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The Emergence of Traumatic Birth

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by

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ABSTRACT

This study is a content analysis on the emerging concept of traumatic birth using the ProQuest Central search database. I analyze the entrance of the term into both peer reviewed and popular texts. The purpose of the study is to understand the cultural and socio-historical context of the concept of traumatic birth and to consider how and by/for whom this concept developed and became accessible. I use theoretical frameworks of embodiment, medicalization, critical constructionism, and feminism to consider the implications of the phenomena of traumatic birth for birthing parents today. Using a grounded theory-based strategy, I examine the ways that the growing lens of trauma has influenced ideas around the experience of childbirth as well as the impact of modern birth rhetoric and practices on birthing parents' interpretations of the event.

INDEX WORDS: Childbirth, Medical Industrial Complex, Traumatic Birth, Institutionalization

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1   INTRODUCTION

My thesis is a content analysis of the emerging concept of "traumatic birth" in the Global

North[1], focusing on the U.S. As a mother of three biological kids, I have encountered birth

personally. I had my oldest child in 2007 and was not at all prepared for the emotional impact of

the ordeal. As a rather naïve 30-year-old white middle-class woman, I believed I would have the

fulfilling birth I dutifully planned for because I had "put in the work." After 30 or so hours of

labor and multiple interventions, I earned the dubious diagnosis of "failure to progress" and gave

birth to my baby by cesarean. Nurses whisked my newborn away to the Intensive Care Unit, and

it was 24 hours before I stopped crying. I was disappointed to say the least, not only in the

outcome but in my perception of the experience itself. My first birth lead me to campaign for a

vaginal birth after cesarean (VBAC) for two subsequent kids and, due to my privilege of

provider choice, general obstinate nature, and a large dose of luck, I avoided unwanted surgery.

In spite of these healing experiences, seven years after giving birth to my first child, I found

myself online telling my story to willing and supportive listeners. It was then that I encountered

the contemporary idea of traumatic birth. Was this what I had experienced? And if so, why had I

experienced my child's birth in this way?

In addition to my first-hand experience, as a mentor in my mostly white middle-class

community, I speak with and support new parents just arriving from the birth journey. Listening

to birth stories, I hear tales of emergency situations, frustration with interventions,

institutionalized coercion and, occasionally, abuse. I also connect with narratives of broken

hearts similar to my own. In the birth world today, these experiences and everything in between

may fall under the conceptual umbrella of traumatic birth. As a popular organization that

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[1] I use the term Global North throughout this paper to indicate the geographic area from which my data originates and to acknowledge the North/South divide in birth practices globally.

supports mothers states on its homepage, "Traumatic symptoms resulting from childbearing experiences are real and can even result from a seemingly 'normal' birth experience" (solaceformothers.org).

Studies find 10% to 45% of birthing parents report experiencing childbirth as traumatic[2] (Greenfield et al. 2016; Beck 2013). The risk factors of traumatic birth reported by birth organizations (e.g. evidencebasedbirth.org, solaceformothers.org, improvingbirth.org, birthworksinternational.org, pattch.org, postpartum.net) and the medical literature, include many facets of medicalized birth as well as the breakdown in provider relationships and perceptions of care as a result. Several studies reporting the short and long-term effects of "post-traumatic stress" in the postpartum period, include damage to maternal well-being, relationships with partners, and the burgeoning relationship between mother and child (Ayers, Eagle, and Waring 2006; James 2015). The importance of this investigation lies in new understandings of cultural influence on the medicalized framing of birth and the postpartum period. A sociological look at the emergence and adoption of the increasingly common phenomenon of traumatic birth provides critical information related to the motherhood transition today. An analysis of the social factors surrounding traumatic birth is particularly relevant at a time when overall maternal mortality rates in the U.S. continue to rise (WHO 2018). Racial disparities in maternal physical health, with birthing people of color at substantially more risk of dying due to childbirth complications than white people, call for an urgent analysis of birth culture as a site of inequality.

I embark on this investigation to explore the larger social processes and messages surrounding childbirth and to create context for understanding traumatic birth. Particularly, how

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[2] This widely varying statistic is reflective of the range of definitions applied to "traumatic birth" in the literature over time.

and by/for whom did this concept develop and become accessible? To explore this question I ask, where and under what conditions do people give birth today? And with this foundational background, I examine traumatic birth as it is framed in peer reviewed and popular discourse. To begin, I synthesize the previous literature on the social construction of birth and parenting from the 1800's to now. Next, I move into a more specific excavation of the development of understandings of trauma. Then I provide a thematic analysis of traumatic birth in peer reviewed literature and popular discourse and finish with theoretical implications and ideas for change.

2   BACKGROUND AND LITERATURE REVIEW

2.1   Childbirth

There is a dearth of literature on the sociology of childbirth. While much scholarship is devoted to the sociology of motherhood, the specific event of childbirth remains less examined. This finding is confirmed reading Oakley's 2016 review of four decades of research in the area in which she refers to the topic as a "neglectful tradition" not often taken up by mainstream sociology (Oakley 2016:689). I weave historical aspects of childbirth and developments of the medicalization and globalization of birth into the review of the sociological body of work concerning birth.

2.1.1   *From Home to Hospital*

Early developments of the medical industrial complex in the late 1800's created a shift from birth as a normal social event happening inside of homes to a private medicalized one taking place in hospitals. For white birthing parents with means, this involved a transfer of power from women assisting birthing parents through the midwifery model to an institutionalized model with white male physicians attending birth and "delivering" babies with medical instruments. By the 1940's many black midwives had been pushed out of urban areas via racist

tactics propagated by state health departments (Rothman 2016). With the 1960's and the end of segregation, came the shutting down of the "Grand Midwives," African-American midwives who served an integral role in providing care for black and poor white people in the south and throughout rural areas (Rothman 2016; Litt 2010). Recently midwifery in hospital practice experienced a slight resurgence in the U.S., but direct entry midwives still face obstacles in attending home births in many states due to the regulation and lobbying by organizations like the American Medical Association (AMA). The home birth rate hovers around 1%, leaving the hospital rate at 99% where it has been since 1955 (Wax and Barth 2017). Over all, the technocratic childbirth model persists, and although by 2010, 80% of obstetrics and gynecology (OBGYN) residents were identified as women, the patriarchal obstetrical management of childbirth continues too (Simonds et al. 2007).

2.1.2   Interventions

Historically, specific interventions in childbirth appeared to alleviate pain and speed labor, all resulting in the "standardization" of maternity care (Simonds 2002). At times, feminists herald interventions as a move toward equality and at others brand them as a tool of oppression. Anesthesia via "twilight sleep" reigned from the 1930's to 1950's and was seen as liberating birthing people from the pain of labor, while the 50's saw an awakening and counter movement toward natural birth without medication. The use of forceps, the mode of supine positioning for labor, and the resulting episiotomy repair of the perineum became standard beginning in the 1920's and did not change much until the 1970's (Simonds, Norman, and Rothman 2007). The epidural began widespread use in the 1970's when oxytocin became popular to augment labor through increasing contractions. This combination of interventions is common as epidurals often slow labor. Developed in 1958, electronic fetal monitoring increased in use throughout the

1960's and 70's. In spite of technical problems including false positives that often lead to surgical interventions, this type of monitoring is the most widely-used obstetric procedure today (Adam 2012).

Arguably the most extreme intervention in childbirth, cesarean section developed before the turn of the twentieth century, and occurred with increasing frequency in urban centers when birth moved to hospitals and obstetricians became specialized surgeons (Sewell 1993). The World Health Organization (WHO) states that the cesarean section rate for necessary and life-saving purposes is 10% or less (2015). The c-section rate in the U.S. climbed from 5% in 1970 to 24.5% in 1988 to reach a high of 31.9% in 2016 (Menacker and Hamilton 2010; Martin et al. 2016).

There is longstanding tension among feminists regarding the meaning and motivation behind the adoption and resistance of medical interventions in childbirth. In 1999, Fox and Worts noted that empirical data on birth experiences were not necessarily in alignment with a sweeping feminist critique of medicalized birth. After interviewing 40 mothers, they concluded that looking at the social context and circumstances around birth is key in understanding individual attitudes towards medicalization. The mothers who readily accepted medical interventions like pain management and longer stays in the hospital were often those who had less social support (Fox and Worts 1999). Most recently, Barbara Katz Rothman makes the case that birth became industrialized much like the food industry and that medicalization through interventions influenced by a risk-averse society have dulled our collective "taste" for birth (2016). Moreover, while the slow-food movement has made progress; it is the culture of birth activism and lack of popular interest that has failed to reverse the industrialization process for childbirth and bring it back to its more organic roots (Rothman 2016).

The meaning behind the politic of laboring and mothering is contingent on location within the social hierarchy, particularly in the U.S. Resistance to dominant hospital protocols (e.g. fetal monitoring, time constraints, restrictions on movement) and embracing intense connection and attachment practices postpartum are an attempt at what Candace Johnson calls unifying split subjectivities: "Split subjectivity can be defined as the occupation of two or more psychic spaces, which compete with one another and shape (or frustrate) identity" (2016). These competing identities are tied to the body politics of birth. Johnson comments on this idea and the intersection of class:

> The political dimensions of women's [birthing parent's] lives are investigated, questioned, and resisted in their experiences of pregnancy and childbirth. And while maternal health might not be at stake for privileged populations, identity and agency (as the power to exert control over directing that identity) clearly are (2016:63.)

The identity and agency embedded in resisting interventions Johnson speaks to is influenced by the ideology of mother and child and intensive parenting.

2.1.3   Ideology of Mother and Child

Cultural understandings of the mother/infant dyad influence attitudes around the implementation of c-sections and other interventions. The construction of the mother/infant pair exhibits various iterations across time. Simonds et al. point out that obstetrics frames pregnancy as a disease state, and thus, the fetus "came to be thought of as a parasite and the mother as a host" (2007:32). In the 1960's, this paradigm shifted when deformities occurred in a large number of infants due to medication taken by mothers and prescribed by doctors. It became clear that the placenta did not serve a protective role. Instead, substances could flow directly to the developing fetus (Simonds et al. 2007). The advent of sonogram capabilities created a vision of the new "patient," and ongoing advancements in technology have allowed treatment of the fetus through surgery and medication in utero (Sewell 1993; Rothman 2016).

Often, baby-focused care prioritizes fetal well-being while the responsibility (as well as blame and praise) lies with the risky, but necessary, life sustaining body called mom. A recent American College of Obstetricians and Gynecologists (ACOG) ethics committee opinion directly disavows this idea by stating:

> When the pregnant woman and fetus are conceptualized as separate patients, the pregnant woman and her medical interests, health needs, and rights can become secondary to those of the fetus. At the extreme, construing the fetus as a patient sometimes can lead to the pregnant woman being seen as a 'fetal container' rather than as an autonomous agent (Marshall and Tucker 2016:3.)

While the current ACOG stance encourages a re-focusing of the obstetrician-gynecologist's attention to "respect patients as whole and embodied individuals" and emphasizes the priority of the pregnant woman's well-being in the care relationship, it is unclear how clinical practitioners interpret and operationalize this mandate (Marshall and Tucker 2016:3).

2.1.4   Intensive Parenting Culture

The dominant parenting culture in the U.S. of recent decades is dubbed "intensive mothering" also impacts the ideology of mother and infant. This dominant parenting culture is evident in popular discourse around childbirth. For centuries parents exhibited great interest in step-oriented approaches to child rearing but more recently the "routinization of parenthood" certainly reached a frenzied pitch (LaRossa and Sinha 2006). In 1996, Hays introduced and articulated the concept of intensive mothering; which includes beliefs that the methods of appropriate child-rearing are child-centered, expert-guided, emotionally absorbing, labor-intensive, and financially expensive. Hays proposed this ideology as the "dominant" ideology of "socially appropriate child rearing" in the United States at the time (1996:17). The concept also emphasizes high levels of involvement with mothers as the essential and integral care provider. Twenty years later, intensive parenting continues to dominate; a quick internet search for

"parenting blog" offers 542,000 results and recent estimates of U.S. mothers working as "mommy bloggers" are upwards of 4 million (Patel 2016).

Intensive parenting begins before birth. New parents feel substantial stress around the timing of pregnancy, birth planning, prenatal health, and consumer decisions that hinge on adhering to popular and state-sanctioned protocols like sleep and eating habits, car seats, and nursery bedding guidelines. Abstract concerns, like establishing best practices for ensuring future "success" for kids also exist (Demo et al. 2015). Since the 1980's, prenatal preparation for the middle class has included researching the "science of birth" and hospital protocol to create birth "plans" as a platform for communicating the pregnant individual's desires for birth to their providers. The internet allows for the proliferation of advice regarding birth planning across various popular sources, including medical sites, birth organization sites, and online parenting magazines (Divall et al. 2017). The birth plan continues to exist as a form of resistance to institutional protocol and pressures of standardization in hospitals as well as a formative site of intensive parenting practice (Debaets 2017). Both birth and intensive parenting practices are influenced by a massive influx of academic and medical research reinterpreted and consumed by popular culture. The body of discourse around the "science of birth" is where we move next.

