

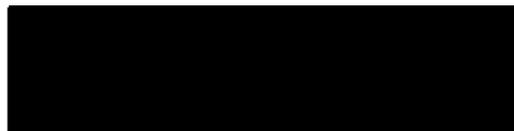
THE PERFECT STORM: UNEXPECTED BIRTHING EXPERIENCES AND
PERINATAL MOOD DISORDERS

Joanne Gerstner Goldbort

Submitted to the faculty of the University Graduate School
in partial fulfillment of the requirements
for the degree
Doctor of Philosophy
in the School of Nursing
Indiana University

May 2006

Accepted by the Faculty of Indiana University, in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

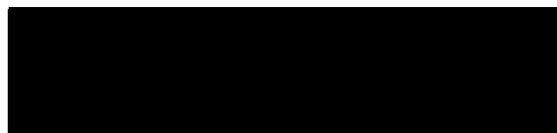


Sharon Sims, PhD, Chair



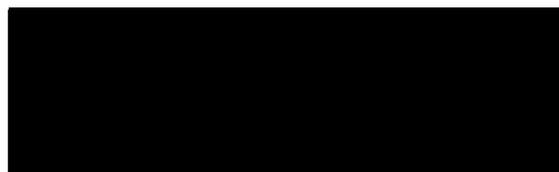
Joanne Martin, DrPH

Doctoral Committee



Melinda Swenson, PhD

Date of
Oral Examination
May 5, 2006



Carol Gardner, PhD

© 2006

Joanne Gerstner Goldbort

ALL RIGHTS RESERVED

DEDICATION

Dedicated to my loving parents, Thomas A. Gerstner and Mabel Fales Gerstner. I credit my mother's remarkable twelve birth stories, relayed to me as a young woman, in prompting my initial curiosity in what happened "behind closed doors" of a maternity ward. My mother's unwavering praise for the nurses who cared for her during her births ultimately led me to my passion in choosing maternal child nursing as my calling.

Dedicated to my mentor and the love of my life, my husband, Robert. His never-ending support, encouragement, and belief kept me grounded in completing this wonderful journey.

Dedicated to my four remarkable birthing experiences—Raechel, Jonathan, Julia, and Sarah. May their experiences of becoming a mother/parent be as satisfying as what mine were like in bringing each of them into the world!

Dedicated to the women in this study who shared their sensitive and amazing birth stories with me. I will be forever grateful.

ACKNOWLEDGEMENTS

Several faculty members, friends, professional colleagues, and family have guided and supported me during my doctoral education journey. First, I am deeply grateful to the members of my doctoral committee: Sharon Sims, whose remarkable insight, creative genius, and constant support at each of our meetings, fueled my passion to discover the qualitative way of being-in-the world; Joanne Martin, a sensitive and caring mentor who guided and directed me in the discovery of women's experiences with perinatal mood disorders and thus opened my eyes and my heart to a morbid condition that has laid silent for too long; Carol Brooks Gardner, an ardent supporter of gender issues, whose guidance and encouragement led me to remain an advocate and voice to encourage women to birth their way; and Melinda Swenson, whose objectivity kept me on the right track in analyzing these birth stories. I appreciate their committed time, guidance, and critique that stimulated my continued learning.

Thank you to the women who shared their birthing stories in this study. Their courage to divulge sensitive information about their lives and how they perceived their births will forever remain etched in my heart.

I could not have done this without the devotion of my mentor and my love of thirty-two years, my husband Robert. From the very beginning he had faith in me and in my potential to succeed in whatever I chose to do. He kept me focused and anchored. He knows my commitment in serving as a nurse and my passion regarding birth. I will be forever grateful for his enduring support and love.

ABSTRACT

Joanne Gerstner Goldbort

THE PERFECT STORM: UNEXPECTED BIRTHING EXPERIENCES AND PERINATAL MOOD DISORDERS

Intrapartum nurses play a significant role in shaping the lived experience of a woman's birth. Examining the lived experience of women's birth can serve as a critical component in nursing practice as a means to improve patient care outcomes with regards to the development of a perinatal mood disorder. The purpose of this qualitative study was to examine women's unexpected birth experience in order to ascertain what contributions from these women's stories might be made to enhance nursing care. Husserl's descriptive phenomenology was the qualitative research design used to examine women's unexpected birth experience, defined as any or all of the following: (1) an instrumentally assisted vaginal delivery either by forceps and/or by a vacuum extractor; (2) a third or fourth degree tear; (3) birth by an emergency Cesarean delivery; or (4) women who *perceived* that their delivery was incongruent with their expectations.

A purposive sample of ten women was recruited through a local Mothering as a Career Club and through a professional colleague who counseled women with perinatal mood disorders. Transcribed interviews were done of each woman's birth experience using Colaizzi's method of analysis. Three critical elements—caring, connection, and control—were missing from these women's unexpected birthing experiences. The following three themes emerged from the data: They're the experts and they know what's best; I just didn't have a nurse who was really there; and you're not in control of

the experience. After careful examination of their experiences, the universal denominator for the women developing a perinatal mood disorder was comprised of the uncaring attitudes, disconnection, and the lack of control that existed between each birthing woman and her nurse/caregivers coupled with all of these women's unmet pre-birth expectations. When the three critical elements caring, connection, and control are missing, then the fall-out from their devastating perfect storm experience propels the women in this study into the downward spiraling condition known as a perinatal mood disorder. Perinatal nurses have an opportunity to influence a caring intrapartum environment for all parturient women to avoid negative experiences and outcomes.

Sharon Sims, PhD, Chair

TABLE OF CONTENTS

Chapter One

Introduction	1
The Phenomenon of Interest	1
Research Questions	1
Background of the Phenomenon of Interest.....	2
Philosophical Stance of the Researcher	7
Definition of Terms.....	8

Chapter Two

Literature Review	12
Medicalization of Birth and Physician as Expert.....	12
Nurse as Expert	21
Social Construction of Motherhood.....	22
Literature Review of Birthing Expectations.....	26
Literature Review of Posttraumatic Stress Disorder.....	29

Chapter Three

Methods.....	34
Philosophy Regarding Qualitative Methods	34
Study Design	46
Interview Guidelines	50
Description of Methods.....	51

Chapter Four

Findings.....	53
Introduction	53
The Perfect Storm.....	58
Caring, Connection, and Control	61
Caring: Theme One	66
Connection: Theme Two.....	75
Control: Theme Three	82
Perinatal Mood Impact.....	87

Chapter Five

Summary and Implications.....	96
Summary	96
Implications for Nursing Education	98
Implications for Clinical Practice.....	99
Future Research.....	106
Conclusion.....	106

Appendices

Appendix A: Dr. Marlow's Letter.....	110
Appendix B: Mothering as a Career Letter	111
Appendix C: Informed Consent Statement	112
Appendix D: Participant Questionnaire	114
Appendix E: Representative Original Protocol.....	115
Appendix F: Significant Statements.....	118

Appendix G: Clusters or Themes 120

Appendix H: Mother Friendly Initiatives..... 122

References 123

Curriculum Vitae

CHAPTER 1

INTRODUCTION

The Phenomenon of Interest

This study examines the lived experience of an unexpected birthing process to gain further insight into one of the precipitating factors of postpartum depression and to develop a method to assist nurses with a more effective and comprehensive process in improving postpartum outcomes for women.

The purpose for this study includes:

1. To describe the unexpected birth experience to gain further insight into one of the precipitating factors of postpartum depression, an unexpected birthing outcome, using a phenomenologic descriptive method of analysis.
2. To develop an approach to assist nurses with a more effective and comprehensive process in improving outcomes for postpartum women.

Research Questions

Examining the lived experience of postpartum women and their birth can serve as a critical component in intrapartum and postpartum nursing practice as a means to improve patient care outcomes. For this investigation, the following questions were explored:

- What is the lived experience of women's unexpected births?
- How are the meanings of these lived experiences interpreted by women?
- What contributions from these women's stories might be made to enhance the experience with regards to nursing care?

Background of the Phenomenon of Interest

The overall prevalence rate for postpartum depression is 13%, with estimates that one in ten women will experience this mood disorder sometime during the childbearing years (ACOG, 2002; Beck, 1999b; Flynn, 2005). The term postpartum depression (PPD) represents one of several mood disorders associated with the postpartum period and is considered a nonpsychotic depressive episode (Beck 1999a, 1999b; Beck & Driscoll, 2006; Cooper & Murray, 1997; Flynn, 2005; Henshaw, 2000, 2003; Kendall-Tackett & Kantor, 1993; Kleiman & Raskin, 1994). It has its own unique pattern of symptoms and is distinguished from the three classified postpartum mood disorders known as postpartum psychosis, postpartum obsessive-compulsive disorder, and postpartum onset of panic disorder (Baker, Mancuso, Montenegro & Lyons, 2002; Beck, 1998; Beck, 1999b; Beck & Driscoll, 2006; Beck & Indman, 2005; Flynn, 2005; Leathers, Kelley & Richman, 1997; Stowe & Nemeroff, 1995). More recently, a fourth condition has been added to perinatal mood disorders called post-traumatic stress disorder (Beck, 2004a, 2004b; Beck & Driscoll, 2006; Brockington, 2004; Hofberg & Brockington, 2000; Melender, 2002; Soet, Brack & Dilorio, 2003). Due to lack of awareness and to the stigma associated with depression after giving birth, a time generally associated with happiness, it is estimated that approximately 50% to 80% of all cases go undetected (Beck, 1999b; Beck & Gable, 2001; Flynn, 2005; Sichel & Driscoll, 1999).

The cause of PPD is multifactorial and can include a combination of biologic, psychosocial, and situational life-stress (ACOG, 2002; Baker et al., 2002; Beck, 1999b; Beck & Driscoll, 2006; Bennett & Indman, 2003; Bonari et al., 2004; Harris, 2002; Henshaw, 2000, 2003; Milgrom, Martin, & Negri, 1999; Parry, 1996; Sichel & Driscoll,

1999; Stowe & Nemeroff, 1995). Biologic factors include the dramatic shifts in hormonal and endocrine functions that accompany birth, such as decreased levels of estrogen, progesterone, or prolactin, and thyroid or neurotransmitter dysfunction (ACOG, 2002; Beck, 1999b; Dennis, 2004; Milgrom, Martin, & Negri, 1999; Parry, 1996; Sichel & Driscoll, 1995; 1999; Stowe & Nemeroff, 1995). The psychosocial risk factors that have been identified in the research as contributing to PPD include any one or a combination of the following: previous episodes of depression/mood disorders, significant loss or life stress in the last year, an unplanned/unwanted pregnancy, prior fetal loss (miscarriage), unexpected birth outcomes, child care stress, marital conflict, low social support, fatigue, genetic predisposition, and an infant with health problems (ACOG, 2002; Baker et al., 2002; Beck, 1999b; Beck & Driscoll, 2006; Bennett & Indman, 2003; Bonari et al., 2004; Bozoky, 2002; Corwin, Brownstead, Barton, Heckard, & Morin 2005; Dennis, 2005; Flynn, 2005; Hall et al., 1996; Henshaw, 2000, 2003; Milgrom, Martin, & Negri, 1999; Miller, 2002; Sichel & Driscoll, 1995; 1999).

Postpartum depression can occur anytime throughout the pregnancy up to and including one year post-delivery (ACOG, 2002; Anderson et al., 2004; Baker, 2002; Beck & Driscoll, 2006; Flynn, 2005) and for some women, symptoms worsen over time (Clemmens, Driscoll, & Beck, 2004). A systematic review of prevalence of depression during pregnancy revealed that during the first trimester of pregnancy depression is similar to the overall rate (7-9%) of depression in women in the general population with a striking two-fold increase in depression during the second and third trimesters (Bennett, Einarson, Taddio, Koren, & Einarson, 2004). According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR,

2000), to be diagnosed with depression the woman must have experienced for at least a two-week period depressed mood or loss of interest in almost all activities and four of the other symptoms from the following list: changes in appetite or weight, sleep and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; and recurrent thoughts of death or suicidal ideation, plans or attempts. However, Beck and Indman (2005) found anxiety and irritability as prominent components of PPD. Early intervention and treatment is critical because the duration of PPD is linked to when it is first diagnosed and treated, with the average length of time between six and nine months (Beck, 1999b; Beck & Driscoll, 2006).

Expeditious interventions and treatment may assist in curtailing the effects that PPD has on the entire family, especially on the maternal infant relationship (Beck, 1999a; Beck & Driscoll, 2006; Brockington, 2004; Britton, Gronwaldt, & Britton, 2001; Horowitz & Goodwin, 2005; Lindgren, 2001). Women who experience postpartum depression have difficulty establishing attachment with the infant due to the “nonaffective symptom” of depression, such as withdrawal, passiveness, intrusive thoughts, and self-preoccupation (Beck, 1999a; Beck & Driscoll, 2006; Brockington, 2004; Britton, Gronwaldt, & Britton, 2001; Lindgren, 2001). The negative impact of postpartum depression on the cognitive, emotional, behavioral, and social development of children can have long-lasting effects (Beck & Driscoll, 2006; Britton, Gronwaldt, & Britton, 2001; Diego, et al., 2004; Horowitz & Goodwin, 2005; Kendall-Tackett, 2001; Lindgren, 2001; Miller, 2002; Righetti-Veltema, Bousquet, & Manzano, 2003). This

further underscores the urgency of prompt identification (Jesse & Graham, 2005) and treatment.

Routine screening of mothers for depression by primary care clinicians, such as pediatricians, during the well-baby visit is strongly advocated (Bennett & Indman, 2003; Chaudron, Szilagyi, Kitzman, Wadkins, & Conwell, 2004; Davies, Howell, & Jenkins, 2003; Georgiopoulos, Bryan, Wollan, & Yawn, 2001; Olson, et al., 2002; Tam, Newton, Dern, & Parry, 2002). Suggested screening tools include: the Postpartum Depression Prediction Inventory (Beck, 1998, 1999b, 2002a; Beck & Driscoll, 2006; Hanna, Jarman, & Savage, 2004; Horowitz & Goodman, 2005), the Postpartum Depression Screening Scale (Beck, 2005; Beck & Driscoll, 2006; Beck & Gable, 2001, 2002; Beck & Indman, 2005; Clemmens, Driscoll, & Beck, 2004; Bennett & Indman, 2003; Hanna, Jarman, & Savage, 2004; Horowitz & Goodman, 2005), and the Edinburgh Postnatal Depression Screening Scale (Bennett & Indman, 2003; Cox, Holden, & Sagovsky, 1987; Hanna, Jarman, & Savage, 2004; Horowitz & Goodman, 2005).

Given the aforementioned negative effects of a perinatal mood disorder on the woman, the infant, and the family, this phenomenological study was developed to more closely examine one of the precipitating factors associated with PPD—the lived experience of women’s unexpected birthing process. For this examination, the unexpected birthing process was defined as any one of or all of the following birthing experiences: (1) a forceps assisted and/or vacuum assisted delivery or a combination of the two; (2) a fourth degree tear into the rectum with vaginal wall lacerations due to the instrumentally assisted delivery and/or due to the result of an unsupported perineum and/or due to a precipitate delivery; and (3) and/or birth by an emergency Cesarean

delivery. The birth experience of women who did not experience any of these assisted procedures but who *perceived* that their delivery was less than expected, such as having shoulder dystocia, hemorrhage, or other unexpected procedural complications, were also examined. Capturing these women's experiences was considered equally important.

A paucity of research exists on the lived-experience of women and their unexpected birthing experience. In my thirty years as a practicing registered nurse in maternal child health, with thirteen years as an intrapartum nurse, I have witnessed a wide range of birthing experiences whereby women had instrumentally assisted deliveries resulting in fourth degree extensions, vaginal wall lacerations, and in some cases ended with an emergency Cesarean delivery because of the failed instrumentally assisted delivery. Other deliveries that I observed included several attempts by the physician in using both the vacuum and forceps with the immediate outcome of a depressed, limp neonate who invariably needed resuscitation. In all of the cases that I witnessed and/or participated in as a nurse, little if any interventions were done by nursing or by the medical staff to inquire about how the mother felt about this unexpected experience post-delivery. I often suspected that this silent event had to have some effect on these women. The purpose therefore of this phenomenological study was to gain further insight into one of the precipitating factors of postpartum depression, the unexpected birthing experience, and to determine the role(s) of the perinatal nurse in facilitating a more effective and comprehensive process to improve postpartum outcomes for these women, especially as it relates to thwarting or decreasing the incidence of perinatal mood disorders.

A descriptive analysis using Husserl's philosophic underpinnings was used to discover the lived experience of women's birth in order to get a better understanding of

this lived experience and what it was like for these women. To support the phenomenon under investigation and to gain insight into three implicit taken-for-granted external forces that have a major impact on a woman's birth, a literature review was conducted in these areas: (1) the medicalization of birth and the physician as expert; (2) the social construction of motherhood; and (3) women's expectations of the birthing experience. Additionally, posttraumatic stress disorder, a newly added perinatal mood disorder, was examined.

Philosophical Stance of the Researcher

In accordance with the underlying premises of empirical or descriptive phenomenology this inquiry was guided by the following assumptions:

1. Experience is unique to the individual, with each individual's concerns qualitatively different. Thus, as self-interpreting individuals, the answer to the phenomenological question, "What is the meaning of one's lived experience?" resides in the individual. Therefore, the individual interprets the experience for the researcher and the researcher interprets the explanation offered by the individual.
2. The ability for the person to establish meanings is shaped by language, culture, history, purposes, and values.
3. Qualitative information acquired from a study is subjective and incorporates the perceptions and beliefs of the researcher and the participants.
4. Findings/meanings discerned from a qualitative inquiry are not generalized in the same way that data are in a quantitative study. However, the meanings from a phenomenon under investigation can give insights that can be applied broadly.

5. Meanings gained from a qualitative study can be used to build nursing knowledge and can be added to theory development.

Definition of Terms

Descriptive/experiential phenomenology: The research method used in this study is based on Husserl's descriptive phenomenology. A German philosopher and Mathematician, Husserl is credited as the founder/father of the school of phenomenology (Fjelland & Gjengedal, 1994; Hein & Austin, 2001; Holloway & Wheeler, 1996; Lauer, 1965; Munhall, 1994; Welch, 1939). Husserl's phenomenology is the study of phenomena as it emerges through the consciousness (Koch, 1995) and as such, through the practice of critical reflection and description, knowledge can be conceived (Hein & Austin, 2001). The fundamental needed of Husserl's phenomenology and the issue of Cartesian duality predominantly assert that experience is represented in the mind by symbols, which allows the external world to be incorporated into internal consciousness by thought processes (Koch, 1995). This experience can then be studied thoroughly and methodically based on how it is presented to consciousness (Hein & Austin, 2001).

Forceps: Two double-curved, spoonlike articulated blades that are used to extract the fetus when there is significant abnormality of the fetal heart rate (Cunningham et al., 2001).

Full term pregnancy: Gestational age of 38 weeks or greater.

Multipara: More than one pregnancy.

Necrotizing fasciitis: A rare form of a frequently fatal complication of perineal and vaginal wound infections of the deep soft tissue involving muscle and fascia, typically occurring three to five days after giving birth. Early diagnosis, surgical debridement,

antibiotics, and intensive care are critical for successful outcomes. Even with aggressive treatment, the mortality rate approaches 50% (Cunningham et al., 2001).

Multigravida: Having birthed more than one child.

Phenomenology: A qualitative approach to a philosophical method of inquiry. It attempts to address the ontological question of “what is being?” and the epistemological question of “how we know” (Holloway & Wheeler, 1996). Phenomenology is derived from the Greek word *phainein* which means “to show,” “to be seen,” “to appear,” (Holloway & Wheeler, 1996) or “that which displays itself” (Welch, 1939). The purpose of phenomenology is to “describe particular phenomena, or the appearance of things, as lived experience” (Streubert & Carpenter, 1995, p. 30) with the goal of understanding what it means to be human (Munhall, 1994). It is a method that attempts to understand the human lived experience through description and is therefore considered a method of discovery, an alternative to the positivistic method of natural science inquiry (Parse, 2001).

Precipitate delivery: Extremely rapid labor and delivery of less than three hours (Cunningham et al., 2001).

Primipara: First time pregnant.

PTSD: The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychological Association [APA], 2000) defines posttraumatic stress disorder as:

The development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an

event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1, p. 463).

Criterion A2 includes the individual's reaction as being that of intense fear, helplessness, or horror. The person will typically demonstrate the following three characteristic symptoms:

persistent re-experiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D, p. 463).

All of the above symptoms must be present for at least four weeks (Criterion E), resulting in impaired performance of daily living (Criterion F). Acute PTSD occurs when symptoms appear within the first 90 days following the traumatic event, with longer time frames indicating Chronic PTSD. A direct traumatic event is defined, but not limited to, the following:

military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness (pp. 463-464).

Unexpected birth experience: For this study, it is defined as: (1) an instrumentally assisted vaginal delivery either by forceps and/or by a vacuum extractor; (2) a fourth degree tear into the rectum with vaginal wall lacerations due to the use of forceps and/or due to the result of an unsupported perineum and/or due to a precipitate delivery; and/or (3) a birth which resulted in an emergency cesarean delivery. Women who agreed to be in the study but who did

not meet the above criteria were included if they perceived that their delivery was unexpected.

Vacuum extractor: A plastic cup-like appliance that is placed by the physician to the infant's head over the sagittal suture and 3 cm in front of the posterior fontanelle. The device is approximately 6 centimeters in diameter. At the beginning of a contraction, the physician pumps the hand-held vacuum up to the clinically accepted "green zone" of pressure. Once the acceptable level of suction is achieved, the physician instructs the patient to "push" while he/she pulls in a downward motion with the handle of the vacuum extractor to facilitate moving the infant into a position that aids the infant down the birth canal. When the contraction is over, as determined by palpating the fundus of the uterus, or by electronic fetal monitoring, or by the mother's cues, the suction on the infant's head is maintained to prevent a "pop-off." The process may be repeated two to three times.

Third-degree episiotomy: Extends through the skin, mucous membranes, and perineal body, and involves the anal sphincter; 30 to 40% of women will have long term anal incontinence (Cunningham et al., 2001, p. 326).

Fourth-degree episiotomy: Extends through the skin, mucous membranes, and perineal body as well as through the rectal mucosas to expose the lumen of the rectum; normal function is not always assured even with correct and complete surgical repairs with some women experiencing fecal incontinence due to injury to the innervation of the pelvic floor musculature (Cunningham et al., 2001, p. 328).

CHAPTER 2

LITERATURE REVIEW

Medicalization of Birth and Physician as Expert

Throughout the ages, birthing primarily took place in the home, attended by females (Declercq, DeVries, Viisainen, Salvesen, & Wrede, 2001; Dick-Read, 2004; Odent, 2002b). Having a baby in a hospital setting is a relatively new phenomenon. Until the mid-nineteenth century, women gave birth with the assistance of a midwife or a female attendant, be it her sister, mother, or aunt. In some circumstances and in some cultures birth occurred without any assistance (Cahill, 2001). The change from a female-attended birth to a predominantly male-centered experience was due to the concerted efforts of the medical profession to take control of this experience by legitimizing their profession and thus making it illegal for midwives to practice (Riessman, 1998; Kitzinger, 2005; Kroeger, 2004). The midwife at the turn of the nineteenth century was “in the way of the development of modern institutional medicine” (Ehrenreich & English, 2002, p. 83). Accordingly, by the early twentieth century, with the rise of the American Medical Association in 1857, birthing became institutionalized and medicalized. For the most part, birth became a hospital practice, whereby women could have better outcomes under the assistance of medically trained personnel (Cahill, 2001). The normal process of bringing life into the world now became a medical event with an emphasis on the medical model and the disease process and, as such, women were expected to be passive individuals with biological factors acting upon them (Beck, 2002b; Cahill, 2001; Davis-Floyd, 1992; Gaskin, 2003; Kennedy & Shannon, 2004; Kitzinger, 2005).

The medicalization and institutionalization of childbirth has resulted in the pregnant woman being transformed into the “patient” (Jordan, 1983). Jordan profiles the term “patient” using Parsons’ sick role model, as follows:

. . . as a patient, the parturient woman is, to a considerable extent, exempt from her normal responsibilities vis-à-vis others and herself; she is helpless to deal with the (medical) problem at hand; and she is obliged to seek technically competent help for her condition (p. 35).

Pregnant women in Western society have accepted this role of “patient” with the physician as the primary caregiver and expert, because to do otherwise would be considered aberrant.

Essential to understanding how a natural process has evolved into one in which a birthing experience can be associated with a perinatal mood disorder, is the appreciation of the nascent role of the physician as expert. It is the expert from whom the pregnant woman seeks care and as such the presumed expectation is that the birthing experience provided by this expert will have a healthy outcome for both mother and infant. Most births in Western society occur in a hospital setting under the auspices of the physician, in particular, the obstetrician/gynecologist. Although the practice of midwifery in the United States is increasing, medicine controls the scope of practice and the midwife’s role (Cahill, 2001; Riessman, 1998; Kroeger, 2004; Kitzinger, 2005).

Over the past fifty years, with changes in the physician’s role as expert and as professional, has further embedded this model of care. Parsons’ (1951) sick role theory, in particular element four, explicitly states that sick individuals (in this example, pregnant women) are “to seek *technically competent* help, namely, in the most usual case, that of a physician and to *cooperate* with him [now her] in the process of trying to get well” (p.437). This element has laid the foundation of medical care in America. As Parsons

(1951) articulated, “. . . the combination of helplessness, lack of technical competence, and emotional disturbance make him [in this thesis, her] a peculiarly vulnerable object for exploitation” (p. 445).

Freidson (1970) asserts that the notion of the physician as the technically competent expert and professional is further elucidated and supported by the fact that the medical profession is an autonomous entity that is professionally dominant in our society. One needs only to examine the role of the obstetrician, who typically is the primary caregiver/expert in the childbirth arena, to validate this assumption. First of all, as the primary caregiver, it is the physician’s expertise that deems the best-qualified individual who will deliver the newly pregnant woman’s baby. Others, such as family practice physicians, can take on this responsibility, but when an unexpected situation arises, such as fetal mal-presentation—breech, or the need for an emergency Cesarean section due to a non-reassuring fetal heart rate pattern—it will be the obstetrician who will take control of the final process. Declercq, Sakala, Corry, Applebaum and Risher’s (2002) national survey of 1,583 American women’s birthing experience revealed that obstetricians attended 80% of women’s births with fetal heart rate problems and complicated births. Assuredly, family practice physicians participate in the birthing process with more of a “low-tech/low-intervention” philosophy, but on the whole, given the litigious healthcare environment, more family practice doctors are opting out of delivering babies.

At this juncture, it is fair to note that women in the early part of the twentieth century colluded with physicians in bringing birth into the hospital setting. The news was out in Europe regarding “twilight sleep,” a technique of giving chloroform during birth to decrease pain and/or erase the painful memories (Riessman, 1998; McGregor,

1998; Simpson, 2000; Kitzinger, 2005). This pain-free experience was very inviting to women seeking a way to escape the fears and suffering of childbirth, and the hospital/physician setting was the only place for this to be done safely and effectively. The public march was on for “Anaesthetics for All,” with no woman in labor or birth having to be in pain (Dick-Read, 2004). Today’s anesthetic of choice is the epidural.

How is it that an otherwise normal process, that is supposedly a happy experience, can result in posttraumatic stress disorder with the potential for postpartum depression? The answer may be found in the notions that women have with regard to the expectations that one may have of the expert(s) and the expectations of the birth itself. After all, the control and satisfaction that women should experience with birth has developed into an event so far removed from being natural that it should come as no surprise to learn that some women feel disconnected from or unsure of what to make of this entire process. Medical socialization has resulted in a separation process, whereby women expect the experts to tell them how to behave or respond to their body’s signals about birth instead of the woman listening to her own intuitive thoughts and feelings about what she is experiencing (Davis-Floyd & Sargent, 1997; Gaskin, 2003; Kitzinger, 2005).

Parsons’ (1951) notions of helplessness, lack of technical competence, and vulnerability for exploitation is evident in today’s birthing environment. Ruddick’s (1995) discussion about birth and how men have come to devalue this natural process concurs with Parson. Birth in Western cultures basically results in the exploitation of women’s bodies:

the envy that lies behind the minimalization of birth fuels a technocratic and legal apparatus able to intrude on and exploit *women’s* bodies in unprecedented ways” (Ruddick, 1995, p. 48; emphasis original).

This is glaringly apparent when one examines how displaced the birth setting has moved from a home environment whereby a woman could birth in the privacy of her home, with close support from friends and family, to the hospital birth environment that exists today. Although most hospitals claim to have a home-like birthing environment, the setting and the locus of control is nonetheless first and foremost under the domain of the physician and the nursing staff.

Giving birth in the twenty-first century in a hospital setting has become a multi-billion-dollar business, whereby physicians, hospitals, vendors, lawyers, and others reap the rewards. The techno-birth and techno-environment of today's hospital setting, as so aptly labeled by Davis-Floyd and Sargent (1997), is part and parcel of the experts' domain. Everything in the room is high-tech (Kitzinger, 2005), from the oxygen and suction equipment encased in armoires, to the fetal monitoring equipment, all the way down to the infant warmer, creating a techno-environment that is arcane to the laboring client (Davis-Floyd & Sargent, 1997). In today's marketing and competitive environment, to lure women to one's facility and to create a home-like environment, these high-tech accoutrements are kept out of sight until needed. Thus, upon entering the birthing room, the expectant family is reassured and comforted by familiar furnishings, such as the rocking chair, fancy quilt on the bed, and maternal/infant pictures that adorn the walls.

Gone are the mastery and control over one's body that feminists of the nineteen seventies and eighties used in challenging the birthing business. Kirley (1999) describes this radical group as the counterculture who challenged the birthing industry and its system of turning birth into a medical emergency. These individuals were successful in

the development of a more humanized way of bringing life into the world, such as the birthing room, giving fathers access, and birthing babies naturally, i.e., without pain medication. It is with group of women that the birth plan first originated, a plan that was necessary to ensure that they could circumvent the routine care that was offered, such as shaving the perineum, receiving an enema, and episiotomies. Be that as it may, today's birthing environment is more high-tech than ever, and it is a rare occasion when a woman presents to the labor and delivery setting with a birth plan.

Today a woman armed with a birth plan is considered suspect. A birth plan automatically sets up red flags for the nursing staff, due in part to the fact that this patient has put in writing what she wants done during this experience, especially her option to do this "naturally." In some cases, the nurses take this as a challenge, because these nurses 'know' it will only be a matter of time before this patient will relinquish her plan and give in to an epidural. Nonetheless, even in the best of circumstances, for those women who do elect to have a natural birth, which usually means little or no pain medicine, the success of a woman's birthing experience is contingent upon having a nurse familiar with assisting her through this process. Most nurses are unfamiliar with the affective signs of labor, such as restlessness, especially the overwhelming and turbulent feelings during the later stages of labor, known as transition, when the woman's cervix changes from seven centimeters to complete dilatation. This lack of knowledge is primarily a result of the increased use of epidurals whereby the laboring woman is so heavily anesthetized that she cannot even move her legs, let alone feel the internal stirrings and whirlwind of transition. Consequently, unless the pregnant woman comes prepared emotionally,

mentally, and psychologically, and/or is accompanied by a doula/coach, or is lucky to get an experienced nurse, her birthing experience is no longer in her control.

