience of feeling alone and or abandoned was not exclusive to them. Participants frequently felt they and their care needs were invisible to the staff around them, where their pleas for guidance, care and or pain relief were ignored. In divergence, the participants were often acutely aware of those around them, as their hyperawareness increased with every interaction and/or encounter they had. They noticed what was said, the tone it was said in, and who said it.

Page had no choice only to navigate much of her childbirth journey at the hospital during Covid-19, without the support of her partner or extended family. The National Covid-19 message she was compelled to live from *'being together by staying apart'*, primed her, like Emily, Alice, Mary and Louise, to feel she had to carry the stresses of childbirth alone.

> *"the midwife first, she takes your blood pressure and she says " have you thought about your plan and I was like actually, here it is. I have printed it and I was like why did I do this and she was like now this is all very detailed and just to let you know like it doesn't and I know it doesn't go to plan I was like I've just done this so that I am aware kinda of what all the, what I suppose all the medical terms are and stuff like that. Em again so that if I went in, I wasn't as if what are they talking about" (Ln17-22).*

This pattern of enforced and circumstantial separation, despite being regularly surrounded by people, exacerbated her aloneness and featured throughout her distressing childbirth hospital experience. Her single-voiced attempt to make a meaningful connection with a hospital midwife during a routine antenatal appointment, minutes before she had a defining visit with her consultant, failed. Page like Grace enthusiastically handed over her typed birth plan when asked by the booking-in midwife. Going against her own better judgment to keep it in her head, she felt admonished, as the midwife's tone displayed her disapproval of the detail it contained. Neither did she attend to Page's reasoning for her childbirth preferences, as she walked towards the consultant's office.

> *"I noticed the tone in her voice changed. She was like have you noticed any fluid leaking and I was like no, nothing like that and then I stopped recording. So I still have that video cause like, so that was the moment like I was gonna be admitted. She was like, the, the fluid is quite low" (Ln26-29)*

Her consultant's out-of-the-blue decision to induce her early because of reduced fluid around her baby shocked her, as she wasn't *"meant to have the baby"* (Ln58). She received this news alone, separated from her partner, who sat equally alone, in the car park, anxiously texting *"what's going on, what's going on" (* Ln39-40). It was only the consultant's audible change in the rhythm and tone of her voice that forewarned Page that something was wrong. Page retrospectively and on hindsight, identifies this alone and unforeseen moment of her admission as the beginning of her anxiety. She equally recognises, like other participants, it's shocking and derealizing impact, as she remarks it "*felt like an outer body experience"* (L33). This brought her into a state of hyperalert and anxiety, that she continues to deal with over a year later, and is clear she had never experienced before childbirth.

"I need to keep this together. I need to carry all this weight and all this stress and all this information because I'm here on my own and then that's why as soon as Eric came in it was just like phewww and, and obviously at that stage she had been born and you know we heard her cry and it was just like ugh, it I felt like I was just holding my breath" (Ln 770-774).

Her aloneness was further compounded by the staff's miscommunication around making sure she had her phone as she was brought to the operating theatre for a C-section. Once again, she and her partner were annoyingly separated, without voice contact, at a critical moment. Page further describes her *"brain just runs away with itself"* (Ln122) as she worries, he may have an accident on his way to the hospital. Held back by hospital security staff, he missed out by minutes on the birth of their baby. Her helplessness, anxiety and aloneness escalated without her husband, leaving her overwhelmed like others, despite a packed operating theatre. She felt compelled to hear, understand, and make sense of it all, so she could impart the details and give some sense of inclusion to her husband and parents later.

"It literally just felt like a dream because like I was sat forward on the table, they were trying to put the, the spinal tap in, but then the midwives were in front of me telling me to lean back cause they had to read the baby, like check heartbeat and then I, All I remember hearing is, cause it was so like, it was like a, it was like your head's under water. It was like "whooooo" like that type of, there was so much going on" (Ln123-128)

To survive the overwhelm, she dissociated, letting go into a dream state, likening the sensation to her head slipping under the water. There was an absence of anything to be heard or remembered. All that existed in this alternative world was the simple *"whooooo"* (Ln127) sound of water. The overwhelm is further evidenced in her use of false starts and repetitions. It was only when she and her husband were finally together did she allowed the release of her emotions.

> *It was just like in absolute agony and on my own and I was like this is like shit* (Ln177)

However, her aloneness persisted after Page was transferred to the postnatal ward without her baby, who went directly to the NICU from the operating theatre. Despite being in a crowded room of four other mothers and their babies, her diverging circumstances left her feeling isolated, in agony, where she acknowledged her circumstances as *"like shit"* (Ln 177*)*. It was a conversation initiated by another mother that bridged this shitty, agonising and isolating gap for Page, where they bonded over their mutual experience of having babies in NICU. Furthermore, she was able to support and reassure Page that all would be well, as an expert by experience with insider information, having had a previous baby in the NICU.

Mia discovered early in her antenatal hospital care that there was little acknowledgement of the aches and pains that she as an individual suffered while pregnant, as all were deemed normal when taken from the perspective of the majority. Mia progressed through her pregnancy as an older mother, only wanting *"to be safe and OK"* (Ln51), which she refers to seven times throughout the interview.

> *"nothing felt normal because you're healthy and normal before you're pregnant and now you're getting pains in all sorts of places and discomfort and it wasn't normal for you as a person from comin from none of this but, everything was considered normal"(Ln26-28)*

Coming from an older, first-time mother's perspective, this seemed to her a dissonant contradiction. Straying from this bio-medical hospital norm left her feeling lonely as an outlier, where her perception of feeling unsupported and unmet, potentially accentuated and prolonged her symptoms.

> *"it felt lonely and em, it felt like if it, it almost felt like it extended it because it was like okay you don't even know what I'm talking about how can you help me if you can't help me then I have to suffer this for how many more months" (Ln34-36)*

Furthermore, she was frustrated at the lack of continuity in her care, having to engage with a different doctor at each of her hospital antenatal appointments. This left her little opportunity to build a relationship or make any meaningful connections with any of them. On one visit, she became concerned for her future care at the hospital, as she was the one defining restless legs and explaining her symptoms to yet another new doctor. This did little to alleviate her worries or her suffering. Furthermore, it eroded her confidence and trust in the system that she had anticipated as supposed to be there to care for her. Consequently, she aimed to stay open to whatever came her way, deciding to *"take what I need to take if I need to take it"* (Ln50-51). Her anxiety, although more manageable over three years later, was alive and palpable in the room, as she recounted her past experiences and understandable desperation. Her mouth became dry, her voice often quivered, and her breath was shallow.

> *"I don't think it was as strong as am I going to die here now, but it was a massive sense of, I really don't know what's going to happen next and I, I don't have anybody around me right now when I'm asking for help to check me more or to talk to me"* (Ln442-445)

Nonetheless, Mia agreed on the advice of her medical team to an induction on her due date, because of her older age. While she attended antenatal classes, she found little correlation between what she was told and heard with what she experienced. Neither had she any significant information to draw on from her wider circle of family or friends, as it largely goes unspoken about. She recognised, in the not knowing, *"so much goes through your head, panic like hope, excitement, em, fear"* (Ln91-92). Subsequently, she found the unfamiliar, intrusive level of intimate physical *"pokin and proddin"* (Ln61) of her actual induction experience all very painful and shocking. No one involved on the day talked her through the steps of the induction process, so she could know what to expect. Mia cried softly and silently as she recounted her sense of powerlessness and near-embodied collapse with the sudden, unexpected onset of intensely painful contractions as she and her partner walked back unaccompanied by a midwife to her ward, following the breaking of her waters by the doctor. While she is uncertain, if she believed she was dying, there was no midwife available to guide her or provide her with knowledgeable professional support. Not knowing how much longer it was going to last, she felt she had no option but to continue suffering, pleading, albeit only non-verbally, for staff to *"please look at my face and the pain in it and, and hear me ask you for help"* (Ln438). Eventually, when help arrived, it was too late for her to have any effective pain relief, as her baby's birth was imminent.

Diverging from all the other participants who gave birth in one of the large city maternity hospitals around Ireland, Emily attended one of the smaller maternity hospitals in Ireland, close to where she lived. Emily, like Page, was pregnant during the pandemic, where she too took on the hospital and the government's expectations during Covid-19 restrictions to cope with any eventualities on her own. Her connectedness within the locality proved to be an empowering resource at critical points following her hospital admission.

> *"the only thing that kept me going during the day was because I was in my local hospital, and here's the networking again, there was a girl there that I played basketball with, as a midwife. There was another girl there who was working on the wards as a healthcare assistant, [*whom she also knew from living locally] *(Ln297-300).*

Her capacity to utilise these networks built up over many years was mostly a game-changer in her favour. As a team player, she noticeably embodied the strategy that it takes a team to win a game rather than a lone person doing a solo run. Therefore, Emily acknowledges the luck and benefit of meeting a very familiar face, as she was being induced. She came across in her interview as calm and confident, regularly laughing, as she recounted this aspect of her distressing childbirth. Moreover, this sense of connectedness, once established, was reciprocated with a similar and intentional focus by the other, who took on the same goal. This was evident following her induction, where the doctor refused Emily's request to have her partner in with her at this early stage of her childbirth, stating she was not yet in labour. However, he had only exited the room when the midwife asked Emily if she wanted her husband to come in. Their strong sense of connectedness allowed for a more agile, personal, and empathetic interpretation of the political and hierarchical rules, thereby strategically influencing this system in their favour.

> *"It was only then, so this lovely lady who was a midwife, she got me sitting up and we pretty much put on a show when the big boys came down from the maternity ward to see me, to see how I was getting on" (Ln164-166).*

This pattern of actively working to influence the system is repeated many times throughout Emily's hospital stay, where she garnered the supportive care she desired and or needed. She was never deterred by an initial refusal of her request. When the head consultant strongly advised her to stay another night in ICU, she persisted, confident in her capacity to achieve what she wanted and was eventually transferred to the postnatal ward to be with her baby, feeling like she *"had won the Lotto"* (Ln197). This contrasted with others who had no connection or capacity to improve their connection to the staff they met.

4.2.3 Submitting to the Systems Demands

Participants frequently felt let down by the professionals and disillusioned with a system that some perceived had primed them for the active management of labour. Eleven of the 12 participants chose a hospital childbirth from the outset, where they expected to be cared for and safe, rather than harmed, as they navigated their childbirth journey. Eight of the participants could be considered professional insiders, with knowledge of childbirth, allied healthcare or other public service institutional systems. Most participants were aware, and some were even despairing, of the negative impact on the maternity care staff, who found themselves providing less than optimal care, in a system where they were run off their feet. In particular, some participants worried about the impact of this overburdened system on the student midwives they encountered, whom they perceived as still having the capacity to empathetically engage with them as they laboured, yet little power to enact any influence. Equally, most of the participants displayed little to no capacity for pushback in

the moment, where they described experiencing inadequate, neglectful, disrespectful, and even coercive care. Those who tried to protest often found themselves very effectively redirected and or thwarted in their efforts to influence the care they received.

Mary and her husband had on more than one occasion advocated for a less medicalised induction from the time they arrived at the hospital. However, the ongoing horribleness of the staff eventually and effectively coerced them both into submission.

> *"you have to be subservient, you know, you have to be docile you know, in order to, for them to want to play ball. Do you know, they didn't like the resistance, do you know. But like John would say of all the times to be entering into a hostile environment, you know, you don't do it when a woman is already in distress like and most vulnerable" (635-639).*

Mary did not bother making a birth plan, as her previous experiences of childbirth suggested; care was determined by what the staff wanted and decided. She came to understand *"it's the luck of the draw"* (Ln19) who was allocated to mind her, as she could sense the *"eye rolling"* (Ln853) when she asked to use the birthing pool, dismissing her request, saying her blood pressure was high. Furthermore, she and her husband were left defending themselves against micro-aggressive *"snide comments" (*Ln292), culminating in a midwife telling her that *"was the system"* (Ln213) she had *"signed up for"* (Ln214).

> *"I was crying to this new nurse trying to say to her look, I'm not a verbally abusive person. I said God, I don't want you to think you know that I'm a horrible person and I was like, I was so now conscious of her thinking I was a horrible person and like. Anyway, so the stuff starts and the Oxytocin is now coming into me now and*

she was trying to explain that you know, it's gonna go up and up and up and all I can equate it to is, it felt like I was in the, the, you know, you know, the chamber, the gas, you know, the chambers where they're trying to execute people" (Ln 332-338).

Having reluctantly agreed to her consultant's recommendations for an induction, Mary was left speechless when accused of being verbally abusive by the ward manager after she asked her consultant to have a different midwife allocated to her care. While this change happened, she vividly recalls the nightmare of watching the ever-increasing doses of oxytocin being pumped into her regardless of her agonising pain. The midwife's slow response to her request for pain relief left her believing *"they wanted to see [her]in pain*" (Ln368-369), the consequence for challenging the system. Like others, she thought she was about to die, equating her overwhelmingly painful experience to being in an execution chamber.

"That really pissed me off then as well. I was like, actually they just, I'm a money bag, a fiscal unit, that's all I am" (Ln752-753)

She is still angry a year later, feeling she mattered so little. Her inadequate care was no better than the public system of her two previous childbirths, despite booking costly private care to receive better care. She concluded she was nothing more than *"a fiscal unit"* (Ln 753), *"a number"* (Ln821), *"an inconvenience"* (Ln738).

Mary acknowledges that for months, the thoughts of what happened, like others, brought her to a very vulnerable and dark place and space. She recounts bawling in front of her mother, brother, and sister in-law, as she relayed her experience while visiting them two to

three months later. However, it was their combined supportive acknowledgement of how horrible her experience had been that left her realising its ongoing impact, articulating "*that really flipped me up*" (Ln547). She uses the metaphor of the darkness of a cloudy day to mirror the darkness of her childbirth experience, which was in stark contrast to the sun that was actually shining that day. Mary continues to regret, one year later, not pausing her induction, feeling ashamed she submitted to the consultant's demands. Moreover, she worries these decisions dictated "*the life course*" (Ln831) of her child, while it "*definitely robbed*" (Ln718) her of the joy, that moment in time and the naturalness of childbirth for her.

> *"modelling is modelling into that nurse, the young nurse who hasn't had kids and has obviously is idealistic, do you know what I mean and has all these preconceived ideas. But she thinks that, that behaviour of, of the bed manager is normal and that's an issue, you know. So, and that's more toxic than anything else cause that then feeds the system, you know. So you, you see and you do, you know, baby sees, baby does, you know" (Ln787-791).*

Mary, like Grace, is further concerned about how her experience of *"toxic"* (Ln790) behaviours, that are perpetuated by poor care, "*feeds the system*" (Ln790). Mary passionately articulates, these toxic behaviours are normalised within the system and thereby are negatively impacting the idealistic young student midwives in that "*baby sees, baby does*" (Ln791). She believes her concerns are well-founded, as she witnesses similar recent changes in her babysitter's temperament, who is a final-year undergraduate nurse. As a result, she has become intolerant of her children, which she cannot allow to continue. Therefore, she concludes that if an environment is making staff "*hard and tough and horrible*" (Ln901), they are in the wrong place.

Sadie went into labour planning to have her baby straight away and do skin-to-skin. However, her experience and reality after her baby was born were very different. She recalls being dissuaded from having her baby, as the midwives decided she was too exhausted to keep him with her.

> *"they said everything was fine but because I wasn't, and they told me, I was exhausted, but they told me I was exhausted and em, they needed to take him away for a while. Yeah, I really felt like I should be able to cope" (Ln-335-337)*

Sadie was devastated when they told her they were taking him away. Having her baby taken from her, apparently without any collaboration, features five times during her interview. Equally, she recognises that while she didn't want them to take her baby away, she didn't protest either. She submitted on the basis that this was *"the best medical advice"* (Ln367) at the time and relinquished him from her care. While she understands they were trying to be kind, it left her believing she was unable to cope and that the midwives perceived her as too "*fragile" (*Ln353) to be a mum. Therefore, she felt robbed of the opportunity, like Alice and Eva, to do the job she *"was programmed to do"* (Ln340) and be the *"good mum"* (Ln119) she wanted to be. Consequently, she was elated when her milk came in. Successfully feeding her baby allowed her to believe she was a proper mum, like Alice, as she was no longer inflicting further injury on her baby. This went some way towards compensating for all she continued to blame herself for doing or not doing throughout the years. She acknowledges this was the point where she came back into herself, got into the zone and started her job as a mother.

Over seven years later, Ruby remains perplexed, not understanding why she didn't ask more questions over the five days it took for her labour to be induced. She wonders why she did not ask and seek to understand the expected normal sequencing of events following the initial attempt by the doctors to induce her.

> *"And maybe I didn't ask enough questions, I do think that now. I do think why didn't I ask or was that the way it worked? I don't know why I didn't. I think I just, I don't know why, I didn't ask enough questions, definitely not. Em, and I should have, I should have said, if this doesn't work what do you do? Or is there a way to do, bypass all those gels? I don't , I don't know, why I didn't ask. You know, that kind of sticks with me. And em, because I know a friend of mine is a nurse and she said, why didn't you just ask them? And I don't know, I don't know" (Ln165-172)*

During her interview, she is aware that her distress started early following her arrival at the hospital, like most of the other participants. Ruby is definite that having no choice but to listen to the comings and goings of the other labouring women, similar to Page, increased her doubt and impacted her confidence in her capacity to do childbirth. She succinctly describes her unnerving experience as *"different women and it was the same screaming"* (Ln 141-142). She felt disbelief that childbirth could be that bad initially. However, over the following two days, her anxiety increased, as well as her doubt in her capacity to go through childbirth, as she came to terms with its painful reality. In the end, her doubt became a self-fulfilling prophecy. Ruby's husband, annoyed and irritated by the environment they were expected to endure, wanted to intervene and alleviate both their distress. He pursued it no further when Ruby somewhat irritatingly expressed her sense of powerlessness to change what the system demanded of them, saying, *"I'm not Kate Middleton having a baby"* (Ln379).

"like there might be a few, like I knew the doctor was talking to the midwife and I couldn't hear what they were saying and I started to go, what are they talking about, why aren't they telling me what's going on?" (Ln123-125)

During her interview, Ruby ponders if she could have bypassed the whole process, as she did for her second childbirth. She found the multiple vaginal examinations she had, checking her progress, to be very *"intrusive and painful"* (Ln352) and began dreading seeing a doctor coming towards her. She defaults, like others, to self-criticism and blame to support her make some sense of her situation at the time and give her control over the cognitive dissonance she was left with. She believed she was *"doing something wrong or her body is wrong, or I don't know, there was something wrong with the baby"* (128-129). When she and her husband were excluded from the doctor-midwife whispering conversations, while desperate to know what they were talking about, neither followed through to ask or requested to be included. Neither were they informed. Rugby recognises, on hindsight, she was *"very trusting in the midwives and doctor"* (Ln122) in her vulnerability. However, she was less trusting, less open to being so vulnerable and emotional during her second childbirth, definitively opting for an elective C-section so she could stay in control and hold on to being her more normal *"together person" (*Ln118). She took this decision following her previous distressing childbirth experience, based on her ensuing belief that she was *"not made to give birth"* (Ln106) and her body didn't do *"what it should"* (Ln108) in childbirth, similar to Alice and Sadie. Her bewilderment at her lack of questioning sticks with her today. Her use of the word *"sticks"* (Ln169), which suggests the lack of answers to her self-questioning endures, and she is unable to shake it off. It is more figure when her friends highlight that they asked lots of questions and or

wonder why she didn't ask them. Equally, her experience in comparison bears no resemblance to theirs.

4.3. Regaining Coherence

"She's literally yours. You can pick her up as much as you want, and I think that came from not having that choice" P2

The third group experiential theme represents what was achieved by all the participants over time. Participants described being flipped and upended by their distressing childbirth experience, although all were very grateful that they and their baby came through the experience alive. For most, it was evident during their interviews that the impact was ongoing, although less raw, regardless of whether it was one or 10 years that had passed since their distressing childbirth. Participants reflected on their passivity, the loss or giving away of their personal agency and for a few, the negative impact of their distressing childbirth on their relationships. Many of the participants felt compelled to voice their distress, seek further clarity and a greater understanding of what happened to them. Over time, they worked through their doubts, fears, anger, and confusion to regain their sense of coherence. Some accessed outside relevant supportive care to fill the gap in the care they had not received. Others sought postpartum appointments directly with their consultant, while others took the opportunity to participate in a reflective birth process offered by the maternity hospital. Six of the twelve participants engaged in some form of individual psychotherapy, group therapy, or body work to support them in working through the negative impact of their childbirth experience on themselves, their child, and their immediate family. Most participants were generous, thoughtful and kind in their articulation of the obvious, conflicting pressures they experienced from the maternity staff and care system to be under. Most participants understood that the various healthcare

professionals working within this environment also bore their own costs. Furthermore, they lamented the detrimental modelling of a deficient and flawed system on the idealistic aspirations of student midwives.

