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Birth Experiences in Kentucky: An Ethnography of Healthcare, Trauma, and Healing

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A traumatic birth experience can occur for a multitude of reasons. For example, it may stem from a communication issue, lack of consent to procedures, or a birth plan gone wrong, or it may even be due to the inherently hierarchical structure of western medicine. Whatever the cause, traumatic birth narratives serve not only as therapeutic mechanisms for the sufferer, but also as a means to use the lessons learned from the lived experiences of people to improve care in the future. Composed of information specific to Kentucky, this research examines the causes of traumatic births and gives voice to those who otherwise may not have their stories shared. Drawing on ethnographic interviews and surveys from those who have experienced a traumatic birth, this study determines common demographics and social determinants of health that may be risk factors for traumatic birth, explores and critiques models of care and healthcare environments that may contribute to traumatic births, and provides insight into future directions for prevention of traumatic births.

Ultimately, three qualitative interviews were conducted, coded, and analyzed to produce these themes: 1) “I didn’t know any better:” The Importance of Knowledge, 2) “Everybody tries to figure out why it happens:” Medical Interventions and Complications, 3) “They don’t have a very good bedside manner I guess:” Communication and Empathy, 4) “Choice is yours:” Choices and the Aftermath, 5) “I’m an intelligent person:” Empowerment in the Wake.

Key Words: Traumatic birth, healthcare, prevention, lived experiences, ethnography

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Introduction

Maya is about to be a mom. She has imagined this moment for almost a year now. In her dreams, she gives one final push, a little sweat upon her brow showcasing her hard work and triumph, and then her baby is caught by her partner, and brought up to her bare chest. She feels her child take her first breath, and her family surrounding her all smile in joy.

This is not that moment.

This is not how it is supposed to go.

Her doctor grabs a sharp object and without asking, disappears it beneath her legs, slicing her open. Hands reach up inside her, and with a sharp twist, yank the infant from her insides. Suddenly nurses grab the baby, and don't answer when she panickily asks them to let her see her. Her pain has not stopped, her family members around her have gone deathly silent and ashen, and all around her staff stare at her body parts, but never look her in the face or say anything to her.

No, this is not how it is supposed to be.

The speaking of a birth story has been described as a cathartic experience: one where people can express the significance of the birth itself, reflect on personal strengths that allowed them to overcome the pain and struggles of labor, talk about the fear they experienced or perhaps their experience of feeling inadequate. The verbal confirmation of a birth story can even create an almost tangible product of a spiritual link, spanning through time and space, which forever links a personal birth story to everyone else who has ever given birth before (Callister 2004). Thus, narrating a birth story brings the experience to life. People who have gone through birth can understand the physical demands on the body, the emotions that arise, the wisdom at knowing what the body is capable of. People can connect with one another based on their birth stories. This tangible product, this link between people who share their stories is almost always complex. As Cooke (2020, 28) puts, it:

> "To give birth and to want to talk about it, or to approach birth and to try to learn about it, is to find oneself at the center of a fraught negotiation of power and powerlessness over a woman's role and place, the inequities she faces or does not face in the United States today. A single story, a moment of violence and vulnerability amid a Western medical culture that aspires to dominion over the body, grows and grows until it becomes a shimmering wall encompassing identity, politics, values, medicine, culture, and more. And beneath it all, no one seems able to agree: What does childbirth mean, and what does it do to the person who gives birth?"

If the telling of a simple birth story can allow for all of that, then a traumatic birth story, then, must take on a special role in a person's life.

As established, telling a birth story serves many purposes, and weaving the narrative of a *traumatic* birth story is no different. Narration of a birth story connects people, allows for reflection, and can be an empowering, therapeutic act. While these benefits have been identified in face to face interviews, Beck (2005) ascertains the benefits of qualitative research on birth trauma conducted via the Internet. Beck's research allowed for people to submit their traumatic birth stories through handwritten or typed stories, even supplementing the narratives through old diaries, journals, medical records, and other paper trails. Beck shared that the participants felt there were several benefits to sharing their story with the researcher: the experience of being cared for through the process of listening and acknowledging, a sense of belonging with the other people who have gone through traumatic births, a better understanding of their own story, and the ability to let it go. The participants also felt that they were empowering themselves and others by sharing their stories, as well as giving voice to their stories so that some greater benefit could emerge from it (Beck 2005). Conclusively, birth stories, no matter the format in which they are shared, can be powerful tools.

The power of telling these stories not only is therapeutic for the individual, but it can reveal a lot about *what* makes a birth traumatic. For this study, a traumatic birth is simply defined as any birthing event in which the delivering person feels was traumatic in nature, whatever the cause may be. Trauma birth narratives can reveal a lot of information about why traumatic births happen and possible ways to prevent them.

Thus, the sharing of a traumatic birth experience to a researcher can come with a lot of psychological benefits to the participants, as well as to interdisciplinary fields such as medical anthropology, medicine, psychology, and more. This thesis in particular explores themes of traumatic births experienced by people in Kentucky. The purpose for focusing on Kentucky specifically is twofold. The first reason being that there is a severe lack of Kentucky specific data on traumatic birth experiences, both quantitative and qualitative. The second reason being that Kentucky consistently has poor health outcomes in general. The United Health Foundations ranks Kentucky 43rd in the nation for health based on criteria assessing health behaviors, policies, community and environment, clinical care, and health outcomes. Kentucky has ranked in the bottom 10 states for decades (America's Health Rankings 2021).

Perspectives told from patients allow for a deep delve into the root cause of traumatic birth experiences, the thoughts and feelings behind the event, and the potential to prevent trauma in the future.

Overall, the purpose of this study is:

1. To gain an understanding of what traumatic birth experiences are like for people in Kentucky.
2. To identify any common demographic factors that correlate with traumatic birth experiences.
3. To gain insight into the past and present experiences, thoughts, and feelings of those who have experienced a traumatic birth.

4. To learn about healthcare providers' model of care and work environments pertaining to traumatic birth experiences.

Background Information

General Health in Kentucky

Kentucky's overall health status is one of the lowest in the United States, ranked 43 out of the 50 states in 2019. Chronic conditions such as diabetes, obesity, substance use disorder, and cancer have been on the rise for the past decade, as well as mental health issues. In 2019, Kentucky ultimately ranked last in the United States for physical activity, preventable hospitalizations, and cancer deaths. Additionally, Kentucky ranked 49th for frequent mental distress (America's Health Rankings 2021).

The health disparities that exist in Kentucky are preliminary indicators of the kind of systemic issues that affect pregnancy and birth experiences and outcomes. Health prior to pregnancy and delivery can have an impact on health and wellness during the pregnancy and birth. Additionally, preventable and chronic health issues that are present in such high amounts in Kentucky can be linked to poverty and income, built environment, lack of access and infrastructure of healthcare and social safety nets, and other systemic problems, all of which impact preventative and intervention care for people who are pregnant.

