ΕΛΕΥΘΩ Research paper
2/2023 vol. 22 (7)
https://doi.org/10.18332/eleftho/166617

Mode of delivery and traumatic birth experience – the role of the midwife. A qualitative pilot study

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KEYWORDS
birth trauma, PTSD, mode of delivery, midwife

Submitted: 30 May 2022, **Decision:** 29 June 2022

ABSTRACT

INTRODUCTION: Labor and childbirth are highly emotional experiences, and if these significant moments are perceived as acute stressors, they can become traumatic and lead to post-traumatic stress disorder (PTSD). The traumatic nature of childbirth can affect not only the woman but also her partner, who witnesses the distressing labor. Furthermore, a traumatic birth experience can give rise to various difficulties such as bonding and breastfeeding challenges. While some women may not meet the criteria for PTSD, they may still exhibit symptoms associated with it. Stress factors during labor can range from life-threatening situations to perceived threats, including loss of control, loss of dignity, negative environments, and a sense of fear, loss of control, and terror. The objectives of this study were to examine the relationship between traumatic birth experiences and the mode of delivery, the role of the partner, the influence of birth preparation groups, the role of the doctor, and, most importantly, the role of midwives during labor and the postpartum period.
DESIGN AND METHODS: This study employed a pilot qualitative research design. Interviews were conducted using a questionnaire divided into three parts. The interviews were conducted between January 2018 and March 2018. Thirteen women who had given birth to their first child via cesarean section participated in the study. These women subsequently attempted to have a vaginal birth for their second child. All participants adhered to the criteria for attempting vaginal birth after cesarean, as outlined by the American College of Obstetricians and Gynecologists and the Royal College of Obstetricians and Gynecologists. All women completed the questionnaire.
RESULTS: The findings indicate that nearly half of the women experienced their first labor as a traumatic event. This traumatic birth experience led to difficulties with bonding, breastfeeding, and overall psychological well-being in the postpartum period. Additionally, the role of midwives was found to be crucial in shaping the birth experience.
CONCLUSIONS: The study concludes that birth experiences can become traumatic when stress factors, such as loss of control, lack of respect, insufficient informed consent, hostile environments, and lack of support, are present. Regardless of the mode of delivery (cesarean, vaginal delivery, or assisted vaginal delivery), a positive birth experience is possible when women feel secure, trusted, supported, and involved in decision-making. Furthermore, the constant presence of midwives during labor appears to play a significant role in shaping both the birth experience and the postpartum period.

INTRODUCTION

Labor and childbirth should be a positive and memorable experience filled with positive emotions. However, there are instances where childbirth can be negative or even traumatic, resulting in Post Traumatic Stress Disorder (PTSD). Several studies have shown that approximately 10.5% to 30% of women perceive their childbirth as traumatic (Schwab, Marth and Bergant, 2012; Shaban et al., 2013), but only 1.5% to 6% develop PTSD (Schwab, Marth and Bergant, 2012; Shaban et al., 2013). Additionally, partners of women can also experience PTSD as witnesses to a traumatic birth (Schwab, Marth and Bergant, 2012).

Stress factors during labor can range from life-threatening situations to those perceived as threatening, such as loss of control, loss of dignity, a hostile or negative environment, and situations where women feel fear, loss of control, and terror (Ayers and Ford, 2012; Manoli and Zisimou, 2016; Hosseini et al., 2020). Studies indicate that the mode of delivery and women's subjective birth experience are fundamental risk factors for postpartum PTSD. Women who undergo vaginal birth with forceps or unplanned or emergency cesarean sections tend to report poorer health and well-being after birth (Rowlands and Redshaw, 2012; Garthus-Niegel et al., 2013; Garthus-Niegel et al., 2014). Furthermore, research suggests that the constant presence of a midwife during labor plays an essential role in promoting a positive birth

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experience (Dahlberg et al., 2016).