2.1.5   *Science of Birth: The Golden Hour/ Skin to Skin/ Breastfeeding*

Interest around the first hour after birth exists in both popular and scholarly discourse, particularly in the past few decades. Contributions from neurobiology and psychology to clinical practice in this area lead to the goal of instantaneous skin-to-skin contact after birth and a push for early breastfeeding initiation (DeChateau 1976; Thomson and Harstock 1979; Hofer 1994; Sabitini et al. 2007; Arabadzisz et al. 2010). The sixty minutes after birth, also called the "Sacred Hour" (Phillips 2013) and the "Golden Hour" in popular and academic discourse (Simkin 2016;

Sharma 2017), represents the co-opting of a medical term related to trauma. Adams Cowley, the founder of the first trauma unit in the country in 1960, is credited with developing the original "Golden Hour" concept. This theory argues that the first sixty minutes after a traumatic injury is crucial in determining mortality even days or months later. Cowley applied data from the French army during WW I and his own clinical experience to demonstrate that the timely application of interventions during this period is critical (University of Maryland Medical Center 2018). The conceptualization of the "golden hour" represented a turning point in trauma care (DeWood 1980; Blow et al. 1999) and significantly influenced maternal and infant health practices as well.

In the late 90's, the Vermont Oxford Network, a nonprofit dedicated to improving neonatal outcomes around the world, adopted the "golden hour" term to refer to "best" clinical practices for the first hour of life for very low birth weight infants (Sharek 2003). The Golden Hour concept represents an organizing theme within popular birth culture underscoring the perceived importance of a particular childbirth experience. This initial period of alertness and calm for healthy newborns is held in birth culture as a "once in a lifetime" opportunity for bonding, establishing a good breastfeeding relationship, and taking advantage of "feel good" hormones. These practices include immediate skin-to-skin contact to increase physiological stabilization of the newborn.

Championed by Nils Bergman, skin-to-skin care emerged as a buzzword in maternal and infant health practice in the late 1980's. Skin-to-skin care refers to an adult (usually the child's mother) holding an undressed baby directly on their bare chest with no barrier of any type between the two bodies. Bergman employed this type of care in lieu of incubators in unindustrialized countries and then brought the idea back to the UK where skin-to-skin contact produced more benefit than incubator protocols in some cases (Bergman 1994; Kirsten and

Bergman 2001). Bergman's work proved influential in developing global health policy. In 1991, WHO and Unicef introduced the Baby-Friendly Hospital Initiative (BFHI) and included the goal of "Helping mothers initiate breastfeeding within half an hour of birth" (2009:3). One strategy toward achieving this goal included skin-to-skin contact for mothers and babies immediately following birth for at least an hour (WHO and Unicef 2009). Furthermore, the idea that skin-to-skin contact is particularly beneficial for pre-term babies has developed into a standard of "Kangaroo care" in hospitals today (Anderson 1986).

As the science around skin-to-skin contact entered the mainstream, French obstetrician Michel Odent authored an article that implored interested parties, "Don't Wake the Mother!" in which he suggested that baby and mother needed uninterrupted time to connect immediately following birth (2002). While Odent did not use the term "golden hour" in this piece, the author's opening statement, "The hour following birth is undoubtedly one of the most critical phases in the life of human beings," had similar meaning and impact (2002:9). The article goes on to identify and describe eight factors of importance related to this period including beneficial hormone levels for mother and baby, thermoregulation, initiation of breastfeeding, and even "adaptation to gravity" (Odent 2002:11). Appearing in the premier midwifery journal *Midwifery Today,* the essentialist message of this article was received by many birth professionals.

Odent's 2002 piece also reinforces the idea that for the fleeting "golden" period to reap its essential and most lasting benefits, it is important that it remains "undisturbed," an aspect that has served to reinvigorate the need for birth plans and advocacy around resisting medicalization. This means that the protocol for many routine interventions like bathing, vitamin K eye-drops, and swaddling must be interrupted and delayed. The importance of the undisturbed immediate postpartum period for mom and baby is an idea legitimated by leading medical organizations.

For instance, the American Academy of Pediatrics (AAP) recommends guidelines to limit interventions in the first hour after birth to increase contact between mom and baby and establish breastfeeding behaviors (AAP 2012; Crenshaw 2014).

Many studies focusing on the potential benefits of breastfeeding gained popular attention in the 90's (Koletzko 2002). As mentioned above, research consumed by the mainstream also popularized the idea that the immediate postpartum period is critical for maternal-infant bonding and the expression of imprinted breastfeeding behaviors through skin-to-skin contact (BreastCrawl.org 2016; Crouch 1995; Varendi and Porter 1994). Coined in 1987, The "breast crawl" describes a sequence of instinctual processes in the first hour of life for a newborn, including mouth and hand reflexes for rooting, suckling, and latching onto the breast for the first time (Widstrom et al.). Beginning in the 90's, the United Nations International Children's Emergency Fund (UNICEF) and the World Health Organization (WHO) promoted this idea through the dissemination of information and policy initiatives including the Breastfeeding Friendly Hospital Initiative (BFHI) to encourage higher rates of breastfeeding worldwide. The "golden hour" and the "breast crawl" developed simultaneously in birth culture and in many cases represent one intertwined concept promoted as the ideal goal for mother-baby care the immediate postpartum period.

Currently, the "golden hour" concept is used on birth professional websites and blogs as well as in institutional marketing. As one community health website broadly states, "That uninterrupted contact between mother and baby during the 'golden hour' is critical to the child's growth and development" (Sanford Health News 2018). And a 2009 flyer titled "the Golden Hour" used by a New Jersey hospital suggests, "We recommend this intimate hour to be reserved for the infant, mother, and her significant other to allow the mother and infant the opportunity to

enjoy the first hour of life privately bonding together" (Saint Barnabas Hospital 2013). It is difficult to say exactly when cultural influencers reimagined and repackaged the "Golden Hour" term as a benefit for *all* neonates, but this term is now used by many hospitals, their customers, and the larger birth culture.

The long-term effects of childbirth for the infant, specifically on attachment, gained scientific interest during the early 90's (Arabadzisz et al. 2010; Ayers et al. 2006; Greenfield et al. 2016; Hofer 1994; Sabatini et al. 2007). Research on the effect of interventions during birth on outcomes for babies has increased -- along with the trend for more interventions -- and shows mixed results. For example, a 1991 extensive retrospective study found no significant differences in cognitive and physical functioning of 17-year-olds who were birthed using forceps and vacuum compared to those without such interventions (Seidman and Laor 1991). More recently, a meta-analysis on cesarean birth and the development of autism spectrum disorder and attention deficit/hyperactivity disorder found the odds of such disorders were "moderately" increased for babies experiencing this mode of birth (Curran et al. 2015).

Overall, the sociology of childbirth is concerned with conflicts of power arising from an increasingly medicalized experience imbued with both cultural parenting ideologies and ever changing interpretations of the science of birth. Ideologies of risk aversion and the optimization of "outcomes" vie for priority within the "natural" and medicalized frames and a dissent exists in sociological discourse between what normal and natural mean regarding birth as opposed to its medicalized form (Oakley 2016:694). Nevertheless, 99% of births in the U.S. take place in a hospital and 31.9% end in cesarean with that rate increasing up to 38.2% in southern states (National Health Statistics 2016). Further, in a survey of 2400 mothers, only 13% reported that they experienced no major interventions (medical induction, epidural, labor augmentation,

assisted delivery, or cesarean section) during or just before the birth of their child, while 57%

reported 2 to 3 of these interventions (Declercq et al. 2013). It is important to note here that

significant differences exist in maternal and child health outcomes and access to services based

on social location. This disparity in access also influences attitudes and meaning given to

receiving or resisting health services during pregnancy and birth (Johnson 2016).

2.1.6   Trauma

The history of our understanding of psychological trauma, like physical trauma,

developed out of wartime experience. Terms like "soldier's heart," popular during the civil war,

and "shell shock," described military personnel that suffered from trauma on the battlefield

(Benedek and Ursano 2009). The Vietnam War marked a turning point in the treatment of mental

trauma. A consensus developed in the field of psychiatry that traumatic symptoms did not occur

in certain individuals due to weakness or vulnerability, but that all people exposed to traumatic

events had equal risk (Benedek and Ursano 2009). The diagnosis of post-traumatic stress

disorder solidified a decade later in the 1980 publication of the American Psychiatric

Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, Third Edition

(DSM-III). In its earliest iteration, Post-traumatic Stress Disorder (PTSD) required symptoms

following a catastrophic event like natural disaster or combat (APA 1980). Eventually, this

criterion broadened to include symptoms related to the experience of an event that threatened

injury or death in the 4th edition (APA 2000), and again in 2013 to include witnessing that of

others, hearing about that of others, and repeated exposure due to job duties (Black and Grant

2014:178).

2.1.7   Traumatic Birth

While postpartum depression is a well-known concept, appearing in the DSM II in 1960 as a stand-alone disorder, postpartum traumatic stress disorder has only recently emerged (Grekin and O'Hara 2014). The DSM V does not mention the postpartum form of PTSD as a separate disorder (APA 2013), but there is a consensus in the scholarly discourse that the diagnosis and parameters are the same as PTSD with a few contextual differences (Ayers et al. 2008). It is understood that the originating traumatic event for postpartum PTSD is experiencing the birth of a child.

Attention and funding for postpartum depression research increased over the past seventeen years due, in part, to the release of the Surgeon General's Report on Mental Health in 2000 (Satcher 2000). This included a push for federal funding and Congressional support for addressing postpartum mental health issues through the Maternal and Child Health Bureau (MCHB). ACOG also recommended a maternal mental health objective for "Healthy People 2020" to, "Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms" (Healthy People 2020 2010). The primary strategy for achieving this objective requires emphasizing screening and referral for therapy (Santoro 2010). The inclusion of a focus on "trauma" related to childbirth within bureaucracy and legislation has yet to materialize.

French scientists are attributed with first describing post-traumatic stress resulting from complicated labor or the loss of a child in 1978 (Bydlowski and Raoul-Duval), but the topic of traumatic childbirth as a psychological concept in the English language medical literature goes back just 20 years. A lack of agreement among researchers regarding what constitutes traumatic birth continues, though a comprehensive concept analysis and literature review recently offered

the following definition: "The emergence of a baby from its mother in a way that involves events or care that causes deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature" (Greenfield et al. 2016:257). Greenfield notes a study conducted by Ayers et al. that describes PTSD occurring without significant physical injury as a pivotal moment in the understanding of traumatic birth (2008). Postpartum PTSD in much of the literature up until that point focused on psychological trauma following "operative" births (Greenfield et al. 2016:255). The separation of psychological trauma from physical trauma in medical discourse due to continued research originating in the nursing field, expanded the bounds of what is considered a traumatic birth.

The experience of traumatic birth can exist outside the PTSD diagnostic criteria. Greenfield and colleagues (2016:255) state, "However, while PTSD and PTSS [post-traumatic stress syndrome] are potential consequences of traumatic birth, not all traumatic births result in a woman experiencing either condition." While up to 45% of birthing parents report traumatic birth, just 1 to 2% will go on to develop clinical PTSD. The risk factors of traumatic birth include previous traumatic experience; history of sexual abuse; psychological distress due to "brusque or unsympathetic care;" as well as the inability to obtain wanted interventions or enduring those which were unwanted; a high level of intervention; loss of control; stillborn and low birth weight infants; as well as extreme pain during labor (Beck 2004; Beck 2009; Beck 2011; Greenfield 2016; Reed, Sharman, and Inglis 2017; Reynolds 1997). Notably, the risk factors in the literature are so wide they apply to many if not most births. Greenfield notes that the variable of time is the one factor that separates traumatic birth from other concepts such as "negative birth experience" or "difficult birth," throughout the literature (2016). Effects of

traumatic birth include difficulty bonding, distress, disappointment, and sadness. These effects can linger for years and range in severity from mild to debilitating (Simkin 1991).

2.2   Where We Give Birth in the Global North

An important part of the story of childbirth rests in place. To add texture to our material understanding of the birth experience and to better understand the emergence of traumatic birth, I briefly summarize the recent history of institutionalized birth in hospitals.

Zwelling and Phillips contend that until recent decades, hospital births took place in an environment designed expressly for "combating disease, accidents, and other complications associated with birth" (2001:2). Much of hospital infrastructure and logistics from the 50's remained unchanged until 1970 when hospitals began to allow partners in the "delivery" room (Zwelling and Phillips 2001). Then, around the late 80's to early 90's, due to policy changes and cost-saving measures, hospitals began marketing their maternity wards as being "home-like" and focused on "Family-Centered Maternity Care." A signature element of the shift included the functioning of hospital rooms, which began to be privatized and used for labor and delivery instead of separate facilities designated for each. Amenities like private bathrooms and showers as well as comfortable seating, TVs, and stereos all became standard fare in labor and delivery wards.

Most recently, in the early 2000's, many hospitals adopted new policies outlined under the BFHI. These include protocol for encouraging and promoting exclusive breastfeeding like "rooming-in," discontinuing the use of pacifiers, and banning formula unless "medically necessary" (Unicef and WHO 2009). A parenting website aligning with BFHI states that medical reasons to supplement with formula include pre-term infants, low blood sugar, excessive weight loss, and "severe" jaundice (Family Education 2018).

The reactions to BFHI vary and a portion of the mainstream objects to the changes strongly based on the perception of decreased support for new parents. Gruber writing in a popular online magazine states:

> So when I heard that more than 350 U.S. hospitals had done away with nurseries all together to encourage on-demand breastfeeding and stronger bonding between infant and mother (and that the number of hospitals doing so is expected to reach 530 by next year), I immediately called bullsh*t. I understand what they are trying to do and that statistics encourage skin-to-skin contact and breastfeeding in the immediate hours after a baby's birth, but what they aren't taking into account is a mother's right to choose what's best for her own sanity. (2016.)