Maternal Social Determinants of Health and Demographics

Continuing on the discussion of determinants of health, the Kentucky "2020 Maternal and Child Health Needs Assessment Survey" reports on top concerns, factors affecting prenatal care, standards of living, and family planning, concerning substances, factors affecting mental health care, social determinants of health, and most effective systems of care for surveyed pregnant people in Kentucky. Important themes that emerge can be broken down into behavioral health issues, socioeconomic issues, sociocultural issues, and access issues. For example, top concerns amongst pregnant respondents are substance use, mental health, and standards of living. Common reported issues such as lack of transportation and lack of employment opportunities points to socioeconomic stressors, and lack of community resources for family planning, lack of availability for mental health treatment in the community, and troubles with chronic health conditions and compliance all point to disparities in access. Finally, some social and cultural issues are a lack of a social support systems (Division of Maternal and Child Health 2020 "Maternal"). Thus, women in Kentucky have significant stressors that impact their overall health, and their ability to have a safe, comfortable, and healthy pregnancy and delivery.

The Center for Disease Control and Prevention's Pregnancy Risk Assessment Monitoring System (PRAMS) is a population public health surveillance system that focuses on maternal behaviors and experiences that impact adverse birth outcomes. The 2008 report for Kentucky establishes some important relevant demographic factors about pregnancy in Kentucky. The report showcases that approximately 55% of respondents were on

private insurance before getting pregnant, 28.8% were uninsured, and 16% were on Medicaid. While the report does examine risk factors for poor maternal and infant outcomes mentioned above, it's section on labor and delivery itself chooses to focus on method of delivery (vaginally, c-section, induction rates), but does not ask about what the respondents think and feel about the birth experience they had (Department for Public Health Division of Maternal and Child Health 2008).There is no state or national data that tracks the rate of people who report that their birth experience was traumatic in nature.

Maternal Outcomes

The United States is one of the most dangerous places to give birth, with the highest mortality rates out of any developed country in the world. Even more alarmingly, the problem has gotten worse over time instead of better, with the maternal mortality rate doubling from 1987 to 2012 (Johnson 2019). Johnson (2019, 17) also extends on the mortality rate to explain that "[f]or every maternal death in the United States, as many as 70 to 100 women experience severe maternal morbidity, or "near misses."' These "near misses" are possible traumatic birth stories that have never been formally reported.

Another troubling aspect of maternal mortality in the United States relates to racial disparities. The Center for Disease Control and Prevention contributes that the pregnancy related mortality ratio in 2017 was 17.3 deaths per 100,000 people in the United States. Of these deaths, non-Hispanic black people were dying at 41.7 deaths per 100,000 non-Hispanic American Indian or Alaska Natives were dying at 28.3 deaths per 100,000, non-

Hispanic Asian or Pacific Islanders were dying at 13.8 deaths per 100,000, non-Hispanic whites were dying at 13.4 deaths per 100,000, and Hispanic or Latinos were dying at 11.6 deaths per 100,000 (Center for Disease Control and Prevention 2020). Thus, the maternal mortality rate is 3-4 times higher for black people than it is for white people in the United States.

Kentucky itself does not have much better rates. The "Maternal Mortality Review 2020 Annual Report" announces that in 2018 in Kentucky specifically, there were 140.9 maternal deaths per 100,000[1]. For black people in Kentucky, the maternal death rate was 42.1 per 100,000 and for white people it was 17.2 per 100,000, keeping aligned with the national black mortality gap. The report indicates that "[o]verall, 79% of the maternal deaths reviewed from the 2017 cohort were considered to be preventable. This is higher than the CDC predicted average that 60% of maternal deaths in the United States are preventable" (Division of Maternal and Child Health 2020, 11). Public health has a lot of room to grow in Kentucky when it comes to maternal outcomes; to know that we have the ability to save lives, to stop 80% of pregnancy related deaths, but to not have the capacity, the dedicated support needed, is astounding. We must do better.

The picture gets even grimmer. Maternal mortality and outcomes are likely to be worse in eastern Kentucky (a portion of Appalachia) and the more rural areas of Kentucky as well. Hansen (2019, 4) comments that "[w]omen of color, women living in rural areas, and

[1] This slightly differs from the CDC's definition of pregnancy related deaths, as this Kentucky number includes deaths unrelated to pregnancy and labor, but that occurs within one year of giving birth.

low-income women have been indicated to be at increased risk for pregnancy-related death." Chronic illnesses, hindrances to family planning services, and reduced access to pre and perinatal care are all exacerbated in rural Appalachia and all contribute to poor maternal outcomes (Hansen 2019). Another study that examines every categorized rural county in America states that "[f]orty-five percent (898) of rural counties did not have any hospitals with obstetric services at any point during the period 2004–14, and 9 percent (179) of the counties experienced the loss of all in-county hospital obstetric services during the study period (Exhibit 1). In 2014, 1.8 million women ages 15–44 lived in counties that never had any hospitals providing obstetric services in the study period, and slightly more than 600,000 women lived in counties that lost those services—for a total of 2.4 million women of reproductive age living in counties with no in hospital obstetric services" (Hung 2017, 1665). Considering that "[t]he greatest loss of hospital-based obstetric services has occurred in counties with a high proportion of black residents" (Hansen 2019, 6), the intersection of rurality, race, and income showcase the worse that the American healthcare system has to offer for women and other pregnant people.

Literature Review of Traumatic Birth Ethnographies

The maternal mortality rate in America is the highest amongst all developed countries, but the simple math of looking at mortality does not tell us anything about the survivors of birth. Beck tells us that "[s]ignificant predictors of traumatic births included cesarean deliveries, high level of medical intervention, long and painful labors, feeling powerless, lack of information, negative interactions with labor and delivery personnel, and

differences between expectations and the actual childbirth event" (Beck 2006, 454). In Beck's own analysis of 11 traumatic birth interviews, the dramatistic pentad (Act, Agent, Scene, Agency, and Purpose, with a sixth additional factor of Trouble to reflect the traumatic nature of the births) is used as a method of narrative analysis. She finds that the ratio between Act and Agency is the most imbalanced, resulting in Trouble, and recommends that a different approach to care during childbirth is needed (Beck 2006).

The people who have experienced a traumatic childbirth may exhibit several similar thoughts and feelings surrounding the event. These insights provide a lot of knowledge about what caused the traumatic birth as well. A meta- ethnography establishes the following themes: "'feeling invisible and out of control', 'to be treated humanely', 'feeling trapped: the reoccurring nightmare of my childbirth experience', 'a rollercoaster of emotions', 'disrupted relationships' and 'strength of purpose: a way to succeed as a mother'" (Elmir 2010). Decision making, communication, empathetic and empowering care, and after care all extremely important in labor and delivery events. When these needs are not met, traumatic births can happen. The occurrence of a traumatic birth can be severe; women included in the synthesis were traumatized by the actions of healthcare professionals, with some describing their traumatic birth as a kind of rape (Elmir 2010). Traumatic births are not always damage done to the body. Traumatic births can be damage done to the self, to the mind, to the soul.