The aim of this study was to explore the factors that contribute to the childbirth experience. To achieve this, the study examined the women's relationships with their partners, their close family environment (parents, siblings), and particularly their mothers. The study also investigated the women's relationships with their doctors and midwives, as well as any associations between the birth experience and the mode of delivery.

METHODS

The present study is a pilot qualitative study that included a sample of 13 women. All of these women underwent a caesarean section for the birth of their first child and expressed the desire to attempt a vaginal birth for their second child. The second pregnancies took place between January 2016 and December 2017 at a private hospital in Athens.

For inclusion in the study, the second pregnancy had to occur at least 19 months after the birth of the first child, and both pregnancies needed to have been conceived naturally without any medical issues for the mother or the embryo. Additionally, all women followed the selection criteria for Vaginal Birth After Caesarean (VBAC) as outlined by the protocols of the Royal College of Obstetricians and Gynecologists (RCOG) and the American College of Obstetricians and Gynecologists (ACOG). For this study, a questionnaire was utilized, which was divided into three parts. The first part consisted of questions aimed at collecting demographic data. The second part of the questionnaire included questions about the participants' first pregnancy, labor, and postpartum period, as well as inquiries regarding their relationship with the obstetrician and midwife. The third part focused on the second pregnancy, labor, and postpartum period, along with the participants' relationship with the obstetrician and midwife. All women in the sample completed the questionnaire.

The interviews for this study commenced in January 2018 and were concluded by March 2018. A 5-point Likert scale was employed to assess the women's relationships with their partners and close family environment. It should be noted that only one woman in the sample was an only child.

Regarding ethics, all women were provided with information about the confidentiality of the interview, and their oral consent was obtained prior to conducting the study.

RESULTS

Table 1 provides an overview of the demographic characteristics of the sample Relationship with the partner: Out of the 13 women, 11 (84.6%) described their relationship with their partner as "very good." Additionally, the data revealed that approximately 70% of the couples had been together for more than 4 years before the birth of their first child.

Relationship with close family environment: The participants reported having a positive relationship with their

Table 1. Demographic data of the sample

		Woman		Man	
		N	%	N	%
Age (in years)	30-35	3	23.1	3	23.1
	36-40	8	61.5	5	38.5
	41-45	2	15.4	4	30.8
	45-50	-	-	1	7.6
Occupation	Household	5	38.5	-	-
	State employee	2	15.4	2	15.4
	Private employee	6	46.1	6	46.1
	Freelance	-	-	5	38.5
Education	High school	-	-	1	7.6
	Technical school	2	15.4	1	7.6
	University level	7	54	8	61.8
	Msc	4	30.8	2	15.4
	Phd	-	-	1	7.6
Family status	Unmarried	1	7.6	1	7.6
	Married	12	92.4	12	92.4
Origin	Greek	12	92.4	12	92.4
	Other	1	7.6	1	7.6

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close family environment. They expressed sentiments such as, "...we are a close and loving family..." and "...we have good relationships and receive support."

Relationship with their mother: Among the participants, 8 out of 13 (61.5%) characterized their relationship with their mother as "very good," 3 out of 13 (23.1%) described it as "good," and 2 out of 13 (15.4%) considered it to be "not good."

First Pregnancy

Desire for normal delivery:

When asked why they desired a normal delivery, 12 out of 13 women (92.3%) responded that it was because it is the natural and right thing for both the mother and the child. Additionally, 3 out of 13 women (23.1%) mentioned a fear of surgery as a factor influencing their preference for normal delivery.

Possible relationship between the desire for normal delivery and their mother's delivery experience:

The data revealed that 9 out of 13 women (69.2%) were born vaginally without epidural analgesia, and their mothers had positive birth experiences. Only one woman's mother had a negative birth experience due to being alone during labor, not because of the labor pain. On the other hand, 4 out of 13 women (30.8%) were born via caesarean section. Among these women, two mentioned that their mothers had negative birth experiences, expressing feelings of fear, pain, and suffering.