Despite detractors, in the 90's sending babies to the nursery became less customary and many hospitals today are doing away with nurseries for healthy babies altogether.

The following section of this review incorporates global policy and discourse around "obstetrical violence," legal terminology originating in Venezuela in conjunction with the South American based social movement to "humanize birth" (Laako 2017). This movement has influenced many US, UK (United Kingdom), and AU (Australia) based birth organizations and energized recent discussion around institutional abuse during childbirth and resulting trauma.

2.3 Globalization of Health and Institutional Violence

In a recent review of the sociology of birth, Oakley notes the influence of the World Health Organization (WHO) and the international medicalization of childbirth beginning in the early 80's in response to concern around maternity services and mortality rates (2016). The Perinatal Study Group was initiated by the European Office of WHO to collect and analyze both statistics and qualitative data around the maternity system; focusing particularly on the comparison of obstetrical and midwifery care. This expansion and concerted communication of the global medical network allowed for comparisons of practices and outcomes between different countries. Oakley contributed to several meaningful WHO recommendations, one being that

science does not justify a cesarean rate exceeding 10-15% (Oakley 2016:697). This globalization process also increased romanticizing of the "third world birth" for the white middle class and a propensity to attempt to adopt similar practices (Johnson 2016:58).

Implemented by WHO in 1987, The Safe Motherhood Initiative addressed maternal and infant mortality across the world. The year 2000 saw a revamp of this initiative with the release of the Millennium Development Goals calling for an increase in access to medical treatment during childbirth across the globe and resulted in a wave of mistreatment of birthing people worldwide due to underprepared and overwhelmed health service systems (Islam 2007). The awareness and activism in response to facility-based abuses contributed to new language for U.S. birth discourse.

The concept of "obstetrical violence" emerged in Venezuela in 2007 as a legal term in response to violations and abuses against laboring people during childbirth. A rising consciousness continues to grow around abuses of power in childbirth; Listening to Mothers III reports two-thirds of new mothers experienced instances of coercion or lack of consent (Childbirth Connection 2013). A recent legal exploration of the topic in the U.S. concludes, "Individual tort litigation is necessary, but not sufficient, to the task of ending obstetric violence. True transformation will also require provider education and greater connection between health infrastructure and civil society advocacy to address harmful gender norms" (Diaz-Tello 2015:62). Various media campaigns based in the Global North include individual's statements of personal experience with an intent to expose institutionalized violence and trespasses by their providers during childbirth (e.g. improvingbirth.org and humanizebirth.org).

Most recently, the term "birth-rape" entered the discourse of birth culture to describe experiences of assault during birth and is greatly debated. Some strongly oppose equating this

offense, perpetuated by a medical professional during childbirth, with a sexual crime (Carmon 2010). The issue of childbirth abuse invokes analogies to domestic abuse and gender violence. This connection brings critique due to the overwhelming presence of female MD's in the profession as well. A rebuttal from Diaz-Tello explains, "This misses an important understanding: an act of gender-based violence is not considered such because the perpetrator is a man, but rather because the victim is a woman" (2016:61).

Due to increased instances of violence against laboring people in targeted regions of the maternal mortality improvement initiative, WHO released a statement titled "The Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth." This report acknowledging increased facility birth rates around the world resulted in "disrespectful, abusive or neglectful treatment during childbirth" (WHO 2015) and outlined action points for change including improvements in staff training (WHO 2015). Bohren and colleagues point out that the rise in people delivering in health facilities globally require "efforts to improve both the coverage and *quality* of care provided to women at health facilities, including women's rights to dignified and respectful care" (2015:2, emphasis mine). The original WHO initiatives neglected these person-centered factors with tragic consequences.

2.4   Maternal Health Disparities

I end this review by bringing the focus back to the U.S. with research on maternal health and the disparities that exist therein. Overall, the U.S. lags behind European countries in commitment and action to improving maternal health. It is the only "developed" country that has not decreased maternal mortality since 1990 (Lancet 2016). In fact, maternal mortality rates in the U.S. have climbed by 25% from 1990 to now; though the CDC points out some of this increase may be due to better record keeping (2016).

Preliminary evidence does not reflect a meaningful incorporation of social stratification into the current discourse of "traumatic birth" as an emerging psychological concept. Further, while popular discourse offers examples of a growing awareness in birth culture of the need to address disparities in outcomes and practice (evidencebasedbirth.com 2017; https://blackmamasmatter.org/bmhw/), an initial review of the literature in this specific area of childbirth shows the intersection of race regarding a traumatic birth and current disparities in maternal health outcomes remain largely unaddressed in dominant discourse.

In summary, the background of our social understandings of trauma and the medicalization of birth build upon each other throughout the decades as maternal health becomes a globalized issue. As the definition of trauma broadens, so too does the reach of medicalization through various interventions in the realm of childbirth and postpartum. "Traumatic birth" frames laboring people's experience as "disordered" through postpartum medicalization and has yet to include many of the experiences and voices of those most vulnerable. I explore the conceptual framing of "traumatic birth," and common messages in birth culture. By considering the actors involved in constructing and interacting with this concept as well as investigating the contextualizing of "traumatic birth" in peer reviewed and popular discourse, this project will contribute a much needed sociological analysis of the emergence of "traumatic birth" out of the gendered and racialized landscape of childbirth.

2.5   Maternal Health Disparities

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U.S. have climbed by 25% from 1990 to now; though the CDC points out some of this increase may be due to better record keeping (2018).

Preliminary evidence does not reflect a meaningful incorporation of the social stratification of race or class into the current discourse of traumatic birth as an emerging psychological concept. Further, while popular discourse offers examples of a growing awareness in birth culture of the need to address disparities in outcomes and practice (Dekker 2017; blackmamasmatter.org) an initial review of the literature shows the intersection of race regarding a traumatic birth and current disparities in maternal health outcomes remain largely unaddressed in this stream of discourse (Kozhimannil 2011; Paul 2008).

In summary, the background of our social understandings of trauma, the medical industrial complex, and increased birth technology build upon each other throughout the decades as maternal health becomes a globalized issue. The definition of trauma broadens, and so too does the reach of medicalization through various interventions in the realm of childbirth and postpartum. In this paper, I explore the conceptual framing and common messages around traumatic birth. By considering the actors involved in constructing and interacting with this concept as well as investigating the contextualizing of traumatic birth in peer reviewed and popular discourse, this project will contribute a much needed sociological analysis of the emergence of traumatic birth out of the gendered and racialized landscape of childbirth.

3   METHODS AND SOURCES

3.1   Data

I chose the term "traumatic birth" partially because of my experience working with and being in community with new moms. I often hear mothers adopt this concept and wording actively, claiming, "I had a traumatic birth," or qualifying an experiential statement with "my birth was/wasn't traumatic." I recognize that there are other possible search terms related to the current project. In particular, "birth trauma," and "postpartum post-traumatic stress" could be viewed as viable alternative search options. My project intends to focus on the material cultural and social aspects of birth, as such the active quality of "traumatic birth" encompasses the experiential and embodied experience of birth where the previously mentioned terms miss the mark of this particular idea of engagement. For example, "birth trauma" yields 2,000 articles between 2000 and 2018, including many biological studies on animals; "postpartum post-traumatic stress" elicits only fifteen articles in that same time period.

I conducted a content analysis using popular web-based texts and peer reviewed literature. First, I conducted two basic literature searches of "traumatic birth" via ProQuest using 18 available databases for peer-reviewed and popular sources. I grouped articles into seven five-year increments from 1980 to 2015. Considering the number of articles available (approximately 300 from peer-reviewed journals and almost 2,000 from popular sources), my line-by-line analysis included four articles from both popular and peer-reviewed sources within each of the seven time periods (four fewer for peer-reviewed and one fewer for popular due to time periods that yielded fewer than four articles for analysis) (N=50). Table 1 includes the list of all of the line-by-line articles analyzed and Table 2 includes articles from my initial sample that are cited within the paper.

First, to document the entire census of articles, I created a graphic representation of the full volume of articles produced in each source from each period. I included the total number of raw articles in the Proquest search and the reduced number indicating the initial sample of articles that remained after inclusion criterion were applied. I briefly scanned each article to note organizing themes. This allowed me to track the frequency of ideas in the literature and guided my choices for later selection of articles for line-by-line analysis. Next, I began the process of selecting my sample for this analysis.

The selection of articles for inclusion in the line-by-line analysis is based on my assessment of their typicality in representing the entire sample from the same time period. More specifically, I looked at common themes and framing of the traumatic birth concept in determining which articles most represented each time segment. For peer-reviewed and popular articles, I looked at each abstract and reviewed the entire article for organizing theme identification. In the selection process, I noted articles with any important deviations from the themes that contributed to the ongoing development of the concept. Then I examined the characteristics of the articles in my final sample, noting: 1) country of origin for all articles, 2) publication type (psychology, medical, or education) and demographics of the sample population for peer reviewed works, and 3) publication type (newspaper, magazine, or book) for the popular pieces. I also identified themes and connections between themes for all seven time periods in the sample and compared and contrasted the peer-reviewed and popular articles' framing of traumatic birth.

Table 1 Articles Included in Line-By-Line Analysis

Popular	Peer Reviewed
1980-1984	*1984-1989*
P1-Lipovenko, Dorothy. 1981. "Women Get Help to Fight Depression after Baby's Birth," *The Globe and Mail*, June 25, p. T.3.	**PR1**-Newman PK, TR Ternety, JB Foster. 1981. "Some observations on the pathogenesis of syringomyelia." *Journal of Neurology, Neurosurgery & Psychiatry*, 44(11): 964.

P2-Noyes, Paddy. 1983. "He Seeks Home to be his Forever," *Philadelphia Inquirer*, July 08, p. C.4.	
P3-Sexton, Sharon. 1983. *Philadelphia Daily News*, Oct 20, p. 45.	
1985-1989	*1985-1989*
P4-Brody, Jane E. 1989. "Personal Health," *New York Times*, Dec 21, p. B.19.	**PR2**-Hull, William F. 1986. "Psychological treatment of birth trauma with age regression and its relationship to chemical dependency." *Pre-and Peri-natal Psychology Journal*. 1(2): 111-134.
P5-Hayes, Pamela. 1989. "Birth Loss Group to Open Doors," *Telegram & Gazette*, July 16, p. B1.	**PR3**-Jacobson, Bertil. 1988. "Perinatal Origin of Eventual Self-Destructive Behavior." *Pre-and Peri-natal Psychology Journal*. 2(4): 227-241.
P6-McKinnon, John D. 1988. "Mom Accused of Killing Girl was Psychotic, Doctor Says," *St. Petersburg Times,* Aug 11, p. 4B.	**PR4**-Rice, Ruth D. 1986. "The Mind-Body Spirit Connection: Ancient and Modern Healing Strategies for a Traumatic Birth and the Sick Newborn." *Pre-and Peri-natal Psychology Journal*. 1(1): 11-19.
P7-Topping, Robin. 1988. "Brain Damage Suit Wins $6.6M," *Newsday*, Nov 20, p. 21.	
1990-1994	*1990-1994*
P8-FitzGerald, Susan; Jaffe, Mark; Drake, Donald C. 1993. "How Three Nations Shape Birth: Canada and Germany Try To Make Sure Every Woman Has a Healthy Pregnancy. In the U.S., Gaps in Maternity Care Exact a High Price," *Philadelphia Inquirer*, April 27, p. A.1.	**PR5**-Roedding, Jude. 1991. "Birth Trauma and Suicide: A Study of the Relationship Between Near-Death Experiences at Birth and Later Suicidal Behavior." *Pre-and Peri-natal Psychology Journal*. 6(2): 145-169.
P9-Levey, Bob. 1990. "A Day With an Intensive Care Nurse," *The Washington Post,* Dec, p. D14.	**PR6**-Calhoun, Asela. 1992. "Sexual Abuse and Its Impact on the Childbearing Years: A Tough Subject with No Easy Answers."
P10-Osborn, Laura. 1994. "Loss of a Homebirth Dream," *Midwifery Today and Childbirth Education*, 29(18): 40-41.	**PR7**-*International Journal of Childbirth Education*. 7(3): 33-34.
P11-1992. "Stork Brings Questions from Patients, State Has Asked a Judge to Close the Stork's Corner Birthing Center and Accused its Owner of Illegally Treating Patients," *Orlando Sentinel*, April 12, p. B1.	
1995-1999	*1995-1999*
P12-Harder-Gissing, Laureen. 1997. "Birth Journey: One Mother's Experience," *Mennonite Reporter,* 27(4): 9.	**PR8**-Allen, Sarah. 1998. "A qualitative analysis of the process, mediating variables and impact of traumatic childbirth." *Journal of Reproductive and Infant Psychology*. 16(2/3): 107-131.
P13-Leeks, Kelina. 1997. "Slowly but Surely: Recovering from a Difficult Childbirth One Day at a Time," *Today's Parent*, 14(3): 22.	**PR9**-Jacobson, Bertil; Bygdeman, Marc. 1998. "Obstetric Care and Proneness of Offspring to Suicide as Adults: Case-Control Study." *British Medical Journal*, 317(7169): 1346.
P14-Ligtermoet, Henny. 1995. "On Postpartum Depression from the Land Down Under," *The Birth Gazette*, 12(1): 38-40.	**PR10**-Reynolds, J Laurence. 1997. "Post-traumatic stress disorder after childbirth: The phenomenon of traumatic birth. Canadian Medical Association." *Canadian Medical Association Journal*, 156(6): 831-5.
P15-1996. "Tricks of The Trade." *Midwifery Today and Childbirth Education*, 39: 10.	**PR11**-Solter, Aletha, PhD. 1995. "Why do babies cry?" *Pre- and Peri-natal Psychology Journal*, 10(1): 21-43.
2000-2004	*2000-2004*
P16-Collins, Lois. 2004. "Birth Nurses have Big Impact," *Deseret Morning News*, July 28, p. B01.	**PR12**-Beck, Cheryl Tatano. 2004. "Birth Trauma: In the Eye of the Beholder." *Nursing Research.* 53(1): 28-35.
P17-Hilpern, Kate. 2003. "Parents: Hard labour: Just how traumatic is childbirth? We all know that having a baby hurts - but that's soon forgotten, surely? Kate Hilpern on why, for	**PR13**-Blasio, Paola Di; Ionio, Chiara. 2002. "Childbirth and narratives: How do mothers deal with their child's