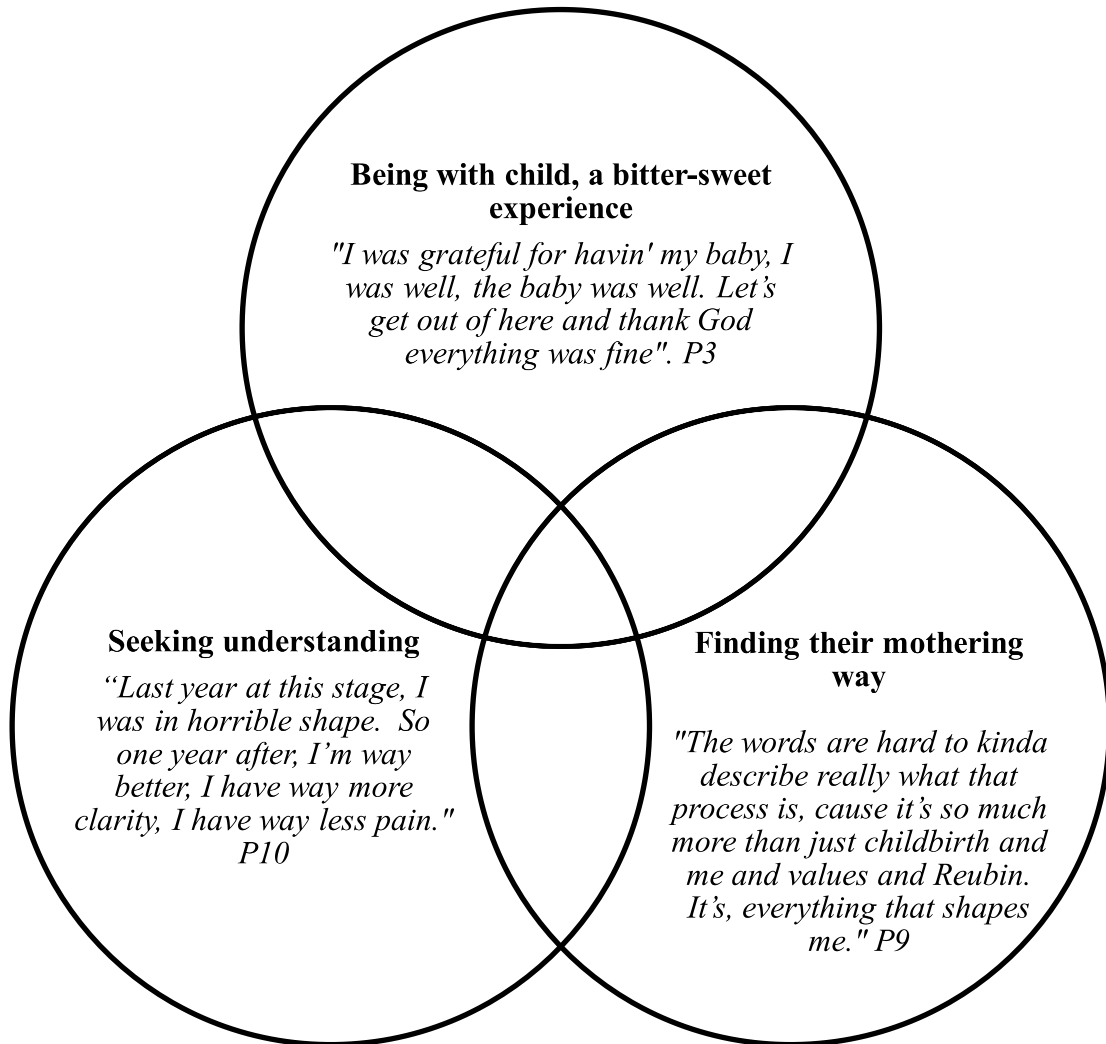
Table 5:

GET 3 with sub-themes and their prevalence in the participants' experiences.

GET 3 Regaining coherence	P1 *	P2 *	P3 *	P4 *	P5 *	P6 *	P7 *	P8 *	P9 *	P10 *	P11 *	P12 *
3.1 Being with child, a bittersweet experience	*	*	*	*	*	*	*	*	*	*	*	*
3.2 Seeking understanding	*	*		*	*		*	*	*	*		*
3.3 Finding their mothering way	*	*	*	*	*	*	*	*	*	*	*	*

Figure 5:

Three sub-themes from GET 3 with relevant participants' quotes



4.3.1 Being with child, a bittersweet experience

"I was grateful for havin' my baby, I was well, the baby was well. Let's get out of here and thank God everything was fine". P3

Many participants articulated how they felt robbed of the joy of giving birth, portraying their childbirth as a bittersweet experience, because of the cumulative, agonising and distress they experienced. The dearth of care the participants received, particularly psychological care, was recounted in detail. This agonising overwhelms and dearth of care

was contrasted and temporarily alleviated on just glimpsing, seeing, and or being with their baby following childbirth. For some, being with their baby following childbirth made it all worthwhile. For others, the government's message of having to do childbirth and care for their baby on their own during Covid-19 left them feeling like a bad mother and a failure when they experienced difficulty coping. Therefore, some of the participants left the maternity hospital as soon as they could, knowing they would recover better in the familiarity, support, and safety of their own home. However, all felt lucky, grateful, and blessed, regardless of their experiences, that their baby was healthy and well. Many participants concluded this notion of feeling lucky was the attitude that the Irish maternity care system fostered and expected them to accept and adopt.

Mary and her husband both believed childbirth to be a sacrosanct experience, where allowing nature to take its course was their preferred option. However, both agreed that the availability of a medicalised childbirth is beneficial when things start to go wrong. However, Mary and her husband were both angered by the speed and painful impact of the induction process on her, as well as the missed care she received.

> *"it's kind of bitter sweet in a way, or it was you know impactful, or like [my husband]was impacted in a different way I suppose, just anger, different emotions. But in a way he, he, he got you know, a baby and we got a baby, so you know, I'm like, and I think that's what they want you to do, well look aren't you lucky at the end of the day, you know, so don't worry about it, you got what you wanted so it didn't matter about the process"(Ln640-644).*

Mary cries softly as she recalls her consultant asserting that it was a gorgeous day for a baby to be born. In divergence, she only connects with how *"unnatural even having the*

conversation" (Ln 807) with her consultant felt, the *"darkness"* (Ln803) of going somewhere she would rather "*block out"* (Ln802) as if she is "*forcing something that shouldn't be"*. She likens it to the system *"playing God"* (Ln809). Mary knows her experience is commonplace amongst her friends, with at least ten of them having a similar story to tell. She further resonates with the commonality and enduring nature of her distressing childbirth experience, having heard the numerous stories of women, and some men, relay their distressing childbirth experiences from across Ireland to RTE Radio One's presenter Joe Duffy for weeks, towards the end of her pregnancy. Her distress is still evidenced in her false start above and repetitions. Yet she and her husband are both grateful for their baby, as they reconcile, this may well be *"the best that you can get"* (Ln628).

Moreover, Mary articulates that she will not have another baby, despite wanting one, wondering what more she could have done, outside of seeking private care. Therefore, her concern moves to her three daughters having to go through childbirth, knowing she and her husband were not asking for a lot, certainly not *"bells and whistles"* (Ln668). She hopes her daughters will be blessed with the opportunity to experience childbirth but worries if the system and the people will treat them "nice" (Ln667). Therefore, she concludes her experience is "*kind of bittersweet"* (Ln640).

> *"but again, I was fearful, I was glad that I had my baby and that I was getting home and that thank God everything had worked out ok. So I was looking at that meeting as a bashing thing, if you know what I mean. I didn't want to go in and start giving out because I was grateful for having my baby, I was well, and the baby was well. Let's get out of here and thank God everything was fine. So I*

didn't want to go in and start telling them what they did wrong or what they should have done" (Ln 930-937)

Louise, like Mary, was grateful for her baby and that he was well, having lived in constant terror that she might die during her high-risk pregnancy. She drew a deep breath in, as she listed off the essential medication she was prescribed, to preserve her and her baby's lives. Louise was grateful for the close monitoring she and her baby received during her pregnancy. In contrast, she felt uncomfortable and under surveillance in case she did something wrong when caring for her closely monitored newborn baby in the NICU. Having discovered he was tube-fed when she missed out on being there to feed him, she decided her baby would be safer at home. She knew she would persevere, giving him the time he needed to take his bottle. Furthermore, as investigative tests proved he was otherwise healthy, she was confident in her own capacity to care for him, having done it all before with her first child. Therefore, she aimed to leave the hospital as soon as she could. However, having got home, the intense regime continued around her baby's feeding, where she expressed, fed and topped up. It continued to resemble *"a factory"* (Ln793) for her, as her focus was consistently on her baby gaining weight. Almost two years later, mealtimes continue to be a battleground of forced feeding, as food holds no enjoyment for her son. Deep down, she believes she will always worry that she may have missed something, yet she and her husband feel blessed, celebrating every word and bit of mischief their child gets up to.

"I have missed the skin-to-skin, I have missed the whole hour after the birth. I have, like the stress I was under in my body physically, my mind was tormented that I wasn't there to feed my child and that he was getting bottles now. And I was missing

all of this, and my sole purpose was to get back to the maternity ward to breastfeed, to breastfeed, to breastfeed." (Ln158-162).

Emily felt tormented finding herself in the ICU recovering from a severe postpartum haemorrhage and separated from her baby, who was being cared for in the NICU. She was acutely aware of all the significant firsts she had missed, including skin-to-skin contact and the precious golden first hour of her baby's birth. The urge to breastfeed her baby consumed her, although she acknowledges she had never bought into it much before her baby was born. Although she expressed some insight that she was not well enough to be on the postnatal ward, her need to be with her baby superseded all else. Having reasoned she was getting no sleep in the ICU, she made an enormous effort, networked for support, and even begged to get back to the postnatal ward so she could be with her baby. She felt she had *"won the Lotto"* (Ln197) when she arrived on the postnatal ward.

Panic quickly set in as the reality of her situation became apparent. Observing, like other participants, that the bells never stopped *"hopping"* (Ln282), she told herself she was a failure and a "*bad mother"* (Ln379) if she couldn't cope alone and had to ring her bell for a midwife to help. Emily remembers her night times as particularly "*horrific"* (Ln294) with her capacity to network help being gravely diminished with the reduction in staff. Her baby "*wailing like a banshee"* (Ln269) was inconsolable. The combination of having been bottle-fed in the NICU, her low milk supply because of her severe pre-eclampsia, and large blood loss were all contributory factors. When she did ring the bell at night, a different midwife or healthcare assistant came each time. Their patronising attitude often left her feeling *"really shitty"* (Ln363) afterwards for taking up their time. Thereby, they were of little help. Only when she and her baby were both inconsolable did she get the advice, help, and support that made an enormous difference initially from the midwife manager

she knew. However, she recalls she only started to see the light when an agency midwife, who happened to be a trained lactation consultant, explained to her that a *"happy mammy"* (Ln412-413) is what was best for her and her baby. She further explained in a "*black and white*" (Ln409) way that Emily was able to understand, that she needed to breastfeed and top-up her baby with a bottle until her milk supply became more established, as she recovered. Emily concluded her baby's distress was as much about "*bad midwifery*" (Ln180) as her insufficient milk supply, as no midwife had taken the time to explain it to her in this way up until then.

"I would say nearly a dagger (laughs). I was cut open, and what it did to me (laughs) as a person, as a new mother, yeah. It traumatised me for a long time".

Emily imagines a dagger when asked for a symbol to represent her childbirth experience. She wonders, like Mary and some of the other participants, if anyone really gets to have a magical moment in childbirth, as she has not met them. Like all of the participants, she was grateful to have got through it all, with both her and her baby coming out of the hospital alive, despite having to endure the trauma that she continues to work through.

4.3.2 Seeking Understanding

The participants used various metaphors to describe their experiences of their distress in the time following their childbirth. Lyndsay described waking up at night, not even seeing her child as she fed him, despite very clearly knowing she loved him. She describes herself as *"just fog"* (Ln 203-206) and thereby has personified the blur she experienced during her childbirth at the time. Mary and Mia spoke about finding themselves in a dark place that is hard as they navigate their way out of their distress. Page and Sadie talk about their efforts to stay out of the rabbit hole of anxiety and the deep hole of despair, respectively. Ruby

describes her distressing childbirth as a crazy time, while Emily spoke about the light in the darkness when she received the help she needed with breastfeeding. The confusion and unanswered questions participants were left with frequently compelled them to seek answers outside of themselves. Many needed and benefited from having their experiences repeatedly affirmed as shocking, horrible and awful by their peers or other healthcare support workers whom they sought out to augment their neglected care needs. Most benefited in their recovery and healing as a result of their capacity to achieve and integrate a greater understanding of what happened to them.

Alice had actively sought clarity over the previous year to make sense of her childbirth experience. She wonders what might have happened if she had been able to say no to being induced or ask for a lower dose of medication in her induction infusion, as is the norm in her country of origin. She experiences a dissonance around being told her baby was in distress, and yet he was born completely fine. She questions whether her C-section was actually needed at all.

> *"I was sure that I did something, or I should have said no. Like the whole thing was like, I should have waited for the induction until the day after, but I didn't want to stay alone but at the same time, if I had waited the labour would have started or maybe I should have told them to use a lower dose. How am I supposed to know? I am not in, I'm not a midwife, I'm not a consultant, I am not a nurse".*

Like the others, Alice initially blamed herself, thinking that she had done something wrong. Until she came to the realisation that, without insider knowledge, she could never have anticipated what actually happened to her. She rationalises that she was neither a nurse, a midwife, nor a consultant and therefore could not have known how childbirth

worked in practice. During those first few weeks and months, she sought *"non-stop"* (Ln696) confirmation from her husband that what she had been through in childbirth was *"horrible"* (Ln695). He reliably filled in her memory gaps after the anaesthetist had heavily sedated her during her C-section. She talked with him about her experience for months afterwards, until *"it was too much for him"* (Ln698) to keep hearing, as he was getting more distressed and vicariously traumatised. Alice used the term nightmare six times, horrible 11 times and fail 27 times to communicate the horribleness of her childbirth experience. Her repeated use of these terms one year later signifies the enduring nature of her distress, which she is still working to understand and *"cannot fathom"* (Ln431) fully. Having reflected on her experience, supported others after their distressing childbirth, as well as heard stories about other women's experiences, she concludes there is *"no scale of who has it the most horrible"* (Ln1037). Despite many visits to her consultant, mental health midwife, physiotherapist, perinatal psychiatrist and discussions with her antenatal class midwife, she construes that next time her childbirth could be worse.

> *"Last year at this stage, I was in horrible shape. So one year after, I'm way better, I have way more clarity, I have way less pain, I still have pain but compared to last year it's a dream, like. Like so, it's, yeah, I don't think I will ever stop being upset about it, but I will grieve it like a grief (Ln1255-1258).*

Six weeks postnatally, Alice's consultant did her first debriefing session after she told him she felt physically and mentally like hell. Hearing that she would need a further six weeks to recover felt realistic. In contrast, hearing that her C-section was a complete success for her and her baby made little sense, considering how much pain she was experiencing. A month later, at her second debriefing session, the consultant took a different approach,

explaining her childbirth in terms of probabilities and percentages, which made more sense to her.

> *"I will never forgive the state, (laughs), like, the cyber-attack and the Covid restrictions and like, all the stuff that could have been avoided if someone in charge had actually put themselves in the shoes of women having babies" (Ln1183-Ln 1185)*

Adding up all the little percentages together, Alice was left very angry that the circumstances surrounding COVID-19 forced her to choose between going ahead with the induction or being on her own in the hospital without her husband. She returned to her consultant again after six months, started on her advice, some breathing techniques, as well as Pilates.

Ten months post her distressing childbirth, Alice had her third debriefing session, which proved to be the most helpful. All was less of a blur, as she was in less pain and could better take in the information. Her consultant explained she cannot control what her body and uterus decide to do yet failed to mention or explain her pain during surgery. Her psychiatrist resonated most when he told her she has *"a right to continue being upset"* (Ln909). Although Alice knows she will continue to work through the consequences of what happened to her in childbirth, including the losses she experienced, she can see no end in sight to the grief she is left with. She is aware of the supportive presence of the perinatal women's birth partner when they were most vulnerable, knowing this severe restriction was not imposed in her home country during COVID-19.

Page attributes her anxiety to feeling she was thrown in the deep end, from the beginning of her distressing childbirth experience. Her ongoing anxiety is evident in her use of false starts and repetitions, which is juxtaposed with her use of the term 'fine' 49 times during her interview, as she verbalises and tries to make sense of what happened to her during her distressing childbirth experience.

> *"Do you know that feeling where em you go, you remember that you forgot something or you did something and Uuh, it's like your stomach drops that's the physical feeling, it's like Uuh, it's, it's not like a heart rate thing, I don't get sweaty, I don't get like clammy, I don't get like, I don't know whether saying I don't get anxious is correct because it was probably a degree of anxiety" (Ln256-259.)*

Page confidently declares at the very outset of her interview the value she places on her sense of self as a planner and her cognitive capacity to plan. However, later in the interview, Page is much less self-assured about the value of her cognitive capacities, considering the notable, embodied effects of her anxiety since her distressing childbirth. Over the previous 14 months, she regularly felt mentally drained by her feelings of fear, doubt, and guilt, which caused her stomach to physically lurch. When confronted by her need to know, be informed, and plan what she should do or not as a mother, she was bewildered by the many contradictions she discovered while Google searching at 3:00 am. She perceives this endeavour now as nothing better than going *"down into a rabbit hole"* (Ln604) because of the doubt and anxiety that comes with comparisons rather than the benefits of seeking to know and understand. Fourteen months later, hearing a breast pump makes her stomach lurch in fear. She is brought back in time, place and space to being *"a rookie"* (Ln310), learning as she goes, worrying about the right or wrong of what she is doing or not and the uncertainty of living in a world of finite resources.

"so I kinda want to do it to see if I missed anything. You know to see if I was like oh I don't actually remember that happening or I thought that this happened and then they were like no that didn't actually happen, I just wanted to make sure that whatever version of what happened in my head was correct, essentially. That's kinda what and the only two things that I did, sorry the three things that I didn't know was that it was an emergency section, that she had to be on a breathing machine and that they used forceps" (Ln -413-418)

Page's lingering unease and need to understand her experience are further evident where she *"self-referred"* (Ln391) for a debriefing of her childbirth, having heard about it from a friend. She wanted to reassure herself that she had not missed anything and had the correct version of what happened during her childbirth in her head. She further suggests it was routine for the healthcare staff communicating with her, as it was their *"day job"* (Ln408). Page expected to be able to talk about her experience during her birth reflection, similar to her participant interview and ask questions. Instead, she got a reading out from her chart of what medically happened in chronological order that was *"very matter of fact" (*Ln457). Afterwards, she rationalised that she was happy with the outcome, as she now had a fuller version of the events, including how they happened. This supported her to evaluate the *"correctness"* (Ln416) of her version of events. Like the other mothers, she is grateful to have had private care, which entitled her to an extra scan with her consultant on the day of her admission. Over the past year, she has often wondered what might have been, as have her friends, if she did not have private care. It is a rabbit hole that she tries not to enter, and she has intentionally decided not to ask about her childbirth reflection, as they have decided not to have more children.

> *"I said, I need to talk to my consultant, you know. So she was kind of getting a bit, bit angry with me, and I was getting a bit angry, I think I was all a bit like, grrr, like you know, what's going on here, like do you know? So I was getting a bit defensive, do you know what I mean? Now I wasn't confrontational but I was more like just trying to make sense" (Ln490-493).*

Mary was determined to discuss her childbirth experience with her consultant, to try and make sense of what happened, before she left the hospital for home. On the day of her discharge, she angrily resisted the pressure from the paediatrician checking out her baby to vacate her bed early. While she acknowledged her anger, she is clear that she wasn't confrontational. She believed her request to speak to her consultant before leaving was both reasonable and proportionate, considering she had already paid most of her fee to secure her private childbirth care at the hospital.

"it was like 1920s Ireland, you know, you know, vulnerable. I said, look, I'm a 41-year-old with means and I feel like a ten-year-old, like a dirty child with this woman" (Ln513)

Nevertheless, Mary wondered if she was better off to have been a public patient, as she believed her care was no better than 1920s Ireland, where she felt like she was treated like a dirty 10-year-old child, of no means. Consequently, she didn't want others, particularly those of lesser means, to receive the inadequate care she had. While waiting, she spent time *"building"* (Ln497) herself up to the conversation, as she worried she would be wasting her consultant's time. However, knowing it would *"be bad"* (Ln498) if she left the hospital without having aired her complaints, Mary got her to sit and listen to her when she eventually arrived in her room. Following an hour-long conversation, Mary concluded it was a total miscommunication. The consultant thought she was protecting Mary, doing

what she wanted and the right thing by inducing her, so her husband could be with her from the get-go during COVID-19 restrictions.

4.3.3 Finding their Mothering Way

"She is literally yours. You can pick her up as much as you want, and I think that came from not having that choice" P2

It took time for participants to understand and make sense of sense of the feeling of being upended and flipped over, due to their distressing childbirths. They had to find their own way out of the fog of confusion, doubt, guilt, self-blame, and shame that they were left with. In contrast, their sense of hope was ignited, as they articulated the benefit of having their voice heard and their intention to influence change for others following their participation in this research study. Equally, participants benefited in their recovery where partners shared a similar understanding of what had happened to them during childbirth. Many couples agreed on how horrible their experiences were, the fear they were left with and how an under-resourced and oversubscribed system contributed to their childbirth distress. Furthermore, this shared understanding was enough to allow participants to be more receptive to their partner's capacity to reframe the narrative around their distressing childbirth experience and work with it.