Another ethnography by Murphy (2018) builds the foundation of understanding birth traumas on the occurrence of "birth pain, mismatches in expectations of childbirth, the

impact of previous trauma, and death of the neonate" which are common processes that may result in a traumatic birth experience. Murphy's ethnography of four participants allows valuable insight into more themes of birth trauma narratives. The first theme, "experiencing birth trauma" is all about the medical interventions and communications that led up to the delivery itself. The experience of medical interventions such as C-sections and exams, and the experience of poor communication with staff is traumatizing. The second theme is identical to Elmir's (2010), which is invisibility. The third, "just get on with it" describes the many ways in which the healthcare team responded to the women in the moment. Improper responses are invalidating, and they diminish the voice of the person in the moment that they truly need an ally. Finally, the final theme is all about making the birth experience better for future people (Murphy 2018).

What these ethnographies ultimately tell us is that there are a lot of causes for traumatic birth experiences and there are many different responses to the experiences. What they also tell us is that we can identify commonalities between stories. These commonalities can exist for good, such as connecting people who have undergone similar experiences, who feel the same way. They can also pinpoint specific problems that need to be addressed, whether that be in the way society and cultures speak of and frame birth experiences or in the way that healthcare teams operate.

Methodology

A full Institutional Review Board process was committed for Human Subjects Research, and approval was granted. Participants consisted of people who experienced a traumatic

birth event, who were above the age of 18. For those who had experienced a traumatic birth, protections were considered for the inclusion and exclusion of participants. Interested participants were screened for: PTSD and other mental illnesses, death or miscarriage of the fetus or infant, and long lasting and severe physical health problems or disability resulting from the event in question. If participants fit any of these criteria, they were excluded from participation. Participants were selectively recruited through the creation of a Facebook page titled "Kentucky Traumatic Birth Research and Support Group." Potential participants exposed to the social media page were provided with a Question and Answer document, a basic informational flyer, and a Google Form survey that screened them for participation. Potential participants who filled out the screening questionnaire were then followed up with via their preferred method of communication, which was typically email.

Participants were asked to take a short one-page survey in addition to an ethnographic interview. Surveys assessed basic demographic factors of geographic location in Kentucky, age, income level, race and ethnicity, and insurance status, with all answers reflecting the time period of their traumatic birth event. The semi structured interview consisted of questions about the prenatal experience, the birth experience, and post birth details. Questions were geared to help participants share their story in a semi-structured format, focusing attention on their thoughts, feelings, and opinions.

All interviews were conducted over Zoom, audio recorded, and transcribed.

The interviews collected are presented here in their entirety, represented under pseudonyms. They have been formatted to be a complete narrative, written as to protect identity but to be complete. This is part of an “experience near” framework approach. Beck (2006) states that “[b]ecause narratives are “essential meaning-making structures” they must not be dissected or fractured. Narrative analysis permits focus on the broad contours of a story, and the informants’ ways of constructing meaning are respected.” It is this approach that guides the telling of these birth stories.

A narrative analysis was also used on these interviews. The concepts of grounded theory outlined by Glaser and Strauss (1967) were used, with transcriptions of the interviews being coded, and then letting themes emerge from commonalities between codes. The analysis portion of this paper is not entirely rigorous in its commitment to grounded theory, and only serves as a preliminary look into some possible themes and understandings of traumatic birth experiences, so as not to unjustly reduce people’s stories down into codifiable data. Beck’s assertion that narratives are meaningful in their own right is heavily used here. This method also aspires to Cooke’s (2020) assertion that we should ponder a lot on: “And so birth stories wind down, in so many cases, to the same thing that consumes how we often talk about women: the need to provide a reason for her story to be important." Reducing these stories to codes, especially with such a small sample and as an amateur researcher, seems counterintuitive to what the goals of this research are, which are mainly to get at the lived experiences of people in Kentucky who have undergone a traumatic birth. Thus, the results and discussion of this research

are simply represented in preliminary themes that are developed from light coding and discussed in length with comparison to more rigorously tested ethnographies.

Results

Charlotte's Story:

Charlotte pats her quite large stomach adoringly, even as she grimaces at the heartburn that has been plaguing her for days. She knows the old wives' tales, and figures that her heartburn is a telltale sign that her baby is going to come out with a head full of hair. Other than the heartburn she has no complaints. She and her husband, both in their 20's, cannot wait to welcome their first-born baby home. Charlotte has a doctor she completely trusts, and nothing but high hopes that her delivery will go as smoothly as her entire pregnancy has gone. Her prenatal care was also exceptional, since she got to see all of the providers at her various visits, so if they were needed during her delivery, she would be familiar and comfortable with them. Her pregnancy itself has been absolutely wonderful, with her grandma feeding her home cooked fried chicken and chocolate pies each day. Her baby is going to be born with luscious locks and chubby thighs.

Soon after, Charlotte's due date comes and goes, and so the family checks in to the hospital in preparation for a scheduled C-section. At some point during the preparation, Charlotte is left temporarily alone in her hospital room. That is when it happens. She feels invisible hands squeeze around her neck. She presses her call button and tells the nurses that she can't breathe. No one comes. She lays there and still can't breathe. She presses the call button again, and then the world goes black.

It is not until weeks later when Charlotte finally opens her eyes. On the bed surrounding her are pictures of her baby. Charlotte says to herself, ‘okay, my baby is fine and he’s a few days old.’ But then they tell Charlotte that her baby is two weeks old. She has been unconscious this whole time and has no clue what has happened to her.

The time that Charlotte is missing from her story was quickly filled in by her family, who had been diligently by her side for weeks. The nurses had not heard Charlotte speak after pressing the call bell once, and assumed it was an accident. After she had pressed it a second time, they decided to check on her. That is when the nurses found her unconscious, unaware of how long she or her infant had been without oxygen.

That morning her doctor was there early, and another high risk OBGYN who was not supposed to be in the building that day, also just so happened to be there. She was rushed into an emergency C-section, where it was discovered that she was suffering from an Amniotic Fluid Embolism. She spent two weeks in the ICU after that, hooked up to a ventilator, her C-section incision packed. She was on dialysis due to her kidneys failing and had gone through 200 units of blood. On the days that they thought she was going to die, they brought her baby in, a healthy, big baby, and laid her on her chest. Her heart rate would always go up while this happened, as if her body knew that her baby was close by. They were sure to take a lot of pictures, so that they could always remember the moments that she and her baby had together. Some of the pictures from the worst days show blood all over the bed, the ceiling, the walls, and the floors. They were pumping blood into her

as fast as it would pour out. Charlotte awoke as one of the few people to survive her condition, a victim who suffered from something that no one could have prevented or responded to differently. And she woke up as a mom to a baby that she had yet to meet while conscious.