Popular	Peer Review
some women, it is an experience that leaves deep psychological scars," *The Guardian*, May 28, p.14.	birth." *Journal of Prenatal & Perinatal Psychology & Health*. 17(2):143-151.
P18-Moorhead, Joanna. 2002. "Parents: Hard labour: Controversial childbirth expert Michel Odent now claims that 'industrialised obstetrics' could be to blame for autism and drug abuse," *The Guardian*, July 10, online.	**PR14**-Gardner, Patti Spiegelberg. 2003. "Previous Traumatic Birth: An Impetus for Requested Cesarean Birth." *The Journal of Perinatal Education*, 12(1): 1-5.
P19-Szalay, Colette. 2003. "Natural Childbirth is Making a Comeback," *Health Matters,Peterborough This Week*, Aug 06, p. 08.	**PR15**-Unkwown Author. *International Journal of Childbirth Education*. 2003. Position statement. 18(3): 35-43.
2005-2009	*2005-2009*
P20-Boulach, Sarah. 2007. "There is Help Out There for New Moms.," *South Bend Tribune*, Oct 03, p. E1.	**PR16**-Fairbrother, Nichole, and Sheila R. Woody. 2007."Fear of childbirth and obstetrical events as predictors of postnatal symptoms of depression and post-traumatic stress disorder." *Journal of Psychosomatic Obstetrics and Gynecology*, 28(4): 239-42.
P21-Kamps, Louisa. 2008. "The Story That Can Change Your Life," *Good Housekeeping*, 247(1).	
P22-Roser, Mary Ann. 2006. "Traumatic Birth Injury Grows Rarer," *Austin American Statesman*, July 30, p. B1.	**PR17**-Lear, Teresa. 2006. "Women's Perceptions of the Birthing Experience: An Ever-Changing Phenomenon." *Journal of Prenatal & Perinatal Psychology & Health*, 21(2): 203-210.
P23-Zimmerman, Rachel. 2008. "Birth Trauma: Stress Disorder Afflicts Moms; Study Suggests That PTSD May Be More Common Than Previously Believed," *Wall Street Journal*, Aug 05, p. D.1.	**PR18**-Simkin, Penny. 2006. "What Makes a Good Birth and Why Does it Matter?" *International Journal of Childbirth Education*, 21(3): 4-6.
	PR19-Slade, Pauline. 2006. "Towards a conceptual framework for understanding post-traumatic stress symptoms following childbirth and implications for further research." *Journal of Psychosomatic Obstetrics and Gynecology,* 27(2): 99-105.
2010-2015	*2010-2015*
P24-Fernández, Ibone Olza. 2013. "PTSD and Obstetric Violence." *Midwifery Today*, 105: 48-49,68.	**PR20**-Elmir, Rakime; Schmied, Virginia; Wilkes, Lesley; Jackson, Debra. 2010."Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *Journal of Advanced Nursing*, 66(10): 2142.
P25-Pacenti, John. 2015. "Wellington Woman Highlights Moms' Mental Health; New Mothers' Psyches can go Haywire, says Support Group Founder," *Palm Beach Post*, Feb 02, p. A.1.	**PR21**-Kendall-Tackett, Kathleen. 2015. "Childbirth-Related Posttraumatic Stress Disorder and Breastfeeding: Challenges Mothers Face and How Birth Professionals Can Support Them."*Journal of Prenatal & Perinatal Psychology & Health*; Forestville, 29(4): 264-275.
P26-Shanley, Laura Kaplan. 2012. "Psychological Effects of a Traumatic Birth on a Family." Pp. 35-42 in *Unassisted Childbirth*. Santa Barbara, CA: Praeger.	**PR22**-Simkin, Penny, PT, CCE, CD(DONA). 2011. "Pain, Suffering, and Trauma in Labor and Prevention of Subsequent Posttraumatic Stress Disorder." *The Journal of Perinatal Education*, 20(3): 166-175.
P27-Shapiro, Dani. 2010. "Chasing Virtue: Claire Dederer's memoir describes how yoga helped her escape her lifelong perfectionism," *New York Times*, Dec 26, p. B9.	**PR23**-Garthus-Nigel, Susan, Tillman von Soest, Margeret E. Vollrath, and Malin Eberhard-Gran. "The impact of subjective birth experiences on post-traumatic stress symptoms: a longitudinal study."

Table 2 Additional Sample Articles Cited

Popular	Peer Review
SA1-Yarrow, Leah. 1992. "Giving Birth: 72,000 Moms Tell All." *Parents* 76(11): 148 – 159.	**SA8**- Prontzos, Peter G. 2004. "Life Before Birth." *Journal of Perinatal and Perinatal Psychology and Health*, 27(1):75-77.

SA2-Blanchard, Susan. 1994. "Grieving a Dream," *The Exceptional Parent*, Boston 24(10):26. **SA3-**Klein, Michele. 2003. "From Birth Hut to the Garden of Eden." Midwifery Today. 66:24-26. **SA4**-Kyle, Anne. 2004. "Giving Birth Could Rekindle Memories of Sexual Abuse," *Leader Post*, Nov 13, p.48. **SA5**- Tritten, J. 2007. WHO are the statistics? *Midwifery Today*. 83(7): 7. **SA6**-Courtenay-Smith. 2008. "I take up to 100 Laxatives a Day," *News of the World*, April 20, p.28. **SA7**-Cloud, Barbara. 2008. "No Matter How Often, It's Always a Miracle," *Pittsburgh Post-Gazette*, May 20, p.C.2.	

3.1.1   Search and Inclusion Criteria

I confined the search for scholarly works to peer reviewed articles with full text availability published in English through the ProQuest Central database. Criteria for removal from the peer-reviewed sample included those referred to as editor's notes, letters to the editor, book reviews, or "spotlights." Additionally, articles were excluded that mention traumatic birth as metaphor (e.g. the traumatic birth of the nation), non-substantively (the concept was not important to the article), or were duplicates. Articles reporting varying accounts of the same news events or following the same story over time were retained.

Popular articles included blogs, newspapers, magazines, books, and other published texts. The bulk of the sources ProQuest provided were newspapers and magazines. In considering articles for inclusion in line-by-line analysis, I looked first for articles published in the U.S. for relevance as this cultural perspective represents my intended focus.

3.1.2   Sample Size and Article Type

After an initial review of articles based on inclusion criteria, the raw sample of peer reviewed articles (N=384) was reduced (N=267) (Figure 1). The final total sample of peer

reviewed articles included in line-by-line analysis (N=23) represented a mix of articles from Medical (N=9), Psychology (N=9), and Education (N=5) journals. Peer reviewed articles focusing on traumatic birth experienced by laboring people represented a predominately homogenous sample of white socioeconomically privileged birthing parents (identified as women) from the Global North, with few exceptions noted in the findings (N=6).

Inclusion criteria reduced the raw sample of popular articles (N=1,892) to (N=426) (Figure 2). This reduction included eliminating one of the international databases (Global Newsstream) from the search collection in an effort to maintain a workable number of articles to analyze. The final sample of popular articles included in line-by-line analysis (N=27) included newspaper (N=19), magazine (N=7), and book (N=1) sources.
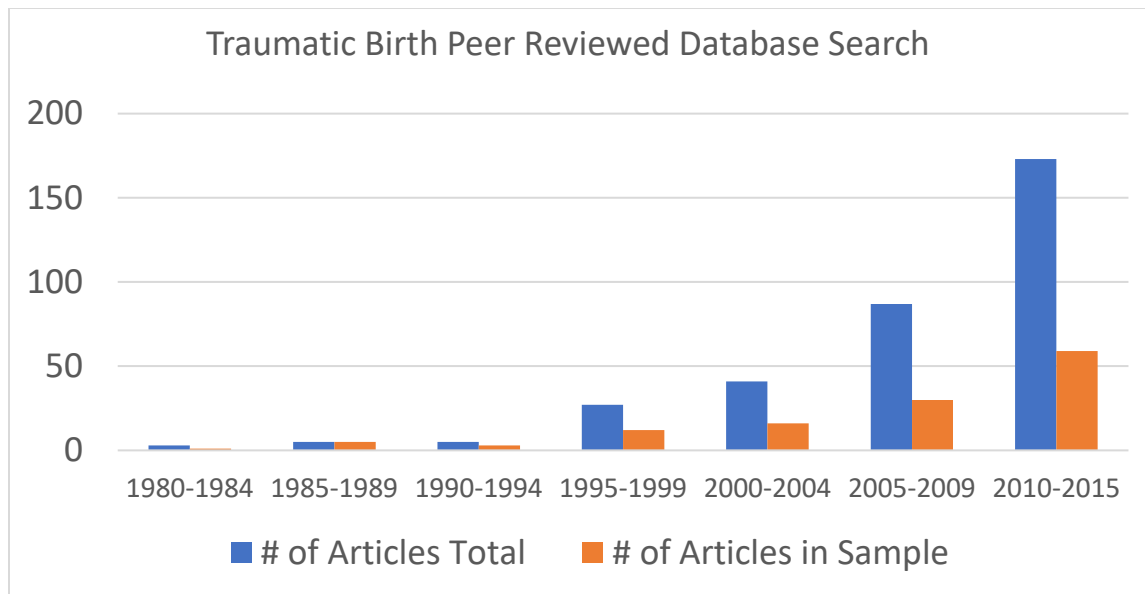
Figure 1 Peer Reviewed Sample
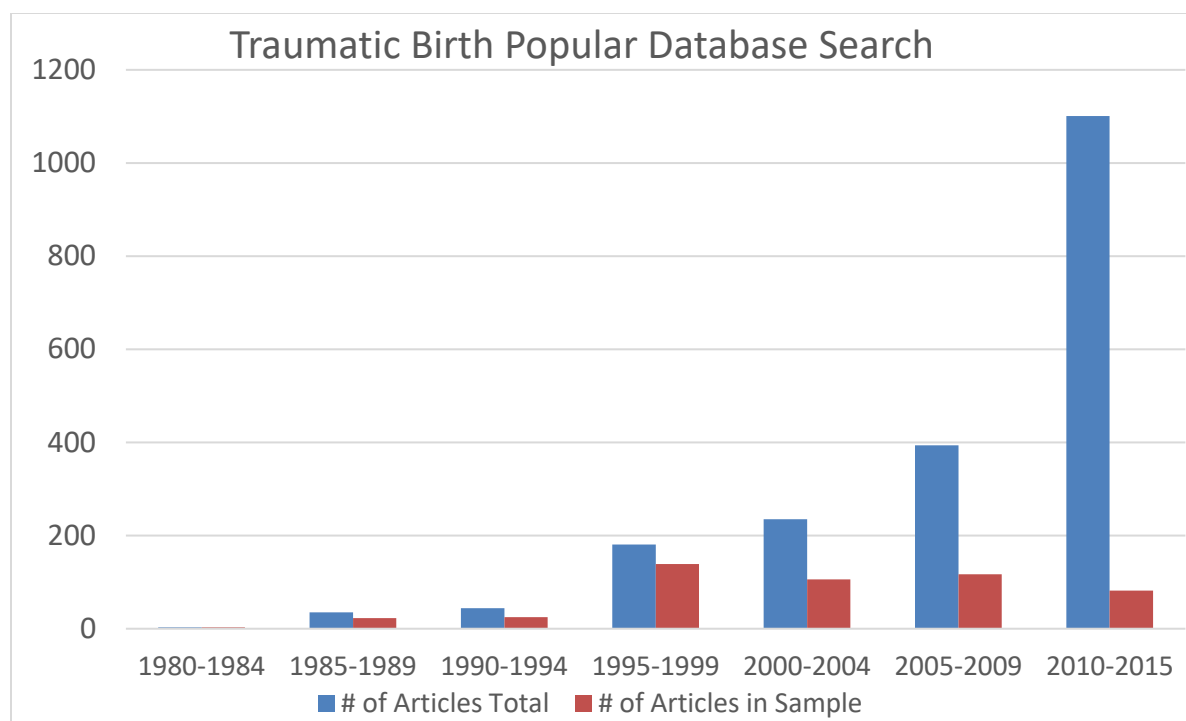
Figure 2 Popular Sample

3.2   Analysis

3.2.1   *Theoretical Background*

The theoretical perspectives of medicalization, embodiment, and critical constructivism inform this investigation and the feminist concept of bifurcated consciousness as put forth by Dorothy Smith provides a lens through which competing themes emerging from the data can be understood (1987). The foundations of the theoretical work that contribute to this analysis concern themselves with the tension between authority and agency and consider the individual simultaneously as subject and actor. The project also benefits from an overreaching critical perspective serving to engage issues of power and social location. The theoretical core of this project lies in the tenuous nature between individual interactions at the micro-level and cultural and societal influences at the macro-level for birthing parents, while engaging in the work of institutionalized birth and early parenthood. Further, meaning making in birth is theorized

throughout this thesis with an understanding that bodies are located within a social hierarchy that privileges some within the medical industrial complex while disadvantaging others and that the contingent physical and psychological experience of birth cannot be separated from the individual or from the socio historical context at large.