The ongoing physical, psychological and emotional challenges and changes which the participants encountered, surmounted and adjusted to, as they navigated their distressing childbirth recovery, took considerable time to achieve. Some also withdraw from those around them: to grieve being robbed of their anticipated joy of childbirth; prioritise and give time to the healing of their physical and psychological wounds; as well as come to some kind of acceptance around what had happened to them. Recovery for all participants

demanded that they take up and reclaim their sense of agency, so they could once more become guardians of themselves. Most sought support from their partners, family members and or paid allied healthcare professionals, private consultations and care. For some, the overwhelming and agonising distress following their distressing childbirth experience contributed to the uncoupling of their relationship. Positively, all participants had regained their coherence and felt sufficiently re-empowered to participate in this research study, motivated by the opportunity to influence change for others coming behind them.

> *"a lot of the time there just isn't the resources, it isn't because of that particular person but the resources just aren't there, or the system is not set up in the right way to be able to accommodate everybody in the ideal way"*

Sarah, who opted for a homebirth, demonstrated empathic understanding for those working in the maternity care system, as well as grasped the multiple intersectional factors that lead to poor outcomes for those involved. However, despite being armed with this knowledge, Sarah concludes that, as a human being, her suffering and severe distress were not important enough to those working within the maternity care system to take the necessary and restorative action.

> *"when I look back it shouldn't have happened, that's really brutal actually. To have to lie within again, within a system that is supposed to be supporting you. So I had to lie and then all the other times when I was told oh we don't usually do this for people, well that's just so wrong it makes me angry and upset again. They are both there. Upset and anger two sides" (Ln 1104-1108).*

Sarah's care neglect left her feeling not valid enough to receive the care she needed and deserved. Sarah had little energy for anyone outside of caring for their baby, following the re-suturing of her episiotomy. She withdrew from contact with her family and friends, who all worried about her living a long distance from them. Equally, she feared and avoided any physical intimacy with her partner, due to the pain and anxiety she was left with following the breakdown of her episiotomy. This left her partner distancing himself from her and unable to meet her in her distress. Equally, Sarah's partner found it difficult to make sense of what happened to her. Four years later, he was able to engage with her and tell her that he had feared for her life and their baby's life at the time. However, this was three years after they separated. Sarah moved back to live with her parents following their separation and attended somatic therapy, knowing she could not undo what had happened to her and them. However, she was eager to understand her part in the dynamics of her rationed perinatal care and the unresolvable issues within their relationship, which led to their separation. She recognised her anger had figured in the foreground of her relationship with her partner, following their distressing childbirth and was impacting her capacity to cope and be a good mother to her son. Equally, having experienced depression in the past, she recognised she needed outside help, as she wasn't her bright, excited and normal self. Sarah's distressing childbirth experience didn't feature much in her therapy sessions, although she believed, if she had attended for longer, it would have been further addressed. However, she feels less devastated, is more accepting of moving on, which includes prioritising her own care needs, since going to therapy and is recently in a new relationship. Therefore, Sarah concludes, despite feeling vulnerable, in pain and in need of care, she had to be much stronger than she felt to access the supports she needed. Like the other participants, she hopes that by participating in the study, others will benefit.

> *"I was like, can I, can I have my baby, you know? And they said, well, you can't, cause he's in the post op, you know, you could have women, you, they're just not allowed in there. And I knew because if there was a woman who lost a baby, they said it would upset them. But I couldn't find my voice to just really press them on it because when I went in, there was no one there" (Ln373-377)*

Grace, at the beginning of her interview, expresses the profound journey she commenced on becoming pregnant and as a new mother. During her interview, she communicates the depth she was forced to go within herself to access the resources needed to navigate the changes and her way out of the childbirth distress she subsequently experienced. She uses the metaphor (particularly the fourth trimester or early post-natal period) of it being similar to taking a *"new train"* (Ln1062). Consequently, she perceived childbirth as an empowering journey and a rite of passage. Therefore, having to be separated like Sadie from her baby made little sense to her, as she recovered in the immediate aftermath following her emergency C-section. Grace, like Ruby, asked repeatedly to have her baby given to her in the recovery room, but her request was also denied based on the needs of other women. She was unable to do the necessary push-back against the recovery room midwives' argument on the day. Resolving the guilt and accepting that she had not achieved the empowering natural childbirth she wanted was hard.

> *"I'm really in a good place in so many ways but it has been really pulling on my deepest you know, resources but also em, yeah, it, I, I, the words are hard to kinda describe really what that process is, cause it's so much more than just childbirth and me and, and values and, and Reubin. It's, it's everything that shapes me, is, was totally transformed regarding that"* (Ln260-263)

Over the last 10 years, Grace has consistently overcompensated, feeling responsible for not achieving the normal childbirth she desperately wanted for them both. Staying with her child until he falls asleep has shattered her and her husband's time together and ultimately their intimate relationship. While Grace recognises that 10 years ago, alternative childbirth choices were limited outside of Dublin, she regrets not being more activated by what she read and persists in seeking out an independent antenatal class and a homebirth midwife. She further regrets not understanding the significance of a single comment made by her midwife at the outreach clinic, advising her to get down on all fours in the evening when she got home from her desk job. This would potentially give room for her baby to move into a more optimal birthing position where his back was no longer at her back. Having since trained as a doula and supported others through their childbirth, she recognises the lost opportunity where it literally and metaphorically was a potential *" key turning point"* (Ln118). Her tone is cynical as she recounts the back-to-back labour she experienced. Her numerous false starts throughout her interview are indicative of the emotionality which is consistently evoked as she articulates her distressing childbirth experience.

> *"the nurse was lovely and she said look it come in, don't, don't, don't tell the rest of them (laughs) do come in for a minute, like do you know so they did actually let the two of us in beside him for like, I don't know, it wasn't five minutes and em, I remember thinking like, okay, that's my baby and he's okay and I'm not able for this" (Ln-645-648).*

Despite her very distressing circumstances, Louise recounts that it was the little things that she was very grateful for, which made her life easier, brought a smile to her face and joy to her heart. A lovely nurse gave her and her husband the opportunity, if only for minutes, to be parents together, with their baby, despite COVID-19 restrictions. Following those

precious moments of connection, she was able to let go and think about herself for the first time in months, knowing she had given and done enough to secure her baby's life. Receiving her free breast pump and an accompanying leaflet from La leche league because her baby was born under 35 week's gestation and was admitted to the NICU, was another example of the little kindnesses that made a memorable difference and jumped out at her towards the end of her interview, having being given the time during her interview to voice all she needed to and wanted to. She drew from the support of her local public health nurses on her return home, valuing their expertise in monitoring her baby's growth and development. She describes them as being there for her as much as her baby. They gave her time and listened to everything she had been through, advising her to book in for a postpartum meeting at the hospital. Louise had not taken up the suggestion at the time of the interview, citing that it would be too awkward.

> *"gauging your patient, understanding your patient, em I suppose listening to your, your patient em, and realising what their capabilities are, what their knowledge is around the subject area, what their worries and concerns are, Em, what their experience was prior to this. Em, and what they know about, what they know and feel about themselves, so important" (259-263)*

Louise, over 20 months later, calls on maternity care staff to gauge their audience. Rather than perceive them as being overly anxious or withholding information from a mother who is an expert by experience, staff should take cognisance of the expertise of their perinatal women. She has zero tolerance to hearing the term 'sleepy baby' since her childbirth and believes she had to at times convince the hospital staff she was not *"an eejit"* (Ln378), as babies in utero are not always sleepy. As an educator herself, she is keenly aware of listening to parents' experiences of their children and the importance of their birth history.

The impact on her family of her pregnancy and hospitalisation was immediately felt following her arrival home after a month in hospital, when her daughter failed to recognise her. Within a relatively short space of time, her husband was also sick. Louise acknowledges that he would not have received the same level of sympathy she got, although he got a lot of support from both their families of origin. While she would love another baby, she is aware like her son's pregnancy, the news would not be welcomed, because of the potential threat it would be to her life. Like most of the other participants, she continues to work through the ongoing worry, guilt and self-blame, always referring back to her pregnancy. She agonises that there could be unknown impacts in the future.

4.4 Conclusion

This chapter communicates the converging and, where evident, the diverging findings, following an in-depth IPA data analysis of 12 participants, who self-identified for this study as having experienced a distressing childbirth and met the inclusion criteria. Participants suffered unimaginably and well beyond any of their expectations in childbirth, which resulted in significant distress for themselves, their partners and at times their babies. Participants had expected to feel safe in childbirth and receive the care they needed. However, they discovered that where staff were run off their feet, receiving respectful, person-centred care was a lottery. Most participants felt robbed of the joy of their childbirth and spoke about the physical and psychological harm they suffered. While most understood the harm done to them could not be undone, they felt compelled to understand and process their confusion, fear, guilt, anger, shame and resentment resulting from what happened to them, enabling them to regain their coherence. Over time, they worked through their brutalising experiences to find their mothering way. Some found meaning in their work, and a few supported others who had similar experiences. Yet most withheld the level of their suffering from others, worried by the potential of its vicarious

impact on them, outside of the odd very close friend who reciprocated with a similar level of honesty and genuineness.

Chapter 5: Discussion

This study explored 12 participants' experience of a distressing childbirth in Ireland: its perceived impact and meaning-making. Following an in-depth analysis of each participant's data, three GETs were identified followed, by an across-case analysis, using an IPA methodological approach.

Each GET embraced three sub-themes, giving greater depth and insight into how the participants navigated their way through and made sense of their distressing childbirths. This discussion chapter aims to situate the findings of this study within the extant literature on childbirth, with the particular objective of adding to the findings on women's experiences of distress in childbirth. Furthermore, it positions the participants sense-making from an integrative, psychotherapeutic, theoretical perspective, while acknowledging the bioecological, adaptive internal and external interpersonal, and neurobiological processes involved. Moreover, it advances the novel perspective of combining the Power, Threat, Meaning Framework (Boyle, M., & Johnstone, L. 2020), as the overarching framework, with the Polyvagal Theory (Porges, S. W., & Dana, D. 2018), as the underpinning framework, to more comprehensively understand and make-sense of women's unimaginable suffering and distressing experiences in childbirth. This top-down, bottom-up approach allows for a more inclusive, integrative exploration, as the participants navigated through the impact of their distressing childbirth, to regaining their sense of coherence and finding their mothering way.

Central to this study's findings and similar to many more recent studies findings, is the notion that childbirth does not exist in a vacuum, rather women's experiences are influenced by the cultural, social, political and institutional values, beliefs and priorities that are both past and present (Hammond et al., 2013; Mellor et al., 2024). Many studies

evidence childbirth as an integrative process between a woman's internal and external lifeworld, where women's physiological, psychological and spiritual experiencing is intertwined with their predominant community and societal discourse (Karlstrom, 2015; Neerland, 2018; Nieuwenhuijze & Leahy-Warren, 2019; Olza et al., 2018; Smythe et al., 2016).

This discussion reveals that it is the advancements in our understanding of the complex neuroendocrine biological processes, alongside our advanced understanding of the neurobiological processes involved in polyvagal theory, that underpins the worthwhile involvement of psychology and psychotherapy in women centred perinatal care. Together these advancements shed light on and reveal the detrimental cascade of events that can occur for women in childbirth, once hypervigilance sets in. Emotional regulation as well as the neuroendocrine processes are interrupted and dysregulated often to such an extent that pathogenic outcomes result (Siegal, 2011; 2014). Therefore, psychotherapy approaches with a neuro-ecobiological focus, where the emphasis is on the psychological impact and intersectionality of the interpersonal environment is required to more comprehensively address perinatal distress on a woman and her family. Moreover this locates the aetiology of perinatal distress away from the predominant medical, individualistic, diagnostic, model of mental illness. This discussion argues for the novel broader, progressive, and dynamic, integrative focus of our understanding of perinatal distress. One which is underpinned by neurobiological interpersonal processes coupled with the overarching power, threat meaning framework, as a comprehensive alternative approach to addressing perinatal distress and pathogenic childbirth outcomes.

It was Bronfenbrenner who was the most influential in arguing for an ecobiological, interconnected systems approach to development, developmental stress and illness where

the role of the environment and its impact was the central focus (Bronfenbrenner & Morris, 2007). His system-based model emphasised how over time, our interactions and supports, within the various interconnecting systems of our lifeworld, positively or negatively impacts mental well-being. (Eriksson et al., 2018). Therefore, trauma informed models of care have adopted an ecological approach to practice interventions, broadening our understanding of the role played by the context within which people live their lives and its impact on mental health functioning and recovery (DeCandia & Guarino, 2020).

Therefore each of this study's three GETs are discussed in relation to relevant literature, situated within the context of a distressing childbirth as an embodied, intersubjective, bio-psycho-socio-cultural and enduring phenomenon, symbiotically influenced by the participants' internal and external systemic demands within the childbirth environment. This IPA study revealed three key findings to add to the extant qualitative literature on women's distressing childbirth experiences, and the type and timing of psychotherapy supports. The first group experiential theme*: "Suffering Unimaginably"* revealed how most participants' expected their childbirth not to go to plan. However they could never have imagined the agonising and brutal impact it had on their well-being, to the extent that they were physically and or psychologically scarred and harmed by their childbirth experience. The second group experiential theme *"Having to Capitulate"* relates to how participants navigated their way through their distressing childbirth experience finding themselves capitulating to the demands of an under-resourced and oversubscribed maternity care system. They received little to no guidance, suffering alone and abandoned, ultimately feeling robbed of the joy of their childbirth experience. The third group experiential theme "*Regaining Coherence*" refers to participants' recovery from their distressing childbirth which took time, as they sought to understand and make-sense of what happened to them. Gradually, they regain a more coherent sense of self, as they

worked through the fog of confusion, darkness, guilt, blame and shame to find their in-particular mothering way.

5.1 Ill-prepared for the Unimaginable

Paradoxically, and in parallel to the above complex understandings and sense-making of childbirth, participants held a singular, simple, objective. They openly acknowledged during their interview that the safe delivery and well-being of their baby and themselves following their hospital childbirth was their *"end goal".* The paramountcy of safety for mother and baby, is a shared understanding across countries and cultures, as Downe et al. (2018), demonstrates in their systematic qualitative review findings of 37 studies across 19 countries. However, to achieve a positive fulfilling birth experience they asserted that perinatal women required: their individual preferences as well as their socio-cultural norms to be considered; a clinical environment that was safe and psychologically supportive, facilitated by competent, encouraging, caring and kind practitioners.

All of the participants in this study understood childbirth to be an uncertain and painful event that they judiciously prepared for. In their umbrella systematic review of qualitative studies, Price et al. (2021), found being prepared for the unexpected reduced women's exposure to adverse childbirth outcomes. The extent of the current study's participants' preparations is reflected in their active engagement seeking out additional information via, childbirth classes, in books and on the internet. They actively listened to friends, other family members and their class facilitator, all repeating a similarly consistent message - childbirth often does not go to plan. Consequently, most participants were vocal in their conscious awareness to stay open and flexible around their childbirth choices.

5.1.1 Loss of Trust

Hospital is the option of choice for 99% of women who give birth in Ireland (O' Reilly & Hanafin, 2016) and therefore could now be considered an enculturated norm. Hospital has been promoted as the safer care environment for childbirth in Ireland by the DoH since 1947. However, Hunter et al. (2017), argue childbirth within the Irish maternity hospital care environment is predominantly an obstetric consultant-led, midwife-managed service model, rather than a predominant women-centred care model. While Edwards et al. (2018), suggest the focus of care is more often on the throughput of labouring women, rather than on person-centred care. Although, midwifery-led care options exist within the Irish maternity hospital care and community care system, they are not evenly distributed across the country and are location specific (Gregory et al., 2023). Therefore, these alternative less medicalised services cannot be equally accessed, meaning for some women in Ireland, the bio-medical option of a hospital childbirth, is the only available care option outside of free birthing. Murphy-Lawless (1998), asserts that the reduction in midwife-led care, cost women the reduction in their sense of agency, knowledge and skills around childbirth, as well as the expectation for more perfect outcomes. Begley et al. (2019), further argues that childbirth practiced within a paternalistic culture of " doctor knows best" with women expected to acquiesce, is in itself a barrier to the equalisation of power needed for the transfer of knowledge from care provider to care recipient, to support authentic shared-decision making. Although according to Rane et al. (2017), women-centred care neither set out to undermine the bio-medical model of childbirth care or overly rely on natural, physiological processes.

Nonetheless, the majority of this study's participants chose hospital as their childbirth option. However, most of the participants subsequently left the hospital, having experienced unimaginable physical and psychological adversity and harm. This experience

is reflected in the group experiential theme *"Suffering Unimaginably"* and in the sub-theme *"Giving birth an unimaginably brutalising experience".* As well as safety, many participants held the expectation to be cared for by maternity care staff in childbirth, as noted previously in Downe et al. (2018), study. While Daly et al. (2022), identify the importance of quality care-giving from healthcare professions, family and peers to support mothers positively navigate the intense transition into motherhood, the expectation to be cared for in childbirth is also socio-culturally embedded within the term "midwifery" itself and is therefore not unreasonable. Translating as being "with woman", the term midwifery encompasses both the historical and philosophical nature of maternity care alongside the well-recognised embodied practices associated with midwifery as a profession (Bradfield et al., 2018). Heidegger's philosophical notion of being 'ready to hand' (Smith et al., 2022) is reflected in Butler (2017b), findings, exploring the content and context of the care role played by midwives in achieving positive childbirth outcomes. Midwives could be considered 'ready to hand', through their continuity of care and masterly inactivity in the early stages of labour, followed by a more intentional, interpersonal, engagement with the woman, to support them cope with the more intense pain of active labour. Midwives are 'ready to hand' and 'with women' when they create a conducive home or low-tech childbirth environment to further support women achieve a positive physiological childbirth experience.

However, many of the participants felt they were misled and lulled into a false sense of security by the information imparted to them during their childbirth classes. This study's findings are similar to Ronnerhag et al. (2018), where a women's sense of safety is threatened where they are lulled into a false sense of security as a result of misleading childbirth information. Similar to the findings of this study, Athinaidou et al. (2024), found attending antenatal classes did not sufficiently prepare or address the participants' capacity

for childbirth complications, and the subsequent suffering they experienced as a result. This study's participants sense of belief and confidence in their capacity to achieve a physiological childbirth was *"upended"* as a result of the fear, *"uneasiness and upheaval"* they experienced when faced with unexpected medical interventions they felt unprepared for. For the current study's participants, their anticipated physiological childbirth did not materialise, despite much research and reading about childbirth, attending antenatal classes, as well as the psychological confidence in their capacity to achieve a physiological childbirth.

5.1.2 Institutional Betrayal; No Choice but to Follow Orders

Several participants felt betrayed because the potential for suffering and distress was not communicated to them in any meaningful way by the facilitators of their childbirth preparation classes, regardless of being delivered by public or private stakeholders. They felt the information given was mostly biased towards a physiological childbirth, that gave little consideration to the political-socio-cultural predominance of the biomedical model of childbirth in Ireland. One participant on hindsight, felt she was primed by her hospital childbirth classes into accepting the active management of labour as the norm, which she felt was deflected by the humour of the facilitator. Despite having professional or personal insider knowledge of childbirth, healthcare or other public service systems, many of the participants regretted their own naivete around this political-socio-cultural predominance. Some used the metaphor of their experience being like "Hell" to describe the torturous nature of the impact of their childbirth experience. Gough, E., and Giannouli, V. (2021), suggest women readily blame themselves for what happened within the therapeutic encounter, similar to women who have been victims of abuse. Therefore, time needs to be given over for the women to explore if they were more accurately failed by a system that allowed them develop unrealistic expectations of childbirth pre-natally, rather than hold

more realistic expectations, supporting them to have a greater flexibility in its unpredictability. They also identified the need to explore previous adverse experiences within the therapeutic space, particularly in relation to what did happen that shouldn't have happened.

Merleau-Ponty suggests we meet and come to know the world and ourselves through the corporeality of our bodies. In this way, we both experience the touch and the being touched by ourselves and others (Moran, 2010). Participants' perceived failure, as a result of their body not doing what it was programmed to do, added to their psychological distress. Therefore their hospital childbirth experience bore little reality to what they had been told and led to believe. Two of the current study's participants had forceps deliveries. Five had emergency C-sections following induction and or augmentation of their labours with syntocin. While two others had elective C-sections and three others had vaginal deliveries following induction or augmentation with syntocin. This is reflected in the sub-theme "*Feeling betrayed, navigating the impact*".

Most participants were left feeling helpless, pointless and hopeless early in their childbirth, as they tried to negotiate to get their care needs met. Some had their birth plans dismissed and rejected the minute they handed them to the midwife, despite being asked for them. Others felt punished where their requests for pain relief or additional pain relief went ignored. The negative impact of this political-socio-cultural predominance also reverberated through to their partners, extended family and friends. One participant told her partner she wasn't *"Kate Middleton having a baby"* and therefore there was no point in complaining. This is despite they both *"freaking out"* as she was not in labour yet was surrounded by women in painful labour. One participant's partner worried her experience would destroy her. For others their intimate relationships were irreparably ruptured. The

participants and their partners trust in the system and people that was there to care for them or at least protect them from any further harm, was eroded.