Charlotte still has the scars on her body as proof of her struggle. Her return home was riddled with just as many difficulties, her time being spent on physical therapy, and her memory failing her of the first few months she was home. She could not lift her baby, could not be alone with her baby by herself. She missed out on what it was like to be a first-time mom with sleepless nights, bouncing her baby in her arms, feeding her. But what Charlotte had was the grace of God and the support of her family, friends and community who would take care of her and her family. Before she even had returned home, her hometown had put on one of the largest community support events with the highest turn out that the town had ever seen before. And once Charlotte got home, she was gifted with food, money, and people's time.

Charlotte feels she owes her and her baby's life to God. Through that strength, she was able to muster up the courage and conviction to have more children. And she now spends some of her time on research and support groups for the condition, where she can connect with other women or family members of people who have gone through the same thing she has. It is important to her to spread awareness, and to connect with people, easing their fears, and saying 'hey, me and my family have been through this too.' Charlotte will

always remember the fear and horror of her first birth, will always commemorate that day, but she will go forward knowing that she is loved, healthy, and here.

Alice's Story:

Alice hates doctors. She has never really been very sick in her life, and she really likes to live life naturally. Her and her husband really want to have a big family, with four to six kids. A house full of kids, family walks in beautiful nature, and hearts full of love. After carefully using fertility awareness, because she doesn't believe in birth control, Alice is ecstatic to learn that she is pregnant with her first child. The pregnancy came right after their honeymoon, and the young couple cannot wait to start their family.

The search for prenatal care begins, because Alice does not already see a regular women's care provider. All Alice knows is that she really does not want a C-section. She searches the internet diligently trying to find the C-section rates of doctors and hospitals and commits to doing interviews with several doctors to ask them her important questions. Alice thinks she can get the best care in a big city, but soon finds out that she is wrong after one doctor just keeps impatiently looking at the clock. She feels as though hospitals are untrustworthy with their C-section rates and that doctors are impatient. She does not want to be on a clock while she gives birth, only to have them cut the baby out of her when the time is up.

After a lot of searching, Alice finally finds a birthing spa that she feels really good about, including their C-section rates. But things start to go a little downhill when her midwife

tells her that she is going to take a break from midwifery to go back to school; Alice is angry that her midwife might miss her birth since her cutoff date for work is so close to Alice's due date.

The time for Alice's baby to be born into this world finally comes around. After being turned away from the hospital at first due to her labor not progressing, Alice and her husband come back to hopefully be admitted. They are finally assigned a room and her midwife does make it to her birth, fortunately. Her pain level is really high, and so Alice begs for an epidural even though she did not want one before going into labor. Looking back on it, Alice will regret the epidural, and figures that what happened next was a result of sitting on the epidural for too long. She feels that that decision is on her though since she asked for it.

Alice ends up laboring for 39 hours in total. The nurses are rude, really cut and dry, and she does not appreciate their lack of sympathy. Alice waits and waits, and they find out that her baby is sunny side up. The doctor comes in to check on her, and they consider a C-section, which Alice really does not want. The doctor and the other staff in the room look at each other and make a scissoring motion with their hands. They then promptly give her an episiotomy without conferring with her. Alice is actually happy about this decision because she is squeamish, although it did kind of bother her that they didn't ask beforehand. The doctor then shows Alice a vacuum and suctions the baby out.

The baby comes out blue, but Alice does not know this. She is simply relieved that it is over. She feels upset that she had to have an epidural, but she is ultimately relieved that she got to have a vaginal birth due to having a good doctor. She feels that any other doctor would have opted for the C-section.

Looking back on her first pregnancy and birth, Alice wishes that she had done things differently. She did not know about natural birth options. Did not know about the spinning babies techniques, the various exercises and practices she could do to make birth easier. She wishes that she had gotten a doula to educate her about these things and wishes that healthcare providers in general did a lot more educating of their patients, because right now they won't tell you much.

For Alice's second child, she still went to the birthing spa, but she had an all-natural birth. She did not have an IV, did not receive an epidural, did not get blood drawn. And they followed her birthing plan to a T. Her second birth was like a dream, and the next day she could even walk a mile and feel fine. For her, an all-natural birth is the way that any birth should go. Her ideal birth is to give birth at home, outside in nature. Alice thinks that traumatic births happen the second you leave the home, and then the next step to a traumatic birth is an epidural. Alice has now done a lot of research about birth and loves reading the likes of Ina May Gaskin. She really wants other people to know the importance of doing their own research, of having a doula, of choosing a natural birth when they can, and of questioning modern birthing practices. The next time Alice shares a birth story, she hopes she can share another perfect one, much different from her first.

Joyce's Story:

"Stop by the front desk and we'll get you set up for a follow up appointment. Congratulations again!" Joyce does as she's told, and then heads home. She had come to the primary care doctor to confirm that she was pregnant. Being only 19 years old, in a new state, and in a new relationship, Joyce feels very alone. She is scared, embarrassed of being so young and pregnant, and does not know what to do. So when the doctor prescribes her some vitamins and invites her back, that is what she does.

Nine months finally pass, and Joyce is two weeks overdue, so she is scheduled to be induced. She checks in to the hospital, where she sees an OBGYN for the first time in her pregnancy, and in her life. Her primary care doctor, who she has been seeing throughout her pregnancy, is there also. Joyce endures labor for 12 hours before it happens.

Suddenly, the monitor indicates that her baby has gone into distress. The room fills up quickly, with nurses and doctors. And then Joyce hears her baby flatline. She watches her primary doctor's face as this happens, sees the doctor back away and stand in a corner. Joyce feels incredibly terrified as the one person who she was supposed to be able to rely on has abandoned her.

Joyce ends up on her hands and knees, a nurse's hand inside of her, and she's being rushed into surgery. Joyce is hysterical, crying and screaming, and all around her doctors

and nurses are doing everything but talking to her. Joyce thinks her baby is dead. The anesthesiologist attempts to console her, but to no avail.

For nearly 45 minutes Joyce exists in the world thinking her baby is dead. It is only once they get her open and once she hears the cries of her baby that she realizes that her baby is okay. The doctors decide to knock her out after the successful C-section because of her hysteria.

Joyce never even figures out what happened until she goes to nursing school years later. She finds out that she had a cord prolapse, and that is why they had a hand inside of her, to keep pressure off of the cords. She realizes that her baby didn't actually flatline and feels that the nurses and doctors overlooked her thoughts and feelings because of her age.

Joyce has learned so much more now that she is a nurse, a mother of multiple children, and has had some more life experience. She deeply regrets her lack of knowledge as a first time mother and wishes that she had known a lot of things. Joyce was never formally educated on her options as a first time pregnant woman, was never referred out, and although she had some community support such as the health department, they never asked her the question that ended up mattering the most to her: are you seeing the provider that you want to? Do you know about your options?