More importantly, however, are the other high-tech interventions that the experts incorporate into their everyday practice of delivering an infant. For example, most first time pregnant women (primiparas) will have an episiotomy performed even though studies have shown that this procedure is not entirely necessary (ACOG, 2001, Cunningham et al., 2001; Kitzinger, 2005; Kroeger, 2004) and can delay postpartum sexual functioning (Signorello, Harlow, Chekos, & Repke, 2001). An episiotomy is a surgical incision that lengthens the perineum to make room needed for delivery of the fetus (Cunningham et al., 2001; Kitzinger, 2005; Kroeger, 2004). The overall rates of episiotomies vary globally, with a low rate of 9.7 per one hundred vaginal births in Sweden to 100 percent in Taiwan, with the United States at a rate 32.7 percent (Graham, Carroli, Davies, & Medves, 2005). Although a consensus has not been established as to what is an acceptable rate, some researchers believe that a rate greater than 30 percent is too high and recommend that rates of 10 percent for primiparas and 5 percent for multiparas, respectively, would be more appropriate (Graham et al., 2005).

Nevertheless, despite evidence-based practices discouraging this surgical intervention, Shorten, Donsante and Shorten's (2002) analysis of 2891 normal vaginal births found that the effects of birth position, accoucheur (birth attendant, e.g., obstetrician), and perineal outcomes demonstrated that episiotomy rates were five times higher for obstetricians than those for midwives. The predominantly influencing factor for the increased rate was birthing position—with the midwives using the lateral position versus the obstetricians' using the traditional semi-recumbent birth position. Declercq et

al.'s (2002) survey further supports this finding, whereby 74% of women who gave birth vaginally pushed their baby out in a semi-recumbent position. Soong and Barnes' (2005) study with midwives and maternal position further supports that the semi-recumbent position is associated with perineal trauma; the authors advocate using lateral positioning and/or the use of all-fours, but most importantly giving women choice in birthing position.

The traditional semi-recumbent position is typically used as the birthing position of choice by obstetricians. This is mainly due to the fact that the woman's legs are supported in stirrups (lithotomy position), making it easier for the physician to do the delivery, to apply forceps and/or vacuum extractor for an assisted delivery, and/or to do the repair (Kitzinger, 2005). What most women do not know is that warm oils, perineal massage, and birthing position can help avoid an episiotomy, which will also result in less pain post-delivery and possibly reduce the risk of perineal trauma (Gaskin, 2003; Kitzinger, 2005; Stamp, Kruzins & Crowley, 2001). Perineal trauma, such as an episiotomy, can cause lifelong problems for the woman, such as urinary and fecal incontinence, sexual dysfunction, pain, and infection (Cunningham et al., 2001; Simpson & Thorman, 2005).

Other high-tech interventions that are the mainstay in the hospital delivery setting are the use of external/internal fetal monitors, intravenous infusions for Pitocin augmentation and/or inductions, non-invasive blood pressure monitoring, epidural analgesia, and the restriction of the patient to the bed due to the use of all of these items (Kitzinger, 2005). In addition, the woman is restricted to oral intake, may be limited as to the number of visitors, and essentially becomes the patient that Jordan (1983) described

previously who *cooperates*, a term Parsons (1951) deemed essential for a successful doctor/patient relationship. Can women's bodies be exploited anymore than this? This medicalized process of childbirth becomes the hegemony of conventional obstetric management (Goer, 2004) and as such has at its core health concerns that focus more with the physiology/pathophysiology of childbirth, e.g., maternal/infant mortality/morbidity rates, than with the psychological and personal satisfaction concerns of the mother (Davis-Floyd, 1997; Kitzinger, 2005; Gaskin, 2003; Thurtle, 1995).

As the medical sociologist Straus (1956) poignantly captured a half-century ago, one of the duties connected with medical sociology is the need to examine the "impact of the hospitalization experience on the post-hospital adaptation of patients" (p. 202). Furthermore, Straus advocated that the common objective for medical sociologists should be:

to provide medical personnel with an understanding of some of the processes of behavior involved in human response to illness and thereby to facilitate a more effective and comprehensive approach to these problems (p. 203).

Fifty years later, despite Straus' prior advice, the medical model of birthing in the United States predominates. The medicalization of birth may be successful in improving birth outcomes for the infant, but at the price of some women's sense of dignity, fulfillment, and autonomy (Cook, 1994). A closer examination of women's birth expectations and experiences are pivotal if healthcare providers, in particular nurses are concerned about thwarting any untoward effects such as PTSD and PPD, or to reiterate Straus' words—the "post-hospital adaptation of patients" to their birthing hospitalization experience.

Nurse as Expert

Just as the public expects expert care from the physician, so too is this an expectation with the nurses who give care. In order to appreciate what defines nurses as experts it is critical to examine Benner's research on novice to expert (Benner, 1984, 2001; Benner, Tanner, & Chesla, 1996). Benner delineates five categories/stages that one evolves through to become the expert nurse: Novice, Advanced Beginner, Competent, Proficient, and Expert. Her hermeneutic research was based on the work of psychologist Dreyfus (1980) with pilots and skill acquisition. Benner applied this skill acquisition model to nurses and concurred that novice to expert is the pathway by which individuals acquire skills and over time become the expert in their field/specialty. Bear in mind that skill acquisition is individually based and some individuals may move into one level faster than another, so the time frames discussed below are fluid.

At the Novice stage, or beginner, the nurse is learning about his/her newly chosen field of practice with an orientation program delivered by a mentor who should be proficient or an expert in the specialty. The Novice's focus is learning the objective data, such as physical findings, and learning the rules. An individual who moves from one area of practice to a new area would also be considered a Novice. The Advanced Beginner is typically a nurse who is still in training with a focus on learning from repeated experiences, becoming more adept with tasks, such as starting IVs, and becoming more knowledgeable with the chosen specialty. The next stage is the Competent. The nurse who is at this level has typically continued practicing in the same clinical area for the past couple of years, has mastered more tasks, and is less focused on

paper work. At this stage of skill acquisition, the nurse is more confident in decision-making and has critical thinking skills that encompass a broader perspective.

After five years of continued full-time experience in the same setting, the nurse moves into the Proficient level of skill acquisition. Here the nurse demonstrates more of an intuitive feel for what the patient is experiencing and acts on these feelings in relaying information to the physician and to her colleagues. She/he has mastered the tasks, can juggle several responsibilities at one time effortlessly, and has a good sense for the overall picture of what is going on in the unit. Finally, after seven years of continued experience in the same specialty, the Expert emerges. This individual is typically the one that everyone goes to for advice on what to do with a challenging patient or how to talk to a physician about a patient who is not doing well. The Expert “knows” how to sense when a patient is “going down the tubes” even though the vital signs are stable and uses her/his intuitive instincts to alert the physician. Oftentimes this Expert’s instincts are correct and a life is saved before a disaster occurs.

Interestingly, it is the expert nurse that the public expects for their care when they enter a hospital setting. After all, this is the place where the experts are giving care and the implicit expectation is that everyone working in this setting will be at this level. Unfortunately, that is not the case, because in reality the hospital is filled with Novice to Expert providers at all levels, including physicians. Perhaps communicating this in some form to the community at-large may help to have patients’ expectations be more realistic.

Social Construction of Motherhood

Mothers are expected to be happy after giving birth and anything less is considered wrong. Not only is the new mother expected to be happy about bringing life

into the world, the expectation is that she is not to express negative feelings, because this goes against the norms of expected maternal behavior. The social construction of motherhood and the myth of motherhood are two other factors that may lead to and/or contribute to postpartum depression, due in large part to the expectation that the female gives birth and societal expectations of mothers are that they will embrace their biological destiny with open arms.

To appreciate how this expectation may not unfold for those women who develop a perinatal mood disorder, it is essential to understand first and foremost what social construction means. Social construction is based on an anti-essentialist perspective that subscribes to the notion that human behavior is not predetermined by any natural or biological process but rather is based on what is considered real and meaningful to individuals and is influenced by socio-historical forces and consensus. It is a collective effort to come to common agreement with regards to human action (Vance, 2002). As articulated by Smith (1987):

the world as we know it sociologically is largely organized by the articulation of the discourse to the ruling apparatus of which it is part (p. 63).

The ruling apparatus referred to here deals primarily with patriarchy and the embedded notions of gender practice that have not changed for centuries, and, that is, the practice of the institution known as Motherhood. Feminists of the nineteen sixties, seventies, and eighties confronted this socially constructed institution. Adrienne Rich (1986) persuasively expresses this notion of motherhood as institution in this narrative:

This institution has been a keystone of the most diverse social and political systems. It has withheld over one-half the human species from the decisions affecting their lives; it exonerates men from fatherhood in any authentic sense; it creates the dangerous schism between “private” and

“public” life; it calcifies human choices and potentialities. In the most fundamental and bewildering of contradictions, it has alienated women from our bodies by incarcerating us in them (p. 13).

“Incarcerating us in them” poignantly captures the prison that women’s sociologically constructed bodies have become. Women have been chained for centuries to the fixed notion and patriarchal hegemony that the primary purpose and function of being female is to reproduce, not only as a biological means for continuation of the species, but as a socio-cultural means for producing its citizens. This gender split, whereby women are expected to function primarily as mother and in the home, sanctions men’s place in the world, which, for the most part, has been as the wardens of this sociological prison.

At this point, it is important to discuss how this socially constructed phenomenon known as motherhood relates to postpartum depression. Throughout the centuries, motherhood has been seen as a natural process, inherent as a female-specific phenomenon. A woman’s place, as has been colloquially expressed, is to be “barefoot, pregnant, and in the kitchen.” Essentialists would argue that being a mother is a natural process, predetermined by genetic, biological, or physiological processes and immutable (Vance, 2002). Or they would assert that human behavior that is similar outwardly shares a basic essence and meaning (Vance, 2002). Therefore, essentialists purport that motherhood is a natural process and, as such, is women’s work and women’s lot in life and inherently their maternal instincts will immediately surface upon the birth of her newborn.

Herein is an underlying problem associated with perinatal mood disorders, namely that because of her biology a woman is expected to embrace the notion of motherhood. She is expected to instantaneously fall in love with her infant and anything

less is considered uncharacteristic. Consequently a woman suffers in silence whenever she feels less than the expected automatic love for her infant, further propelling her into the downward spiral of PPD.

Contrary to the belief that women's sole role is in the home and as mother, Ruddick (1995) asserts that being a mother does not necessarily mean that one has to be female. Ruddick's definition of being a mother can include any person "who takes on responsibility for children's lives and for whom providing child care is a significant part of her or his working life" (p. 40). This definition by Ruddick is further supported by her brainchild conception that "all mothers are adoptive" (p. 51), which burst opens the socially constructed doors to the notion that to mother is not only a learned process but also one in which a person can choose to mother.

This type of thinking allows and advocates that men too can be mothers, that nurturing is integral to parenting/mothering and does not necessarily have to be gendered. This should not be confused with the gender-specific process of giving birth. Nevertheless, what Ruddick suggests is that "mothering" can be learned, is not instinctual, and therefore can be performed by either sex. However, throughout history, the social construction of motherhood has excluded this notion and, to date, mothering/nurturing has been categorically a female responsibility. Ruddick believes that being a mother can be an "adoptive" process. Given that artificial formula exists so that an infant can be nourished and/or that the newly developed state-of-the-art breastfeeding pumps are available for those families who do not want their infants fed formula, there is no reason, other than the socially constructed one of gender, that fathers cannot "mother." As a learned process, fathers too can be taught how to nurture and care

for their offspring. Keep in mind that one of the primary reasons for allowing the fathers to participate in the birthing process was for him to witness what the woman went through, with hopes of making him more sensitive to what the woman underwent during this challenging time (Kitzinger, 2005). In addition, it was to give him an experience that would hopefully enhance and promote nurturing and attachment to the infant.

Literature Review of Birthing Expectations

Given these taken-for-granted biological and social constructions of women's bodies, it is only fair that women should expect their births to be attended by the best experts, honored and respected by society, and with lasting memorable birthing experiences. After all, birth is considered one of the most memorable and life-altering experiences in a woman's life. The impact reverberates throughout the years with countless occasions in which the birth story is expressed to friends and family. Given the advanced technology of the twentieth century, with birth labeled as "techno-birth" (Davis-Floyd, 1992, 1997; Kitzinger, 2005) or industrialized birth (Odent, 2002a, 2002b), women have come to expect a healthy outcome for themselves and for their infant (Sandelowski, 1984) and with that a memorable, emotional experience (Simkin, 1996). The nurse, who attends every birth in all intrapartum settings across the United States, is a key player in facilitating this memorable experience and as such, it will primarily be the nurse whom each pregnant woman will depend upon for nothing less than expert care during a woman's labor and delivery process.

One way for nursing to impact this expected outcome is for the nurse to ascertain before delivery the woman's expectations and plans for the pending delivery, such as pain management options, technical interventions, coaching, and family support (Carlton,

Callister & Stoneman, 2005; Mozingo, Davis, Thomas, & Droppleman, 2002; Simkin, 1996; Tumblin & Simkin, 2001). The level of congruency between the woman's expectations and the nurse's will greatly impact the outcome (Carlton, Callister & Stoneman, 2005; Fox & Worts, 1999; Goodman, Mackey, & Tavakoli, 2004; Larrabee & Bolden, 2001; Sandelowski, 1984; Turriss, 2005; Tumblin & Simkin, 2001; VandeVusse, 1999). Manogin, Bechtel, and Rami (2000) elucidated from their research that a positive birth experience can be achieved when caring behaviors, such as assessing knowledge levels, explaining events, correcting misconceptions, and answering questions, are incorporated by the nurse and/or healthcare provider. The influence of the nurse during this vulnerable birthing experience can have lasting effects, with research indicating that women vividly remember the events of the birth and their feelings even fifteen to twenty years later (Simkin, 1996). Furthermore, lack of control over the birthing experience and/or a difficult birth that ended in a Cesarean section has been cited as pivotal reasons for postpartum depression (Cooper & Murray, 1997; Henshaw, 2000; Kendall-Tackett & Kantor, 1993).

Satisfaction with the birthing experience is attained when care is given in a respectful and thoughtful manner and, under such conditions, when women's expectations are met, satisfaction with the birth rises (Tumblin & Simkin, 2001; Waldenström, Borg & Olsson, 1996). Not only is the successful birthing experience contingent upon the relationship with the physician (Davey, Brown & Bruinsma, 2005), but also how the nurse relates to the pregnant woman is equally important, with personal control being a key component in the overall satisfaction with one's birth experience (Goodman, Mackey & Tavakoli, 2004). In contrast, Mozingo et al. (2002) revealed that

when expectations about trust, power, control, and being kept informed were not met, the women in their study felt violated and angry, which resulted in mistrust between the woman and the nurse and a negative birthing experience. Post-delivery feedback to the nursing staff can be conducted to determine maternal satisfaction with inpatient postpartum nursing care by using the Newcastle Satisfaction with Nursing Scales (Peterson, Charles, DiCenso, & Sword, 2005).

Beck's (2004a) descriptive phenomenological study of mothers' traumatic birthing experiences revealed four essential themes of nursing care that can be summed up as the following: not caring, not communicating, not providing safe care, and ignoring the mother's experience for the resultant healthy infant. In Beck's study, women felt that their traumatic birth experiences were regarded as routine by the health care givers. The above prior studies further validate women's stories of unmet needs and dissatisfaction with birthing experiences. To avoid this type of undesired effect, upon each admission to the labor room setting, nurses should establish with the pregnant woman mutual goals for the ensuing birth and provide holistic care to promote a positive childbirth experience (Carlton, Callister & Stoneman, 2005). It is therefore critical for nurses to be cognizant of their role in influencing the immediate and, ultimately, the long-term impact of their actions and words on this impressionable experience.

Hodnett's (2002) systematic review of 137 women's evaluations of their childbirth experiences revealed the influence that a reciprocal relationship can have on an outcome, with the patient being more forgiving when unexpected outcomes occur. Accordingly, when four factors are met—personal expectations, amount of support from caregivers, quality of the caregiver-patient relationship, and involvement in decision

making—the experience supersedes any of these influences: age, socioeconomic status, ethnicity, childbirth preparation, the physical environment, pain, immobility, medical interventions, and continuity of care. Thus the key to a successful experience lies in meeting the four factors.

Declercq et al.'s (2002) survey of women's satisfaction with their care concluded that women were satisfied with the care they received. For these women, the satisfaction was due to the following: (1) understanding what was happening (94%), feeling comfortable asking questions (93%), getting the attention they needed (91%), and being involved in the decision-making (89%). Similar themes were found in the 1995 British national survey on women's view of maternity care. Women want (in addition to technically competent care) good communication with their caregivers, information on what is happening, to be treated with respect, and support when in pain (Young, 1998b; Waldenström, et al., 2004).

Literature Review of Posttraumatic Stress Disorder

At this juncture it is important to examine the fourth perinatal mood disorder, known as Posttraumatic Stress Disorder (PTSD) and how this has become associated with a women's birthing experience. The first cases reported in 1978 in the scientific literature of PTSD in childbirth was reported by Bydlowski and Raoul-Duval's "*la nevrose traumatique post-obstetricale*" in which they attributed report that their patients' trauma resulted from long difficult births, or births in which a stillborn or a handicapped infant was the outcome (Ayers & Pickering, 2001; Ballard, Stanley, & Brockington, 1995; Fones, 1996; Reynolds, 1997; Soet, Brack, & Dilorio, 2003). However, Hofberg and Brockington (2000), going further back in history, credit Marce in 1858 with

describing newly pregnant women's fear of parturition (tokophobia) due to the "expectation of unknown pain," which

preoccupies them beyond all measure, and throws them into a state of inexpressible anxiety. If they are already mothers, they are terrified of the memory of the past and the prospect of the future (p. 83).

Tokophobia is defined as a dread of childbirth (tokos) that is avoided as much as possible (phobia); when tokophobia predates pregnancy or birth it is considered primary and when it occurs after a traumatic or distressing delivery it is considered secondary (Hofberg & Brockington, 2000; Hofberg & Ward, 2003, 2004; Saisto, Ylikorkala, & Halmesmäki, 1999).

Symptoms of PTSD have been established in a number of reviews. Ballard, Stanley, and Brockington's (1995) qualitative analysis of four women, who reported stress reactions after delivery, showed that they had symptom profiles of PTSD. The women relived the painful experience again and again (PTSD-B), with feelings of lingering terror, as well as sweating and trembling, or feelings of intrusive thoughts and anxiety (PTSD-D). In addition, nightmares, anxiety, and avoiding contact with the baby due to intrusive recollections occurred (PTSD-B, C, and D). All of these women's experiences persisted for months after delivery (PTSD-E).

Fones' (1996) case report of a long painful childbirth experience that resulted in a forceps delivery concurs with the above PTSD symptomatology. This woman experienced recurrent, intrusive recollections and nightmares of her labor, dreams of dying during childbirth, depression for a month after delivery, avoidance of anything that discussed childbirth, and a distant relationship with her spouse (fear of getting pregnant),

with all of these symptoms repetitive over a nine year period (PTSD-B, C, E).

Subsequently, three months after sterilization, her symptoms of PTSD resolved.

Creedy, Shochet, and Horsfall (2000) did a prospective, longitudinal study of pregnant women who were recruited in the third trimester and later interviewed four to six weeks post-delivery via telephone about the details of their birthing experience. They found that 33 percent of the women reported the birthing event as traumatic, with three or more PTSD symptoms: the reexperiencing, avoidance, and arousal categories.

Furthermore, 5.6 percent met all of the DSM-IV diagnostic criteria for PTSD.

Soet, Brack, and Dilorio (2003) did a prospective study of one hundred and three women recruited from childbirth classes. These women were interviewed via telephone four weeks postpartum about their birthing experience (interviewing four weeks later is in keeping with the DSM-IV criteria of being symptomatic for at least one month to diagnose PTSD). These researchers found that 1.9 percent of the participants had developed all the symptoms of PTSD (criteria B-D), with 11.7 percent experiencing intrusion, avoidance, and/or arousal.

Ayers' (2004) review examines the evidence for the prevalence of postnatal traumatic stress responses after investigating PTSD itself and two other categories: birth as traumatic and traumatic stress responses (defined by Ayers as severe symptoms of intrusions and avoidance that does not fulfill all the criteria for PTSD). Included in his review are the prenatal, perinatal, and postnatal vulnerabilities and risk factors, screening for postnatal PTSD, and suggested interventions and treatment modalities. Ayers' conclusion in this study is that 10% of women have severe traumatic stress responses to birth, with 1 to 2 percent of women developing chronic postnatal PTSD.

Beck's (2004b) qualitative study of 38 mothers' PTSD stories collected via the Internet revealed five themes that demonstrated the essences of the mothers' experience. All the mothers belonged to a support group (TABS—Trauma After Birth Support) of women who had experienced birth trauma. The results in Beck's study revealed that these women had characteristic symptoms of PTSD, such as flashbacks, persistent avoidance of stimuli associated with the trauma, anxiety, emotional detachment, and fear of future pregnancies.

For women who have reported having all the symptoms of PTSD related to a traumatic birth, the incidence ranges from 0.2 percent (Reynolds, 1997) to as high as 6 percent (Menage, 1993). However, the incidence increases four-fold or 24 percent (Soet, et al., 2003) when some of the symptoms of PTSD are reported. Interestingly, at six weeks post-delivery the rate of PTSD was 2.8 percent and at six months the rate was 1.5 percent as reported in a prospective study done by Ayers & Pickering (2001). The 1.3 percent decrease between six weeks and six months postpartum is consistent with other research, and that after six months women should be considered chronic cases with continued need for treatment (Ayers & Pickering, 2001). Establishing prevalence rates of PTSD as a result of a traumatic birth remains a challenge, primarily due to the fact that as a newly classified perinatal mood disorder, under-reporting and under-recognizing of the symptoms muddy the waters. Additionally, the symptoms of PTSD are often confused with postpartum depression, resulting in women being diagnosed and treated for the wrong illness (Ayers & Pickering, 2001).

To assist in caring for women during the perinatal period and to minimize or prevent PTSD, a detailed history should be done to include questions related to: (1) past

sexual trauma; (2) women's expectations and experiences about pain; (3) feelings of powerlessness; and (4) obstetric intervention and traumatic delivery (Fones, 1996; Hofberg & Brockington, 2000; Hofberg & Ward, 2004; Melender, 2002; Reynolds, 1997; Soet, et al., 2003; Seng, Low, Sparbel, & Killion, 2004). Preventing a traumatic delivery and subsequent PTSD is critical because of the detrimental effects that have been reported on infant attachment (Ayers & Pickering, 2001; Ballard, Stanley, & Brockington, 1995; Beck, 2004b; Reynolds, 1997); on lactation (Reynolds, 1997); on partner intimacy (Fones, 1996; Reynolds, 1997); on women's psyche, including low self-esteem, feeling cheated, flashbacks, and panic attacks (Kitzinger, 1998; Beck 2004b); and on future pregnancies, with more women opting for Cesarean deliveries in subsequent pregnancies (Hofberg & Brockington, 2000; Hofberg & Ward, 2003, 2004; Kitzinger, 1998; Reynolds, 1997; Wax, Cartin, Pinette, & Blackstone, 2005) and some obstetricians choosing Cesareans for themselves due to this high level of tokophobia (Klein, 2005).

CHAPTER 3

METHODS

Philosophy Regarding Qualitative Methods

The qualitative paradigm is a human science approach, and as such centers on the interpretive model and is concerned with the subjective experience (Holloway & Wheeler, 1996; Holliday, 2002). The qualitative method of inquiry that one chooses to use depends on the answer to the following three interconnected areas: ontology, epistemology, and methodology. According to Guba and Lincoln (1994)

The ontological question asks, What is the form and nature of reality; the *epistemological question* asks, What is the nature of the relationship between the knower or would-be knower and what can be known; and the *methodological question* asks, how can the inquirer (would-be knower) go about finding out whatever he or she believes can be known? (p. 108; emphases original)

Phenomenology is a qualitative approach to a philosophical method of inquiry. It attempts to address the ontological question of “what is being?” and the epistemological question of “how do we know?” (Holloway & Wheeler, 1996). Husserl (1913) set out to explain and differentiate transcendental phenomenology from psychology by examining the everyday world as it confronts the individual, and to establish transcendental phenomenology

not as a science of facts, but as a science of essential Being (as “eidetic” Science); a science which aims at exclusively at establishing “knowledge of essences” (*Wesenserkenntnisse*) and *absolutely no “facts.”* (p. 44; emphases original).

Husserl’s phenomenology and the issue of Cartesian duality predominantly assert that experience is represented in the mind by symbols, which allows the external world to be incorporated into internal consciousness by thought processes (Koch, 1995). This

experience can then be studied thoroughly and methodically, based on how it is presented to consciousness (Hein & Austin, 2001). The *phenomenological epoché* is the term used to describe the universal detachment from the objective point of view (Husserl, 1929). Correspondingly, it is through this phenomenological method of experiencing, perceiving, thinking, judging, valuing, desiring, etc. of the objective world that the individual comes to understand him/herself (Husserl, 1929).

Accordingly, all experiences “are a consciousness of something and thus can be called ‘*intentionally related*’ to this something” (Husserl, 1913, p.119). Husserl elaborated upon this concept of intentionality, which basically states that our consciousness is intentional and that conscious awareness is what accounts for this directedness with the intentional content a description of reality (Hein & Austin, 2001; Koch, 1995; Welch, 1939). Therefore, conscious awareness should be the first step in our development of reality (Koch, 1995). Intentional content, or “the consciousness of something” can be perception/real, imaginary/fiction, or conceptual (Husserl, 1913; Hein & Austin, 2001).

Besides Husserl’s notion of intentionality, two additional salient features of phenomenological/epistemological research, which are part and parcel of this method of inquiry, are essential to examine: essences and bracketing. Hence, phenomena are *essences or eidos* and signify the “sphere of objective Being, ‘existing’ in its own right, independent alike of the objects of nature and experience” (Hein & Austin, 2001; Welch, 1939). Husserl was primarily concerned with the question, “What constitutes the meaning—or meanings—of all experiences?” (Welch, 1939, p.10). He believed that experience had its own peculiar phenomenological properties that had nothing to do with

space and time. The basic Husserlian phenomenological maxim, “To the things themselves—*Zu Sachen selbst*” (Stapleton, 1983; Munhall, 1994)—captures an underlying principle as to what Husserl’s transcendental version of phenomenology is about (Annells, 1996; Koch, 1995). It is to this lived experience, the “taken-for-granted experience,” that Husserl believed needs to be examined. For that reason, phenomenologic inquiry explores the meaning of human experience: “*to each psychic lived process there corresponds through the device of phenomenological reduction a pure phenomenon . . .*” (Husserl, 1907, p. 35).

Husserl believed in the “essentiality” of all objects and developed a method that would be autonomous from any theoretical connections (Welch, 1939). He rejected scientific explanations and thought it vital to develop a phenomenological method by which the authentic/real nature of “sensa” could be examined as they are “regardless of their empirical manifestations or relations, and moreover, without any reference to such relations themselves” (Welch, 1939, p. 11). Husserl (1913) believed that essences (eidos, or pure essence) could be comprehended in intuition “in the data of experience, date of perception, memory, and so forth” (p.57) just as objective reality is grasped in perception. Thus phenomenology is “the ground for a corresponding reciprocal relationship between sciences of fact and sciences of the essence” (p. 61) or as Husserl later qualifies, “a grounding of the theory of the soul in the theory of the body” (p.79).

Additionally, the researcher must avoid any judgment getting in the way of the subject’s description of an experience (Drew, 2001). This is referred to as bracketing (Husserl, 1913), a mathematical term (Holloway & Wheeler, 1996) that has been described in the research as a reduction process whereby researchers detach and/or

remove themselves of all preconceived notions (Bailey, 1997; Koch, 1995; Munhall, 1994, 2001; Sadala & Adorno, 2002) with regards to the essence of the informant's language and behavior in comprehensive interviews (Annells, 1996; Bailey, 1997; Koch, 1995). Bracketing underscores the importance of removing all theories, positivistic or otherwise, from the researcher's preconceptions so that the individual's experience is examined as closely to reality as possible. Husserl (1913) reminds the researcher that the bracketed matter is "not wiped off the phenomenological slate" but rather is "reintegrated in the main theme of the inquiry" (p.212).

The suspension of belief is necessary in order to defend the validity of the objectivity of interpretation against the self-interest of the researcher, thus refraining from judgment, which includes "bracketing not only the outer world but the individual consciousness" (Koch, 1995). Hence, bracketing is indispensable as a means to get a comprehensive understanding of an individual's viewpoint, along with any and all positions inherent to it (Husserl, 1913). Bracketing is reflexive and is fundamental for the validity of the research (Drew, 2001).

Bracketing for this phenomenologic study necessitates that I, as the researcher, suspend the following biases that may influence how I "see" the participant's traumatic birth experience. First and foremost, I must suspend my own notions of childbirth "being a natural event" with expectations that birthing should occur with as little interventions as possible. The births of my four children were essentially done in this "natural" manner, with control over what I wanted that was equally distributed between my family practice physician and myself. Having control over my births was important to me based on two earlier influences in my life. The first influence was that of listening over the years as a

young girl to my mother's birthing stories, of her thirteen children. All of her stories were positive, even when something went wrong, such as the demise of her fourth son (twelfth pregnancy) at one hour of age due to hemorrhaging from a placenta previa. My mother's stories painted a picture of caring nurses and physicians and I believe my interest in obstetrical nursing was a direct result from listening to these stories, which created a sense of curiosity in me to see what exactly did take place during the birthing process.

The second major influence regarding my interest in birth came about from my experiences as a student nurse in the early nineteen-seventies in Pennsylvania. My rose-colored perceptions of birth from my mother's stories were clearly put into perspective with what I witnessed as a student nurse. To my chagrin, I observed many horrendous birthing scenes in the hospital setting. I saw young women alone and crying in pain, laboring on a gurney in a small and quiet dark room. Limited time was spent in giving the laboring woman any emotional support, and whatever time the nurse did give to the woman was done to "quiet" her by giving narcotics intravenously or intramuscularly and to periodically check the fetal heart rate by use of a fetoscope. When the woman's cervix was fully dilated, she was whisked off to the delivery room and transferred onto a surgical stainless steel table. To keep the woman's hands out of the sterile field, her wrists were restrained by the use of leather straps on either side of the table and her legs were secured in the stirrups. Delivery of the fetus was done with the woman in a lithotomy position and flat on her back, often instrumentally assisted by forceps.

From the births that I witnessed, the women would be screaming and totally out-of-control, with little support from the physician or nurse. It was also typical that at the

crowning stage of delivery, the mother would receive a spinal block or ether by mask (or some other anesthetic agent, such as scopolamine) that would place the mother in an unconscious state. My resolve after witnessing these births was not to let my births occur in this fashion and to do what I could to make other women's births a more positive experience. The incongruity between what I heard from my mother and what I witnessed as a student puzzled me over the years. Without her alive to validate what she said, I believe that my mother's birthing stories were more about what happened after the births of all her babies rather than during the birth itself. The medication that women received during the crowning phase placed them in a "twilight sleep" with little or no memory of the actual birth. However, the postpartum period was a time when women were hospitalized for ten days or longer and it is to this period that my mother must have been referring. In her words, going to the hospital to have a baby was her "mini-vacation." I imagine that being served three meals a day in bed, with snacks served between these meals, the infant cared for by nursery nurses, and no siblings allowed to visit, could indeed qualify as a mini-vacation.