Betrayal that is external, systemic and institutionally focused has been described as institutional betrayal (IB). IB is characterised where an institution *"causes harm to an individual who trusts or depends on that institution"* either by "*omission or commission of protective, preventative or responsive actions"* (Smith & Freyd, 2014, p. 578). Participants were often left in no doubt by their assigned midwife, that this was the system they had signed up to, regardless of their public or private status. Midwives, usually declared in their defence that they too had little choice but to follow the orders given. Therefore, many of the participants in the current study who reluctantly agreed to an induction of labour, had no idea of the speed of onset or the severity of the pain they were about to experience. They found themselves completely unprepared and vulnerable where one participant almost fell to her knees in pain, while another equated her induction process and its augmentation to being in an execution chamber. Some participants recalled watching their syntocinon drip, dripping into them, dismayed at it being regularly increased by midwives, in line with hospital protocol, with no regard for them as an individual or the severity of their pain and obvious distress. In taking this position, midwives neither perceived themselves as adding to the problem or having the autonomy to provide a solution to the problem in the form of a more flexible person-centred care approach, as sought by the participants in their care. Smith and Freyd (2014), suggest that employees are equally impacted similarly to service users where IB exists. Therefore, midwives could be perceived to be both actors and victims of IB, where they failed to adequately respond to deficits in the participants' care needs or felt equally helpless and hopeless to influence the system in any meaningful way.

Moreover, Kulkarni and Fielding-Singh (2025), in their descriptive study of 588 participants exploring institutional betrayal (IB) on childbirth outcomes, found there was a negative corelation between IB and women's mental health postpartum. While 39% of women had experienced at least one type of IB, the presence of prenatal mental health or pre-pregnancy risk factors were also noted as contributory factors. Surprise findings were that participants who had higher levels of educational attainment also had higher incidences of IB, while there was no increased incidence found of IB amongst marginalised communities. This study's participant's demographics suggest all could be considered to be from the middle to higher income bracket. While none came from a marginalised group, two were born and had lived most of their lives, up until their early 20's in western Europe. The presence of pre-pregnancy and or mental health issues were not specifically sought for consideration in this qualitative study, prior to or during one-on-one interviews with the participants. While some participants freely spoke about childhood and or early adulthood distressing events during their interviews, others did not. Therefore further discussion of their relevance to betrayal trauma is beyond the scope of this study. Kulkarni and Fielding-Singh (2025), further suggest that IB is an under researched aspect of obstetric violence. This human rights issue is still poorly understood in high- and middle-income countries, as it has been associated mostly with lower income countries (Garcia, 2023). Few studies on childbirth in Ireland to date have focused on obstetric violence. Both have researched it from a reproductive, justice perspective, revealing the historical cultural dominance of religion and national politics as well as the medical professions power over women's reproductive bodies in Ireland (Delay & Sundstrom, 2019; Grimes, 2024).

However, participants of this current study recounted equally harrowing accounts of their childbirth experiences, as were detailed in the recent UK and Australian reports (Keedle et

al., 2022). This is despite half receiving public and half receiving private care. Recent cross-political parties reports on traumatic childbirth in Australia (2023) and the UK (2024) report that obstetric violence where care is inappropriate, disrespectful, or abusive is an across income phenomenon. Moreover, its incidence is found to be higher amongst marginalised communities within both countries. Therefore, receiving optimum care in childbirth is postcode dependent and described as a postcode lottery. Participants in this study spoke about a different kind of lottery. For them, the lottery was who got allocated to their care. Despite their middle class post codes and educational achievements, participants identified there was no guarantee their voices would be heard and or their individual care needs would actually be met. Although, all of the participants vocalised and understood the maternity care staff were doing their best, considering they were run off their feet, some acknowledged there was also *"bad midwifery"* involved where care appeared to be rationed, neglectful or missed.

More recent childbirth research findings show there is an increased risk of post-traumatic stress disorder following childbirth, associated with an operative delivery, inadequate/missed care, and an insecure attachment style, (Ayers et al., 2014; Jess et al., 2025). Heard and Lake (2009), argue that the capacity to negotiate and sustain supportive/companionable interactions and patterns of relating in adulthood, similar to Bowlby, (2005) secure base, are rooted in our very first careseeking/caregiving relationships. Where careseeking behaviours are intuitively attuned to by the caregiver and are met supportively and companionably, an interdependent system of self-management develops. Where this intuitive attunement occurs amongst adults, it is experienced as feeling understood. Where there is misattunement, defensive careseeking takes place where an over dependence or over independence develops.

Some of the participants recounted their experiences of a more confident senior midwife coming in to care for them towards the end of their childbirth. These participants noted the difference in the senior midwife's care, which could be described as supportive/companionable. The senior midwives gave them a step by step understanding of what was happening, what was about to happen, the limitations to what could happen and the clinical reasonings behind their decisions. The participants and their partners were grateful and responded well to the clarity and directness of this approach. However, they wondered if their bio-medical childbirth outcome could have been different if this level of attuned guidance had been available from the beginning, and they had not already been worn down by the distressing impact of experience to that point, adding to their sense of betrayal.

5.1.3 Forever Scars; Living with the legacy of Distress

Although, the physical scarring of their instrumental or surgical childbirth was seriously disfiguring for many of this study's participants, it was the unresolved, enduring psychological scarring that motivated their decision-making in self-identifying for this study. This is reflected in the sub-theme "Living with forever scars". The enduring and emotive impact of participants' experience as being forever scarred is evident throughout their interviews in: their resolute intent to participate in the study; their determination to have their voices heard in the lengthy narrative accounts; the level of detail given; their vivid recall of what happened to them; their rich, metaphorical use of language; their visible emotional distress and; their tone of indignation, regardless of years past, as they remembered and recounted their distressing childbirth experiences.

Furthermore, the pathological worldview of the bio-medical childbirth context conflicted with the participants' ideological natural, physiological childbirth expectation and

worldview. The inconsistencies they experienced left the current study's participants experiencing a mismatch and a critical gap in their sense-making or what Sutton et al., (2023) termed a birth dissonance. Birth dissonance is derived from the concept of cognitive dissonance as described by Festinger in 1957. Cognitive dissonance occurs where psychological conflict is activated as a result of holding two inconsistent beliefs or behaviours (Cooper & Carlsmith, 2001). Trying to navigate this mismatch between their ideological psychosocial model of physiological childbirth, they believed their bodies were programmed to have, and the reality of the pathological, risk-based, bio-medical childbirth, interventions they actually had, contributed to participants' enduring distress and subsequent trauma. These findings are supported by Webb et al. (2021), in their systematic review exploring the impact between birth expectations and experiences. They found where childbirth expectations are not met, childbirth satisfaction is lower, while the risk of developing PTSD is higher.

Perls et al. (2006), integrative Humanistic-Existential, Gestalt psychology perspective adds to our understanding of the distress caused by the psychological dissonance the participants experienced in not having the physiological childbirth experience they prepared for and anticipated, despite knowing it may not go to plan. They suggest psychological distress will inevitably arise from the psychic conflict generated, when our efforts to complete an expected task or gestalt is frustratingly interrupted. Clarkson, (2008) outlines the seven stages involved in the Gestalt Cycle of Formation and Destruction (also known as Contact Cycle or Cycle of Awareness) namely: Sensation; Awareness; Mobilisation; Action; Final contact; Satisfaction and; Withdrawal. Moving through all seven stages would be considered necessary to achieve satisfaction and completion.

Defending against and surmounting interruptions as and where they arise would also be necessary. Interruption and incompletion of the Cycle of Contact is considered by Perls et al. (2006), to be the enduring, embodied, root of dis-ease and pathogenic responses resulting in anxiety, depression, neurosis or psychosis. However, they, as well as Clarkson (2008), acknowledge there are times where it is wiser to intentionally choose not to seek its completion. Many of the participants recognised they prioritised the safety of their baby when they gave way to the external control of bio-medical interventions, letting go their desire for an intervention-free physiological childbirth. However, in failing to complete the cycle and achieve the physiological childbirth they planned and prepared for, they supressed fulfilling their own needs, to ensure the safe delivery and wellbeing of their baby. All of the participants, as a result of their active engagement in preparing for their childbirth, expertise by experience, as well as their sense of readiness, could be considered to have completed the first four stages of the cycle. However feeling *"the joy"* of their childbirth was *"robbed"* suggests participants did not experience a sense of satisfaction following their childbirth. Furthermore, participants sense of failing to achieve a physiological childbirth implies they were interrupted at the earlier stage of final contact.

The content and context of the participants' increasing and enduring distress resonates with Drapeau et al. (2012), critical review of the clinical features of psychological distress. Many of the participants similarly described feelings of anxiety, unhappiness and desperation as a result of their emotional suffering. Their capacity to cope was overwhelmed by the agonizing pain of their suffering, particularly as most of the participants described a point where they feared for their own and or their baby's life. Yalom (1980), further identifies, the emotional turmoil posed by the possibility of death, as one of the core causes of existential anxiety. Therefore, death as a threat to our very existence must be defended against.

This death worry, particularly in relation to the participants' children left many of them anxious, irritable and unable to sleep, despite being exhausted, while trying to navigate what felt like a more dangerous and hostile world postnatally. One participant vividly described "*white knuckling the pram"* while out walking with her baby and partner alongside a river, as an example of the adaptive embodied restrictions and constrictions she endured to protect her and her baby from further harm. Other participants spoke about the anxious overfocus or helicopter parenting they continued to exercise around their child's safety and well-being many years later, often at the expense of their own well-being. This hypervigilant state results from an increased production of cortisol by the adrenal glands, hyperstimulation of the amygdala induced by fear/threat and the responsive hyperarousal of the autonomic nervous system into either a state of flight/fight/please and appease. While hypervigilance is a necessary, adaptive defensive response to immediate threat or adversity, it becomes maladaptive where it is prolonged and endures beyond the threat event (Cozolino, 2017; Herman, 2015; Porges & Dana, 2018; Siegel, 2011) as was evident in many of the participants accounts.

5.2 Neurocepting for Safety in a Potentially Hostile World

Steve Porges (2018), the renowned neuroscientist who developed the polyvagal theory, coined the term '*neuroception*'. It describes how our subconscious, embodied, neurological system scans for cues of danger and or safety within our environment by searching people's facial expressions as well as the tone and prosody of their voices. While it is recognised that a single event is sufficient to cause a traumatic response, it is also argued that implicit memory of accumulated trauma and its activated responses may start to accumulate in the pre-natal programming of the last trimesters of pregnancy (Cozolino, 2017; Sandman et al., 2011) or in very early infancy (Bowlby2005 ; McCluskey, 2005).

Adverse Childhood Experiences (ACE) studies found a strong corelation between multiple adverse events, which accumulated through childhood and poorer health outcomes later in adult life (Felitti et al., 1998). Childbirth and the perinatal period are no exception to poorer health outcomes for women who have Adverse Childhood Experiences. Reed et al. (2017), acknowledge that women who have a previous history of experiencing adverse events have the potential to be retriggered where they perceive their childbirth environment as hostile.

This accumulation of stress and subsequent distress from psychological and or physical adverse events over the lifespan is termed allostatic load (Riggan et al., 2020). Moreover, Herman (2015), explains that those who experience and survive a traumatic event or events, will relive it long afterwards, as if it were happening in the present, once triggered. While Browne (2009), fittingly terms this persistent, here and now, reliving of the traumatic past, as the frozen present. He argues unprocessed memories cannot be forgotten, remain frozen within our bodies until they can be fully processed, allowing them fade into our memories. Therefore, there is no doubt that the negative impact of childbirth distress will endure, continuing to psychological impact many years later, unless it is intentionally addressed.

5.3 Capitulating; Unspoken Words Echo Loudly

Shortly after their admission into an Irish maternity hospital, many of the participants' sense of psychological, and at times physical safety, were unimaginably challenged. These dismissals presented in the form of the early rejections of participants' childbirth plans, or being left inappropriately alone beside other labouring women, while not in labour themselves or being excluded from conversations as staff huddled and whispered together about participants in plain sight. Participants often felt they had no choice but to acquiesce

and give way to whatever the more powerful maternity care system demanded of them, for the sake of their baby. This is reflected in the group experiential theme*, " Having to Capitulate"* and the sub-theme; *"Giving way to whatever it took".* All of the participants remembered their distressing childbirth experiences during their one-on-one interviews, recounting in minute-by-minute detail between one and ten years later. As an allied healthcare professional, Eva accurately presupposed she was not alone in being retriggered and tearing-up in the here and now of her interview. Eight years later, she was transported back in time, space and place, as she described what happened to her. Similar to Eva, all the participants were acutely aware and had specific non-verbal gestures, facial expressions and voice tones etched in their memory that caused them distress at the time of their childbirth.

Therefore, it was understandable participants became distressed, as they vividly recalled during their interview, the people they met, the gestures they made, the language and tone they used. Moreover, participants' accounts highlighted the activation and heightening of their defence systems, as they increasingly experienced distress through interpersonal internal and external environmental factors. Activity that happened around them, or concerned them but did not include them, and they didn't understand, particularly distressed them. For a number of participants, staff whispering to each other in plain sight, while actively excluding them from the conversations, often confirmed their sense of something being wrong, heightening their hypervigilance. They also detailed environmental cues like bells hopping, seeing midwives run off their feet - which they interpreted as "midwives too busy to ask for care" or "not enough midwives to care" (Larkin et al., 2012), thereby give the impression of being unavailable to support. Consequently, their focus was increasingly drawn to external cues of risk, danger and threat as they progressed through childbirth as a result. This left participants reluctant and

less able to access the help they desperately longed for and needed as they shutdown, aiming to reduce the risk of the danger cues around them. Some reached out to familiar, safer family members who sought help on their behalf.

5.3.1 Depleted of Resources; Unsupported & Alone

Despite their sense of earlier readiness, without a midwife or other healthcare professional supportively guiding them through the stages of their childbirth labouring and or induction process, the majority of participants were left in a state of distress. For some their defences was activated, as they experienced being pressured and rushed through childbirth. Others waited in a less-than-optimal environment not knowing what was happening yet trying to hold it all together. This is reflected in the sub-theme *"suffering, lonely and abandoned"*. Mia spoke about the shock she experienced, as she navigated the intrusive, painful, *"pokin and proddin"* of her induction process that bore little resemblance to anything she had remembered learning at ante-natal classes or hearing her friends talk about.

Rogers (1995), asserted that certain person-centred conditions were necessary to create and sustain a relationship, in order for therapeutic change and personal growth to occur. Rodgers further argues that without empathic understanding, unconditional positive regard, congruence in the behaviours and expression of those behaviours by the caregiver, a trusting relationship will not be established with the care seeker. This theory provides depth to the understanding of what was clearly absent in the participants' care. This is despite Rodgers notion of person-centred, respectful care transcending psychotherapy, where it is now widely researched within the healthcare sector, including maternity care (Hoffkling et al., 2017; MacLellan, 2020; McGarry et al., 2017; Rane et al., 2017; Smythe et al., 2016). While person-centred or women centred care (WCC) is promoted as the

optimum standard for salutogenic healthcare and in particular childbirth outcomes, barriers exist in its implementation.

Hunter et al. (2017), shed some light on the complexities involved for midwives in executing women centred care (WCC) within an environment of an obstetric consultant-led, midwife-managed service in Ireland, in their qualitative study involving 31 women and clinicians (Midwives, Obstetricians and GP's). While they found a genuine willingness among clinicians to support WCC, women's lack of knowledge and experience around other maternity care models means they, as well as clinicians, ascribe to the paramountcy and norm of safety inherent in the biomedical model of care. Within this overburdened hierarchical model of consultant-led care, there was an acknowledgement amongst all participants that there was little real focus and room for women's choices to be attended to in a system of not enough midwives, alongside a rapid turnover policy. Midwives put forward that the existing hierarchical structure was based and maintained on the perceptions of skill, power and decision-making positioned in the order of doctors, midwives and only then women. Begley et al. (2019), further argues that childbirth practiced within a paternalistic culture of " doctor knows best" with women expected to acquiesce, is in itself a barrier to the equalisation of power needed for the transfer of knowledge from care provider to care recipient, to support authentic shared-decision making. Therefore, Curtin et al. (2020), go beyond respectful person-centred care, exploring humanisation concepts in maternity care practice which are inclusive of the biomedical model of care. They identified, human being interaction, benevolence, and being a protagonist, as key humanisation maternity care elements. Being a protagonist supports women to know their human rights in relation to childbirth and to hold their personal agency during childbirth. Alternatively where this is not possible for the mother, her midwife needs to hold the agency on her behalf.

Correspondingly, Ruby dreaded those who came to care. She eloquently describes the dominance, intrusiveness and vulnerability she experienced as *"who knew so many came to stare",* as she lay in theatre crying uncontrollably awaiting her emergency C-section. Sartre philosophically speaks to this notion of the impact of *"the look"* of others, on others. In the presence of a dominant look, self-consciousness, humiliation and shame are evoked, coming from a person's concern of being judged and found out (Van Deurzen, 2004).

Despite decades of research on the notion of a good or not so good childbirth, including more recently the impact of the external and internal environments, (Karlstrom, 2015; Neerland, 2018; Nieuwenhuijze & Leahy-Warren, 2019; Olza et al, 2018; Smythe et al,2016), the dearth in the interpersonal interactions, along with both the quality and quantity of care, was recounted over and over within the participants' individual accounts. Across all of their accounts of their distressing childbirths, not one participant recounted anyone who came into their room, offering their names. Neither did the midwife caring for them introduce who came into the room, despite an ongoing *"hello, my name is"* campaign by the HSE since 2017 to support more compassionate caregiving by healthcare staff (HSE, 2024).

However, after many hours of labouring, having experienced varying degrees of neglectful care, participants were depleted of their internal resources. Many of the participants experienced levels of pain that left them unsure if they were dying or in a state of panic and overwhelm. McCluskey (2005), suggests care-seeking behaviours that go unmet activate the defence system which has a ripple effect on all other systems. Survival

responses are heightened, while exploration of the environment is inhibited. Exploratory interactions that are inhibited lead to dominant-submissive interpersonal interactions.

Where their external environment was unsupportive of their needs, and they were too depleted to internally support themselves, the overriding impact on participants was the loss of capacity or strategy. This left them unable to protest or push back against the powerful, hierarchical, obstetric consultant-led, midwife-managed, Irish hospital maternity care system (Gregory et al., 2023), which failed to guide or adequately support them through their transformative, yet intense childbirth journey (Olza et al., 2018). This was despite three of the participants being experts by experience, having already had one child. Some were experts by profession working within the healthcare profession, including one insider who worked as a healthcare professional in a large urban maternity care hospital. Others had professional expertise of working within public service systems. Only one participant in this study, expressed a diverging and more positive perspective of the bio-medical model of care, where she was glad to see the operating theatre fill with people. She interpreted their presence as meaning she was receiving the optimum care for herself and about to be delivered, premature baby. Notably different was her relationship with her medical team as opposed with the midwives, because of her frequent antenatal appointments with them, as a high-risk pregnancy.

Overwhelming pain that causes women to lose control, has the capability to interrupt their sense of coherence and lead to breakdown and dis-ease (Drapeau., 2012). In their well-documented application of polyvagal theory, Porges and Dana (2018), explain these behaviours as consistent with the activation of our fear defence system. There is a move towards self-protective behaviours where we socially disengage, mobilise into a sympathetic nervous system flight response, thereby becoming dysregulated. While some

participants dissociated, others lost control, screaming out in pain and panic, others sobbed uncontrollably, and some withdrew into themselves and were muted in their distress. None of these patterned and troubling behaviours supported the participants to use their voice, to seek the understanding and care they needed. Only one participant successfully used her networking capabilities to intentionally foster rapport with the maternity care staff and elicit the care she needed However this was context dependent on the interpersonal connections she had personally made within her community and professionally through playing sports competitively. Where and when she was unable to make these interconnections, her care was equally unpredictable and neglectful as for other participants, which she recalls was particularly horrific, particularly at nighttime.

McCluskey (2005), describes this as defensive careseeking. These interconnected, instinctive, defensive careseeking behavioural strategies to get basic care needs met vary depending on the predominant insecure attachment style. Therefore they have unpredictable levels of securing supportive caregiving and thereby success as was evident from the participant accounts. Moreover, it is not just the quantity of interactions but also the quality of presence, intention of interactions and the capacity to adapt and flow with what is happening in the here and now within the environment of interpersonal encounters, that dictates if final contact is achieved. Final contact in the Gestalt Cycle of destruction and formation is interrupted by our defensive resistance which Zinker (1977, p34), philosophically described:

> *"Although I may be observed to resist some behaviour, idea or attitude, my own experience is that I am acting to preserve, maintain, and enhance myself, my integrity. And what appears to you, on your observing surface, as a casual reluctance to change may be an inner crisis for me, a fight for my life".*

5.3.2 Derealisation; Handing Over Power

These participants willingness to preserve their babies life, yet fight to live themselves, is evident where many of the participants during childbirth depersonalised/derealised. They comprehended that there was no other escape from the overwhelm of the circumstances causing their distress, while their baby was still in utero. This is reflected in the sub-theme *"Having to meet what the system demanded".* Van der Kolk (2015), interprets depersonalisation as the outward expression of the polyvagal freeze response, when circumstances that are inevitable and or inescapable are encountered. There is no effort put into thinking, feeling, remembering or making sense of what is happening in the moment (Cozolino, 2017; Van der Kolk, 2015). Porges and Dana (2018), illuminate depersonalisation occurs when the dorsal vagal system triggers an adaptive fear induced, immobilising response, where the threat of death or a threat to a person's physical integrity is neuroceptively detected. This behavioural shutdown, death feigning, dissociative response is described as reducing the person to resembling an inconspicuous inanimate object, that is practically invisible (Herman, 2015; Porges & Dana, 2018). Adler et al. (2014), explain that derealisation supports individuals or objects to be experienced as unreal, dreamlike, foggy, lifeless or visually distorted, and that this causes or has the potential to cause impairment. Herman (2015), further argues that once terror and helplessness become overwhelming, capacity for a concerted, coordinated and purposeful effort to achieve completion of the task in hand is broken. While in gestalten terms, Mackewn (2006), suggests the context and the content of any interaction must be considered to achieve completion. This necessitates the joint realities of those involved must be considered from a physical, psychological, socio-cultural, economic and political perspective.

