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The Journey towards Resilience following a Traumatic Birth: A Grounded Theory

Abstract

Statistics have shown that up to 30% of women experience birth as traumatising. However, most women do not go on to develop post-traumatic stress disorder (PTSD), and instead appear to be resilient. Research is still sparse in the field of traumatic birth and resilience, and it is not known how women develop resilience after a traumatic birth.

Objectives: The aim of this study was to understand the process of fostering resilience after a traumatic birth.

Method: Semi-structured interviews were conducted with eight female participants aged 30 to 50 years who experienced a traumatic birth. A constructivist grounded theory was used to analyse interviews.

Results: Two main themes were identified which were developed into an emergent model: 1) the feeling of powerlessness during a traumatic birth; and 2) the journey towards resilience. The powerlessness of a traumatic birth was related to a perceived lack of voice and abandonment by healthcare professionals. The model revealed that women's journey towards resilience was aided by both internal and external resources that included healing self-care and ownership of the role of mother; and drawing upon faith, spirituality and supportive relationships.

Discussion: The findings suggest resilience is a process whereby women draw upon internal and external resources or both at different points in their journey. The implications of the findings include training healthcare professionals in communication to avoid trauma during labour; and prompting women to identify and utilise both internal and external resources to help them to overcome any trauma.

Keywords Traumatic Birth, Resilience, Birth Trauma, PTSD, Perinatal mental health, Grounded Theory, Qualitative Research

The Journey towards Resilience following a Traumatic Birth: A Grounded Theory

The birth of a child is a key life event for many women. With support and care during labour and birth, this can be described as a moment of great joy and fulfilment (Nelson, 2003). However, some women experience the birth of their child as deeply distressing. An estimated 20–30% of women will have a birth experience that they appraise as being psychologically traumatic (Alcorn et al., 2010; Ayers et al., 2008; Creedy, Sochet & Horsfall, 2000; Soet, Brack & Dilorio, 2003). This can occur for many reasons, including labour complications, a lack of control, or not feeling supported (Hollander et al., 2017), or because a woman may fear that she or her baby may die or be severely injured during birth (American Psychiatric Association, 2000; Hollander et al., 2017). The experience of birth as traumatic has been associated with poorer psychological outcomes for mothers, with an estimated one in four women with this experience going on to develop post-traumatic stress disorder (PTSD) (Dikmen-Yildiz, Ayers & Phillips, 2017a). Further, PTSD has been found to be co-morbid with postnatal depression in some women (Dikmen-Yildiz, Ayers & Phillips, 2017b; Zaers, Waschke & Ehlert, 2008). As poor maternal mental health can negatively impact on childhood attachment (Barnes & Theule, 2019) and child development (Oyetunji & Chandra, 2020), it is important to ensure those who experience a traumatic birth are well supported (Thomson et al., 2021).

Research has identified four potential psychological pathways following a traumatic birth (Dikmen-Yildiz, Ayers & Phillips, 2018; Kim et al., 2015). These are: 1) “Resilient” women who experience a traumatic birth but do not meet diagnostic criteria for a psychological condition (Alcorn et al., 2010; Coates, Ayers & de Visser, 2014; Dikmen-Yildiz et al., 2018; Greenfield, Jomeen & Glover, 2016); 2) “Recovered” women who have trauma symptomatology at 4–6 weeks after birth but where this is resolved some months following the traumatic birth (Haagen et al., 2015; Kim et al., 2015); 3) “Delayed PTSD”,

where the onset of trauma symptoms occurs some time following the traumatic birth (Kim et al., 2015); and 4) “Chronic PTSD”, where PTSD symptoms develop, continue and worsen over time (Alcorn et al., 2010; Sentilhes et al., 2017; Zaers et al., 2008). This raises the question as to why some women do not experience ongoing distress, whilst for others, the distress continues.

