

**Someone Else's Child:
Women's Experiences of
Disconnection and Birth Distress**

by

Helen Marie Dunn
B.A., Queen's University, 2000

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Approval

Name: Helen Marie Dunn
Degree: Master of Arts
Title of Thesis: Someone Else's Child: Women's Experiences of Disconnection and Birth Distress

Examining Committee:

Chair: Dr. Sharalyn Jordan
Assistant Professor of Counselling Psychology

Dr. Patrice Keats, Ph.D
Senior Supervisor
Assistant Professor of Counselling Psychology

Dr. Janny Thompson, Ph.D., R. Psych
Supervisor
Assistant Professor of Counselling Psychology

Dr. Erika Horowitz, Ph.D., R. Psych
External Examiner
Associate Director
SFU Health and Counselling Services

Date Defended/Approved: September 26, 2011

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Abstract

The increasing rates of caesarean sections worldwide raise critical questions about the effects of such births on women and on their attachment relationship to their infants. This research examined the subjective experiences of women who have experienced both a caesarean section and a vaginal birth (with a particular focus on the caesarean section experience) using semi-structured interviews and a narrative method of analysis. Analysis of the resulting narratives revealed common themes across participants: suffering a traumatic experience, forces of relation, and expectations of birth and bonding. The results of this research indicate that some women whose infants are delivered by caesarean section may experience a subjective feeling of disconnection from their infant as well as profound birth distress. These experiences are presented and explored using the narratives of the women themselves. This research is of particular interest to mental health and birth professionals who may wish to gain a greater understanding of the effects of birth experience.

Keywords: Disconnection; Birth Trauma

Acknowledgements

When I first set out to conduct this research project, I had no real idea of what my topic would be. I knew that I wanted to do something around birth trauma, specifically caesarean sections, not simply because I was interested in trauma, but because that was what I had experienced. When I pitched the idea to Dr. Patrice Keats in 2009, I was pregnant with my second child and hoping that Patrice would not only take a chance on me, but that my labour and delivery would go differently than it had with my first son. Fortunately, both hopes have been fulfilled, and both came together beautifully to give me, not only a unique research topic but a unique opportunity to meet other women like me, share their stories and perhaps along the way make sense of my own.

As I write now, it has been exactly eight years and one day since I had an emergency c-section with my first son. Just over two years ago, my second son was born vaginally, midwife assisted. This past year I have heard a lot of stories, opinions, arguments, and pleas from women who have experienced these two vastly different births, but I have also heard from women who are deeply invested in the care of these women: activists, nurses, public speakers, midwives and renegade midwives, and mental health clinicians. I want to extend my deepest appreciation to these women: particularly those that called me, opened my envelopes and posted my participant recruitment flyers, emailed my call to their mailing lists, sent me articles and resources, and especially those women who

allowed me to witness and record their stories. They met me in their homes, at the library of my school (infants in tow), at my home, and long distance over the phone. To you, my research participants, my co-researchers, I extend my thanks for your bravery, your honesty and your vulnerability. Every woman I spoke to expressed the deepest desire to make a difference in the lives of other women and the hope that their participation in this research will do so.

Thank you to Dr. Patrice Keats for all of her hard work and dedication on this project, for her knowledge and support. Thank you for believing in my work and me. Thank you to Dr. Janny Thompson for her feedback and guidance.

Thank you to my family for their encouragement and sacrifices they made in order for me to complete this project, particularly my sister Barbara who never, ever failed to help me when I reached out for support personally or academically. Thank you to Sean for all of his help in my completion of graduate studies with two small children. Thank you to my father Derek, my sister Catherine and especially my mother Monika, without whom I would never, ever had been able to complete this work. Thank you finally and most especially to my children, Malachy and Micah, without whom none of this would have been possible, I love you all very much.

This project is not the end all, be all, of this entire topic; there is much more work to be done, even stemming from these interviews themselves. Expressed in this work are only one-half of my participant's experiences. Left unaddressed and unexplored are the experiences of these women and vaginal delivery. I hope in the future to write more about these experiences and how

they are related to the piece of work presented here. This project is a starting point for which future research will be conducted. There are so many more aspects to explore of the experiences of these women, their children, their families. My hope is that this project will open a door to a dialogue, an understanding, a difference in the way women and their children are treated in all models of care both traditional and otherwise. My deepest belief is that the quality of the relationships between women and their birth experiences, women and their infants is the starting point from which all the positive change and growth in any society occurs. My highest hope is that this work will create awareness and change, positively affecting the experiences of women and their children.

Dedication

I would like to dedicate this work to my mother and my sons—thank you for teaching me how to mother. In addition, I dedicate this work to the women who participated in this research and their children:

May you be well.

May you be happy.

May you be free from suffering.

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Chapter 1. Introduction

The birth of a child and the experience of holding one's baby for the first time are often lauded in North American culture, as some of the best experiences of a woman's life, as moments of joy, relief and satisfaction. However, in the lives of some women, this first meeting may be quite different from these idealized images. A woman who has just endured the painful and often terrifying event of a caesarean section (c-section) may look upon the infant presented to her with emotions that are anything but positive: aversion, fear, dread, even anger. Some women, may look upon that child, and feel perhaps the worst feeling a new mother can experience: nothing at all, as if the child held before her is not her own but a perfect stranger who is now entirely dependent on her care for survival. This phenomenon of disconnection from one's child has been mentioned many times in the research literature in relation to postpartum depression, posttraumatic postpartum stress disorder, or an otherwise disrupted attachment. These terms have been defined in the Literature Review section of this text. However, there is a lack of research on the subjective experiences of women who have endured and struggled to make sense of this phenomenon. In this research, I hope to illustrate and highlight the role that a birth trauma, such as a c-section section, may play in a mother's perception of the early relationship between her and her child. Specifically, I would like to demonstrate that in women who have experienced both a c-section and a normal vaginal delivery, a

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pervasive sense of disconnection and birth distress may occur in the former and be glaringly (and gratefully) absent from the latter. Similarly, I would like to convey how women, using adjectives and metaphors, describe their subjective feelings towards their child and the sense they make of their experience.

Personal Narrative

My interest in this topic is both personal and academic. The birth of my first child was by an emergency c-section after a failed 17 hour induced labour. I heard the fetal heart monitor that I believed was standing guard over the life of my child stop registering his heartbeats. I heard the footsteps of the nurse in charge as she ran into the hall and saw the face of the obstetrician looming over me, "We need to get this baby out now." I was terrified, something terrible was happening and it was entirely out of my control to stop it. I do not remember much of what happened next until, somewhere, I heard a baby crying. It was my baby, the child I had no memory of delivering, the child that was taken from me in cold surgical precision, and the child that I was terrified I might lose. I do not remember my feelings then, if I wanted to see him, if I wanted to hold him, if I wondered about his condition, or mine. I remember the nurse showing him to me, wrapped tightly, stocking cap on his impossibly small head, his eyes looked gummy and glazed, and his forehead wrinkled and red. He stuck his tongue out at me. I remember very clearly what I felt and it was something I kept secret for months and I would continue to keep until my distress caused me to share it. The

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secret? I felt nothing. This child was a stranger to me, an impostor; he should have been someone else's child.

Since that time, I have received many different kinds of treatment and support to make sense of the experience I had. I saw a therapist well versed in these types of experiences. I saw a psychiatrist and two psychologists. I attended two support groups. I read books. I met other mothers with whom I grieved my lost experience and my lost relationship with my son. I wondered what had happened to me and what had gone so terribly wrong. After our son was born, I remember telling my husband that I had not once called the nurses for help during my three-day stay at the hospital. "I'm a natural mother," I said but I felt anything but natural. Instead, I felt intense shame and great pain around my feelings towards my child. My attempts to reach out for support were clumsy and ineffectual. I told a nurse I felt "funny" and she said it was the drugs. Months later, I finally got the courage to tell my trusted therapist what was happening to me and she responded with her own story of disconnection and pain. Her experience resonated with mine and her shame was so deep and profound that at age sixty, *I was the first person she had ever told.*

Almost six years later, I found myself in the throes of labour again. It was different for me this time. I knelt on my living room floor, my husband rubbing my back and chatting with the midwife sitting next to him with the drone of the television in the background. When the labour became very advanced, my midwife decided it was time to go to the hospital. Attempting a vaginal birth after caesarean (VBAC) I wanted to be sure of medical care in case something went

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wrong (a decision that I would reconsider in the future because I was just fine at home). Twenty minutes later, I gave birth to my second son: one big push and he slid into my husband's hands. At the midwife's prompting, he held the baby up and I pulled him to my chest. His face struck me: moon like and round, dark shining eyes, and a familiarity I cannot begin to express in words. My baby, my child, in my arms after that long, long wait and I knew he was mine. I felt a rush of love and a sense of familiarity for him immediately. The contrast between my two labours continued to haunt me for many years and I continue to feel deep regret and sadness for my first little boy. One child, cut out of me and removed, the other eased out, in tremendous pain but in perfection; I never once mistook him for a stranger.

During my graduate studies in Counselling Psychology I found myself in a unique position to have the opportunity to explore this topic. With a strong desire to do this research project, I now had the means and the opportunity to hear the stories of other women who had had similar experiences. Would their stories be the same or different than my own? What were women's possible subjective feelings of disconnection from their children delivered by c- section and how did they make sense of their experience? Through the following text, I will take you through the literature on the topic, the method I used to answer these questions, the women's experiences, and the conclusions I have drawn from their stories.

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Background

The rates of c-section have been on a steady increase in the Western world: in Canada and the United States the rate is over 30% of all deliveries. As a result, many more women are delivering their children in a highly medicalized, often traumatic manner (Meddings, Phipps, Haith-Cooper, & Haigh, 2004). Several theories have been offered for the rise in the use of this intervention. Specifically, the notorious unreliability of fetal heart monitors, practitioners' fear of litigation, and maternal choice (Eyer, 1993; Meddings, et al. 2004). Some women have reported feelings of disconnection from and even aversion to infants they have given birth to in this way.

In this research, I explore the narratives of women who have experienced two types of deliveries: a c-section, and an uncomplicated vaginal delivery. Specifically, I seek to understand further women's possible subjective feelings of disconnection from their children delivered by c-section and to explore how they make sense of their experience. I chose to interview women who had had both experiences in order to hear from women their impressions of the differences and similarities between those experiences. It was my hope that women who had a basis for comparison would be able to more explicitly convey in their narratives what was distressing for them about their experiences. In this thesis, I have placed particular emphasis on the c-section experience, with occasional comparisons between the two, as my primary area of interest is in women's experience of disconnection and birth distress and in this sample, these subjective experiences were absent from participants' vaginal births.

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Method of Inquiry

I used a narrative method of inquiry conducted through a feminist lens in order to analyse the data I collected.

Narrative inquiry. Narrative inquiry is, in its essence, the presentation and examination of stories. In the realm of qualitative research, narrative inquiry strives to present the stories related by research participants to the audience in a way that is holistic and as close to the original telling as possible. In the research I have conducted here, my focus has been on the stories of women who have had two categorically different experiences in the labour and delivery of their babies.

Feminist lens. The importance of narrative research through a feminist lens is not limited to the fact that all of my research participants are women. Pregnancy, labour, delivery, birth, and the post-partum period center around women and their babies. Women alone have had the great pain and privilege of this experience. At the same time, women's voices have been silenced in a variety of realms and that of pregnancy and birthing has been no exception. Over time, labour and delivery, once the domain of women supporting other women, has become the territory of the medical establishment and its patriarchal norms, which has led, for example, to the movement from women labouring as they felt most comfortable, to the confinement of the lithotomy position for the benefit of the male doctor (Simkin & Klaus, 2004).

In utilizing a narrative method of inquiry through a feminist lens, I have sought to relate the stories of women, their perspectives and experiences as a

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marginalized group, to the reader. I have done so with a view that many of the shared experiences of these women occurred in the context of a male dominated medical model of care and certainly, existing within a patriarchal culture and were influenced in part by the media and other purveyors of societal norms. Societal pressure on women as mothers is a complex and multifaceted issue involving considerations not only of gender but also of power and privilege, including race, class and sexual orientation. To illustrate this point:

In the 1970's, Ann Oakely described the contemporary myth of motherhood as resting on three beliefs: "that all women need to be mothers, that all mothers need their children and that all children need their mothers." Each of these beliefs is made plausible by the social and cultural conditioning that impel women to become mothers. Further the beliefs are buttressed by 'science'. (Glenn, 1994)

Women have suffered in silence with the divergence between the expectations of motherhood and the reality of the medical model of care. A feminist informed narrative method of inquiry has allowed me to give expression to the voices of the participants as well as draw attention to the social pressures that women may experience in North American culture. It is my belief that mothers are trapped in between two opposing forces, both of which are demanding and nearly inescapable. These are: (a) dominant cultural expectations of birth and bonding that insist a mother be satisfied with her birth and deeply bonded to her baby (the evidence of which is clearly seen in the media and advertising), and (b) a male dominated medical model of care that at

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times insists that normal birth is a medical emergency necessitating potentially traumatizing interventions including major surgery.

Thematic analysis. As part of this method, I employed a narrative thematic analysis, with a particular emphasis on the images and metaphors women used to describe their experiences as a way of understanding how women made sense of their experiences. The words one uses to describe one's experience convey that experience to a listener. Capturing the feelings that accompany an event with a visual image, such as a metaphor, draws the listener into understanding the experience of another in a flash of insight. Lokoff and Johnson (2003) state that metaphor is a means of understanding one type of experience in terms of another. They conceptualize metaphor as a structure which involves "all the natural dimensions of our experience, including aspects of our sense experiences." (p.235).

The function of metaphors here is important not only in conveying the experience of one person to another who may not have the means of experiencing it themselves, but also of providing a contrast to what may be anticipated and expected in birth and bonding within North American culture. The metaphors generated by the participants provides a contrast to the normative experience of birth and bonding and therefore, poignantly convey the experience of distress and disconnection that is typically left out of cultural representations of the experience. It is my hope that the inclusion and emphasis on metaphor will aid the reader in entering the narrative expression of the participant's experience. The stories presented here may be difficult for

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someone who has never experienced labour, delivery and the post partum experience themselves to understand. Similarly, even women readers, who may have experienced birthing themselves may struggle with grasping the profound distress experienced by the participants. It is my hope that the use of metaphors will allow an emotional, empathic entry into the experience. It is also my hope that women readers who have had similar experiences will see themselves in the narratives and metaphors and perhaps experience a sense of communion, a better understanding of their own story, and perhaps a vehicle with which they may present their story to others.

Analysis of the use of these metaphors and adjectives in this context is of great interest to me as a researcher and practitioner. Helping professionals with an interest in this topic may benefit greatly from the analysis in terms of gaining a deeper understanding of and empathy for their clients' birth experiences.

Similarly, professionals may gain an understanding of the use of metaphors as interventions in counselling. For example, Tom Strong (1989) writes, "acceptance of metaphor as a genuine form of clients' experience and communication could provide counsellors with viable medium for effecting change." (p. 203). He goes on to note, "metaphors . . . have important implications for understanding the contexts of our clients' problems and the possible solution strategies for ameliorating them." (p.203). Practically, Strong proposes that three basic strategies can be used to work with metaphors in therapy: explicating what is implicit, therapeutically extending or modifying the metaphor, and creating and delivering therapeutic metaphors. Therefore, there

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are two main types of metaphor in therapy, those generated by the client and those generated by the therapist. Both may be employed to shed awareness on a client's particular struggle and therefore effect change. For example, Strong cites the successful use of metaphor in research by Witztum, Dasberg, and Bleich (1986) in which a patient was successfully treated with the use of metaphor: "by using his 'bomb shelter' repeatedly in therapy, with gradual suggestions from therapist metaphors and guided visualizations, the patient was able to 'leave his shelter' and end ten years of post traumatic stress disorder." (p.207). The emphasis on metaphor in the research I have conducted can be similarly useful in application. Clinicians may gain a greater awareness of the metaphor's their clients employ to describe their experiences and use these to facilitate healing. Similarly, by learning of the metaphors used by the participants I have interviewed they might be able to generate metaphors for their clients to explore in order to gain awareness of their suffering, make sense of what parts of their experience were important to them and why, and ultimately move towards healing.

Analysis of the ways in which women make sense of their experience, is both informed by, and affects the societal milieu in which we live. Shamed by the prevailing notion of motherhood as the epitome of feminine expression, a woman who experiences a birth as traumatic or who feels disconnected from her baby may suffer in silence, blame herself, feel deficient, and therefore not seek desperately needed support. Exploration of meaning making in a constructivist fashion may inform practice by increasing practitioners' awareness of when

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mothers may need help and how to reduce the shame and isolation when the birth experience is less than ideal. Women themselves, when given a voice in research such as in this project, may feel empowered by telling the story of what they have experienced and knowing that they were not alone in the experience.