Comparatively, current birthing options are diametrically opposed to what I witnessed as a student in the nineteen-seventies, with changes ranging from the presence of fathers/significant others and doulas as coaches to epidural anesthesia for pain management. As a labor and delivery nurse for the past twelve years, I have witnessed many births that included both positive and negative outcomes. Women have more choices now in how they want their births to unfold. However, birthing in a hospital setting continues to have many challenges. As an intrapartum nurse, I have witnessed instrumentally assisted deliveries and/or a traumatic birth, but have never seen the

woman counseled postdelivery, nor to my knowledge did anyone ask these women about their experience. The focus is typically on getting a physically healthy delivery for both the infant and the mother, with minimal follow-up on how this experience impacted the mother psychologically. It is this lack of attention that has prompted my interest in doing this qualitative study. I wanted to discover what effect an unexpected/traumatic and/or perceived unexpected/traumatic birthing process has on the woman so that as perinatal nurses we are enabled to care for the whole person and not just the parts.

To assist me with ongoing bracketing and reflexive thought throughout this research project, I incorporated Ahren's (1999) suggestions on tips for reflexive bracketing, beginning with the above reflexive thoughts that I expressed on my biases regarding birth. Ahren's ten suggestions are to:

1. Identify some of the taken for granted issues as a researcher, such as gaining access. This includes personal assumptions associated with my gender, race, socioeconomic status, and political location of my research. Plus an examination of the power held in relation to this project and where I belong in the power hierarchy.
2. Clarify personal value systems and identify those areas that I know subjectively and refer back to these areas when analyzing the data.
3. Describe potential areas of role conflict, such as particular types of people and/or situations that may make me feel anxious, uncomfortable, or irritated. Consider how these feelings could influence whom I approach or how I approach them. Make mental notes to recognize when anxiety, annoyance, or enjoyment arise in me during data collection and analysis.
4. Identify gatekeepers' interests and how they are positively or negatively influenced toward the research.
5. Be familiar with feelings that I have during data collection that may indicate a lack of neutrality, such as avoiding negative situations or seeking out situations that create positive feelings (such as friendly and articulate participants). Revisit notes in my reflexive journal to determine the origins of these feelings so that I can separate any reactions from past events and the present research. Consult with a colleague when unable to identify feelings to ensure that data collection and analysis techniques are not colored by my feelings.

6. Disclose any new or surprising findings in the data collection and analysis. Before assuming that saturation has occurred with data analysis, consult with colleagues to rule out being bored, blocked, or desensitized.
7. Reframe any blocks that may occur. Transform methodical problems into opportunities. Ask another group of colleagues to shed light on the phenomenon.
8. Consider how writing up the findings will be done. Will quotes from one participant be used more often than another's? If so, why? Will the analysis be written in first or third person? Why? Check to make sure that a more articulate respondent's voice has not biased the analysis by mere virtue of making the analytic task easier.
9. Be certain that the supporting literature review is reflective of the findings and is not expressing the same cultural background as myself.
10. Re-interview a participant or reanalyze the transcript to address any bias in data collection or analysis. (p. 411)

The above ten elements assisted me in remaining cognizant throughout data collection and analysis of the role of bracketing and of the following factors that influenced my decision-making.

Number One: The taken for granted factors as a researcher in this study. These would include my position as a Director of Maternal and Child Nursing, being female and Caucasian, my socioeconomic status, and being a graduate student at a prestigious university. Additionally these factors allowed me to gain access to participants as a result of a professional relationship with a counselor.

Number Two: My personal values related to this area of research. I view birth as a natural process whereby women should have autonomy in choosing how they would like their birth to unfold. I am mindful that not all women choose to take responsibility for their births due to societal and outside expectations or influences, given this bias I went into each interview with an open mind.

Number Three: Researcher role conflict. At times, some participants wanted to focus

more on their perinatal mood disorder than on the birthing experience. I discovered that giving time to this expressed need was equally important after which I would bring them back to the birthing experience. One participant from the Mothers as a Career Club felt that the epidural experience was so unexpected that it warranted being shared. She was the only participant of the ten who had a detailed birth plan. This individual knew from the announcement by the Club's President that I was Director of Nursing at the hospital where she delivered her baby six months earlier and seemed to want to apprise me of her overall less-than-satisfactory experience so that I could do something about it. I did not realize this connection with her birthing experience until after taping of the interview began. However, I did know beforehand through our telephone conversation that she wanted primarily to talk about her "horrible, unexpected" epidural experience. She aroused my interest by telling me that she had this awful experience despite her detailed birthing plan. I agreed to interview her because I was interested in finding out what a planned experience gone awry could offer to this study.

Another participant, who was the wife of my husband's colleague, seemed hesitant about being candid in the telling of her story possibly because of this relationship between the husbands. In other cases, the interview flow was interrupted either to occupy a child or to feed an infant, leading to a break in the participant's train of thought. One child screamed on several occasions to get his mother's attention, was recorded, and later when transcribing I noticed the high picked up such interferences. Interestingly, before each interview the participants would generally do a mini-interview of me and ask me why I was interested in hearing about women's birth.

Number Four: The gatekeepers for this study. These were from two sources, the Mothers as a Career Club and a perinatal counselor. I had hoped to get more participants from the Mothers club but there did not seem to be as much interest from its members as I had expected. There was a turnover of leadership and the successor to my first contact did not seem as impassioned about this project, although she did volunteer to be a participant. The counselor's referrals were a godsend. As an expert in the field, and one of few in the state devoted to helping women with perinatal mood disorders, she wanted the voices of these women heard and made every effort to make sure I had the number of participants that I needed.

Number Five: Feelings that I had during data collection. On several occasions when the participant would relay sensitive and heart wrenching information about her birth and cried while she relayed/relived the event, I found it difficult to hold back my tears. I even noticed the same feelings would resurface during the transcribing of the interviews. Additionally, due to my eleven years of clinical practice in the labor and delivery setting, listening to these women's stories as they unfolded and again during transcription, I could visualize each birth as it unfolded in my mind's eye. From my immediate experience as a Director and from my many visits to explore other hospitals' labor rooms for remodeling purposes, plus from my having gone to many conferences where the same furnishings and instruments are showcased, I now know that most labor room settings are standardized. Because of this, each story relayed to me drew me in and it felt as though I were witnessing each birth with the only difference being that the doctors and nurses remained faceless in each story.

Number Six: The surprise findings in this study. These are twofold, one relating to the epidural, the other to pushing and the second-stage of labor. With regards to the first surprise finding, several of the participants who had a vaginal birth with an epidural equated the epidural experience as an “out-of-body” experience. This is the first time in my eleven years as a practicing intrapartum nurse that I ever heard anyone articulate this epidural effect. The following two participant examples demonstrate this phenomenon:

Krissy: But the whole labor, the delivery, the pushing all that I can't say, well I guess the best way to describe it is sorta like an out of body experience once I got the epidural because I didn't usually you know, I mean, doing all this work and I'm pushing but I don't really even feel it, you know, I'm not feeling it. Almost, I'd say both times it's almost a surreal experience, it almost to me seemed like something I was watching! And it wasn't necessarily happening to me. And I don't know if that's more of, because if you, if I had gone naturally, if I would have felt like more of this was actually happening to me because that you would feel the pain. But with the epidural I'm not feeling anything. It was more almost a disconnected feeling I would say that you know I realized I was having this baby that I was delivering her. But I, you almost feel, I almost felt like a spectator at the whole thing and not necessarily an active participant. I don't know that seems a little strange after I pushed for three hours I was certainly an active participant! But it just sorta seemed more of you know, just happening.

Annie: I ended up being so numb with this epidural that at one point I touched my leg and I felt like someone else was in bed with me, it was the weirdest feeling. It was like, I was sooooo numb that I couldn't, I had no sensation in touching myself. I could barely I just couldn't feel what I was doing. I knew I wasn't pushing effectively because I couldn't feel anything. And they were telling me, don't push in your face, but of course I was pushing there because I could actually feel that! And actually, with both epidurals I felt this very weird sensation that like my body was out of my hands.

The second surprise finding was that during the second stage of labor, the pushing stage, practitioners used directed pushing and prolonged Valsalva-type pushing rather than the evidenced based practice of “laboring down” (AWHONN, 2000; Sampelle, Miller, Luecha, Fischer, & Rosten, 2005; Simkin, 2002). Directed pushing is when the

practitioner has the woman push as soon as her cervix becomes completely dilated regardless of any urge on the woman's part to push. The instructions given to the woman are to take a deep breath, hold it until her coaches reach the count of ten, and exert downward pressure i.e., the Valsalva-type pushing (AWHONN, 2000; Peterson & Besuner, 1997). Directed pushing causes decreased oxygenation to the fetus (AWHONN, 2000; Simpson & Thorman, 2005), increasing exhaustion in the woman (AWHONN, 2000; Mayberry, Gennaro, Strange, Williams, & Anindya, 1999; Roberts, 2003), and can lead to perineal trauma (AWHONN, 2000; Sampsel & Hines, 1999). In contrast, the practice of laboring down allows the woman to push when she has the urge, which may take upwards of two hours, but during this time the woman can rest and recuperate so that she can expend the stored energy for the final stages of pushing (AWHONN, 2000; Sampsel, Miller, Luecha, Fischer, & Rosten, 2005), plus the detrimental effects on fetal oxygenation are decreased (AWHONN, 2000; Simpson & Thorman, 2005).

Number Seven: Reframe any blocks that may occur. I did not experience this.

Number Eight: Writing up the findings. This was done by using quotes from all of the participants' stories. The analysis is written in first person. All of the participants were very articulate so no one voice dominated in the analysis.

Number Nine: Supporting literature review. This is reflected in the findings. Quotes from the participants' interview were interspersed with reference to the literature.

Number Ten: Re-interview a participant or reanalyze the transcript. This was done to address any bias in data collection or analysis. Reanalysis of the transcriptions was a regular part of my procedure.

Study Design

A purposive sample was composed of ten women who gave birth in a hospital setting and had an unexpected birthing experience, i.e., had an instrumentally assisted delivery, either with the use of forceps and/or a vacuum extractor, which resulted in a fourth degree extension, and/or delivered an infant by an emergency cesarean section, and/or perceived that their delivery was unexpected. Women were excluded from this study if the unexpected birthing experience resulted in a fetal demise and/or an infant born with congenital anomalies. My advisor and I agreed upon having ten participants. Given the potential that any of the participants might need counseling as a result of sharing sensitive information during the interview process, a local psychologist who was familiar with perinatal mood disorders agreed by letter (Appendix A) to accept any immediate referrals.

The study was conducted following IRB approval and interviews took place over a six-month period, beginning in May and ending in November. Recruitment of participants occurred through the following means. Prior to the university's IRB approval of this project, I contacted the president of a local community organization, the "Mothers As a Career Club," for a letter (Appendix B) stating that this organization would participate in the study by making an announcement of the research project in the club's newsletter as well as at one of the club's monthly meetings. I had the good fortune of presenting an educational offering on the subject of postpartum depression to this group several months prior to the inception of this project. As a result of the announcements, three participants were recruited from this club. Six other referrals came

from a professional acquaintance that served as these women's Counselor for their diagnosed perinatal mood disorder; and one was referred from a friend.

All of the women selected met the criterion of being at least two weeks postpartum in keeping within the DSM-IV criteria of being symptomatic for PPD, and all were one month post-delivery, in keeping with criteria for being diagnosed with PTSD. All participants had a full term pregnancy, i.e., 38 weeks gestation or greater, and gave birth to healthy infants without any congenital sequelae. Prior to the interview, each woman was contacted by telephone and a date and place of meeting was determined. All but two interviews took place in the participant's home—one interview was conducted at a Panéra bakery and the other interview took place at the participant's office. Seven of the eight women who were multigravidas had their other child(ren) present but occupied the child(ren) by having them watch a video or a children's television program. None of the fathers were present during the interview.

At the interview, the participant was given an informed consent to sign (Appendix C) and an opportunity to ask questions about the research, including questions regarding my reasons for doing research about women's unexpected birthing experience. In some respect, this questioning period was a mini-interview of me by the participant. All were informed that they could withdraw from the research project at any time with no repercussions for withdrawing and that there was no remuneration for participating. To avoid the possibility of linking a participant to specific comments, any names mentioned during the interview were replaced with a pseudo-name and will be referred to in the analysis section as the following names: Myra, Anita, Krissy, Kathy, Annie, Patty, Peggy, Becky, Liz, and Jane. The participants were informed that their identity would be

held in confidence in any published reports of the study. All transcribed materials will be kept in a locked cabinet by the principle investigator and destroyed at the end of three years. When I told them that I would be transcribing the interviews wearing headphones, the participants seemed more candid in telling their stories.

Prior to the interview, each participant filled out an information sheet (Appendix D) requesting the following demographic information: Marital status, age, place of infant's birth, expected due date and actual date of infant's birth, high school graduation status, years of college completed, family's annual income, and ethnic background.

Nine of the women were married and one woman reported being recently divorced. The average age of the women was thirty-two years, with a range of twenty one to thirty-seven. Seven births took place in a mid-western state with two births occurring on the east coast and one birth in a southern state. All of the births occurred within two weeks of the expected due date (EDD). All participants graduated from high school with only one not having gone to college. Four participants completed four years of college, and four completed one or more years of graduate school with one of those individuals earning a doctoral degree. The annual family income was reported as follows. No one had an income less than thirty thousand dollars. Six participants had an income between thirty and seventy thousand dollars. Four participants' income was reported as being greater than seventy thousand dollars. All of the participants were Caucasian. The results of the demographic survey are shown in Table 1.

Table 1. Demographic Characteristics of the Sample (n = 10)

<u>State Where Birth Occurred</u>	<u>n</u>	<u>%</u>
Indiana	7	70
New Jersey	1	10
Virginia	1	10
Texas	1	10
<u>Marital Status</u>		
Married	9	90
Divorced	1	10
<u>Education</u>		
Graduate	5	50
College	4	40
High School	1	10
<u>Annual Income</u>		
< \$30,000	0	0
\$30,000 - \$70,000	6	60
> \$70,000	4	40

Eight of the women were multiparas, with the other two being primiparas.

Interestingly, the first eight interviewees were multigravidas. This was not planned but just occurred by happenstance. Of the eight multigravidas, six of these women's stories were about their subsequent birth experiences. All of the participants had an epidural. Nine of the ten women reported having experienced some form of postpartum depression, with six women clinically diagnosed with PPD and two women with PTSD.

Table 2 shows the participants' obstetric characteristics.

Table 2. Obstetric Characteristics of the Sample (n = 10).		
<u>Parity</u>	<u>n</u>	<u>%</u>
Primipara	2	20
Multipara	8	80
<u>Epidural</u>		
Yes	10	100
No	0	0
<u>Induction of labor</u>		
Yes	4	40
No	6	60
<u>Delivery</u>		
Vaginal	8	80
Cesarean	2	20

Interview Guidelines

Unstructured, audiotaped interviews were done and transcribed verbatim by myself in my home office. Headphones were used during the transcription so that the stories were audible only by me. All notes made by the interviewer were also transcribed and used as part of the data. The interviews were conducted in the participants' place of choice. The length of the interviews ranged from 30 minutes to three hours. The following are sample questions that were used during the interview to facilitate conversation between myself and between the participants.

1. What was it like for you to have experienced giving birth by use of forceps and/or vacuum extraction and/or an emergency cesarean birth?

2. Tell me about your birthing experience.
3. What were you experiencing before the birthing process? During? Afterwards?
4. Did you discuss it with someone else afterwards?
5. Tell me about your expectations about giving birth and how those expectations were met or not met. Dialogue was enhanced by asking several probing questions, such as: Please clarify that for me. Could you elaborate on that? Can you give an example of how that made you feel?

Description of Methods

Interpretation of the interviews was done using Colaizzi's phenomenological method of data analysis (Colaizzi, 1987; Polit & Beck, 2004). This analysis involved the following seven-step process. First, the participant's description was read to get a feel for what she was expressing and to make sense of her description. At this stage of analysis, I cut and pasted all the actual birth events into a sequential order to get a better feel for the flow of the birth as it unfolded, because their stories were interspersed with remembering other components not directly related to the birth itself, such as when family arrived and their influences, or when the participant would focus on one of their other births in comparing that birth with the unexpected birth. However, in the discussion section of this analysis, these portions of the participants' stories will be incorporated as needed for emphasis.

Next, each description (Colaizzi terms these as *protocols*) was read again to pull out or "extract" significant statements (Appendix E). At this step, statements that were repetitive, i.e., containing the same or similar statement, were removed. Meanings from each significant statement were formulated (Appendix F). This step required "creative

insight,” with the goal being to make meanings from what the participants said without severing connection with the original statements and to elucidate any hidden meanings in the varied contexts of the phenomenon under investigation. The formulations that were developed allowed the data to “speak for themselves” without imposing conceptual theories upon the data. Successful completion of this step required the use of bracketing.

The first three steps were then repeated for each participant’s description, and the combined formulated meanings were organized into clusters or themes (Appendix G). The goal here was to allow themes to emerge that were common to all of the participants’ descriptions. The clusters of themes were referred back to the original descriptions in order to validate them. This was done to determine whether there was anything contained in the original descriptions that were missed or unaccounted for in the clusters of themes, and to determine that the clusters of themes did not propose anything that was not implied in the original descriptions. At this point, when it was determined that the themes were incongruent with the original descriptions, i.e., not validated, the above process was repeated. The three themes that emerged from the data were grouped under the headings of caring, connecting, and controlling.

The results of the thematic analysis were integrated into an exhaustive description of the phenomenon under study. In this step, an attempt was made to formulate the in-depth description of the phenomenon under investigation into as incontrovertible a statement of identification of its essential structure as possible.

CHAPTER 4

FINDINGS

Introduction

The unexpected birthing experience as one of the precipitating factors in the development of postpartum depression was the focus of this phenomenological inquiry. The intention of this study was to examine women's lived experience of an unexpected birth to hear these women's stories as to what this experience was like for them and what effects, if any, this unexpected birthing experience may have had on these women after their birth. The word "unexpected" was chosen in this study because my original word "traumatic" was considered to be a loaded and prejudicial term with the belief that using this word would influence the participant's story. Six participants (Anita, Patty, Peggy, Becky, Liz, and Jane) were referred to me from a perinatal counselor and had been diagnosed with postpartum depression, with two of these women (Anita and Patty) meeting all the criteria for post-traumatic stress disorder. Three of the women (Myra, Krissy, and Kathy) were not officially diagnosed with PPD but openly stated during the interview that they believed they did experience PPD that lasted for approximately three months and that they recovered from PPD on their own. Only one woman (Annie) did not report any issues with a perinatal mood disorder. One other woman (Jane) expressed that she believed she had some form of depression antenatally, which she attributed to her unrelenting hyperemesis (morning sickness or nausea) experience.

Five of the eight vaginal births were instrumentally assisted deliveries—three (Anita, Krissy, and Patty) were delivered with forceps and the remaining two (Kathy and Peggy) had vacuum assisted births. Anita's birth had both forceps and vacuum used in an

attempt to deliver the baby. Two births were delivered by Cesarean section. Becky's was a repeat Cesarean section, although she had planned on being a VBAC (vaginal birth after cesarean) but her physician and midwife insisted that the infant would not tolerate labor and therefore needed to be delivered by Cesarean. In Becky's Cesarean delivery, forceps were also used to "help get the baby out." The other woman, Jane, had a primary Cesarean for non-reassuring fetal heart tones (Jane mentioned that there were fetal heart rate decelerations over a two hour period and although she did not say this was the actual diagnosis for the Cesarean, as an expert labor room nurse I made the decision to label this as such given the information about Jane's experience). Table 3 describes elements related to the birthing experience.

Table 3. Birthing Experience Characteristics.

	Referred by	Forceps, Vacuum, Cesarean Section	Episiotomy	NICU present	PPD Exp=experienced Dx=diagnosed	PTSD
Myra	Club	None	Yes	No	Exp	No
Anita	Counselor	Forceps, Vacuum	4 th degree	Yes	Dx	Yes
Krissy	Friend	Forceps	3 rd degree	Yes	Exp	No
Kathy	Club	Vacuum	Yes	No	Exp	No
Annie	Club	None	Yes	No	No	No
Patty	Counselor	Forceps	4 th degree	Yes	Dx	Yes
Peggy	Counselor	Vacuum	3 rd degree	Yes	Dx	No
Becky	Counselor	Cesarean, Forceps	No	No	Dx	No
Liz	Counselor	None	Yes	Yes	Dx	No
Jane	Counselor	Cesarean	No	Yes	Dx	No

All of the eight vaginal births had episiotomies performed with two women (Krissy and Peggy) reporting that they had third-degree episiotomies and two other women (Anita and Patty) exclaimed they had fourth-degree episiotomies and were labeled by their counselor as “vaginal C-sections!” The length of time that elapsed between their unexpected birthing experience and interview ranged from three months to seven years.

Other interesting aspects related to their birthing experiences were reported as follows. All of the women reported that they received an epidural at some point in the laboring process. In five of the nine vaginal births (Myra, Anita, Patty, Peggy, and Liz), the women pushed for approximately two-and-a-half hours, with a range of one-and-a-half hours to three hours. Half of the women (Anita, Krissy, Patty, Liz, and Jane) reported that there was meconium-stained fluid (infant’s first bowel movement) at delivery, which is an indicator of fetal distress at some point in the laboring process. One woman (Peggy) did not mention meconium-stained fluid as being present but did say that the baby had “very low Apgars” and that the neonatal intensive care unit (NICU) team was called into the delivery room to assist with the infant. Five other women (Anita, Krissy, Patty, Liz, and Jane) reported that the NICU team was present at delivery for possible assistance with the infant.

As best as I can discern from their stories, although the question was not directly asked, the average length of labor for eight of the vaginal births was twenty-one and-a-half hours, with a range from five hours to forty-eight hours. The participant (Liz) whose birth is recorded as five hours had been dilated four centimeters for several days before she went into “full-blown” labor; thus, not knowing when she actually went into labor, the readjusted average length of labor would be twenty-four hours. Successful

breastfeeding was done by seven of the participants (Anita, Kathy, Annie, Patty, Peggy, Becky, and Jane); two others (Myra and Krissy) chose to bottle feed; and Liz was upset that she planned to breastfeed but was unsuccessful. The father of each baby was present at the birth. The question of birth weight was not directly asked, but six women reported this in their narrative. Accordingly, the weights of six infants ranged from seven pounds thirteen ounces to ten pounds eleven ounces, with an average weight of eight pounds five ounces.

In order to make sense of why these women termed their experience as unexpected, an examination of what was expected is central. All of the women expressed a shortened ideal version of what they thought birth would be like when asked the question, “how did your experience compare to what you thought was going to happen?” Krissy and Kathy’s experience aptly summarizes what all of these women expected: as expressed here:

Krissy: I guess there were definitely, the actual labor and delivery were much different from what I expected, I had sort of just expected it would be you know a text book sort of thing even you know—I’d go into labor, I’d be in labor for a few hours and you know deliver a baby. And that’s not what happened, the first was when, you know, the decision to induce! I mean that was the first step that right from the start it was not what I had expected you know, I never thought I’d have to be induced! You know, and I’d get to experience that—you’re at home, and is it time? Should we call? Shouldn’t we call? And that wasn’t there you know, we went out, we had a good dinner, because we knew the next morning we were going and we were gonna have a baby! So definitely that was not what I had expected. I, you know I’d say the whole way, the whole thing, the whole process in general was not what I, you know, expected. I think most people go in thinking you know—they’re healthy, they’ve had a healthy pregnancy, no complications whatsoever, I figured delivery would be just the same.

Kathy: I don’t know, you see all the little movies about delivery and everything and all the moms are just happy and smiling and then okay they’re pushing and it wasn’t like that for me. And, I mean I know

everybody is different but, it was, it was a lot of unknown I think. And I don't know, and we took all the classes and you know, childbirth preparation stuff and I don't think anything can prepare you for it really, unless maybe you've been in with someone else who's delivered a baby that might make the difference. I don't know. It was different, different than I thought it would be. I don't know how to explain it. I think my expectation was that it would be easy, just like you saw in the videos.

In essence, all of these women anticipated a relatively easy labor and delivery process of short duration, little intervention, some pain, but an ideal version as predominantly revealed in the media, such as the Baby Channel and/or videos shown at childbirth classes. They expected that the experts, the physicians, midwife, and nurses would be there to care for them, would “know” what they wanted and/or needed, would be there to help steer them through this idealized birthing process. Ultimately their experiences were anything but easy and were truly unexpected. The subsequent analysis will illustrate the unexpected experiences that emerged from the data in the birth stories told by these women. Contrary to these women's expectations, this analysis will demonstrate that the experts neglected to provide each of these women with three essential elements—caring, connection, and control—that are vitally needed for a woman to successfully traverse the uncharted waters of giving birth.

For this analysis, a metaphor that aptly portrays their overall experience is that of the “perfect storm” (Junger, 1997). Similar to a perfect storm to occur, three events—in this case, three raging weather fronts—are needed for the meteorological havoc to take place. For these women, the three critical components of caring, connecting, and controlling were sorely absent from their birthing experience, plunging these women into the downward spiraling effect of the “perfect storm” of a perinatal mood disorder. These

absent components, along with personal historical issues unique to each woman, and together with the unexpected birth itself all contributed to this perfect storm.

The Perfect Storm

The perfect meteorologic storm develops when three forces—an extratropical low-pressure system or cyclone, a vigorous cold front, and a hurricane—converge to create a crippling and devastating storm. Thus a hurricane (in this case, Hurricane Grace) is formed in the center of a cyclone (called the Halloween Storm) vitalizing the storm with catastrophic outcomes. This system actually took place on October 28, 1991 with reports of widespread damage in the millions of dollars in New England, including beach erosion, severe coastal flooding, businesses and homes destroyed, boats sunk, and loss of life. The perfect storm requires the three interacting elements which ultimately creates the devastation. It is called a perfect storm primarily because it is a rare event, but when it does occur it leaves a lasting impression.

In predicting outcomes or possible untoward events, the present analogy is that technology is highly implemented in the areas of both weather and birth. For weather prediction, meteorologists forecast events by satellite imagery and employ a national system called “the Limited Fine Mesh, a grid superimposed on a map of the country where the corners represent data-collection points” (Junger, 1997, p. 100). Compare this to a hospital setting where fetal monitoring (external or internal) is utilized in most labor room settings throughout a woman’s stay. A central monitoring system at the nurses’ station enables nurses and physicians to constantly view and interpret how the fetus and the woman is tolerating labor as evidenced by the fetal heart rate tracing in response to uterine activity. Undulations or waves of uterine activity are charted by the use of a toco-

transducer against the variability of the fetal heartbeat by the use of an ultra-sound transducer. Each transducer is strapped around the woman's expanding abdomen and the extending wires are connected into a bedside machine that continuously graphs the activity of the woman's uterus and fetus' heartbeat.

The information acquired from a fetal monitoring strip (and in some cases intuition by the nurse) along with other factors—such as weeks gestation, presence of meconium, amount of amniotic fluid, the mother's prenatal history, etc.—is used to predict/forecast the anticipated birth. The nurse is required to learn how to interpret the fetal monitoring strip and thus “knows” when the fetus is having problems as evidenced by repetitive late decelerations and/or variable decelerations. If the physician/midwife is not in attendance (and typically he/she is at his/her busy office practice attending to other patients) it becomes the nurse's responsibility to call the physician/midwife to apprise him/her of significant changes (Fetal monitoring evaluation is too lengthy for this discussion so I refer readers to the (2006) Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) Practices and Principles of Fetal Monitoring for more detail). In some hospital settings, the physician has access to fetal monitoring via a computer and can evaluate the tracing either in the office or at home.

Similarly, for weather interpretation and prediction, technological equipment is used, such as weather balloons to measure temperature, dewpoint, barometric pressure, and windspeed, done two times a day, and the data are relayed back by way of a calibrated optical instrument. The collected data are fed into computers, numerical models of the atmosphere are developed, and forecasts are made which are then sent out

to regional offices and then readjusted by local meteorologists (Junger, 1997). This information, combined with the meteorologist's intuition, forecasts the weather.

Other technology used to inform the public about weather and about birth is the media, primarily through television. For meteorologists, daily forecasting is delivered on the Weather Channel and during the daily local news. Women can get information about birth on the Baby Channel. An implied aim of these televised shows is to present to the public the prediction/forecast of what one can expect of the weather or of one's birth with the following exception. Unlike the Weather Channel that graphically forecasts the devastation, the Baby Channel only shows the perfect shortened and idealized version of the birth of an infant. For litigious reasons, one can only assume that a less than desirable birth can not be shown. But even when birth is dramatized on television sit-coms the message given is that birth is fun, of short duration, and not a big deal. In any event, the viewers incorporate into their thoughts what to expect and to prepare accordingly.

Analogous to the calm before the storm, typified by a beautiful sunny day with blue skies, a tranquil sea, and people going about their daily activities, is the lived experiences of the women in this study, who prior to labor and birth, had optimistic anticipation of their birth as expressed by their happy, uneventful, supportive, and planned pregnancies with the expectation that they could navigate their births with ease and with the assistance of the experts at the helm. Regrettably, just like the lingering hours of a perfect storm with pounding winds and high seas followed by the aftermath of damage and destruction, these women's long hours of labor, unrelenting pushing, a damaging episiotomy, and fetal distress—plus the absence of caring, connection, and control by the experts—leads to the devastation of the perfect storm of a perinatal mood

disorder. Similar to a perfect storm's far reaching effects and varying degrees of impact created by the outer bands of wind and rain are the varying degrees of devastation created by each woman's perinatal mood disorder—three of the women report having PPD for a short period of time, while six others reported PPD and/or PTSD lasting months. But unlike the immediate measurable damage created by a storm, the damage produced by a perinatal mood disorder on the woman, her infant, and her family can be immeasurable.

In this study, three essential elements of caring, connection, and control that are absent during the participants stormy birthing experiences should be a part of all caregivers' expertise in tandem with the high technology and skill of the providers. For a better understanding of the importance of each of these essential elements that are necessary for a woman's birthing experience to be positive, a brief overview will be done of the research on caring, connection, and control, respectively.

Caring, Connection, and Control

The concept of caring has a variety of meanings to many people in the health care area, in particular the nursing profession. The past thirty years is replete with research by nurses on this subject, as demonstrated by the following examples of caring, defined as: providing informed consent (Alvino, 1986); essential to nursing practice (Beck, 2001; Benner, 2000; Benner & Wrubel, 1989; Cook & Cullen, 2003; Watson, 2003); a practical science (Bottorff, 1991); a core concept in nursing with these attributes: relationship, action, attitude, acceptance, and variability (Brilowski and Wendler, 2005); an ethical value (Carper, 1979; Lagana, 2000); an essential component of being human (Cohen, 1991); a hermeneutic form (Dunlop, 1986); existential advocacy (Gadow, 1980); respect for an intentional human action (Gaut, 1983); a nurse-patient relationship (Griffin, 1983);

Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006); unselfish interest in the welfare of others (Kurtz & Wang, 1991); a process with moral, cognitive, and emotional components (Kyle, 1995; Sumner, 2001); purposeful interaction to promote health (Phillips, 1993); situated to the carers' acts and thoughts (Skott & Eriksson, 2005); carative, core of nursing, transpersonal and intentional (Watson, 1979, 1985, 1997, 2002b, 2003, 2005); and synonymous with nursing (Wilkin & Slevin, 2004).