For Joyce's second pregnancy, she finally got an OBGYN. Joyce advocated for herself, told her doctor exactly how she wanted the birth to go, and scheduled a preemptive C-

section, because she was terrified of giving birth again. And now as a nurse, Joyce has more empathy for the situation she was in. She has an appreciation for the nurses and the doctors that helped her, and doesn't blame them, although she knows mistakes were made. Joyce ultimately wants young pregnant women to have more knowledge than she did when they give birth.

Demographic Results

All three participants were from rural, Appalachian counties in Kentucky (2 of the 3 were from the same county). The age of the participants at the time of their traumatic birth ranged from 19 years old to 24 years old. One participant's income level at the time of the birth was in the 0-$25,000 range, one participant indicated NA, and the other participant did not respond with the survey. One participant had Medicaid and the other had employment-based health insurance.

Discussion

There are five various themes that emerged from each interview that offer some insight into future recommendations for the prevention of traumatic births.

1. **"I didn't know any better:" The Importance of Knowledge**

Alice's Insights:

"I just think that those C-section rates should be posted. I want to know. That's all. They should be readily available and easy to find."

"There's no education, like at all. Like none. Zero."

"And so I didn't really know a whole lot about birth, I didn't even know I wanted a natural birth, so I don't know."

Joyce's Insights:

"I didn't know any better, and I didn't have support, so I went to a primary care doctor and I didn't realize that I should be going to an OBGYN."

"I think if I maybe would have been 25 or 30, I would have known more. I would have known more questions to ask, I would have seemed more um, I don't know, mature...I was scared to death when I was pregnant. And I don't think I had the confidence or the knowledge to know what to ask, how to ask."

Participants Alice and Joyce exemplify that lack of knowledge prior to pregnancy and birth can alter or erase the chances that people have for making their own health decisions, whether that be choice of provider, choice of medical system, choice of designing individualized birth plans, or choice of actions to take during pregnancy that could impact the labor itself. For Alice specifically, she did not truly understand her options for childbirth the first time. Alice expressed that she wished she had a doula, was more informed about exercises to do during pregnancy, and expressed frustration that what she did know to do during pregnancy (find a provider with an acceptable C-section rate for her preferences) was made exceedingly difficult. Joyce was likewise uneducated about her options and was not even aware that she didn't have to default to the first provider she saw for pregnancy.

What stands out about Alice and Joyce is that for each woman, their preferred health choices now that they are able to look back on their traumatic births in hindsight, are vastly different from one another. Alice discovered her passion for natural birth, and her confidence to be able to do so. Joyce discovered that she wanted the most specialized medical care she could receive from an OBGYN and from scheduled C-sections for her subsequent pregnancy. The inherent part of both of their stories is that the choice itself, whatever the choice might be, was unavailable to them because they did not know that they even had a choice.

The experiences of Alice and Joyce are commonplace and reflect bigger issues within the world of labor and delivery surrounding choice, informed consent, and shared decision making. Moore (2016) explores the idea of the "framing effect" which is an intentional or unintentional framing of medical information that reduces shared decision making by overstating the importance of the physicians' information or opinion over the importance of the patients'. Moore explains that a "clinician's framing of information and the patient's inherent trust in clinicians influences the decision-making process... [which calls] into question whether informed, shared decision making has actually occurred if bias has been introduced into the discussion" (Moore 2016, 219-220). This is especially true for Joyce's case in that the primary care provider who oversaw her prenatal period never offered other care options for Joyce; by leaving out valuable information about the options for care, Joyce was unable to take part in a shared decision making process and unable to truly give informed consent since the process relies on physician mediated "mutual sharing of information [which] occurs over the time to facilitate patient

autonomy in making choices as opposed to treating it as a signature on a form" (Moore 2016, 220).

Comparatively, Alice differs from Joyce because she actively tried to educate herself more about pregnancy and birth by looking up C-section rates and interviewing providers. And while she didn't know as much about natural birth as she does now, she still had some more clear ideas as to what she wanted in a birth plan and provider. The evidence backs up Alice that there are a large percentage of medically unnecessary C-sections performed in the United States each year (Gibbons et al 2010), and Alice did get farther than Joyce in the shared decision-making process. Yet, Alice still found herself wishing that she had known more and done more during her first pregnancy.

All of this begs the question: what is it that people need to know about pregnancy and birth, and how do we make it as easy as possible for the exchange of that knowledge? Because as Alice would say, "just to research everything you can because your doctor is not going to tell you anything." When you unravel the pieces of the narratives, and examine the evidence, Alice and Joyce were both failed by a system in which they and their providers operate on a hierarchical care model that simply is not built on shared decision making or informed consent. A system that does not prioritize the patient's values, thoughts, feelings, opinions, does not test the boundaries of what that person already knows, and fails to offer an equal relationship.

Macdonald (2018) beautifully gets at the heart of this by outlining the difference between informed consent (a more cut and dry legal proceeding to protect patient and provider) and informed choice (a midwifery rooted, fundamentally different way of caring). Macdonald (2018, 287) also explains that the difference arises because "informed consent is circumscribed by the way that medicine is typically practiced—short appointments, doctor-patient hierarchy, and limited continuity of care." In other words, the way the westernized healthcare system is built is simply not conducive to the level of care that could prevent traumatic births arising from issues of knowledge and shared decision making. Additionally, Macdonald says "what counts as authoritative knowledge in informed consent versus informed choice in midwifery care differs. With the former, patients listen to health care providers impart information—evidence and clinical options—in an accessible way and then make a choice. The latter involves this too, but midwives also grant authority to other kinds of knowledge—a woman's own knowledge, feelings, and past experience about her body and previous pregnancies as well as her lifestyle and moral or religious orientation" (2018, 287). Thus, traumatic births are born when someone's own personhood is forgotten in the clinical exchange.

2. "Everybody tries to figure out why it happens:" Medical Interventions and Complications

Charlotte's Insights:

"So I had no idea what had happened to me."

Alice's Insights:

"I mean, I feel like the reason it was traumatic was because they did listen to me. I mean, I told them I wanted the epidural, I said I wanted it. I was like, begging for it."

"I almost had to have a C-section, that was pretty upsetting."

Joyce's Insights:

"They rush me into surgery and I'm on my hands and knees with her hand up inside of me. I didn't even know until I went to nursing school what had happened because nobody mentioned this to me."

"I just thought he was dead so I didn't ask. I didn't, you know, that's not something you want to ask. So I just, I just assumed that was what was going on. And yeah. They were just rushing around, nobody really said anything about anything. Nobody told me it was going to be okay."

All three participants experienced some form of medical intervention or complication that impacted their birth experience. For Charlotte, it was an unpreventable, medical emergency that nearly killed her and her baby. For Alice, the fact that she asked for an epidural, even though she initially didn't want one, was traumatic, as well as the fact that she almost had to have a C-section. And for Joyce, the majority of the distress she felt during the medical complication was the result of a lack of communication; no one had bothered explaining what was happening.