The specific questions that guided me in my inquiry included: What are women's expectations of labour, delivery, and motherhood? What are their actual experiences of labour and delivery? What is the nature of their subjective postpartum experiences? How did they make sense of their feelings and thoughts about the causes of that experience? How did they describe their relationship to their children as a result of each birth experience? How did they cope with their feelings about those relationships? How did they access help and social support (including how they approached others with their concerns, if in fact they did)? And finally, how have they healed (if they have) from any negative experiences they may have had?

Significance of Research

This research is significant in that it provides an intimate and detailed portrayal of the experience of mother's profound birth distress and subjective feelings of disconnection from their children. It is my hope that presenting such a portrayal through the voices of the women themselves, may provide a catalyst for further research. In addition, this research project is important for mental health professionals who help such women. Through these narratives, practitioners may gain a personal understanding of the suffering endured by their clients

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allowing them to enrich an empathic therapeutic relationship. Most importantly, it is my hope that by understanding the emotional costs of such a traumatic delivery, rates of c-sections may be reduced and further support may be offered to women during labour, delivery, and postpartum recovery in order to relieve women's distress with support in facilitating satisfying attachment and bonding with their babies. Similarly, it is my hope to diminish the stigma associated with women's subjective feelings of disconnection and birth distress and to stand against the ideal cultural expectation of labour and delivery thereby freeing women to move away from self-blame. It is my hope that women's subjective feelings towards their children may be addressed by professionals (either immediately postpartum or later when a woman is in need or reaches out for help) in order to offer support and normalization. For example, armed with the knowledge generated by this research, a nurse may recognize what might be going on for a woman when after a c-section she refuses to see her child, or becomes distressed by the sight of the infant. Another example would be that a clinical counsellor who sees a woman for the trauma of birth might wonder aloud how the woman feels about her infant knowing that disconnection might be part of what she is struggling with but has too much shame to admit. Such professionals might open dialogue on the subject with a woman after having read this research and having a detailed understanding of what she might be experiencing. Such a professional may begin by asking, "Some women feel very distressed/disappointed/angry/like a failure after a c-section delivery, is this something you might be experiencing?" Or, "some women do not feel as

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connected to their infants as they think they should but they are too ashamed to admit this to anyone else, have you noticed any of these thoughts or feelings?"

Of course, any interventions such as these would be tempered by the use of other skills such as active listening, normalization, and the conveyance of deep empathy and compassion.

This research fills a void in the literature in which the subjective feelings of women about labour and delivery and their feelings towards their infant are scarce. We will turn now to reviewing what research has already been conducted.

Chapter 2. Literature Review

In conducting the literature review for this project, I noticed that the vast majority of articles addressing the birth experiences of women were on the topics of postpartum depression and postpartum posttraumatic stress disorder. Studies relating to the former were often of a more dated nature, while the latter were quite recent; the topic of trauma during labour and delivery appears to be a relatively recent area of interest for researchers. More generally, a modest amount of research has been conducted around the implications of the effects of a c-section, emergency or planned, on a woman's mental health. Similarly, I noticed that there were only one or two studies that spoke directly to women's subjective experiences, and noted that this area has been mentioned as one that requires further attention. For example; Taylor, Atkins, Kumar, Adams and Glover (2003) state, "some mothers find it hard to relate to their new baby, and such failure may have long term effects on the infant. This has been a neglected area of research" (p.45). Similarly, Feldman, Weller, Leckman, Kuint, and Eidelman (1999) stated that, "little attention has been paid to the unique experience in the life of an adult of forming a selective and enduring bond with a baby: the mental, emotional, and behavioural changes that accompany the formation of the parent's tie to his or her infant" (p.292). Additionally, Mauthner

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(1999) writes about the importance of qualitatively based research by focusing on:

. . . how much we can learn about their psychological and social worlds by eliciting and attending closely to their words. Yet, the majority of research in the area of postpartum depression has disregarded mothers as a source of knowledge or understanding about their experiences.

Mothers' perceptions, subjectivities and accounts have been accorded little value in a field of inquiry, which has been dominated by quantitative research. (p.143)

It is my hope that this research study will be successful in meeting this need in the literature.

Many of the studies conducted since the late 1970s were in response to research by Klaus and Kennell (1976/1982) on the topic of a critical bonding period between mother and her infant child (sparked by the seminal work of John Bowlby on attachment). On the basis of animal research and the observation of interaction between mothers and their premature infants, Klaus and Kennell postulated that there exists a period after birth during which critical contact (usually in the form of skin-to-skin contact, or "kangaroo care"), must take place in order for the mother to adequately "bond" with the child, and for the child to "attach" to the mother (Taylor, et al. 2003). The concern for these researchers was that infants were being prematurely removed from their caregivers in hospitals and this "disrupted attachment" could potentially lead to a host of ill effects for the mother and child dyad (Lamb, 1983). Much research conducted

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since that time has disputed the idea of a “critical bonding period,” but most agree on the importance of the “mother—infant bond” which has been defined as:

. . . a clearly defined set of maternal behaviour post partum behaviours . . .

. these behaviours include proximity seeking, touch, and contact. . .

Additional maternal bonding behaviour in humans are gaze at the infant, “motherese” vocalizations, positive expression, and adaptation to cues expressed by the infant. (Feldman, Weller, Zagoory-Sharon, & Levine, 2007)

Four types or indicators of attachment between caregiver and child have been proposed: pleasure in proximity, tolerance, needs gratification and protection, and knowledge acquisition (Cordon & Corkindale, 1998). Therefore, although it may not develop (or fail to develop) quite in the manner in which Klaus and Kennell originally proposed, attachment has been found to be important for the health and development of both mother and child.

Post Partum Adjustment Disorders

Early research focused on postpartum adjustment disorders, specifically depression (postpartum depression; PPD) in women and the effects this disorder may have on the mother-infant relationship. PPD is characterized by meeting the criteria for both a major depressive episode and the postpartum onset specifier i.e., the episode must occur within four weeks after delivery. Women are diagnosed with PPD if they meet the following criteria of five or more of the

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following symptoms being present during a two week period: depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others; markedly diminished interest in pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others); significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down); fatigue or loss of energy nearly every day; feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day; diminished ability to think or concentrate, or indecisiveness, nearly every day (either subjective account or as observed by others); recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide; the symptoms do not meet the criteria for mixed episode; the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; the symptoms are not due to the direct physiological effects of a substance or a general condition; the symptoms are not better accounted for by bereavement (American Psychiatric Association, 2000). PPD has also been described as being accompanied by anxiety and overwhelming feelings of guilt, shame, isolation, fatigue, a sense of loss and, sometimes, very frightening fantasies (Kleiman & Raskin, 1987). A review of the literature has shown that in some cases, but not all, an

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unsatisfactory relationship between mother and infant may co-exist as a part of this disorder. A debate has ensued around how this disrupted relationship may be related to PPD, specifically which one leads to the other--the disrupted relationship to depression, or depression to the disrupted relationship (Kumar, 1997).

I was able to locate a very limited sample of research conducted on the relationship between PPD and method of delivery. One notable exception conducted by Glazener, Abdalla, Stroud, Naji, Templeton, and Russell (1995) surveyed 1249 women in Scotland at 1 week, 8 weeks, and 12 to 18 months postpartum. The study found that women who experienced birth by c-section reported higher levels of health concerns, including depression. Interestingly the level of distress and discomfort after birth was similar in women who had c-sections and assisted vaginal births (i.e., the use of medical interventions to extract the infant). Similarly, in a study of 245 British women, Miller, Thornton, and Gittens (2002) noted that women who had normal, spontaneous vaginal births experienced high feelings of fulfilment and low levels of distress or sense of being cheated continuing at six months. These women's perceptions of difficulties at delivery had also decreased. Women who had assisted vaginal births or c-sections under general anaesthetic had low levels of fulfilment, high levels of distress and perception of delivery difficulties, and a sense of being cheated, also at six months postpartum. Clearly, more research on this topic would be valuable.

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Post Traumatic Stress Disorder

The diagnostic criteria for post-traumatic stress disorder were revised in 1994 to include “frightening or life-endangering childbirth” as meeting the criteria for a traumatic event. This revision was the catalyst for research on post-traumatic stress disorder after childbirth (Simkin & Klaus, 2004). The etiology of PTSD always follows a traumatic event which causes intense fear and/or helplessness in an individual. Typically, the symptoms develop shortly after the event, but onset may also be delayed. In order to meet the diagnostic criteria, symptoms must persist for at least one month. Symptoms may include: re-experiencing the trauma through nightmares, obsessive thoughts, and flashbacks (feeling as if you are actually in the traumatic situation again). There is an avoidance component as well, where the individual avoids situations, people, and/or objects, which remind him or her about the traumatic event. Finally, there is increased anxiety in general, possibly with a heightened startle response (American Psychiatric Association, 2000).

Most research findings have concluded that a particularly painful or traumatic experience in childbirth (e.g., emergency c-section, forceps delivery) may contribute to reactions in the mother consistent with a diagnosis of PTSD. For example, Ferber and Feldman (2005) state:

. . . studies have shown that traumatic deliveries, such as Caesarean sections or instrument deliveries (vacuum or forceps), delay the formation of the mother-infant bond in the immediate postpartum period, possibly as a result of prolonged maternal preoccupation with the experiences of

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delivery, which interfere with her investment in the infant and the emerging relationship. (p.44)

Similarly, Gamble, Creedy, Moyle, Webster, McAllister, and Dickson, (2005) reiterate:

. . . adverse childbirth experiences related to unexpected medical intervention, severe pain, or threat of death may evoke fear and overwhelming anxiety for some women and precipitate posttraumatic stress disorder. (p.11)

Symptoms of PTSD in a mother may include flashbacks, nightmares, impaired daily functioning, and exaggerated responses to reminders of the trauma, as well as intrusions, avoidance and hyper arousal (Davies, Wright, Slade & Stewart, 2008). The unique condition inherent in PTSD relating to labour is that the traumatized mother is forced to be in near constant contact with a significant reminder of the person in the event that she endured--her own child (Allen, 1998).

Interestingly, research has shown that women may deny the effects of a traumatic delivery, even when the effects of that delivery are obviously negative. A study by Soet, Brack, and Dilario (2003), followed 112 women to determine if any had posttraumatic stress disorder as a result of their birth experience and what factors might have come into play in the etiology of their symptoms. The authors noted that:

Curiously, 19 women reported having symptoms of posttraumatic stress disorder without perceiving it [the birth] as traumatic, which may be due to

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several factors. One possibility is a reluctance of women to admit to a negative birth experience. During the post-partum interview, many women had difficulty discussing the negative aspects of the birth and would follow up a negative comment with assurance that they were happy to have a healthy baby. Counsellors who work with this population note the strong societal pressures on women to be happy with their birth, and to put the baby's health and needs before their own. (p.43)

I will discuss this concept of denial of the magnitude of the trauma suffered by women later in the research I have conducted.

Caesarean Section

Few studies I located concentrated specifically on the nature of posttraumatic stress disorder sustained during c-sections. Notable exceptions were conducted by Ryding, Wijma and Wijma (1997; 2000). In the study conducted in 2000, Ryding et al. found that the majority of the 25 women whose narrative accounts of their experiences were analyzed experienced their emergency c-sections (EmCS) as a "mental trauma." Of interest in these accounts were the experiences of almost half of the women, "on seeing the baby they could hardly believe the baby was real, *and their own*" (Ryding et al. 2000, p.37; italics mine). Similarly, "caesarean section has been found to be associated with more physical and mental distress than vaginal delivery. In particular, emergency caesarean sections have been reported to be psychologically distressing, resulting in symptoms of traumatic stress" (Ryding et

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al. 1997, p.26). The same study found both an increase in negative experiences of delivery reported by women after a c-section (emergency c-section in particular) than after any other kind of delivery and more symptoms of depression postpartum.

Women's Subjective Feelings

Interspersed throughout the literature on postpartum depression, postpartum post-traumatic stress and disorders of bonding, were descriptions of women's feelings towards their infants. The subjective descriptions mentioned include irritability, detachment, resentment, hostility, emotional numbing, hatred, rejection, aversion, and impulse to harm. Similarly, women perceived their infant as less warm, invasive, difficult, prone to distress, less easy to soothe, and more avoidant than mothers who reported satisfactory birth and bonding experiences (Bailham & Joseph, 2003; Davies et al. 2008; Kumar, 1997). Similarly, studies have found that some mothers (specifically those who have experienced an emergency c-section) have a much harder time viewing their child as a person as opposed to an object than women who experienced a vaginal birth (Trowell, 1982), and that these perceptions of an infant may lead to mechanical infant caring (Herishanu–Gilutz, Shahar, Schattner, Kofman, & Holcberg, 2009).

These feelings may be disturbing to many because they are inconsistent with idealized cultural construction of mothers' responses to newborns. In North American culture, there appears to be an expectation that mothers greet the births of their children with joy, exhilaration, and unconditional love. This idea

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has been relentlessly perpetuated by the mass media and there is no doubt that many mothers who find themselves lacking in these experiences may feel deficient, flawed, even evil—the dreaded *bad mother*. Kleiman and Raskin (1994) write:

If you believe what you see in television commercials and magazine advertisements, every mother has a perfectly flawless infant with a twinkle in his eyes and a smile of contentment on his face. His mother wakes happily to feed him. She is always rested and her makeup is in place. She places the baby to her breast as they both gaze meaningfully into each other's eyes. *They bond instantly*. . . Society reinforces the myth of the perfect baby in the arms of the perfect mother, with all her maternal instincts in tact. In previous years, there was so much emphasis on the phenomenon of “bonding” that women often plummeted into despair when they failed to feel an instant love attachment to this blessed creature.

(p.198; italics mine)

Women who experience these feelings may suffer from great shame and the desire to hide their distress from others. Indeed, “early feelings towards the baby are particularly well remembered by the mother. However, it may also be easier for the mother to admit to an earlier detachment or resentment towards her newborn baby at a later date” (Taylor, et al. 2003, p.49).

In examinations of other cultures, particularly in communities with high infant mortality rates, many of these feelings are not expected of women (Small,

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1998). This cross cultural examination of the expectations of women will be discussed later in more detail.

Notable research into the nature of the mother-child relationship after caesarean section was conducted by Judith Trowell in the mother-baby unit of the British Psychiatric hospital. Trowell (1982) writes:

. . .the author became aware of a group of mothers, whose children had been born by caesarean section, who showed particular difficulties.

These mothers were not different from the other mothers in the nature and degree of their psychiatric disturbance but took longer and had more difficulty in establishing a good mother-child relationship. They were detached, disinterested, indifferent to their babies and found the responsibility of parenthood more difficult to accept. They lacked confidence so that the practical tasks of motherhood very quickly became overwhelming, many of them reported that their baby had nothing to do with them or was not their child. (p.42)

Trowell explored differences in the mother-child relationship between women who had emergency c-sections and those who had normal vaginal deliveries. She found several differences between the groups including: length of time between delivery and first contact, levels of eye contact, and differences in attitude and behaviour. For example, mothers who had experienced emergency c-sections had more doubts about their capacity to care for their babies, were more depressed and as aforementioned, and, did not feel their babies became a person until later.

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Several studies have touched upon the negative effects of care giving that is not attuned, responsive, or loving. Specifically, there have been found to be “fewer optimal interactive behaviours between depressed mother and their babies” (Tuohy & McVey, 2008, p.43); and “poorer infant cognition outcome at 18 months and later time points such as 7 years postpartum . . . follow up data on the offspring of depressed and anxious mothers indicate increased mental health risks across generations” (Swain, Tasgin, Mayes, Feldman, Constable and Leckman, 2008, p.1049). In a study conducted by Hay, Paulby, Sharp, Asten, Mills, and Kumar (2001), the authors found just such problems as children of women who were depressed at three months postpartum had significantly lower IQ scores. Further, a disrupted mother-child relationship may continue to exist in terms of maternal attitude and behaviour towards the child 3 years after delivery (Trowell, 1983). These findings are important in that they may demonstrate some possible long lasting effects of disrupted attachment; however, it must also be noted that factors other than the mother-child relationship may contribute to these findings. It is of utmost importance that studies such as the aforementioned not be misconstrued and contribute to the shaming and blaming of mothers.