In a seminal study done by Morse, Bottorff, Neander, and Solberg (1991), five conceptualizations of caring emerged: As a human trait, as a moral imperative, as an affect, as an interpersonal interaction, and as a therapeutic intervention. Watson (1985) developed ten "carative" factors she regarded as crucial to nursing practice in the care of patients, such as these two salient examples: "the development of a helping-trusting relationship" and "the promotion and acceptance of the expression of positive and negative feelings." More recently, Watson (2005) changed these factors from the word "carative" to "caritas" to convey the transpersonal relationship that exists between caring and love, which to Watson is indispensable in the caring-healing relationship. Wolf, Giardino, Osborne, & Ambrose (1994) categorized nursing into five dimensions: respectful deference to others, assurance of human presence, positive connectedness, professional knowledge, and attentiveness to the other's experience

Noddings' (1996, 2002, 2003) research examines the relationship between the one-caring and the cared-for. In the one-caring, the person is present and receptive to the cared-for as evidenced by the cared-for's verbal and non-verbal cues. A reciprocal relationship should exist between the one-caring and the cared-for where the cared-for responds to the one-caring. In this relationship the one-caring places her/his attention on

the cared-for, with concern for that person's objective needs, expectations, and viewpoint (Noddings, 2003).

Benner and Wrubel (1989) define the primacy of caring in the opening page of their text follows:

Care means that persons, events, projects, and things matter to people. Caring is essential if the person is to live in a differentiated world where some things really matter, while others are less important or not important at all. 'Caring' as a word for being connected and having things matter works well because it fuses thought, feeling, and action—knowing and being. And the term *caring* is used appropriately to describe a wide range of involvements, from romantic love to parental love to friendship, from caring for one's garden to caring about one's work to caring for and about one's patients. (p.1; emphasis original).

Equally important to the caring relationship is the element of connection.

Noddings (2002) distinctly differentiates between care as a virtue and care as an attribute of relation by stating, "caring will always depend on the connection between the carer and cared for" (p. 20). The carer cannot be focused on the self but should be immersed in the cared-for's plans, pains, and hopes with the objective to actuate the plan, alleviate the pain, and actualize the hope (Noddings, 1996).

Watson (2005) supports the concept of connection in her research and believes that connection occurs when the nurse exists in consciousness with the patient; i.e., when she/he is receptive to the other. Watson (2005) expands the notion of a connecting moment as to one in which a transpersonal-intentional relationship develops between the nurse and the patient, which evolves into a "spirit to spirit unitary connection within a caring moment" (p. 62). This caring moment occurs when there is an "intersection between and among" the relationship and the "holding of another's life in one's hands in the moment of encounter" (p. 62). Watson (2003) maintains that in order for a

transpersonal caring relationship to develop in the practice of nursing one must transcend the ego and connect human-to-human and spirit-to-spirit. This can be accomplished when the nurse engages in the practice of “honoring each person . . . speaking and listening without judgment . . . and honoring the reality that we are part of each other’s journey” (p. 201).

Benner and Gordon (1996) believe that the skills of connection and involvement are essential for caring to occur. Connection is a “being-in-relationship to particular persons/situations” (p.45). They assert that being with patients requires more than just the knowledge and technical skills and that equally important for a trusting relationship to develop is the ability of the caregiver to be with/connected to the patient and to practice engaged caregiving. It is the “encounter and recognition, the ability to *be with*, see and hear who the other is” that is more important than “*doing* something to or for that patient” (p. 47). Davis’ (2005) phenomenological study of participants’ lived hospital experience defines the nurse’s presence as being gentle, calm, courteous, kind, attentive, comforting, sincere, available, empathetic, and reassuring.

Moustakas (1995), a child psychologist and phenomenologist, categorizes the ways of identifying the nature of relationships into three distinct parts: Being-In, Being-With, and Being-For. Being-In necessitates the skills of “conscious recognition, focused attention, and concentration of energy” in order for one to understand “another person, the other’s thoughts, feelings, behaviors, and experiences, as presented and articulated” (p. 155). Essential to knowing the other person and Being-In requires listening, authentic presence, empathy and compassion, and the other’s “frame of reference, goals, purposes, interests, preferences, and directions” (Moustakas, 1995, p.155). Being-For is described

as “being clearly and definitely present as an ally . . . to promote [a] common purpose” (p.156). Being-With creates the “I-Thou” [carer-cared-for] relationship where the individuals work together as a team, with “expressions of mutuality and regard, the valuing and enjoying of the sheer human presence of two people traveling on a common path” (pp. 156-157).

Although Moustakas is referring to the child-therapist relationship, these three distinct parts can be closely aligned with what is necessary for “connection” to occur in the nurse-parturient relationship, particularly as this relationship unfolds in the labor and delivery setting. Every new patient that the nurse encounters necessitates the “presence of a sensitive and caring human being,” which should be “anchored in the reality of one person’s presence to another, in the being there, and in the safety, security, compassion, and acceptance of this other person” (Moustakas, 1995, p. 71).

The last of the three elements to be examined is that of control. Control in this study refers to how the participating women perceived the amount of control that they had over their births in the form of decision-making, including self-control and control over what was done to/for the patient. Goodman, Mackey, and Tavakoli (2004) demonstrated that personal control is a key component in the overall satisfaction of one’s birth experience. Hodnett (2002) found that when the nurse incorporates involvement in decision-making, i.e., personal control, patient satisfaction increases. Declercq et al.’s (2002) survey of women’s satisfaction with their care concluded that women were satisfied with the care they received when due to the following areas: (1) understanding what was happening (94%), feeling comfortable asking questions (93%), getting the attention they needed (91%), and being involved in the decision-making (89%). Green

and Baston's (2003) examination of women's expectations and satisfaction with their birth found that three types of control—feeling in control of what staff do to you, feeling in control of your own behavior, and feeling in control during contractions—contributed to their overall emotional well-being.

The research on caring, connection, and control provides support and evidence that these three essential elements were clearly absent during the labor, delivery, and postpartum processes of the unexpected birthing experience of the women in my study. Six of the eight women's stories in this study are based on their first birthing experience. When offered by the woman in the interview, I will present examples from her second positive birthing experience to help validate why she perceived the first experience as unexpected and essentially negative.

CARING: Theme One: *“They're the experts and they know what's best.”*

This thematic quote represents the overarching absence of nursing care from the birthing experiences of the women in this study. Examples of non-caring behaviors are pervasive in all of the stories, but the following experiences of two participants Annie and Patty will be used as examples of how non-caring behaviors significantly impacted each of these women's birth.

Annie, the fifth participant, came prepared for her second birth with a birth plan. Annie's unexpected experience centered on the high-dosed epidural that she received, but in general she was unhappy with her experience because she believed that the nurse essentially sabotaged her birth plan, as she states here:

But I had given a birth plan; I'd given it to the doula in advance, the doctor in advance, and the nurses when I arrived. And one of the things in there was, it says something about—I'm aware of the medical option, you know, for pain and I just prefer you not offer them to me unless I ask. I

just don't want them brought up. Well, earlier into the day or before, I was like to the point of having Pitocin and all, the nurse had told me, and she did make some statement like, "After this I won't say anything. But I want you to know that you can have this, you can have you know, you can have oral, you can have you know Demerol or whatever those types are, I forget—narcotic I guess, and or you can have an epidural. And I want you to know those are your options." And you know at the time I was like not really mad at that or her but I was saying, you know, "You read my birth plan, I gave you my birth plan, I didn't want to hear that from you. I'm well informed and you know, that's why I gave you that plan." But, so anyway, they kind of, I felt kind of pressured into the epidural and I tried to resist it and I tried to say, oh you know, and I really had a hard decision and then they left for awhile and, anyway, but, I ended up, you know, go ahead and getting it and, and I guess I just felt defeated by just having, needing the Pitocin or choosing the Pitocin and that whole thing and . . .

Feelings of defeat and giving-in by Annie demonstrate a total disregard and lack of respect by the nurse for Annie's hopes of a natural birth as requested in her birth plan.

Watson's (1985) trusting, helping relationship and her transpersonal relationship of caring and love (2005) are truly nonexistent between this patient and her nurse. Another example of undermining Annie's birth plan is evident in this account:

She'd come in and say, "Okay, with an epidural you know you have to be in bed the whole time." And I'm like, "Yeah, I know that." And "you have to have an IV the whole time." And I'm like, "I know." And whenever she got to hook me up to the monitor, cause it says, it's all in there, I understand, you know, I prefer, I want intermittent monitoring, I understand, you know I understand there's some requirement but I don't have to be in the bed laboring the entire time with a monitor on. But I don't know, I felt like they would leave it on longer than they needed to or you, I don't know, I just felt like, I mean it was nothing real verbal and I certainly wasn't going to get into any confrontations because how good is that when you feel like, you know, they'll intentionally, you know they can intentionally do something wrong or they could intentionally forget to do something.

Again, the nurse did not establish a helping-trusting relationship (Watson, 2005) with Annie. Instead, just the opposite occurred, as captured in this comment:

It was scary to feel bad and sort of not know what's going on and why you feel so bad and I guess part of it, at the time I said, you know, well you get

the epidural, you don't have that pain and whatever but instead you get, you know, the itching and you get, you can't feel the push and you. I guess, obviously the bleeding whatever, I guess part of that was perhaps due to maybe progressing a little faster than I would have naturally, and so I maybe tore a little more or something, in the cervix. I think the doctor told me that! But that might have been it. So I guess I was just tracing it all back to you know, my original birth plan and what I had hoped for and what I have by my own choices, you know abandoned and then all these things that sort of happened as a result.

Annie is referring to the cascade of events (beginning with her relinquishing to the Pitocin augmentation) that occurred as a result of abandoning her birth plan—an abandonment that might not have happened had she had a nurse advocate.

Next is Patty's story, the second mother diagnosed with PTSD and who had a fourth-degree tear. The following anecdote describes her desperate cry for help from her nurse:

And I had labored all night long, kind of walking the halls at the hospital. And the next, so it's like seven in the evening until about four or five in the morning I just, I was totally, completely exhausted. And I remember I was like six centimeters and I finally just said, you know I think I want an epidural. I was going to do the wait and see thing, and I remember I just kept looking to the nurse like, you know, "What should I do? What? You know?" And I'm looking back, if I would have had somebody that would have supported me, or a midwife or a doula I think I, it would have been fine. But I was scared. I was exhausted. I could not even think. And the nurse is like, "Oh I'd have an epidural! Just do it!" They just didn't, she didn't care. I was just one of her patients and she could manage me better if I had an epidural.

Patty's interview is interspersed with sobbing as she recalls the painful events leading up to her horrific birth. In the above passage, Patty is distressed by the fact that no one is there for her who cares about her dilemma as to whether she should get an epidural or continue laboring without. Her plan was to "wait and see" but after labor for over twelve hours and finally dilating to six centimeters, Patty was at a crossroads as to what to do. Here was an opportunity for the nurse to reassure and comfort this woman, perhaps even

to coach and assist with breathing so that she could birth her baby without an epidural.

But instead the nurse opts to tell the patient to go ahead and get the epidural.

Later on in Patty's arduous laboring process, she again seeks advice from the nurse and as before is given little assistance:

I remember they all seemed extremely distant. One of them was in and out, friendly but not, I was grasping towards her like, "I want information I want information. I want to know what, what should I be doing?" You know? And she just was not really interested. And then the second time, you know the second shift nurse was a nice girl and I remember looking at her and saying, "I want you to tell me the truth, would you let this doctor work on you?" because I didn't know him. She's, "oh yeah, they're all good, you know, oh yeah they're all good, of course." You know and I talked to nurses who have been around a lot and they seem like somebody with more experience may have told me something different. You know, just, they were young. I remember the one girl was really young and just not interested, really. And I get the feeling you know, I didn't have any nurses, and then on the postpartum floor they said, well here's the phone and if you need me, just call me on the phone. So I had a phone and I never really bothered.

In this situation, Patty's observations shed light on three examples of non-caring by the nurse. This example demonstrates distance and disinterest by the nurse who by Noddings' (2002) is considered indisposible, i.e., the nurse is not "there" even when physically present. Additionally, Patty's statement regarding nurses' experiences supports research on what a novice nurse might have said/done versus what a more experienced/expert nurse would have advised (James, Simpson, & Know, 2003; Spichiger, Wallhagen, & Benner, 2005).

The following example depicts a clear message of the nurse(s) and the doctor as being unavailable, distant, and apathetic to Patty's efforts at pushing:

It was just horrible labor. It was just, just, I had two anesthesiologists who kept running in and out and, and the epidural would wear off and then the one would give me more medicine and the one would let it wear off, and the one would give me more, it was just like nobody was, you know. And

I was pushing with the nurse, so finally when it was time to deliver, and I just remember I was puking and just in so much pain and I knew one of the anesthesiologists from work and he was just like, he told me later, he's like, "I felt so sorry for you." He's like—it was just so awful. And I remember I kept saying, "Where's the doctor?" And the nurse, I kept trying to you know, push! And get the baby out! And I kept thinking—it's going to happen, it's going happen. And he was, just like busy with, with, he was busy! There were three other women, he's like—you know I have all these other things to do! There was all these other people that needed help and he just was not really concerned with this, I sensed with this first time mother giving birth and I just didn't have a nurse that was really there.

Clearly absent in the above encounter are Noddings' (1996) two fundamental characteristics of "caring by the professional," which are:

First, we are in a receptive mode. We attend non-selectively to the cared-for. We are, at least momentarily, engrossed in the other's plans, pains, and hopes, not our own. Second, we feel our motive energy flowing toward the other. We want to help in furthering the plan, relieving the pain, or actualizing the hope (p. 161).

For Patty, the professionals were lacking both of these attributes. She received no help in furthering her plan, no relief for her pain, and little hope in her pushing efforts. Other heartrending examples of Patty's non-caring and traumatic experience are unmistakable in this quote:

So they took me to the operating, they took me back into the operating room and, and I just remember they just put me in the lay, just kind of you know, I was on this bed with these huge, my legs were up in huge stirrups just, you know, just separated and I was so humiliated. I just remember feeling so humiliated. And I just, the doctor came in and just basically ripped her out with forceps, it's just like extracted her from my body. I really think part of it was the position, all these people in there, and the total lack of connection that there was a human being on the table going through this! It's like, I was a body, I was a piece of meat that needed to have a procedure done to get this child out and when that was over then it's fine, and it's done and. But to me who was going through it, nobody was talking to me. I was, it's not a natural position to be laid, filleted opened naked in front of all these men and people that didn't, that really don't even know your name.

No effort is made to help Patty through this difficult experience; her dignity and privacy are not protected. No one is offering consoling words and the humiliation that she expresses is palpable. Moustakas' (1995) recommendation that there should be the "presence of a sensitive and caring human being" is clearly missing in Patty's delivery room. A birth is taking place, the first experience for Patty, and no caregiver is "anchored in the reality of one person's presence to another, in the being there, and in the safety, security, compassion, and acceptance of this other person" (p. 71, Moustakas, 1995). This lack of safety and compassion, along with no control over what occurs, is evident in this next passage:

And my baby was, you know, over in the ICU area, and I, it was just so, I had, it just felt like I had left my body on the table, it was just like a horrible experience and then the doctor has this resident walk in. Never met, never asked me if I'd like a resident to work on me, who starts sewing me up and then proceeds to rip out all the stitches because they're not right! And he's telling me, he's torn my rectum in half and all this stuff and I'm just like, kind of in shock that this is considered "okay?" to do this to a woman? This is okay? And so, so then when they, they sew me up and I, I just, I felt like I didn't even have the power to say, I don't want a resident! I just felt like every ounce of power or saying that I had over what was happening to me was totally gone. And it, I think that was the, was one of the biggest things that affected me that I've had to heal from.

The non-caring behaviors that Patty has already experienced continue into the postpartum stay. At this point, Patty is exhausted from a lengthy labor, a three-hour pushing process that resulted in a forceps delivery and a fourth-degree tear. Her compromised infant is in the neonatal intensive care unit, and yet with all these critical issues, the care that she should be receiving is nonexistent:

And I could not; I couldn't even walk down to see her in the ICU. I mean they had to wheel me down, and my tailbone had been broken and all this stuff. And so when I went down to see her I just, you know I, I just, I was so, I can't believe how exhausted I really was. I look back at pictures and I think I was just so exhausted. And I think that's what made me angry is

that I felt like, you really trust someone to take care of you and then you don't get good care and you get bad care. And then nobody will acknowledge it.

Even the most basic items are not offered, such as ice to her swollen bottom:

I walk, I knew there was a big ice machine down the street, down the, they gave me a little pad, just a little, and I knew there was a, I knew there was a refreshment stand thing for the dads and the families, since I would, asked for some bags and I just would walk down and got big bags of ice and I would just pack my body with ice for those three days, I just, that's what I did. I remember asking for an anti-inflammatory because I was so, and I remember calling the doctor's office myself and just saying, I need some Toradol. I asked for Toradol I think because nobody would, it just seemed like I must just not have had a good, ex. But it just was, I think they gave me some painkillers but.

It is incomprehensible that the devastation Patty experienced in the delivery room went unreported and/or unnoticed by the nursing staff. A fourth-degree extension requires the bare minimum of nursing care that includes ice, Colace as a stool softener, sitz baths, pain medicine, and routine checking of her bottom to make sure no further bleeding or swelling has occurred (Cunningham et al., 2001). Her visit to the doctor's office validates that the absence of postpartum care by the nurses for Patty and her injured bottom constituted gross negligence:

My perineum was so swollen that it was unbelievable! And so I went to the, back to the doctor that day before I picked her up and I, I, this was the doctor that I had gone to for all my prenatal care and he said, he kind of was like, he's like, "How are you?" And I'm like, "Oh, I've had better days you know, and it was kind of rough." And he goes, "Oh, okay!" Kind of smiling, like, yeah, that's you know . . . and then he said, "Well just let me take a look." And he looked, and literally, I saw his jaw drop! Like, oh my gosh! I could see him get really nervous and he said, "This looks like necrotizing fasciitis!" It was so bad. And he was just kind of tiptoeing around the room a little bit and he's like, mmhmm, just let me get you some antibiotics. And I could tell he was kind of like, what happened to her?

In the above example, necrotizing fasciitis may have been minimized or avoided had her nursing care on the postpartum unit been more vigilant. Basic nursing care seems to have been neglected. If Patty had received the minimum interventions in following routine postpartum care orders—such as examining her episiotomy and applying ice to her bruised perineum followed by sitz baths—these two interventions alone would have alerted the nurse to any problems so that the nurse could have alerted and informed the physician that Patty’s episiotomy was not healing properly.

Patty’s poor postpartum care experience was not an isolated event in this study. All the women expressed that they received the minimum care such as ice and an antiseptic/analgesic spray (Dermaplast[®]) for their episiotomies. But what equally resonated throughout most of their experiences was the lack of care and respect for their physical and emotional well-being after having just birthed an infant following long hours with pushing and/or receiving a third or fourth degree episiotomy. Myra’s experience (after two arduous days of labor followed by hours of uninterrupted pushing, and then two more days of interruptions by the postpartum nursing staff) illustrates the overall feelings of the women in this study toward their postpartum care:

So the baby was with you 24 hours a day, so by the time I left on Thursday, I had not slept since Monday night more than maybe two or three hours at a time for you know a stretch and was pretty sleep deprived at that point. The nurses would come in every half hour on the hour, every half hour and check you, vitals and that kind of thing, so it was an impossibility to sleep more than a half hour at a time. Finally by Tuesday, I basically had said, “Please do not touch me anymore, I have had enough and I would like to go home.”

This first-time mom sorely needed both sleep and care following her two-day ordeal in the labor room with little or no relief or time to recover on the postpartum unit. Where is the report between the nurses in the labor room with the nurses on postpartum

describing the lengthy process that Myra had just experienced? Where is the concern and care for Myra so that when she went to the postpartum unit the nurses there would know from the labor room report that Myra would need periods of uninterrupted sleep and that her infant would need to be cared for in the nursery? Continuity of care by the nursing staff about Myra's labor and birth and postpartum stay is vital, so that by discharge Myra would have the required stored-up energy to care for herself and her baby. Myra's dismay with her care is summarized in this next quote:

So coming home from that was a huge overwhelming experience. They did not prepare me at all to take care of myself, what I needed to do post-delivery or what to do with her . . . And I just remember, we weren't even in the house for fifteen minutes and I sat in my chair, the chair in her room, and I just cried. Because I just felt so overwhelmed, I was so tired.

This overall experience of non-caring, resulting in fatigue and being overwhelmed, may be one of the contributing factors that thrusts Myra into the perinatal mood disorder of postpartum depression. Corwin et al. (2005) support this notion of fatigue and underscored in their study that the leading predictor for developing postpartum depression is severe fatigue.

Kathy seems to be the only participant who had a nurse that took care of her during the postpartum period, as exemplified by this statement:

I had a great nurse who worked with me. At that time they had separate nurses for baby and mom and as for the nurse that worked with me was absolutely wonderful. She came in and gave me ice packs and you know all that and told me what to do and I mean she helped me with everything. I felt, I felt helpless. It's like I don't know what to expect with, I felt like a little kid because I was just in whole new ball game. And of course having a baby and he didn't want to nurse and you know, it was just like, I needed all the help I could get, I felt like I needed somebody to take care of me and she did, she really did.

In this example, Kathy expresses that she “needed somebody to take care of me,” which is strongly promoted by childbirth advocates, especially during the postpartum period, and has become known as “mothering the new mother” (Klaus, Kennell, & Klaus, 2002; Placksin, 2000; Salt, 2003; Simkin, Whalley, & Keppler, 2001).

CONNECTION: Theme Two: *“I just didn’t have a nurse that was really there.”*

The participants’ birthing experiences are riddled with examples of disconnection by their caregivers or an absence of the nurses being fully present and inattentiveness (Jonsdottir, Litchfield, & Pharris, 2004). Examples from the interviews of Anita, Krissy and Becky will lend support to the disconnection experienced by the other participants.

In this example, wherein the labor room is left in shambles after the birth, the moral, cognitive, and emotional components (Moustakas, 1995) and sense of dignity (Matthews & Callister, 2004) are missing, as vividly depicted here by Anita:

The room was a mess. It was—the floor was covered in blood! The one image that I have is stepping off the table onto the floor and trying to make it to the bathroom with the help of my sister and I had to step on bloody tennis shoe prints and I was barefoot at the time and I just, you know, stepping on my own blood and it was just imagery that I, I won’t forget! So my sister helped me to the toilet, and tried cleaning me up.

From my eleven years of experience as a nurse in the labor room setting, it is a customary practice for the labor room to be “put back together” by the nurse and/or by an assistant immediately following the birth and prior to the family entering the room. Not cleaning the blood off the floor is thoughtless and insensitive.

Anita’s family, (sister, mother, and father) were present for this birth and photos were taken which she shared with me after the interview. Her words describe the chaos, panic, and her heartache that developed around the birth of her baby girl:

These photos were definitely not a picture of joy and excitement. There was a lot of chaos with people coming and going and nurses changing because I had been in for so long, my labor took thirty over thirty-six hours! So I did have some shift changes in there, it was happening, I delivered at ten-thirty a.m. so I remember there was a shift change before the delivery and my epidural was starting to wear off, so I was in a lot of pain while I was pushing. The doctor had tried forceps and also tried suctioning a few times, at least three times I was suctioned and we were still having a hard time, I was given an episiotomy and somehow you know that baby, she finally came out. I think that's what tore me to pieces at that point, and my episiotomy or my ripping or tearing it was horizontal rather than to the rectum so I had it in both directions.

But she definitely was not breathing. She was an apgar of one. She, she was, she looked like she was dead. I remember my husband; he walked over to the other side of the room where all the pediatrics people were waiting for the baby. While in the middle of this, it just seemed very chaotic! Haphazard with people, just people coming and going and more people in the room and then more people in the room. So then I knew, you know, this is not going to be easy, this is, something's wrong with the baby. So I had that heartache. When *** was born she was completely limp, no crying, she looked purple, she was definitely in a state—I didn't know if she was alive or not, definitely you know, she could have been a still birth, if, if they, you know.

Anita cries as she relays her story and I too am choking back tears. Essential to knowing the other person and "Being-In" (Moustakas, 1995) requires listening, authentic presence, empathy and compassion, all of which are missing in this moment of Anita's experience. Additionally, nowhere in her story is there any mention of affection being relayed to her by her carers. Although this section deals with lack of connection, I believe it is appropriate to bring in how caring is equally absent when Anita's experience is measured against Morse et al's (1991) five conceptualizations of caring—as a human trait, as a moral imperative, as an affect, as an interpersonal interaction, and as a therapeutic intervention—all of which are nonexistent in Anita's care. Additionally, no one is even giving Anita information about her newly delivered infant, as seen here:

There was not any joy or excitement about whether this was a girl or boy. I, I do recall my mom stepping in and saying, “Oh, you know, do we know what it is, what the baby is?” And through all the tears and anguish, my family they were still trying to be joyful and optimistic about this delivery. And, the doctor did say, “Oh, it’s a girl.” And as my husband went over to be with the baby, my mother came to me, and I was in a state of, I was in a lot of pain—I remember, my bottom must have been moving while the stitches, while I was being repaired and stitched up and she had asked, the doctor asked, “Oh, does that hurt?” and I said “Yes! You know I can feel all that.” So they did give me a localized shot and I looked over at my mom and I asked if my baby was alive and she then stood up in her protection, you know mode, and said, “you know, my daughter would, my daughter wants to know if her baby’s alive.” And the doctor then stood up and said, “Oh we’re working on the baby, we’re checking, checking her out, we’re working with her right now, you know, let me get you, get you cleaned up and stitched-up!”

Anita’s first birthing experience empowered her to be more assertive with her second delivery and she knew that she would ask for a different nurse if things were not going well, as stated here:

You know if there’s not a connection with that nurse, maybe they should switch out nurses! Or, not be offended if, you know, at this point I would ask for a nurse to be switched out, if I was not having a connection and I would be in labor for thirty some odd hours then I know there’s more than one nurse on staff and I might ask, you know, could you . . .

Anita’s example clearly supports Noddings’ (2002) characterization that caring will always depend on the connection between the carer and the cared-for.

Most of the women in this study believed that once the epidural was given, the time in-between, i.e., up until the woman became fully dilated and began pushing, constituted long moments of isolation interspersed with mundane tasks performed by the nurse, such as taking vital signs. One woman, Krissy, expresses here the overall feelings regarding this time period:

But once I had that epidural, basically it’s almost like, you know the sign goes up, “Okay, she’s in bed, you know we’ll check back and see how far she’s dilated!”

All of the women had an epidural for pain control. It seems as though, given their experiences of prolonged pushing and not being able to move or feel to push, the women in this study did not receive the newer neuraxial technique of minimal motor blockade (Poole, 2003a, 2003b). The regional epidural analgesia these women received, although an effective means for pain management, has several pitfalls: Prolonged second stage of labor, decreased maternal urge to push, the need for an episiotomy, and increased risk of instrumental/operative vaginal delivery (Kitzinger, 2005; Salt, 2003; Tillett, 2004). An epiduralized patient typically requires little contact from the nurse, except to perform technical tasks such as vital signs, catheterizations, and recording of data (Tillett, 2004). In some intrapartum environments, epiduralized patients are termed as being on “cruise control” or “automatic pilot” due to the woman typically receiving Pitocin to induce or augment labor, vital signs and contractions monitored by machines, a foley catheter in place to continuously empty the bladder, and all that remains is for the cervix to dilate. Thus it becomes a waiting game until the woman is ready to become actively involved with pushing.

However, this time could be used by the nurse to engage in teaching opportunities such as what the woman can expect with pushing, how to effectively push or to address questions about decisions regarding immediate post-delivery requests, such as placing the infant on her abdomen, cutting the cord, and initiating breastfeeding. Chances are the nurse utilizes this time to take care of one or two other women who have presented in labor (Tillett, 2004). In either case, communicating to the woman and her family that the nurse is available may reduce the perception of isolation and abandonment.

The next case used in illustrating how connection is missing from the birthing experience will be Becky's story. Becky desperately wanted to have her second baby vaginally (VBAC-vaginal birth after Cesarean). To her, giving birth vaginally was "what her body was meant to do." Her first birth was a Cesarean, which she believed was unnecessary and was performed because:

I wasn't dilating like they wanted me to. And the doctor comes in around four (in the afternoon) and she was like, "Well, you're barely three, we're gonna have to do a c-section now while everybody's here, or you can wait five hours and do one then." So I just chose to do it then, 'cause she said my cervix was swelling, not dilating, which made everybody there like— Oh! She just wants to go home for dinner! You know? That thought.

Thus, when she was told that this infant needed delivered by Cesarean, her plans for a natural birth were crushed:

So I really just I, I just felt so betrayed! I felt so rushed! They didn't care! And that hurts me a lot too. 'Cuz I made it so clear in the whole nine months to all the midwives I talked to, I said I don't want any advice, I don't want anything. And I was really nervous that, because I was a VBAC my doctor would be in the hospital. And she made it clear—unless if there was anything going wrong I wouldn't see her. Because I didn't want to see her! I didn't want to see her face. 'Cause I knew something would be going on if I saw her.

Becky's loss of trust with her caregiver in the first experience is only magnified and reinforced with this second birth, both being instances where decision making is in the control of the provider (Shorten, et al., 2005). The decision to perform the second Cesarean was made by the on-call physician and midwife as a result of an ultrasound. Becky was six days overdue and an ultrasound, known as a biophysical profile, was done to determine whether the fetus was tolerating its intra-uterine environment or needed to be delivered. The results of the test, as explained by the technician and later by the doctor and midwife, indicated that the fetus had a low score, "no fetal movement," and

that Becky should have a Cesarean section. Becky was not convinced that there was a problem with the baby. She believed that lying flat on her back for a long time, plus along with the time of day that the test was taken, which was normally her naptime and thus her baby's, was the cause for the decreased movement. Her frustration is expressed as follows:

I was six days overdue and they wanted to schedule me for a biophysical profile. I didn't think anything of it. I really didn't, I was there the day before with a non-stress test, and everything was fine. So the ultrasound girl is like, we, I took a really long time and I was in a lot of pain from lying on my back, she was not laying right in me or something (referring to the baby) and she just did the profile. So she scored two and that was because she didn't move the whole time she was, we did the thing. So that scared everybody. And it scared me because I went to the doctor, or the doctor came in that I didn't know, mine was out of town, because she's like, "You're gonna, you have to have that baby today and there's no, there's no other options besides a C-section!" I'm like devastated, 'cause you know, that was like not what I wanted to hear. I knew in my heart that the baby was fine. I really felt like she was okay. I know that she was moving, she moved as soon as I got up. I think it was the positioning that, with me lying on my back.