Once again, these narratives offer very different insights into medical complications and interventions. For some, it could not be prevented, but for others, the trauma itself could have definitely been circumvented.

The categories focused on communication and empathy, the aftermath, and empowerment further explains ways that medical interventions and complications can be addressed by providers in the moment, as well as by women after the fact.

3. "They don't have a very good bedside manner I guess:" Communication and Empathy

Alice's Insights:

"Some of the nurses were really rude. Nurses when you're in labor are rude. They all are. I wish I told them to just not talk. Just come in, don't say anything, just don't talk to me."

"My second labor I waived literally everything. Like I didn't have an IV, I didn't have an epidural, I didn't have anything and they were like 'okay well if your baby dies then it's not on us' ... they don't have a very bedside manner I guess. They didn't feel very sympathetic. That was both times. But the second time one of them held my hand so that was kind of nice. She was pretty nice. And then after the fact they're as sweet as can be, but when you're in labor it's like, I don't know."

Joyce's Insights:

"So I think that this baby is dead because no one cared to tell me that he was alive. So...they get me in there and go in and open up and I hear him cry. And that's like what, 30-45 minute period that I think this baby is dead."

"I watched my provider as he flatlined, I watched her, the person I'm supposed to be looking to for like, confidence, her back away. And stand in the corner."

Alice and Joyce are the two participants who had the most to say about the communication skills of the healthcare professionals surrounding them during birth. Alice speaks of the rudeness of nurses, whereas Joyce speaks on the lack of clear communication about the specifics of her situation. Recall Elmir's (2010) similar findings of women feeling invisible and Murphy's (2018) emphasis on the removal of the woman from the labor itself, to the point of disembodiment. Murphy's selected quotes pair well with Joyce's experience, in that both narratives centered around the exclusion of the woman in medical conversations. Joyce, like other women, was never even informed on the problem at hand.

What Alice's and Joyce's experiences ultimately point to is that routine occurrences for staff during labor (a relatively normal labor, a labor with some elevated risk such as a cord prolapse) is not in the least bit ordinary to the patient. A person during childbirth is extremely vulnerable, in the sense that they are yielding control of their bodies to nature (and a lot of the times to the healthcare provider) and in the sense that they are about to meet their child for the first time. Pregnancy and birth is typically highly significant for a

variety of reasons, yet the communication of staff exploits the vulnerability of people doing labor, disregards empathy, and sets patients up for trauma.

At its best, poor communication is an annoyance. At its worst, poor communication (or lack thereof) is the direct cause of extreme terror and trauma. Even in a medical emergency, people in labor are still in charge of their bodies and still deserve informed consent and choice. This is ethically, and lawfully, the truth (Stohl 2018). But how can this be observed and honored without clear communication, unwavering empathy, and constant obedience to best protocols and practices?

4. "Choice is yours:" Choices and the Aftermath

Charlotte's Insights:

"I was terrified. There were days that I thought 'what have I done?' and then there were days that I was like 'okay God's got this' you know, there were just always some...now I always tried to keep thinking you know, God's in control, he's got this, he brought me through the first one, he's going to take care of this one. Don't get me wrong, there were some days that I would just sit there and cry because I'd be like, you know, what if something happens, here I'm leaving two kids and a husband. Um, but most of the time it was all positive. I just kept thinking God was going to take care of me. And that's what he did."

Alice's Insights:

"The second time for sure. I went in there and I was like, I'm having a natural birth or I'm having it at home. Choice is yours. And my doctor, he was really really supportive. I had a traumatic birth the first time and then a dream birth the second time.

Joyce's Insights:

"[The traumatic birth] did make me have a scheduled C-section the next time. Not because I had to, [but] because I was scared to death to go through what I had went through. So I obviously went to a different, or you know a regular OB doctor that I made them schedule. They didn't really want to, but I was like, I'm not doing this again. I'm not."

"I don't think I would have been okay any other way because I was terrified when I got pregnant again. "

All three participants chose to have more children after their initial traumatic birth experience. Likewise, all three participants altered their health choices due to the traumatic experiences. Common threads that tie all three participants together are that: 1) They sought out further information or help, 2) They were all afraid to get pregnant again, and 3) They made different choices than the first time.

One ethnographic study that delves further into this occurrence finds that people typically focus on avoiding a repeat of the traumatic experience and seeking control in their birth plans and bodies by researching and communicating more with providers (Greenfield et al 2019). What is worth pointing out is that lack of access to easy information and lack of

communication with health providers were precursors to traumatic birth in the first place; simply by looking at what women choose during a second pregnancy already reveals so much about why traumatic births occur in the first place. If this process could be done easily by people for their first pregnancy, their first delivery, and if these components were tied into the foundation of healthcare and practices itself, then they wouldn't feel so much intense and long lasting terror because they never would have had that traumatic birth.

5. "I'm an intelligent person:" Empowerment in the Wake

Charlotte's Insights:

"So now I belong to a group on Facebook... we have shirts and stuff that we wear in honor of that day."

"These women are all over the world that are on there [the Facebook page]."

"I think the other day a girl posted. She had just been home a month after having one and was terrified and cried the whole time and was asking 'is this normal?' So yes, it's great to have those people out there who have been through it. And then there are people in the group who are their mothers or their fathers or their husbands, that you know, the wife passed away while giving birth. So you know, it's good to see their view on it as well."

Alice's Insights:

"Girl, you've got to look up Ina May, look up Ina May and the woman's guide to childbirth or something, I read that book. It's, oh, it's really good."

"Okay, well it's like exercises you can do to encourage the right positioning for your baby and to speed up your labor and stuff."

"Yeah! I feel like I know a lot about birth. Like maybe I don't but, I don't know. I've done a lot of research."

Joyce's Insights:

"But you also learn from your mistakes and move on."

"I think it's (being a nurse) the only reason I know that I don't blame anyone really. I said those nurses on the floor knew their jobs, knew what to watch for, because as a nurse, a lot of times we're a lot more aware of what's going on with our patients than the doctors are because we're here and we're watching, so I really do trust those nurses were really watching my baby and me and had monitored everything."

All three participants not only found ways to cope with their experiences, but they found ways in which to use that specific experience to empower themselves and others. Charlotte joined a research and support group, which gives her an extensive network of other people who have gone through what she had to go through. Not only is this helpful for Charlotte to be part of a group that commemorates and honors those lost from the condition and raises awareness, but it is helpful for Charlotte because she knows that she can give back to others by offering her own perspective and support.

Alice also ended up researching a lot after the birth of her first child and is very passionate about the self-education she has done about natural methods and childbirth.

She is empowered because she knows a lot more about what she can do in the future to have her ideal pregnancy and birth and she is eager to share that information with others.