Conclusion

In summation, it may be readily apparent that a subjective sense of negative feelings towards one's child and profound birth distress certainly does exist and is troubling for many women and may in fact be detrimental to the

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development of the child. We can see the existence of these feelings in cases of postpartum depression and post-traumatic stress disorder as a result of labour and delivery. The etiology of such feelings is not clear, and in fact may not be traceable to one causal factor alone. There are a number of theories about the root of women's experiences of disconnection and birth distress, for example: oxytocin levels (Swain et al. 2008), premature removal of the child from the mother (Lamb, 1983), trauma in emergency c-section (Gamble et al. 2005), and the use of anaesthetics that may dull the behaviour of both mother and child. A qualitative analysis of the narratives of women who have suffered such feelings of negativity has been left out of the literature. I explore this neglected area of inquiry here. It my hope that this research may help to inform mental health practitioners of this phenomenon so it can be approached and discussed with clients rather than avoided, missed, or seen as taboo.

In order to facilitate this exploration, I employed a particular research method of design and analysis and discuss it in more detail in the following chapter.

Chapter 3.

Research methods and design

The research methodology I have chosen to employ is narrative inquiry through a feminist lens. Several specific elements make this perspective different from other approaches and necessary for this particular study. These elements include: One, a holistic reading and interpretation of interview material through which I was able to emphasize the role of culture and society in contributing to the experiences of these participants. Two, this perspective allows the experiences of participants to be analyzed within the context of larger societal influences, recognizing that the successes and struggles we experience individually are not in isolation from the culture in which we find ourselves immersed.

In addition to a narrative method, I have chosen to interpret the narratives through a feminist lens. This orientation is appropriate and valuable, in that it recognizes the marginalization of the research participants and allows them a voice. The women whose stories are examined in this research project may be viewed as doubly bound: first, in terms of their gender and second, in terms of their experience of disconnection from their child, which might be viewed as contrary to societal norms. Verta Taylor (1996), in her extensive research on women suffering from postpartum illness and their involvement in the self-help movement writes:

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When a mother feels and expresses anger towards the very persons she is expected to love and cherish, she is resisting strong gender norms.

When she admits depression rather than basks in maternal satisfaction and pride, or guilt when the bonding she anticipates does not come automatically, or anxiety in connection with the enormous responsibilities of caring for her family, she abandons the script of American motherhood.

(p.174)

A feminist orientation, with its emphasis on honouring the voices and experiences of women, allies itself naturally with a narrative inquiry, which strives to offer the stories of research participants to readers intact.

Context

By employing this research method, I had three goals. The first was to gain a better understanding of the circumstances under which women might experience disconnection and birth distress. The second was an analysis of this sense of separation and distress--how women describe their experience in terms of metaphors and adjectives. The third goal was to examine how women make sense of their experience in terms of societal expectations and gender norms around mothering.

I used a narrative thematic analysis of the data in order to keep the story "intact by theorizing from the case rather than from component theories (categories) across cases . . . with the primary attention on 'what is said, rather than 'how', 'to whom' or 'for what purposes'" (Kohler Riessman, 2008, pp. 53-54).

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Specifically, I worked with a single interview at a time, using qualitative coding software in order to label and categorize segments of the narratives as potential themes; for example, participants' use of metaphor to describe a particular experience such as the first sight of the baby. I then grouped the codes into themes and then the themes into categories, which reflect general patterns emerging from the narratives, for example, the subjective feelings of having failed in labour and delivery. I moved back and forth in my analysis among the participants narratives to compare them to each other in terms of similarities and differences and between the themes societal norms. This method of analysis fits with the intention of this study, which is to collect and interpret women's subjective experiences in a holistic manner, without fragmenting the data while at the same time keeping in mind the social context in which these narratives take place.

Participants

I recruited research participants by advertising in community centres, social service agencies and midwifery clinics along a diverse and densely populated main avenue in a large metropolitan city, in order to attract as broad a range of demographics as possible (see Appendix 1 for recruitment poster). The advertising posters called for mothers to "participate in a research study on the topic of women's relationship with their infants." The inclusion criteria included being a woman who has had two different birthing experiences (one c-section

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and one vaginal birth), and who has experienced differences in her relationship with her infants after these two types of births.

I conducted semi-structured interviews with seven women who had experienced both a c-section and a vaginal birth. I specifically sought out participants who had both types of delivery and therefore the ability to compare and contrast their experiences and their feelings towards their children. This research however, will focus primarily on participants' experiences of c-sections. I hope to explore the participants' vaginal birth experiences at a later date. These experiences, in the cases of vaginal birth after caesarean (VBAC) in particular, were joyful, satisfying, and often redemptive, and provide an intimate portrayal of birth as it is intended, a loving and empowering experience.

Participants ranged in ages from 28-42. Six of the women self identified their ethnicity as "Caucasian" (one participant identified as "Caucasian/Jewish") and one identified as "Mediterranean." All participants had at least two live births, one by c-section and the other by vaginal birth. Of the seven women interviewed, four had vaginal birth after caesarean and one had a VBAC followed by another c-section with her third child. The other two women had vaginal births followed by c-sections. Only one of the participants had a planned c-section because her first birth was of twins, her second birth was an unassisted home birth

The socio-economic status of the women ranged from lower to upper middle class according to self-reports. Six of the seven women were married or partnered with men at the time of their children's births. One woman was newly

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widowed at the time of her delivery. Three out of four VBAC participants had midwife-assisted homebirths; the fourth woman, as previously mentioned, had an unassisted homebirth.

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Figure 2: Participant Details

Participant	Mother's Age at Time of Deliveries	Age of children at Time of Interview	Children's Delivery Method and Birth Order
1	24, 33	11, 2	Vaginal birth, C-section
2	28, 30, 34	11, 9, 5	C-section, VBAC, C-section
3	26, 28	2, newborn infant	C-section, VBAC
4	40, 42	2, newborn infant	C-section, VBAC (homebirth)
5	30, 33	6, 3	C-section, VBAC (homebirth)
6	23, 33	14, 4	Vaginal birth, C-section
7	26, 31	11, 6	Scheduled C-section of twins, VBAC (unassisted home birth)

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Procedure

I began my interviews with the question, “tell me about what childbirth was like for you?” I conducted the rest of the interview in a semi-structured manner, with a list of prompting questions (see Appendix 2 for interview protocol). The benefit of conducting a semi-structured interview is that it allowed the participants to “freely express their own thoughts, beliefs and interpretations in order for the researcher(s) to begin to develop a true understanding of their perspectives” (Meddings, Phipps, Haith-Cooper, Haigh, 2007, p.162). This focus is particularly important in order to allow the reader to fully appreciate the experience of the research subjects. This understanding in turn has several implications: a detailed understanding of women’s experience becomes the catalyst for contributions to future research; it can lead to practical applications of support services in a medical setting, and more skilful treatment for women in the context of counselling. There are two main goals to studying the narratives in their entirety: (a) to determine under what circumstances a woman feels a disconnection from her child and birth distress, and (b) to analyse the way in which a woman interprets this disconnection and distress.

Finally, I transcribed all interviews and coded them using coding software, in a manner consistent with a narrative thematic analysis. I chose to transcribe the interviews by hand in order to really “live” within the material, to become immersed and familiar with the narratives of the participants. I have represented the quotations of the participants in their original formats as much as possible with the intention of preserving the voices of the participants as they spoke to

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me. In keeping with the research methodology I have chosen, it is important to me that the narratives of my participants are represented accurately and remain true to the nature of their original expression.

Reliability

The research I have conducted is a qualitative design. Qualitative research has been described as:

holistic in its concern with processes and context rather than simply outcomes or focusing on differences and comparisons . . . empirical because it occurs in natural settings . . . interpretive, focusing on gaining meaning and understanding and building concepts and theories . . . [and] empathetic, concentrating on the frames of references and values of those involved. (Conrad & Serlin, 2006)

Reliability in qualitative research may best be conceptualized as a matter of “dependability” and “trustworthiness” (Lincoln & Guba, 2000). Similarly, traditional approaches of rigor, as previously employed in quantitative research may be replaced in qualitative research by taking a more “local, personal, and political turn.” (Conrad & Serlin, p.11). Specifically:

Substituting the concepts of usefulness—enlightening those who read the report—for objectivity; underscoring conceptual completeness, including drawing on multiple voices and tacit knowledge; considering researcher positioning, that is, how the research is aware of his or her relationship to the situation being studied; and developing a writing style that achieves

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verisimilitude, telling a story so richly that the reader can feel it. (Altheide & Johnson, 1994)

In order to ensure the reliability of the research I conducted, I have attempted to meet all of these requirements. Specifically: usefulness, completeness, researcher positioning, and writing style/research design.

Usefulness. Miles and Huberman (1994) recommend that a measure of validity is whether or not research causes the “users” including those studied, to make better decisions by being better informed. They similarly contend that the study must be accessible, offer knowledge and prompt change.

The research that I have conducted is intended to enlighten the reader in a number of ways depending on the audience. In the case of counselors and other mental health professionals, I hope to give insight and understanding into the concerns of some clients they may encounter. It is my hope that, exposure to the narratives of women who have experienced disconnection and birth distress first hand, will give clinicians a leg up on what their clients may be struggling with before they even walk in the door.

I hope that birthing professionals in reading this material, will gain empathy and understanding into the experiences of some of their patients and therefore be able to offer them more appropriate care in order to prevent or buffer the effects that a c-section might have on a mother and child.

I hope that researchers will be spurred forward into further research with the aim of addressing some of the components of these experiences that have

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not been answered here. I hope that this work is the catalyst for future research that benefits women and their families.

Finally, I hope that those women who have access to this work that have experienced births similar to those described here, find validation and support for what they have endured. I hope that this research serves to strengthen women and empower them to move towards their own healing and perhaps the healing of others in terms of engaging in advocacy or action.

Completeness. In order to ensure completeness, I engaged in two practices. The first was the literature review I conducted in which I found support for the research I intended to conduct myself. In reviewing the literature (and therefore triangulating data sources) it became apparent that disconnection and birth distress does impact the lives of a number of women and their families, and yet is not given the attention I feel that it deserves. The second practice I used to ensure completeness was to draw upon multiple voices to inform my results. While seven participants may be considered a small sample, the thick descriptions of the participants serve to provide a deep and complex narrative of their experiences.

Although this research paints a complete picture of the experiences of the participants I interviewed, is not generalizable to the majority of women. Not all women that experience c-sections will feel disconnected from their child, or suffer any great distress. Similarly, some women will experience the devastating effects of a traumatic birth after a vaginal delivery, particularly if it is complicated. Rather than demonstrating causation in this research, I hope to bring the reader's

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awareness to the very real and very devastating experiences of some women. I know that the awareness that a handful of professionals had about what I was going through after the delivery of my first son went a tremendous way towards my healing. I hope that this work in some way helps to make that awareness more widespread and ultimately lead to the prevention of disconnection and birth distress under whatever context it might occur.

Researcher Positioning. In considering my relationship to the experiences I studied, I acknowledged my own experience of disconnection and birth distress. The impetus for this research was not only my own c-section experience and subsequent feelings of disconnection from my child, but also my awareness that I was not alone in this experience, but that it was not widely discussed. In my attempt to find answers and heal from my experience, I met other women who had had similar experiences as my own and yet each described feeling shamed, isolated, and alone. When I began to research the literature in preparation for the proposal of this topic, I came in contact with an even greater community of women for whom this experience was not only not unheard of, but it was apparent that there is a desperate lack of visibility of these experiences. This community consisted primarily of midwives, therapists specializing in attachment disruption, and activists. These connections and the feedback they generated about the work that I was doing served to provide validation that I was working on a valuable and necessary topic. I also came to understand further that my experience was not an isolated event and that there

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are people in the community who care deeply about preventing these experiences from taking place.

In light of having experienced disconnection and birth distress myself, I carefully kept a reflexive journal while conducting the interviews in order to examine my own reactions, impressions, and lenses through which I was viewing the material. I was particularly aware of not discounting participants' experiences because they did not match with my own.

Writing Style/Research Design. In preparation for conducting the research, I considered a number of research designs. I settled with narrative inquiry through a feminist lens, which seemed the most likely to meet my ultimate goal which was to present participants' experiences accurately to a wider audience.

Miles and Huberman (1994) contend that a good qualitative researcher is familiar with the phenomenon and setting under study, has strong conceptual interests, a multidisciplinary approach, and good "investigative" skills, including the ability to draw people out. When I met with the participants, I took great care to create an environment in which they felt safe and contained in telling their stories. As a graduate student in counselling psychology, I used skills such as advanced empathy and active listening in nonverbal ways in order to convey a sense of validation and acceptance and allow the participant to tell her story in detail. I believe that each of my participants was open, honest and very descriptive in the narratives they shared. In an exception to this depth of disclosure, under the guidance of my supervisor I decided to exclude an

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interview with an eighth participant when it became clear that the participant was not being honest about the details of her experience for fear that there would be repercussions from the professionals involved in her birth experience.

In order to ensure the accurate transmission of the participants' narratives, I transcribed the interviews verbatim and by hand, in order to preserve the material. In coding and analysing all of the data I collected, I compared and contrasted the seven different voices of the participants in order to include a multiplicity of views and experiences. Marshall and Rossman (1999) contend that, "some subjectivity is inherent in qualitative research; the researcher will shape the research. Nevertheless, if done well, qualitative inquiry enables the researcher to enter the world of the participants in the research, providing deep understanding of complex social systems" (Conrad & Serlin, p. 23).

I discussed the results of the coding of the participants' narratives at length with my supervisor, and finally, I revisited the literature and compared my results with what has been reported there.

In order to meet the goal of "telling the story so richly that the reader can feel it" (Conrad & Serlin, p.11), I employed not only a narrative method of research which strives to maintain the depth and complexity of participants' narratives, but I also placed an emphasis on the metaphors and adjectives that participants' used to describe their experiences. It is my hope that the coupling of these two techniques, has allowed the reader a unique perspective on the experiences the participants expressed to me.

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In taking these steps, I hope to have ensured that the reliability, trustworthiness, and dependability of this research is definitive in order to provide the greatest impetus for the healing of women and children and change in the system in which these experiences occur. The specific results of the research method and analysis I employed will be discussed further in detail.

Chapter 4. Results

Three main themes each with two to three subthemes emerged in the analysis of participants' narratives. The first theme is *suffering a traumatic experience*, with the subthemes of *birth environment*, *potential loss of child*, and *predisposition to trauma reaction*. The second theme is *forces of relation*, with the major subtheme of *feelings of disconnection*, which is then reciprocally influenced by factors such as *shame driven inability to reach out for support* and *lack of supportive relationships*. The third theme is *expectations*, which encompasses two areas of expectations participants described: *expectations of birth* and, *expectations of bonding*. All of these themes and their subthemes will be discussed in further detail, supported by quotations from the women whom I interviewed.

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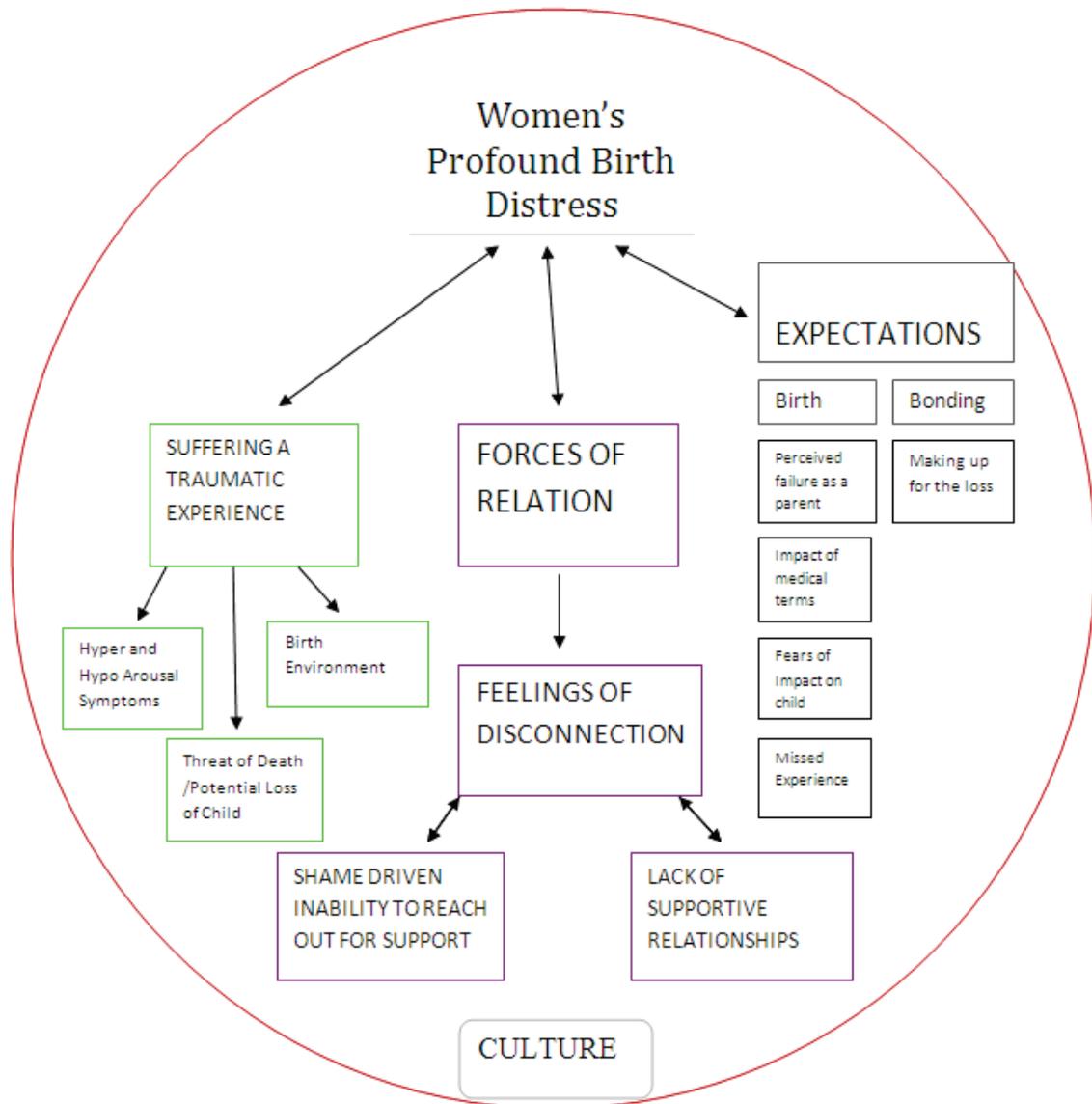


Figure 1: Themes and Subcomponents of Women's Profound Birth Distress
 Note. © Helen Dunn, 2011.