Women who have a traumatic birth but do not go on to develop PTSD are less likely to suffer from complications during birth, after birth, or with their infant (Dikmen-Yildiz et al., 2018). Several risk factors to developing chronic or delayed PTSD have been identified, including previous abortion, previous postpartum haemorrhage, low haemoglobin levels after birth (Sentilhes et al., 2017), poor satisfaction with healthcare professionals, and pre-term birth or caesarean birth (Dikmen-Yildiz et al., 2018).

In addition to birth events, psychological factors also play a part in the psychological pathway women follow. For example, bad memories of the birth in the early postnatal period (Sentilhes et al., 2017) or more severe anxiety or depression symptoms in pregnancy or at 4–6 weeks after birth (Dikmen-Yildiz et al., 2018) are associated with the development of chronic or delayed PTSD. Furthermore, a cohort study identified that women who experienced self-blame, rumination and perception of loss were more likely to have more severe PTSD symptoms (Tomsis et al., 2018). Another study found that mothers of infants hospitalised in the Neonatal Intensive Care Unit (NICU) were more likely to have PTSD if they engaged in denial, and behavioural and mental disengagement (Aftyka et al., 2017). On the other hand, women who reported good social support were more likely to be described as resilient (Dikmen-Yildiz et al., 2018).

Resilience is a psychological term that reflects one’s ability to rise above adversity, and adapt or adjust to new challenges (Aburn, Gott & Hoare, 2016). Researchers define this as a multifaceted process, active in multiple different systems including individual (self-

esteem, optimism), social (positive family relationships), and environmental (financial resources) systems (Young, Roberts & Ward, 2019).

There is little research, however, that focuses on resilience in the perinatal period (Ayers, 2017; Ayers & Sawyer, 2019). Available research suggests resilience can be a protective factor which shields women from experiencing psychological distress. For example, Mautner et al. (2013) found that in women with pre-eclampsia, those who had high levels of resilience were less likely to be depressed, and were more likely to have a better quality of life. Furthermore, resilience is a characteristic demonstrated by women who have survived traumatic experiences related to their baby, such as infant death, or having an infant in the NICU (Kaye et al., 2014; Rossman et al., 2017). Additionally, one US study of over 1,300 women found that those who were identified as resilient were characterised by having low levels of depression and stress, and high levels of support and self-efficacy (Maxson et al., 2016).

Although these studies offer some insight into women's ability to become resilient following adverse complications during birth, they do not provide an extensive understanding of this process or the resources women rely upon to help them become resilient. As resilience is a protective factor in the prevention of PTSD (Kaye et al., 2014; Mautner et al., 2013; Rossman et al., 2017), it is important that we understand how women develop resilience after a traumatic birth. This has the potential to provide key insights for the prevention of PTSD development. Therefore, the aim of this study is to understand the process of women becoming resilient and to identify which resources women utilise as a way of positively adapting after a traumatic birth.

Method

Design

This was a qualitative interview study about the resources women utilise as a way of adapting following a traumatic birth. Grounded theory was selected as the best methodological fit to explore the phenomenon as the aim of grounded theory is to construct theory where little is known about the area (Charmaz, 2014).

Ethical considerations

Ethical approval was given by City, University of London, Department of Psychology Ethics Committee. Participants were anonymised by use of pseudonyms, and all identifying information was removed. All data was stored in line with the Data Protection Act 2018 and City, University of London's data protection policies.

Participants

Participants were recruited using a snowball technique through word of mouth, and advertisements via the National Childbirth Trust website. All participants in the study were women who viewed themselves as resilient from their experience of a traumatic birth. Women over 18 years who classified themselves as having overcome the experience of a traumatic birth were invited to participate. These traumatic experiences varied, and included still-birth, pancreatitis, pre-eclampsia, placenta abruption, haemorrhaging, feeling violated and perceived lack of care. Participants were excluded if they had given birth within the previous year, viewed themselves as experiencing postnatal depression and/or were currently experiencing PTSD symptoms such as flashbacks, avoidance or hyperarousal.