As for Joyce's empowerment, it arises from the knowledge that she gained years after the birth once she went to nursing school. Joyce was not only able to make different decisions about birth with her future children, but she was also able to learn more about the intricacies of being in the medical field; she could look back on the event and know that she really was taken care of, or at least physically speaking.

This empowerment after a traumatic birth stands out as incredibly important: to make yourself feel seen after once feeling invisible, to make yourself knowledgeable after once feeling uneducated, to make yourself feel some peace after once feeling none, and to make yourself heal after once being hurt. Beck (2005) highlights the many reasons why people share their traumatic birth stories. The answers she received were all rooted in empowerment of self and others.

Future Directions and Conclusion

There were many limitations to this research project, including the small number of participants (3) and the exclusion of some interested participants due to prior existence of a mental health problem such as PTSD. By excluding people with PTSD specifically (self-diagnosed or otherwise) a valuable perspective on traumatic births has been lost to this research. And the small sample size only offers three perspectives out of the sea of many.

This paper, while offering an abridged version of these stories in full, only scratches the surface of the importance of these stories. The importance of understanding what it is like to have a medical complication or intervention, the insight into what poor communication and bedside empathy can wrought, the importance of knowledge and access to that knowledge, the aftermath, and the empowerment following that is only touched on briefly here. But what it can help us conclude is that:

1. Understanding common and unique threads of birth experiences is important for validating people's experiences.

Recalling the "experience-near" framework and Cooke's (2020) question, "What does childbirth mean, and what does it do to the person who gives birth?" also points us back to Cooke's (2020) other assertion that we culturally have "the need to provide a reason for her story to be important." Charlotte, Alice, and Joyce all have unique answers to the first question. And maybe even more importantly, their stories and experiences have value and merit in their entirety. In the undissected, full narrative form, there lies a deep and true vulnerability, a chance for them to make their own meanings, and a chance for readers to decipher their own.

2. A westernized, hierarchical model of care can create power imbalances and environments that are not conducive to consent, communication, empathy, and best practices when it comes to birth experiences.

Some traumatic birth experiences happen or are made worse by the way our healthcare system is set up, particularly when it comes to care for women and other pregnant people. There are a multitude of healthcare recommendations, and I'll just touch on a few here: taking a trauma informed care approach to all patients, adapting a midwifery/doula model

of care at all levels, more mass education of birth options to people, better support for pregnant people in the public health sphere, providing multiple diverse care providers to patients, and a lot more.

3. Even when traumatic birth experiences cannot be prevented, there are still extremely important components of aftercare that need to be addressed.

These three participants commented on how traumatizing and difficult it was to deal with what happened afterwards. Joyce stated that she did not fully process the trauma until well after the event, and both Joyce and Charlotte experienced fear with their decision of having more children. None of the participants were offered or sought out mental health care in the aftermath, even though it could have helped them navigate the difficulties of processing their emotions and being able to navigate future decisions about family planning as well. It was also difficult on their partners and their friends and families who took care of them in the aftermath as well. Both Charlotte and Alice specifically commented that the event was traumatizing for their husbands. Social support systems were extremely helpful in Charlotte's case, but when these are lacking, or when the partners, friends, and family themselves are emotionally affected by the birth, these sources of strength can be depleted. Accessible mental health care needs to be available in these cases.

4. There needs to be more room in our society and culture to talk openly about birth experiences that are traumatic.

Not all birth experiences are the best day of people's lives. Culturally, we like to talk about pregnancy and birth as if it is a positive, lovely experience of a lifetime, full of strife and work but worth it in the end, but it is not always. And some people are made to

feel like failures in their own bodies due to medical complications or ways that births happen. Women's bodies (and other bodies capable of becoming pregnant) do not exist in isolation. They exist within specific societies, cultures, values, beliefs, and opinions in the health, political, social, and cultural spheres that have an impact on the experience of pregnancy and labor.

5. All traumatic healthcare experiences need more research done on the causes, and ways to prevent future traumas.

Traumatic experiences do not stop at childbirth. There are a multitude of other vulnerable populations that experience traumatic healthcare experiences as well, such as the LGBTQ+ population or BIPOC groups. While these groups do intersect with experiences of traumatic births, there are also ample opportunities for traumatic healthcare experiences outside of the sphere of birth. What this research really reveals is that these stories deserve to be told, and action needs to be taken to prevent poor healthcare encounters in the future.

This research also opens the door for a lot of future research that needs to be done. Looking at Kentucky specifically, it would be worthwhile to do larger scale studies to better examine risk factors (geographic location, race, and income level specifically) as it pertains to traumatic birth. Additionally, a more rigorous study of qualitative interviews, combined with participant observation, and perhaps an examination of Kentucky birth stories told on the Internet would provide a lot of valuable information. Finally, this research did not include participants who gave birth during the COVID-19 pandemic, which opens up a world of investigations into how pregnancy and birth experiences are

altered during a pandemic, what that does to people and their families, and how it pertains to traumatic births.

References

America's Health Rankings. 2021. "Annual Report." *United Health Foundation*, 2021. Accessed [March 24th, 2021]. https://www.americashealthrankings.org/explore/annual/measure/Overall_a/state/KY

Beck, Cheryl. 2006. "Pentadic Cartography: Mapping Birth Trauma Narratives." *Qualitative Health Research* 16 (4): 453-466. 10.1177/1049732305285968

Beck, Cheryl. 2005. "Benefits of Participating in Internet Interviews: Women Helping Women." *Qualitative Health Research* 15 (3): 411-422. 10.1177/1049732304270837

Callister, Lynn Clark. 2004. "Making Meaning: Women's Birth Narratives." *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 33 (4): 508-518. 10.1177/0884217504266898

Center for Disease Control and Prevention. 2020. "Pregnancy Mortality Surveillance System." Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm

Choi, K. R., Records, K., Low, L. K., Alhusen, J. L., Kenner, C., Bloch, J. R., Premji, S. S., Hannan, J., Anderson, C. M., Yeo, S., & Cynthia Logsdon, M.. 2020. "Promotion of Maternal-Infant Mental Health and Trauma-Informed Care During the COVID-19 Pandemic." *Journal of Obstetric, Gynecologic, and Neonatal Nursing* : JOGNN, 49(5), 409–415. https://doi.org/10.1016/j.jogn.2020.07.004

Cooke, Julia. 2020. "Intimate Odyssey: Modern Motherhood and the Birth Narrative." Virginia Quarterly Review 96 (4): 26–37. https://search-ebscohost-com.libproxy.eku.edu/login.aspx?direct=true&AuthType=ip,uid&db=asn&AN=147523786&site=eds-live&scope=site.

Department for Public Health Division of Maternal and Child Health. 2008. "Kentucky Pregnancy Risk Assessment Monitoring System (PRAMS) Pilot Project 2008 Data Report." *Kentucky Cabinet for Health and Family Services.* 1-83.