Suffering a Traumatic Experience

Suffering a traumatic experience refers to the labour and delivery experiences of the participants in which they endured events of a traumatic nature. This section will focus on two areas related to trauma: posttraumatic stress symptoms, and the role of the birthing environment.

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Posttraumatic stress symptoms: hyper and hypo arousal. One participant named the c-section explicitly as a trauma and described both the disconnection she felt from her son and the flashbacks she experienced:

. . . the c-section was a traumatic event and I feel like that really separated . . . me from my son and like, I had depression that was untreated, I had, like I would have flashbacks that would leave me paralyzed, I cried all the time like, I wasn't whole as a person, like I was traumatized and so I didn't even have the capacity I think to like bond with this person... so to heal from a surgery and then also have to care for a little person who is so needy . . .

Another participant describes the nightmares she experienced:

If I slept at all I would have horrific nightmares of people killing the baby or like later in his life him being murdered and just like really graphic really violent nightmares. Right away, within hours of having him, if I was unconscious at all that is what would happen.

This same participant goes on to describe violent intrusive images that she continues to experience:

. . . obviously I've always been concerned about my children but I've never had like graphic kind of flashes of what might happen. You know I was telling my ten year old you know "be careful when you cross the street" and I used to just be able to say that and you know have this sort of vague fear that he's going to get hit by a car but now when I say it I have this

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graphic image of him getting hit by a car and being splattered across the street.

Another participant describes similar disturbing thoughts after the c-section birth of her third child:

I did get depressed after [baby] a few weeks later . . . I know it really came to a head when she was about three months. And that's when I started having like the, the weird sort of visualizations and that's, that's when I asked my doctor you know, I told her this is, this doesn't feel right and she agreed with me.

This participant was able to disclose to her doctor what was going on for her and receive validation. However, when I prompted the participant to describe what she meant by "visualizations" she was clear that the violent images she envisioned were not of her as perpetrator. For example, "horrible visions of like something like a big boot stomping on her and just not . . . not appropriate like and it wasn't my boot but it was still just all . . . and they were you know, quite common."

This participant noted that she experienced these "visualizations" with both of her c-section births but not her vaginal birth. These quotations demonstrate some of the immediate and longer term effects of a traumatic birth.

As is apparent in the trauma literature, one of the effects of a traumatic experience can be a persistent focus on the self and the presence of overwhelming physical and emotional sensations (American Psychiatric

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Association, 2000). This symptom makes both caring for a newborn and recovering from surgery particularly difficult. One participant noted, "I didn't feel like I had any capacity to care for him."

Another participant found herself reviewing the events of the c-section when she was alone with her child, she told me:

. . . it is also very difficult because I think that one of the triggers is the baby. So often I find that, even now, I'll be nursing him and thinking about his birth you know and it's like wow, it's a year and a half later and I remember with my first son [vaginally born] nursing him and thinking about his nose and thinking about his eyelashes and thinking about him and instead I'm kind of staring off at the side thinking, "I wish that Doctor was nicer and I wish that people had talked me through it and I wish that it wasn't so traumatic" and not focusing on him.

Another mother recalled her interactions with her twins born via caesarean section: "I was kind of dissociative with the twins like I never really tuned into them or interacted with them."

It is not difficult to see how problematic such a preoccupation with the traumatic experience of birth might be. Attachment theory tells us that bonding between a mother a child occurs in an intimate interaction—holding, mutual gaze, mirroring, a synchronicity between two bodies that once were one (Figueiredo, Costa, Pacheco & Pais, 2008). Can this still be possible in a highly medicalized

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environment? Can it take place between a traumatized mother and perhaps a traumatized child?

Participants described in detail symptoms of hypo arousal associated with a traumatic experience. One participant described the dissociative state she experienced:

. . . it was like watching a movie . . . it was like, coming in the [operating room] . . . that journey and seeing all these like really, like these newfangled panel of lights, seeing all of the equipment, that seems really vivid and kind of stark in my, in my memory, but then after, it almost seems like, just watching as a spectator.

Another mother commented, "It still felt like it wasn't my body." This sense of dissociation is an experience that was echoed by other participants particularly using the word, "surreal" to describe their experience.

Fear of death/potential loss of child. Several women mentioned another classic component of traumatization: the fear of harm or even death to oneself or one's loved one (American Psychiatric Association, 2000). One participant recalled, "I was so scared I was going to die. I didn't know what was happening and I felt alone and I just said to her [the midwife], 'don't leave me.'"

Another participant recalled the experience of having been present at a friend's delivery, when she birthed a stillborn child. The participant recalled that her friend declared quite suddenly, "the baby has died and I am okay." She hypothesized that perhaps as an adaptive function from an evolutionary

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perspective when a mother does not have immediate contact with her infant she may disconnect herself emotionally from the child, with a deep understanding that the infant has not survived. This process would serve a dual function: (a) allowing the mother to accept the loss of her child and move forward in her life and the responsibilities inherent in survival, and (b) preventing the mother from a fruitless preoccupation with finding her lost child and perhaps becoming a danger to herself or others in a tribal community. She explained her hypothesis in terms of her own experience:

. . .one of the theories that I had 'cause I thought a lot about these births and why did I react differently to them and why was I so upset by the second one and I wonder if one of the things that might happen . . . I think that maybe we're . . . sort of programmed in a really, like you're meant to get your baby right away, you're meant to have your baby and be given your baby and if you're not given your baby right away, if you don't grab your own baby or if you don't get the baby . . . we have such strong instincts and we are so good at self-preservation but I bet you chemicals kick in really fast that tell you, "your baby has died and you're going to be okay. You're going to be okay, you're going to go forward, you're going to survive this." And I think that maybe some of those things got triggered and that then seeing a baby . . . yeah that maybe it makes sense that if we see a baby when our baby has died that we not attach to it. So that you're not trying to take other people's

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babies and you're just very aware that any baby that's out there is not your baby because it's been eight minutes and you haven't seen a baby and no baby's nursing you and you know, especially with caesarean delivery the hormones are not the same, so you know that's how I made sense of it to me.

This phenomenon of disconnection from one's infant is the pivotal component of this research.

The role of the birthing environment. Another striking feature of the birth experience mentioned by participants was the role of the birthing environment. One participant and her husband had built a home with the specific intention of having a home birth with their first child. The shock of the discrepancy between reality and the expectation of birth made the event particularly hard to bear. She told me:

It was all very shocking, just leaving my house, leaving a place that I had, basically a nest that I had built to have my baby . . . I can remember you know, the operating room and just the shock, just feeling absolutely shocked.

The vivid memory of the hospital and the cold, clinical, sterile environment of the operating room were reported by a number of women. One research participant in particular had the terrifying experience of being able to see the surgery reflected in the operating room lights overhead. She poignantly described:

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. . . suddenly you are strapped down with your hands, like strapped down like you're being crucified and I look up and like you can see the reflection in the . . . lights like I could see the steel reflecting down and I sort of said to the anaesthesiologist, "do you know you can see yourself reflected up there?" and no one had cut me yet but . . . He just didn't say anything.

The same participant described how her arms being strapped down interfered with her ability to hold her baby for the first time. A number of participants spoke about this, they were either strapped down, too weak to hold their child or feared that they might drop their infant, or they were not even given the opportunity:

. . .I was like, "I can't touch my baby" like, and they wrapped her up, I didn't even get to see her and she was already wrapped up, and they brought her, you know they put her head beside [my] face and I was like, "hardly enough!" like, "no that's not good enough" and . . . I just wish at the time I had been able to say you know, "can you unstrap my arms? I mean, or at least one of them?"

And another participant, a mother of c-sectioned twins:

I remember they were, there was so much between me and them that, I couldn't move from my waist down, so I was really frustrated by that, I wanted to grab them away from all the doctors who had them. I could hear them crying but I couldn't reach out to them and that was profoundly disturbing for me.

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Forces of Relation

The result forces of relation, refers specifically to relationships between participants and important others in their birthing experiences: specifically, relationships between the participant and her infant, her family and friends, medical professionals, and mental health professionals within the community. All of these relationships are encompassed within the culture at large which will be addressed in this section.

When I gave birth to my first son, via c-section, my first experience of him was that he was someone else's child. I felt disconnected from him and this was profoundly disturbing for me and not at all what I had expected I would feel; this experience was echoed in one way or another by all of the research participants. Naomi Wolf, feminist, author, and mother of a c-section born child, describes her feelings of disconnection in her book, "Misconceptions Truth, Lies, and the Unexpected on the Journey to Motherhood" (2001). She writes, "When, I wondered woozily as the tiny child was laid upon my breast, will her mother come for her?" (p.141). And later, "By the time she had found my breast and clung to me like a shipwrecked traveller, I was entirely hers. Though I did not yet recognize that she was mine." (p.142). Later still, Wolf writes, ". . . in spite of my love, both because of my emerging depression and because of my trauma-slowed sense of understanding her fully as my child, I still had a hard time thinking of her by name." (p.207). I have included these quotes in order to demonstrate a feminist perspective in naming the reality of one's birth experiences despite the social stigma around such admissions.

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In this section, I will discuss several important factors relating to relationships. These include: the experience of disconnection from one's infant, both upon first sight and over time; the experience of reaching out for support; the role of culture and society; the lack of supportive relationships; the unintended harmful effects of well-meaning family and friends; and finally, the seeking out of resources within the community.

Experiencing disconnection. All of the research participants described feeling disconnected from their infants, and sometimes as they grew, children. This disconnection showed itself in a variety of ways. Participants fell into three categories: (a) those that recalled feeling disconnected from their infants directly immediately after birth (two out of seven participants); (b) those that felt dissociative and therefore disconnected from the experience due to the traumatic nature of the delivery more than from the infants themselves (two out of seven participants); and (c) those participants that wanted to, but were unable to connect with their infants immediately and felt that their relationships with their children suffered later as a result (three out of seven participants). All of the participants however, felt that the c-section experience impacted their relationships with their children. Two types of disconnection were expressed by the participants: those that occurred immediately, and those that were delayed or not made immediately apparent.

Experiencing disconnection on first sight. On first sight of their c-sectioned infants, two participants recalled feelings that caused them profound

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distress; the most prominent feeling may be described as *disconnection*. One participant told me:

I did catch one glimpse of him through the people, because he was laying on the table there and they sort of parted for a minute and I just saw him for this brief second and it was very strange because the first thing I thought was, "that doesn't look like my baby". Which was so strange, like I don't know why that was just what I thought when I saw him was, "that's not my baby."

This same participant described her c-section born son as a stranger or someone else's baby (in her case, the child of a friend: "It still seems this [sic] funny . . . like some other baby was there in the room"). She noted further, "he wasn't familiar, he was unfamiliar."

This sentiment of not recognizing one's own child was hypothesized by one participant as being due to the lack of experience of having birthed the child vaginally. This specific participant had had the experience of a vaginal birth prior to her c-section and she noted the differences between the two experiences:

. . . I mean 'cause then you get your baby [in a vaginal birth], you know and then I was like, then suddenly someone gives you your baby and I was like, "whoa okay I have this baby on me now" and I guess I knew he was coming but it just seemed so surreal. There was no birth part. Like I was like, "we missed the birth". Like we did all the labour and then we skipped right to the baby.

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This same participant, commented on her vaginal birth experience, “there is no mistaking it you’re having a baby.”

The second participant recalls her experience in this way:

. . . when they first brought him to me, in the OR . . . I could barely even connect like, it was like, “okay I have a baby.” Like it felt very surreal and I felt really sad for him that I couldn’t hold him . . . but I didn’t feel like, “oh I’m his mother” . . . in my head I knew that but there was no heart connection to that, it just, like everything felt so disconnected and it just fell really . . . I felt like I was in a nightmare and, and then the nightmare ends and they had you a baby but . . . I didn’t feel like I had given birth.

This participant has clearly described her experience of longing for a heart connection, but receiving only a feeling of disconnection after a nightmare of an experience.

Two participants described not remembering the first time they saw their infants at all; one was incredibly grateful to have the images captured on film for what she could not recall and the other (who had been administered general anaesthetic) stated: “I have an image of my husband holding him . . . but the feeling that comes up is just confusion . . . it’s not love.”

Experiencing disconnection over time. Another piece of the puzzle of disconnection emerged as participants’ children aged. Two participants reported long term differences in how they felt towards their children, and specifically by continuing to feel disconnected to the c-sectioned birth child. All of the

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participants could not help but compare their feelings towards their c-section born children with those towards their children who were vaginally born, five participants felt connect to their children but were troubled in other ways. Two participants described a variety of scenarios they would imagine and what they would do in each case, which child they would save in the event of an emergency, which child they would sacrifice themselves for and why. One participant envisioned a scenario in which she found herself and the children trapped in her car in the water. She told me:

. . . I remember thinking, "if we went in the water, I probably couldn't get the baby out [c-sectioned baby] well, I'd just have to get the ten year old" and that moment of like, wow that I would just leave the baby, like it was such a weird thought for me and so disturbing. I was like, "why am I not even in my imaginary world, when I'm imagining how I would get us out of the car if I happened to be underwater, why even in my imaginary world am I not thinking that I'm gonna get the baby out?"

This participant was particularly curious to know if others had similar experiences, if their feelings changed over time and how they coped. What I learned over the course of these interviews, is that indeed, other participants felt similarly and were equally troubled by their feelings. Another participant who had twins born by c-section and then a vaginally born singleton told me:

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I feel really bonded to my youngest son in a really primal way, and if something were to happen to him you know, like I would stand in front of a train . . . willingly stand in front of a train, so that he wouldn't get hit by the train, you know? My two older boys, yes! Of course, I would stand in front of the train so that they wouldn't get hit, but I would do it, instead of out of a primal urge, I would do it out of an intellectual duty.

This same participant described her boys as feeling more like *guests* to her, not really hers, or that they had been “adopted into the family” or more like the visiting friends of her child than her actual children. She describes another facet of her experience:

Also, the other difference is, you know how when a mother has a child she's got this irrational belief that no matter what her child does he's good right? Well I have that with my youngest; I don't have that with the twins. There's a disconnect there, so if they do something that I'm not pleased with, I don't have that irrational, “yeah well you know he's still, there's still a fantastic person in there” you know, and, and that disturbs me as well.

She goes on to describe her relationship to her twins with the metaphor of animals being purposefully, callously bred and birthed:

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I was parenting the twins because I had to cut off, like I had to separate how my heart felt 'cause it was too painful, you know when I actually think about how I didn't get what I wanted right from the beginning with the twins . . . with the twins I felt like . . . when I look at a cow in a field about to calf and her baby is going to the slaughterhouse to be turned into veal . . . I feel like that cow with the twins . . . the same way that you know . . . they breed a horse so that you can get horses for show so that the men around them can buy them up and use them for racing and jumping and whatever but not, you know . . . I feel really betrayed by, by the whole society that I live in, and I feel betrayed by the medical model of care.