Eight British women were included in the analysis, as can be seen in Table 1. Ages ranged from 30 to 50 years ($M = 41.34$ years; $SD = 6.32$). The majority of the participant sample self-identified as White British, with two identifying as Black British. Time since

traumatic birth ranged from 6 to 15 years ($M = 8.75$ years; $SD = 2.96$). Five of the women were employed outside of the home.

Data collection

A semi-structured interview of 11 questions was designed to elicit discussion on what helped women become resilient following their traumatic birth experience. Interviews were carried out by AB, a Black British counselling psychologist with personal experience of a traumatic birth.

Participants signed a consent form prior to the interview, and all interviews were conducted in participants' homes. Interviews were recorded using a digital voice recorder and lasted 60 to 90 minutes. Notes were not taken during the session to avoid interrupting the flow of the discussion. At the end, participants were asked to reflect on their feelings about participating in the interview and any potential bias AB may have brought to the interviewing process was recorded.

Data analysis

All interviews were transcribed verbatim by AB and were double-checked against the audio recording. The analysis was completed using handwritten notes and Microsoft Word. Analysis was based on Charmaz's (2014) version of Constructivist Grounded Theory. The initial phase began with line-by-line coding, which allowed the researcher to identify participants' implicit and explicit statements. After this, focused coding helped the development and identification of the most prominent codes, which helped condense and sharpen the emerging analysis. Finally, theoretical coding was used, which advanced analytic thinking by focusing on and searching for significant categories that developed into emerging theory.

To minimise potential interviewer bias, memos were used throughout to capture thoughts, and help guide the research direction. Memo writing provided the researcher with

the opportunity to develop new ideas whilst engaging in critical reflexivity (Charmaz, 2014). Further, reflection was carried out with JJN where coding and themes were discussed. Two participants were also contacted for member validation, and both agreed that the results captured the process of their journey towards resilience.

Results

Two themes were identified which were developed into an emergent model that can be viewed in Figure 1: 1) the feeling of powerlessness during a traumatic birth; and 2) the journey towards resilience.

Theme One – The feeling of powerlessness during a traumatic birth

Women constructed their birth experience as traumatic due to various struggles they experienced. Within this major theme of powerlessness, there were three sub-themes: 1) Am I worthy of care?; 2) Who's accountable?; and 3) Do you have my consent?

Am I worthy of care?

Participants described feeling unworthy of care by healthcare professionals during and after labour, which they believed contributed to their trauma. Participants described healthcare professionals as ignoring essential information, not being supportive and not listening to their concerns or acknowledging their pain and distress. This made them feel insignificant and unworthy:

Although I was in excruciating pain ... they didn't even bother to read my notes that the doctor had made me carry around. They still sent me home again ... They still hadn't picked up that the womb wasn't reacting as it should do, and the doctor had written on my notes that if it went on for more than four hours ... that I was going to have a Caesarean ... (Jenny)

A common experience among most participants was a feeling of “not knowing” or “not understanding” what was happening to them and their baby during labour. They could

sense something was wrong, but did not have the knowledge or experience to understand or communicate, or to be heard. The lack of two-way communication and understanding left women feeling extremely vulnerable. They were terrified, and felt they did not matter:

I was lying there by myself for about half an hour. And then someone came back, wheeled me into theatre, and then they did the operation. No one was explaining what was happening. (Onika)

Who's accountable?

Participants felt unable to take care of themselves or their baby, and relied on the guidance and support from health professionals. However, when complications occurred, this support was compromised, leaving them feeling frightened, that no one was responsible, and that no one was in charge.

I know something's wrong. And basically erm, they all leave the room. I'm still screaming ... She [the health professional] looks and she goes, "oh my God – the baby's on the bed". I'd delivered by myself ... We were told he wasn't gonna last the week ... (Rhianna)

The perceived lack of care and communication led to feelings of powerlessness, which made the women question whether the complications they experienced could have been avoided:

You know, they could have been more careful. They could have checked, they could have not left me with a student nurse who didn't know what to do. Someone should have been there to take my hand and say, "You know what? You're losing too much blood." And I should have been seen before I lost that amount of blood. (Onika)

Do you have my consent?