Medicalization, originally defined by Conrad and reinterpreted by Simonds to describe a more expansive and active perspective, refers to "the dynamic set of processes by which authorities, institutions, and ideologies come to (re)organize, (re)define and (re)structure our everyday experiences, culture, and social life" (Conrad 2013; Simonds 2017:11). Simond's (2017) expanded definition which accounts for internalized acceptance of medical authority is particularly salient in childbirth today as Oakley and colleagues note, "women having babies in the first years of the twenty-first century accepted the definition of even natural childbirth as a medical event" (2005:696).

Shilling's theory of embodiment, "corporal realism," is based on the idea that "theories of the body-society relationship should not seek to account for the body exclusively in terms of social construction, or for society in terms of its corporal construction" (2004:21). This theory posits that both the body and the societal constructs bodies encounter have co-existing realities and mutual influence. The interplay of embodiment and society is heightened in this thesis as laboring people are both physiologically and emotionally vulnerable while often having to navigate complicated institutional structures as well as the people representing them. The idea of corporal realism brings this exchange between embodied laboring people and social structures to the forefront.

Embodiment theories are relatively new to sociological discussions and attempt to take into account the relationship between experiences in the body and the social world as well as the

meaning making that results. While embodiment theory would logically exist as an integral piece of the birthing literature precisely because birth occurs intensely within the body, it is considered an under-theorized concept (Walsh 2010). The influence of popular science and globalization on birth practices also emphasizes a physically embodied birth and immediate postpartum experience. Embodiment is especially relevant to an inquiry into traumatic birth as many parents who experience birth in this way indicate feelings of disembodiment (Bateman et al. 2017; Zimmerman 2013).

Bifurcated consciousness, described by Dorothy Smith, relates to a unique subjectivity women possess due to their divided labor in the social world (1987). This bifurcation involves everyday activities performed in an ongoing way that often contribute to situating individuals within and preparing them for abstract institutional frameworks (DeVault 2009). "Women who work in these locations, at the juncture of embodied specificity and ideological abstraction, hold in their consciousness both ways of seeing and thinking" (DeVault 2009:65). The act of labor and birth in this historical moment requires both embodied knowledge and ideological understandings of institutions as well the crossing back and forth across the borders of both sites of knowledge. Recent scholars have emphasized the importance of situating the experiences of birthing parents living in the Global North within cultural context just as they are elsewhere (Johnson 2016; Wedeen 2009). Johnson describes how the restrictive North American ideologies of motherhood and the deep divide between public and private life, particularly for privileged mothers, "seems to intensify the split subjectivity of pregnancy, childbirth, and motherhood" (Johnson 2016:65).

Lastly, Critical Constructionism also contributes an important theoretical thread to this research. As Heiner and others described, this perspective positions social reality as both

constructed and problematic (2002; Kincheloe 2008). This theoretical view emphasizes aspects

of power and processes of privilege in the construction of issues framed as problematic and the

solutions to them. Further, my research builds on the developing tradition of critical

constructionism in nursing research. This approach "treats the world of health care as a political

and contested site while at the same time centralizing the importance of engaging people as

persons" (Holstein and Gubrium 2013:156). Additionally, this view is interested in

understanding who decides the value of medical practices and, in turn, who benefits.

3.2.2   *Analytical Approach*

Utilizing the theories mentioned above as a background, I employed grounded theory

strategies to identify emerging themes and conceptual framing of traumatic birth from the data. I

analyzed the data for commonalities, linkages, and differences (Strauss and Corbin 1998;

Thomas 2006). Focusing on social/cultural considerations, I then examined the framing and

adoption of traumatic birth in both peer-reviewed and popular discourse to illuminate the

conditions and context within which the concept emerged as cultural knowledge. With an interest

in relationships of power around the development of this concept and resulting accessibility, I

also examined these texts for common themes and differences, particularly around embodiment,

medicalization, and reference to the science of birth.

This project is guided by several principles of Grounded Theory Method (LaRossa 2005;

Struass and Corbin 1998), including the idea that "the microanalysis of written texts, the heart of

a grounded theoretical analysis, is a worthwhile enterprise" (2005:2). I employed the

fundamental idea of emerging themes in the initial coding process of the articles. Using Nvivo as

an organizational tool, I used a line-by-line coding strategy and an initial open coding process for

each selected text to contextualize the messages at the most substantive level (Glaser 1978).

After this initial coding process, overlapping nodes were collapsed, and I re-coded into the most salient themes. Distinct and dominant themes are noted, and specific sub-coding within main categories and additional dividing at the third level is explored to allow for the thick description of texts including subtle differences in messaging and framing. Lastly, I examined and analyzed relationships between common themes for theoretical implications around the emergence of the traumatic birth concept.

3.2.3   Line by Line Analysis: Peer Reviewed Data

During the initial line-by-line coding process for the peer reviewed body of work (N=23) three dominant and organizational themes emerged from the data; Birth Story, Relationship, and Avoidance. After recoding the data, initial thematic nodes were divided and collapsed according to salient meaning creating hierarchical categories and sub-categories. The Birth Story parent node included fifteen child nodes and after the iterative process of coding a third level of description emerged including six additional nodes. These nodes relate to the subjective experience of birthing parents, the importance of the birth experience, as well as the importance of processing the birth event. The main theme of Birth Story also included a cluster of conceptual frameworks of birth including alive and well, birth as accomplishment, life-changing, and normal birth as stressful.

The theme of Relationship displayed robustness for both labor and the postpartum period. This category included sub-categories of Relational Breakdown indicating deterioration of relationship between providers and laboring people and Relationship Effects Postpartum including strain in partnerships and the mother-child bond. This major theme also included ideas of the importance of maintaining relationship during labor with related sub-categories described as importance of provider care, importance of continuity of care, and concern and vigilance.

Finally, the theme of Relationship included the highly salient sub-themes of trust and betrayal related to the perceived quality of the relationship between the provider and the laboring person.

Avoidance emerged as a prominent theme as well. This parent node included distinct sub-categories of avoiding trauma for neonates and avoiding trauma and subsequent posttraumatic stress disorder for laboring people through supportive and surgical strategies. Additionally, the theme of avoidance emerged as related to coping mechanisms for traumatic experience including the behavior of avoiding future childbirth for parents who experienced "fear of childbirth" and a previous traumatic birth.

Several interconnected secondary themes emerged related to the three themes described above: Expectations, Control, and Postpartum Maternal Feelings. The theme of Control emerged as important for birthing parents both around physiological aspects of birth as well as over the particular unfolding of the event within the hospital setting. Expectations consisted overwhelmingly of the concept of unmet birth expectations contributing to the experience of trauma while Postpartum Maternal Feelings included sub-categories of shame, guilt, and failure.

3.2.4   Line-By-Line Analysis: Popular Data

Initial line-by-line coding of the popular texts set (N=27) revealed four dominant themes; Birth Story, Relationship, Postpartum Maternal Feelings, and Interventions. The iterative process of coding revealed subthemes within these categories specifying messages of the texts. Birth Story presented a particularly rich theme including importance of birth experience, importance of narrative, and subjectivity. The Birth Framework descriptive coding included essentialism, all or nothing, and alive and well.

The dominant theme of Relationship for popular texts contained substantive messages for both labor and the postpartum period and revealed subthemes of importance of relationship

during birth, postpartum relationships, and communication. The Communication node included the third level theme of the importance of being heard and mother-child bond was a salient aspect of the postpartum relationship category. The first level theme of Postpartum Maternal Feelings was prominent in the data and included guilt, shame, blame, and anxiety. The subtheme of Anger was also conceptually important in this category. Finally, the dominant theme of Interventions in the data included fetal heart monitor as an important third-level code.

4   FINDINGS

4.1   Comparisons and Change: Trauma, Diversity, and Postpartum Emotions

Figure 3 depicts the expanding lens of trauma throughout the initial sample of articles. Over all, early discourse in both bodies of early work focused on traumatic birth as experienced by the infant and the potential long-term effects from that trauma. Over time, the discussions of trauma grew to encompass physical *and* psychological effects for the birthing parent. In 1997, Reynolds describes the shift in peer reviewed discourse, "Most health care professionals tend to think of birth trauma in terms of physical injury. However, childbirth can be psychologically traumatic as well" (1997: 156), ". . . it appears that apparently even a normal birth can be traumatic for some women" (157). The focus on birth as psychologically traumatic for moms emerged more slowly in the popular dataset than the peer reviewed data. PTSD related to traumatic birth for moms did not emerge in popular discourse significantly until the 2000's. This was the same time the framing of the possibility of birth trauma as self-originating developed as well.

Widening Scope of Traumatic Birth in Texts Over Time

BP, Baby, Birth Professional, Partner

Physical and/ **OR** Psychological

BP or Baby

Physical and Psychological

Baby

Physical

2015

2000

1980

BP – Birthing Parent
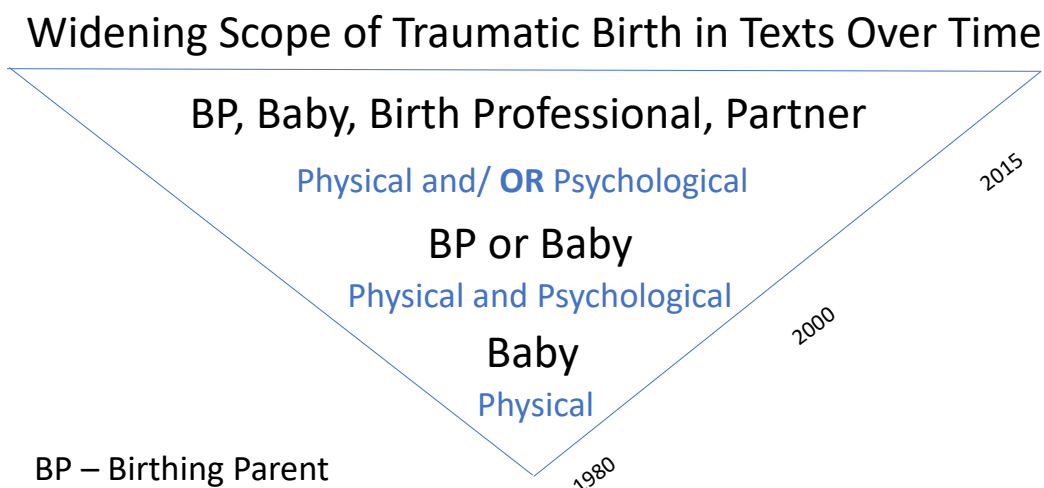
Figure 3 Scope of Trauma

An ongoing sensationalized focus on the impact of traumatic birth on babies, and particularly the far-reaching long-term effects, is reflected in stories around liability and litigation in the popular articles. The potential of mothers to harm babies after a traumatic birth is hyped as well. The continued medicalization of the postpartum period is colloquialized in popular messages like this one, "New mothers' psyches can go haywire, says support group founder" (P25-Pacenti 2015:A1). Both sets of data presented evidence of an ever-widening scope of traumatic birth in the later time periods with articles focused on the potential of vicarious trauma for partners and providers witnessing a traumatic birth.

Importantly, the emerging theme of diverse experiences of traumatic birth appeared around 2010 in both peer reviewed and popular data. A 2008 article reporting data from a large national survey brings social stratification in the U.S. into the conversation for the first time in the popular data, stating, "The survey also found that African-American women, those without

private health insurance and women with unplanned pregnancies were more likely to have PTSD symptoms" (P23-Zimmerman 2008:D1). The peer reviewed data offered an increase in research using diverse sample populations including adolescents (N=3), and non-Europeans (N=6) during that time period as well. What remains absent is qualitative data around the particular experience of birth and the postpartum period for marginalized individuals in the U.S.

In the line-by-line analysis across time points, the theme of Postpartum Maternal Feelings exhibited greater dominance in the popular texts and the subthemes of anger and failure stood out. The salient emotional theme of anger emerged most often in personal accounts from the popular data (N=7). For example, a mother reports, "For nearly a year, I experienced back pain and smoldering rage" (P12-Harder-Gissing 1997:9). In 2012, Shanley includes a mother's remarks on this emotion in regard to the relationship with her partner, "I did not feel close with my husband after those births either; in fact, I was angry with him for allowing them to do all the things they did to me" (P26-p.40). While the text commonly presented many emotions clustered together, anger and failure often stood alone with feelings of failure emerging equally in both sets of data (N=14; Popular=7, Peer Review=7).