As previously noted, Benner and Gordon (1996) believe that the skills of connection and involvement are essential for caring to occur. What is absent in Becky's experience is the trusting relationship, that connection of "being-in-relationship to particular persons/situations" (p. 45). Becky may be receiving the knowledge and technical skills of the experts but what is clearly missing is the "encounter and recognition, the ability to *be with*, see and hear who the other is" that is more important than "*doing* something to or for that patient" (p. 47).

This lack of "being-with" the other (Benner & Gordon, 1996; Hunter, 2002; MacKinnon, McIntyre, & Quance, 2003; Moustakas, 1995) is apparent when the nurse

comes into the room to do further testing, a non-stress test, on Becky to determine if the prior ultrasound is correct. Contact with this nurse clearly lacks any connection:

And I got into the room and a nurse came in and she's like, "Here's a gown, go ahead and change, you can leave your under-ware on but your baldies come off!" I'm like, they— just like that! I was like a patient! When I was just supposed to have a test run! And I, I just lost it! I mean that was it for me. I said in my mind, I was still fighting, I said—I'm not having a C-section! I'm still fighting! But at that point I had already become the patient.

A defining moment of disconnection during Becky's birth is cogently expressed here:

And surgery was so long I decided, I layed there and I looked at *** [her husband] and said, "I feel like you're a deer being gutted." Cuz they were pulling—you know and just gutting me it felt like! They used forceps, they and she floated back up! And, it was just, it was just weird like. It was just weird. I, I felt so violated lying there. You know—lying there, everything's exposed. They can't get a damn catheter in me. It's just, you know? It's just, you don't know! But . . .

But equally disconcerting is Becky's equating what happened to her during this second Cesarean experience to rape (Becky was raped at age fifteen). To lead into this quote, Becky relates in the interview how she had an opportunity to examine her medical record and when she read that the doctor wrote her Cesarean was a "repeat" without mentioning the "stress" factor and urgency of the infant needing delivered, this caused her to feel betrayed and violated:

It was repeating, it was a repeat, now it's in paper in black and white ink and the doctor wrote—it's having a simple repeat. When I felt it was because of the stress or because of my baby not doing good. [Referring to the word "repeat"] It is, it's awful. I mean that's almost as bad as rape! And it, in that, it's funny because like *** [her Bradley coach] she goes, "You know all these feelings are okay." She goes, "People that have C-sections feel like that they've been raped!" And I, I just smiled and I'm mean like she doesn't even know. [Becky has not told many people about her rape when she was fifteen]. I was like this has been worse than that ever probably will be besides the fact that it has already changed a lot of who I am. Just because, I mean, I guess it's just because I trusted the people! I put myself in the situation. I trust, yeah, I trusted the doctor! And

who's going to trust some seventeen-year-old boy? That you don't know very well? I mean if you look at it, if you put like, if you do like a split line and put all the reasons that like the trust or the situation, the environment! Which one's scarier? I mean, thinking that you're in the safest position, like you have doctors, midwives, hospitals, staff that can take a baby out of you in a matter of minutes and then like that you would feel safer there. And I'm like and that was the choice than a bunch of, a bunch of teenagers drunk! Drugs! Alcohol! I mean you wouldn't feel safe there. So it's, it's worse to me. That I felt safe and wasn't. If everybody would just let their body do what it's made to do in a supportive loving atmosphere then it would happen. You know, it would happen right.

Had the caregivers taken time to “be-with” Becky, had they connected with her at some point along the continuum of care, they might have discovered that she had an experience of rape. Mason, Rice, and Records' (2005) phenomenological research found that prior abuse influences one's cognitive frame of reference back to the abuse experience itself.

CONTROL: Theme Three: *“You're not in control of the experience.”*

Peggy's and Liz's birthing stories will be used to illustrate how lack of control in decision-making, including self-control and control over what was done to/for the patient.

In the next story, Peggy's unexpected birth experience and lack of control is apparent when she discusses her unrelenting, three hours of pushing:

I pushed for three hours and nothing! Just nothing! And I, and my husband, I didn't really know I was pushing for three hours. I saw the clock but I didn't realize that that's how long I had been pushing. It was, it wasn't even taking a break. The doctor never left the room, she was there the whole time and I was just contraction after contraction pushing! I mean I guess I was crowning but not enough and my husband said, “Do you think she needs a c-section? Do you think that this, that it's time to do a c-section?” And the doctor said, “No, let's just try one more, one more push, one more, we'll just try a little bit longer.”

In Peggy's experience, as well in the experiences of five other participants (Myra, Anita, Krissy, Patty, and Liz), “laboring-down” seems to be an unfamiliar practice to the

caregiving experts. Peggy's birth necessitates the use of the vacuum extractor to aid in delivery of the baby:

And they did, they finally did the vacuum thing on the head and with the vacuum, I think I pushed three more contractions and he finally came out!

And Peggy ends up with a third-degree tear that initially is incorrectly repaired by the physician. This example demonstrates that control of what is done to her is not in her hands:

When they were sewing me up they, I guess they missed stitching up one area or one area started bleeding and I was bleeding and bleeding and bleeding. And my pressure dropped and they, I don't remember what happened during that part, but they paged the doctor to come back to take care of me and she didn't come back! She sent a resident! And that really, I didn't care for that!

Her infant was also distressed at birth:

And he was not breathing. I think, I don't re, my husband won't tell me what his Apgars were but they were incredibly low. They were very, very low and I was just relieved to have him out and I don't really remember a whole lot of, I don't remember any of you know the, them trying to get him breathing, they didn't really include me in on that part. They took him off to the side and so, in fact they didn't even tell me if it was a boy or a girl at first.

Given that Peggy's birthing experience is overwhelming, with three hours of relentless pushing, a third degree episiotomy, postpartum bleeding, and an infant requiring resuscitation, one would only expect that her postpartum experience would be one in which she would have time to recover and to heal. But that was not Peggy's experience. The following statement reveals a marked absence of control in not getting the attention she desperately needed and deserved, plus neither involvement nor respect in making decisions (Declercq et al., 2002):

In the hospital that experience was horrible. My husband was next to me and he slept through the whole thing. I felt like all of my insides were

falling out and I was still the one getting up, getting the baby. I didn't know that you should, that I should have sent the baby to the nursery to get some sleep. I, I'm just like—you're the good mom, she's having [the baby] next to you, you know, with you all the time after you have the birth and that was mistake number one! But I, so from the minute I had him I was the one doing everything, even though I felt horrible. The nurses didn't answer the call buttons. I didn't get the medications that I was supposed to get. Really got no help whatsoever in the hospital, from nurses, even though I felt horrible, the nurses didn't answer the call buttons. I'm in a lot of pain because of this, but they didn't, nobody really seemed to trigger that that would hurt, you know? And so, so they kicked me out at forty-eight hours. They actually were cleaning my room before I had my last instruction on breastfeeding. They, I, said, "I really want one more time to learn how to do the side-lying, you know breastfeeding" because I was really gun-ho on doing the breastfeeding thing and they stripped my bed down, was taking out my trash, mopping the floor and I got on a bare bed to, to learn how to do this. That, I mean they had me in the wheelchair ready to scoot me out. And so I did, I had learned how to do the breastfeeding one more time and went home! And that was, that's when all the problems began!

Having experienced lack of control with her first birth, Peggy made sure that she had more control with her second experience, as this quote confirms:

That's why with *** I said I didn't want any visitors at the hospital. And I did—they had the birthday party at the hospital where they—this hospital does birthday parties for the newborns so people are allowed to come to that but after that I had no visitors. And I had my phone on privacy, so I didn't get phone calls. So if I wanted to talk to somebody I called them. And if somebody wanted to come and see me they had to go through the nurse and say, hey so-and-so here, do you want to see them? So, I did not accept any visitors and they got upset with me but I'm like, "you're not the one going home to a two year old and a newborn with essentially no help." So, that's what I learned about the second time around is—I had to speak up for myself and what I wanted.

The above examples support the research that underscores the idea that patient satisfaction increases when the nurse incorporates personal control for the patient into the care plan (Goodman, Mackey, and Tavakoli, 2004; Hodnett, 2002).

The following examples examine Liz's birthing experience to illustrate her frustrations with lack of control over her birthing events. Liz's pregnancy went tens days

over her due date and during this time her cervix had dilated to four centimeters, but her physician was against doing an induction of labor. Thinking that she was in labor, she had several visits to the labor room but was sent home each time. Here is what Liz had to say about these visits:

I was very angry about that experience! I mean I remember being super frustrated, thinking—gosh! You know I'm walking around, I mean I literally was. I think I quit work probably at four centimeters dilated cause I quit a few days before I had him finally. But I remember—who walks around at four centimeters dilated, you know? And I'm having pain or I wouldn't be here and it was in the middle of the night and they would hook me up and keep me there for hours and—oh! Say things like, “You know honey when it's time you'll know it!” And kind of just, you know washing away the feelings that I was having and it was painful. I mean it was uncomfortable! I went overdue ten days! You know from my August twenty-sixth to my September tenth, that was quite a, you know by then you're just so ready anyway! And I was so uncomfortable just being pregnant! And so excited to have this baby! I mean, so I was having a lot of feelings of frustration. And yet those visits I was, I was upset! And I did think—gosh! You know—have me walk the halls! Or have something happen here where it looks like you're trying. I mean it just kind of kept feeling like—get out of here! You'll come back when you're in a lot of pain. That's totally the message I got!

Liz's birth experience itself demonstrates several instances of not having control, as she declares in this statement:

I think yeah, that feeling of just loss of control, then when people start coming into the room and it, they're all in gowns and masks, I felt completely out of control there too. I couldn't feel my legs! I felt like I could be paralyzed. I felt like there was going to be something wrong with my baby! They take my baby right away! I just think that all summed up to pretty much to being a loss of control!

She poignantly encapsulates her overall birthing experience as a tornadic event. Liz had first hand experience with a tornado the day before her wedding that is mentioned at the end of the following passage:

Yeah, that's exactly how I felt when I got to the hospital—Okay! Now you're right! Yeah, I'm in pain. I can't stand it! I think I'm going to die!

Now deal with me and you're eating your potato chips? And it was the same woman like I said, who wasn't very nice the first couple of times and so there she is in my face, when it's really—this is what you told me and this is how I feel and you're not hurrying! [Another nurse hears Liz's cries and comes to take her to a room] . . . because this other nurse just—not listening to my husband! Not listening to me cry...I'd cried for probably a minute or two! Right in her, right there in front of her and the other nurse heard me and didn't stop to get a file or anything just threw me on the table. And that felt a little, I mean literally it was like—swoosh! And clothes off and thrown on you know? And we're like—waited all this time and then boom! Everything's happening! And doctors rushing! And anesthesiologist being called! And he was in an emergency C-Section! And so that's when I had this—Oh, I'm not going to get it in time! Because everything was going so fast! The whole time. And I remember—Don't move! And I was in that kind of intense and I think—Oh! I'm going to paralyze myself because I can't not move—this hurts soooo bad. And they also had, which really angered me; they had a survey, a medical history survey that I was to complete during my contractions! And it was like—here you go! And I had to sign so many pieces of paper because I guess the lady couldn't find what I, whatever! So they brought it all in to me and I'm literally like and I remember looking at the lights thinking—Oh! I'm going to just die! There's no way! And they literally, and my signature, I remember it was just like a scratch across the page! And she continually...and it was like this long with everything, I didn't read—has my mother had this? Have I had? And would not let me not do that! It had to be done. So I remember just thinking, trying to get through these contractions and that was all prior to an epidural. They could not wait till I had my epidural for that and there was just a lot going on and a lot of ups and downs! A lot of things going really slow! Things going really fast! Then really slow again! You know? Again all out of control! I had no control over any of it! It felt like a tornado again! Because that was the same way—we were all happy and fixing up the place for the wedding and then— swoosh! Like that comes a tornado and we all scatter to different places and then we all got together again and it was like this calm . . . sirens were going off everywhere but no one could help! Because the firemen were, you know, there was buildings literally just tumbled to the ground with people in them so we were assuming everyone was killed in those buildings right across the parking lot so it, they came by to make sure we weren't having life threatening, you know, issues and then they would leave. It was so just that eerie sound—and it was kind of like the birth went. It kind of did the same pattern of—I wonder too if that didn't have the same thing—planning for this perfect next step in my life—the same thing—just disarray! It felt like it could have just been eaten up along side the—my wedding cake was literally in the funnel of it and got thrown in somebody's yard three miles away and I truly, I remember thinking—gosh! That was kind of my we-you know my delivery

experience and my postpartum experience was just . . . and I just felt like it got swept away from me, you know?

The above metaphor of a tornado fittingly describes the unpredictable and uncontrollable nature of Liz's birthing experience but also lends a good fit for all of the women's stories of control being absent in this study. Just as a perfect storm requires a combination of three weather fronts to bring about destruction so too when the three factors of caring, connection, and control are absent from the birthing experience, the perfect storm of a perinatal mood disorder can develop.

Perinatal Mood Impact

When the above three critical elements caring, connection, and control are missing, the fall-out from their devastating perfect storm experience propels the women in this study into the downward spiraling condition known as a perinatal mood disorder. And just like the damage incurred from a perfect storm, with an aftermath that can last for years, so too can a perinatal mood disorder have devastation with long-lasting effects, as evidenced in the following examples. Anita's and Patty's experiences with PTSD will be illustrated first, beginning with their painful after-effects that permeated their lives following their traumatic births. First, here is Anita's account:

But I was still in a lot of pain for the next week, two weeks, three weeks Continuously! Continuously! I was gaining some strength and my soreness was alleviated a little bit after time but I was still having major problems especially six weeks after the baby was born. After *** was born I still had major feminine problems and had to . . . well at that time I tried seeing my general practitioner and I did see my OB, but there were no red flags at that time that I was going through postpartum depression or had any signs of that because I was not crying all the time. My depression ended up being more anxiety—loss of appetite! Sleepless nights! Irritability! Rage. You know that feeling of, you know I just, repetitive thoughts! Suicidal thoughts! That this overwhelming activity, that just like my brain just would not turn off, especially at night! And then I'm exhausted on top of that, and then you know, finally when maybe I am, am

maybe able to turn, turn if off, it's—back up with the feeding! I nursed *** for twelve months, and followed through with, with that. After ten months I realized, you know what? Something is really still wrong! I need to go back to a doctor. I did go to my general practitioner this time, I was I was sent to my general practitioner and he took a thyroid test. So still that depression was not realized. I, I called an 800 number in the *** Book that the hospital had handed out, and they had gotten me in touch with *** then I had my first meeting with ***. Discovered that I was not alone in the feelings I was having! That really this birth traumatized me! So the baby, she was, she was fine, but I was not! I wasn't able to have intercourse for a year or have any you know sexual because of the pain. I was in terrible pain still after you know, after six weeks we laughed at the doctor—even my husband laughed at the doctor! I felt like I was barely walking at that point. And then after six months we considered you know starting to have a relationship again, an intimate sexual relationship. And that still was not working. I went to a sex therapist, a physical therapist, it ended up that I, I did go through a divorce and I feel like some of it was contributed to this depression and not being able to you know, feel like I functioned as a wife, as a spouse, a lover.

In the above example, Anita's traumatic experience not only affects her physical and emotional well-being but also has a negative impact on her relationship with her spouse, an outcome effect supported in the research (Beck & Sichel, 2006; Lydon-Rochelle, Holt, & Martin, 2001; Morof et al., 2003; Williams, Lavender, Richmond, & Tincello, 2005) which eventually culminates in a divorce, as verbalized here:

This is the start of the, the failing of my marriage, the start of the end of our marriage. After the baby hit three or four milestones, my first child *** she was functioning! She was, motor skills were right on. You know physically her checkups were great! My husband didn't understand why I couldn't snap out of it! And those were his words, "Just snap out of this! You know you should be thankful! There is nothing wrong with ***. Why, why are you still so upset about this birth?" I would replay this birth over and over and over in my head. I mean it was constant for a year.

Similar to Anita's husband's lack of understanding, Patty's spouse is equally unsympathetic as shown by this passage:

I mean we, my husband could not understand what my problem was. And I think that was part of the most hurtful part was that he would say the most insensitive things to me, like, "You know so and so your friend

didn't have this problem, what's wrong with you? I need my sleep, I need you know, I need to sleep and you need to be up with the baby. This is your job!" Kind of that whole sense of just, isn't this just what you were born to do? And don't you just love it! Aren't you just loving every minute of this because you want to be a mom? And I just was in so much silent pain, you know? And I think too just the physical pain prevented us from ever having any kind of sexual intercourse for a long time! Because it was just, just out of the question. From my understanding with him, he was just like, very black and white—the baby's stuck, get it out, procedure done, success, let's move on with life. And there was no, nothing happened to him. Nothing happened. He was, and he tells me, "I was there ***. I was there and nothing happened. I was there." So I couldn't argue. He was there! He saw it! The baby was stuck, they got him out, and it was over. That was it! It was nothing else happened! And so I am just basically out of my mind to think that this huge thing happened. And, and that's where it, even, even today. Like telling him that you were coming—it just brings up this, this thing that we have between ourselves but he cannot understand that something else happened. He can't! Nothing happened to him!

Both husbands' insensitive words (Kleiman, 2000) clearly express the anger, frustration, and disbelief about their wives' birthing experiences.

Due to this devastating first birthing experience, Anita fires her first physician and interviews countless doctors before she gets pregnant again, as even the thoughts of her first doctor bring on anxiety, as this passage demonstrates:

She really never knew the problems I had afterwards and all of the damage that I had afterwards. I switched hospitals; I did have panic attacks through my second birth. When I switched doctors I remember passing the hospital on the highway and having a panic attack. I just couldn't breathe, I had to pull off; I had to pull off the exit where the hospital was.

Patty's overall experience mirrors that of Anita's. This quote demonstrates Patty's dissatisfaction with her physician and the action taken:

I just said, I'm not going back to them for anything because I had called the doctor after just weeks of crying and crying and crying and all this stuff and I went to him because they had also . . . Later I found out that they had just sewed through my urinary track and the repair was not very good! And I had a lot of urinary issues and my doctor was just like, "There's nothing wrong! There's nothing wrong with you!". . . So I was

like, they're not going to help me so I'm just not going to go back there anymore. And I was terrified to see, to follow up with the guy that delivered me. I was terrified! So I didn't follow up with him. I followed up with my regular doctor. So after I kind of just thought, well this practice doesn't really care much about me or how I'm doing and I'm, I'm gonna go somewhere else

Patty has PTSD symptoms as she voices here crying:

I mean I was having constant nightmares and if somebody would come behind me and I would just jump! And just I was constantly crying! And I couldn't eat. I couldn't sleep. It just was, it was just so horrible. And you know, my mom would just go like, you need to eat, you need to get out of bed and get over this, and nobody in my life was recognizing, I thought I was crazy! I mean I was like suicidal. I mean I thought that my daughter hated me; I thought I was completely out of my mind. And I just thought I was crazy. And then physically though, I was in so much pain . . . I then realized that the forceps had, had ripped through, totally lacerated my vagina and my perineal nerve had been severed and my rectum and all the anal muscles and then all the scar tissue when they sewed it up had just kinked through my, my urethra. That I just, here I went from being this strong athletic girl to sitting in my house crying because I couldn't even take my child for a walk around the block. I mean it was just a total insult physically to where I did not know how to handle not being able to just walk! And I after going through all the physical and emotional issues it just practically destroyed our marriage.

Other PTSD symptoms that Patty experienced are articulated in this account:

I was very hypersensitive. I was extremely irritable. I, would just, a normal day would be just to basically cry, everyday unless I was with other people. And I would, be very jumpy. If I was in my closet, like I, couldn't stand to have my back to where maybe somebody could touch me or, or I couldn't see them, you know, like if I was in my, cleaning out the bottom of my car, like in a car wash or something. I, I would just be petrified to have, I would always have to look around my back and really make sure that nobody was going to get me you know? And just a lot of strange things! Like constantly waking up with nightmares. And just feeling like I, if somebody would bump me just be hypersensitive to being injured, you know. To being, it was just really, and I think it was cause I was in a lot of physical pain. But it was just weird, like I remember reading all the symptoms of post-traumatic stress and I thought I have everyone of these. And I thought, I thought you had to go to war to have that happen to you, you know?

Both Anita's and Patty's experiences strongly support research on the negative consequences of a third-degree and a fourth-degree episiotomy (Williams et al., 2005) and Beck's (2004a, 2004b) PTSD reviews. The aftermath of the incurred injury results in a perinatal mood disorder, wreaking havoc on the woman as well as on her spouse. The women's voices in Beck's (2004b) research echo the sentiments of these two women as having struggled "to survive each day while battling terrifying nightmares and flashbacks of the birth, anger, anxiety, depression and painful isolation from motherhood" (p. 216).

Seven women in my study had the same reported symptoms of postpartum depression and/or anxiety as found in the research, such as feelings of foginess, uncontrollable crying, lack of appetite, insomnia, and panic-like feelings (Beck, 1999b, 1999c; Beck & Indman, 2005; Beck & Sichel, 2006; Gaynes et al., 2005; Misri, 1995). Jane's PPD experience captures how the seven women's symptoms were consistently expressed:

I just feel so foggy. I can't function because I just feel like my head is always in a cloud . . . I'd just start crying. And I cry and I cry and I cry. And no matter when I went to sleep, I'd wake up in a panic! And just like—my heart racing! Just like—was real anxious . . . I couldn't tell you what I was anxious about or anything. I was just anxious. When she [referring to the baby] would cry it was like—electrical shock going through my body. It was just like—I didn't want her to cry but I didn't want to stop it! I think it was two weeks; you have your check-up with the doctor, I went in. I wasn't eating. I was below my pre-pregnancy weight. I just I couldn't eat. I think it was just a struggle. I went in and my doctor looked at me and said, "Honey, you are depressed!" And I said, "Huh?" You know? And she [the doctor] laughed and said, "I'm going to go get you something for this!" And she left and I turned to my husband and I said, "Do you think I'm depressed?" And he said, "I just know you're not right! Something's not right!"

A common theme in nine of the women's narratives was that of not being informed by the professionals about perinatal mood disorders, education that Garg, Morton, and

Heneghan (2005) believe should be provided by nurses at every opportunity. Again, a quote from Jane, demonstrates how the participants generally believed this vital information was omitted:

I was just angry because nobody told me. I did hear people had the baby blues. Okay, well, what is that? What does that look like? I mean it wasn't brought up I don't think in any of my what is it—childbirth classes? Or classes you take. You know it wasn't really talked about or if it was it was kind of glossed over like—you know, you might have these sad feelings and that's okay! And that was it! But I was kind of angry that no one said—hey! There's this thing called postpartum depression. Here are signs and symptoms, you know, at least if, and you know, obviously I wouldn't recognize the signs and symptoms but my husband would have. You know what I mean? And he had no idea. Whereas if he would have had, you know—said—okay, if she's not eating, she's not sleeping, she's not, you know—she might be depressed! And I mean he didn't have any idea either! So I feel like, yeah I feel like you know—no one told me that when you know someone should have at least mentioned it! You know, not, you know and I never thought I would have had it anyway but ... yeah I kind of feel like—oh, oh, we're just going to leave that out! First thing I'm going to tell you about that and hope that you don't have it and if you do well then we'll deal with it then! So . . . and since then I've talked to several people who didn't even know that there were people like *** that dealt with it. So I was just like—how could you not-not tell people? And even at work somebody said something and I said, “Well you know I have postpartum depression,” blah, blah. And they're like, “No, I didn't know that!” And they don't even know because they'll be like what, what was that like? You know and when I tell them they're like, “Oh my gosh! You're kidding?” I'm like, “No!” And I mean they don't have any idea and I mean most of these people are in the medical field! And they don't know! So I mean ...it, it was just very frustrating! That no one bothered to mention it. And I'm sure everybody's optimistic and wants you to have a good birth experience! But you know I think you know when you go to surgery they always tell you know—you might lose blood, there's a chance of death! They always tell you that! Even if it's you know getting a mole removed or something, they tell you that! But you know, this wasn't death but no one mentioned it! So . . . yeah, I feel kind of lied to. Like part of the story was left out I guess maybe.

Nine women in this study experienced varying degrees of a perinatal mood disorder. One could reasonably doubt that the birth-experience itself could have been the only risk factor that caused their perinatal mood disorder. But in this group of women,

only two of the nine mentioned in their narratives any predicting risk factors that would have given one a clue that they were at risk. For instance, Becky had a history of having been raped at the age of fifteen and Liz had two prior unresolved traumatic episodes in which she witnessed a brutal murder in her teens and experienced the direct hit of a tornado the day before her wedding. Aside from these two examples, all of the women in this study had more positive factors that are associated with a healthy emotional outcome. All were planned and wanted pregnancies. All but one woman had a college education. All had supportive spouses and families. All had above average annual incomes. All had attended prenatal classes and received prenatal care. All but one was over thirty years of age. All were married at the time of their unexpected experience.

None of the women in this study had any of these psychosocial risk factors: Significant loss or life stress in the last year; an unplanned/unwanted pregnancy; prior fetal loss (miscarriage); child care stress; marital conflict; low social support; (ACOG, 2002; Baker et al., 2002; Beck, 1999b; Beck & Driscoll, 2006; Bennett & Indman, 2003; Bonari et al., 2004; Bozoky, 2002; Corwin, Brownstead, Barton, Heckard, & Morin 2005; Dennis, 2005; Flynn, 2005; Hall et al., 1996; Henshaw, 2000, 2003; Milgrom, Martin, & Negri, 1999; Miller, 2002; Sichel & Driscoll, 1995; 1999). Two other risk factors that are typically included in the research, but not readily apparent in this study, are genetic predisposition and previous episodes of depression/mood disorders. Since neither of these risk factors was addressed, they will be left unanswered as to whether they played any part in these women's history.

After careful examination of their experiences, the universal denominator for the women developing a perinatal mood disorder was shown to be the uncaring attitudes,

disconnection, and the lack of control that existed between each birthing woman and her caregivers coupled with all of these women's unmet pre-birth expectations. Myra expresses it rather well in this narrative:

I just felt that I was so ill-prepared to deal with it and I felt that I, you know, I went through the prenatal classes and the labor classes, my husband and I did that but they never really told you what it was going to be like. And compare that experience to the one I just had when I delivered my son, it was night and day! It was night and day! And I wholeheartedly believe that if you do not have the knowledge before you leave there and the support of a nurse or a doctor, it just makes all the difference in the world.

Liz, another participant and a social worker who attended PPD support groups, encapsulates this common denominator when asked what her expectations were before the birth:

There's so many expectations . . . I mean too numerous to count . . . And I think that's that one other common thread I saw. Cause we were all pretty high achievers! Like my group that I was a part of—we all had our Masters' degrees. We all breastfed or wanted to. We all have pretty good husbands! And so we talked about that, like, you know—what is it? And how high were your expectations? –Oh mine were just as high! I think we all kind of have that nature, you know? Overachievers! And of course that happens to everyone in different groups but I was definitely in a group where we have a lot in common and our expectations were all really high! Too high! And we were all really well supported and we talk about how grateful we were! Because we know and I know now having seen some of these women in this program that there's just so many women that suffer from it that just don't have anything! They don't have the re-resources to take care of their baby! They don't have the family support! Friends! They don't have transportation! I mean they are prisoners in their own home with this horrible affliction. Whereas we could drive our cars to this group and talk.

Although Liz is speaking primarily about the women in her support group, what she said equally applies to all of the women in this study.

A perinatal mood disorder can have a negative impact on the relationship between the woman and her child (Beck, 1999a; Beck & Sichel, 2006; Britton, Gronwaldt, &

Britton, 2001; Diego et al., 2004; Lindgren, 2001). Several of the women in this study expressed concern, guilt, and sadness about their relationship with their child and this overall sentiment is expressed in Patty's words:

I had a terribly hard time connecting and bonding with my first child, which has been a struggle even, even I think today [five years later].

All of the participants in this study were ready to navigate the uncharted course of their births. What they did not anticipate was the impact of the rough seas tossed at them throughout the course of their labor, birth, and postpartum experience. For these women's birthing experiences, the rough seas turned out to be the pounding storm of uncaring, disconnection, and loss of control.

CHAPTER FIVE

SUMMARY AND IMPLICATIONS

Summary

Caring, connection, and control in this study were clearly the missing elements from these women's births. This study affirms my cognitive and emotional interest as an intrapartum nurse as to what effect an unexpected birthing experience has on women. Having witnessed countless births in which women pushed for extended periods of time, resulting in an operative delivery, third- and fourth-degree episiotomies, and a depressed infant, I often wondered how this experience affected the woman's psychological health as well as her physical health. Although not all of the participants had this exact experience, I discovered—even with Annie who had a birth plan—that to a successful and satisfactory birthing experience are the three critical elements of caring, connection, and control.

This study demonstrates that the overall negative birthing experience for these women was influenced by the nurses' and physicians' un-caring attitudes, disconnection, and the mothers' minimal control over what happened to them during the birthing process and during the postpartum period. These factors may have played a pivotal role in the development of each of their perinatal mood disorders. Generally speaking, women present to the labor room setting with the implicit expectation that the individuals/nurses placed in positions of care are there to assist them in producing a healthy and memorable outcome. Unfortunately, these ten women, whose births took place in different hospitals throughout the United States, did not have such experiences that they expected. Their expectations of a happy and joyful experience were fraught with frustration, anger, pain,

and disillusionment. The research cited earlier regarding women's negative satisfaction with their birthing experiences (Carlton, Callister & Stoneman, 2005; Goodman, Mackey, & Tavakoli, 2004; Hodnett, 2002; Mozingo, 2002; Waldenström, et al., 2004) validates these ten women's adverse experiences.

A revolution in Western culture's birthing practice needs to take place for birth to get back to a normal and natural process (Goer, 2004; Kennedy, & Shannon, 2004; Lothian, 2004; Simkin, Whalley, & Keppler, 2001) and less of a medical model event. The World Health Organization and Lamaze International (Lothian, 2004) support and advocate normal birth that would include these six care practices:

Labor begins on its own; freedom of movement throughout labor; continuous labor support; no routine interventions; non-supine (e.g., upright or side-lying) positions for birth; and no separation of mother and baby with unlimited opportunity for breastfeeding (p. 1).

Nurses who are at the bedside of every parturient in every hospital across this country and in most settings internationally have a golden opportunity to influence how this change will unfold. The following transformations are critical for a caring intrapartum environment to take place. "Care" is the operative word for all nurses to incorporate into their lexicon if women are going to navigate their births without unnecessary morbidities, e.g., operative deliveries, which may then lead into a perinatal mood disorder.

The question to answer is: What lessons can nurses and other caregivers learn from this study on women's birthing expectations that will ensure that all women can expect a satisfactory and memorable birthing experience with little morbidity in the postpartum period? The answer is complex and multifaceted due in large part to the embedded history of birth in western cultures being steeped in a medical paradigm, endorsed by a socially constructed view of motherhood, and cultivated by women's

irrational fear of pain and thus of giving birth. The following proposals are offered in an attempt to answer this question.