Giving birth is an emotional and personal experience, involving invasive experiences that are unlike other medical interventions. Women experienced the midwives as invading their bodies without discussion or consent. This made them feel invisible, powerless and – at times – violated, as Laura describes during her experience of having her waters broken:

I mean you're not supposed to say, "I'm going to break them anyway." You're supposed to say, "Right, we need to sit up and have a discussion about this." And wait five minutes [laughs]. Not in the middle just get the hook out. I mean I looked away at that point because I knew what she was going to do. It was done without consent. At that point I think I just felt completely violated. Because somebody had just done something without asking me, and it's kind of ... (pauses). (Laura)

The lack of communication and consultation experienced by participants removed their choices and sense of control. At times, some found it difficult to trust the actions of health professionals, such as with Laura's experience of trying to stop the hormone drip to induce labour:

I said "I'd rather you'd turned it [induction of labour hormone drip] off", ... And she said, "But I turned it off", and I said, "No you haven't, I can see you haven't!" And she said, "Yes, I have!" And there's nothing I could do about it. (Laura)

Some participants were aware that their birth complications could mean that their death was a possibility – a permanent outcome, and terrifying prospect, yet something they had no control over.

And then they were like, "I'm sorry ..., we have to take you into theatre. We've got to stop this bleed." ... literally raced me off into theatre. I just

thought, “Right okay, if I’m going to die ... Well there we go.” There was nothing that I could do. (Lorna)

Theme Two - The journey towards resilience

Participants described how they were able to make the journey towards resilience following their traumatic birth experiences. From their feelings of powerlessness, they were able to move forward by drawing upon external (faith and spirituality; supportive relationships) and internal (motherhood becomes you; self-care) resources in order to do so.

Moving towards faith and spirituality

External resources were utilised during points on the journey as a way of regaining control, feeling protected, and gaining a new understanding of their trauma.

Finding faith seemed to play a significant role in helping women process their moments of pain and abandonment, and make sense of their experience to help them move on. Extreme pain can transport women from not being spiritual to focusing on their faith as their key to survival:

Absolutely feeling alone. That terrible, terrible feeling of alone, I turned to God. I am not the most spiritual person I know. I’m not even the most orthodox person. And yet in that moment, I found my faith. In that moment and in the meditation the pain was ... I was almost like external from pain. I could disconnect my mind from my body almost. That’s what I did to preserve myself. (Rhianna)

Rhianna’s experience was typical, highlighting the extreme limits women reached after being unable to rely on the health professional for action and support. The resilience of the human spirit in such circumstances allowed participants to engage in self-preservation, which led to new strategies to manage their pain, trauma and distress. Women knew that they

had changed as a result, as highlighted by Deidre, who found comfort and strength despite the loss of her infant:

I'm a firm believer that everything happens for a reason – traumatic or otherwise. Finding my faith was a way of dealing with why it happened and also understanding where that baby might be now – happy, healthy. Happy, healthy, but living somewhere else in the spiritual sense. Taking that from my faith now makes you see it in a totally different way and makes you understand. And that gave me strength as well, um, because it gave me something to reflect upon. But yeah, finding my faith was a huge support. But I did that on my own. (Deidre)

Participants described an appreciation of life, having faced their own mortality, and perceived God as the giver and helper – responsible for them surviving their traumatic birth experience:

And during the whole time all I was thankful for was to God for giving me life. (Jenny)

Meditation, mindfulness and prayer were the actions in which participants were able to connect to and draw upon a higher spiritual power, giving themselves more strength:

I was in a meditation circle. That really helped. Just meditating and being who you want, you know, being me. (Jenny)

Meditative practices were described as bringing forth “natural” resilience, which suggests that women could find resilience within themselves by drawing upon spiritual practices.