First labor

All women had caesarean section at their first child. 11/13 (84.6%) gave birth at a private maternity clinic and 2/13 (15.4%) at a public maternity clinic, not for financial reasons but because they thought that they would gave birth vaginally. Table 2 shows the week of pregnancy that they gave birth and the way labor started.

Birth experience

Regarding the birth experience, several factors were examined. These included the absence of control, respect, trust, and security during labor. Additionally, the absence of participation in decision-making was considered. The presence and active involvement of the partner during the labor process were also evaluated. Furthermore, the roles of both the obstetrician and the midwife were taken into account in assessing the overall birth experience. It seems that 7/13 women (53.9%) had a negative birth experience and 5 of them described it as traumatic. It seems that all these women experienced lack of control, lack of respect, lack of trust and security and finally lack of taking part in the decision-making.

Women say

K. *«....my labor started with oxytocin at the possible date of birth....next day I gave birth with an emergency caesarean...I was 3-4 cm dilation.... I was crushed... I felt they told me lies... I had doubts for the caesarean...».*

S. *«...they did U/S and they told us that the baby is small 2500gr, so the labor was induced... in the morning the water broke and after 2-3 hours the doctor told us that the baby is in danger and the caesarean is necessary...they didn't gave time... they didn't wait... I had panic crisis when they told me for the caesarean...and the weight of the baby was 3800gr... they told us lies... I was like crazy... I cried so much... I felt no respect...».*

A. *«...I saw some blood mucous and I went to the hospital...the doctor didn't examine me vaginally...he just told me that the baby is too big for my pelvis...I think that I disturbed him and he wanted to finish...his behavior it was not a professional one... I felt guilty...».*

K. *«...my water broke and after 2-3 hours they started oxytocin...after the first contractions they told me to do epidural....and then my doctor insisted for caesarean...I cried... I was trembled and cried during the surgery... I felt like being raped...».*

S. *«...I had contractions and I felt pain, so I asked for epidural but there was any anesthesiologist...they gave me pethidine and after that I was like drunk... I didn't felt my body... I was somewhere else...at some point I had no sense of control...I didn't push... I gave up because I felt abandoned...it was a very bad experience.... I don't want to remember it...».*

M. *«... they didn't let me stand up...they examined me*

Table 2. The week of pregnancy women gave birth and the way labor started.

Week of pregnancy	Non induced labor (N)	Non induced labor %	Induce of labor (N)	Induce of labor %	Scheduled Caesarean (N)	S. C. %
37^1- 38^0	1		1		1	
38^1- 39^0	0		1		0	
39^1- 40^0	3		1		2	
40^1- 41^0	2				1	
Total number	6	46.1%	3	23.1%	4	30.8%

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and then they left...they spoke for the progress of labor as I was not there...doctor told me about a woman who insisted for vaginal delivery and nothing went good with her labor...I cried a lot during the surgery and after that... it was a very bad experience...».

E. «...my doctor insisted for caesarean from the 40th week of gestation...he didn't want me to wait but I knew I could, so I told him my decision...he called me after two days and told me that I put baby's life at risk ... he told me to do an U/S...they punished me...they told us the baby is at risk again and with any discussion we went to the surgery...I cried...I felt so angry and sad... during the surgery I felt like crossed...I couldn't hold my baby...my baby's look was a look of terror...».

The remaining 6 women felt disappointed and sad with the caesarean but they didn't experience it as traumatic.

X. «... my doctor called me some days after the 37 week of pregnancy and asked me when I wanted to give birth.....the labor was induced...I had caesarean....I didn't care because of my historic... I just wanted to have a healthy baby...».

R. «...I had no doubt for the caesarean...I just felt disappointed because I was very near to have normal birth...».

C. «...I was 7 cm dilation and the baby was distressed and they told me that caesarean is needed...I was relieved and I had any disappointment or regret...».