Sadly, this participant eventually turned care of her twins over to their father who had not been a part of their lives since the boys were infants. She described her decision as being due in part to depression she suffered after the death of the father of her third child. She told me:

. . . [he] died when the twins were just turning five . . . I was really, really depressed for two and a half years . . . whatever relationship we had was fractured by that and also because I felt a lot of low self-esteem about not having had them in the early years the way I needed to have them or like I felt like a failure for not having birthed them the way I needed to or, so any love they did show me I rejected. And one day when they were eight

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years old, I came out of my depression and I tried to play with them and they didn't want anything to do with me. And I was like, "oh my god" like I, I knew that I had lost them at that point and it didn't matter what I tried to do to make, make it up to them after that, it was gone, the opportunity was gone.

This mother now has limited contact with her first sons. She told me, "I was very disturbed inwardly that it was so easy for me to let them go."

Reaching out for support. An important feeling that emerged from participants' narratives was shame about their feelings towards their infants. It was this shame that impeded many of the participants from seeking help and support, either in their personal relationships or with professionals, and even when they described themselves as having a number of close, supportive relationships. One participant noted, ". . . I started having anxiety attacks, I started crying all the time . . . I did not feel connected to the baby at all and I felt like . . . I just had a lot on my plate and I felt so much guilt that I wasn't connected to this baby." This same participant, when asked if she told anyone how she was feeling, responded that in fact she did not. When prompted as to the nature of her reluctance she replied:

You're in it, and then also saying, "I don't feel bonded with my baby" isn't something you want to tell people . . . there's that piece like you don't want to tell people that . . . that feels like a shameful thing. Like you're supposed to, like our society tells us that you

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should love your children. So to say that you don't feel connected to your child is a horrible, horrible thing.

Another participant described being unable to reach out to other mothers for support:

. . . the years after his birth I couldn't talk about his birth. And I'd talk to women, friends of mine, you know like mommy group friends who had babies, and I couldn't listen to them talk about their vaginal births, like I just felt so envious and so . . . I felt like a failure, like I felt I had failed. Like at a really deep level, I felt like I had failed like I had somehow let this happen . . . [son] is almost eleven now . . . I couldn't have talked about this, you know, five years ago at all.

When I asked the participant who delivered twins by c-section if she ever told anyone how she felt disconnected from her infants, she simply responded, "No. I was too afraid to." This same participant did however, attempt to reach out to her mother, she reconstructed their dialogue for me: "Well mom really, you know, I actually feel really disconnected from the twins." "No! That's impossible, you're their mother!" and I'm like, "Yeah that's what's disturbing about it mom, I'm their mother and I feel really disconnected." When prompted about the nature of her fear about disclosure and seeking help, this participant pointed to the role of society and the paradigm of motherhood that exists.

The role of culture and society. The role of culture and society here cannot be ignored. Predominant media images, particularly in advertising,

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demonstrate what the relationship between mother and newborn child “should” look like. These expectations (which will be discussed later in more detail) may set women up to have intense sensations of shame and guilt when their feelings do not match the cultural ideal of “love at first sight” and being a “natural” mother, intuitively knowing what is best for one’s child and coping effortlessly with their care. One participant related:

I know that mothers are supposed to love their children and you know there's this . . . there's so much talk about like, bonding . . . I knew that I wasn't . . . I did not have an emotional bond with him and . . . I wanted to, like I wanted to feel that and it just wasn't, it just wasn't there.

Indeed, this same research participant noted the societal shame that was heaped upon a well-known celebrity, Angelina Jolie, when she referred to her newborn twins as “blob babies;” she confided to me that she felt the same way.

Lacking supportive relationships. A surprising six out of seven participants reported that they felt highly supported in their personal lives overall. However, many described a lack of social support during their labour and eventual caesarean sections, particularly in terms of hospital staff and administrators, but also from at times well meaning but helpless family and friends.

One participants described being unable to access help or services post partum, despite their attempts to do so.

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All of the participants described feeling intruded on by the number of strangers in the room, taking control over the experience the mothers so desperately wanted to be theirs. One participant recalls:

I just remember him coming out and him . . . being lifted out and onto a scale, not being able to hear him so not even knowing if he was okay, and just kind of watching as a spectator, like being detached from this experience that was supposed to be my experience, with a whole bunch of strangers in the room . . . with masks on that you know, you can't see their faces.

And another a mother of twins who at first felt a strong desire to connect with her children and later suffered from her lack of relationship with them noted:

. . . when they finally came to me they were all cleaned and swaddled and I was really resentful and indignant that I wasn't the one who did the cleaning and the swaddling like just, and, and that I couldn't have the proper amount of privacy that I wanted with them. And I just, I wanted to drag them both away to a cave and just nurse them, I didn't want anyone else around. I was so mad that, that other people had interfered in what was mine.

Two participants recalled overhearing conversations about golf taking place over them as she was paralyzed by fear (and strong medications). One participant spoke about her c-section experience:

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. . . there's all this like talk about . . . golf and shit, like the doctors are talking and, and I remember how cold I felt and, and so, my midwife came in and they started the surgery and the, the doctor took the scalpel and ran it across here [indicating lower abdomen] and I felt it and so I said, "stop I can feel what you're doing!" and the OB's saying, "what the fuck!" and he said, "that's it, general." And I said, "no I want you to try another spinal like this is what happened with the epidural, it didn't take the first time." "No, general." And, and I remember looking at my midwife because my husband wasn't there [mother begins to weep] and . . . I was so scared I was going to die . . . I didn't know what was happening and I felt so alone and I just said to her, "don't leave me" and then I was out like that was it."

This piece of narrative perhaps best exemplifies the stifling of a woman's voice in what is meant to be her experience.

Well-meaning family and friends. Narratives of well meaning family and friends also emerged as themes. Many participants spoke about the helplessness of their partners, their husband's missing of experiences they hoped to have (i.e., the cutting of cords, the announcing of the infant's sex). One participant describes how she reached out to her husband about how she was feeling:

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. . . my husband was very confused he was just kind of like, “what do you mean you don’t think the baby is great?” and I was like, “no it’s not that I don’t think the baby is great, it’s that I don’t . . . I’m not finding it as easy to be just in awe of him as I was with my first son and I feel like it’s because I’m in trauma and I’m not . . . I’m just kind of consumed by me, I’m not, I’m not giving him the kind of attention that he deserves and needs.

This participant describes herself as having told people how she felt, but as this quotation demonstrates, she felt compelled to explain what she meant by her feelings.

Another participant remembered:

I was just crying the whole time I just lay there crying through the whole surgery and my husband was, and my husband was like, he was singing to me and trying to calm me down but you know there wasn’t really too much anyone could do.

Another participant recalled her post c-section baby shower, attended by her friends and family and filled with the heaviness of a reality left unsaid, this mother believes that the organizer of the event asked everyone to not mention the birth.

She described:

I didn’t let any of my friends come to the hospital. I didn’t want to see anybody, it was just like I didn’t, I didn’t want to acknowledge that that’s how it happened, I didn’t want anybody else to see it, or witness it, or . . . it took me [three months] to be okay with my friends having a baby shower,

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like I didn't . . . I couldn't do it, I didn't want to talk about the birth and I knew that people would ask and, and so I didn't . . . I'm sure they [the shower organizers] said to everybody, "these are the things you are not allowed to talk about" right? Because you know, nobody, nobody talked about the birth.

As we can see, not only did this participant in particular feel unable to discuss her feelings with others, but there was a code of silence from those around her as well.

Seeking resources. Over time, many participants sought help and support in their communities. Some turned to books and internet resources to find out what had gone "wrong", if they were at fault some how, or if the caesarean section was in fact medically necessary or could have been avoided. Some turned to health care professionals looking for answers, their midwives, doctors and attending nurses. Some wrote letters of complaint and took decisive action in planning their next births (those who were striving for a vaginal birth after caesarean). Some participants attended counselling, contacted post partum organizations for help, or went to listen to speakers and meet other women who had similar experiences. Some participants shared very positive effects of these activities, while others were not so fortunate. One participant related her narrative of two attempts she made to reach out. The first attempt was with a nurse who specializes in post-partum depression that she saw at six weeks post-partum. This nurse told the participant that she was being "narcissistic" and should "stop wallowing in sadness." This participant continues,

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“I don't think people realized, other than my husband, I don't, he understood but he couldn't do anything, but I don't think anyone else realized that it wasn't disappointment, I was like, devastated. The participant goes on to describe her second attempt to reach out, when her c-section born child was approximately four years old:

. . . a couple of months ago I went to my doctor and I . . . I thought, “well it's been a few years I should probably try to process some of this” and I went to the doctor, a new doctor, and told her that I wanted to see, I wanted like a referral to a psychologist or somebody and she said, “for what?” and I sort of said, “well you know I had this c-section” . . . “but your baby's fine” “yes” “so what's the problem?” . . . and I was like, “yeah it's not about the baby it's about me” and she goes, “so why are you upset, your baby's fine right?” So I was like, “[Dr.], you're just not getting this” like and I just, I couldn't you know, “forget it, like just forget I asked, it's not worth explaining, I don't feel like doing it, I don't feel like educating you right now, like I'm done, I'll figure it out on my own.”

This particular participant wrote about her experience in her blog:

. . . next time . . . if you are a primary care practitioner and a woman has the guts to come in and ask for help . . . just don't laugh at her, you know, even if you can't help, just say, “I'm sorry I don't know or I can't help,” take on the responsibility of not know what to do and

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at least then nobody feels belittled. I mean, then it's just a matter of, "okay well, thanks anyway" as opposed to walking away feeling like an idiot.

At the time of our interview, this participant still had not accessed any professional help for her trauma after her initial attempts, I was able to provide her with a referral.

Yet another participant recalled her midwife's ten-day visit after her c-section under general anaesthetic:

I was sitting in my living room bawling and she came to do a visit and I was talking about how disappointed I was and how I had let myself down and I had let [husband] down and, and she said to me, "you know, I just came from visiting a mom who um, the man she says is the father is denying paternity and, and so she's having to get blood tests." And, and she basically was saying like, "you've got a loving husband, what do you have to be upset about?" And that, again, I think her intention's probably good but the message I got was "it's not okay to talk about this." 'Cause if it's not okay to talk about it with my midwife who is it okay to talk about with? And then, so then that's when I really started shoving people away because I thought, "I can't tell you what I feel so what's the point of talking because it's all I feel, it's all I feel all day, and I spend all day trying to make it up to this baby." . . . what does stand out for me is that it's not okay for us not to talk about it. And it's not okay to try to refocus women

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who are feeling that sense of disappointment and say, "oh well you should be grateful for this, or your baby's healthy" the number of times I heard that . . . yeah, I'm not saying that's not true but I'm a broken mess and nobody wants to pay attention to that.

Participants being told that they should be feeling just fine because their baby was healthy was very common, and experienced by participants as hurtful.

Another participant stated:

Whenever I talked about those feelings all I got was, you know, "well you have a healthy baby, and isn't that great, you have a healthy baby," and but, but that's not what I was talking about, you know . . . it's really mourning, it's grief. And, and I don't, I think maybe it might be different now, there's a lot more awareness now, but at the time um, there was no room for that for anybody, it was all, "well, well, you've got a healthy baby, what are you complaining about? What's wrong? That's all that matters." It isn't all that matters, really, like it didn't feel that way anyway.

Experiences such as these confirmed for participants that their shame was and fear of judgment was justified.

Expectations of Birth and Bonding

Expectations of birth and bonding refer to participants' particular hopes and dreams for her labour and delivery. None of the participants I interviewed had hoped for a c-section and only one planned for one, under the influence of family and medical professionals due to her pregnancy with twins. Similarly,

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participants had hopes that they would have loving and bonded relationships with their infants.

From the time women are little girls, they are often preparing to become mothers. In Western culture in particular, little girls may seek out and are often provided with baby dolls and all of their accessories. Kleiman and Raskin (1994) write:

Our image of ourselves as mothers begins very early in our psychological development. By the age of two or three, little girls start to identify with their mothers and see themselves as potential mothers. The expectation of becoming mothers when we grew up permeated our childhood play—before we even knew where babies came from, most of us were dressing up as Mommy and playing “house”—and shaped our sense of what being female would mean to us. (pp. 198-199)

When a woman becomes pregnant as an adult, she may start to plan for the birth of her child. The expectations that arise from this planning may involve two very distinct processes: birth and bonding. Under these two categories are several subcategories. Under the category of expectations of birth: perceived failure as a parent, impact of medical terminology on feelings of failure, fears about the impact of the c-section on the child, and finally, missed experiences. Under the category of expectations of bonding falls the subcategory of making up for the loss.

Expectations of birth. A very small minority of women elect to have c-sections, often for very personal reasons (such as prior trauma during a vaginal

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birth, or childhood sexual abuse) or out of a sense of fear of the pain, discomfort, and inconvenience of a vaginal birth. One participant planned a c-section, on the advice of her family and medical practitioners due to carrying twins. None of the participants anticipated the pain and emotional turmoil they would experience as a result. In fact, several participants commented on their lack of preparedness for the occurrence of such an event, one participant aptly commented, “what the hell is happening?” and after some time, “what the hell just happened?”

One participant, who had a planned c-section, described her feelings about the birth in this way:

It was very mechanical and it was like the doctors took credit for what I felt was my work, you know, like you know . . . like if you're an artist or you write a book or something and then they, they take credit for it, so I didn't really feel like the twins were even mine and I felt really betrayed by my midwife who didn't tell me that I could have had an option or helped me through it emotionally.

Many participants felt an absolute sense of failure, that their bodies had betrayed them, or that they had lost control. One participant told me:

. . . I was still in a lot of pain and I was depressed and . . . I just felt like I had failed right, like . . . if I tried harder or something, like nothing that makes any sense, but it was that stress and the, the trauma of everything that unfolded that just sunk me further into depression.

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And from another participant:

. . . that first day was, I'm not going to sleep 'cause I really spent a lot of time thinking really, what the hell happened? How did all of this happen? How can a person prepare so much and do all of the things that you're supposed to do, and, and then end up with a c-section? . . . I felt disappointed in myself . . . I just felt like, what the hell happened? I felt like my body failed me. I felt like I failed giving this gentle experience that I wanted to give my baby because I had done so much . . . preparation in my head.

Another participant described her feelings the first night she spent in the hospital after her c-section:

. . . the first night was actually probably the worse night of my life, like I've never felt so totally just . . . I don't even know how, what the word would be, just every negative word you can think of, vulnerable and miserable and in pain and . . . devastated.

Some participants felt that their own feelings of failure and loss were compounded by their interactions with others, at times medical staff and at other times, well-meaning family and friends.

Perceived failure as a parent. All of the participants wondered if their "failure" in delivering vaginally was reflective of what kind of parents they would be. One participant said:

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I just can't even believe that I was in that place and I felt so hopeless and so fucked up . . . and then I just laid there and thought about what a shitty mother I was, you know? I just felt . . . I just . . . I couldn't do pregnancy right and I couldn't do delivery right, and now I couldn't be a mom.

Another participant thought that the lack of control she felt during her delivery contributed to that feeling continuing into her parenting role. She described:

I feel like I would have been a better mother if I had, if I had been more in control of the birth and what was going on around me . . . it was that feeling of loss of control and when I look at the way that I was . . . the way I parented him as a baby I think that, I think it kind of set the stage for how I . . . I felt very out of control, I felt like I wasn't making the decisions or calling the shots, it was, it was very much reacting all the time to what was going on, and with him as well . . . I feel like it [the c-section] set the stage for how I was when he was a tiny little person.

Impact of medical terminology on perception of failure. One participant noted the use of medical terminology in describing her labour and delivery:

I have all my birth records and when you read through it, when you read through what the hospital writes, it's . . . it sounds awful. It's all these . . . you get all these magical phrases like uh, "failure to progress" . . . So you read all this stuff and um, it makes you feel . .

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. kind of made me feel awful reading that stuff as well, especially the "failure to progress" 'cause that just kind of stuck with me and it's like does that translate to other . . . is that what I'm going to be like as a mom?

Fears about impact of c-section birth on child. All of the participants I interviewed were concerned about the long-term effects of the c-section on their children. Many noticed differences in the way their children behaved as opposed to their vaginally born children and some participants speculated as to whether or not that was an effect of the birth, or an effect of how they may have treated their children differently. One participant describes it in the following way:

. . . [I was] really worried . . . feeling really worried about how this was going to affect the baby. Because I had done enough reading to know, this is not the way that they are supposed to come out and I was worried about bonding, I was already worried . . . I was just petrified about all this stuff; worried about bonding, worried about all of the hormonal things that are supposed to happen when you have a baby vaginally . . . you know that birth marks every, every person right, their birth story is so important. And if we had this kind of frustrating experience how is that going to mark [my son]? Like what kind, how is this going to, is this going to be an imprint on his life, is this going to be something that he'll have to work on, you know? And then I feel guilty about that.