Supportive relationships

Supportive relationships were another external resource in the model that helped women in their journey towards resilience. These relationships helped women regain

confidence and allowed them to slowly trust others again following their experience of being abandoned when they were at their most vulnerable. For example, Deidre recognised the central role that family support played in helping her to move forward:

One hundred percent my family. The support of my family, partner's family and my parents, my brother, was immense. One hundred percent wouldn't have got through it. And they were able to keep my spirits up and keep me going. I got through it through people caring. (Deidre)

It was notable that fathers were rarely mentioned during the occurrence of the trauma, perhaps highlighting that they were not physically available to women for support, and unable to be called upon as a resource during their medical emergency. However, it was clear that fathers were seen as a strength in terms of the compensatory roles they played on the return home, allowing women to regain their strength:

I didn't have to do very much, my partner took over. He cooks, he cleans. He took a paternity leave – so he took two weeks. (Onika)

Female friendships appeared to play an important role, seemingly helping these participants to reconnect with their sense of identity as women which was lost through traumatic birth experiences. Becoming sociable again helped women to awaken and regain parts of their inner self and identity, and friends helped put back together parts of the self:

I think Louise came around once and she had said, "Right. Get your lippy on, we're going out." And actually getting up and going out and being sociable again, and being me. (Jenny)

Those who had experienced similar trauma and loss were uniquely able to provide a sense of shared understanding that seemed validating. Finding these similar others in formal group settings, or more informally through social media, showed participants that although

they were alone and isolated during their traumatic experience, they were in fact not alone.

Others had experienced this, and had been able to find their own unique way through:

Just kind finding your tribe, finding a bunch of women locally. We all had the same sort of life view. That was supportive in that they were just there. I think having the confidence to go to a different place and think, "Okay these people are saying this ... I'm not sure that's quite right for me, but that's okay because I've taken something from it." And recognising that you are also on a bit of a journey. And you might on your journey stop at different places.
(Laura)

Talking about their struggles helped women find their voice and empowered them, which in turn allowed them to feel supported and less isolated.

Find someone, talk to someone about it. Um your friend might say, "Oh! I've been through that too" ... Because it is that knowing that you are not alone. When you're going through things ... You always think it is just you and when you feel it's just you, it seems ten times harder. (Lorna)

Motherhood becomes you

The process of resilience was also linked to internal resources women found in being able to incorporate the role of motherhood, which gave them a sense of purpose and helped them to continue to move forward. Women recognised that their role as a mother helped them to feel capable:

I realise that I am a lot stronger than I thought I was. I think I'm gonna be able to achieve something. I know I'm a lot more capable than I thought I was. And I think being a mother makes you very capable. And that's, erm resilience, I think, it's just a question of strength, I think. (Vivian)

But one doctor asked me a similar question. And I said to her because at the end of every day, I feel I've achieved something. I feel proud if my son is still alive. So I am a success every day because he's alive. (Rhianna)

While some women came to this realisation themselves, others only discovered their developing resilience when it was pointed out to them.

The first turning point was when I went to see the health visitor when [my daughter] Kendra was having an arterial check. And she said to me, "You're a model parent." (Jenny)

Being able to see their child survive – and thrive – was an important part of being able to move forward from their traumatic experiences:

But I think, and seeing Andrea every day. I sort of think, you know, wow, she's amazing. I think how tiny, tiny she was, when I first saw her ... and now she's like, really strong. (Vivian)

Participants now saw themselves as role models, which aided them in their journey towards resilience. Motivation to teach their children how to overcome challenging situations, which they hoped would promote resilience within their children, seemed to reinforce their own capacity to improve their lives:

I want to set an example for them, a role model for them. You know, that's part of my strengths of something to show them, that this is how you try to live your life in a positive way and joyful way. (Onika)

Self-care as a way of owning my journey

Self-care evolved as another internal resource in the model, which required women to become assertive by talking about their struggles, and looking after themselves. After moving towards faith, feeling empowered in their roles as mothers and receiving much support from

family, friends and social networks, participants described a renewed strength and desire to take back control of their life through the practice of self-care.