Implications for Nursing Education

First, it is critical for the intrapartum nurse to have a solid educational foundation regarding the evolution of birthing practices and how the medicalization of birth changed from that of a natural process into its current high-tech industrialized one. Most nurses take current hospital birthing practices as the norm and this taken-for-granted way of how birth is typically practiced in these settings blinds them to other possibilities. Second, maternal child nursing education must be: Less focused on the medical model and in favor of an emphasis on a caring practice model (Benner, 2000; Benner & Wrubel, 1989; Benner, Tanner, & Chesla, 1996; Spichiger, Wallhagen, & Benner, 2005; Watson, 2005; Watson, & Smith, 2002); enhanced by social support research (Logsdon, 2000; Logsdon, Birkimer, Simpson, & Looney, 2005; Logsdon, Gagne, Hughes, Patterson, & Rakestraw, 2005; Sleutel, 2003; Warren, 2005); more family-centered (Grambling, Hickman, & Bennett, 2004; Martell, 2000); mother/baby friendly (Hotelling, 2004) and include a “being with woman” or midwifery model (Hunter, 2002). Given that ninety-five percent of all births are estimated to be normal (Jordan, 1983; Davis-Floyd, 1997), the emphasis of maternal child nursing education should primarily reflect the normalcy of pregnancy and birth and include, but not be limited to, research on the history of medicalization of birth, the social construction of motherhood, women’s expectations, and how birth unfolds in other cultures.

Education about the untoward high-risk conditions, i.e., the medical model, can be incorporated only as a means to inform the undergraduate nurse of the potential problems

that can occur during pregnancy and birth. When a nurse graduates and is accepted into a birthing practice, part of the didactic orientation program into her/his newly chosen specialty would include the specifics of technological and high-risk care that a patient may need and/or receive. The onus of a nurse's competency in this area of practice would then fall on the shoulders of her employer, which is essentially what occurs already. Testing and certification of that person's expertise would then be done on a regular basis by qualified certification agencies. Equally important to this formal educational process is the on-going informal dialogue from the experts with the novice about their successes and failures in the reality of caring for birthing women.

Implications for Clinical Practice

A shift in practice from the hegemonic medical model to one of birth being normal would necessitate a concomitant shift in who would be at the helm of this new ship. Here again is where nursing can take leadership, which in some respects is currently taking place in practices across the country where freestanding birthing centers and/or hospital-based birthing centers exist. The past thirty years has seen a resurgence of nurse midwives in this country's birthing arena and one can only hope that their numbers will continue to their upward trend. The age-old tradition of women caring for women holds promise with midwives, a "being with woman" philosophical change that is necessary if changes are to occur for women who want to give birth their way, with personal mastery and control. Hunter (2002) defines being with woman model of care as:

A willing and desired relationship between the midwife/nurse and the woman for which the care providers acts as a companion and guide . . . providing available human presence and social support as indicated by the woman's perceived needs: emotional, physical, spiritual, and psychological (p. 655).

Social support as applied to pregnancy is defined as a reciprocal relationship between the pregnant woman and the support persons, whereby information, nurturance, empathy, instrumental help (e.g., helping with household chores), and recognition of competence is provided (Logsdon, 2000; Sauls, 2006). The primary support person is usually the spouse or partner, or the pregnant woman's mother but in a "being with model" the support person is the doula, defined later in this discussion. Social support interventions have demonstrated improved outcomes with both physical and psychological health (Brugha et al., 1998; Logsdon, Birkimer, & Usui, 2000; Séguin et al., 1999). Logsdon (2000) lists examples of these improved outcomes:

Attachment to infant and improved interactions with infant; compliance with health care regimen; improved self-efficacy; improved functional status; improved coping; improved birth outcomes; increased incidence of breastfeeding; reduced physical symptoms; reduced psychological symptoms; reduced loneliness; satisfaction with support; and satisfaction with intimate relationships (p. 13).

The certified nurse midwife (CNM) would take charge of all normal pregnancies and births, with the obstetrician available for consultation of high-risk cases and any emergencies. Evidenced-based research demonstrates that outcomes for the mother/infant dyad improve when attended by a midwife (Kennedy, & Shannon, 2004; Schuiling & Sampsel, 1999; Vincent, Hastings-Tolsma, & Park, 2004). Midwife-attended births have demonstrated a decrease in these areas: Cesarean section rates, episiotomies rates, operative (forceps or vacuum assisted) deliveries, and epidural rates (Anderson & Murphy, 1995; Davidson, 2002; Shorten, Donsante, & Shorten, 2002; Walsh & Downe, 2004). Satisfaction with birth increases due to midwife attended births when the midwife is perceived as caring and has these attributes: Giving the woman undivided attention, sharing the course of events, touching, and providing professional

intimacy, connectedness, and support (Hunter, 2002). Nurse midwives are typically viewed as activists for women-centered birth (Kirkley, 2000) and with their advocacy women can regain the control over their bodies and likely develop a new vision for normalcy of birth. Although favorable outcomes are generally associated with midwifery care, as in any professional arena, each person has their unique way of practicing and thus a mutual relationship between the birthing woman and the midwife should be the goal.

The certified nurse midwife's partner in this birthing environment would be the Registered Nurse and alongside her would be another key contributing player, the doula. The term doula comes from an ancient Greek word, which some authors have interpreted as: The woman who mothers the mother (Bolane, 1999); woman caregiver of another woman (Scott, Berkowitz, & Klaus, 1999); in service of (Perez & Herrick, 1998); and woman's servant (Young, 1999a). Typically, a doula is a layperson who herself has experienced giving birth and has developed a natural childbirth philosophy. Doulas undergo a rigorous training program by approved trainers from the organization known as Doulas of North America (DONA). The focus of the doula is on attending to the emotional needs of women in labor and their families and on interventions that are non-medical, as well as to provide measures for both physical and emotional comfort. For the most part, a doula serves as an advocate for the pregnant woman during the prenatal visits, the labor and delivery process, and several weeks following the birth.

Research reveals that continuous labor support by a doula significantly reduced the Cesarean section rate by 50%, forceps deliveries by 40%, requests for epidural use by 60%, oxytocin use to stimulate labor by 40%, and duration of first time labor by 25%

(Bolane, 1999; Jordan, Van Zandt, & Oseroff, 2001; Scott, Bewkowitz & Klaus, 1999; Young, 1998). Furthermore, providing nonprofessional but emotionally supportive companions during labor (Simkin & O'Hara, 2002) helps facilitate feelings of self-esteem with a decrease in postpartum depression scores weeks later (Wolman, Chalmers, Hofmeyr & Nikodem, 1993). Winslow and Jacobson (1998) believe that the positive outcomes a doula facilitates may be due to the laboring woman feeling safer and calmer, which in turn may reduce the need for obstetric interventions such as epidural anesthesia. Young (1999a) explains that given the benefits of intrapartum support, all women should receive labor support, including the continuous presence and hands-on care of a trained caregiver.

A doula's support and advocacy for the client usually begins in the second trimester and extends into the early postpartum period. The early relationship during the prenatal period provides the client with added support during office visits, in which the doula can clarify medical jargon and/or prescriptions of care. The doula as a support person can assist the client in articulating a birth plan (Lundgren, Berg, & Lindmark 2003) with her healthcare provider, and thereby prevent tensions between the physician's and client's expectations of what her options are during the birthing process, such as pain medication choices, episiotomy preference, and birthing positions. That way, if the physician does not offer what the client desires there is time for negotiation or for seeking a physician whom the client feels will accommodate her goals and requests.

The intrapartum nurses' role would primarily be to provide the expert physiological surveillance, psychosocial comfort, and caring interventions (James, Simpson, & Know, 2003) that are necessary for a safe outcome for mother and fetus.

When this role occurs in tandem with a collaborative relationship between the nurse and the doula, healthy outcomes are fostered and patient satisfaction increases (Mayberry, & Gennaro, 2001). Providing suggestions about relaxation, coaching during contractions, could facilitate the nurse's expertise with labor support interventions with the help of a doula, such as, position changes for comfort, and assisting with ambulation (Hottenstein, 2005; Miltner, 2002). With today's harried healthcare environment and nursing shortage, having a second pair of hands could prove to be beneficial for all involved (Gale, Fothergill-Bourbonnais, & Chamberlain, 2001).

To enhance, support, and guide a Being-with model of care could be achieved using the evidence based Mother-Friendly Childbirth™ Initiatives (MFCI) developed by the Coalition for Improving Maternity Services (CIMS) as a means to improve birth outcomes and reduce costs (Hotelling, 2004; Kroeger, 2004). A guide labeled "Ten Steps of Mother-Friendly Care" assists birthing arenas to incorporate change in their practices. After the organization successfully complies with all ten steps, it is designated as "Mother-Friendly." However, in order to receive this designation the institution must also meet requirements of being "Baby-Friendly," which is the tenth step in the MFCI guide (Appendix H). The process is comprehensive and includes these salient features:

Unrestricted access: to birthing companions of her choice, to continuous emotional and physical support by a skilled woman and to a professional midwife. Provide statistical information to the public regarding interventions and outcomes, culturally competent care, freedom of movement, and education to staff on non-pharmacologic pain management options. Encourage parental contact in the NICU with the premature infant. Discourage the non-religious practice of circumcisions.

The ultimate challenge for an organization will be to meet the following MFCI benchmarks:

An induction rate of 10% or less; an episiotomy rate of 20% or less with a goal of 5%; a cesarean section rate of 10% or less in community hospitals and 15% in tertiary care hospitals; a VBAC rate of 65% with a goal of 75% or greater.

Successful breastfeeding and “Baby Friendly” guidelines include:

Have a written breastfeeding policy and train all staff in skills of breastfeeding; inform all women about benefits of breastfeeding; initiate breastfeeding within the first half hour of life; assist mothers with breastfeeding and how to maintain lactation; no pacifiers; no supplements unless medically indicated; encourage rooming-in; breastfeeding on demand; and provide breastfeeding support groups.

Being designated as both a mother- and baby-friendly facility will become the standard by which women will know that the facility in which they choose to birth will be the best place to bring a new life into the world. In preparation for this process, a comprehensive questionnaire developed by Hotelling (2004) can be used. In the meantime, nurses can play a pivotal role in changing the current culture of high tech/low touch into a culture of high-touch/low tech.

During the interim of implementing the above new cultural changes, the other pressing area of nursing education that will need attention is that of perinatal mood disorders. As the women in this study demonstrated, lack of knowledge about PPD made them angry and the expectation was that someone along the continuum of care should have informed them better. Thus, nurses need to take a more proactive role in educating themselves, as well as educating the women and families in their care, about perinatal mood disorders. All nurses need to know the symptomatology, screening tools, interventions, and treatment modalities related to perinatal mood disorders. Knowing

these elements will empower the nurse to care for the family in a more comprehensive manner. Educating all families about PPD before discharge from the postpartum unit will be integrated with their care so that the negative effects of a perinatal mood disorder are lessened. Part of this education will be to inform women and their partner that PPD can occur anytime up to and including the first year of life. Educating the couple before discharge will reinforce what was taught during the prenatal period and hopefully will open the lines of communication so that if the woman experiences any of the symptoms of a perinatal mood disorder, both she and her partner will know what to expect and seek help earlier. Giving women permission to express their feelings, to ask for help when needed, will help to decrease the stigma associated with not being “happy” (Kendall-Tackett, 2001; Maushart, 1999; Wolf, 2001) after giving birth and/or adopting.

The final area of change for the new family, which begins immediately after delivery and should extend up to a month post delivery or to the first postpartum visit, is the continued social support of “mothering the mother.” In the hospital setting every effort should be made to ensure that the new mother’s sole responsibility should be to establish breastfeeding and to help her connect with her newborn and to develop her new role in becoming a mother (Mercer, 2004). She needs to be waited on hand-and-foot and given the special care and consideration that other cultures bestow on their women after giving birth. For example, *peiyue* or “doing the month” (Lee et al., 2004) is practiced in Asian countries, whereby social support is given to all new mothers by the mother-in-law or other females who take over all household chores and cooking for forty-days. Oates, et al. (2004) believes that the role of social support that non-Western societies provide to new mothers may protect those mothers from becoming depressed. Given that women in

this country are discharged from the hospital after forty-eight hours, perhaps adopting a practice of *peiyue* would assist the new family with transitioning into parenthood and potentially decrease postpartum depression in Western cultures (Hung, 2004; Matthey, Barnett, Ungerer, & Waters, 2001).

Future Research

A one-year follow-up interview may be beneficial to determine if the participants' response to the experience under investigation changed over time. Research on the lived experience of nurses who bear witness to unexpected birthing processes may be of interest for discovering any impact a traumatic birth may have on the nurse, incorporating Benner's novice to expert model. It would be informative to discover how each level of skill acquisition impacts the nurse. Another intriguing possibility would be a qualitative examination of the fathers' and/or grandparents' lived experience in witnessing an unexpected birthing process as defined in this study. Interviewing women with more diverse backgrounds, such as adolescents, and women of different cultures and ethnic backgrounds would be informative to discern what effects an unexpected birthing process had on them. Examining women's experiences with epidurals would also be beneficial to further examine the "out of body" experience described by the women in this study.

Conclusion

Medicalization of birth slowly evolved over the past one hundred and fifty years with the physician as expert at the helm. Women in western cultures have come to expect that their births will take place in a hospital setting with care given by these experts. Given the experiences with the experts of the ten participants in this study, one can only hope for a dramatic shift in birthing practices. Odent (2001a, 2001b, 2002a,

2002b, 2004), a French surgeon, who also trained and served as an obstetrician and as a midwife, strongly advocates and believes that a revolution in birth also must take place. The tenets that he proposes are founded on the normalcy of birth and also on the long-term effects that disturbance of the normal birth process has on the individual and ultimately on society in general. Odent believes that the neurophysiology of birth has been grossly interrupted by modern medicine's methods of interference in this natural process. According to Odent, the two primary needs of all birthing women are privacy and safety. These two concepts and practices that are consonant with the midwife model of care (Gaskin, 2003; Goer, 2004).

Privacy refers to birthing done in a quiet, dark room away from any noise and lights so that the neocortex is not stimulated. The primary function of the neocortex is to produce adrenaline, which is secreted in times of the fight/flight response. A woman needs a quiescent neocortex so that she can concentrate on being relaxed throughout the birthing process. When the neocortex is stimulated, e.g., lights turned on or a loud noise, the woman's concentration is broken, which then interferes with relaxation and can cause labor to slow down or stop altogether. For Odent (2001a, 2001b) safety is a secure, comfortable environment with caring female attendants, preferably attendants who have also given birth in as natural a way as possible. Odent further proclaims that when medial interference occurs—such as by induction of labor, epidurals, or operative deliveries—a cascade of untoward events unfold that places both mother and infant at risk for life-long problems with health. Interference with this primal period (Odent, 2002a) of time—during intrauterine life, birth, or infancy—has a direct impact on how adults will tolerate disease processes, such as cancer and heart disease. Odent proposes

that a revolution in birthing practices is desperately needed, to include the fundamental principles of privacy and safety, but he understands that this will take many years to bring about.

The current medical model as the hegemonic way of birthing in Western cultures will take some time to change but the existing disease-oriented model will and must change to facilitate the healthiest beginnings of each new life and family. Given the soaring costs of medical care, converting to a midwifery-centered model could dramatically alter and/or forestall these soaring costs. Education will be critical in making this cultural change happen and is necessary to happen not only in nursing and in medicine, but most importantly for enlightening the one key player—the birthing woman. Women demanded “twilight sleep” in the early nineteenth century; today the time is ripe for women to demand a safer, more caring, and truly connecting environment for their births. Today’s epidural has replaced yesterday’s “twilight sleep.” Both pain management initiatives were and are fueled by women’s fear of birth propagated on an historical foundation that women’s bodies are frail (Weitz, 1998), with birth viewed as a disease process needing medical intervention (Declercq et al., 2001; Kitzinger, 2005; Riessman, 1998).

A revolution of change will happen gradually when women begin to trust their bodies to birth naturally after experiencing the devoted help of a nurturing, caring support system offered at each and every birthing encounter. Women cared for by—i.e., by certified nurse midwives, nurses, and doulas—in this caring and loving environment will empower the parturient to birth her infant with as little interference as possible. Over time the fear of birth will be lessened as women successfully navigate each birthing

encounter. Fear will be replaced by trust and from a biological standpoint a woman's body will maximally do what it is meant to do, and that is to bring life into the world hopefully with a caring and even a celebratory environment. In the meantime, intrapartum nurses' greatest challenge is to provide all patients with a caring, connecting environment where control is shared (Wittmann-Price, 2004).

Appendix A
Dr. Marlow's Letter



1606 North Seventh Street
Terre Haute, IN 47804-2780
(812) 238-7000

Joanne Goldbort / Dissertation Committee
Indiana University School of Nursing

Dear Joanne / Dissertation Committee,

I am pleased to hear that you have accepted Joanne's proposal for her doctoral research. I'm happy to assist Joanne by providing ongoing psychotherapy visits to subjects that may be detected to need further therapy. It is important research and significant issues may be "brought to light" indicating that psychotherapy may be necessary or beneficial. I'll standby ready to assist in any manner needed.

I trust this is the information you desired. If I can be of further assistance, please do not hesitate to write or call.

Sincerely,


Steven L. Marlow, Ph.D., HSPP
Supervisor Behavioral Healthcare
Union Hospital, Inc.

A PARTNER IN THE UNION HOSPITAL HEALTH GROUP

Appendix B
Mothering as a Career Club Letter

To Whom It May Concern:

The Mothering as a Career Club (MACC) was very grateful to have Joanne Goldbort come and speak at our general meeting for all members several months back. At that time she mentioned her possible research project into 'women's unexpected birthing experience'. Several of our mothers (including myself) expressed an interest in volunteering for her research. We have announced her project in our newsletter and verbally at our monthly meeting. Our primary purpose as a club is to support mothers, so a project that may lead to more positive birth options in Terre Haute is desirable.

Respectfully,

[REDACTED]

Kristine Riopelle
MACC - Membership

[REDACTED]

Appendix C

IUPUI and CLARIAN INFORMED CONSENT STATEMENT

The Perfect Storm: Unexpected Birthing Experiences and Perinatal Mood Disorders

STUDY PURPOSE:

You are invited to participate in a research study of women who have given birth and to describe that birthing experience. The purpose of this study is to have women describe their expectations of the entire experience and what their experience was like so that nurses can have a better understanding of what impact these experiences may have on childbearing women.

NUMBER OF PEOPLE TAKING PART IN THE STUDY:

If you agree to participate, you will be one of approximately 10 women who will be participating in this research locally.

PROCEDURE FOR THE STUDY:

If you agree to be in the study, an open-ended interview will be conducted and each interview will begin with the question, "Tell me about your unexpected birthing experience." This will be an audiotaped interview, with length of time based on the time that it takes for you to describe your experience. The time and place of the interview will be your choice. There may be a possible second interview to clarify or expand on the first interview and this can be done over the phone. There may also be a follow-up interview one year later to examine what change(s), if any, occur over time in the telling of one's birth experience.

RISKS OF TAKING PART IN THE STUDY:

Participation in this study is completely voluntary. You have the right to withdraw from the study at any time. Leaving the study will not result in any penalty. While in the study, the risk associated with completing the interview is the possibility of being uncomfortable answering the questions. At any time during the interview, you can tell the researcher that you feel uncomfortable or do not care to answer a particular question. Referral for counseling is available if needed.

BENEFITS OF TAKING PART IN THE STUDY:

The benefits to participation are in the telling of your delivery experience.

ALTERNATIVES TO PARTICIPATING IN THE STUDY:

You have the option not to participate.

CONFIDENTIALITY:

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if

required by law. Your identity will be held in confidence in reports in which the study may be published. To avoid the possibility of linking a participant to specific comments, any names mentioned during the interview will be deleted at the time of transcription or replaced with pseudonyms.

The transcribed records will be stored in a locked file cabinet in the principal investigator's office for a period of 3 years, and will be destroyed at the end of that time. The tapes will be stored in a separate locked file cabinet and will be erased upon completion of data analysis for this study. Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the investigator and her research associates and the IUPUI/Clarian Institutional Review Board or its designees. This study does not involve the use of health information that can be either linked or used to identify an individual.

COSTS/COMPENSATION:

There are no costs to the participant for taking part in the study. You will not receive payment for taking part in this study.

CONTACTS FOR QUESTIONS OR PROBLEMS:

For questions about your rights as a research participant or complaints about a research study, contact a subject representative who is not involved with the study in Research Compliance Administration at [REDACTED] or [REDACTED]. For questions about the study you may contact the researcher, Sharon Sims, at [REDACTED] pager).

VOLUNTARY NATURE OF STUDY:

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled.

In consideration of all of the above, I give my consent to participate in this research study.

I acknowledge receipt of a copy of this informed consent statement.

SUBJECT'S SIGNATURE: _____ **Date:** _____
(must be dated by the subject)

SIGNATURE OF PERSON OBTAINING CONSENT: _____ **Date:** _____

Indiana University Hospitals

**Appendix D
Participant Questionnaire**

Personal information:

Please take time to fill out the following information.

1. **Today's date:** _____
2. **Marital Status:** Married _____ Single _____ Divorced _____
3. **Your Age:** _____
4. **Place of infant's birth:** _____
5. **Expected due date of birth:** _____ **Date of Infant's birth:** _____
6. **High School Graduate?** Yes: _____ No: _____
7. **How many years of college have you completed:** _____
8. **What is your family's annual income:**
Under \$10,000 _____ \$10,000-20,000 _____
20,000-30,000 _____ \$30,000-50,000 _____
50,000-70,000 _____ Over \$70,000 _____
9. **What is your ethnic background:**
Caucasian _____ African American _____ Hispanic _____
Asian American _____ Native American _____ Other _____

Appendix E

Representative Original Protocol

Representative Original Protocol (Step 2 of Colaizzi's method of analysis. The following statements were extracted from the ten transcribed interviews.

1. I had a very healthy normal pregnancy, I had gone through birthing classes, had the perfect life of a husband being very supportive, a family being present for the birth, excitement happening with the birth of this child, she [or he] was a planned baby and we were ecstatic!
2. I started to be induced; thin out my cervix and had some Pitocin; they had hooked me up to various monitors.
3. Feeling very frustrated; didn't know what to expect; none of the nurses would provide you a next step; just very felt very alone; being extremely scared because you didn't know what to anticipate and hoped that everything would go as planned.
4. It took an hour-an-a-half [or up to three hours] to deliver my daughter [or son].
5. I just did not want to be in that hospital, it was very emotionally cold.
6. I had a doctor that I didn't know. I had seen him one time and I remember not liking him when I saw him that one time.
7. I was immediately given an epidural, and the epidural was helpful; I was not in any discomfort or pain; it took almost 24 hours for it to actually occur. But once I had that epidural, basically it's almost like, you know the sign goes up—Okay, she's in bed, you know we'll check back and see how far she's dilated!
8. The way they make you push and that kind of thing, I didn't feel any of it, and it was difficult to do it. It was a weird sensation, it was like having a bowel movement, you know that you had to push it, push and push, and I didn't feel any of it. So it was kind of hard to push and not feel what you were trying to push out. I probably pushed for, heavy push, pushing maybe an hour and a half; pushed for three hours straight without a break; So my body was completely shaken and worn.
9. It was so uncomfortable; the pushing all that I can say, well I guess the best way to describe it is sorta like an out of body experience. Once I got the epidural because you know, I mean, doing all this work and I'm pushing but I don't really even feel it, you know, I'm not feeling it; it's almost a surreal experience, it almost to me seemed like something I was watching! And it wasn't necessarily happening to me.
10. She was like a cheerleader in the delivery room as well; that this was definitely going to be a natural delivery, you know a vaginal delivery.
11. But it wasn't fast enough, but then in some regards I had no concept of time either. I remember looking at the, the clock and it was eleven fifteen, and I looked at it again and it was one thirty and she had been born and it seemed like it was fifteen minutes in some regards.
12. But it was just you know, the heart rate had been high the whole time, it was a sign to her that not only was I exhausted but the baby had had enough and she

- decided you know, we were gonna try and do the forceps! I think had she not had any luck with the forceps then probably it would have gone that way but.
13. He's like we either need to do forceps or you need to have a c-section. I had in my mind that I would not want a c-section. I could do this; well I don't want a c-section and that's all I could think of because I was afraid of surgery.
 14. What tore me to pieces at that point, and my episiotomy or my ripping or tearing it was horizontal rather than to the rectum; so I had it in both directions. I had a vaginal c-section; I felt unprotected and very exposed.
 15. There was a lot of chaos with people coming and going and it just seemed very chaotic! Haphazard with people.
 16. There was not any joy or excitement about whether this was a girl or boy . . .
 17. I had a lot of bleeding; I mean it just seems like lots of clots. But I know it took me a long time to stop bleeding. So my stomach was constantly massaged and rubbed, and they were concerned about me as well as they were concerned about the baby.
 18. I was just physically exhausted; I was tired, sleep deprived; the nurses would come in every half hour on the hour, uh every half hour and check you, vitals and that kind of thing, so it was an impossibility to sleep.
 19. I was a very active watcher of "The Baby Story" on Lifetime.
 20. It was just a horrible experience and I realized it wasn't normal when I had spoken with other women; I felt kind cheated, that I didn't have a really good experience.
 21. My husband and I had no idea what to do. And I think just that feeling of helplessness just became overwhelming that really this birth traumatized me!
 22. And was taking this transition into motherhood really hard.
 23. We have to know, you know if there's not a connection with that nurse, maybe they should switch out nurses; that's why I think I felt so disconnected to it also, I'm not saying I wanted to feel any of that but I think knowing a little bit of something is happening.
 24. The total lack of connection that there was a human being on the table going through this! It's like, I was a body, I was a piece of meat that needed to have a procedure done to get this child out and when that was over then it's fine, and it's done.
 25. I guess there was just a disconnection of not being able to relate to my spouse at that time.
 26. I just didn't have a nurse that was really there; I remember they all seemed extremely distant; the doctor was just very non-emotional and not present.
 27. And I was angry at the time. I was hurt. I wanted to know why I had to go through ALL of the pushing! Why she didn't give me a c-section? Why was this a miserable time for me?
 28. I feel more cared about when somebody can do can share something with me and you're going to put it in layman's you know, lay person's terms. And that doesn't happen a lot of times. And nurses are busy. And doctors are busy. So they're in and they're out! They do their job and their gone!
 29. If I had had somebody that would have supported me, or a midwife or a doula I think I, it would have been fine.

30. I felt like I was sorta just not that, that your not in control of the experience maybe? They're the experts and they know what's best, so you sorta just follow their lead
31. I just felt . . . insecure and I felt . . . I don't know how to explain it. I felt . . . like I didn't have any rights! Like I, I didn't really matter! Kind of like—they're the ones caring for me—the nurses and the doctors. I need to do what they say. And whatever happens will happen and you'll get a healthy baby at the end!
32. I think that I had less control of my own body than I had thought in advance that I would be; I just felt defeated in so many ways, --Not defeated, I mean, it's not like I was so upset but I really had hopes, you know, that this all would be more natural and I felt like I was like giving in one thing after another.
33. They took her right away over to the neonatologist were in the room, because she had meconium so they knew right, you know, once she was delivered they would have a neonatologist in to suction her out.
34. Coming home from that was a huge overwhelming experience; they did not prepare me at all to take care of myself; what I needed to do post-delivery; or what to do with her. And the complications are very briefly touched on with an education class that you might have postpartum depression; I went through the prenatal classes and labor classes, my husband and I did, but they never really told you what it was going to be like; more of an overwhelmed feeling you know that this was all, I was responsible for all this now and I felt lousy and it was, you were supposed to walk out of the hospital with this wonderful smiling baby and everything was supposed to be wonderful and it was hard work!
35. That this is considered "okay?" to do this to a woman? This is okay. I just felt like every ounce of power or saying that I had over what was happening to me was totally gone.
36. I remember some friends came to visit like three days later and they were like all excited and happy and there was just something inside of me that didn't understand why I could not be happy. Because I was kind of in shock you know.
37. I was terrified to see, to follow up with the guy that delivered me. I was terrified. So I didn't follow up with him.
38. You really trust someone to take care of you and then you don't get good care and you get bad care. And then nobody will acknowledge it or because I felt that that was, I felt like I knew what taking care of somebody well was: and I was kind of shocked that, just the whole the manner of so many people was so bad. Because of the, just the disconnection, the disconnection and the lack of feeling.
39. I felt . . . like I didn't have any rights! Like I, I didn't really matter! Kind of like—they're the ones caring for me—the nurses and the doctors. I need to do what they say. And whatever happens will happen and you'll get a healthy baby at the end! You know? I guess I didn't stand up for myself. I didn't know what to stand up for.

Appendix F

Significant Statements

The protocols were formulated into meanings (Step 3 of Colaizzi's Method of Analysis). The numbers at the end of the meaning represent the number assigned to each participant.

1. Frustrated and feelings of being alone, nurses not informative 1, 2, 3, 4, 6, 7, 9, 10
2. Constant pushing for hours with no break, frustrating, exhausting 1, 2, 3, 6, 7, 9
3. Long, slow laboring process especially after getting epidural 1, 2, 3, 4, 6
4. Husband had to pitch-in or assisted with pushing 1, 4, 7, 9
5. Little concern for how I was feeling 1, 2, 6, 8, 9, 10
6. Nursing staff not friendly, not helpful 1, 2, 6, 7, 8, 9, 10
7. Doctor standoffish, non-caring, insensitive 1, 2, 4, 6, 7, 8
8. Scared not knowing what to expect 1, 2, 6, 10
9. Not able to feel pushing due to epidural 1, 2, 3, 4, 5, 6, 7, 9
10. No concept of time 1, 4, 7, 9
11. Physically exhausted from nursing interruptions/tasks; sleep deprived 1, 2, 3, 6, 9, 10
12. Overwhelmed going home, no instructions on care for self or infant 1, 2, 3, 4, 6, 7, 9, 10
13. Horrible experience felt defeated, felt cheated 1, 2, 5, 6, 7, 8, 10
14. Pregnancy healthy, uneventful, happy, supportive family 2, 3, 4, 5, 6, 7, 8, 9
15. Waiting period after epidural 2, 3, 4, 5, 9
16. Nurses mainly visible for vital signs and checks 1, 2, 3, 4, 5, 6, 7, 9, 10
17. Chaos, haphazard at time of delivery with NICU 1, 2, 6, 7, 9, 10
18. Forceps and vacuum, to get infant out now! 3, 6, 7, 8
19. Meconium at delivery, concern for infant's well-being 2, 3, 4, 6, 7, 9, 10
20. Delay in mother getting the baby 2, 3, 4, 5, 6, 7, 9
21. Episiotomy performed, tearing or ripping 1, 2, 3, 4, 5, 6, 7, 9
22. More response from husband helping 2, 4, 7, 9
23. Exhausted, no break, felt like a failure, felt unprotected, exposed 1, 2, 6, 8
24. No one saying the sex of the infant 2, 6, 7, 9, 10
25. Post-delivery bleeding, concern also about the mother 2, 5, 7
26. Feel more care for with a gentle, nurturing person/nurse
27. Expected more due to media portrayal, text books 2, 3, 4, 5, 6, 7, 8, 9, 10
28. Complications/PPD briefly touched on in classes 1, 2, 6, 7, 9, 10
29. Husband not understanding, "nothing happened," disconnection with the spouse 2, 6, 7, 9, 10
30. Doctor and husband as cheerleaders with pushing 2, 3, 4, 7, 9
31. Anger over lengthy pushing, 2, 3, 6, 7, 9
32. Changed doctors after the delivery 1, 2, 4, 6, 7, 8
33. Would like to hear about painful, problem births as well as the good 2, 6, 7, 9, 10
34. Difficulty with catheterization 3, 5, 8
35. Out of body experience, surreal, not happening to me, weird feeling, disconnected 2, 3, 4, 5, 6, 7, 9
36. Little support, encouragement during long hours of labor 1, 2, 3, 5, 6

37. Pain, little nursing help after delivery 2, 3, 6, 7, 8, 9, 10
38. I feel kind of lied to. Like part of the story was left out I guess maybe 2, 6, 7, 9, 10
39. Made me feel like an outsider something that was just happening to me not that I was in control of 2, 3, 6, 7, 8, 9, 10
40. More interested in paper work than relieving pain 4, 9
41. Not my own doctor, trust issue 1, 4, 6, 8
42. Nurses/doctor rely on monitor for information/care/pushing 1, 2, 3, 4, 6, 7, 8
43. May have to do cesarean if don't push better 4, 6
44. Not in control 1, 2, 3, 4, 6, 7, 8, 9
45. Felt violated 2, 6, 8
46. Disbelief that pushing was effective 1, 2, 3, 4, 6, 7, 9

Appendix G

Clusters or Themes

The following themes are the overarching concepts that seem to define the birth experiences of each woman interviewed.