Another participant described her thoughts in this way:

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. . . I just felt like I owed it to her, to try and you know, make up for this really awful entry into the world that she had. I mean, I just, I have this photo of her on the scale just screaming, naked, being weighed and just thinking, "my god this poor child, like this newborn baby gets ripped out of a stomach and stuck by herself naked on a scale, I mean this poor thing."

Five participants noticed differences in the personality and temperaments of their children, which they attributed in part to the mode of delivery they experienced, and the way they interacted with them early on due to the nature of the event:

. . . he's having to learn later how to self soothe and how to problem solve on his own because I rushed in all the time you know and that was about me and my sense of disappointment in his birth and I think that that has shaped his personality some . . . [it] still persists to this day even though she is four years old. I just, she's--where her sister was this like kind of strong thing, she's not. Like she's, she's not a fearful child . . . but there's-- she has a different personality, she's a much more vulnerable personality than her sister . . . I need to protect her in a way I never felt with my other child.

This participant's protective feelings towards her baby born by caesarean section were apparent in other choices she made. Here she explains:

. . . with my first child I just did all the shots when you are supposed to, I did everything by the book. With her, with the second . . . I didn't want to

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give her any shots at first, I waited until she was two before doing any vaccinations like, I just didn't want, I wouldn't let other people hold her as much, like I just . . . I just couldn't let her, I couldn't, I couldn't let her go I had to um, watch her.

Another participant expressed her fears about how the c-section would impact her child:

I worry that I've damaged him, I worry that, that somehow the birth and the way I was . . . you know I worry that that caused damage . . . I believe that birth trauma affect the child, you know almost, equally to how it affects the mom.

Finally, a participant asserts that although she is not certain how the c-section birth has affected her daughter specifically, she believes that it has had an impact. She told me, "there's no question, that the nature of her birth has had an impact on her life. I don't know in what ways, like I don't know exactly what that pathway is but there's no question that there's been an impact . . . whether I created it or whether it was inherent 'cause of the birth itself I don't know." This final quotation reiterates an important point about the impact of the c-section experience on a child. The question remains what impact there is if any, and whether it occurs as a direct result of the surgery itself, or as a result of the mother's reactions to that experience.

Missed experiences. Quite naturally, partners plan together the significant events of their baby's birth, assuming it is a vaginal birth: the crowning

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of the head, the cutting of the cord, the announcing of the sex of the baby, and even what to do with the placenta (more than one participant I interviewed was profoundly disturbed by the disappearance of her placenta after the caesarean section and expressed that the control of deciding how it would be taken care of after a vaginal birth was empowering). Participants heartbreakingly spoke to me of the loss of their missed experiences, and the interference of strangers in the rituals of birth. One participant thought on several occasions that her baby had already been born before she was actually sure, no one told her what was happening:

. . . I didn't know that he was born. I remember laying there going, "okay, like I did read the section on caesarean's in my book once or twice" like you know, I didn't go into them because I just really never thought that's what's going to happen. But I did remember that I might feel tugging and I remember at one point I kind of felt I was being moved and I was like, "okay, does that mean he's born?" and then eventually the anaesthesiologist said, "one twenty five!" like right in my face and I was like, I just stared at him like, "what the heck does that mean?" and then he said it again. And I remember I didn't react that time either, he said, "that's the time of birth" and I was like, "oh okay so the baby's been born."

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And in another example, "My husband was standing there and did the symbolic cutting of the cord but it was already cut." Another mother was not clear about the sex of her baby:

. . . .as soon as I kinda came to enough I, I looked over and [my husband's] sitting there holding the baby and my girlfriend's standing behind him and, and he said, "we have a boy". And I was just like, "what?" like, and so it's just one more piece of none of it making sense you know like, "what the hell just happened to me" and, and so, and it was a disappointment like you know I was thrilled but it was just one more piece of confusion.

Another participant told me how painful it was for her to lose the experience of giving her baby her first bath:

. . . I didn't actually get to touch her and the nurse . . . the nurse gave her a bath right there as I lay there and I just remember again thinking, "oh my god, she's giving her her first bath and I didn't even get to do that" . . . so, yeah just watching her, watching the nurse give her a bath was, I just lay there crying like I, I just couldn't even speak . . . I couldn't say no because I couldn't, my thoughts weren't together and I just, even though I knew I didn't want them to do it I couldn't really get that out and nobody else I think understood how important that would be.

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This same participant described how, as she lay recovering from surgery, she could hear another woman giving birth normally. This was incredibly difficult for this participant. She begged the nurses to move her so she could not hear what was going on, but they refused to do so. This participant described what the experience of hearing the other woman labouring was like for her she told me:

It was like salt in the wound, I mean it's like all the things I wanted that I'd spent nearly a year planning for I didn't, you know . . . it's like if you'd go to a, you know, it's your birthday and someone else gets to eat cake but you don't get to eat cake so you just have to watch them eating cake and you're like, "fuck, that's not right."

Several of the women explicitly talked about how difficult it was to not be the first person to hold their baby, that the first person was often a stranger in gloves and mask:

It wasn't until I was pregnant [again] and reflecting on my first experience that I realized that I spent a lot of time in the early months and probably still today, trying to make up for those lost moments of bonding. And even though he was, you know I know he was with my husband, I just felt like the hands that were on him first, you know a surgeon's hands and then a nurse's hands it just . . . just felt like it should have been us, right?

Another participant describes how she has altered the story of her c-section born son's birth to make it sound more like the homebirth she experienced with her daughter. She told me:

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He knows he was born by caesarean and we talk about how daddy was the first one to hold him and that's a lie because [participant begins to sob] the midwife was the first one to hold him and she, she basically as soon as the paediatrician checked him she grabbed him and ran out to the other room and gave him to [husband] you know like there was not a delay and, and so I know he was okay you know, like I know that, but it still pisses me off that it wasn't me, it still pisses me off that I wasn't awake.

Two of the seven participants in this study later became aware that it took so long for them to see their infant for the first time (let alone hold the baby) because the paediatric assessment was conducted by more than one person, the second being an intern in training.

Expectations of bonding. As has been mentioned, the notion of bonding has been a double-edged sword for many women. On one hand, we are told about the importance of bonding, how attachment matters for all areas of development of an infant and child's life. On the other hand, we are inundated with images of effortless bonding in the media, love at first sight, and intuitive mothering. What many women may not know, however, is that animal research has shown us that at times even primates must be shown how to breastfeed their young, that bonding is not necessarily effortless and natural. All of the participants I interviewed were concerned about the lack of bonding they experienced and the loss of the birth experience they had intended for their child. All of the participants devised ways to make up for the perceived loss.

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Making up for the loss. A common theme amongst participants was an urge to make up for the loss of the birth experience, and in many cases, the loss of the experience of bonding with the child that the participant had anticipated. Participants described devising a number of strategies to make up for the loss, including carrying the baby in a sling, breastfeeding and extended breastfeeding, and (in one case) consciously over attending the child ("Baby TV"). One participant told me:

I don't have this emotional connection I know I'm suppose to have so at least I can breastfeed him and . . . I will hold him and not put him down and I will wear him in the sling as a sort of a replacement for the feelings that I . . . didn't have.

In addition, another participant describes the way she carried her son:

I felt like I could never put him down . . . I carried him, I was going to carry him anyways but it felt like I was carrying him and he was a big boy and he grew, he grew fast. So for me it was like I was carrying around a big, big boy even though my back was sore or like I couldn't do it anymore I was still, I would never put him down . . . I think that in retrospect it was just trying to make up for not being there in the first few moments.

Finally, another participant with a graduate degree in Child and Youth Care describes how her education affected her behaviour towards her son:

. . . I know how important attachment is and I know how important that, those first few months are . . . I think I overcompensated like I never put him down, you know . . . in terms of my relationship with him, it was like I

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was gonna do everything I could to make sure that he never knew that I was falling apart. And so, when he went to sleep I felt like shit and I would cry a lot and, but when I was with him and awake there was just no way that I would let myself do that you know like I just really overcompensated. Several participants discussed the importance of breastfeeding in fostering a closer connection between them and their babies:

. . . the first time I nursed her I was like, "okay this is the, okay at least this is working, if nothing else worked at least this is working" . . . I just felt like okay, at least this I can do and this I can give her . . . the baby was amazing and she nursed really beautifully which in retrospect like definitely saved the day, I mean I nursed her for two and a half years whereas her sister I only nursed for four months, you know I had more, I'd committed to more nursing with the second anyway but I probably nursed her longer because of her birth.

Some participants found themselves with an aversion to their infants, finding themselves lapsing into memories of labour and delivery rather than being present with their child. One participant who had a vaginal birth prior to her caesarean section recalled the discrepancy in the way she interacted with her babies. With the former, she engaged in what she called "Baby TV," watching him for hours, engage by the intricacies of his tiny body. She found it tremendously difficult to do this with her son born by c-section and compensated by actively, consciously spending time gazing at him:

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. . . I actively started doing it on purpose. So I'd sit there and I'd force it, I'd be like, "I'm not going to think about his birth I'm not gonna let my mind wander I'm gonna just look at him, I'm gonna focus on him, I'm gonna think about him, I'm gonna practice Baby TV."

She poignantly recalls the moment she felt the rush of love she had with her first-born that she had found lacking in her relationship with her second:

. . . I guess just two days ago I was watching him while he was playing, and really being aware that I was giving my attention to him and I was trying not to daydream about all the housework I had to do, and you know he turned around and he smiled and I actually felt that sort of rush that I just haven't felt as much with him at all whereas with my first one I feel it a lot.

Another participant related to me the moment when she first felt bonded to her son when he was several months old. She had gone out for the first time with some friends and had left the baby at home with his father. On her way home, she learned that there had been a shooting on the reserve where her home was located. She told me about the feelings that arose for her:

. . . my heart dropped and I was like . . . "oh my god, like what happened and my baby is there" and in that moment like I missed my baby, and I wanted to get home right then to make sure that he was okay and, and things definitely picked up like that, that was sort of my moment of like, magical bonding.

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For these participants, it was months or even years before they felt connected to their infants in the way they thought they would like to. Sadly, as we have already seen, the bonding never seemed to come for one of the participants.

As has become apparent, perhaps more than any other component of this research, the expectation a mother held for her labour and delivery and the feelings she would have towards her child upon his or her arrival, proved to be the most painful and difficult due to a discrepancy between hope and reality.

Participants' Use of Adjectives and Metaphors

Interspersed throughout this work has been mention of participants' use of adjectives and metaphors to describe their experiences. I was my own experience that led me to take interest in this particular way of conveying meaning. Specifically, I used metaphor myself to explain to others how I felt when I first saw my c-section born son, in order to convey my subjective sense of disconnection. With this in mind, I listened carefully as participants recounted their narratives for their use of adjectives and metaphors. In coding the data, I kept a running log of these descriptions and found that they fell into one or two of three categories: descriptions of birth, descriptions of sense of self in birth, and descriptions of the infant. The majority of descriptions occurred in the category of birth. As aforementioned, the major theme was that of adjectives and metaphors commonly used to describe war. For example: shell shocked, in a battle, and trying to protect oneself. One participant described the birth as a nightmare. Two participants described it as surreal and three outright called the

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birth a trauma. One participant described the birth as mechanical and the medical model of care as a machine.

In describing their sense of self in birth, participants' terms and images such as being shocked, feeling damaged, feeling like an object, or not in one's body, and feeling like being suffocated. Two participants described the experience as not unlike being crucified. One participant described the c-section as like being an artist or an author and having someone else take credit for your work. Another, upon hearing a woman delivering her baby vaginally in another room, described the experience as like wanting to have cake, not being able to, and being forced to observe as someone else enjoyed a slice.

Finally, one participant very vividly described her sense of her infant twins. She referred to experience of a planned c-section as being like a cow in the field about to give birth to a calf that is intended to be taken for veal, or horses that are bred for show, so that the men around them can buy them up. She described her sense of her children as if they were guests, or children who had been adopted into the family. Finally, this participant painted a vivid picture of the difference in how she felt towards her c-section children and her vaginally born son when she described standing in front of a train for them, in the case of the former, out of a sense of intellectual duty, and in the case of the latter, out of a primal urge.

These metaphors vividly describe women's experiences of disconnection and birth distress in only a few short words. They allow an outsider a glimpse of the experience as it was lived by these participants. It is my hope that these

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snapshots serve to give the reader a better understanding of the tremendous impact these experiences had on the women who lived them. In order to provide a more complete understanding of the results that this research generated, we will now turn to a discussion of the findings.

Chapter 5. Discussion

The themes that have unfolded from the participants' narratives as they were shared with me have been gratifying to disassemble and reconstruct. There has been a tremendous amount of overlap in themes, images, and metaphors yet every woman's experience has been different. I initially set out to demonstrate that c-sections can lead to a feeling of disconnection between a mother and child and what I have found is that while that is sometimes the case, what also occurs on a wider scale is a profound sense of distress around labour and delivery. These feelings may extend beyond the birth to the post partum period and perhaps even years later. They might affect the lives of not just mothers and children, but also partners, families, communities, and society as a whole. I heard participants describe themselves as failures, as feeling betrayed--by their bodies, by a medical model of care, and by their midwives. I have heard participants refer to their c-sections as war zones, fighting to protect themselves and their babies, and ultimately losing control. Participants have referred to themselves as shell shocked, devastated, and traumatized. Participants have wept openly out of guilt, shame, anger and a deep sense of sadness, regret, and loss. Through these interviews, I have been witness to participants struggling to connect with their children despite their sense that something precious and vital had been severed between them as a result of the birthing process.

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The results of this research have been grouped into three main themes: suffering a traumatic experience, forces of relation, and expectations. All of these themes are encompassed within the context of culture, which inevitably touches and colours all of these aspects of a woman's experience.

Discussion of Suffering a Traumatic Experience

The trauma of birth that participants endured is apparent in their language, use of metaphors, and narratives of the birth experience (e.g., surgery, lingering after-effects). For example, participants described themselves as feeling shell shocked, in a battle, and as if they were being crucified. They described themselves as spectators, not in their bodies, and as objects with no control over their own birthing process or bodily experience. Participants struggled with significant post trauma symptoms including dissociation, hyper arousal, hyper vigilance, flashbacks, nightmares, social withdrawal, and isolation.

One of the main contributing factors to the traumatic nature of these births was the environment in which the delivery took place. Several participants intended to give birth at the hospital, several did not, and all but one had planned to have a vaginal birth. Participants recalled explicit details of the operating room and the cold sterility of the environment--so much different than what many participants had anticipated (most particularly those who intended to give birth at home). Many participants described the presence and interference of strangers in the hospital setting. Some hospital staff were supportive, others were

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dismissive and still others were described as cruel. Simkin and Klaus describe a typical caesarean section:

This operation is considered necessary if there are *insoluble* problems with the baby's or mother's health and well-being, if labour progress stops and does not respond to measures to speed it up, or if the *baby seems stuck* and won't move down.

You will be anesthetized, probably with a spinal or epidural, which *numbs you* from your breasts to your toes. Or you might on rare occasions receive general anaesthesia, which causes *loss of consciousness*.

You are *unable to move your legs or roll over*, so 3 or 4 staff members will place your body on rollers and slide you between your bed and the delivery table. You cannot help move yourself. Your legs are *strapped together* onto the table, so they won't fall off.

A drape is placed between your head and lower body so that you cannot see the surgery or the surgeons and they cannot see your face.

One or both arms are usually strapped to boards that extend out from each side of the table.

Everyone in the room, including your partner, *wears a mask*. You may have an *oxygen mask on your face*.

You may feel some *pressure and pulling sensations* (though you should feel no pain) during the surgery.

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The surgeons often discuss unrelated matters with each other *as if you are not there*, such as other patients, sport events, vacations, good restaurants. . .

After the surgery it is common for women to *feel nauseated and to tremble* for a period of a few minutes to an hour. There are medications to stop those reactions, but some may make you *groggy*.

Your first contact with your baby occurs after the baby has been checked and found to be healthy. The baby is wrapped so that you can see only the face. The nurse *frees at least one of your arms* so that you can touch your baby, but *you will not be able to hold the baby* until later. Your partner may hold the baby close to you.