Women recognised that they went from feeling powerless and helpless, without a voice, to feeling assertive and empowered. Women now described having more confidence to trust in their own abilities, and not see healthcare professionals as “God-like” and all-knowing:

We [my partner & I] became assertive people, and no longer take it for granted. We no longer see a professional and think because they are a professional they're next to God. We use our common sense. We're both very, very, very bright so why we let them get away with what they did to us in the birth? I don't know. But now, we stand our ground. And we're not scared. (Rhianna)

In subsequent pregnancies, participants went from feeling silenced to using their voice to ensure they were listened to and understood, as described by Onika:

“Where are the midwives? Why am I giving birth alone?” And I shouted it over and over again. There was no way I was going to sit in silence. Because I just can't ... I thought for someone to take my life at that pace and say, “Her life doesn't matter, her pain doesn't matter.” It matters. And I make sure that people know it matters. For me, that's a very powerful thing – to have a voice. (Onika)

Upon reflection, participants felt that they needed time to be able to reflect and make sense of their experiences. Their experiences mattered – and *they* mattered. For example, Deidre spoke about the importance of taking the time and space to recover:

Take that time out. Because I know through other experiences, you throw yourself back into life and you just bottle it all up and you pop it away in this little box. You need to take that time to recover, understand, discover,

explore, and to be able to understand why it happened, how it happened.

(Deidre)

Taking back control of one's life and owning one's journey seemed to capture the whole journey towards resilience. Knowing that they could rely on themselves gave a sense of pride to these women and allowed them to feel empowered, despite their traumatic experiences. The overall journey was beautifully described by Rhianna, but was alluded to by all the women in this study:

This is my baby. This is my birth. This is my journey. Only I know how to look after myself. (Rhianna)

Discussion

The aim of this study was to understand the process of women becoming resilient after experiencing a traumatic birth. The analysis identified an emergent model with two main themes: 1) the feeling powerlessness during a traumatic birth; and 2) the journey towards resilience. Related to the theme of powerlessness, women questioned whether they were worthy of care and felt neglected and abandoned during their traumatic birth. Other research supports this finding, for example a meta-synthesis of women's traumatic birth experiences identified feeling "invisible" as contributing towards their birth trauma (Elmir et al., 2010). Further, a survey of over 700 women who experienced a traumatic birth found that many women's experiences were disregarded, for example, women stated that when they said they needed to push during labour this was ignored by healthcare professionals (Reed, Sharman & Inglis, 2017). This current study supports the existing literature in determining that perceived powerlessness is one of the key features leading to the development of trauma during complicated birth experiences.

Poor communication between healthcare professionals and women was also found to be a key factor in the development of birth trauma in this study. This finding is also reported by previous research. For example, a survey of over 2,000 women found that healthcare professionals not explaining things fully, and not listening to women, were key contributors to the development of birth trauma (Hollander et al., 2017). A lack of consent from women before healthcare professionals carried out procedures also explained birth trauma in the current study. Previous research has also supported this, with women having procedures performed on them without their consent being associated with birth trauma (Elmir et al., 2010; Rodríguez-Almagro et al., 2019).

During the experience of a traumatic birth, women in this study felt abandoned and alone, with their trust in others seemingly irretrievably broken. They appeared to have nowhere else to turn. Despite this, these women were able to utilise external and internal resources they did not know they had. Reaching out to a higher power, and finding strength in faith and spirituality, helped women to regain a sense of control at a time where they felt powerless, and helped counter feelings of pain, suffering, and abandonment during and after labour. Research in other populations has identified that for some people, belief in a higher power can similarly aid resilience. For example, a survey of 236 individuals recovering from substance abuse described how many also turned towards faith and spirituality, and higher levels of religiosity were associated with higher levels of optimism and resilience (Pardini et al., 2000). Furthermore, Díaz-Gilbert (2014) found that faith helped individuals to “transcend suffering”, and if participants found meaning in their suffering then they could begin the process of healing. These consistent findings from those experiencing powerlessness and trauma highlight the incredible nature of resilience, in that despite feeling as if there is nothing more, people do seem to find their own way forward.