- I. **CARING:** the following examples are more of what *uncaring* looks, although the following selected quotes may not overtly say “I wanted my nurse (and or doctor) to be more caring” but instead the meaning/concept behind what they expected. Therefore, the term caring will be used. I’ve also noticed that some of the quotes that I placed under “caring” could overlap with “connecting” decided to keep a quote in one place.
 1. Nurses not being informative results in feelings of frustration and feelings of being alone.
 2. Nurse apathetic, shows little concern for how I was feeling.
 3. Nursing staff not friendly, not helpful; performed basic care, mainly visible for vital signs and checks.
 4. Nurses insensitive, not aware of need for sleep and rest, felt physically exhausted from nursing interruptions/tasks; sleep deprived.
 5. Nurses interrupt bonding/attachment due to delay in mother getting the baby.
 6. Feel more cared for with a gentle, nurturing person/nurse.
 7. Nursing care after delivery is less than desirable, a lot of pain with little regard for my well-being.
 8. Nurses’ level of technical expertise questionable.
 9. Nurses’ accountability missing when bad care given.
 10. I feel more cared about when somebody can do, can share something with me.

- II. **CONNECTING:** the following examples address how the woman felt that the connection and presence of the caregiver was missing.
 1. Lack of engagement as evidenced by nurses more interested in paper work and on the monitor.
 2. Lack of communication leading to feeling lied to, like part of the story was left out.
 3. Coaching from the nurses during pushing was met with disbelief that pushing was effective.
 4. Disconnection due to not having my own doctor, trust issue.
 5. Epidural experience surreal, out of body experience, not happening to me, weird feeling, disconnected.
 6. Nurses not advocating breaks with pushing, resulting in constant pushing for hours leading to frustration and exhaustion.
 7. Nurses demonstrate little concern for how I was feeling.
 8. I had a doctor that I didn’t know.
 9. They all seemed extremely distant.
 10. The disconnection and the lack of feeling, little concern for privacy.

- III. **CONTROLLING:** This theme refers to how the patient feels out of control with self and with decision-making.
1. Threats used to get the infant delivered--may have to do cesarean if don't push better.
 2. Not in control on many levels—before getting an epidural and decision making with the epidural.
 3. Expectations of a normal birth replaced with horrible experience felt defeated, felt cheated.
 4. Made me feel like an outsider something that was just happening to me not that I was in control of.
 5. Anxiety increased due to need to deliver infant, to get infant out now!
 6. Overwhelming feeling due to chaos, haphazard at time of delivery with NICU.
 7. Little concern by caregivers in this new birth, no one saying the sex of the infant, no excitement.
 8. Felt violated from having the infant extracted or taken from the body.
 9. No control over one's body when episiotomy is performed.
 10. Feelings of giving in one thing after another.
 11. Feelings powerless over what was happening to me.
 12. You're not in control of the experience. They're the experts and they know what's best, so you sort of just follow their lead.

Appendix H

Mother-Friendly Initiatives

Ten Steps of the Mother-Friendly Childbirth Initiative

For Mother-Friendly Hospitals, Birth Centers, and Home Birth Services*

To receive CIMS designation as Mother-Friendly, a hospital, birth center, or home birth service must carry out the above philosophical principles by fulfilling the Ten Steps of Mother-Friendly Care:

A mother-friendly hospital, birth center, or home birth service:

1. Offers all birthing mothers:
 - Unrestricted access to the birth companions of her choice, including fathers, partners, children, family members, and friends;
 - Unrestricted access to continuous emotional and physical support from a skilled woman—for example, a doula,* or labor-support professional;
 - Access to professional midwifery care.
2. Provides accurate descriptive and statistical information to the public about its practices and procedures for birth care, including measures of interventions and outcomes.
3. Provides culturally competent care—that is, care that is sensitive and responsive to the specific beliefs, values, and customs of the mother's ethnicity and religion.
4. Provides the birthing woman with the freedom to walk, move about, and assume the positions of her choice during labor and birth (unless restriction is specifically required to correct a complication), and discourages the use of the lithotomy (flat on back with legs elevated) position.
5. Has clearly defined policies and procedures for:
 - collaborating and consulting throughout the perinatal period with other maternity services, including communicating with the original caregiver when transfer from one birth site to another is necessary;
 - linking the mother and baby to appropriate community resources, including prenatal and post-discharge follow-up and breastfeeding support.
6. Does not routinely employ practices and procedures that are unsupported by scientific evidence, including but not limited to the following:
 - shaving;
 - enemas;
 - IVs (intravenous drip);
 - withholding nourishment or water;
 - early rupture of membranes*;
 - electronic fetal monitoring.

Other interventions are limited as follows:

- Has an induction* rate of 10% or less;
 - Has an episiotomy* rate of 20% or less, with a goal of 5% or less;
 - Has a total cesarean rate of 10% or less in community hospitals, and 15% or less in tertiary care (high-risk) hospitals;
 - Has a VBAC (vaginal birth after cesarean) rate of 60% or more with a goal of 75% or more.
7. Educates staff in non-drug methods of pain relief, and does not promote the use of analgesic or anesthetic drugs not specifically required to correct a complication.
 8. Encourages all mothers and families, including those with sick or premature newborns or infants with congenital problems, to touch, hold, breastfeed, and care for their babies to the extent compatible with their conditions.
 9. Discourages non-religious circumcision of the newborn.
 10. Strives to achieve the WHO-UNICEF “Ten Steps of the Baby-Friendly Hospital Initiative” to promote successful breastfeeding:
 1. *Have a written breastfeeding policy that is routinely communicated to all health care staff;*
 2. *Train all health care staff in skills necessary to implement this policy;*
 3. *Inform all pregnant women about the benefits and management of breastfeeding;*
 4. *Help mothers initiate breastfeeding within a half-hour of birth;*
 5. *Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants;*
 6. *Give newborn infants no food or drink other than breast milk unless medically indicated;*
 7. *Practice rooming in: allow mothers and infants to remain together 24 hours a day;*
 8. *Encourage breastfeeding on demand;*
 9. *Give no artificial teat or pacifiers (also called dummies or soothers) to breastfeeding infants;*
 10. *Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospitals or clinics.*

* See glossary above.

REFERENCES

- Ahern, K.J. (1999). Pearls, pith, and provocation: Ten tips for reflexive bracketing. *Qualitative Health Research*, 9(3), 407-411.
- Alvino, D. (1986). A caring concept: Providing information to make decisions. *Topics in Clinical Nursing*, 8(2), 70-76.
- American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. (2001). *Guidelines for perinatal care*. (5th ed). Washington, DC: Author.
- American College of Obstetricians and Gynecologists (2002). *Clinical updates in women's health care: Depression in women*, 1, 1-82.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- Anderson, R.E., & Murphy, P.A. (1995). Outcomes of 11,788 planned home births attended by certified nurse-midwives: A retrospective descriptive study. *Journal of Nurse-Midwifery*, 40(6), 483-492.
- Annells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing*, 23(4), 705-713.
- Association of Women's Health, Obstetric, and Neonatal Nursing. (2000). *Nursing Management of the Second Stage of Labor*. Washington, DC: Author.
- Ayers, S. (2004). Delivery as a traumatic event: Prevalence, risk factors, and treatment for postnatal posttraumatic stress disorder. *Clinical Obstetrics and Gynecology*, 47(3), 552-567.
- Ayers, S., & Pickering, A. (2001). Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. *Birth: Issues in Perinatal Care*, 28(2), 111-118.
- Bailey, P.H. (1997). Finding your way around qualitative methods in nursing research. *Journal of Advanced Nursing*, 25(1), 18-22.
- Baker, J., Mancuso, M., Montenegro, M., & Lyons, B.A. (2002). Treating postpartum depression. *Physician Assistant*, 26(10), 37-44.
- Ballard, C.G., Stanley, A.K., & Brockington, I.F. (1995). Post-traumatic stress disorder (PTSD) after childbirth. *The British Journal of Psychiatrists*, 166(4), 525-528.
- Beck, C.T. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research*, 15(2), 263-265.

Beck, C.T. (1998). A checklist to identify women at risk for developing postpartum depression. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 27(1), 39-46.

Beck, C.T. (1999a). Maternal depression and child behavioral problems: A meta-analysis. *Journal of Advanced Nursing*, 29(3), 623-629.

Beck, C.T. (1999b). Postpartum depression: Case studies, research, and nursing care. *Symposium developed for AWHONN, the Association of Women's Health, Obstetric and Neonatal Nurses* (pp. 1-38). Washington, DC: Author.

Beck, C.T. (1999c). Postpartum depression: Stopping the thief that steals motherhood. *AWHONN Lifelines*, 3(4), 41-44.

Beck, C.T. (2001). Caring within nursing education: A metasynthesis. *Journal of Nursing Education*, 40(3), 101-109.

Beck, C.T. (2002a). Revision of the postpartum depression predictors inventory. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 31(4), 394-402.

Beck, C.T. (2002b). Theoretical perspectives of postpartum depression and their treatment implications. *MCN: The American Journal of Maternal/Child Nursing*, 27(5), 282-287.

Beck, C.T. (2004a). Birth trauma: In the eye of the beholder. *Nursing Research*, 53(1), 28-35.

Beck, C.T. (2004b). Post-traumatic stress disorder due to childbirth: The aftermath. *Nursing Research*, 53(4), 216-224.

Beck, C.T., & Driscoll, J.W. (2006). Postpartum mood and anxiety disorders: A clinician's guide. Sudbury, MA: Jones-Bartlett.

Beck, C.T., & Gable, R.K. (2001). Further validation of the postpartum depression screening scale. *Nursing Research*, 50(3), 155-164.

Beck, C.T., & Gable, R.K. (2002). *Postpartum depression screening scale (PDSS) manual*. Los Angeles, CA: Western Psychological Services.

Beck, C.T., & Indman, P. (2005). The many faces of postpartum depression. *Journal of Obstetric, Gynecologic, & Neonatal Nurses*, 34(5) 569-576.

Benner, P. (1984). From novice to expert: Excellence and power in clinical practice. Menlo Park, CA: Addison-Wesley.

- Benner, P. (2000). The wisdom of caring practice. *Nursing Management*, 6(10), 32-37.
- Benner, P. (2001). From novice to expert: Excellence and power in clinical practice, commemorative edition. London: Prentice Hall.
- Benner, P., & Gordon, S. (1996). Caring practice. In Gordon, S., Benner, P., & N. Noddings (Eds.), *Caregiving: Readings in knowledge, practice, ethics, and politics*. (pp. 40-55). Philadelphia: University of Pennsylvania Press.
- Benner, P., & Wrubel, J. (1989). The primacy of caring: Stress and coping in health and illness. Menlo Park, CA: Addison-Wesley.
- Benner, P., Tanner, C.A., & Chesla, C.A. (1996). *Expertise in nursing practice: Caring, clinical judgment, and ethics*. New York: Springer.
- Bennett, H.A., Einarson, A., Taddio, A., Koren, G., & Einarson, T.R. (2004). Prevalence of depression during pregnancy: Systematic review. *The American Journal of Obstetricians and Gynecologists*, 103(4), 698-709.
- Bennett, S.S., & Indman, P. (2003). Beyond the blues: A guide to understanding and treating prenatal and postpartum depression. San Jose, CA: Moodswings Press.
- Bolane, J.E. (1999). *Doulas: Ten great reasons to have a doula at your labor and birth*. Waco: TX: Childbirth Graphics.
- Bonari, L., Pinto, N., Ahn, E., Einarson, A., Steiner, M., & Koren, G. (2004). Perinatal risks of untreated depression during pregnancy. *Canadian Journal of Psychiatry*, 49(11), 726-735.
- Bottomoff, J.L. (1991). Nursing: A practical science of caring. *Advances in Nursing Science*, 14(1), 26-39.
- Bozoky, I. (2002). Fatigue as a predictor of postpartum depression. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 31(4), 436-443.
- Brilowski, G.A., & Wendler, M.C. (2005). An evolutionary concept analysis of caring. *Journal of Advanced Nursing*, 50(6), 641-650.
- Britton, H.L., Gronwaldt, V., & Britton, J. (2001). Maternal postpartum behaviors and mother-infant relationship during the first year of life. *The Journal of Pediatrics*, 138, 905-909.
- Brockington, I. (2004). Postpartum psychiatric disorders. *The Lancet*, 363, 303-310.

Brugha, T.S., Sharp, H.M., Cooper, S.A., Weisender, C., Britto, D., Shinkwin, R., Sherrif, T., & Kirwarn, P.H. (1998). The Leicester 500 project: Social support and the development of postnatal depressive symptoms, a prospective cohort survey. *Psychological Medicine*, 28(1), 63-79.

Cahill, H.A. (2001). Male appropriation and medicalization of childbirth: an historical analysis. *Journal of Advanced Nursing*, 33(3), 334-342.

Callister, L.C. (2003). Making meaning: Women's birth narratives. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 33(4), 508-518.

Carlton, T., Callister, L.C., & Stoneman, E. (2005). Decision making in laboring women: Ethical issues for perinatal women. *Journal of Perinatal & Neonatal Nursing*, 19(2), 145-154.

Carper, B. (1979). The ethics of caring. *Advances in Nursing Science*, 1(3), 11-19.

Cesario, S., Morin, D., & Santa-Donato, A. (2004). Evaluating the level of evidence of qualitative research. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 31(6), 708-714.

Chambliss, D.F. (1996). *Beyond caring: Hospitals, nurses, and the social organization of ethics*. Chicago: The University of Chicago Press.

Chaudron, L.H., Szilagyi, P.G., Kitzman, H.J., Wadkins, H.I.M., & Conwell, Y. (2004). Detection of postpartum depression symptoms by screening at well-child visits. *Pediatrics*, 113(3), 551-557.

Clemmens, D., Driscoll, J. W., & Beck, C.T. (2004). Postpartum depression as profiled through the depression screening scale. *MCN, The American Journal of Maternal Child Nursing*, 29(3), 180-185.

Cohen, J.A. (1991). Two portraits of caring: A comparison of the artists, - Leininger and Watson. *Journal of Advanced Nursing*, 20, 899-909.

Colaizzi, P.F. (1978). Psychological research as the phenomenologist views it. In Valle and King, *Existential-phenomenological alternatives for Psychology* (pp. 48-71). New York: Oxford University Press.

Cook, M. (1994). The role of social support in midwifery practice and research. *Hunter Valley Midwives Association Journal*, 2(6), 2 pp (online text version).

Cook, P.R., & Cullen, J.A. (2003). Caring as an imperative for nursing education. *Nursing Education Perspectives*, 24(4), 192-198.

- Cooper, P.J., & Murray, L. (1997). Prediction, detection, and treatment of postnatal depression. *Archives of Disease in Childhood*, 77(2), 97-99.
- Corwin, E.J., Brownstead, J., Barton, N., Heckard, S., & Morin, K. (2005). The impact of fatigue on the development of postpartum depression. *Journal of Obstetric, Gynecologic, & Neonatal Nurses*, 34(5), 577-586.
- Cox, J.L., Holden, J.M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.
- Creedy, D.K., Shochet, I.M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: Incidence and contributing factors. *Birth: Issues in Perinatal Care*, 27(2), 104-111.
- Cunningham, F.G., Gant, N. F., Leveno, K.J., Gilstrap, L.C., Hauth, J.C., et al. (2001). *Williams Obstetrics*. (21st ed.). New York: McGraw-Hill.
- Davey, M., Brown, S., & Bruinsma, F. (2005). What is it about antenatal continuity of caregiver that matters to women? *Birth: Issues in Perinatal Care*, 32(4), 262-271.
- Davidson, M.R. (2002). Outcomes of high-risk women cared for by certified nurse-midwives. *Journal of Midwifery and Women's Health*, 47(1), 46-49.
- Davies, B.R., Howell, S., & Jenkins, M. (2003). Early detection and treatment of postnatal depression in primary care. *Journal of Advanced Nursing*, 44(3), 248-255.
- Davis-Floyd, R.E. (1992). *Birth as an American rite of passage*. Berkeley and Los Angeles, CA: University of California Press.
- Davis-Floyd, R.E., & Sargent, C.F. (1997). *Childbirth and authoritative knowledge: Cross-Cultural perspectives*. Berkeley and Los Angeles, CA: University of California Press.
- Davis, L.A. (2005). A phenomenological study of patient expectations concerning nursing care. *Holistic Nursing Practice*, 19(3), 126-133.
- Declercq, E.R., DeVries, R., Viisainen, K., Salvesen, H.B., & Wrede, S. (2001). Where to give birth? Politics and the place of birth. In DeVries, R., Benoit, c., Van Teijlingen, E.R., & Wrede, S. (Eds.), *Birth by design: Pregnancy, maternity care, and midwifery in North America and Europe*. (pp. 7-27). New York: Rutledge.
- Declercq, E. R., Sakala, C., Corry, M.P., Applebaum S., & Risher, P. (2002). *Listening to mother: Report of the first national U.S. survey of women's childbearing experiences*. New York: Harris Interactive.

Dennis, C.E. (2004). Preventing postpartum depression Part 1: A review of biological interventions. *Canadian Journal of Psychiatry*, 49(7), 467-475.

Dennis, C.E. (2005). Relationships among infant sleep patterns, maternal fatigue, and development of depressive symptomatology. *Birth: Issues in Perinatal Care*, 32(3), 187-193.

Dick-Read, G. (2004). *Childbirth without fear: The principles and practice of natural childbirth*. (Rev. ed.). London: Printer-Martin. (Original work published 1959).

Diego, M.A., Field, T., Hernandez-Reif, M., Cullen, C., Schanberg, S., & Kahn, C. (2004). Prepartum, postpartum, and chronic depression effects on newborns. *Psychiatry*, 67(1), 63-76.

Drew, N. (2001). Meaningfulness as an epistemologic concept for explicating the researcher's constitutive part in phenomenologic research. *Advances in Nursing Science*, 23(4), 16-31.

Dunlop, M. (1986). Is a science of caring possible? *Journal of Advanced Nursing*, 11, 661-670.

Dzurec, L.C. (2003). Poststructuralist musing on the mind/body question in health care. *Advances in Nursing Science*, 26(1), 63-76.

Ehrenreich, B., & English, D. (2002). Exorcising the midwives. In Grewal and Kaplan (Eds.), *An introduction to women's studies: Gender in a transnational world* (pp. 82 – 85). New York: McGraw-Hill.

Field, T. (1997). The treatment of depressed mothers and their infants. In L. Murray & P.K. Cooper (Eds.). *Postpartum depression and child development* (pp. 201-220). New York: Guilford.

Fjelland, R., & Gjengedal, E. (1994). *A theoretical foundation for nursing as a science*. In Benner, P. (Ed.), *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness*. (pp. 3-25). Thousand Oaks, CA: Sage.

Flynn, H.A. (2005). Epidemiology and phenomenology of postpartum mood disorders. *Psychiatric Annals*, 35(7), 544-551.

Fones, C. (1996). Posttraumatic stress disorder occurring after painful childbirth. *Journal of Nervous and Mental Disorders*, 184(3), 195-196.

Fox, B., & Worts, D. (1999). Revisiting the critique of medicalized childbirth: A contribution to the Sociology of birth. *Gender and Society*, 13(3), 326-346.

Freidson, E. (1970). *Professional Dominance*. New York: Atherton.

Gadow, S. (1980). Existential advocacy: Philosophical foundation of nursing. In Spicker, S., & Gadow, S. (Eds.), *Nursing: Images and ideals*. (pp. 79-101). New York: Springer.

Gale, J., Fothergill-Bourbonnais, F., & Chamberlain, M. (2001). Measuring nursing support during childbirth. *MCN, The American Journal of Maternal/Child Nursing*, 26(5), 264-271.

Garg, A., Morton, S., & Heneghan, A. (2005). A hospital survey of postpartum depression education at the time of delivery. *Journal of Obstetric, Gynecologic, & Neonatal Nurses*, 34(5), 587-594.

Gaskin, I.M. (2003). *Guide to childbirth*. New York: Bantam.

Gaut, D. (1983). Development of a theoretically adequate description of caring. *Western Journal of Nursing Research*, 5(4), 313-324.

Gaynes, B.N., Gavin, N., Meltzer-Brody, S., Lohr, K.N., Swinson, T., Gartlehner, et al. (2005). Perinatal depression: Prevalence, screening, accuracy, and screening outcomes. *Summary developed for Agency Healthcare Research and Quality*, 119, 1-8.

Georgiopoulos, A.M., Bryan, T.L., Wollan, P., & Yawn, B.P. (2001). Routine screening for postpartum depression. *The Journal of Family Practice*, 50(2), 117-122.

Goer, H. (1999). *The thinking woman's guide to a better birth*. New York: The Berkley Publishing Group.

Goer, H. (2004). Humanizing birth: A global grassroots movement. *Birth: Issues in Perinatal Care*, 31(4), 308-314.

Goodman, P., Mackey, M.C., & Tavakoli, A.S. (2004). Factors related to childbirth satisfaction. *Journal of Advanced Nursing*, 46(2), 212-219.

Graham, I.D., Guillermo, C., Davies, C., & Medves, J.M. (2005). Episiotomy rates around the world: An update. *Birth: Issues in Perinatal Care*, 32(3), 219-223.

Grambling, L., Hickman, K., & Bennett, S. (2004). What makes a good family-centered partnership between women and their practitioners? A Qualitative Study. *Birth: Issues in Perinatal Care*, 31(1), 43-48.

Green, J.M., & Baston, H.A. (2003). Feeling in control during labor: Concepts, correlates, and consequences. *Birth: Issues in Perinatal Care*, 30(4), 235-247.

Griffin, A.P. (1983). A philosophical analysis of caring in nursing. *Journal of Advanced Nursing*, 8, 289-295.

Hall, L.A., Kotch, J.B., Brown, D., & Rayens, M.K. (1996). Self-esteem as a mediator of the effects of stressors and social resources on depressive symptoms in postpartum mothers. *Nursing Research*, 45(4), 231-238.

Hanna, B., Jarman, H., & Savage, S. (2004). The clinical application of three screening tools for recognizing post-partum depression. *International Journal of Nursing Practice*, 10, 72-79.

Harper, B. (1994). *Gentle birth choices: A guide to making informed decisions about: birthing centers, birth attendants, water birth, home birth, and hospital birth.* Vermont: Healing Arts Press.

Harris, B. (2002). Postpartum depression. *Psychiatric Annals*, 32(7), 405-415.

Hein, S.F., & Austin, W. J. (2001). Empirical and hermeneutic approaches to phenomenological research in psychology: A comparison. *Psychological Methods*, 6, 3-17.

Henshaw, C. (2000). Clinical and biological aspects of postpartum blues and depression. *Current Opinion in Psychiatry*, 13(6), 635-638.

Henshaw, C. (2003). Mood disturbance in the early postpartum period: A review. *Archives of Women's Mental Health*, 6(s2), s33-s42.

Hodnett, E.D. (2002). Pain and women's satisfaction with the experience of childbirth: A systematic review. *American Journal of Obstetrics and Gynecology*, 186(5), 160-172.

Hodnett, E.D., Lowe, N.K., Hannah, M.E., Wilan, A.R., Stevens, B., Weston, J.A., et al. (2002). Effectiveness of nurses as providers of birth labor support in North American hospitals. *JAMA: The Journal of the American Medical Association*, 288(11), 1373-1381.

Hofberg, K., & Brockington, I.F. (2000). Tokophobia: An unreasoning dread of childbirth: A series of 26 cases. *The British Journal of Psychiatry*, 176(1), 83-85.

Hofberg, K., & Ward, M.R. (2003). Fear of pregnancy and childbirth. *Postgraduate Medical Journal*, 79, 505-510.

Hofberg, K., & Ward, M.R. (2004). Fear of childbirth, tocophobia, and mental health in mothers: The obstetric—psychiatric interface. *Clinical Obstetrics and Gynecology*, 47(3), 527-534.

Holliday, A. (2002). *Doing and writing qualitative research.* Thousand Oaks, CA: Sage.

Holloway, I., & Wheeler, S. (1996). *Qualitative research for nurses*. Cambridge, MA: Blackwell Science, Inc.

Horowitz, J.A., & Goodman, J.H. (2005). Identifying and treating postpartum depression. *Journal of Gynecologic, Obstetric, & Neonatal Nurses*, 34(2), 264-273.

Hotelling, B.A. (2004). Is your perinatal practice mother-friendly? A strategy for improving maternity care. *Birth: Issues in Perinatal Care*, 31(2), 143-147.

Hottenstein, S.E. (2005). Creating optimal birth experiences through theory-driven nursing care: Continuous labor support. *AWHONN Lifelines*, 9(3), 243-247.

Hung, C.H. (2004). Predictors of postpartum women's health status. *Journal of Nursing Scholarship*, 36(94), 345-351.

Hunter, L.P. (2002). Being with woman: A guiding concept for the care of laboring women. *Journal of Obstetric, Gynecologic, & Neonatal Nurses*, 31(6), 650-657.

Husserl, E. (1931). *Ideas: General introduction to pure phenomenology*. (W.R. Boyce Gibson, Trans.). New York: Humanities Press, Inc. (Original work published 1913).

Husserl, E. (1964). *The idea of phenomenology*. (W.P. Alston, & G. Nakhnikian, Trans.). The Hague: Martinus Nijhoff. (Original work published 1907).

Husserl, E. (1964). *The Paris lectures*. (P. Koestenbaum, Trans.). The Hague: Martinus Nijhoff. (Original work published 1929).

James, D., Simpson, K.R., & Know, G.E. (2003). How do expert labor nurses view their role? *Journal of Obstetric, Gynecologic, & Neonatal Nurses*, 32(6), 814-823.

Jesse, D.E., & Graham, M. (2005). Are you often sad and depressed? Brief measures to identify women at risk for depression in pregnancy. *MCN, The American Journal of Maternal/Child Nursing*, 30(1), 40-45.

Johanson, R., Newburn, M., & Macfarlane, A. (2002). Has the medicalisation of childbirth gone too far? *British Medical Journal*, 324, 892-895.

Jonsdottir, H., Litchfield, M., & Pharris, M.D. (2004). The relational core of nursing practice as partnership. *Journal of Advanced Nursing*, 47(3), 241-248.

Jordan, B. (1983). *Birth in four cultures: A crosscultural investigation of childbirth in Yucata, Holland, Sweden and the United States*. Montreal: Eden Press.

Jordan, E.T., Van Zandt, S.E., & Oseroff, M. (2001). Educating undergraduate nursing students as birth companions. *Nursing and Health Care Perspectives*, 22(2), 89-91.

Junger, S. (1997). *The perfect storm: A true story of men against the sea*. New York: Norton.

Kendall-Tackett, K.A. (2001). *The hidden feelings of motherhood: Coping with stress, depression, and burnout*. Oakland, CA: New Harbinger Publications, Inc.

Kendall-Tackett, K.A., & Kantor, G.K. (1993). *Postpartum depression: A comprehensive approach for nurses*. Newbury Park, CA: Sage.

Kennedy, H.P., & Shannon, M.T. (2004). Keeping birth normal: Research findings on midwifery care during childbirth. *Journal of Obstetric, Gynecologic, & Neonatal Nurses*, 33(5), 554-560.

Kirkley, D.L. (2000). Is motherhood good for women? A feminist exploration. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 29(5), 459-464.

Kitzinger, S. (1998). Sheila Kitzinger's letter from Europe: The cesarean epidemic in Great Britain. *Birth: Issues in Perinatal Care*, 25(1), 56-58.

Kitzinger, S. (2005). *The politics of birth*. Philadelphia, PA: Elsevier-Butterworth-Heinemann.

Klaus, M.H., Kennell, J.H., & Klaus, P.H. (2002). *The doula book: How a trained labor companion can help you have a shorter, easier, and healthier birth*. (2nd ed). Cambridge, MA: Perseus.

Kleiman, K. (2000). *The postpartum husband: Practical solutions for living with postpartum depression*. USA: Xlibris Corporation.

Kleiman, K.R., & Raskin, V.D. (1994). *This isn't what I expected: Overcoming postpartum depression*. New York: Bantam Books.

Klein, M.C. (2005). Obstetrician's fear of childbirth: how did it happen? *Birth: Issues in Perinatal Care*, 32(3), 207-209.

Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21(5), 827-836.

Kroeger, M. (2004). *Impact of Birthing Practices on Breastfeeding: Protecting the Mother and Baby Continuum*. Sudbury, MA: Jones-Bartlett.

Kurtz, R., & Wang, J. (1991). The caring ethic: More than kindness, the core of nursing science. *Nursing Forum*, 26(1), 4-8.

Kyle, T. (1995). The concept of caring: a review of the literature. *Journal of Advanced Nursing*, 21, 506-514.

Lagana, K. (2000). The "Right" to a caring relationship: The law and ethic of care. *The Journal of Perinatal and Neonatal Nursing*, 14(2), 12-24.

Larrabee, J.H., & Bolden, L.V. (2001). Defining patient-perceived quality of nursing care. *Journal of Nursing Care Quality*, 16(1), 34-60.

Laur, Q. (1965). *Phenomenology and the crisis of philosophy*. New York, NY: Harper-Row.

Lavender, T., & Walkinshaw, S.A. (1998). Can midwives reduce postpartum psychological morbidity? A randomized trial. *Birth: Issues in Perinatal Care*, 25(4), 215-219.

Leathers, S.J., Kelley, M.A., & Richman, J.A. (1997). Postpartum depressive symptomatology in new mothers and fathers: Parenting, work, and support. *The Journal of Nervous and Mental Diseases*, 185(3), 129-139.

Lee, D., Alexander T.S., Yip, S.K., Leung, T.Y.S., & Chung, T.K.H. (2004). Ethnoepidemiology of postnatal depression: Prospective multivariate study of sociocultural risk factors in a Chinese population in Hong Kong. *British Journal of Psychiatry*, 184: 34-40.

Lincoln, Y.S., & Guba, E.G. (1985). Processing naturalistically obtained data. In *Naturalistic Inquiry* (pp.333-343). Beverly Hills, CA: Sage.

Lindgren, K. (2001). Relationships among maternal-fetal attachment, prenatal depression, and health practices in pregnancy. *Research in Nursing and Health*, 24, 203-217.