X. «...the baby was in breech position...I was sad for the caesarean but I felt that I did my best for the baby...».

K. «...I had no doubt for the caesarean... I just wanted to see a healthy baby...».

E. «...I felt terrible and I cried a lot when they told me for the caesarean but I had no doubt that it was needed...».

Role of the partner during labor

The role of the partner during labor was examined regarding his presence and his support. In 9 women the partner was present during labor, except those 4 who had scheduled caesarean.

Women say:

K. «...the pressure to have caesarean was too much... I couldn't fight any more...I was tired...so we decided to proceed in caesarean...».

E. «...my partner was supported to wait but at some point he was also stressed...he couldn't do something else...».

M. «...my husband was with me but he sat on a chair and because I wasn't feeling pain I told him not to stay all the time with me...what else he could do...».

S. «...my husband was with me during labor but he didn't know what to do to help me...».

It seems that the presence of the partners during labor could be more helpful, if they had some information about the procedure, so as to have more active role.

Role of the doctor

Data show that 6/13 women (46.1%) trusted for the following of their first pregnancy their gynecologist. They knew the doctor for at least 3 years to 10 years.

They say *«...I knew the doctor for years...I thought that he would take care of me...he supported normal delivery...there was a friendly relationship...I felt secure...I knew friends that have given birth vaginally with the doctor...».*

7/13 women (53.9%) change the doctor. Two of them because they changed the place of their residence and the remaining 5 because *there was any close relationship with the gynecologist.*

Role of the midwife

The role of the midwife regarding the support during labor, breastfeeding and postpartum period was examined.

Data show that 4/13 women (30.8%) didn't have a midwife during labor as they were very sure that would have normal delivery and the midwife was unnecessary.

The remaining 9/13 (69.2%) had a midwife, which was collaborated with the obstetrician. From these women only 3 say that were supported during labor and breastfeeding. These women had at least 3 meetings with the midwife before 36 week of gestation.

«...sometimes doctor may see you as a patient but midwife can deal with your emotions...I had beside me a person...midwife helped me to be more relaxed... she supported normal delivery and gave me secure and support...».

The remaining 6 refer no support. They also refer that there was no personal relationship with the midwife. These women had 1 or 2 meetings with the midwife after 36 week of gestation.

«...midwife supported caesarean...I had no support during labor and breastfeeding...she had an authentic style...»

«...there was no contact with the midwife...I had no support during labor and breastfeeding...».

«...midwife only came once to see me after birth...no support...»

Role of the birth preparation groups

Only 6 out of 13 women (46.1%) participated in preparation for labor groups, attending 6-10 meetings. These women reported positive experiences, stating that the meetings helped them gain knowledge, information, and better prepared them for labor. On the other hand, the remaining 7 women (53.9%) did not participate in such groups. One woman had a medical issue that prevented her from attending, while the other 6 women felt that these groups were unnecessary. Some women were confident in having a vaginal delivery, while others believed that their midwife or doctor would provide sufficient support without the need for additional preparation groups.

Influence of birth experience postpartum

The influence of birth experience was examined in relation to the following aspects: emotional state, connection with the child, and connection with the partner.

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Emotional state - Connection with the child

Data shows that 8 out of 13 women (61.5%) did not experience childbirth as traumatic, but they did have feelings of disappointment, sadness, guilt, and failure, even among those who did not feel that the caesarean section was unnecessary. These women did not have difficulty with bonding. On the other hand, the remaining 5 women experienced birth as traumatic and reported difficulties with bonding. Although they were not diagnosed with PTSD, they met the criteria for PTSD based on DSM-IV.

More specifically, all of these women experienced emotional distress related to labor for more than a month, including symptoms such as crying, tachycardia, stress, and depression. They did not want to remember their labor experience and had difficulties with daily activities such as caring for the baby and doing household chores. Two of them had symptoms for a year, with one woman facing additional challenges due to the loss of her job and another woman struggling because she did not have the support of her mother while being on board. Only one woman was diagnosed with depression and required medication.