Related to this was the finding in the current study that women discovering their voice and talking about their struggle aided their journey towards resilience. Having lost their voice during their traumatic birth, women found it empowering to then re-find it, by talking with others and learning that they were not alone in their abandonment. Listening to others, and talking about their own experiences, gave them confidence to use their voice in the future. Existing literature suggests the voices of women in relation to labour and birth are more likely to be silenced (Das, 2017; Shabot & Korem, 2018), and women of Black and ethnic minority backgrounds are more likely to be ignored (Vedam et al., 2019). As racial and ethnic disparities in maternal outcomes continue to persist and maternal mortality rates among Black and other ethnic minority women increase, it is imperative that policies and recommendations are put in place to protect all women (Newall et al., 2012; Wang et al., 2021; Wren Serbin & Donnelly, 2016). Therefore it is important that women are given the opportunity to find their voice after experiencing a traumatic birth (Vedam et al., 2019).

Another important external resource identified in this study that helped to build resilience was supportive relationships. Social support is a well-recognised protective factor generally, and has also been associated with resilience following birth trauma (Ayers et al., 2016; Dikmen-Yildiz et al., 2017). In the current study, it was interesting that partners were rarely mentioned as playing a central role in developing resilience following a traumatic birth. However, partners provided a very real tangible support role by taking on practical tasks around the home that then gave time to aid these women in their recovery. This finding is in contrast to research carried out by Abboud and Liamputtong (2005) who found that the support and encouragement of partners and husbands were important factors in women coping with and getting through a traumatic birth. Furthermore, a scoping review of women's experiences of birth trauma also identified that women valued empathetic, honest and non-dismissive support from their partner throughout labour and after birth and that this offered a

degree of relief during their recovery from birth trauma (Watson et al., 2020). More clarity is needed as to why women were not able to draw upon the support of their partners. This may be due to fathers also being excluded and powerless during the birth process; or simply not available at the time needed. Alternatively, it may be that women find more strength by drawing upon other women, to aid in their journey of becoming a mother as well as reclaiming their identity as a woman who matters.

When women felt abandoned and alone in their experiences, they were also able to draw upon their own inner resources to develop the resilience they needed to keep moving forward in terms of being a mother. This empowered women and allowed them to experience growth in their sense of self as worthy and capable. Previous research supports this finding; for example, Lévesque and Chamberland (2016) identified that young mothers overcame adversity by establishing their maternal identity and creating a bond with their child. Further, Gibson (1995) described the process of empowerment for mothers of critically ill children as one in which mothers become aware of their personal strengths, abilities, and resources. Women described a renewed desire to take back control of their life. This can be seen in the literature on post-traumatic growth. Post-traumatic growth goes beyond resilience and includes changes in self-perception, philosophy of life, and renewed appreciation of relationships (Tedeschi & Calhoun, 2004). Research suggests that approximately 50% of women will experience at least a moderate amount of personal growth after a traumatic birth (Sawyer & Ayers, 2009) and the women in this study were no different. These women's journey towards resilience took them away from being powerless, with no voice, to being assertive and empowered, transformed from shy individuals to confident women able to vocalise their needs as a way of preventing future trauma.