Logsdon, M.C. (2000). Social support for pregnant and postpartum women: Symposium developed for AWHONN, The Association of Women's Health, Obstetric and Neonatal Nurses. Washington, DC: Author.

Logsdon, M.C., Birkimer, J.C., Simpson, T., & Looney, S. (2005). Postpartum depression and social support in adolescents. *Journal of Obstetric, Gynecologic, & Neonatal Nurses*, 34(1), 46-54.

Logsdon, M.C., Gagne, P., Hughes, T., Patterson, J., & Rakestraw, V. (2005). Social support during adolescent pregnancy: Piecing together a quilt. *Journal of Obstetric, Gynecologic, & Neonatal Nurses*, 34(5), 606-614.

Lothian, J. (2004). Promoting, protecting, and supporting normal birth. *The Journal of Perinatal Education*, 13(2), 1-3.

Lundgren, I., Berg, M., & Lindmark, G. (2003). Is the childbirth experience improved by a birth plan? *Journal of Midwifery and Women's Health*, 48(5), 322-328.

Lydon-Rochelle, M.T., Holt, V.L., & Martin, D.P. (2001). Delivery method and self-reported postpartum general health status among primiparous women. *Paediatric and Perinatal Epidemiology*, 15, 232-240.

MacKinnon, K., McIntyre, M., & Quance, M. (2003). The meaning of the nurse's presence during childbirth. *Journal of Obstetric, Gynecologic, & Neonatal Nurses*, 34(1), 28-36.

Malinowski, A., & Stamler, L.L. (2002). Comfort: Exploration of the concept in nursing. *Journal of Advanced Nursing*, 39(6), 599-606.

Manogin, T.W., Bechtel, G.A., & Rami, J.S. (2000). Caring behaviors by nurses: Women's perceptions during childbirth. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 29(2), 153-157.

Martell, L.K. (2000). The hospital and the postpartum experience: A historical analysis. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 29(1), 65-71.

Mason, W.A., Rice, M.J., & Records, K. (2005). The lived experience of postpartum depression in a psychiatric population. *Perspectives in Psychiatric Care*, 41(2), 52-60.

Matthews, R., & Callister, L.C. (2004). Childbearing women's perceptions of nursing care that promotes dignity. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 33(4), 498-507.

Matthey, S., Barnett, B., Ungerer, J., & Waters, B. (2001). Prenatal and maternal depressed mood during the transition to parenthood. *Journal of Affective Disorders*, 60(2), 75-85.

Maushart, S. (1999). *The mask of motherhood: How becoming a mother changes our lives and why we never talk about it*. New York: Penguin Books.

Mayberry, L.J., & Gennaro, S. (2001). A quality of health outcomes model for guiding obstetrical practice. *Journal of Nursing Scholarship*, 33(2), 141-146.

Mayberry, L.J., Gennaro, S., Strange, L., Williams, M., & Anindya, D. (1999). Maternal fatigue: Implications of second stage labor nursing care. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 28(2), 175- 181.

McGregor, D.K. (1998). *From midwives to medicine: The birth of American gynecology*. New Brunswick, NJ: Rutgers University Press.

McQueen, A., & Mander, R. (2003). Tiredness and fatigue in the postnatal period. *Journal of Advanced Nursing*, 42(5), 463-469.

Melender, H.L. (2002). Experiences of fears associated with pregnancy and childbirth: A study of 329 pregnant women. *Birth: Issues in Perinatal Care*, 29(2), 101-111.

Mercer, R.T. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship*, 36(3), 226-232.

Milgrom, J., Martin, P.R., & Negri, L.M. (1999). *Treating Postnatal Depression: A Psychological Approach for Health Care Practitioners*. England: John Wiley & Sons, Ltd.

Miller, L.J. (2002). Postpartum depression. *JAMA: The Journal of the American Medical Association*, 287(6), 762-765.

Miltner, R.S. (2002). More than support: Nursing interventions provided to women in labor. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 31(6), 753-761.

Misri, S. (1995). *Shouldn't I be happy? Emotional problems of pregnant and postpartum women*. New York: The Free Press.

Morof, D., Barrett, G., Peacock, J., Victor, C.R., & Manyonda, I. (2003). Postnatal depression and sexual health after childbirth. *Obstetrics and Gynecology*, 102(6), 1318-1325.

Morse, J.M., Bottorff, J., Neander, W., & Solberg, S. (1991). Comparative analysis of conceptualization and theories of caring. *Image: Journal of Nursing Scholarship*, 23(2), 119-126.

Morse, J.M., Bottorff, J., Anderson, G., O'Brien, B., & Solberg, S. (2006). Beyond empathy: expanding expressions of caring. *Journal of Advanced Nursing*, 17, 75-90.

Moustakas, C. (1995). *Being-in, being-for, being-within*. Northvale, NJ: Jason Armson.

Mozingo, J.N., Davis, M.W., Thomas, S.P., & Droppleman, P.G. (2002). Women's experience of childbirth-associated anger. *MCN, The American Journal of Maternal/Child Nursing*, 27(6), 342-348.

Munhall, P.L. (1994). *Revisioning phenomenology: Nursing and health science research*. New York, NY: National League for Nursing Press.

- Munhall, P.L. (2001). *Nursing research: A qualitative perspective*. (3rd ed.). Sudbury, MA: Jones-Bartlett.
- Nicolson, P. (1990). Understanding postnatal depression: A mother-centered approach. *Journal of Advanced Nursing*, 15, 689-695.
- Noddings, N. (1996). The caring professional. In Gordon, S., Benner, P., & N. Noddings (Eds.), *Caregiving: Readings in knowledge, practice, ethics, and politics*. (pp. 160-172). Philadelphia, PA: University of Pennsylvania Press.
- Noddings, N. (2002). *Starting at home: Caring and social policy*. Berkeley and Los Angeles: University of California Press.
- Noddings, N. (2003). *Caring: A feminine approach to ethics and moral education* (2nd ed.). Berkeley and Los Angeles: University of California Press.
- Oates, M.R., Neema, S., Asten, P., Glangleaud-Fredenthal, N., Figueiredo, B., Gorman, L.L., et al. (2004). Postnatal depression across countries and cultures: a qualitative study. *British Journal of Psychiatry*, 184, s10-s16.
- Odent, M. (2001a). *New reasons and new ways to study birth physiology*. *International Journal of Gynecology & Obstetrics*, 75, 539-545.
- Odent, M. (2001b). *The scientification of love*. London: Free Association Books. (Original work published 1999).
- Odent, M. (2002a). *Primal health: Understanding the critical period between conception and the first birthday*. East Sussex, London: Clairview Books.
- Odent, M. (2002b). *The farmer and the obstetrician*. London: Free Association Books Limited.
- Odent, M. (2004). *The caesarean*. London: Free Association Books Limited.
- Olson, A.L., Kemper, K.J., Kelleher, K.J., Hammond, C.S., Zuckerman, B.S., & Dietrich, A.J. (2002). Primary care pediatricians' roles and perceived responsibilities in the identification and management of maternal depression. *Pediatrics*, 110(6), 1169-1176.
- Parry, B.L. (1996). Premenstrual and postpartum mood disorders. *Current Opinion in Psychiatry*, 9(1), 11-16.
- Parse, R.R. (2001). *Qualitative inquiry: The path of sciencing*. Sudbury, MA: Jones-Bartlett.
- Parsons, T. (1951). Social structure and dynamic process: The case of modern medical practice. (pp. 428-479) in *The Social System*. New York: The Free Press.

Perez, P.G., & Herrick, L.M. (1998). Doulas: Exploring their roles with parents, hospitals, & nurses. *AWHONN: Lifelines*, 2, 54-55.

Perry, B. (2005). Core nursing values brought to life through stories. *Nursing Standard*, 20(7), 41-48.

Peterson, L., & Besuner, P. (1997). Pushing techniques during labor: Issues and Controversies, *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 26(6), 719-726.

Peterson, W. E., Charles, C., DiCenso, A., & Sword, W. (2005). The Newcastle Satisfaction with nursing scales: A valid measure of maternal satisfaction with inpatient postpartum nursing care. *Journal of Advanced Nursing*, 52(6), 672-681.

Phillips, P. (1993). A deconstruction of caring. *Journal of Advanced Nursing*, 18, 1554-1558.

Placksin, S. (2000). *Mothering the new mother: Women's feelings & needs after childbirth, a support & resource guide*. (2nd ed). New York: New Market Press.

Polit, D.F., & Beck, C.T. (2004). *Nursing research: Principles and methods*. (7th ed). New York: Lippincott-Williams-Wilkins.

Poole, J.H. (2003a). Analgesia and anesthesia during labor and birth: Implications for mother and fetus. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 32(6), 780-793.

Poole, J.H. (2003b). Neuraxial analgesia for labor and birth: Implications for mother and fetus. *Journal of Perinatal and Neonatal Nursing*, 17(4), 252-267.

Reynolds, J. (1997). Post-traumatic stress disorder after childbirth: The phenomenon of traumatic birth. *Canadian Medical Association Journal*, 156(6), 831-835.

Rich, A. (1986). *Of woman born: Motherhood as experience and institution*. (reissued 1995). New York: Norton & Company.

Riessman, C.K. (1998). Women and medicalization: A new perspective. In Weitz, R. (Ed.), *The politics of women's bodies: Sexuality, appearance, and behavior*. (pp. 46-63). New York: Oxford University Press.

Righetti-Veltema, M., Bousquet, A., & Manzano, J. (2003). Impact of postpartum depressive symptoms on mother and her 18-month-old infant. *European Child & Adolescent Psychiatry*, 12, 75-83.

Rogan, F., Shmied, V., Barclay, L., Everitt, L., & Wyllie, A. (1997). 'Becoming a mother'—developing a new theory of early motherhood. *Journal of Advanced Nursing*, 25, 877-885.

- Ruddick, S. (1995). *Maternal thinking: Toward a politics of peace*. New York: Ballantine Books.
- Sadala, M.L.A., & Adorno, R.C.F. (2002). Phenomenology as a method to investigate the experience lived: A perspective from Husserl and Merleau Ponty's thought. *Journal of Advanced Nursing*, 37(3), 282-293.
- Saisto, T., Ylikorkala, O., & Halmesmäki, E. (1999). Factors associated with fear of delivery in second pregnancies. *Obstetrics and Gynecology*, 5(1), 679-682.
- Salt, K. (2003). *A holistic guide to embracing pregnancy, childbirth, and motherhood*. Cambridge, MA: Perseus Publishing.
- Sampselle, C.M., Miller, J.M., Luecha, Y., Fischer, K., & Rosten, L. (2005). Provider support of spontaneous pushing during the second stage of labor. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 34(6), 695-702.
- Sandelowski, M. (1984). Expectations for childbirth versus actual experiences: The gap widens. *MCN, The American Journal of Maternal/Child Nursing*, 9, 237-239.
- Sauls, D. (2006). Dimensions of professional labor support for intrapartum practice. *Journal of Nursing Scholarship*, 38(1), 36-41.
- Schuilung, K.D., & Sampselle, C.M. (1999). Comfort in labor and midwifery art. *Image: The Journal of Nursing Scholarship*, 31(1), 77-81.
- Scott, K.D., Berkowitz, G., & Klaus, M. (1999). A comparison of intermittent and continuous support during labor: A meta-analysis. *American Journal of Obstetrics and Gynecology*, 180(5), 1054-1059.
- Seng, J.S., Low, L.K., Sparbel, K.J.H., & Killion, C. (2004). Abuse-related post-traumatic stress during the childbearing year. *Journal of Advanced Nursing*, 46(6), 604-613.
- Séguin, L., Potvin, L., St-Denis, M., & Loiselle, J. (1999). Depressive symptoms in the late postpartum among low socioeconomic status women. *Birth: Issues in Perinatal Care*, 26(3), 157-163.
- Shorten, A., Donsante, J., & Shorten, B. (2002). Birth position, accoucheur, and perineal outcomes: Informing women about choices for vaginal birth. *Birth: Issues in Perinatal Care*, 29(1), 18-27.
- Shorten, A., Shorten, B., MCom, J.K., West, S., & Morris, J. (2005). Making choices for childbirth: A randomized controlled trial of a decision-aide for informed birth after a cesarean. *Birth: Issues in Perinatal Care*, 32(4), 252-261.

Sichel, D.A., Cohen, L.S., Robertson, L.M., Rutenberg, A., & Rosenbaum, J.F. (1995). Prophylactic estrogen in recurrent postpartum affective disorder. *Biological Psychiatry*, 38, 814-818.

Sichel, D.A., & Driscoll, J.W. (1999). *Women's moods: What every woman must know about hormones, the brain, and emotional health*. New York: Harper-Collins.

Signorello, L.B., Harlow, B.L., Chekos, A.K., & Repke, J.T. (2001). Postpartum sexual functioning and its relationship to perineal trauma: A retrospective cohort study of primiparous women. *American Journal of Obstetrics and Gynecology*, 184, 881-888.

Simkin, P. (1996). The experience of maternity in a woman's life. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 25(3), 247-252.

Simkin, P. (2002). Supportive care during labor: A guide for busy nurses. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 31(6), 721-732.

Simkin, P. P., & O'Hara, M. (2002). Nonpharmacologic relief of pain during labor: Systematic review of five methods. *American Journal of Obstetrics and Gynecology*, 186(5), S131-59.

Simkin, P., Whalley, J., & Keppler, A. (2001). *Pregnancy, childbirth, and the newborn: The complete guide*. New York: Meadowbrook Press.

Simpson, K.R. (2000). A critical evaluation of the past 25 years of perinatal nursing practice: Opportunities for improvement. *MCN, The American Journal of Maternal/Child Nursing*, 25(6), 300-304.

Simpson, K.R., & Thorman, K.E. (2005). Obstetric "Conveniences"—Elective induction of labor, cesarean birth on demand, and other potentially unnecessary interventions. *Journal of Perinatal & Neonatal Nursing*, 19(2), 134-144.

Skott, C., & Eriksson, A. (2005). Clinical caring – the diary of a nurse. *Journal of Clinical Nursing*, 14, 916-921.

Smith, D. (1987). *The everyday world as problematic: A feminist sociology*. Boston, MA: Northeastern University Press.

Smith, L.J. (2004). Physics, forces, and mechanical effects of birth on breastfeeding. In Kroeger, *Impact of Birthing Practices on Breastfeeding: Protecting the Mother and Baby Continuum* (pp. 119-145). Sudbury, MA: Jones-Barlett.

Soet, J.E., Brack, G.A., & Dilorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth: Issues in Perinatal Care*, 30(1), 36-46.

Soong, B., & Barnes, M. (2005). Maternal position at midwife-attended birth and perineal trauma: Is there an association? *Birth: Issues in Perinatal Care*, 32(3), 164-169.

Spichiger, E., Wallhagen, M.I., & Benner, P. (2005). Nursing as a caring practice from a phenomenological perspective. *Scandinavian Journal of Caring Science*, 19, 303-309.

Stamp, G., Kruzins, G., & Crowther, C. (2001). Perineal massage in labour and prevention of perineal trauma: Randomised controlled trial. *BMJ*, 322, 1277-1280.

Stapleton, T.J. (1983). *Husserl and Heidegger: The question of a phenomenological beginning*. Albany, NY: State University of New York Press.

Stowe, Z.N., & Nemerhoff, C.B. (1995). Women at risk for postpartum-onset major depression. *American Journal of Obstetrics and Gynecology*, 173(2), 639-645.

Straus, R. (1956). The nature and status of medical sociology. *Sociological Review*, 22, 200-204.

Streubert Speziale, H.J., & Carpenter, D.R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative*. (3rd ed.). Philadelphia, PA: Lippincott-Williams-Wilkins.

Sumner, J. (2001). Caring in nursing: a different interpretation. *Journal of Advanced Nursing*, 35(6), 926-932.

Tam, L.W., Newton, R.P., Dern, M., & Parry, B.L. (2002). Screening women for postpartum depression at well baby visits: Resistance encountered and recommendations. *Archives of Women's Mental Health*, 5, 79-82.

Taylor, V. (1996). *Rock-a-by baby: Feminism, self-help, and postpartum depression*. New York: Rutledge.

Thompson, J.F., Roberts, C.L., & Ellwood, D.E. (2002). Prevalence and persistence of health problems after childbirth: Associations with parity and method of birth. *Birth: Issues in Perinatal Care*, 2(29), 83-94.

Thurtle, V. (1995). Postnatal depression: the relevance of sociological approaches. *Journal of Advanced Nursing*, 22(3), 416-424.

Tillett, J. (2004). Epidural anesthesia: A resource to use judiciously. *Journal of Perinatal & Neonatal Nursing*, 19(3), 207-209.

Tumblin, A., & Simkin, P. (2001). Pregnant women's perceptions of their nurse's role during labor and delivery. *Birth: Issues in Perinatal Care*, 28(1), 52-56.

Turriss, S.A. (2005). Unpacking the concept of patient satisfaction: A feminist analysis. *Journal of Advanced Nursing*, 50(3), 293-298.

Vance, C.S. (2002). Social construction theory: Problems in the history of sexuality. In Grewal & Kaplan *An introduction to women's studies: Gender in a transnational world*. (pp. 28-31). New York: McGraw-Hill.

VandeVusse, L. (1999). Decision making in analyses of women's birth stories. *Birth: Issues in Perinatal Care*, 1(26), 43-50.

Vincent, D., Hastings-Tolsma, M., & Park, J. (2003). Down the rabbit hole: Examining outcomes of nurse midwifery care. *Journal of Nursing Care Quality*, 19(4), 361-367.

Waldenström, U., Borg, I., & Olsson, B. (1996). The childbirth experience: A study of 295 new mothers. *Birth: Issues in Perinatal Care*, 23, 144-153.

Waldenström, U., Hildingsson, I., Rubertsson, C., & Rådestad, I. (2004). A negative birth experience: Prevalence and risk factors in a national sample. *Birth: Issues in Perinatal Care*, 31(1), 17-27.

Walsh, D., & Downe, S. M. (2004). Outcomes of free-standing, midwife-led birth centers: A structured review. *Birth: Issues in Perinatal Care*, 31(3), 222-229.

Watson, J. (1979). *Nursing: The philosophy and science of caring*. Boston, MA: Little-Brown.

Watson, J. (1985). *Nursing: Human science and human care: A theory of caring*. East Norwalk, CT: Appleton-Century-Crofts.

Watson, J. (1997). The theory of human caring: Retrospective and prospective. *Nursing Science Quarterly*, 10(1), 49-52.

Watson, J. (2002). Intentionality and caring-healing consciousness: A practice of transpersonal nursing. *Holistic Nursing Practice*, 16(4), 12-19.

Watson, J. (2003). Love and caring: Ethics of face and hand—An invitation to return to the heart and soul of nursing and our deep humanity. *Nursing Administrative Quarterly*, 27(3), 197-202.

Watson, J. (2005). *Caring science as sacred science*. Philadelphia, PA: Davis.

Watson, J., & Smith, M.C. (2002). Caring science and the science of unitary human beings: A trans-theoretical discourse for nursing knowledge development. *Journal of Advanced Nursing* 37(5), 452-461.

- Wax, J.R., Cartin, A., Pinette, M.G., & Blackstone, J. (2005). Patient choice cesarean—The Maine experience. *Birth: Issues in Perinatal Care*, 32(3), 203-206.
- Webb, D., & Culhane, J. (2002). Hospital variation in episiotomy use and the risk of perineal trauma during childbirth. *Birth: Issues in Perinatal Care*, 2(29), 132-136.
- Weitz, R. (1998). A history of women's bodies. In Weitz, R. (Ed.), *The politics of women's bodies: Sexuality, appearance, and behavior*. (pp. 3-11). New York: Oxford University Press.
- Welch, E.P. (1939). *Edmund Husserl's phenomenology*. Los Angeles, CA: The University of Southern California Press.
- Wilkin, K., & Slevin, E. (2004). The meaning of caring to nurses: An investigation into the nature of caring work in an intensive care unit. *Journal of Clinical Nursing*, 13, 50-59.
- Williams, A., Lavender, T., Richmond, D.H., & Tincello, D.G. (2005). Women's experiences after a third-degree obstetric anal sphincter tear: A qualitative study. *Birth: Issues in Perinatal Care*, 32(2), 129-136.
- Winslow, E.H., & Jacobson, A.F. (1998). Benefits of continuous support during labor. *American Journal of Nursing*, 98(1), 16-21.
- Wittmann-Price, R.A. (2004). Emancipation in decision making in women's health care. *Journal of Advanced Nursing*, 47(4), 437-445.
- Wolf, N. (2001). *Misconceptions: Truth, lies, and the unexpected on the journey to motherhood*. New York: Doubleday.
- Wolf, Z.R., Giardino, E.R., Osborne, P.A., & Ambrose, M.A. (1994). Dimensions of nurse caring. *IMAGE: Journal of Nursing Scholarship*, 26(2), 107-111.
- Wolman, W., Chalmers, B., Hofmeyr, J.G., & Nikodem, C.V. (1993). Postpartum depression and companionship in the clinical birth environment: A randomized, controlled study. *American Journal of Obstetrics and Gynecology*, 168(5), 1388-1393.
- Young, D. (1998a). Doulas: Into the mainstream of maternity care. *Birth: Issues in Perinatal Care*, 4(25), 213-214.
- Young, D. (1998b). First class delivery: The importance of asking women what they think about their maternity care. *Birth: Issues in Perinatal Care*, 25(2), 71-72.

CURRICULUM VITAE

JOANNE GOLDBORT

EDUCATION

2006	Ph.D., Nursing	Indiana University, Indianapolis, IN
2000	M.S., Nursing	Indiana State University, Terre Haute, IN
1997	B.S., Nursing	Indiana Wesleyan University, Marion, IN
1973	Diploma	Butler Hospital School of Nursing, Butler, PA

HONORS & AWARDS

- Director of the Quarter (3rd & 4th) Award, Union Hospital (2005)
- Fellow, Institute for Action in Research in Community Health (IARCH) (2005)
- Graduate Fellowship Research Award, Indiana University (2005)
- Jessie Cross Graduate Nursing Scholarship, Indiana University (2004)
- Candidate for Board of Directors, Region III, AWHONN (2004)
- Nominated by IUSON for Graduate Student Chancellor's Award (2004)
- Director of the Quarter Award, Union Hospital (2003)
- National AWHONN's Award of Excellence in Advocacy (2003)
- Outstanding Poster Presentation Award for AWHONN's National Conference (2003)
- IUPUI Medical Humanities Student Essay Award (2002)
- Graduated magna cum laude with B.S.
- Sigma Theta Tau Lambda Chapter Academic Excellence Award (2000)
- ISU Outstanding Academic Achievement Award (2000)
- AWHONN Indiana Section Award of Excellence in Nursing Practice (2000)
- Sigma Theta Tau International Honor Society of Nursing
- Sigma Theta Tau Research Scholarship (1999)
- ISU School of Graduate Studies Research Scholarship (1999)
- Phi Kappa Phi National Honor Society

EXPERIENCE

2001	Director Maternal and Child Services Union Hospital, Inc., Terre Haute, IN
2001	Community/Perinatal Education Liaison Indiana Perinatal Network, Inc.
2001	Instructor "Prenatal Care II," Healthy Families Indiana

- 2000 **Clinical Instructor** Indiana State University, Terre Haute, IN
- 1990-2001 **Staff Nurse** (Clinical Level 4) Labor and Delivery, Union Hospital,
Terre Haute, IN
- 1998-2001 **Perinatal Educator** Matria Home Health, Indianapolis, IN
- 1995-1997 **Perinatal Educator** Apria Healthcare, Women's Health Services,
Indianapolis, IN
- 1977-1990 **Assistant Department Head and Staff Nurse**, Newborn Nursery and
High-Risk Ante-/Postpartum, Sparrow Hospital, Lansing, MI
- Managed 56-bed high risk ante-/postpartum unit
 - Supervised 56 employees
 - Prepared unit's budget
 - Coordinated unit day-to-day (hired, interviewed, evaluated, and
scheduled employees).
- 1979-1980 **Instructor** Maternal-Child Health, Continuing Education, Sparrow
Hospital, Lansing, MI
- Developed classes for family newborn care (bathing, breast and bottle
feeding, family planning).
- 1975-1977 **Assistant Head Nurse and Staff Nurse** Hemodialysis, North Shore
University Hospital, Manhasset, NY
- Managed 72 patients every two days
 - Scheduled and supervised 9 employees
- 1974-1975 **Charge Nurse** Medical-Surgical, Indiana Hospital, Indiana, PA:
- Managed 32-bed unit; supervised 6 employees

PROFESSIONAL MEMBERSHIPS

- AWHONN
- Healthy Families Indiana Advisory Board
- Indiana Perinatal Network Advisory Board
- Lambda Sigma Chapter of Sigma Theta Tau International Nursing Honor Society
- Phi Kappa Phi Honor Society
- VHA Central Maternal and Child Health Council
- Indiana Perinatal Leadership Group

PUBLICATIONS

- 2006 Transcultural analysis of postpartum depression. *MCN: The American Journal of
Maternal Child Nursing*, 31(2), 121-126.

- 2005 Collaborative initiatives for postpartum depression. *AWHONN Lifelines*, (9)5, 377-381.
- 2005 Postpartum Depression Consensus Statement & Guide updated for the Indiana Perinatal Network, primary author.
- 2003 Prenatal II. *Healthy Families Basic Training Participant Manual*.
- 2002 Postpartum Depression Consensus Statement & Guide developed for the Indiana Perinatal Network, primary author.
- 2002 Postpartum depression: Bridging the gap between medicalized birth and social support. *International Journal of Childbirth Education*, 17(4), 11-17.
- 1993 Sexual harassment in the hospital. *Revolution: The Journal of Nurse empowerment*, 65, 95-96 (with D. Luegenbiehl).

CONFERENCE PRESENTATIONS

- 2006 (Mar) "Postpartum Depression" Presentation for Maple Center Healthy Self and Family Seminar, Terre Haute, IN
- 2006 (Mar) "Perinatal Mood Disorders" Lecture for Undergraduate and Graduate Gender Sociology Classes, IUPUI
- 2005 (Oct) "Nurses Role in Pre-term Labor," Hendricks Community Hospital, IN
- 2005 (Jan) "Contributions of Nursing Research and Nurses Role in Pre-term Labor," Community Hospital, Andersen, IN
- 2004 (Oct) "Changing Epidemiology of Pre-term Labor," and "Contributions of Nursing Research and Nurses Role in Pre-term Labor," for *P.E.P. Rally 2004: A Perinatal Conference*, University of Evansville, IN
- 2003 (Oct) "Postpartum Mood Disorders" Presentation for Meade Johnson Conference, Washington, D.C.
- 2003 (Sep) "Postpartum Depression" Presentation for Medical Sociology Graduate Class, IUPUI
- 2002 (Sep) Presented "Update on Postpartum Depression," at Union Hospital, Terre Haute, IN
- 2002 (Sep) Presented "Postpartum Mood Disorders," for Gender & Health Sociology Graduate Class, IUPUI, Indianapolis, IN

- 2002 (Jan) Presented "Perinatal Issues" at the Medical/Surgical Smorgasbord for Union Hospital, Terre Haute, IN
- 2001 (June) Poster presentation "Responses of Pregnant Women to Potential Preterm Labor Symptoms: A Partial Replication Study," for the National AWHONN Convention, Charlotte, NC
- 2001 (May) Poster presentation "Pain Management Options in the OB Department," for Union Hospital, Terre Haute, IN
- 2000 (Sep) "Responses of Pregnant Women to Potential Signs and Symptoms of Preterm Labor--A Replication Study." 12th Annual Nursing Research Conference, Sigma Theta Tau International, Lambda Sigma Chapter, ISU, Terre Haute, IN (also presented at ISU student Research Showcase, April 2000).
- 1999 (Apr) "Development of a High-Risk Perinatal Home Health Care Service for the Vigo County Community." Poster presentation, Indiana Public Health Association annual meeting, Indianapolis, IN (a version was also presented at Indiana Rural Health Association annual meeting, June 1999).

M.S. CULMINATING PROJECT

"Responses of Pregnant Women to Potential Signs and Symptoms of Preterm Labor: A Replication Study." May 2000.

PROFESSIONAL SERVICE

- 2006 (May) Candidate for Board of Directors, Region III, AWHONN
- 2006 (Apr) President-elect Lambda Chapter Sigma Theta Tau International Honor Society of Nursing
- 2006 (Apr) Planning Committee "Springing Forward with Perinatal Issues Conference," Terre Haute, IN
- 2006 (Jan) Board of Directors, March of Dimes, Wabash Valley
- 2005 (June) Candidate Section Chair, Indiana AWHONN
- 2005 (Apr) Chairperson, Indian Perinatal Depression Summit, Indianapolis, IN
- 2004 (Nov) Emcee for March of Dimes Prematurity Summit, held in Indianapolis, IN
- 2004 (Oct) Planning Committee "Diverse Issues in Perinatal Care Conference," Terre Haute, IN

- 2004 (Oct) Consultant and Chairperson for Indiana Perinatal Network subcommittee, "Indiana Postpartum Depression Project," which included updating the IPN PPD Consensus Statement and PPD Guide
- 2004 (June) Facilitator/Moderator AWHONN National Convention, Tampa, FL
- 2004 (July) Candidate for Board of Directors, Region III, AWHONN
- 2004 (Apr) Planning Committee "March of Dimes Prematurity Campaign Summit," Indianapolis, IN
- 2004 (Mar) Planning Committee "3rd Annual Perinatal Outcomes" Conference, Terre Haute, IN
- 2004 (Mar) Planning Committee, Indiana AWHONN's Conference, Terre Haute, IN
- 2004 (Mar) Co-Grant HRSA Writer for Indiana Perinatal Depression Project
- 2004 (Jan) Planning Committee, Indiana AWHONN Section Conference held in Sept. 24, 2004, Terre Haute, IN
- 2004 (Feb) Member, Ad Hoc Committee for Delineation of Privileges for CNM Services, Union Hospital, Terre Haute, IN
- 2003 (Oct) Ad Hoc Committee for Recruitment of Neonatologist, Union Hospital, Terre Haute, IN
- 2003 (Oct) Member, Indiana Access Public Policy Committee, Indianapolis, IN
- 2003 (Oct) Planning Committee "Taking Care of the Caregiver," for the Indiana AWHONN Conference, Muncie, IN
- 2003 (Sep) Chairperson, Patient Care Council, Union Hospital, Terre Haute, IN
- 2003 (Apr) Planning Committee "2nd Annual Perinatal Outcomes: Current Perspectives on Recurrent Themes." Terre Haute, IN
- 2003 (Jan) MOD Prematurity Campaign Ambassador for Terre Haute and for Indiana AWHONN
- 2002 (Oct) Chairperson, "Women and Depression," for IPN, HFI, & AWHONN State Conference, Indianapolis, IN
- 2002 (Apr) Chairperson, "Perinatal Outcomes: Current Perspectives on Recurrent Themes," Terre Haute, IN

- 2000 (Sep) Chairperson “Enhancing Women’s & Infants’ Health Through Life Changes, Program for the AWHONN Indiana Section Meeting, West Lafayette, IN
- 1999 (Oct) Chairperson “Evolving Professionally: High Tech/HighTouch Into the 21st Century” Program for the AWHONN Indiana Section Meeting, Greenwood, IN