The current study's findings offer support for these theories. One participant used the metaphor *"letting the river take"* her to describe her sense of derealising, as a result of feeling confused, disempowered and dehumanised when a midwife started to shout at her. Others also used water metaphors, to describe their derealisation into nothingness, as they allowed themselves sink into the "*whooooo"* sound similar to being underwater. This was their only way to escape the sense of being overwhelmed by all that was happening to them and around them, in that moment. Some described their derealisation as similar to being in a fog where everything was blurred.

These findings are further reflected in Wigert et al. (2019 p3), meta-synthesis where they found women do recognise childbirth as a *" point of no return"* and therefore understand there is no escape. Leinweber et al. (2022b), definition of traumatic childbirth found women who were overwhelmed by the distress of their childbirth experience, including their responses to it, as well as its ongoing impact on their health and well-being, defined their childbirth as traumatic. More specifically, Reed et al. (2017), in their study reported two thirds of the participants traumatic childbirth experience resulted from care provider's actions and interactions, while the remaining third described a complication of their childbirth, or their baby being admitted to the neonatal special care as the issue.

5.4 Regaining Coherence; Making Sense of What Happened

As they worked through the mental and physical challenges of their distressing childbirth experience from one year and up to ten years later, all of the participants were still trying to make-sense of and more fully resolve what happened to them. Most left the hospital, bearing the cost of their distressing childbirth experience, either physically, psychologically or both. This recovery process is reflected in the group experiential theme*" Regaining Coherence".* Having a Sense of Coherence (SOC) is described by

Antonovsky (1996 p1), as *the capacity to comprehend, manage, and make-sense of a given situation, using the available resources to mitigate against dis-ease (pathogenesis) in order to achieve health-ease (salutogenesis).*

The complex and enduring nature of a distressing childbirth for this study's participants' is not new and resonates with the findings of earlier studies (Bossano et al., 2017; Salmon et al., 1990; Takehara et al., 2014). However, many theorists recognise the trauma recovery journey as more complex and arduous, the distress more impactful and the sense of betrayal more devastating when trauma is enacted by those who are supposed to care. Moreover, where interpersonal responses fostering safety are unpredictable or absent, the capacity to initiate a repair of the ruptured relationship may also be absent (Cozolino, 2017; Herman, 2015; McCluskey, 2005; Porges & Dana, 2018; Siegel, 2011; Van der Kolk, 2015). Siegal (2011), explains a rupture in the relationship with oneself and or others occurs where attuned communication is disrupted and broken. While he suggests repair allows us to compassionately acknowledge the rupture and put effort into the re-establishment of an attuned connection with ourselves and others.

5.4.1 Robbed of Joy: Navigating the Bittersweet Impact

Many of the participants, as a result of their distressing childbirth experiences, intentionally left the maternity hospital before they were required. They believed they would recover better in the safety of their home, with their supportive partner and or extended family members. Seeking and re-establishing safety is considered by Herman (2015), as the first stage of her three-pillar trauma recovery process. Therefore, participants intentional decision to leave hospital, often earlier than required and return home to a safe, more supportive environment, was timely. Most of the participant's spoke specifically and regretfully of feeling robbed of their anticipated joy, as a result of their distressing

childbirth experience. For others it was more implicit across their accounts. Paradoxically, they felt lucky and were grateful that they and their baby were alive, having come through what some termed as the *"conveyor belt"* of the Irish Maternity Hospital childbirth system. The conflicting feelings experienced by the participants are reflected in the sub-theme: "*Being with child, a bittersweet experience"*.

The participants' polarised view of childbirth as bittersweet, echo's an existential perspective, along the continuum of great happiness, strength and healing against the opposite polarity of suffering and despair (Kuipers et al., 2024). Some participants were faced with the potential morbidity or even death of their baby, as they reluctantly agreed to an instrumental delivery or emergency C-section. For others the concern was for their own life, having to navigate excruciating pain with little or no assistance, not knowing what was happening. For others they experienced the failure of their neuraxial (spinal/epidural) block, as their C-section was being performed. Some participants also found themselves pleading with staff to be reunited with their baby, while being monitored in the recovery room following their emergency C-section. None were successful. Their babies were given to their partners who were equally left alone, feeling distressed, not knowing what to do.

Therefore, participants frequently wondered what they were doing staying in a maternity hospital, where bells were continually hopping and midwives were run off their feet. Overhearing this never-ending high level of demand on midwives, left all participants reluctant to add to the burden of the midwives on duty, particularly when staffing levels were reduced at nighttime. They interpreted their external environment as *"midwives too busy to ask for care"*, similar to Larkin et al. (2012), study findings of *"not enough midwives to care"*. Many participants spoke about being made feel bad for taking-up the midwives time, when they actually did seek care. Others spoke about their vulnerability in

seeking care within a maternity care system that had the invisible expectation for them to not need care. While most of the participants acknowledged they had received *"little kindnesses that made a memorable difference"* many acknowledged they were not enough to undo the harm that had already been done. Therefore, Daly et al. (2022), argue peri-partum women continue to feel invisible within a see-sawing continuum of inconsistent maternity care provision, where at worst women-centred care remains aspirational. While at best Larkin et al. (2017), suggest Ireland's maternity care system lags behind similar maternity care services within the global north.

Once home, many of the participants withdrew from those around them to grieve being robbed of their anticipated joy of childbirth. This allowed them prioritise and give time to the healing of their physical and psychological wounds, as well as come to some kind of acceptance around what had happened to them. Herman (2015), describes the remembering of what happened, as well as the mourning for what happened, as the second phase of trauma recovery. While she acknowledges it takes great courage on the part of the survivor to confront their traumatic experience, it cannot be bypassed if the integration of what happened is to be achieved. She further recognises that traumatic experiences often transcend language and is therefore unlanguagable, which Van der Kolk (2015), aptly terms as "*Speechless Horror"*. However, traumatic events that are not understood, integrated and resolved remain unfinished. Clarkson (2008), from a gestalt perspective, reflects that unfinished business stays in the foreground of our here and now experiencing, seeking opportunities for completion as what is resisted persists. The flow of our psychological growth stagnates, integration of the experience is incomplete, resulting in unfinished business. Consequently needs go unmet and are repressed in favour of survival. Therefore unresolved past gestalts, continue to interrupt in the present and go on to

influence the future, until through intentional awareness they get completed and are fully integrated, informing our experiencing of the world.

5.4.2 Regaining Understanding; Seeking to Resolve Trauma

Therefore, participants, appeared compelled over-time to understand and accept the ongoing consequences of their distressing childbirth experience within their lifeworld, as is reflected in the sub-theme *"seeking understanding"*. Seeking and discerning the truth of what is experienced is according to Van der Kolk (2015), one of the critical components necessary for healing to take place. No delivery type was stipulated as a selection criteria to participate in this study. Yet all the participants who self-identified as experiencing a distressing childbirth had experienced some form of bio-medical intervention, that had not been explicitly or sufficiently explained to them prenatally. This left participants unable to imagine or predict and thereby integrate an assisted biomedical childbirth as an embodied possibility.

Eleven of the twelve participants booked into an Irish maternity care hospital for their childbirth, where predominantly the biomedical risk-based model of maternity care was practised (Grigg et al, 2014; O'Driscoll, et al, 1973). This was despite the participants' predominant biopsychosocial, low-risk orientation towards childbirth prenatally. Consequently, most of the participants and their partners displayed little knowledge of the deleterious influence that a bio-medical, risk focused, hospital maternity care environment posed to their expectation for women centred care and their desire for a physiological childbirth in Ireland.

Participants who experienced a previous positive hospital childbirth that went well, held the assumption that their upcoming experience would not be all that different. Only one

participant chose a homebirth, based on her insider experience of a family relative receiving rationed/ missed care (Kirwan & Matthews, 2020) within the Irish mental health system. With the encouragement of her partner, one other participant changed from free public to fee paying private consultant-led maternity care, having experienced rationed/neglectful care on her two previous childbirths. Her partner's belief in the private system to deliver the responsive, respectful, person-centred, care his wife deserved, directly challenged her long-held core belief in the integrity of the public system. Gadamer (Moran, 2000) explains it is through genuine open conversation that we come to appreciate the additional understanding gained through a fusion of horizons. However, despite half of the participants choosing private consultant-led care, as an intentional mitigating additional resource to support a salutogenic childbirth outcome, most felt at some point during their childbirth commodified as nothing more than a "fiscal unit" within a private system that *"can't even get it right"*.

Some participants recalled the potential for bio-medical interventions during childbirth being covered in their antenatal classes, but only in a vague *"theory-ey"* way or so routine it was unremarkable. Therefore, none of the first-time mothers came away with any meaningful insight, as to how the information might practically relate to their actual childbirth experience. Neither did they discuss or know to discuss the information with their birth partners, so they and their birth partners were better informed for medical interventions that might happen. As a result most of the participants and their birth partners were ill-prepared for bio-medical interventions, where a physiological childbirth was no longer deemed safe by the maternity care staff. Participants had neither assimilated, accommodated or integrated the bio-medical information as meaningful or applicable to their individual perinatal circumstances. Participants' stability and equilibrium was severely disrupted which Kegan (1982), from a Piagetian cognitive constructivist

perspective, suggests is inevitable when assimilating new information into a reconstructed newly informed reality.

While, Perls et al. (2006), proffers from Gestalt's differentiated unity perspective that assimilation of an experience can only occur where it is first deconstructed in a way that all of its parts can be understood before being reconstructed and owned, as our own. Otherwise it is introjected whole, as is reflected in many of the participants accounts where they believed what they were told in ante-natal classes, by their consultant or by family and friends. No deconstruction and reformation of the information available to them appeared to take place. It was only later and following their distressing childbirth experiences that the participants began to question their understanding of what happened and make sense of their distress. A valuable learning and growth opportunity was inadvertently lost, particularly for the 75% of participants who were first-time mothers, where the majority attended formal antenatal classes.

This is despite the participants' desire and openness to learning evidently reflected in: their already high levels of educational attainment; their self-motivated and directed research around childbirth; their capacity to seek relevant expertise outside of themselves perinatally by talking with friends and family who were experts by experience; and where they sought private professionals to fill the gaps in their care needs. Merriam (2018), in Illeris (2018) drawing from Andragogical, Self-Directed and Transformative humanistic psychological learning theories affirms these competencies as necessary conditions to optimise adult learning. However, it was only following their distressing childbirth experiences that the participants began to question their lack of knowledge and understanding around what had happened to them. Merriam (2018) in Illeris (2018), argues these three foundational learning frameworks, while significant, take an individualistic

rather than a collective approach to learning and therefore are insufficient by themselves. She posits that the social and political context in which learning occurs must be considered. Understanding how political and socially accepted power structures influence ideology, thoughts and actions is essential for adults to learn in order to manage the inequity and oppression that is concealed beneath these taken for granted systems.

Moreover, the participants believed themselves to be adequately prepared and showed no conscious awareness antenatally, that their care in childbirth could be inadequate or rationed (Kirwan & Matthews, 2020). Furthermore, the two participants who had some experience of inadequate or rationed care, did not succeed in mitigating for rationed/inadequate care, despite considering it in their preparations. Many of the participants willingly made allowances for the less-than-optimal maternity care conditions they found themselves in, grasping the multiple intersectional factors that lead to poor care outcomes, while empathically understanding that the maternity care staff were doing the best they could with what they had. However, despite most of the participants making these allowances for those who cared for them, it was not reciprocated when they were in need of care. Therefore, participants concluded, their suffering and severe distress was not important enough to those working within the maternity care system, for them to take the necessary, restorative action and interventions that could have alleviated some of their distress. Even where participants actively sought out information, through follow-up meetings with their consultant or through the hospital childbirth reflection service, so they could better understand their childbirth experience, they experienced them as little more than fact finding missions or consultants "*dancing around the responsibility*", blaming miscommunication for their poor childbirth outcomes.

Mathias et al. (2021), in their application of Antonovsky's (1996) salutogenic theory to maternity care practices, in their best-fit framework analysis of 31 qualitative studies from ten high income countries, elucidate the central role midwives play in supporting women to comprehend, manage and make-sense of their childbirth experience to achieve a salutogenic childbirth. However Hammond et al. (2013), demonstrate that place and space are permeated by ever evolving social, political, and ideological influences, both past and present. Therefore it not only impacts the much needed production or not of oxytocin to support women's physiological childbirth, but also impacts the oxytocin level of midwives, which in turn influences their capacity to sustainably and sensitively engage with women and meet their care needs. Furthermore, oxytocin mitigates against the fear of meeting unknown individuals/experiences and increases the capacity for social engagement. While the impediment of oxytocin as a result of a negative external environment experience has a constricting impact on social engagement and sustainable relating, leading to shut-down and the potential of an instrumental or surgical delivery.

From an interpersonal neurobiological perspective, Siegel (2011; 2014), argues having the capacity to integrate the elements of the many complex systems in our interpersonal encounters, is a key contributing factor to sustaining our health and well-being. Without having integrated the bio-medical information, participants and their partners were unwittingly more vulnerable to a pathogenic outcome going into their childbirth, despite feeling informed, confident and open to what might evolve. He further theorizes where integration is impeded, our responses tend to become polarised as either chaotic or overly rigid, at the expense of harmony and flow. These unintegrated responses to biomedical interventions was evident in all the participants' accounts. Many of the participants found themselves screaming or crying uncontrollably because of the internal chaos they experienced following unanticipated and or at times unwanted biomedical interventions.

They described feeling*: "upended"; "out of control"; hysterical and "falling apart".* While others adopted a more rigid response, describing: *"becoming more mechanical"* as they kept it all together. Therefore, participants' incapacity to flexibly adapt, harmoniously respond to dynamically meet the complex bio-psycho-social systems within themselves as well as, within the wider socio-cultural-political system of their interpersonal maternity care relationship and environment limited their capacity for self-regulation, coherence, safety and integration, (Antonovsky 1996; Porges & Dana, 2018; Rodgers 1995; Siegel, 2011) which ultimately disrupted their potential for a salutogenic childbirth experience.

5.4.3 Moving Forward, Awakening from the Fog

The ongoing physical, psychological and emotional challenges and changes which the participants' encountered, surmounted and adjusted to, as they navigated their distressing childbirth recovery took considerable time to achieve. Most of the participants benefitted in their recovery and healing as a result of their capacity to achieve and integrate a greater understanding of what happened to them. Participants' sense of being upended and flipped over as a result of their distressing childbirth took time for them to resolve in order to find their way out of the fog of confusion, doubt, guilt, self-blame, and shame that they were left with, having not achieved the empowering natural childbirth they so desired. Their experiences of how they navigated their recovery and integrated their understanding of their experiences following their distressing childbirth, are reflected in the sub-theme 'Finding their mothering way'.

Gregory et al. (2023), in their mixed-method survey comparing the childbirth experiences of 141 women who birthed at home and in hospital, go as far as describing the bio-medical model of care as holding hegemonic status in Ireland, as well as across the world. This is despite a person/women centred model of maternity care being pursued as a global policy.

This hegemonic status of the bio-medical model is further evidenced in the participants' accounts where their induction and or augmentation of their labour was a one size fits all and predominantly system driven. No participant recounted that their syntocinon infusion protocol was sensitively regulated to align with the rate, rhythm and strength of their contractions, despite their reporting their obvious distress and excruciating levels of pain to the midwives caring for them. One participant discovered the use of syntocin in the induction protocol of her European country of origin is much less concentrated than what she experienced during her induction in Ireland. Daly et al. (2020), identifies that there is no agreed standardisation internationally for the judicious use of oxytocin for the induction and or augmentation of childbirth. This is despite many studies demonstrating the judicious use of syntocinon in the induction and augmentation of labour improves childbirth outcomes, particularly reducing C-section rates and foetal distress (Acharya et al., 2021; Rossen et al., 2015; Saccone et al., 2017)). Almost 34% of the participant's childbirths were C-sections, who were induced. While only 17% of those induced had a spontaneous vaginal delivery. Ensuring this one size fits all approach is mitigated within the therapeutic encounter through the judicious use of an integrative therapeutic approach rather than Risk the overuse of CBT which can itself be perceived to be inflexible and a one size fits all approach (Gough, E., & Giannouli, V. 2021).

The participants used various metaphors to describe their experiencing of their distress in the time following their childbirth, once discharged home. Some participants described continually being in a fog or even being *"the fog"* waking up in a blur at night, hardly seeing their child as they fed them. Many expressed feeling they were *"bad mothers"* despite their intense feelings of protection and love towards their baby. Others spoke about their levels of distress, anxiety and deep despair bringing them into a dark place that was really hard to navigate their way out of. The confusion and unanswered questions

participants were left with, frequently compelled them to seek answers outside of themselves. Many needed and benefitted from having their experiences repeatedly affirmed as shocking, horrible and awful by their peers or other healthcare support workers whom they often privately sought out to augment their neglected care needs. Equally, participants benefitted in their recovery where partners shared a similar understanding of what had happened to them during childbirth. Many couples agreed on how horrible their experiences were, the fear they were left with and how an under resourced and oversubscribed system contributed to their childbirth distress. Furthermore, this shared understanding was enough to allow participants' be more receptive of their partner's capacity to reframe the narrative around their distressing childbirth experience and work with it. For others the overwhelming and agonising distress following their distressing childbirth experience contributed to the uncoupling of their relationship, as neither were able to support the other, often detrimentally. Two of the participants' relationship broke down over a year later. Johansson et al. (2020), study and Delicate and Ayers (2023), qualitative study of 18 parents, using a framework analysis, supports this study's findings where the wellbeing of their couples relationship were negatively and distressingly impacted.

Positively, all participants had regained their sense of coherence and felt sufficiently re-empowered to participate in this research study and were intentionally motivated by the opportunity to influence change for others coming behind them. In contrast to their distressing childbirth experience, their sense of hope was ignited, as they articulated the benefit of having their voice heard, amongst other voices. They clearly understood the power to be gained when their voice could be amplified alongside other voices. Many of the participants voiced the healing benefit of the length of uninterrupted time given to them to recount their distressing experience, at the end of their interview. They were equally

grateful that their care needs for rest breaks and food was also sensitively attended to during their interview. This frequently reminded them of not getting the time or care they needed in childbirth, including not being given the "*wonderful tea and toast"* after delivery, that many of their peers spoke about.

In stark contrast, all of the participants acknowledged the suffering they experienced and navigated during their hospital childbirth had largely gone unspoken about among their peers, their families, within their communities or during childbirth classes. This withholding of the reality of pain and suffering in childbirth, left them vulnerable, with no realistic opportunity to be prepared and somewhat reliably predict how they might navigate the internal and external stressors they were inevitably faced with. However, some of the participants were equally economical with the truth about the level of suffering they experienced as a result of their distressing childbirth experiences when in conversation with friends and family. They feared negatively framing their family or friends experiences before they had the opportunity to experience childbirth for themselves. Their concern around the risk of vicariously negatively impacting other childbearing women with their distressing childbirth accounts is supported in Wigert et al. (2019), meta-synthesis of qualitative studies exploring women's experiences of fear in childbirth. Positively, those who did talk more openly about their distressing experiences to extended family and friends were surprised by the authentic support, empathy and affirmation they were met with.

Herman (2015), argues this veil of silence, similarly to soldiers returning from war, allows for a purposeful, communal forgetting, of a reality that is too painful and too unpleasant to be spoken about. In this way, the pain and powerlessness of those who have experienced harm is juxtaposed against the pain and unequal power of those who cause the harm, albeit

often unconsciously. This results in isolated bystanders having to look the other way, leaving the weaker victim losing out and discredited unless a socially supportive environment exits. Accordingly, Van der Kolk (2015), suggests the world for the survivor becomes a divided space and place. A shared understanding exists amongst those who know and identify as having similar experiences with those who don't know and cannot share in the understanding. This leaves survivors seeking out places and spaces that resonate with their distressing experiences, allowing them to forge shared meaningful connections that support healing and according to Van der Kolk (2015), leave them feeling alive rather than dead.

Therefore, many of the participants in this study found meaningful connection in supporting others who had similarly distressing childbirth experiences. Reconnecting is the third pillar of Herman's (2015) trauma recovery process. No longer naïve to the hospitals invisible expectations of perinatal women to require little to no minding, they aimed to prevent or at least minimise the impact of what happened to them, happening to others. Many participants have worked with women to educate, inform and support them in the hope of positively influencing the trajectory of their experiencing, including their childbirth experience. One participant only recognised the connection with their distressing childbirth experience and how it has unconsciously been informing her professional decisions and work-life for many years, as she came towards the end of her interview.