All women in the study expressed feeling a sense of loneliness, as they felt that no one could understand why they were sad despite having a healthy baby.

E. «... I was in a terrible emotional status after caesarean...I felt cut in the middle... I was cold and I didn't want my husband and my child...I had a hole and it was very deep... I was depressed for about 3 months...»

K. «...I felt that baby was responsible for everything I've been through...I didn't want to hold it and the baby cried all the time... »

S. «...I had melancholy after childbirth...»

M. «... there was no contact with the baby...I just wanted to cry all the time... I was depressed for a whole year... »

S. «... I had difficulty with bonding...baby cried all the time...I suffered...»

Relationship with the partner

Only 2 women mentioned that their relationship with their partner was tense after childbirth, but they were unsure whether the cause was the birth experience or the adjustments that came with having a baby. Additionally, 2 more women expressed the need for more support from their partner in terms of baby care and breastfeeding.

On the other hand, the remaining 9 women reported receiving great support in caring for the baby and breastfeeding. Table 3 presents the duration of breastfeeding for all women per semester, indicating that over 60% of them breastfed for more than 6 months.

2nd LABOR

None of the women in our study required labor induction. Approximately 44.5% of them experienced the onset of labor between 40+1 and 41+0 weeks of gestation.

Out of the 13 women, 9 (69.2%) successfully achieved vaginal birth, while 4 (30.8%) delivered via cesarean section. The duration of labor, from the onset of contractions to placenta detachment, was 15 hours for two women and approximately 6 hours for seven women.

Only 6% of the women who had a successful vaginal delivery did so without any interventions. The remaining women required various interventions: episiotomy (33%), epidural (17%), forceps (22%), and 22% required all three interventions (episiotomy, epidural, and forceps).

Role of the doctor

For the subsequent pregnancies, 11 out of 13 women (84.6%) decided to change their obstetrician, believing that the first caesarean could have been avoided. Out of these 11 women, 7 found their new doctor through the internet, while the remaining 4 received recommendations from close friends or family members.

The characteristics of the doctor that gained women and chose the doctor were the followings:

«...Calm, simple, sincere, illustrative... I felt secure and trust...professional, human...doctor answered to every question we had...he was relaxed and never frightened us... he gave full and straight information...experienced doctor...»

Role of the midwife

All the women chose to have a midwife for their labor, and the midwife collaborated with the obstetrician. Only two women chose the same doctor and midwife. Each woman had at least three meetings with the midwife before reaching 37 weeks of gestation, and then had weekly meetings until labor.

The midwife remained present during labor until two hours after childbirth. Additionally, the midwife visited the women daily at the maternity clinic to provide counseling on breastfeeding and baby and mother care.

Data indicates that women felt secure and trusting with the presence of the midwife, which likely contributed to their positive birth experiences, even for those who did not have a successful vaginal birth. Also, the counseling and support regarding breastfeeding seems that helped women to breastfeed 1 – 6 months more in relation to the first child. Only one woman gave formula from the start as she had medical issue.

Table 3. Duration of breastfeeding for all women per semester from 0 - 24 months

Duration of breastfeeding	N (13)	%
0 – 5 months	5	38.5
6 - 12 months	4	30.7
13 - 18 months	2	15.4
19 – 24 months	2	15.4

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Women say

«... midwife was calm and explained everything...there was trust...»

«...I felt secure...midwife was very supportive during labor and breastfeeding... I had with me a person of mine...»

«...it was very nice that I saw the midwife every week the last month of pregnancy...she cared for me...I don't remember labor pain...»

«...I felt close with the midwife...I trusted her...during labor I felt like giving birth all together, as we were all a team...».

«...I believe that the greater part of labor belongs to midwife...she helped me with breastfeeding a lot...»