In comparing other themes by source in the Popular and Peer Reviewed line-by-line coded data (N=51) there are many commonalities in number of sources coded; Long-term Effects (Peer Review=8, Popular=9), Essentialism (Peer Review 4, Popular=10), Control (N=16; Popular=7, Peer Review=9), Unmet Expectations(Popular=6, Peer Review=11), Relationship (N=23; Popular=8, Peer Review=15), and Birth Story (Peer Review=14, Popular=20). Figure 4 depicts these themes.

Themes by Peer Review (N=23) and Popular (N=27) Source
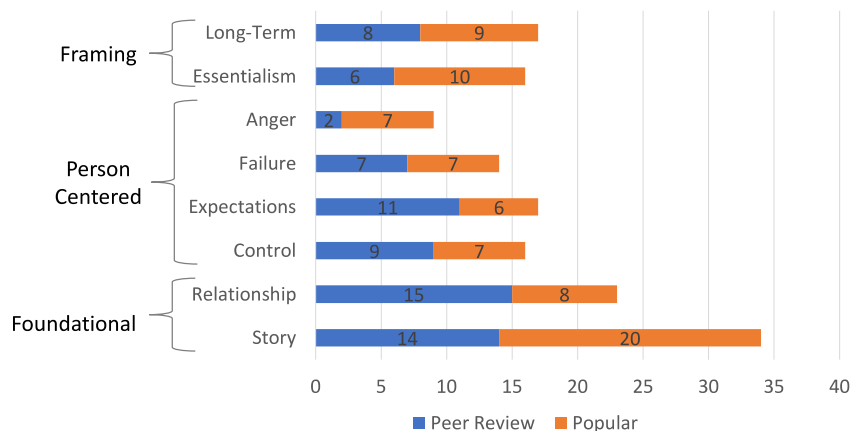
Figure 4 Themes by Source

4.2   Thematic Analysis: Foundational Themes

4.2.1   Birth Story and Relationship

Both datasets point to the emerging concept of traumatic birth as a subjective

psychological experience for mothers and narrative as a mechanism for processing events. "She

[the birthing parent] needs to make sense of her childbirth by reconstructing it and putting into

words what happened to her and how she felt" (PR18-Simkin 2006:6). The dominance of the

Birth Story theme in both datasets support the idea that birth is accepted as a threshold moment

and that incorporating the birth narrative into one's larger life narrative is important. The

following passage connects the importance of an individual's perception and the use of narrative

facilitated by "healthcare providers" around traumatic birth:

    Through narrative, a woman is able to tell her story as it is perceived by her alone…

It is incumbent on all those who have contact with a new mother, particularly healthcare providers, to listen to the telling and retelling of the birth narrative to gain an understanding of how her experience was perceived (PR17-Lear 2006:205).

This overreaching thematic constant of narrative creates the tapestry of meaning within which all the additional and varied themes are woven.

The texts indicate a cultural shift for birthing parents from a narrative around birth valuing health and safety as sole concerns to one with a focus on the quality of the experience and the reflection of individual wishes. The following quote from a peer-reviewed source is typical of the underlying message of this shift to highlight the importance of perceptions, relationship, and validation during the birth experience, "The difference between negative and positive memories of the birth experience depends not only on a healthy outcome but also on a process in which the woman was respected, nurtured, and aided" (PR22-Simkin 2011:170). The personal story of the birthing parent impacted through relationship is beginning to eclipse the importance of the medical birth story. This quote from a midwifery journal illustrates the privilege involved in the access to participating in this shift:

The main goal in childbirth, both for the expectant parents and those helping at birth, has always been that mother and baby should be safe and healthy at the end of the day. *Today many expectant parents take this for granted*. Their concern has shifted from just surviving the ordeal and accepting whatever others decide should be done to a concern about the quality of the experience... (SA3-Klein 2003:26.)

To be sure, a large portion of the population does not take safety and health "for granted" at the end of the day.

Like Birth Story, the theme of Relationship emerged as fundamental to understandings of traumatic birth in both sets of data. The social aspects of interaction at the individual level were important both during birth and in the postpartum, between providers, partners, newborns, and birthing people. The differing standpoints of the actors influencing the interpretation of the

events emerged as an underlying obstacle to this fundamental aspect of relationship with

providers:

> What a mother perceives as birth trauma may be seen quite differently through the eyes of
> obstetric care providers, who may view it as a routine delivery and just another day at the
> hospital (PR12-Beck 2004:28).

Perceptions of quality of care and overall experience of the birth experience is noted in this quote

around the same time period, "Women's satisfaction with birth is associated primarily with being

treated with respect and empathy by the caregiving staff, feeling in control over what is done to

the woman, and a sense of accomplishment in giving birth" (PR18-Simkin 2006:5). By using the

term "accomplishment" this statement also underscores the idea that there is a possibility of

"failure" in birth by contrast. Under the conceptual umbrella of Relationship, the data also

demonstrate a theme of mistreatment and experiences of abuse that are perceived in much the

same way as rape. This thread is not explored here as I believe it requires a separate and focused

examination in the future.

4.3   Thematic Analysis: Person Centered Themes

4.3.1   Perceptions of Control, Care, and Choice

Throughout the data, a tension between the perception of control for laboring

people and true agency emerged. Consider, for instance, this statement directed to providers:

"During labor and delivery, clinicians should strive to enhance a woman's *sense* of control by

offering her options when possible" (PR12-Beck 2004:29, emphasis mine). Additionally, the

following statement reminds us that laboring people at best have constrained agency in the

hospital setting: "Maternity professionals should therefore attempt to produce an environment

that provides optimal support and *feelings* of being in control, although it is acknowledged that

practicalities, i.e. staff shortages, busy wards, mean that this ideal is not always possible" (PR8-

Allen 1998:130, emphasis mine). Professionals suggest priming birthing parents for this scenario

when putting together a birth plan:

> Obviously, in her [the birthing parent's] birth plan (or another term instead of "plan" may
> be used), the woman should use polite and flexible language (couching her preferences in
> language such as "as long as the baby is okay," or "if no medical problems are apparent").
> (PR22-Simkin 2011:170.)

This excerpt also reveals the common message delivered to expectant parents to "stay flexible"

and strategize desires around birth through emotion work which is thought to better their odds of

achieving them.

 The impact of control on birthing parents' appraisals of birth is continually emphasized

throughout the texts. Peer-reviewed and popular articles point to strategies of planning and

preparation as pathways to achieve greater control. For instance, Gardner states, "Counseling for

these women should include information about resources that help them gain more control in

planning their next birth experience" (PR14-2003:2). Paradoxically, peer-reviewed texts also

frame this control-seeking behavior as problematic. For example, one journal states, "Difficulty

trusting authority figures, multiple questions and extremely detailed birth plans may indicate that

a woman has a strong need for control and severe anxiety about childbirth" (PR10-Reynolds

2007:833). This tension results in a conceptual bind where feeling out of control is a risk for

experiencing trauma during birth while at the same time needing to feel in control is pathological

and can lead to trauma as well. One source describes this paradox of control as a cultural catch

twenty-two, "In addition, it may be that increasingly well-developed expectations about control

and planning in life may lead to difficulty tolerating the uncertainty and unpredictability

associated with the birth process" (PR19-Slade 2006:104). Control plays into tension in the texts

around true agency for birthing parents and perceptions of provider care.

Per peer-reviewed articles, authentic control belonging to laboring people is subordinate

to the importance of *perceptions* of provider care in determining appraisals of traumatic birth.

For example, Elmir and colleagues suggest, "Healthcare professionals' demeanor and

interactions with women in labour have a major influence on women's feelings of control of

their birth experience" (PR20- 2010:2150). Suggestions emerge that completely empathetic

providers can make up for this lip service paid to agency. Simkin writes that "emotional safety,

with unconditional acceptance from and unity among professional staff and family supporters"

are imperative for a "good birth" (PR22-2001). Additionally, advice to sow "seeds of

accomplishment" after a traumatic birth encourages a paternalistic view of the relationship

between providers and birthing parents:

> Before leaving the birth, a few specific, positive, and complimentary words from the
> "expert"-the woman's doctor, midwife, or nurse-will remain in the woman's mind as she
> ruminates on her traumatic birth. Caregivers can plant a seed of accomplishment in the
> woman's mind by sharing constructive comments, such as the following: "I was so
> impressed when you said you wanted to try walking when the labor had stalled for so long";
> or ". . . when you said you wanted to push a little longer"; or ". . . when you realized that
> we had to get the baby out right away, and you said, 'Do whatever you have to do.'" (PR22-
> Simkin 2011:170.)

This strategy stands as an attempt to avoid the reality a birthing parent describes saying, "I would

have done anything to have this baby and *did* everything, even stuff I didn't want to. All I get

told when dealing with the residual emotional effects is, 'You should be happy with the

outcome'" (PR12-Beck 2004:34). The pointed validation in the previous excerpt is thought to be

important in dealing with such "residual emotional effects" and can be "planted" by

professionals.

Ideas of promoting choice and agency exist throughout the texts. In 2003 Gardner states,

"Giving birth is an empowering experience for women and their partners when they have the

opportunity to make choices that will influence the outcome of this significant life event" (PR14-

p.1). These "choices" though, must be made within an institutional context that privileges the power of providers as is clear in excerpts above. In spite of the best laid plans, the data suggest many desires surrounding birth do not come to fruition in traumatic birth experiences. These desires are often connected to the immediate postpartum period and are paired with intense emotions.

4.3.2 Unmet Expectation, Separation, Feelings of Failure and Anger

Many popular accounts reflect the disorienting experience of the separation of mother and baby immediately following birth:

> Twenty-four hours ago I had my first baby. I haven't seen him yet. As I approach a row of incubators I am crying. I ask my husband, 'Which one is he?' I guess I thought I should know. As I hold him I wonder if he knows I'm his mom. (P13-Leeks 1997:22.)

Two popular articles in 1994 describe a similar situation in conjunction with losing a "birth dream." These texts provide detailed accounts of birthing parents' experiences of childbirth regarding dashed expectations and separation from their babies immediately following birth. The first account links the birth process and immediate postpartum period to longer-term attachment and breastfeeding problems:

> I gave up my dreams of being so psychically connected with her that we'd wake in the night simultaneously for nursing, or that my milk would let down when she cried, even if I was away from her. The foundation for those connections is a gentle, drug-free birth with immediate bonding-which we didn't have. (P10-Osborne 1994:4.)

The birthing parent tells us what they learned through their own research and what they believe they lost. The second separation narrative emphasizes the "birth dream" contrasted with complicated medical realities:

> I didn't get the dream I envisioned.... Doctors immediately carried her to a table on the other side of the room to be revived, then rushed her out of the room to the neonatal intensive care nursery....We cried, but mostly we were in shock. Nothing could have prepared us for a birth like this. (SA2-Blanchard 1994:26.)

A peer reviewed article reporting findings from a qualitative study clearly states, "The women who participated in this study reported that their expectations for their labor and delivery care were shattered" (PR12-Beck 2004:32). Accounts of separation in the immediate postpartum period also tie unmet expectations to desires for embodiment in interpreting the birth experience. "Of all the things in our birth plan, the only crucial one was that we hold the baby immediately" (P10-Osborn 1994:4). The data reveal that expectations around birth can result in great loss when they are not realized.

Feelings of failure and anger in the text often surround birth and events in the immediate postpartum period. These events were related to interventions, birth ending in unwished for outcomes (particularly instrumental birth or cesarean), as well as birthing parents being separated from newborns. Many popular accounts use the explicit and succinct language of failure, "I felt like a failure, wrote Kim Barkwell of Bittern Lake" (P13-Leeks 1997:22) and "Initially, I felt shocked and that I was a failure" (P17-Hilpern 2003:14). Another 1997 story emphasizes an unexpected outcome and connects this event with the theme of failure, as Gunn explains "I'd set myself up for a natural birth and when that didn't happen, I thought I was a failure." She also describes preparing for a particular birth, in that she "set [herself] up for a natural birth," and describes feelings of entitlement when she states that "I also realize that I did not deserve that experience of birth" (P12-Harder-Gissing:9).

The emotion of anger often results from perceived failures resulting in separation from newborns, "I ache inside when I see pictures of mothers with their babies right after birth. I am still very angry about what happened" (P13-Leeks 1997:22). We hear in a longer passage the connection between anger and messages of the impact of birth on bonding, attachment, breastfeeding and perceptions of the birth experience:

> Suddenly, I was intensely angry at the hospital staff for whatever glitch had led them to believe they'd left a clip inside me. I felt terrified, too, that I'd missed a vital window to bond with my boy. Holding Charlie just after he came out of me was the thing I'd dreamed about most during pregnancy -- a rite of passage of motherhood that would signify we were hooked for life. But, no -- where was I? Passed out cold during Charlie's first few hours (P21-Kamps 2008:n/a.)

This excerpt represents multiple dominant themes: unexpected events in conjunction with the loss of a birth "dream," as well as the framing themes of long-term effects and motherhood initiation.

4.4   Thematic Analysis: Framing Themes

4.4.1   Long-Term Effects, Essentialist Definitions of Motherhood, and PTSD

The mainstream acceptance and broadening of popularized science around birth and its potential long-term effects on babies is an important theme. A book review of *Life Before Birth: The Hidden Scripts That Rule Our Lives* by Arthur Janov describes this developing understanding: "researchers are beginning to discover…that the events and environment surrounding pre-conception, pregnancy, birth and early infancy set the template out of which we live our lives." The article goes on to further describe the importance of early experiences and frames traumatic birth through epigenetics as an event that may affect future generations (SA8-Prontzos 2004:D4).