Van Deurzen (2004), explains, suffering from Karl Jaspers existential perspective is seen as a limit situation, that must be endured and acknowledged, as it is inescapable. Furthermore, Jaspers suggested life is experienced through the limit situations of uncertainty and suffering. While Frankl (2006), suggests although we may not be able to change that we are suffering, we can choose our attitude towards suffering, allowing us to

give it meaning within our lifeworld. Cozolino (2017), supports Frankl's view of suffering. However, taking from the Buddhist perspective he suggests the pain from living is an inevitable fact of life, while suffering is optional, as it is dependent on the attitude taken in relation to the pain. He further argues that Buddhist psychology and Cognitive Behaviour Therapy are similar from the perspective of how our distorted thoughts contribute to pain. The difference in their approach is the depth and intensity of treatment. CBT is focused on thoughts, influencing feelings, which go on to influence behaviour, while a Buddhist approach is more in-depth and holistically internally and externally focused on intentions, speech, actions, livelihood, effort, mindfulness and concentration.

For all participants the outcome of their distressing childbirth impacted their sense of self. The participants' sense of shame around their bodies failure to achieve a physiological childbirth and their embodied sense of inadequacy is evident in how many of them spoke about the discomfort they experienced at feeling watched at some point during their childbirth experience. In blaming themselves, many of the current study's participants perceived their body as failing them. They frequently questioned their naivete around their actions and inactions. They experienced the shame of their not knowing, their regret at giving their power away and the guilt of not having achieved a physiological childbirth. They felt anxious and responsible for the impact of their distressing childbirth on their child.

Herman (2015), argues integrity must be re-established, where trust in a relationship is shattered and needs to be restored. Kierkegaard's existential philosophy supports our understanding of regret in that life can only be understood backwords, yet must be lived forward (Van Deurzen & Young, 2009).Therefore, perinatal women can only understand more fully what happened to them in childbirth, as they reflect and look backwards, yet in

order to care for their baby they must navigate the dichotomy of living forward. Merleau-Ponty, contributes a subjective embodied and symbiotic perspective, where we experience our world through our body sensations, emotions and feelings. We reach out to meet, touch and feel ourselves and then the other, giving us a unique, subjective, corporeal way of relating within our life-world (Smith et al, 2009). The intention we ascribe to our corporeal experiencing of our life-world shapes the unique meaning we create from these experiences. Interruptions to our corporeal experiencing of the world through our body sensations, emotions and feelings forces us into an eidetic reduction of our understanding of our perceptions. As a result, while we can observe and have empathy for another's experiencing of their intersubjective life-world, we cannot be their body and so can never fully know their actual experience (Smith et al, 2009; Smith et al., 2022).

Over time and during their interview, all participants reflected on their passivity as well as the loss or giving away of their personal agency. Many of the participants felt compelled to voice their distress, seek further clarity and a greater understanding of what happened to them following their distressing childbirth. Over-time they worked through their doubts, fears, anger, shame, confusion and intrusive thoughts, to regain their sense of coherence. Many of the participants had flashbacks and intrusive thoughts relating to their distressing childbirth over a year later. While most experienced them as less activating a year later, all of the participants were moved to tears, as they recalled their distressing childbirth during their interview, regardless of the time that had passed.

Most of the participants recalled conversations initiated by their consultant within 24 hours of their distressing childbirth. However, they were unable to recall why the conversations happened or any of the specific details of the conversation, only that the conversation had happened. This was in contrast to their memory of interpersonal interactions they had with

midwives, where they remembered minute details. Almost all of the participants had follow-up appointments with their consultant following their distressing childbirth up to two years later following their distressing childbirth. For some they sought an appointment to better understand what had happened. For others it was a follow-up to address a physical injury as a result of a surgical or instrumental delivery and for others it was to discuss the management of their care for a subsequent pregnancy. One participant sought a birth reflection with the hospital Birth Reflection Midwife, so she could fill-in the gaps in her childbirth where she had derealized. While these appointments went some way towards explaining what had happened, they had little impact on participants' levels of hypervigilance. However, most participants were generous, thoughtful and kind in their articulation and acceptance of the obvious, conflicting pressures they experienced the maternity staff and care system to be under. Most participants understood that the various healthcare professionals working within this environment also bore their own costs. Furthermore, they lamented the detrimental modelling of a deficient and flawed system on the idealistic aspirations of student midwives. Therefore six of the twelve participants engaged in some form of individual psychotherapy, group therapy, or body work to support them work through the distress of their childbirth experience on themselves and in turn on their child, and on their immediate family.

The participants' noted passivity and loss of agency, as well as their acknowledgment of having to capitulate to the systems demands is according to Boyle (2020), suggestive that the operation of power has negatively impacted their well-being, resulting in troubling and distressing experiences. Gregory et al. (2023), argue that the bio-medical model approach to childbirth in Ireland holds hegemonic status, thereby dominating the socio-cultural-political context of maternity care. Furthermore, the participants awareness that the maternity care system they depended on for their care was flawed, where they observed

those who worked within it equally paying a cost, is further suggestive of a greater socio-cultural-political power dominance. Dong and Temple (2011), recognise the unequal, unjust and dehumanising and thereby oppressive conditions that nurses may work under. As a result they can move between being the oppressed or the oppressor. Participants equally lamented the plight of what could be considered the yet untainted and unflawed student midwives, whose idealistic attitudes and empathic care was still evident in their eyes. Boyle and Johnstone (2020), suggests the inequalities of power that exist between service user and service provider, employers and employees, state institutions and the government of the day, women and men may become social norms, with the capacity to induce distress. However, overt conversations exploring the negative impact of these often implicit, as well as explicit power inequalities on the populations mental health is rare. Boyle (2020), argues psychology and psychotherapy theories and practices are mostly devoid of conversations around the relevance of power or the lack of, as a critical factor in poor mental health outcomes. McCluskey (2005), advances the notion that relating from a dominant and submissive stance or a supportive and companionable stance is a choice available to all. That choice is often made depending on how our care seeking needs are met or not.

The power threat meaning framework has been specifically developed by Boyle and Johnstone (2020), where they advance an alternative framework to the bio-medical models of diagnosing and treating mental ill-health. As a framework its focus is similar to the bioecological model, exploring *"what happened to you"* rather than *"what is wrong with you" (*Boyle & Johnstone, 2020 p37; DeCandia & Guarino, 2020 p13). Similarly it emphasises the complex interconnecting roles impacting mental health outcomes, played by our interpersonal interactions within our internal and external environments. However, they argue that Bronfenbrenner and Morris (2007), ecological model continues to locate

the issue of distress predominantly within the person, similar to other psychotherapeutic models, potentially leaving contributing organisational and power issues unaddressed.

Boyle and Johnstone (2020), go on to describe seven groups of power that they suggest operate within our everyday life. Moreover, Boyle and Johnstone (2020), suggests, power allows us influence our environment in a way that meets our interests and needs. These power groups impact positively or negatively as well as covertly or overtly. These seven power groups are as follows: biological/embodied power, interpersonal power, coercive power/power by force, legal power, economic and material power, social/cultural capital and ideological power. More than one power group may be operating at any given time.

The operation of power is evident in the participants' accounts where as highly educated, middle class participants their available social/cultural capital, economic and material power, as well as their, embodied/ ideological power supported half of the participants to access private consultant care. Participants capacity to exercise their power was evident prenatally and postnatally, where they attended mostly private antenatal classes and or availed of private external guidance following their return home. However, despite the evidence of power and capacity for personal agency pre and postnatally, participants were ill-prepared and unable to successfully pushback against the dominance and power of the maternity care system. As a result they felt they had no choice but to submit, as they experienced the system and the people who cared for them, as a threat to their and or their baby's safety and survival, their bodily integrity, their sense-making and or their well-being.

Siegal (2014), *"mindsight"* perspective offers some insight into the participants' noted passivity, capitulation and loss of agency as a result of the distress they experienced during

childbirth. He explains mindsight as having an integrated sense and awareness of one's own mind as well as that of the other. He further suggests our capacity for mindsight is based on our reflexive ability to attune to ourselves and others, respond empathically and flexibly, while displaying a sense of resilience in our interpersonal relating which then integrate as experience. Mindsight allows us to differentiate ourselves from the other, attune, understand and empathically respond to their verbal as well as their non-verbal cues. Therefore mindsight is dependent on the integrating of our systems of attachment, neurobiology and interpersonal neurobiology, supporting our capacity for self-regulation based on a secure sense of self. From a mindsight perspective, participants in being unprepared for the prospect of biomedical interventions as well as being upended by an unfamiliar system, place and space that their capacity for mindsight was diminished, leaving them dysregulated. This left them overwhelmed, passively responding to what was happening to them and unable to maintain their sense of coherence to support their bodies achieve a physiological childbirth.

Arora et al. (2025), findings suggests the DSM 5 PTSD checklist is a potentially reliable screening tool to be used by healthcare professionals for the early diagnosis of CB-PTSD amongst perinatal women who report a traumatic childbirth experience. This potentially will allow for early and targeted psychotherapeutic interventions to be offered to women who have experienced a distressing childbirth. While Bartal et al. (2023), use of a natural language processing model and machine learning algorithms to identify CB-PTSD will also support therapists have a heightened awareness around listening to the language used by their clients. Clients whose narratives and language use around their childbirth experiences are longer, more emotional and negative, particularly including more references to death may be experiencing CB-PTSD. However, women are empowered to psychologically adapt to what happened to them, where therapists empathically give them

the opportunity and space to tell their distressing childbirth story and support them over time to re-construct a more coherent and comprehensive narrative. Furthermore, in this empowering process women compassionately find redemption, while their trust in themselves and their reasoning is restored, allowing them move forward with greater stability as a responsible parent of their baby (Gough, E., & Giannouli, V, 2021).

Researcher's Reflexive Comment

The writing of this discussion section has required an integration of already available knowledge taken from the literature review with novel information taken from the findings from this study's participants. The hoped for outcome has been to present the integrated information in a way that sparks curiosity for others around the perinatal journey. Prior to undertaking this qualitative research study, I as a midwife, a mother and a psychotherapist took the knowledge and knowing I brought to the therapy room for granted. The challenge throughout this thesis has been to deconstruct what I know, allow the unknowing to happen, so a new knowing could emerge, thus privileging the participants' experiencing. Furthermore coupling an Interpersonal Neurobiological Perspective, with the Power Threat Meaning Framework supports our understanding of the complex processes involved in women's experiencing of a distressing childbirth and their recovery journey afterwards.

Chapter 6: Conclusion and Recommendations

This final chapter concludes with the implications of this study for healthcare practitioners, including psychotherapists. It explores the strengths and limitations of the study, supporting the extant literature on distressing childbirth. It concludes with recommendations and direction for further research.

6.1 Study Strengths

This study's findings resonate with previous qualitative studies' findings on the negative impacts of childbirth on perinatal women, their partners, their children and their extended families. What is obvious from this study's findings and the many findings of other studies, reviewed in the literature, is that distress in childbirth and its enduring impact go across all boundaries, all social classes and all continents. Furthermore, its qualitative in-depth findings aim to inform and support psychotherapists and other healthcare professionals in their work within this specialised field of perinatal psychology and psychotherapy. Moreover, the philosophical underpinning of IPA supports the use of an interpersonal, neuro-ecological psychotherapeutic perspective to explore the phenomenon of a distressing childbirth. This study further argues for the novel coupling of the interpersonal neurobiological perspective with the Power, Threat, Meaning Framework to openly address the issues of power that operate and contribute to women's distressing childbirth experiences.

This study's qualitative findings add to the growing body of qualitative literature on women's experiences of childbirth in Ireland. Its unique, broad focus exploring women's experiences of distress in childbirth, is inclusive of childbirth that is negative, difficult, complex, pathogenic and or traumatic in Ireland. This study further explores the impact of a distressing childbirth on the participants and the meaning they attributed to their

experiencing, using an IPA methodological approach. IPA's idiopathic approach gives voice to women's unique, in-depth and detailed understanding of their experiencing of a distressing childbirth while simultaneously acknowledging its commonality with others (Smith et al., 2022). Moreover, most of the participants intentionally chose to participate in this study, in the belief that their voice was strengthened amongst others. Taking the opportunity to give support to their friends was an important aspect of the participants recovery process. Through helping and working with others, they were in parallel, helping and empowering themselves, often becoming more knowledgeable in the process. Influencing meaningful change for other women coming after them gave meaning to their suffering and what had happened to them.

This study's particular focus on how language is used supports the inclusion of frequently used, interchangeable terms indicative of childbirth distress within the childbirth literature such as, negative, difficult, complex, pathogenic and or traumatic. The three group experiential themes, their nine sub-themes as well as the metaphors and linguistic phraseology of the participants adds to the lexicon of trauma informed language. Sensitive supportive use of language is a key element of trauma informed practice as it interpersonally communicates empathy, support and respect for a survivor's experience (DeCandia & Guarino, 2020).

Therefore this study's findings are reflective of its 12 participants' unique diverging and converging perspectives, as well as the unique, interpretation this researcher brings to data analysis as a psychotherapist and midwife. As a result this study supports Brockington et al. (2016), call for a comprehensive, evidence-based expertise to be built up in the growing area of perinatal mental health, among multi-disciplinary professionals, where the vulnerability of both mother and baby is held at the centre of care. Psychotherapists

undoubtedly have a place on a multidisciplinary perinatal mental health team and can play a valuable role in the support of mothers, their partners, and positively influence their children's developmental psychosocial outcomes

All participants freely spoke about their distressing childbirth experience during their interview. Participants were given the time they needed and chose to take, to complete their account of their distressing childbirth experience, with the aim of minimising the retriggering of their traumatic experiencing. As a result of the outpouring of information, interviews ranged from one to three hours long. At the end of the interview, all participants voiced the benefit in being able to self-identify as experiencing a distressing childbirth with the opportunity to openly speak, mostly uninterrupted, about their experience, to a knowledgeable, multidisciplinary researcher.

6.1.2 Study Limitations

Although, this IPA study involved the maximum number of 12 participants as recommended by Smith et al. (2022), it is still considered to be a small sample size, and while its findings are seen to be transferable, they are not generalisable. This study was carried out by a novice researcher who can be considered to be an expert by experience and an expert by profession. Although knowledgeable, she is open to a biased interpretation of the participants' data.

IPA's data analysis demands the researcher to dwell in and embody the data. Therefore, time and a patient acceptance were required as this researcher built-up the skill required to preserve both the idiopathic individual participant voices alongside the identified similarities and differences across all voices (Smith et al., 2009). However, in my search to understand Engward and Goldspink (2020), spoke to my experiencing, where they

described dwelling with their participants' data, as similar to sharing space with lodgers. Goldspink elaborates suggesting that the researcher needs to learn to live with the embodied daily uneasiness, uncomfortableness, and uncertainty of being absorbed in the experiencing of her participants' data, as she was both instrumental in its interpretation and the instrument through which it was interpreted during data analysis. While these studies normalised my experiencing, ensuring I sought out adequate supervision, as I completed the many emotive aspects of this study, was equally a significant ethical responsibility.

Although relatively small, a purposive and reasonably homogenous sampling, adhering to IPA guidelines, was used for participant selection. While each participant was required to meet the study's inclusion criteria before they were accepted as a participant onto the research study, participant's demographics suggest all could be considered to be from the middle to higher income bracket, where half received public and half received private care. While none came from a marginalised group, two were born and had lived most of their lives, up until their early 20's in western Europe. Furthermore, all participants had experienced some form of biomedical intervention, despite this not being included in the distressing childbirth inclusion criteria.

Participants were accessed and recruited through healthcare practitioners (accredited psychotherapists, accredited psychotherapy supervisors, doula's, GPs, GP practice nurses and physiotherapists) Careful balancing of the benefits and risks of using other professionals to filter access to and recruitment of participants was closely considered, as it risked a sampling bias, by inadvertently eliminating people who were eligible and willing to participate. To mitigate against this risk, participants' recruitment was supported by clear, detailed inclusion and exclusion criteria. Therefore, healthcare professionals who acted as gatekeepers were given guidance via email, to support an open and transparent recruitment process that was clear, detailed and easily understood.

6.2 Implication and Recommendations

6.2.1.Recommendations for Psychotherapists

Practitioners need to be aware of the enduring nature of a distressing childbirth experience when perinatal women come into the therapeutic space. A central aspect of this study is the concept of Antonovsky's (1998), sense of coherence and the role it has in ensuring experiences are understandable, manageable and make-sense, providing us with health-ease rather than dis-ease. Therefore regaining a sense of coherence is a good roadmap for a therapist supporting women who have experienced a distressing childbirth.

Equally, Herman's three stage Trauma Recovery Process can also be used to support the trajectory of the recovery journey for the participant. Herman (2015), situates a clients recovery within the following three stages: 1. safety, 2. remembrance and mourning and 3. reconnection. Ensuring a client achieves a sense of safety following a distressing childbirth may involve exploring both their internal and their external world for present issues around their emotional regulation, physical, psychological, social, cultural, financial and political safety. Giving a client the safe space to speak about their experiences will be essential in their overall journey of recovery. One participant noted how she repeatedly needed to tell her story to make sense of what happened to her during her distressing childbirth. Over time, the client is able to integrate what happened as they tell their story in a more embodied way, in comparison to their emotionally numb and disconnected telling of what happened initially (Cozolino, 2017; Herman, 2015; Van der Kolk, 2015).

It is worth remembering that clients who have experienced a distressing childbirth may have felt abandoned in their suffering. Therefore, adhering to Rogers (1995), person-centred necessary conditions (empathic understanding, unconditional positive regard, congruence) to create and sustain a trusting relationship with the client, in order for

therapeutic change and personal growth to occur will be needed. In a sense to be 'with woman' in the midwifing of the clients recovery process.

Supporting an empathic, understanding, unconditional positive regard and congruent relationship with the client may awaken their sense of its absence in their distressing childbirth. As a result, it may trigger flashbacks causing them distress, as if it were happening in the now of the therapy room, as such experiencing the frozen present (Browne, 2009). Furthermore, this may bring a client back in time to earlier childhood adversity or relationship trauma in adulthood, including issues in their current relationship, that may or may not be related to their distressing childbirth experience. The adaptive numbing into nothingness response of a client, is considered by Van der Kolk (2015), and others to be often learned early in life as an adaptive coping mechanism to deprivation, neglect or trauma. Positively, where observed it has the potential to alert psychotherapists to the presence of earlier adversity in peri-natal women

Childbirth as a painful experience that involves considerable suffering, needs to be discussed more openly, where every pain has a purpose in supporting a woman towards their end goal of a physiological childbirth, if that is their desire and is deemed medically safe for a mother and her baby. Therefore, how women and their birth partners are educated, so they are more realistically, as well as strategically prepared to predict internal and external pressures must be considered in perinatal education programmes. Merriam (2018) in Illeris (2018), drawing from Andragogical, Self-Directed and Transformative humanistic psychological learning theories affirms these competencies as necessary conditions to optimise adult learning. However Merriam (2018), in Illeris (2018) further argues these three foundational learning frameworks, while significant, take an individualistic rather than a collective approach to learning and therefore are insufficient

by themselves. She posits that the social and political context in which learning occurs must be considered. Understanding how political and socially accepted power structures influence ideology, thoughts and actions is essential for adults to learn in order to manage the inequity and oppression that is concealed beneath these taken for granted systems. Furthermore, learning is an embodied experience and therefore the role played by embodiment and spirituality must be included in our learning.

Merriman's review of learning theories integrates well with an integrative ecobiological model of psychotherapy for supporting recovery (Illeris, 2018). Equally, it is supportive of allowing a client who had participated in antenatal education and may feel misled to understand the complex processes involved in adult learning. Furthermore, Hattie and Donoghue (2016), support an integrated perspective for adult learning. They illuminate that different learning strategies are used at various stages of learning. They propose there is three similar inputs and outputs to adult learning namely: Skill; Will; and Thrill; while simultaneously there are three phases to learning namely: surface; deep; and transfer and an acquiring, and consolidation phase to each of the three phases. Deep learning allows for more critical strategic strategies to be learned, developed and transferred. This notion of learning is supportive of Siegel (2014), interpersonal neurobiological concept of mentalisation, that is best fostered through a secure attachment in childhood. However, it can be taught and according to Hattie and Donoghue (2016), where an earned secure attachment has been established in Adulthood. Rockliffe et al. (2021), explored pregnancy as time that motivates health behaviour change, with a specific focus on teachable moments. Having knowledge, understanding and advice supported women in pregnancy to make necessary behaviour changes. Therefore understanding an adult's learning needs, including how, where, and when adults learn best is important for psychotherapists to understand, as well as antenatal class facilitators. Subsequently, this approach should

ensure women and their birth partners are better able to meet the demands posed by the Irish hospital maternity care system that is an obstetric consultant-led, midwife-managed service model, and not be vicariously traumatized by what they hear, what happened when they feel misled or unprepared for unexpected biomedical interventions.

Experiencing Institutional betrayal as a result of feeling unprepared for the unexpected biomedical childbirth interventions, despite attending antenatal classes, as well as feeling unsupported and betrayed by the childbirth maternity care system will need to be understood and processed during the grief and mourning phase of recovery.

Psychotherapist will need to support their learning and knowing of the Power Threat Meaning Framework, so they can integrate it into their psychotherapeutic practice in order to address the overt and covert elements of how power operates and oppresses in everyday life (Boyle & Johnstone, 2020).

Attending specific continuous professional development on childbirth, including distressing childbirth would be advisable to improve the integrative trauma informed methods provided to the client as well as having the potential to increase the efficacy of the therapy that is given.