Division of Maternal and Child Health. 2020. "Maternal Mortality Review 2020 Annual Report." Kentucky Department for Public Health, 1-12.

Division of Maternal and Child Health. 2020. "2020 Maternal and Child Health Needs Assessment Survey." Kentucky Cabinet for Health and Family Services, 1-6.

Elmir, Rakime, Virginia Schmied, Lesley Wilkes, and Debra Jackson. 2010. “Women’s Perceptions and Experiences of a Traumatic Birth: A Meta-Ethnography.” *Journal of Advanced Nursing* 66 (10): 2142-2153. http://dx.doi.org.libproxy.eku.edu/10.1111/j.1365-2648.2010.05391.x

Furuta, Marie, Jane Sandall, and Debra Bick. 2014. “Women’s Perceptions and Experiences of Severe Maternal Morbidity- A Synthesis of Qualitative Studies Using a Meta-Ethnographic Approach.” *Midwifery* 30 (2): 158-169. http://dx.doi.org/10.1016/j.midw.2013.09.001

Gibbons, Luz, José M. Belizán, Jeremy A. Lauer, Ana P. Betrán, Mario Merialdi, and Fernando Althabe. 2010. "The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed Per Year: Overuse as a Barrier to Universal Coverage." *World Health Report* 30 (1): 1-31. [Accessed February 01, 2020].

https://www.researchgate.net/profile/Jose_Belizan/publication/265064468_The_Global_Numbers_and_Costs_of_Additionally_Needed_and_Unnecessary_Caesarean_Sections_Performed_per_Year_Overuse_as_a_Barrier_to_Universal_Coverage_HEALTH_SYSTEMS_FINANCING/links/549d75b30cf2fedbc31193f5/The-Global-Numbers-and-Costs-of-Additionally-Needed-and-Unnecessary-Caesarean-Sections-Performed-per-Year-Overuse-as-a-Barrier-to-Universal-Coverage-HEALTH-SYSTEMS-FINANCING.pdf

Greenfield, Mari, Julie Jomeen, and Lesley Glover. 2019. "'It Can't Be Like Last Time'-Choices Made in Early Pregnancy by Women Who Have Previously Experienced a Traumatic Birth." *Frontiers in Psychology* 10: 1-13. 10.3389/fpsyg.2019.00056

Hansen, Anna, and Mairead Moloney. 2019. "Pregnancy-Related Mortality and Severe Maternal Morbidity in Rural Appalachia: Established Risks and the Need to Know More." *Journal of Rural Health* 36 (1): 3-8. 10.1111/jrh.12383

Horstman, Haley Kranstuber, Jenn Anderson, and Rebecca A. Kuehl. 2017. "Communicatively Making Sense of Doulas within the U.S. Master Birth Narrative: Doulas as Liminal Characters." *Health Communication* 32 (12): 1510-1519. 10.1080/10410236.2016.1234537

Hung, Peiyin, Carrie E. Henning-Smith, Michelle M. Casey, and Katy B. Kozhimannil. 2017. "Access to Obstetric Services in Rural Counties Still Declining, With 9 Percent Losing Services, 2004-14." *Health Affairs (Project Hope)* 36 (9): 1663-71. 10.1377/hlthaff.2017.0338

Johnson, Tahra. 2019. "Maternity Care in Crisis: American Women are Dying from Childbirth at a Higher Rate than in any other Developed Country." *State Legislatures* 45 (1): 16-19. [Accessed February 02, 2020].

https://eds-a-ebscohost-com.libproxy.eku.edu/eds/pdfviewer/pdfviewer?vid=1&sid=16e369 cc-38fe-464f-b4b6-33cd9947c846%40sessionmgr4007

King, Jeffrey C. 2012. "Maternal Mortality in the United States-Why Is It Important and What are We Doing About It?." *Seminars in Perinatology* 36 (1): 14-18. https://doi.org/10.1053/j.semperi.2011.09.004

Macdonald, Margaret E. 2018. “The Making of Informed Choice in Midwifery: A Feminist Experiment in Care.” *Culture, Medicine, & Psychiatry* 42 (2): 278-294. https://doi.org/10.1007/s11013-017-9560-9

Moore, Jennifer. 2016. “Women’s Voices in Maternity Care: The Triad of Shared Decision Making, Informed Consent, and Evidence-Based Practices.” *The Journal of Perinatal & Neonatal Nursing* 30 (3): 218-223. http://dx.doi.org.libproxy.eku.edu/10.1097/JPN.0000000000000182

Murphy, Helen, and Joanna Strong. 2018. “Just Another Ordinary Bad Birth? A Narrative Analysis of First Time Mothers’ Traumatic Birth Experiences.” *Healthcare for Women International* 39 (6): 619-643. https://doi.org/10.1080/07399332.2018.1442838

Owens, Deirdre Cooper, and Sharla M. Fett. 2019. “Black Maternal and Infant Health: Historical Legacies of Slavery.” *American Journal of Public Health* 109 (10): 1342-1346. 10. 2105/AJPH.2019.305243

Reed, R., Sharman, R., & Inglis, C.. 2017. “Women's Descriptions of Childbirth Trauma Relating to Care Provider Actions and Interactions.” *BMC Pregnancy and Childbirth*, 17(1), 21. https://doi.org/10.1186/s12884-016-1197-0

Rodríguez-Almagro J, Hernández-Martínez A, Rodríguez-Almagro D, Quirós-García JM, Martínez-Galiano JM, Gómez-Salgado J. 2019. “Women's Perceptions of Living a Traumatic Childbirth Experience and Factors Related to a Birth Experience.” *Int J Environ Res Public Health.* 16(9). Published 2019 May 13. doi:10.3390/ijerph16091654

Sheffield, Karen Miles. 2014. “Step 3: A Mother-Friendly Hospital, Birth Center, or Home Birth Service 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.” In *How to Become Mother-Friendly: Policies and Procedures for Hospitals, Birth Centers, and Home Birth Services.*, edited by Barbara A. Hotelling and Helen A. Gordon, 19–23. New York, NY: Springer Publishing Co.

Stohl, Hindi. “Childbirth Is Not a Medical Emergency: Maternal Right to Informed Consent Throughout Labor and Delivery.” 2018. *Journal of Legal Medicine* 38 (¾): 329-353. https://doi.org/10.1080/01947648.2018.1482243

Vedam, Saraswathi, Kathrin Stoll, Marian MacDorman, Eugene Declerq, Renee Cramer, Melissa Cheyney, Timothy Fisher, Emma Butt, Y. Tony Yang, and Holly Powell Kennedy. 2018. “Mapping Integration of Midwives across the United States: Impact on Access, Equity, and Outcomes.” *PLOS One* 13 (2): 1-20. https://doi.org/10.1371/journal.pone.0192523

Wolf, Jacqueline H. 2018. *Cesarean Section : An American History of Risk, Technology, and Consequence*. Baltimore, MD: Johns Hopkins University Press.