Many articles claim that traumatic birth can affect bonding for mothers and even the establishment of love. The controversial French (male) obstetrician Michel Odent is featured in a piece connecting industrialized birth to wide variety of potential issues including autism and anorexia (P18-Moorhead 2002). A view of dire long-term consequences is combined with an essentialist view of the mother infant pair:

> in a natural labour a woman produces what he [Odent] calls "a cocktail of love hormones" - principally, oxytocin. These, Odent believes, prime the mother and baby to fall in love with one another in the days after birth. As there is evidence that the quality of this first

attachment lays down patterns for all future relationships, human beings tamper with it at their peril (P18-Moorhead 2002:2.8.)

The lens of trauma through birth injury also widens by the final time period. For example, one article states that almost all US birthing parents and babies (98%) are victims of iatrogenic injury and ties these injuries, "caused by lack of support or respect, early cutting of the cord, separation of mother and baby or unkind words," to "deep, deep wounds that cause much damage" (SA5-Tritten 2007:7). The article cites autism, death, and "maiming" of mother and child as potential long-term effects of these injuries and points to resulting mood disorders in mothers who "should be happy and high" as a known but unrecognized "pandemic" for laboring people and potentially for newborns as well (SA5-Tritten 2007:7). Again, the underlying message of a critical period for emerging motherhood and well-being of the newborn contributes to distress around separation following birth. These dramatically framed claims surrounding long-term effects play into essentialized ideas of motherhood and connect the idea of bonding in the immediate postpartum period to "appropriate" behaviors and emotions around motherhood.

Immediate love, attachment, and feelings of fulfillment are compulsory in dominant culture around birth and motherhood today. A 2006 article reminds us that on the other side of any experience of birth should be a particular and complete "motherly" love. Simkin states, "At the end of all this, she has undergone a complete role change that includes responsibility for a tiny, dependent, helpless human being, with whom she falls unconditionally in love" (PR18-2006:5). When new parents deviate from this expectation, the medicalized frame of the postpartum period through established understandings of postpartum "mood disorders" is already in place. The data here suggest that the concept of traumatic birth offers a range of psychological possibilities beyond those established for postpartum depression for birthing parents who encounter emotional realities outside of the expected boundaries for motherhood. The excerpt

below suggests that birthing parents should be "monitored" for deviant feelings after giving birth even if they are "doing everything right":

> One in three women has a traumatic birth," she [the researcher] said, noting caregivers should monitor women, who demonstrate a lack of interest in their newborn, are reluctant or have an inability to breastfeed despite doing everything right or are overly protective of their baby, and ensure they get the help they need. (SA4-Kyle 2004:A7.)

Traumatic birth as a defining event for early motherhood emerged prominently in the data. This included several narratives in popular discourse like the following, directly linking feelings of failure after traumatic birth to postpartum mood disorders:

> Her problems started in September 2004 with the traumatic birth of her son Joey, now three. 'I felt I'd failed at the first hurdle of motherhood - giving birth,' says Ellie who then developed severe post-natal depression" (SA5-Courtenay-Smith 2008:28.)

For many new parents, this feeling of failure is framed as coming from subjective assessments of birth and the early postpartum period. One birthing parent recounts her difficulty adjusting to motherhood after a complicated birth. She describes a narrative of drawn out labor and its effects on her emerging identity as a new mother, "The five days of start-and-stop labour, an emergency c-section and a lingering haze of medication left me exhausted as I began the adjustment to being a new mother" (P13-Leeks 1997:22). Finally, Allen reflects this idea in a peer reviewed article stating, "Socialization, and cultural stereotypes relating to motherhood being only a positive experience, also influence feelings of failure and distress when expectations are not met" (PR-8 1998:107). A popular account specifies separation from the newborn as a trigger event of mood disturbance, "Gunn was not allowed to see her baby for eight hours and believed this triggered the depression" (P12-Harder-Gissing 1997:9).

In later time periods, traumatic birth is seen as a trigger for disruptive distress during the postpartum period distinct from that of postpartum depression. Hilpern makes this argument, stating that, "PTSD is distinct from postnatal depression and far more damaging," and goes on to

link to maternal suicide to PTSD resulting from traumatic birth: "'Suicide is now the largest single cause of maternal death,' adds Robinson, who believes that many of the cases are due to PTSD" (P17-2003:14). This idea is further articulated through the diverging frames of postpartum depression and PTSD in the following excerpt:

> The term "postpartum depression" is actually misleading, as some women do not experience sadness but feel other very intense emotions. Miller said, "I felt very blindsided by my experience of postpartum depression primarily because I didn't feel depressed. My symptoms included anxiety and panic attacks, along with intrusive thoughts of harm coming to my baby. I also experienced a lot of trauma during my labor and delivery and I would relive these traumatic birth memories, which only added to my anxiety. (P20-Boulach 2007:E1.)

This account also expresses unmet expectations at the level of medicalization and demonstrates how mainstream cultural knowledge of postpartum depression impacts individual interpretations and the construction of postpartum experience. The alternative framing of traumatic birth linked to PTSD accommodates a different set of postpartum symptoms with a difficult birth acting as a focus of origin. Overall, the data speak to the emotional weight of long-term consequences and expectations driven by intensive "mothering" practices and standards that demand a high level of investment and include the risk of "failure."

5   DISCUSSION AND IMPLICATIONS

The data reviewed in this study illustrate the development of a multitude of important conversations around traumatic birth in the Global North today. The themes analyzed and discussed in detail here represent just one prominent narrative of many throughout the texts. While the increase in awareness of maternal health issues globally in the past 40 years, as well as research and discourse around trauma can partially explain the emergence of this concept, the exponential increase in discussions of traumatic birth seems timely for other reasons as well. The industrialized birth experience encountered by the vast majority of laboring people today

continues to impart interventions, protocol, and surveillance in ways that fail to achieve

humanized health *interaction* much less true health*care*. My findings and the literature suggest

that people across the spectrum of birth experiences, from low intervention to highly

medicalized, may define their birth as traumatic. It is the challenge of the unexpected,

complications, and the break-down of social support, rather than the face-value acceptance or

resistance of medicalization that most greatly impacts birthing parents' accounts of

psychologically traumatic birth. My findings around separation in the data contribute to a better

understanding of the mechanism through which complicated birth may create especially

distressful feelings for birthing parents today.

Reducing the phenomena of traumatic birth to binaries of over-medicalized versus natural

birth does not explain and cannot correct this contemporary phenomenon. Thus, social and

cultural contingencies of birth need to be considered when analyzing meaning making. Finally, it

is important to address issues of privilege emerging from this expansive study of the past 40

years of available literature. The access to privilege and social capital that allow particular voices

and birth stories to be heard is evident as well as the privilege involved in constructing the

contemporary definition of traumatic birth.

5.1 Socio-Historical Context of Birth: Technology, Consumerism, and Privilege

Paradoxes abound when analyzing the context of the emergence of traumatic birth. It is

undeniable that birth plunged into industrialization since the 50's, but at the same time an

opposing frame in the Global North emerged, idealizing the "third world" experiences of

"natural" birth (Johnson 2016:58). My findings illustrate how messages around the importance of

practices like to skin-to-skin contact emerged over the past 40 years as part of the "authentic"

and "sought after" experience of childbirth. Thus, many parents evaluate their birth experience in

relation to their "achievement" of such experiences today. This evaluation is multiplied and emphasized by both social and mainstream media presentations of birth and motherhood.

Findings here support existing literature (Zwelling 2001; Phillips 2003; Katz 2012; Kuo 2012) which argues that between the 80's and 90's people giving birth in hospitals experienced some tentative gains in autonomy and increased desire for a relationally-based birth. For example, by 1992, the institutional birth experience moved to a one-room model for labor, delivery, and postpartum, significant others were invited to be a part of the experience, and prepping procedures like pubic shaving had been discontinued (SA1-Yarrow 1992). With these perceived changes, came an increased expectation of individual control of the birth experience. While mothers and the general public accepted all of the "family centered maternity care" developments between 1980 and the early 90's with gratitude (SA1-Yarrow 1992), cesarean rates during the same time period doubled in the U.S.

Approximately one in three laboring people gives birth via cesarean; a statistic at odds with prominent ideology around birth in the Global North that values a less medicalized birth process. Evidence of the appeal of this ideology is seen in marketing materials that offer "a home-like birth experience" and convey a commitment to keep mom and babies together during their hospital stay. However, the reality is that more cesareans means more newborns spend their early days in the neonatal intensive care unit (NICU). A recent study concluded that from 2007-2012 the admittance of newborns to the NICU *across all birth weights* increased by 23% (Harrison and Goodman 2015). Further, the data found here present a vagueness and flexibility around the concept of traumatic birth for babies that affords increased opportunity for institutional intervention,

> …but complications came within 15 minutes as what they [medical staff] labeled a "traumatic birth" had somehow taken its toll on Grace and she was not responding as they

had wished after being toweled and suctioned, swaddled and capped and held by her adoring parents and grandparents (SA7-Cloud 2008: C.2.)

Phrases found in the data, like "as long as the baby is ok," and "if no medical problems are apparent," indicate the continued focus on possible infant "abnormalities" in childbirth that require intervention (PR22-Simkin 2011:170). Whether newborns end up in the NICU or not, due to institutionalized protocol, cesareans increase the physical distance between birthing parents and babies in the immediate postpartum period.

Dominant birth culture in the Global North informed by intensive mothering ideology frames birth not only as a personally important and life changing event but one with serious and fundamental long-term consequences for baby, mom, and the family system as a whole. In order to benefit from this critical period for both themselves, their child, and family laboring people have to call on cultural capital to avoid trauma or avoid being "traumatized" by difficult events. A mother and writer speaks to this idea from a white middle-class perspective:

> "We were a generation of hollow-eyed women, chasing virtue," she tells us. She was constantly terrified in the wake of her daughter's harrowing birth, which left the baby temporarily in quarantine and hooked up to an oxygen tank. "The bargain was this: I will do everything perfectly and avert disaster. My idea of motherhood grew from this bargain." (P27-Shapiro 2010: B.9).

While the middle-class may interact with intensive parenting from a privileged view point, every birthing parent is subject and policed according to its tenants. Failure looms large for all within a parenting culture that calls for high levels of emotional investment and an all-consuming attention to every detail of child-rearing beginning even before birth.

Modern birth practices act as an initial testing ground for maternal knowledge and competence for birthing parents in the Global North. This idea is complicated by the accessibility of information and messages of responsibility like this one, "You have a right to choose the type of birth you want. There is nothing wrong with questioning the use of routine protocols and

taking more control and responsibility over the birth experience" (P19-Szalay 2003:08). The data discussed here show an emphasis on the importance of relationship with providers and messages of responsibility for birthing parents to ensure overall provider "fit" through consumer choice. Both sets of data indicated communication and the perception of quality of care and relationship as important to mothers before, during, and after birth. Finding a health professional deemed suitable to provide the support and care necessary for the preferred birth experience may be the first step in dominant prescriptions for getting it "right" in motherhood today. Thus, the large proportion of parents in the U.S. who lack access to insurance and choice of health provider are destined to fall short of this cultural standard.

5.2   Laboring Bodies and Psyches within the Medical Industrial Complex

As actively laboring bodies inside institutions, birthing parents are influenced both by physiology and by the institutional assessment of their bodies' physiology in labor. The data clearly exhibit the idea that subjective experiences of birth are greatly impacted by assessments of relationship and whether or not laboring people feel connected to those responsible for providing support. A deep analysis of the texts reveals that this connection includes "being heard" as an embodied voice as well as being included as an embodied stakeholder in the decision-making process. Birthing parents who experience birth as traumatic often report "being talked over" and recall conversations among professionals who ignore their presence. Feelings of betrayal contribute to a fractured reality that is experienced as highly stressful during the process of birth for many.

The data support a perspective established in previous literature distinguishing disembodiment during birth from feelings of alienation (Walsh 2010). Walsh disentangles the concept of alienation in birth from both the agency based "disembodiment" some birthing people

use as a strategy to cope with pain as well as the experience of "letting go" and giving in to the

body's physicality completely (2010:496). "Alienation negates any agency and the woman is left

in limbo until she can ground herself again with some meaningful embodied subjectivity. It may

be that this experience of alienation is at the kernel of birth trauma narratives" (Walsh 2010:496).

Evidence here aligns with literature that suggests the industrialization of birth, particularly seen

in discontinuous labor support and insensitive protocols, creates a sense of alienation (Rothman

2016:93).

Narratives of separation throughout this work contribute to the idea that this unresolved

alienation may be a core element of traumatic birth today. Further, the data underscore the idea

that any institutionally enforced separation of neonates from their mothers immediately

postpartum creates substantial distress. An "ideal birth" in the texts reveals an emphasis on

continued bodily contact, "I especially looked for pictures of the ideal birth where everyone is

smiling and the wet, shining baby is laid on the mother's chest" (SA2-Blanchard 1994:26).

Further, from a corporal realist perspective, birthing parents' perceptions of birth include

challenges navigating the understandings of their physicality contrasted with social meanings of

that reality within the institutional setting.