The first feeding takes place one or two hours after the birth, when you are in your bed. If groggy from post-operative medications, you may be *unable to do the first feeding or to remember later that you did it*. The *nurse might grasp your breast* and put it in your baby's mouth.

Your partner may have more time and cuddling with your baby than you in the first days after the delivery. (pp. 263-264)

I have included this description in order to demonstrate the many potential circumstances under which a woman could be traumatized under even the best of scenarios. Indeed, many of these very events were described by the participants in this research, and we can see the impact that they had by the metaphors the participants used to describe them.

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We must not forget that women who have c-sections not only give birth to their child, but also undergo major surgery. Naomi Wolf (2001) writes:

If the new mother has had a caesarean, her incision will have only begun to knit at the time she is usually left alone with the baby; the wound is six weeks away from healing. Certainly, no one expects men recovering from major organ surgery to do *anything* continually strenuous in the weeks that immediately follow the operation, much less provide daily care, mostly alone, for a tiny, demanding infant. (p. 217)

This quote reminds us that there is more than one element of potential traumatized occurring in the case of a c-section: the birth of a child (which may be painful and distressing under the best of circumstances) and major surgery.

Yet, another traumatic component of their experiences related to how participants described fearing for the life of their child or of themselves. For example, in order to try to understand this fear, one participant described a (fascinating) theory about how the disconnection from one's child may, in fact, be an adaptive function in case the child dies in utero, or during labour and delivery. It is also possible, although not explored in this particular piece of research, that women who are most affected by the c-section births may have a history of prior trauma experiences. Such a history of trauma might make the event of a caesarean section even more distressing (than it might be for someone without such a history) as it could be reminiscent of the details of the earlier trauma. For example, the feelings of loss of control or fear of imminent harm or even death might trigger or compound those same experiences which occurred at an earlier

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date. This issue has been addressed in research conducted by Soet et al.

(2003) they write:

. . . results indicated an association between the experience of trauma during birth and history of sexual trauma . . . Women who had experienced past sexual trauma were 12 times more likely to experience the childbirth event as traumatic. (p. 44)

It is not difficult to understand how labour and delivery could be a trigger for retraumatization in the case of women who have a childhood sexual abuse or sexual assault history. However, the participants in my research mentioned none of these experiences, and I did not inquire into them.

Finally, as was aforementioned, there is some evidence that some women may deny the effects of a traumatic birth. Specifically, societal pressure, as we have discussed, may be so great that a woman adamantly asserts that she is pleased to have had a "healthy child" and will admit to no long term negative effects.

Discussion of Forces of Relation

The forces of relation in the narrative of the participants I interviewed are also impossible to ignore. The principle focus has been on the nature of the relationship between the mother and her infant child. Five out of seven participants explicitly described themselves as feeling disconnected from their babies born via caesarean section, or not as connected as they were towards their children who were born vaginally; all expressed profound distress at their c-

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section birth experience. For example, participants described their babies as strangers, visitors, the child of someone else, and even like an animal bred specifically for the benefit of a powerful man. All of the participants I interviewed suffered from very intense negative emotions both at the time of the c-section birth and when recalling their experiences of it for me. The intensity of these emotions made it difficult for some of the women to reach out to others for support.

Cultural Implications of Forces of Relation

As we have seen, culturally it may not be viewed as acceptable to experience anything other than deep joy and love at the birth of one's child. For example, "Our culture and the media play a powerful role in shaping our expectations. And these expectations, in turn, create enormous pressure on mothers to strive for perfection" (Kleinman & Raskin, 1994, p.198). In a related field of study to psychology, ethnopediatrics may be described as:

a way of looking at infants from an evolutionarily informed perspective . . . by combining cross-cultural studies on the various ways in which culture influences child-care styles, we can explore the effects those varying styles have on infant biology. (Small, 1998, p.xii)

Despite a plethora of research done on the cross-cultural practices of infant and child care, there has been very little research done on the subjective feelings mother's have towards their infants cross culturally. One exception is a study done on the prenatal and postpartum attitudes of Greek women towards a variety

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of factors involved in motherhood, including their feelings towards their infants.

The author writes:

Maternal attitudes are a product of a dynamic, interactional process whereby the infant's disposition and behaviour, as well as societal and cultural assumptions, influence maternal reactions to infants, which, in turn, influence infant reactions to maternal caregiving. Pregnancy, labour, and care of the newborn have changed drastically in response to more general social changes. Whereas they used to be social and cooperative par excellence, now they are performed mainly by the mother in a rather isolated framework. (Dragonas, 1987, p.267)

Greek culture may be seen as not unlike North American culture in a number of ways and therefore it is not surprising that this author would have found that the Greek participants of this study experienced a certain amount of anxiety as mothers.

Meredith Small (1998), differentiates between "traditional" (e.g. !Kung San of the Kalahari, the Ache of Paraguay, and the Gusii of East Africa) and "industrialized" societies (e.g., Japan and the United States of America). She defines "traditional" and "industrialized" in the following way:

I have divided these examples below into "traditional" and "industrial" societies. These labels are efficient, but they are really smoke and mirrors. What does traditional mean when it is clear that societies and culture change over time? Where do we draw the line for "traditional"? Nor are all people in industrial societies "westernized". And various

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industrialized societies clearly do not share the same values . . . but this division *will* set apart in the reader's mind more unfamiliar societies from those that might, at first, appear to be more familiar to most readers. We expect the traditional societies to be quite different from our, and they are, but there are also surprising commonalities. (Small,1998, p.76)

From this definition of "industrialized" and "traditional" societies it becomes apparent that even though these labels are not necessarily discrete entities, a predominant cultural milieu may be seen to exist in countries that fall into either of these categories.

Small goes on to describe how the core values of a society influences parenting behaviour:

Parents in different cultures believe they have some influence on the development of their child, but how much influence varies from culture to culture. Some parents think that their job is first and foremost to keep the child alive, and that only later, when the dangers have passed, training can begin. Others believe that much of how a child turns out is *destined from birth*. And every parent, every adult member of a society, has an opinion on how kids should be brought up "right." (p.108; italics mine)

And therein perhaps lies the crux of the cultural influence. In industrialized societies such as North America the belief of many may be that birth and bonding mark an individual for life, a sentiment certainly echoed by many of the participants in this research. However, in traditional societies, more of a focus may be placed on the physical survival of the child thereby removing the

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expectation that the child needs to be instantly and gloriously loved, perhaps it is an expectation that the loving comes later, when a child may be expected to survive beyond infancy and early childhood.

There are other cultural differences that impact a women's subjective feelings towards her infant as well. For example, inflated rates of c-sections in industrialized societies and the traumatic experience that may be for mothers. Although six out of the seven participants in this research described their levels of social support as high, there can be little doubt that North American culture for the most part, does not have the same cooperative communal living as might a traditional community. As Dragonas (1987) pointed out, the mother is for the most part, isolated. This isolation puts an additional pressure on a mother, the expectation is that the very future of her child is dependent on her successful birth and bonding which may then be believed to determine the quality of her care towards the child. Wolf (2001) writes:

In India, Pakistan, Ecuador, and Brazil . . . special postpartum care involves feeding the new mother special ritual foods—often chicken—or marrow-based soups—that replenish the new mother's lost protein, blood, and fluids and build her iron levels. This tradition of older, more experienced women feeding and essentially "babying" the new mother, so she has the resources to baby her baby, also gives the new mother the nurturing that frees her to grow into her own maternity. It is natural, as a new mother, to regress. But our culture, in contrast, operates under the misconception that the woman who has just given birth will automatically

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know how to be a mother and will naturally have enough left in her, after the crucible of birth, to give her all without replenishment. (pp. 220-1)

This quotation serves to further expand on the notion that North American society is not necessarily the ideal context within which to give birth, even under the best of circumstances. Combining societal pressures on mothers as well as the economical capitalistic structure that often has partners working full time to survive (and at times the woman herself) the expectations of motherhood are nearly impossible to achieve.

Three of the participants that I interviewed kept their feelings of disconnection to themselves (out of a sense of immense shame) until their symptoms of distress became so severe they needed to talk about it. Four participants reached out for support, yet felt invalidated, dismissed, or shamed by those to whom they disclosed their feelings. Two participants explicitly described how they were not spoken to by medical staff during the process of surgery and had no idea what was going on or what to expect. Two recalled conversations about golf taking place between surgeons and other medical professionals over them. One could see her own surgery about to take place in the overhead operating room light, and no one did anything to help her. Another participant called out that she felt pain during the surgery and she was immediately put under general anaesthetic, which she did not want. Several participants commented that as well meaning as support people were, they often only helped to make the situation feel worse (one participant commented that her husband may in fact have been nearly as traumatized by the c-section as she was).

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There has been a variety of research conducted on social support and its impact on women's experiences both during labour and delivery and post-partum. Some examples include: Turkish women and their post partum experience (Gungor, 2011); the role of social support in maternal role development in Australian women (Emmanuel, Creedy, St John, Gamble & Brown, 2008) and a study on the topic of "Pain and Enjoyment in Childbirth" (Norr, Block, Charlee, Meyering & Meyers, 1977). All of this research came to similar conclusions: "social support during labour is a critical factor in improving birth experiences" (Norr et al. 1977, p.260). These research findings have determined that without social support, women are vulnerable to anxiety and depression (Gungor, 2011), difficulty in adjusting to the role of motherhood (Emmanuel, et al. 2008), and increased perception of pain and decreased perception of pleasure in the birthing experience (Norr et al. 1977). The latter authors similarly comment on the role that medical practitioners play in a women's experience:

In addition to the presence of a familiar person during labour, a women must also relate to strangers. The medical staff—nurses, residents, interns and the attending physician—can have a positive effect on the woman's birth experience by providing moral support, reassurance and specific help including instruction in pain control. The staff can also have a negative effect, by increasing fear and anxiety or being particularly annoying (p.263).

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The participants I interviewed would most certainly agree with this statement, they might add however, how absolutely devastating the negative effects of the unsupportive behaviour of medical staff can be.

Discussion of Expectations of Birth and Bonding

The final theme that I explored was of expectations, specifically of birth and bonding. Women are encouraged by medical professionals to create for themselves and their partners a birth plan where they detail what they would like and how they would like to handle the variety of events and rituals that accompany a labour and delivery. The most dramatic disruption of these plans may be seen in the cases of participants who had planned on a homebirth and in fact laboured at home for an extended period of time before transferring to the hospital (sometimes with no bags packed and no preparations made).

Participants once again expressed a variety of strong emotions around the reality of their births: failure, loss of control, shame, and at times a deeply shaken belief in their own ability to parent their children. Participants heartbreakingly described their lost experiences: the first hands holding their child, seeing them for the first time, cutting the umbilical cord, announcing or discovering the sex of the baby, nursing immediately, skin to skin contact, and the first bath. Many participants felt that these experiences had forever been lost and were deeply saddened, but also angry and resentful at the medical model of care and the general lack of regard by medical professionals (and at times even well meaning family and friends) for the experience of both mother and child. Several participants

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questioned the need for a c-section altogether and continue to wonder to themselves whether it was medically necessary. Some participants sought out answers from their care providers and other professionals, particularly if they were looking forward to a vaginal birth after caesarean and wanted to ensure that what had gone wrong the first time would not happen again.

Two of the seven participants expressed feeling equally bonded to all of their children regardless of mode of delivery. All of the participants felt they had missed the “bonding experience” that they were expecting (i.e., a rush of love, a rush of recognition of the child that they had carried), either due to a lack of the feeling taking place as expected, or due to external constraints such as the involvement of medical staff which delayed mother-infant interaction. As we have seen, this expectation of instant bonding arises from a variety of sources. These include: cultural norms (and their delivery via the media), and scientific literature which has expressed that bonding occurs within a critical period, and that there may be detrimental effects to both mother and child if it fails to occur (Kleinman & Raskin, 1994; Klaus & Kennell, 1977). Many of the women felt that they had to “make up” for the birth of their baby born via c-section. The most common ways of doing so were by carrying the child in a sling, breastfeeding and, in one case, actively attending to the child in an attempt to forge a connection. Two participants described in detail the moment when they felt “bonded” to their baby in some cases many months after the birth. All of the participants wondered about the long term effects of the birth on their children. Some wondered whether the birth had anything to do with the differences they

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saw in the personalities or behaviours of their babies born via c-section. Others wondered if perhaps they treated those children in particular differently, if they were more protective, more disconnected and how that would shape them into the future. All of the participants expressed a deep desire and longing for their children to be okay, to be healthy and happy and to be and feel loved.

Soet et al. (2003) describe the nature of women's expectations around birth and bonding:

. . . women whose experience was more negative than expected were more likely to experience the birth as traumatic . . . women who have high positive expectations for the birth may have low anxiety. Such women may be unrealistic or feel unprepared when the unexpected happens (e.g., caesarean section). Either way, when the childbirth event does not fit with expectations, it may be more likely to be perceived as traumatic. (p. 44)

These same authors propose ways in which some of the negative outcomes of labour and delivery might be handled in preventing a woman from suffering a traumatic experience. They suggest:

The results of this study suggest several intervention points for health caregivers to help prevent a negative or traumatic birth experience. As suggested by Reynolds (1994), an important first step is taking a careful history during pregnancy, including an inquiry into past sexual trauma. . . In addition, childbirth education classes may be particularly effective. They may include information on how past sexual experiences may influence a woman's perceptions during the birth, and examining a

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woman's psychosocial functioning, including social support and expectations of the birth. Providing women with opportunities to discuss their expectations and realistic ideas of the experience of birth and hospital procedures may be useful. During delivery, medical personnel should strive to ensure good communication and excellent pain control, including allowing the woman to have a sense of control by giving her options. . . After delivery, Reynolds encourages discussion of the birth experience and ruling out post partum depression. (p. 45)

I believe, that the participants in this research would agree with these recommendations, and certainly add to the list the deliberate reduction of unnecessary c-sections being performed. I believe that policy based on sound research would go a long way to improving the lives of women and their infants which would in turn improve the quality of life for families, communities, and society as a whole.

Discussion: Conclusions

This piece of research, which is so near and dear to my heart, so close to my own experience, is preliminary. Perhaps it opens more questions than it answers and certainly more research in the same vein would undoubtedly be worthwhile and valuable. I conducted a literature review on some of the questions that remain unanswered and found in most cases a small number of valuable research projects that could stand to be expanded on. Specifically, what is the subjective experience of "bonding" exactly? How do women define

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this experience, what are the specific expectations? Of course, there are a number of papers that describe “bonding” (Klaus & Kennell, 1976/1982, Taylor, et al. 2003, Lamb, 1983, Cordon & Corkindale, 1998)—in most cases, using one or two of a variety of bonding and attachment scales. In one such study in particular, researchers conducted post partum interviews with mothers and calculated scores in three areas: maternal preoccupation, attachment representations, and checking behaviour (Feldman, et al. 2007). I would argue however, that none of these areas would adequately portray how a mother feels about her baby. The subjective feelings of bonding, and the expectations that a mother may have (even prenatally) can only in my opinion be discerned through a method of qualitative interviewing in which the voices of the women themselves are heard.

In cases of disconnection and birth distress, what is a mother's prenatal relationship like with the fetus she carries inside her? Several research participants mentioned being very ill during their pregnancies and one, a very young mother of twins in a very unsupportive partnership, felt a deep sense of foreboding about the future particularly since her chosen option for birthing her babies was ruled out early on in her pregnancy. I was only able to find a couple of articles that began to address this topic of a women's prenatal relationship with her infant and its effect on post partum attachment. One such article notes:

Daniel Stern observed that women progressively construct during pregnancy a representation of the child and of herself as a mother, which

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facilitates mother-infant interaction after delivery. (Figueriedo et al. 2009, p. 539-540)

We have seen what happens to this mental representation, when the birthing process the mother expects becomes glaringly and painfully difficult in reality. As Soet et al. (2003) noted, the woman is more likely to suffer a traumatic experience, and therefore, profound birth distress.

There have been several studies done on the relationship between birth trauma and previous trauma experiences in a woman's life. According to this research, a woman is more likely to experience labour and delivery as traumatizing if she has experienced prior trauma, particularly, childhood sexual abuse, and particularly if that trauma has not been "resolved" (Simkin & Klaus, 2004, p.31; Soet, 2003). There are a number of elements of labour and delivery that may serve as reminders of previous abuse, including the loss of control a woman may experience (Simkin and Klaus, 2004). In the case of the relationship between prior trauma and birth trauma, once again, the value of the expression of women's experiences in their own voices cannot be overestimated

Many questions remain about the birth experience in particular. For example, what is the effect of the duration of separation between mother and child on mothers' experiences of bonding/disconnection? A stronger, more satisfying connection may be forged if the mother sees her infant sooner. A mother may feel more disconnected the longer she has to wait to see her child. Perhaps there are differences in cases of c-sections with spinal anaesthesia versus general anaesthetic. The role of hormones (both natural and artificial)

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may play a more important role than we know in the process of bonding and attachment between mother and child. These processes may be disrupted by a wider variety of factors than we know; for example, a mother's extreme fear without the mitigating factors of social support and control as previously discussed.