Therefore psychotherapists and other healthcare professionals are well-positioned to work strategically with perinatal women to increase their capacity (mitigating resistant resources) and confidence, to achieve a salutogenic childbirth experience. They will need to recognise the safe delivery of a mother, and their baby is paramount, rather than the type of delivery (Hunter et al., 2017). Three group experiential themes, their nine sub-themes as well as the metaphors and linguistic phraseology of the participants in this study, adds to

the lexicon of trauma informed language. It supports the work of psychotherapists who are not allied healthcare professionals as these themes are rooted within the context of a distressing childbirth experience. Sensitive supportive use of language is a key element of trauma informed practice, as it interpersonally communicates empathy, support and respect for a survivor's experience (DeCandia & Guarino, 2020).

6.2.2 Implications and Recommendations for Supervisors

Historically supervision has long been in place to support, educate and monitor psychotherapy practitioners in their work (Page et al., 2014). All of the recommendations already delineated above for psychotherapy practitioners apply to the practice of supervision. However, the outpouring and harrowing nature of the stories of women and their families who experience a distressing childbirth undoubtedly have a significant impact on practitioners who care for them. Therefore, supportive, informed and regular supervision is required.

A particular focus of supervision needs to explore the notion of oppression and institutional betrayal, as a parallel process for practitioners and clients alike. This necessitates the exploration of defence mechanisms used by the client within the therapy room, and how they may transfer and counter-transfer within the client-therapist relationship. Furthermore, addressing how power operates from Boyle and Johnstone (2020), perspective in the everyday life of the client, the therapist, the supervisor and the organisational systems they operate within, will be necessary in ensuring practitioners and clients do not get stuck in the impasse of presenting issues and or the gaps associated with cognitive dissonance. Dencker et al. (2017), suggests the benefits of employing an observing eight eye/I, within the supervision process, when employing the Hawkins and

Shohet clinical supervision model to monitor and address covert issues that have the potential to go underground and remain unaddressed.

The place and space of supervision is tasked with providing the safety for the educative and restorative work of supervision with a supervisee. Therefore using it to explore Teachable Moments to increase the supervisees understanding of the process of supervision will provide an embodied transferable deep learning experience to their work with clients, who have experienced a distressing childbirth.

Providing a safe, nurturing, unconditional positive regard space for a supervisee to navigate their way of working with a woman who has experienced a distressing childbirth is invaluable. This allows the supervisee to be open and honest about their work in supervision while fostering and paralleling a trusting relationship (Page et al., 2014.).

6.3 Future research

This study adds to the body of research literature on childbirth, while uniquely focusing more broadly exploring childbirth distress as an umbrella term for negative, difficult, complex, pathogenic and or traumatic.

Future research needs to explore a trauma informed Power Threat Meaning Framework either separately or coupled and integrated with an interpersonal neurobiological lens using a qualitative methodology. Integrative psychotherapy offers a depth psychotherapy model with the capacity to provide worthwhile integrative therapeutic interventions for perinatal women who have experienced a distressing childbirth.

Future research needs to explore the concept of institutional betrayal as a stand-alone concept, contributing to childbirth distress. It also needs to be considered within the broader context of antenatal education, and within the context of the more controversial topic of obstetric violence.

Exploring models and theories of learning, with a specific focus on learning in an antenatal context is worthwhile to minimise the possibility of women feeling unprepared and misled around biomedical childbirth interventions. Additional research focusing on teachable moments in childbirth is also worthwhile in support of deep and transferable learning theories.

Ireland has yet to undertake a national investigation into distress in childbirth, similar to the United Kingdom, Northern Ireland and New South Wales in Australia. This study suggests it would be a worthwhile endeavour and bring a depth and richness to understanding and implementing optimum care strategies to support women in childbirth.

Exploring Curtin et al. (2020), humanisation concepts in maternity care practice which are inclusive of the biomedical model of care and go beyond respectful person-centred care is equally worthy of further research and was beyond the scope of this study.

6.5 Concluding Reflective Thoughts

This study was a privilege to undertake, although it has proven to be a huge commitment with many ups and downs along the way. At all times, I have tried to privilege the voice of the participant and hope this goes some way towards improving practice outcomes for perinatal women and for psychotherapists. The participants desire was to make a difference through their collective voices in the hope of positively influencing practice for those

coming behind them. Their authentic voices and their capacity to articulate their emotive experiences of their distressing childbirth has undoubtedly added to the ever-growing volume of literature on childbirth. Furthermore, this study's findings add to the much smaller volume of available psychotherapy literature on women's experiences of distressing childbirth. Using an IPA methodology has allowed for the findings of this study to be firmly situated within the context of a distressing childbirth, which many psychotherapists will be less familiar with. It's additional emphasis on the use of language has ensured the many participant quotes used throughout, will support and increase psychotherapists lexicon around the experience of a distressing childbirth.

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Appendices

Appendix A: Letter of Approval, DCU Research Ethics Committee

Ollscoil Chathair Bhaile Átha Cliath
Dublin City University

Kathleen Noone

School of Nursing, Psychotherapy and Community Health

Dr. Aisling Mc Mahon

School of Nursing, Psychotherapy and Community Health

Dr. Mary Farrelly

School of Nursing, Psychotherapy and Community Health

27th January 2022

REC Reference: Proposal Title:

Applicant(s):

Dear Colleagues,

DCUREC/2021/272

Women's lived experience of a distressing childbirth in Ireland: perceived impacts and meaning-making.

Kathleen Noone, Dr. Aisling Mc Mahon, and Dr. Mary Farrelly

Thank you for your application to DCU Research Ethics Committee (REC). Further to full committee review, DCU REC are pleased to issue approval for this research proposal.

DCU REC's consideration of all ethics applications are dependent upon the information supplied by the researcher. This information is expected to be truthful and accurate. Researchers are responsible for ensuring that their research is carried out in accordance with the information provided in their ethics application.

Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee. As part of DCU REC's ongoing monitoring process, during your research you may be asked to provide DCU REC with a progress report. Should substantial modifications to the research protocol be required at a later stage, a further amendment submission should be made to the REC.

Yours sincerely,

Dr. Melrona Kirrane

Chairperson
DCU Research Ethics Committee

Taighde & Nuálaíocht Tacaíocht
Ollscoil Chathair Bhaile Átha Cliath,
Baile Átha Cliath, Éire

Research & Innovation Support
Dublin City University,
Dublin 9, Ireland

T +353 1 700 8000
F +353 1 700 8002
E research@dcu.ie
www.dcu.ie

Appendix B: Recruitment E-mail for Professional Practitioners

Women's Lived Experience of a Distressing Childbirth in Ireland: perceived impacts and meaning-making

Dear ________________

My name is Kathleen Noone. I am a doctoral student in psychotherapy in DCU's school of Nursing, Psychotherapy and Community Health. I am carrying out a research study exploring women's lived experiences of distress during childbirth in Ireland, how this may have impacted on their quality of life, the life of their child and other family members and the meaning they may have attributed to it

I am seeking your support with the recruitment of participants who have self-identified to you, as having a distressing childbirth experience in Ireland for the above research study. This ensures that the initial contact for potential participants will be sensitively made by someone who is known to them. I have attached a classified advertisement and a participant information sheet in the form of a plain language statement (PLS) that you can email to women, whom you may know have experienced a distressing childbirth in Ireland, and would like to participate in this research study. Alternatively as appropriate, you can give them the information or sensitively place it where they can access it. I have also included the interview schedule so you can give it in advance to any potential participant who may be concerned about it.

I can be contacted by email at: kathleen.noone5@mail.dcu.ie or by phone on 0858375030. My research supervisors overseeing this research study are Dr. Aisling Mc Mahon (aisling.mcmahon@dcu.ie) and Dr. Mary Farrelly (mary.farrelly@dcu.ie) if you have any concerns that this researcher is unable to answer.

Participating women will need to meet the following criteria to be eligible to be included in the study. They will need:

-To self-identify as having experienced distress during their childbirth in Ireland;
-To be living in Ireland, preferably within the Leinster area, so they are within a reasonable driving distance of this researcher;
-To be over the age of 18 years to give their informed consent to participate in the study;
-To be at least one year and no greater than 10 years following their distressing childbirth experience to give them sufficient time for recovery;
- their **c**hild whose distressing birth is the subject of this study must be living and generally well at the time of the study;
-To be registered with a general practitioner (GP) in Ireland where they can gain access to the Counselling in Primary Care (CIPC) services or be referred to the perinatal Mental Health services or the Community Mental Health services if further support is required.
-To have fluent English to ensure they fully understand the process to give informed consent, and are able to give a detailed, rich and reflective account through English of the distress they experienced during childbirth.

All the pre-prepared written information about this study, including the relevant attachments with this email, have been reviewed and approved by DCU's Data Protection Unit and DCU's Ethics Committee. For matters related to GDPR compliance the Data

Controller is DCU and the DCU Data Protection Officer is Mr. Martin Ward, contactable on (01)7005118 / 7008257 or at data.protection@dcu.ie You have the right to lodge a complaint with the Irish Data Protection Commission if you feel your data has been mishandled. Alternatively, you can contact The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000 or rec@dcu.ie

Appendix C: Classified Advertisement

Women's Lived Experience of a Distressing Childbirth in Ireland: perceived impacts and meaning making.

-Did you experience a distressing childbirth in Ireland between one and ten years ago?
-Would you like to tell us about your experience?
-Are you over the age of 18?

We are exploring women's experiences of distress during childbirth and how it has impacted on their lives. We also hope to offer insights into how psychotherapists and other healthcare professionals can support women and their families mental health during pregnancy and following childbirth.

We would be delighted to hear from you if you meet the following criteria:

-You self-Identify as having experienced a distressing childbirth in Ireland.
-You feel sufficiently recovered to participate in the study.
-Your child is still living and is generally well.
-You are fluent in English and are willing to participate in a 60-90 minute interview.

For further details about this study, please contact Kathleen Noone, who is a doctoral student in psychotherapy in DCU's school of Nursing, Psychotherapy and Community Health,

Kathleen can be contacted by email at: kathleen.noone5@mail.dcu.ie or by phone on 0858375030.

Appendix D: Plain Language Statement

Women's Lived Experience of a Distressing Childbirth in Ireland: perceived impacts and meaning making.

I. Who will carry out this Research Study?

This research study is exploring women's experiences of a distressing childbirth in Ireland. The research will be carried out by Kathleen Noone, who is a doctoral student in DCU's school of Nursing, Psychotherapy and Community Health. Her research supervisors are Dr. Aisling Mc Mahon (aisling.mcmahon@dcu.ie) and Dr. Mary Farrelly (mary.farrelly@dcu.ie)

Kathleen can be contacted by email at: kathleen.noone5@mail.dcu.ie or by phone on 0858375030

2.What is this Study About?

This research study aims to capture and explore the descriptions, understandings, and meanings, which women who gave birth in Ireland, attach to their distressing childbirth experiences between one and ten years later. It is hoped this research study will add to our understanding of how women in Ireland's quality of life, the life of their child and other family members is impacted by their distressing childbirth experience. Additionally, it hopes to identify how psychotherapists and other healthcare professionals can support women and their families mental health during pregnancy and following childbirth.

3.Why is the Research being done?

Every year up to 60,000 women mostly navigate their individual experience of childbirth in Ireland, with or without assistance in hospital, with a very small minority choosing a home birth. Most women will experience childbirth as a positive experience. However, some women describe their experiences of childbirth as difficult, negative, or distressing. These women's experiences can have long-term negative consequences on their life, as well as that of their child and other family members. Researching women's experiences of a distressing childbirth in Ireland will help to further inform a more recent health-ease approach to maternity care. A health-ease approach to maternity care aims for women to have a better understanding of their childbirth experience, for childbirth to feel more manageable and in turn be more meaningful for women. Hearing and valuing women's voices around their distressing childbirth experiences in Ireland will help to inform and improve perinatal mental health supports for other women, including practices among psychotherapists and healthcare professionals generally.

4.What can you expect by participating in this study?

You will be invited to attend an interview at a place, date and time that feels safe and convenient to you. This can be your home, the researchers professional office in Kilcock, County Kildare, a room in DCU's Healthy Living Centre or a hotel conference room. The researcher will arrange an interview with you by email or by phone using the contact details written above. The interview will last for approximately 60 -90 minutes and will be audio recorded by the researcher. You will be asked to sign a written consent form before you take part in the interview. You will be asked during the interview to describe: Your individual experience of the distress you experienced during childbirth; The effect this has

had on you, your child and other family members; How you have come to understand/gained some knowledge around your distressing childbirth experience; What supports you may have/may not have found helpful during childbirth and since giving birth, including psychotherapy supports if accessed or attended and; The meaning you have given to your experience, including how you have made sense of it within your life either in relation to other pregnancies/children or more generally in your life to date.

5. How will your privacy be protected as a participant?

Your initial contact with this researcher will be made either through this study's secure designated phone number, via a password protected iPhone XR, or DCU email address, as provided above**.** Audio recordings of your interview, using a DCU encrypted, pin lock, DS 9000, digital audio recorder will be uploaded and securely stored on DCU's google drive following your interview. The hard copy of your signed consent form will be uploaded and the electronic copy of your demographic details will be kept separately to your interview data on DCU's google drive. This is in line with EU data protection guidelines and DCU's data protection impact assessment. You will be given a pseudonym and the researcher will make every effort to ensure that all your information is pseudo-anonymised. While your anonymity cannot be 100% guaranteed, as some specific phrases/words from your interview may be used in the writing up of the study, which someone close to you could recognize, your name will not be associated with these words. Following successful completion of this study, you can request a summary of the findings, via a password protected email that has been previously agreed with this researcher.

6.How will data be used and disposed of?

This research study will be presented as a thesis for a doctorate in psychotherapy award in DCU at a Viva Voce. On satisfactory completion, this doctoral thesis will be available through DCU's library via their open access data base known as Doras. Findings of this study will be presented to interested, relevant professional groups at research conferences and or written up as a research article for suitable peer reviewed publications. If accepted for presentation and or publication, the findings will be widely available within the public domain. The audio recordings of your interview, using a DCU encrypted, pin lock, DS 9000, digital audio recorder will be deleted once it has been safely uploaded onto DCU's google drive and successfully transcribed by this researcher following our one on one interview. A Hard copy of your signed consent form will be stored, for the duration of the study in a locked filing cabinet within this researchers locked private practice rooms, where only she authorizes access. This allows this researcher access to a safe storage site within 5km of her home which mitigates against any potential future government restrictions imposed as a result of Covid-19. The hard copy of your consent form will be shredded on completion of the study. Your interview data will then be pseudo-anonymised as far as possible, analysed using DCU's google docs in DCU's google drive and will be retained for a maximum of five years from completion of data collection and then deleted in line with GDPR and DCU's research data retention guidelines.
For matters related to GDPR compliance the Data Controller is DCU and the DCU Data Protection Officer is Mr. Martin Ward, contactable on (01)7005118 / 7008257 or at data.protection@dcu.ie You have the right to lodge a complaint with the Irish Data Protection Commission if you feel your data has been mishandled.

7.What are the legal limitations to confidentiality in this research study?

Confidentiality is limited, as confidentiality of information can only be protected within the limitations of the law i.e. it is possible for data to be subject to subpoena, a freedom of information claim or mandated reporting by some professions where there is a danger of harm to the participant, or any other person around them. This is in accordance with the researchers integrity requirement of DCU and her accrediting bodies Code of Professional Ethics.

8. What are the benefits to participating in this research study?

While there are no immediate benefits to you, indirect benefits following a time lapse may include the opportunity for you as a participant to voice, and have heard, your possibly emotive experiences of your distressing childbirth, for the purpose of this research study. The benefit to you may be further enhanced if you believe others will benefit from the subsequent research findings of the study.

9.What are the risks of taking part in the research study?

You will be observed throughout the interview process for ongoing consent due to the potential upsetting nature of speaking about your distressing childbirth experience with this researcher. Any undue distress caused to you by the research process will be attended to in a timely manner and alleviated as far as possible by this researcher. If you experience obvious distress you will be given the opportunity to slow down, pause, stop the interview and reschedule, or opt out of the process if you wish. You will be given sufficient time for debriefing at the end of the interview. Contact details of relevant support services and resources will be given to you during the debriefing process that you may find helpful, if you would like further information or are experiencing some distress following your interview

10. Confirmation of the right to withdraw from the study?

You have the option to review your interview data/ transcripts and or can opt out of the study at any point up until completion of the study.

11.Contact details for further information?

If you have any concerns about this study please contact this researcher Kathleen Noone at kathleen.noone5@mail.dcu.ie or by phone on 0858375030, or her supervisors aisling.mcmahon@dcu.ie and mary.farrelly@dcu.ie

Alternatively, if participants have concerns about this study and wish to contact an independent person, you can contact The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000 or rec@dcu.ie

Appendix E: Interview Schedule

Women's Lived Experience of a Distressing Childbirth in Ireland: perceived impacts and meaning-making

These interview questions act as a guide to exploring participants' experiences and are not prescriptive. This researcher will be led by the participant, while remaining sufficiently flexible to follow emerging and interesting information provided by the participant. The gentle prompts outlined below will only be used, where needed, to keep the conversation focused and relevant.

1.Tell me about how you were recruited to participate in this study?

2.Demographic details-Tell me about yourself?
Prompts: Participant's age now and age when they experienced their distressing childbirth; Gender and age of their child now whose birth was distressing for them; age(s) of any other children they have; marital/relationship status now and at the time of the birth, highest educational attainment now and at the time of the birth, occupation and employment status now and at the time of the birth; and have they any history of adverse childhood events.

3.Can you describe what was distressing about your childbirth experience?
Prompts: What had you expected? Can you tell me more about that?

4.Has there been an effect/impact from your distressing childbirth experience on you?
Prompts: On your child; On your partner or other family members?
What was that like for you? How does that make you feel? Is there anything else that stands out about your experience?

5.Has your knowledge/understanding of your distressing childbirth experience changed over time?
Prompts: How has it changed? What would you say to other pregnant/postpartum women about your experience?

6.Have you received any therapeutic support to help you deal with your distressing childbirth experience?
Prompts: What type of support did you receive? Were you offered support or did you look for the support? What did you find helpful/unhelpful about the support you received?

7.If you were to use a word/symbol/image/metaphor that represents your distressing childbirth experience what would it be?
Prompts: Can you say some more about how this word/symbol/image/metaphor represents your experience?

8.What does your distressing childbirth experience mean for the way you have lived your life since?
Prompt: Can you say more about how it has influenced your life in relation to other pregnancies/childbirths.
Can you say more about how it has influenced you in relation to how you have lived your life generally since then. What has helped you to realise this?

Thank you for taking the time to participate in this research study.

Appendix F: Informed Consent Form

Women's Lived Experience of a Distressing Childbirth in Ireland: perceived impacts and meaning-making

This research study explores women's experiences of a distressing childbirth in Ireland. The research will be carried out by Kathleen Noone, who is a doctoral student in DCU's school of Nursing, Psychotherapy and Community Health. Her research supervisors are Dr. Aisling Mc Mahon (aisling.mcmahon@dcu.ie) and Dr. Mary Farrelly (mary.farrelly@dcu.ie) if you have any concerns that this researcher is unable to answer.

Kathleen's email is: kathleen.noone5@mail.dcu.ie or by phone on 0858375030

This research study aims to capture and explore the descriptions, understandings, and meanings, which women who gave birth in Ireland, attach to their distressing childbirth experiences between one and ten years later. It is hoped this research study will add to our understanding of how women in Ireland's quality of life is impacted by their distressing childbirth experience. Additionally, it hopes to offer insights into how psychotherapists and other healthcare professionals can support women and their families mental health during pregnancy and following childbirth.

I am aware that in agreeing to participate in this research study, I will be invited to attend an interview at a place, date and time that feels safe and convenient to me which the researcher will arrange by email or by phone, using the contact details written above. I will be asked during the interview to: describe my individual distressing childbirth experience; the effect it has had on me and my family; the supports that may or may not have been helpful and the sense I have been able to make of it in my life. The interview will last for approximately 60-90 minutes. I understand that I will be given a pseudonym and that the researcher will make every effort to ensure that all my information is pseudo-anonymised. I understand that my anonymity cannot be 100% guaranteed as some specific phrases/words from my interview may be used in the writing up of the study which someone close to me could recognize. However, my name will not be associated with these words. I will be asked to sign a written consent form before I take part in the interview, which includes permission for the researcher to seek a follow up interview with me where greater clarity, or understanding of my recorded data is needed or additional data, is required.

I am aware confidentiality is also limited as confidentiality of information can only be protected within the limitations of the law i.e. it is possible for data to be subject to subpoena, a freedom of information claim or mandated reporting by some professions where there is a danger of harm to the participant, or any other person around them. This is in accordance with the researchers integrity requirement of DCU and her accrediting bodies Code of Professional Ethics.

I am aware the audio recordings of participant interviews, using a DCU encrypted, pin lock, DS 9000, digital audio recorder will be deleted once they have been safely uploaded onto DCU's google drive and successfully transcribed by this researcher following our one on one interview. A Hard copy of my signed consent form will be stored, for the duration of the study in a locked filing cabinet within this researchers locked private practice rooms, where only she authorizes access. This allows this researcher access to a safe storage site within 5km of her home which mitigates against any potential future government

restrictions imposed as a result of Covid-19. They will be shredded on completion of the study. My interview data will then be pseudo-anonymised as far as possible, analysed using DCU's google docs in DCU's google drive and will be retained for a maximum of five years from completion of data collection in line with GDPR and DCU's research data retention guidelines.