Birth involves a kind of dual bifurcation of consciousness in that a person giving birth is

moving between the highly contrasted spaces of "labor land" (the physical and psychological

sensations of birth) and the everyday world (the hospital). A birthing person is also navigating

between institutional knowing and embodied knowing. As suggested by Root and Browner,

"pregnancy is, above all, characterized by a split subjectivity in which women straddle the

authoritative and the subjugated, in telling and often strategic ways" (2001:195). I note in the

texts that informed "choices" in both sets of discourse are usually made *before* birth and

informed "decisions" are made *during* birth. These "decisions" are often made in tense dialogue with providers expressing their authority in popular texts, while at the same time peer-reviewed texts encourage providers to work toward helping laboring people *feel* as though they are participating in the process. The data suggest that when laboring people cannot reconcile this split reality or forge a satisfactory outcome for themselves it can be particularly difficult.

The contested politic of the laboring and mothering space is not new and neither are the feelings that accompany mistreatment and unwished for outcomes. Forssen recently shared results from in-depth interviews with Swedish birthing parents who experienced "violations of their dignity and abuse" while giving birth in the mid 1900's and found many of the same themes as those in accounts of traumatic birth today: "The women experienced feelings of failure as mothers, of guilt, and of shame, which influenced their self-esteem and their future childbearing" (2012:1543). The current data contextualize these historically pervasive themes of birth within an expanding lens of trauma and under the additional pressure of parenting culture.

In line with Foucauldian ideas of the interplay between the individual and medical institutions (2003), the internalization of medical authority that demands our bodies to "behave" in birth, or be disciplined into conforming to institutional standards, creates a sense of failure when complications arise and our bodies do not comply. Extending beyond birth, this internalized medical gaze is illustrated in personal accounts in the popular and peer reviewed literature during the postpartum period that point to traumatic birth as a point of origin for distress. As noted by Simonds, medicalization involves "understand[ing] one's body, mind, [and] self through a medical lens" (2017:11). This self is in flux during birth and the immediate postpartum while consumed with developing and integrating an emerging identity. The findings here demonstrate that a subset of birthing parents is utilizing the medical lens of trauma to make

sense of challenges around this complicated transition. The medicalization of the postpartum period by health authorities in recent decades cleared the way for understandings of trauma to incorporate postpartum distress. As the benign form of postpartum depression (affecting 1 in 9 birthing parents nationally), the "postpartum blues," is reported to affect 75% of the birthing population (Ko et al. 2017), following a similar formula traumatic birth is reported to affect up to 45% with a much lower number developing PTSD.

Who has access to the privilege required to reject and accept medicalization based on individual desires? The data illustrate the fact that a segment of birthing parents is reporting unplanned and emergency cesareans as an origin of trauma while at the same time embracing scheduled cesareans as a strategy for avoiding subsequent trauma. Economic as well as social capital to communicate and navigate with agency amid the medical industrial complex is mandatory for this type of control and self-determination. Who defines traumatic birth and who benefits from this form of medicalization? Traumatic birth as it is conceptualized in the data is bound to dominant culture through expectations and socially located perspectives within the institution of medicine. For example, I suggest the relational subthemes of trust and betrayal regarding the birth experience are particularly salient for white middle-class birthing parents because prior experiences contribute to expectations and establishment of trust. I posit the distrust many birthing parents in hold regarding the institution of medicine would likely prohibit the possibility of "betrayal" as it is described here. Presumably, differences in interactions within the institution of medicine due to social stratification by race and class influence the experience of psychological trauma related to childbirth.

It is important to situate the emerging concept of traumatic birth within this current moment in U.S. history. The U.S. ranks at the bottom of comparable countries in maternal health

outcomes (Kassebaum et al. 2016). Popular and Peer reviewed findings showed an increasing awareness of the intersections of class and race in child birth experiences in the years between 2010 and 2015. Racism and stratification within the healthcare system create differences by race and class in maternal treatment both at the individual and institutional level. While research around discrimination and its impact on *initiating* prenatal care shows an inverse relationship, researchers are just beginning to explore social determinants of disparities in prenatal care on maternal *outcomes* (Gadsen et al. 2017;). A large national survey cited by a popular article revealed that 24% of respondents experienced discrimination during their hospital stay and Black and Lantinx birthing parents were much more likely to report discrimination, citing race, language, or culture as the cause (Listening To Mothers III 2013). Findings like this strongly indicate more work in this area is imperative.

5.3   De-Essentializing and Grounding Birth and Early Parenthood

In line with Simonds and Rothman (2007), Simonds (2017), Rothman (2016), and others (Oparah and Bonaparte 2016) writing on birth and the medical industrial complex, my research indicates that steps toward dismantling the patriarchy, extreme capitalism, and white supremacy, undergird any true action toward making birth supported and valued within society. Addressing traumatic birth as a culture includes normalizing a spectrum of ways to create family and give birth while validating a range of ways to cope with the pain, uncertainty, and unexpected events inherent in the process. Taking the lead from reproductive justice groups lead by people of color, I attempt to use language in this paper that best imagines and allows for unlimited possibilities regarding sexuality and gender for birthing parents. This starting point of resistance to dominant ideology and acceptance of authenticity, serves to support ideas for uncoupling birth from traditionally rigid expectations and roles for laboring people.

Childbirth preparation classes and material can avoid promoting essentialist rhetoric and particular outcomes by discouraging dichotomous thinking (ie. good/bad, black/white, success/failure) while promoting and fostering the discovery of an expanded range of expectations. This intention represents a natural extension of a larger agenda aimed at social justice as well. Additionally, parenting educators and childbirth professionals should work to dispel myths about "instantaneous" bonding by providing information about attachment that emphasizes the non-biological aspects of a process that develops over time and can (and does) occur well after the immediate postpartum. Educating parents about the fact that evidence-based benefits of skin to skin contact are not exclusive to birthing parents and newborns but are elements of care that any willing and loving adult can provide is also important. Additionally, de-emphasizing "long-term effects" tied to fleeting periods in the immediate postpartum that exclude a wide array of experience and privilege a particular, often uncontrollable, circumstance would go a long way toward lessening feelings of "failure." Instead, emphasizing the effects of a long term authentic (yet inherently imperfect) relationship over the life course between family members creates realistic and achievable expectations for most.

Avoiding alienation in birth can be achieved by grounding the experience through relationality and is linked to empathy. As Walsh states,

> During these times [of alienation during birth], achieving a grounding may be crucially linked to interpersonal connection with a childbirth carer or companion…In its simplest form this may require ongoing communication, kindness and empathy only, with additional clinical skills of secondary importance." (2010:496.)

The findings here implicate the importance of relationality and perceptions of care particularly between laboring people and support figures. This connection that people need for an integrated experience of birth is possibly the simplest yet hardest thing to achieve within an institutionalized framework.

Ideas of empathy seen in the peer reviewed texts attempt to change laboring people's *perceptions* of care yet do not maintain individual integrity and certainly do not go far enough to actually change the broken provider/patient paradigm. Empathy is not successful when used as a tactic to maintain favorable optics but only when utilized for genuine connection. While empathy may be a contemporary buzzword, it holds important meaning in sociological understandings related to the critical role of alienated relationships in upholding oppressive social hierarchies (Feagin 2006; Moore 2008; Chou 2015). True empathy pushes providers outside of rote behavior protocols and institutionalized manners of interacting to *authentically* connect. This act of care requires a lack of fear regarding closeness and emotional response, two relational values highly regulated by hegemonic masculinity and strictly ruled (and disciplined) within the institution of medicine. Our society would benefit from valuing emotional intelligence and socializing *all* people to recognize, name, and sit with a full range of feelings. To address the problem of emotional burn out and shut down for practitioners, researchers in the field of nursing suggest ongoing mandatory debriefing sessions for all birthing professionals to acknowledge and process difficult experiences on the job (Beck, Driscoll, and Watson 2013). My analysis fully supports this idea.

In conclusion, the data suggest that positive relationship and care at the micro level may create a bridge that unifies subjectivities of the birth experience for laboring people and prevent suffering in the postpartum period. All laboring people would benefit from intra and interpersonal connection no matter how they give birth. The default for many laboring people who experience a disconnected birth is to internalize the failure of the medical industrial complex to adhere to protocol that respect agency and humanness in birth. To combat this, it is

necessary to a push for policy that supports agency and "yes means yes" forms of consent, backed by the recent recommendation by ACOG (2016).

Finally, the data display an urgent need to ground both birth and the early parenthood experience in social relationship. Family centered cesareans that include various accommodations for connection (including lowering the dividing drape during the birthing moment) and allowing contact between the baby and birthing parent during recovery are limited throughout the U.S. but successful and should be the standard (Tumblin 2013). Community building approaches for maternity care like Centering Pregnancy groups that utilize a cohort system of care with the added benefit of continuous peer-support also deserve more attention (Centering Healthcare Institute 2018). Efforts should be made to make programs like these more widely understood in the mainstream and easily accessible for all pregnant people. Additionally, policy that supports paid family leave would act to de-essentialize family work and lessen stress and anxiety for all new parents. This kind of policy also diffuses stress and apprehension around separation from the newborn due to paid work responsibilities as well as provides less constrained time for developing families to ground themselves through relationship in their new life together.

5.4   Limitations and Future Research

While this content analysis is helpful in gaining a particular understanding of conversations in the popular and academic literature around traumatic birth, it is a view limited by the privilege of access to knowledge production. While birth has historically been fraught with trauma and remains traumatic for marginalized people in the U.S., the data engages minimally with this reality. I did not find evidence that the medical community has considered the possible relationship between psychological trauma during the birth experience and the dire

disparities between social categories in maternal morbidity and mortality. There are presumed differences the data does not represent in the way potentially traumatic birth experiences are perceived, interpreted, and defined by birthing parents due to disparities in economic, social, and personal resources (i.e. the time, space, and energy to process the experience).

Many important themes in the data could not be extrapolated in this work due to constraints of time and scope. Themes related to pain, abuse, and sexuality deserve a separate analysis and discussion. As do links between the concept of obstetrical violence originating in the Global South and the emerging discussion of traumatic birth and related activism in the U.S. Finally, a country comparison including the UK, AU, NZ and the US would lead to a better contextual understanding of issues of colonialism and the impact of varying health systems on traumatic birth experiences.

6   CONCLUSION

Birth is an everyday occurrence, yet one that can be emotionally complicated at its core and made even more challenging through required interactions with medical institutions. We know that mothers are experiencing difficult births and that white middle-class mothers, in particular, have reported experiencing psychologically traumatic birth at substantial rates; up to 45% according to one source (Beck 2013). The data examined in this investigation demonstrate tensions around expectations, embodiment, medicalization, relationship, and resulting negotiations of power.

Who gets to tell their birth story? and who is listening? Who can take health and safety for granted and expect "more" out of the birth experience? Class, race, and consumerism are part of the larger story of contemporary understandings of traumatic birth as explored in this project. The dominant message of "informed" birth as a path to wished-for outcomes creates a particular

dilemma for educated (predominately white), middle-class birthing parents. These parents often research and prepare intellectually for birth but are confronted with unexpected outcomes and institutional realities during the process. Traumatic birth as it is understood currently, helps explains the resulting unresolved identity challenge and the accompanying emotional turmoil that can extend into the postpartum period, creating a shaky start for a many new mothers. Childbirth is largely a consumerist and intellectual pursuit in Western culture for the middle class; as Rothman points out, "Babies are not products. They are relationships" (2016:253). It stands to reason that babies, as well as *all* pregnant and laboring people, would benefit physically and psychologically from a relationally-grounded and culturally-sensitive birth experiences.

I propose that we consider experiences of birth within the context of cultural and social factors with multiple sites of intersection and most importantly turn toward birthing people not centered in the current data. This approach also includes looking outside of traditional and mutually exclusive frameworks of the "natural" and "medicalized model" of birth and points to a newly emerging cultural framework of that exists in relationship to the absence or presence of trauma. Today birth is overwhelmingly perilous for black, brown, and poor birthing parents while the emerging concept of psychologically traumatic birth is primarily defined by, and accessible to, those who are at substantially less risk. Celebrity narratives of traumatic birth in popular U.S. media like those of Serena Williams and Beyoncé bring the voices and lived experience of birthing parents of color into public view while movements against obstetrical violence in the global South and activist movements based in the U.S., including Sistersong and Black Mamas Matter, continue to bring attention to the collective traumas of marginalized groups around reproduction. Aligning with a history of resistance, Black communities continue a

mission toward reproductive justice by reclaiming traditional ways of knowing and promoting advocacy and agency in healthcare (Decolonizing Birth Conference 2018).

This thesis presents the finding that a range of birth experiences have the potential to significantly affect well-being for new parents. A thoughtful approach to investigating birth today requires us to explore the influence of social factors like emotional and practical support, culturally specific understandings of birth and motherhood, racism, discrimination and access within the health care system, varied subjectivities, as well as issues of identity. Birthing people are not a monolithic group. Researchers interested in the phenomena of traumatic birth need to be sensitive to the multi-dimensional aspects impacting birth and create space for birthing people to lead the discussion. Narratives of marginalized birthing people should be sought out and listened to by policymakers with particular urgency. This thesis provides a first step in describing the sociological framing of the phenomenon of traumatic birth. My hope is that it provides background for more specific research of less-studied populations in the U.S. and possible links to disparities in postpartum maternal health outcomes.

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