All of these questions have been addressed in the literature, some more briefly than others and many with conflicting results. For example, there has been evidence both for and against a "critical bonding period:"

The time after delivery may be critical for the establishment of the bonding, but it would be extremely dangerous for the species survival if maternal attachment could not be elicited in other moments as well.

(Figueiredo et al. 2009, p.540)

There has similarly been some evidence that analgesics may interfere with bonding in both affecting the natural responses of the mother as well as a medicated infant. Figueiredo et al. (2009) conclude the following:

Mother bonding and child attachment are interdependent, seeing that one is determined and developed by the establishment of the other, also meaning that in the extent that the child is able to show his/her attachment to the mother, the mother has more cues to bond with the child." (p.540)

This finding demonstrates the reciprocal nature of the mother-child relationship.

The role of hormones has also been studied, particularly the hormone oxytocin. One such study found, "OT [neuropeptide oxytocin] is related to human bonding; OT levels are consistent across pregnancy, and initial levels predict

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postpartum bonding behaviours; and OT is related to the mental, as well as the behavioural aspects of bonding” (Feldman et al. 2007, p.969). What is unaddressed however, is how the neuropeptide oxytocin may be disrupted by birth trauma (or even how its production in the prenatal and postpartum mother may be affected by prior life trauma). Similarly, the effects of the variety of medications that are administered to a women during a c-section and in some cases, an induction as well (i.e., the use of Pitocin) remains a concern.

A number of questions remain unanswered: the number and type of medical interventions prior to the c-section and their impact, and whether or not the c-section is an emergency or planned (how prepared the mother may be for what she is about to experience). I would hypothesize that the larger the number of medical interventions conducted on a woman in the process of birth (including those that may be involved in a vaginal birth), the more likely the event is to be perceived by the mother as traumatic. Similarly, I would hypothesize that the more prepared the mother is for a c-section and all that it entails, the less likely she is to feel traumatized by the experience. This last point is particularly important, especially when it comes to medical staff and support people present at the birth, to speak directly to the mother (if she so chooses) in order to inform her about what is occurring and what she can expect.

Similarly, an area of research to be considered in the future is the experiences of older women with adult children and how their relationships changed over time, as well as an examination of what factors may have facilitated closeness and connection for them, if in fact that occurred. One article

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on this topic described adult children's perceptions of their mother's depression and their memories of bonding. Adult children in this study perceived their "depressed" mothers as having "anxious" and "avoidant" attachment and reported fewer memories of maternal "care" (Aaronson, 2010). A study by Simkin (1991) explored the nature of women's memories of their labour and deliveries many years after their births. The participants completed questionnaires and provided an unstructured account of their experiences shortly after birth and 15-20 years later. Simkin found that:

Women reported that their memories were vivid and deeply felt. Those with highest long-term satisfaction ratings thought that they had accomplished something important, that they were in control, and that the birth experience contributed to their self-confidence and self-esteem. They had positive memories of their doctors' and nurses' words and actions. These positive associations were not reported among women with lower satisfaction ratings. (p.203)

The results of these two pieces of research affirm that indeed the perceived effects of labour and delivery are long lasting on both mother and child. What is missing from the literature, however, is a description of women's subjective feelings towards their infants and how these may or may not change over time. It remains of interest to determine how feelings of birth distress and disconnection may be reconciled over the course of a women's lifetime, how and why her feelings might change over time, and how she may feel towards her c-section born and vaginally born children when they are adults.

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Final Conclusions

In going into the future and perhaps beginning to answer some of these questions, my hypothesis is that the answer will be “it depends.” Each participant that I interviewed was unique and yet also expressed feelings shared by other participants. It is crucial that this type of research be conducted on a wider variety of participants, with a greater diversity, particularly in terms of age and ethnicity. Finally, and perhaps most interestingly, the question of culture is important to address. When I first discussed this project in a research class, my predominantly Indonesian classmates had no idea what I was talking about. They had never heard of the women in their country experiencing a sense of disconnection from their infants. Is that because it does not exist? Is it due to differences in medical care, social support or expectations?

Importantly, the results of this research are in no way meant to lead to the conclusion that all vaginal deliveries result in satisfactory bonding for mother and child. Certainly, there are women who have experienced satisfactory c-sections and women who have been profoundly distressed by their vaginal births, and the outcomes of these methods of delivery may be dependent on a variety of individual factors. Some possible factors contributing to birth distress that have been mentioned in the literature include: severity, duration, and continuation of pain; past experiences related to traumatic events; fear the baby will be harmed, and feeling out of control (Allen, 1998). The findings of this research are intended to shed light on the experiences that some women have when they undergo a c-section and how these experiences may be prevented and treated.

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The counselling implications of this study are extremely important. It is my hope that mental health clinicians will gain a deeper, more personal understanding of what a woman might be going through when she experiences birth distress and disconnection from her infant. In being exposed to the findings of this research, clinicians may be more skilful in empathically entering the experience of their clients and will therefore be much more successful in not only conveying understanding but also in formulating treatment plans for healing and recovery. I hope that in reading this thesis, clinicians will find comfort and confidence in asking their clients about their experiences of labour and delivery and the post partum period as part of an assessment procedure in order to counter some of the shame their clients may bring into the counselling room with them. Similarly, I hope that clinicians will employ the very valuable use of metaphor as a treatment intervention. Finally, clinicians with the desire and means to do so, may be motivated to pursue further research projects in this same vein, with the intention of improving the physical and emotional care of women and their children.

We will now turn to the conclusion and final remarks relating to the findings of this research.

Chapter 6. Conclusion

It has been my intention to share the experiences of women who have had a very specific and not often discussed experience: birth distress and feelings of disconnection from their infants. A number of themes and subthemes have emerged from the analysis of these experiences including the roles played by trauma, relationships, and expectations. All of these themes are encompassed within the larger context of culture and the pressures that mothers experience to birth in a particular way and be satisfied with the results. There is no doubt that these narratives have been shaped and coloured by pain, loss, feelings of failure, shame, guilt, and betrayal by a system whose stated intention is to care in the best possible way for women and their babies. This study serves to enlighten, inform, comfort, and provide a shared sense of connection among women.

Specifically, professionals in fields of mental and physical health can also benefit from this research. First, mental health professionals who see women who are profoundly distressed by birth experiences can benefit from reading this thesis as a means of understanding better the variety of potential effects of these experiences. Simkin and Klaus (2004) write:

Women and their partners need the opportunity to express distressing feelings related to a negative birth experience. They need permission to feel the pain and anger, and take the time to grieve the experience and

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eventually move forward. . . trauma that is not acknowledged will manifest in a variety of destructive and negative behaviours. (p.97)

Keeping this in mind, a clinician, having been acquainted with the findings of this research, could wonder aloud if the client perceived the experience of labour and delivery as traumatic. The clinician could explore with a client if she feels a sense of disconnection from her child and perhaps has been too full of shame to disclose to anyone else. The client could be asked about the birth environment, if she feared for her life or the life of her child, and importantly, if she has experienced previous trauma, particularly childhood sexual abuse or a previous sexual assault. The clinician could inquire about perceived support that the woman may or may not have received, from both professionals and family members. Finally, inquiring about a woman's expectations about birth and bonding would undoubtedly prove to be therapeutic for the client and may indeed be the only time the woman has felt safe enough to discuss her difficult and potentially shameful feelings.

Second, birthing professionals, whether they are a midwife, nurse, doula or doctor, can also benefit from the results of this research, and certainly help to improve the care they provide to patients. Simkin and Klaus (2004) remind us that "a truly positive birth experience includes both a good clinical and a good emotional outcome for mother and baby. A healthy newborn with a depressed or traumatized mother is not a good outcome" (p.77). Professionals armed with an understanding of what factors might potentially damage a woman, and negatively affect her birth experience, could take steps to minimize these events, even if a

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c-section is necessary. Having an understanding of what is important to women in terms of a birthing experience, can help professionals to give some of this to their patients as much as they are able. For example, communicating with a patient, allowing her some sense of control over her experience, validating and affirming her feelings of distress, and importantly, allowing a woman the safety and opportunity to express her needs and seeing that they are met to the best of the professional's ability.

In both of these cases, a greater, more intimate understanding of a woman's experience can help professionals support the experience of both mother and child, and change how women and their families are cared for if they do experience trauma and distress during birth. For example, in their text on the topic of childhood sexual abuse and birth trauma, authors Simkin and Klaus (2004), provide recommendations for the care of a traumatized mother and her infant. Specifically, they provide solutions to aid a mother who may feel a sense of disconnection or aversion from her infant. They write:

Allow expressions of anger, lack of confidence, dislike toward baby.

Encourage a more positive family member to be with baby. Don't rush the contact between mother and baby. . . Model ways to hold the child; encourage positive gestures by mother; point out how baby responds to her; show her infant cues. Make sure mother has resources and follow-up after leaving hospital. (p.83)

These recommendations are extremely important. I did not personally experience this level of care in a hospital setting, nor did the participants in this

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research. It is my hope that bringing awareness to this topic will be a catalyst for change in care.

Finally, and perhaps most importantly, in reading this research, women who are suffering right now in shame and silence will be drawn into greater connection with other women and know that they are not alone. They may be comforted by the nature of the shared experiences with other women, and also energized (as connections are apt to do) into action: to seek out help for themselves and their families, to share their stories, and to demand better care for themselves and other women. Similarly, I hope that I have been successful in drawing attention to the way in which societal pressures may contribute to a mother's experience of trauma in childbirth: that her deep pain may be complicated by the expectation that her labour and delivery unfold in a particular way and that she must be unfailingly satisfied with the experience--and her baby. I hope to empower women to be at peace with their role in their labour and delivery, no matter what the outcome, and to recognize the incredible forces that they are standing against in forgiving themselves for any perceived wrongdoing.

Glenn (1994) writes:

How do we break mothering free of ideological encapsulation? Such an effort involves deconstruction at two levels. First we need to decompose mothering into constituent elements that are fused within the master definition of mother. Woman is conflated with mother, and together appears as an undifferentiated and unchanging monolith . . . Actor and activity are similarly conflated when only women or birth-mothers are

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recognized as nurturers and caregivers. This fusion excuses others from responsibility, denies recognition to those, including men, who are provide nurturance and care, and assumes nurturance flows in only one direction. Thus, women's need to be mothered is ignored. Another form of fusion involves treating mother and child as a single entity with unitary interests. This fusion denies personhood and agency to both. In fact, mothers' interests and children's interests may conflict, and mothers may be forced to choose between them . . . Decomposing mothering would broaden our field of vision to encompass the variety of actors who mother, the multiple identities/roles of women who mother, and the separate personhood and agency of mothers and children. (p.13)

I would argue that Glenn's notion of "decomposing" motherhood would also serve to diminish some of the societal pressure on women thereby relieving some of the tremendous shame and guilt experienced when birth and bonding do not meet expectations.

In short, my own experience initiated this study and as a result, perhaps touched the lives of other in a positive way.

Limitations

The research I have conducted has only begun to answer the question of what factors may lead to disconnection and birth distress in some women. I made the greatest effort to ensure reliability, specifically in the areas of usefulness, completeness, researcher positioning and writing style/research design. I fulfilled the requirements in the following ways: I intended to enlighten

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the reader, whether mental health professionals, birthing professionals, researchers, or a general audience, and hopefully provide the catalyst for change in all of these realms; I conducted a thorough literature review, and drew upon multiple voices who offered thick descriptions of experience; I have personally experienced disconnection and birth distress, and finally, I employed narrative inquiry through a feminist lens in order to provide rich, thick descriptions of participants' narratives as well as addressing the cultural context in which these experiences occurred.

The participants that I interviewed offer a unique contribution to this field of research. Their experiences are deeply personal, complex, and entirely their own. Although it is certain that commonalities emerged within the narratives, it is just as correct to say that these experiences are unique. Not all women who have had c-sections will experience disconnection and birth distress, just as not all vaginal births will conform to the societal image of an ultimately pleasurable and connected experience. Childbirth is painful. It can be frightening. And not all women deliver under the same circumstances. Some women deliver babies that they did not want or cannot care for. Some women as babies were not wanted or cared for themselves. It has been my hope and intention throughout this research to not re-enact the very societal pressures that mothers experience: that of a "right" way to do labour and delivery, a "right" way to feel about one's child. Naomi Wolf (2001) writes:

C-sections are not like tonsillectomies. In fact, many women who have undergone C-sections have had traumatic experiences. Calling attention

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to these serious downsides of the surgery is not to suggest that the decision to have the surgery or the decision to avoid it is the “right” decision. Nor is it to overlook the fact that when caesareans are truly medically necessary, they are a Godsend for mother and baby, rescuing them from situations that might have killed either or both a century ago. I am struck, however, by how little real information is available to women to help them understand the pressure toward C-sections that are not necessarily medically called for. (p.176).

In this quote, Wolf demonstrates the dilemma that many women are faced with when wanting to do the best for themselves and their babies. What are the costs in labour, delivery, and motherhood of conformity or rebellion?

The opportunity to conduct this research with these participants has been an incredible privilege for me. Yet, having lived a similar experience myself is a double-edged sword. On one hand, I deeply related to the narratives the participants shared. On the other hand, I do not want to assume too much, imposing my own experience, or view experiences of other's through my own lens. I have made the greatest attempt to provide some context for these stories, to demonstrate how they both fit into a pattern of shared experience and stand uniquely on their own. I hope I have done them justice.

I sincerely hope that the results this research has generated is of interest to a variety of populations as well: the women and children affected, their partners and families, medical professionals, psychological professionals and other researchers. I hope that these findings have helped to shed a sliver of light

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on the experiences of women that seem so tragically common and yet are so rarely openly discussed.

Appendices

Appendix 1: Participant Recruitment Poster

Mothers Wanted

Participate in a Research Study on the topic of Women's Relationship with their Infants

Are you a woman who has had two different birthing experiences?

Have you experienced both a c-section and a vaginal birth?

Did you experience differences in your relationship with your infant after these two types of births?

Would you like to participate in a confidential interview to talk about these differences?

If you are interested in participating or would like more information, please contact:

Helen Dunn, BA (Graduate Student, MA)
Supervisor: Dr. Patrice Keats, PhD
Simon Fraser University - Department of Counselling Psychology
778-782-8479
hmv@sfu.ca

Women's Experience
Helen Dunn, BA
778-782-8479
hmv@sfu.ca

Appendix 2: Interview Protocol

Demographic Information

1. Current Age
2. Age at time of deliveries
3. Modes of delivery and order of birth (i.e. first child delivered via vaginal birth, second via c-section)
4. Ethnicity
5. Marital Status (currently and at time of deliveries)
6. Socioeconomic Status (lower, middle, upper); (currently and at time of deliveries)
7. Level of social support (currently and at time of deliveries)

Interview Protocol

1. Opening Question: "tell me about what childbirth was like for you?"

Semi-Structured Prompt Questions

- How did your experience differ from your expectation of what it (labour, delivery, feelings toward child etc.) was going to be like?
- In that moment what do you remember it being like for you?
- What do you remember feeling?

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- Tell me how you felt about your baby? How did you feel towards him?
- How did you feel *about* your feelings towards your baby?
- Please tell me how you made sense of your feelings. Did you conceptualize your feelings as normal? Feelings that anyone may have (feeling like you were not connecting with their baby right away)?
- Please tell me about when you began to have feelings of closeness and connection to your baby. Was it something you felt like you eased in to or was there one moment in particular that you can recall?
- How have your feelings towards your baby changed over time? How do you feel about your child now?
- What was going on for you at that time?
- Please share with me anything else that you think you might want to tell me about that experience.
- Am I getting that right?
- Please say more about what that was like for you.
- Tell me what you remember thinking or feeling.
- What was it in particular about the support you received that was so important to you?
- Please tell me what you recall when your baby was handed to you (after the c-section)? What was that experience like for you?
- Please tell me about any differences you may have felt towards your children based on the level of physical difficulty (i.e. amount of pain, length of labour) involved in the labour?

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- Please tell me if you think there was a difference for you in knowing what to expect in your second delivery having gone through the experience once before?
- How did your experience of social support impact your bonding experience with your children?
- Please share with me anything you'd like to tell me or think that you'd like me to know that you haven't mentioned yet.

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