Implications for practice

The findings from this study draw attention to the crucial role that healthcare professionals play during and after labour. Healthcare professionals need to be mindful that during traumatic and emergency situations, how they communicate will have a huge impact upon how women perceive their birthing experience, and may also directly contribute to distress that goes well beyond the acute emergency situation. Being alert to feelings of powerlessness, and taking action to support women to feel more in control, can potentially reduce the negative psychological outcomes following a traumatic birth. Violation, helplessness and dissociation can occur if communication and consent are not clear, adding to trauma of birth complications. The lack of care reported in this study made women experiencing a traumatic birth feel invisible, not worthy of care, neglected and helpless, while the absence of fathers suggests that more consideration be made to the untapped potential support of fathers during complicated births. Care providers should therefore be given training on the importance of communication, choice, control, listening, and their use of language when caring for the birthing mother pre- and post-labour.

The constructs within the model can provide a useful framework to help healthcare professionals promote resilience by exploring their interactions, communications, and support, both at the time and following birth as a routine part of perinatal mental health. Practitioners can promote this by discussing with birthing mothers the internal and external resources pre- and post-labour that can help build resilience, such as encouraging exploration of faith, encouraging women to identify and draw upon their existing social support network, and signposting to resources and organisations that provide niche support following traumatic births. Further, discussion of the birth and talking therapies such as counselling may reduce the risk of developing PTSD after a traumatic birth (Jotzo & Poets, 2005; Ryding et al., 1998; Shaw et al., 2014).

Strengths and limitations of the study

This study has identified the resources that help women on their journey towards resilience after a traumatic birth. A strength of this study is the use of a rigorous grounded theory methodology which enabled a deeper qualitative understanding of these women's experiences, allowing for a clinically relevant model to be developed. The main researcher and interviewer (AB) had a previous traumatic birth experience which drove the focus for this project, and which may have influenced the analysis of the work. However, steps were taken to reduce any impact of this, including memo writing, critical reflexivity and discussion of analysis with other authors (JJN & KR).

One key limitation is that interviews were carried out retrospectively, sometimes years after the birth. This may have influenced these women's accounts of their traumatic birth experience as they would have had the time to make sense of their experience, having already developed resilience. While interviewing women soon after their traumatic birth experiences may have identified more powerful and emotive responses, it was important ethically not to re-traumatise participants by interviewing too soon. Another limitation relates to participants not having a voice – the open-ended nature of the questions may have only elicited a limited range of their lived experiences of powerlessness, with additional factors such as gender, race and exclusion of fathers possibly playing a bigger role than was identified through open-ended questions. Therefore, these findings should be considered alongside the existing literature to help build a more comprehensive overview.

Conclusion

The findings of this primary exploratory study identified that along with the unexpected medical complications (i.e. pain, perceived threat to life of self and baby), traumatic birth experiences are further compounded by feelings of powerlessness, not being heard, lack of consent, and losing one's voice, so leading to feelings of abandonment. An

emergent model shows the development of this powerlessness, highlighting some directions for clinical practice during complicated births to avoid adding to distress. Importantly, the emergent model also shows the way in which women seem to be able to draw upon resources to develop resilience. The grounded theory model proposed can be used by health professionals in clinical settings as a guide for mothers both during and following their traumatic birth experiences, and adds to the existing literature. While complicated births sometimes cannot be prevented, it is hoped that this research provides some important guidance on how to best empower women in order to minimise the risk of developing ongoing distress.

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Table 1. Participant characteristics

Participant	Age Range	Ethnic Group	Employment Status	Traumatic Experience	Number of Children	Years Since Traumatic Birth
Deidre	40–49	White British	Employed	Still birth	1	8
Jenny	50+	White British	Employed	Pancreatitis	1	15
Vivian	40–49	White British	Employed	Pre-eclampsia	1	8
Marva	40–49	White British	Homemaker	Placenta abruption	2	10
Lorna	30–39	Black British	Homemaker	Haemorrhaging	4	6
Onika	40–49	Black British	Employed	Haemorrhaging	3	10
Laura	40–49	White British	Employed	Feeling violated	1	6
Rhianna	30–39	White British	Homemaker	Perceived Lack of Care	2	7