For matters related to GDPR compliance the Data Controller is DCU and the DCU Data Protection Officer is Mr. Martin Ward, contactable on (01)7005118 / 7008257 or at data.protection@dcu.ie You have the right to lodge a complaint with the Irish Data Protection Commission if you feel your data has been mishandled.

I am aware this research study will be presented as a thesis for a doctorate award in psychotherapy in DCU at a Viva Voce and will be available on DCU's open access data base known as Doras. Thereafter, the findings will be presented to interested, relevant professional groups, presented at research conferences, and written up as a research article for suitable publications, including peer reviewed publications. I can request a summary of the findings via a password protected email that has been previously agreed with this researcher, following the successful completion of this study.

I am aware I will be given the option to review my interview data/ transcripts and or can opt out of the study at any point up until completion of the study.

Please complete the following (Circle Yes or No for each statement):

I have read the Plain Language Statement (or had it read to me) Yes/No
I understand the information provided Yes/No
I have had an opportunity to ask questions and discuss the study Yes/No
I understand the information in relation to data protection Yes/No
I have received satisfactory answers to all my questions Yes/No
I am aware that my interview will be audio recorded Yes/No
I consent to direct quotes being used in the writing up of findings Yes/No
I consent to a follow-up interview where greater clarity is required.
Yes/No

Signature:

I have read and understood the information in this form. My questions and concerns have been answered by the researcher, and I have a copy of this consent form. Therefore, I consent to take part in this research project

Participants Signature: ____________________________________

Name in Block Capitals: ____________________________________

Witness:____

Date:_______________________________________

Appendix G: Debriefing Document

Women's Lived Experience of a Distressing Childbirth in Ireland: perceived impacts and meaning-making.

Please retain these sheets following your interview so you can refer to it as needed.

This research study aims to capture and explore the descriptions, understandings, and meanings, which women who gave birth in Ireland, attach to their distressing childbirth experiences between one and ten years later. While there are no immediate benefits to your participation in this interview, indirect benefits include the opportunity for your individual voice to be heard and your experiences of your distressing childbirth to be recorded. You may also benefit by knowing others may benefit from findings of this study. You can request a summary of the findings, via a password protected email that has been previously agreed with this researcher when this study is successfully completed.

The audio recordings of your interview, using a DCU encrypted, pin lock, DS 9000, digital audio recorder will be deleted once it has been safely uploaded onto DCU's google drive and successfully transcribed by this researcher following our one on one interview. A Hard copy of your signed consent form will be stored, for the duration of the study in a locked filing cabinet within this researchers locked private practice rooms, where only she authorizes access. This allows this researcher access to a safe storage site within 5km of her home which mitigates against any potential future government restrictions imposed as a result of Covid-19. It will be shredded on completion of the study. Your interview data will then be pseudo-anonymised as far as possible, analysed using DCU's google docs in DCU's google drive and will be retained for a maximum of five years from the date of completed data collection in line with GDPR and DCU's research data retention guidelines.

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You have the option to review your interview data/ transcripts and or you can opt out of the study at any point up until the study is completed. If you have any concerns about this study please contact this researcher Kathleen Noone at kathleen.noone5@mail.dcu.ie or by phone on 0858375030, or her supervisors aisling.mcmahon@dcu.ie and mary.farrelly@dcu.ie Alternatively, if you have concerns about this study and wish to contact an independent person, you can contact The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000 or rec@dcu.ie

The following are a list of support services and resources that you may find helpful if you would like further information or are experiencing some distress following your interview.

-Aims(Association for Improvements in the Maternity Services) Ireland: Is a voluntary charitable organisation offering information and a number of support services to women using Irish maternity services. They also campaign for women to be afforded more: choices in pregnancy and labour; support for normal

childbirth practices; for the improvement to maternity and postnatal care services in Ireland; using evidenced based research. Further information about their services can be accessed at:
https://aimsireland.ie for support email: support@aimsireland.com

Cuidiu (formerly The Irish Childbirth Trust): Is a charitable support group with 26 branches around Ireland offering education and support to empower parents in their choices and care around pregnancy, childbirth, postnatally, with breastfeeding and parenting to adulthood. They have an extensive interactive guide to maternity services in Ireland as well as peer to peer support groups. Further information about their services can be accessed at:
http://www.cuidiu.ie/ or email: info@cuidiu.ie or info@antenatalireland.ie or breastfeeding@cuidiu.ie or parentsupport@cuidiu.ie

-Public Health Nurse (PHN): Your public Health Nurse can give you information on local support groups and services for mothers and babies, as well as carry out checks on your baby's weight and development up until age 5. Further information about the service can be accessed at.
https://www2.hse.ie/wellbeing/babies-and-children/checks-milestones/health-checks/during-first-week/

- General Practitioner (GP): Your GP will be able to care for you if you are experiencing mild to moderate mental health difficulties.

-Specialist Perinatal Mental Health Service: This service cares for women in Irish maternity hospitals with new or existing mental health difficulties up until their baby is a year old. Women who have more severe mental health difficulties can access the service before they get pregnant. A referral can be made by your GP, your booking midwife, specialist mental health midwife, obstetrician or adult psychiatrist. You can self-refer if you have previously used the service or are currently using it. Further information about the service can be accessed at:
https://www.hse.ie/eng/services/list/4/mental-health-services/specialist-perinatal-mental-health/

Health Service Executive (HSE) National Counselling Service (NCS): This is a free HSE Adult Counselling and Psychotherapy Service provided at Primary Care Centres (CIPC) and Adult National Counselling Service centres (CaPa) throughout Ireland. It provides free short, medium or long term therapy. An initial assessment is made to ascertain the suitability of the service for potential clients.

-Counselling in Primary Care (CIPC) service: This is a therapy service for adults over 18 who have a medical card and are experiencing mild to moderate psychological and emotional difficulties. It is time limited service (approximately eight sessions) and you can be referred by your GP, PHN, primary care physiotherapist or primary care occupational therapist. Further information about the service can be accessed at:
https://www.hse.ie/eng/services/list/4/mental-health-services/counsellingpc/cipc.pdf

-Counselling and Psychotherapy for Adults (CaPA): This is a service for adults who have experienced childhood abuse and neglect. It has more recently been extended to former residents of mother and baby homes. A referral can be made

by your GP or you can self-refer if you have experienced childhood abuse/neglect or have been a former resident at a mother and baby home. Further information about the service can be accessed at:
https://www.hse.ie/eng/services/list/4/mental-health-services/national-counselling-service/

-Community Mental Health Services: This multi-disciplinary team service cares for a wide range of mental health difficulties, in all age groups, within the community with access to an in-patient unit where necessary. A referral can be made by your GP or Emergency Department. Further information about the service can be accessed at:
https://www.hse.ie/eng/services/list/4/mental-health-services/

-Other mental health support services include:

Aware: Offers information, support, education and daily peer support groups for those experiencing anxiety, depression, Bi-polar and other mood disorders and their concerned others. Further information about the service can be accessed at:
https://www.aware.ie/ email: supportmail@aware.ie or freephone 1800 80 48 48

turn2me. Offers adults and young people, from age 12 upwards, individual counselling, group support or peer support online.
https://turn2me.ie/

Relationship Support for Families: Offers education and mentoring supports to parents and children who are experiencing separation and divorce. Further information about the service can be accessed at:
https://www.separationsupport.ie/ or email: info@separationsupport.ie or Phone: 0871213245

HSE Drugs and Alcohol helpline: Drug and alcohol support for teenagers, parents and carers. Further information about the service can be accessed at:
https://www.drugs.ie/live_chat/ or Phone: 1800 459 459

Al Anon: Alcohol support services for families and friends of problem drinkers. Further information about the service can be accessed at:
https://www2.hse.ie/wellbeing/alcohol/coping-with-difficult-situations/alcohol-support-services-for-families.html

-24 hour helplines and support can be found at:

The Samaritans
Call: 116 123 email: jo@samaritans.org

Women's Aid: Offers information and a number of support services to women experiencing intimate partner violence, including a free 24 hour helpline. They also campaign for changes to social and political responses to domestic violence. Further information about their services can be found on this web-site:
https://www.womensaid.ie/ or Phone: 24 hour helpline 1800 341 900

Pieta House: Offers support to those who feel suicidal, are self-harming or have been bereaved by suicide. They also offer crisis support via a free 24 hour helpline and text messaging service. Further information about the service can be found on this web-site:

https://www.pieta.ie
For an appointment: phone: 0818111126 24 hour Crisis helpline: 1800 247 247 or Text HELP to 51444

- Private Accredited Psychotherapists convenient to you can be accessed at:

The Irish Association and Humanistic and Integrative Psychotherapy (IAHIP) at: https://iahip.org/ or email: admin@iahip.org or phone 012841665
or
Irish Association for Counselling and Psychotherapists (IACP) at:
www.iacp.ie or email: iacp@iacp.ie or phone: 012303536

-Private Family Therapists can be found at:

The Family Therapy Association of Ireland (FTAI) at:
http://www.familytherapyireland.com/
or
The Clanwilliam Institute: Is a not for profit charitable family therapy centre offering family psychotherapy, couples therapy, including low cost therapy and mediation services.
www.clanwilliam.ie or email: office@clanwilliam.ie or phone: 01 2055010

-Private Psychologists convenient to you may be accessed at:

The Psychological Society of Ireland's (PSI) at.
https://www.psychologicalsociety.ie/ or email: admin@psychologicalsociety.ie or phone **01 472 0105**

-Other low cost counselling and psychotherapy services within the Leinster area can be accessed at:

Aspen Counselling Service, Lucan, Co Dublin. Offers low cost counselling to individual adults, couples, families, teenagers, and play therapy for children.
https://www.aspencounsellingservices.com/ or email: aspenabc@gmail.com or phone: 016217063/0868534391
or
The Village Counselling Service, Tallaght, Dublin 15. Offers low cost counselling to individual adults, couples, adolescents, children and suicide intervention.
http://www.villagecounselling.ie/ or email: amanda@villagecounselling.ie or phone 0879049497
or
One in Four, Holles street, Dublin 2. Supports adult survivors of childhood sexual abuse.
https://www.oneinfour.ie/ or Email:info@oneinfour.ie or phone: 016624070
or
Dublin Rape Crisis Centre, Lesson Street, Dublin 2. Offers support to those who have experienced rape, sexual assault, sexual harassment or childhood sexual

abuse via their 24 hour helpline, one on one counselling, webchat support, court accompaniment, online trauma support programmes, outreach services, youth programmes and outreach Services.

https://www.drcc.ie/ or email: info@rcc.ie or phone: 016614911 or 1800 77 8888

Appendix H: Sample PET's with relevant PES': Participant 10

Participant 10

PET	Distressing childbirth, fucked up everything, unimaginable suffering	Sinking, like a ship into a mental mess	Sidelining fathers, imposing second world war conditions during Covid-19	Nothing prepares you, the distress from all you don't know	Healing, gaining clarity, finding her mothering way,
1PES	Opting reluctantly for an Induction, intensely strong, painful experience	Dying way easier, than living with the aftermath	Restricting partner access, unforgivably unsupportive	Realizing Anxiety is relatively normal in matresence	Linking missing memories, husband compassionately supportive
2	Hating, being naked and powerless in a crowded theatre	Nightmaring, haunted by memories, a mental mess	Suffering, waiting on husband's arrival and supportive presence	Strategized all eventualities, betrayed by what she read, was told and her body	Enduring triggers, sticking and staying much less
3	Screaming believing she was dying, organs exploding in pain,	Losing confidence, shamed, unable to do what women are programmed to do	Feeling super angry, husband and baby left on the street	Disarmingly disconnecting, baby supposedly distressed, yet amazingly well	Sequencing adaptive biological responses, Consultant's debriefing helped
4	Taking her baby away into the shadows, barely touching his toes	Trying to survive the gap of childbirth dissonance	Finding no comfort in World War Two, like hospital conditions	Recognizing, no horribleness scale, in distressing childbirth	Perceiving complete failure, until finally breastfeeding successfully
5	Distressing childbirth, an abnormal immobilizing experience	Perceiving herself weak, the destructive force of distress	Having to care for their baby alone, provoked husband's anxiety	Trying to make sense of her experience, as an outsider	Learning experience was horrible, has right to keep being

Appendix I: Participants 1-12 Personal Experiential Themes (PETs)

Participants	PET - 1	PET - 2	PET- 3	PET- 4	PET - 5
Participant 1	Going through Hell	Going Shit-Nobody knows what to do here	Needing to be stronger than you feel	Healing through Restoring Supportive Connections	
Participant 2	Unnerving, what you don't know and few people tell you	Surrendering power, a mental survival strategy	Overwhelming fear of unimagined changing circumstances	Recovering, an iterative journey back to a trusted self	
Participant 3	Surviving in the face of death	Identifying with Being a Problem for Others	Acknowledging the Temporal nature of a Distressing childbirth	Acknowledging her expertise through experience	Calling for a Collaborative Approach to Childbirth
Participant 4	Childbirth, Distressing from the Beginning	Feeling abandoned, Having No One To-Hand to Care	Covering Up the suffering of Childbirth is Unhelpful	Acknowledging What Happened/the harm Cannot be Undone	Moving forward, holding the good and the adverse side by side/changing script
Participant 5	Devastating, failing to do Childbirth, as she was Programmed to	Distressing Childbirth, an Enduring Shared Experiencing	Feeling Responsible for Inducing Injury on Her Child	Healing through compassionate, safe connection to self & others	
Participant 6	Distressing Childbirth, an Accumulative Experience	Living with Gut-Wrenching Scars	Capitulating, to others despite not wanting to	Healing Facilitated by Compassionate Appreciation	Advocating open, honest dialogue around childbirth
Participant 7	Battling, labouring in a horrible hostile environment	Feeling Rushed and Pushed on the Induction Conveyor Belt	Acknowledging, the lottery of care during childbirth	Delivering a Baby, A bitter-sweet experience in a hostile culture	Healing, utilizing personal strengths
Participant 8	Adopting tunnel vision, where nothing can go wrong	Acknowledging, external happenings influenced distress	Distressing childbirth, an unimaginable brutal experience	Ensuring she survived, brought her family closer	Moving forward, holding umbrella vision
Participant 9	Carrying an intergeneration al burden into childbirth	Distressing, hospital lacking compassionate understanding	Getting childbirth wrong, making-up an endless task	Feeling Joyless, Debilitating Low Grade Depression	Healing, empowering self and others as a Doula
Participant 10	Distressing childbirth, fucked up everything,	Sinking, like a ship into a mental mess	Sidelining fathers, imposing second world war	Nothing prepares you, the distress	Healing, gaining clarity, finding her

	unimaginable suffering		conditions during Covid-19	from all you don't know	mothering way,
Participant 11	Distressing childbirth, a complete upheaval of life	Waiting for labour, in scary pre-labouring conditions	Enduring whatever it took, to have their baby	Feeling very grateful, despite a distressing process	Moving forward, living on the relief, it had all worked out
Participant 12	Nerve-racking navigating childbirth alone, in Covid-19	Networking, utilizing connections, mobilizing support	Becoming rapidly ill, things going majorly wrong	Needing help, feeling bad, looking like a failure	Recovering, making sense of what happened

Appendix J: Drafts 1-7: GETs Developed from 12 Participants' In Particular Horizons of Understanding of their Distressing Childbirth Experience

Draft 1: GETs Developed from 12 Participants' In-Particular Horizons of Understanding of their Distressing Childbirth Experience.

	GET 1	GET 2	GET 3	GET4
GET's	**Experiencing Unimaginable Suffering, Beyond the Expected**	**Being Rushed and Pushed on the Conveyor Belt of Childbirth**	**Having to Capitulate to institutional power, igniting shame anger and resentment.**	**Recovering, becoming guardian of self, determined to influence change**
Theme 1	Giving birth, an unimaginable brutalizing, experience	Battling from the beginning, yet still robbed of their joy	Surrendering to dominance, enduring whatever it took to have their baby	Delivering a baby, a bittersweet experience in a hostile culture
Theme 2	Nothing prepares you for the covered up suffering	Recognizing it's a lottery, who cares for you	Requiring no minding, an invisible rationed care expectation	Living with what happened, the harm cannot be undone
Theme 3	Living with gut-wrenching scars	Devastating, failing to do childbirth, as body programmed to do	Having to meet institutional demands, make staff hard, tough, and horrible	Seeking understanding, Finding their mothering way and empowering others.

Draft 2: GETs Developed from 12 Participants' In-Particular Horizons of Understanding of their Distressing Childbirth Experience

	GET 1	GET 3	GET4
GET's	**Experiencing Unimaginable Suffering, Beyond the Expected**	**Having to Capitulate to institutional power, igniting shame anger and resentment.**	**Recovering, becoming guardian of self, determined to influence change**
Theme 1	Giving birth, an unimaginable brutalizing, experience	Battling, to work with their body programming, eventually surrendering to dominance	Delivering a baby, a bittersweet experience in a hostile culture
Theme 2	Nothing prepares you for the covered-up suffering	Devastating, rushed, pushed and sometimes crushed on childbirth's conveyor belt	Living with what happened, the harm cannot be undone
Theme 3	Enduring whatever it took, living with gut-wrenching scars	Requiring no minding, an invisible rationed care expectation	Healing, utilizing their personal strengths, finding their mothering way

Draft 3: GETs: Developed from 12 Participants' In-Particular Horizons of Understanding of their Distressing Childbirth Experience

	GET 1	GET 2	GET 3	GET4
GET's	**Suffering unimaginably (? in childbirth), beyond reasonable expectations**	**Inducing agonising overwhelm, violating body integrity.**	**Having to capitulate, navigating institutional power dynamics**	**Regaining coherence, becoming guardians of self, influencing change**
Theme 1	Giving birth, an unimaginable brutalising experience	Recognising it's a lottery, who cares for you in childbirth	Surrendering to dominance, enduring whatever it took to have their baby	Giving birth, a bittersweet experience in a hostile culture
Theme 2	Nothing prepares you for the unspoken sufferings of childbirth	Being robbed of joy, rushed, pushed, and crushed on childbirth's conveyor belt	Requiring no minding, an invisible rationed care expectation	Seeking understanding, assuaging fear, anger, shame, and resentment
Theme 3	Living with enduring gut-wrenching scars	Devastating, failing to do childbirth, as body is programmed to do	Having to meet institutional demands, make staff hard and horrible	Finding their mothering way, developing, and imparting umbrella vision

Draft 4: GETs: Developed from 12 Participants' In-Particular Horizons of Understanding of their Distressing Childbirth Experience

	GET 1	GET 2	GET 3	GET4
GET's	**Suffering unimaginably**	**Experiencing agonizing overwhelm**	**Having to capitulate**	**Becoming guardians of self**
Theme 1	Going through hell	Acknowledging, the lottery of care	Enduring whatever it took	Giving birth, a bittersweet experience
Theme 2	Navigating unspoken sufferings	Feeling robbed	Feeling abandoned	Seeking understanding
Theme 3	Living with gut-wrenching scars	Bearing the cost	Having to meet systemic demands	Finding their mothering way

Draft 5: GETs: Developed from 12 Participants' In-Particular Horizons of Understanding of their Distressing Childbirth Experience

	GET 1	GET 2	GET3
GET's	**Suffering unimaginably** *"I had been through such hell"* *P1*	**Having to capitulate** "it was the best for the baby so I obviously went ahead with it" P6	**Regaining coherence** *"I'm like a strong enough woman I'd say, and I think that just you know, upended me"* *p11*
Theme 1	Being dismissed	Enduring whatever it took	Giving birth, a bittersweet experience
Theme 2	Navigating unspoken about suffering	Feeling abandoned	Seeking understanding
Theme 3	Bearing the cost /Living with gut-wrenching scars	Meeting systemic demands	Finding their mothering way

Draft 6: GETs: Developed from 12 Participants' In-Particular Horizons of Understanding of their Distressing Childbirth Experience

	GET 1	GET 2	GET3
GET's	**Suffering unimaginably** *"I had been through such hell"* *P1*	**Having to capitulate** "it was the best for the baby so I obviously went ahead with it" P6	**Regaining coherence** *"I'm like a strong enough woman I'd say, and I think that just you know, upended me"* *p11*
Theme 1	Giving birth, an unimaginable brutalizing, experience	Enduring whatever it took	Giving birth, a bittersweet experience
Theme 2	Navigating unspoken about suffering	Feeling abandoned	Seeking understanding
Theme 3	Living with gut-wrenching scars	Meeting systemic demands	Finding their mothering way

Draft 7: GETs : Developed from 12 Participants' In-Particular Horizons of Understanding of their Distressing Childbirth Experience

	GET 1	GET 2	GET3
GET's	**Suffering unimaginably** *"I had been through such hell"* *P1*	**Having to capitulate** "I really hated the fact that someone else gave birth to my baby" P6	**Regaining coherence** *"She's literally yours. You can pick her up as much as you want and I think that came from not having that choice" P2*
Theme 1	Giving birth, an unimaginable brutalising experience	Giving-way to whatever it took	Being with child, a bitter-sweet experience
Theme 2	Feeling betrayed, navigating the impact	Suffering lonely and abandoned	Seeking understanding
Theme 3	Living with forever Scars	Having to meet what the system demands	Finding their mothering way