«...we were all as a team...she was very supportive...»

«...she was calm and reassuring...»

«...my childbirth was a wonderful experience because of her...»

«...she was experienced...calm and reassuring...although I had caesarean the experience was nice...»

«...I felt secure and trust...»

Role of the birth preparation groups

Only two women did not participate in preparation groups for their second pregnancy, as they had already participated in such groups during their first pregnancy. Out of the 13 women, 11 actively participated in preparation groups for labor during their second pregnancy. These groups typically consisted of 8 to 10 meetings, and it appears that the women gained valuable information and prepared themselves for labor through these sessions.

Question: «How these meetings helped you?»

Women say:

«...the meetings helped me to understand what I did wrong the first time and what I could avoid...»

«...I really enjoyed the meetings...they helped me to prepare and to understand what I did wrong the first time...»

«...I felt confident and that vaginal delivery after caesarean is a reality...I saw other women who wanted the same thing...I was not crazy...»

Partner and experience of labor

All women who succeed vaginal delivery had the constant support of their partner during labor. Also, the experience of labor was positive for the partners.

Women say:

«...my husband was very happy to experience labor... he congratulated me and he was very proud of me...»

«...my husband was excited from the experience as it was so easy and fast...»

«...it was a unique experience for my husband... he felt very proud of me and he was so excited...»

Differences regarding first caesarean and vaginal delivery

Out of the nine women, seven (77.7%) reported minimal pain during the first 1-2 days following childbirth, while two (22.3%) experienced less pain for 14 days due to the episiotomy procedure. The reduced sensation of pain appeared to facilitate breastfeeding and the overall care of the baby, as it allowed the women to move more comfortably and easily.

Emotional state during postpartum period after vaginal delivery

All women, including those who required assisted vaginal delivery, reported positive feelings from their labor experience, such as happiness, pride, confidence, empowerment, fulfillment, and satisfaction. Only one woman mentioned feeling melancholic three months after labor, but it is likely that the lack of support from her partner and changes at home had an impact on her psychological well-being Women say:

«...it was a positive experience...I remember no pain...I felt relief and joy when I hold my baby...»

«...I felt no pain during labor...it was a great victory...I felt very proud of myself and stronger...»

«...everybody congratulated me...I was so proud of myself...»

«...I felt fulfillment...I remember no labor pain...»

«...my emotions were in an order after labor...I felt so strong to care my children...»

«...some things were cured inside my heart after labor... baby is more calm and our interaction is very good...»

«...I had no difficulty to move and I breasted more easily... I could care my baby without help...»

«...I felt so satisfied and happy...»

It seems that the lower intensity and duration of pain and the positive birth experience helped women to connect better with their second child.

Differences regarding first caesarean and second caesarean

Four out of thirteen women (30.7%) delivered via caesarean section but reported experiencing less pain compared to their first caesarean, as well as less difficulty with movement and caring for the baby. In terms of their emotional state postpartum, they did not experience feelings of depression and reported better bonding with their second child. Women reported:

«... I cried when caesarean was decided but I was calmer this time...everything was easier...I felt less pain...I enjoyed the experience...no one lied, no one hurried...I had better bonding with my second child...»

«... I felt less pain and I could move better...»

«... I was disappointed but this time baby decided to start the labor... I had more easy recovery after caesarean...»

«...caesarean was fantastic...I felt no pain...I had no problem to move... I felt respect... I felt stronger and I had no difficulty with bonding...baby was calmer...»

«...I had no difficulty to move and to care my baby...»

It seems that even women who didn't achieve vaginal delivery had a positive birth experience, as they felt secure, trusted, supported, and were able to participate in decision-making.

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DISCUSSION

In the present study, various factors that can contribute to a traumatic birth experience were explored, including the mode of delivery, the role of the partner, the influence of birth preparation groups, the role of the doctor, and, most importantly, the role of the midwife during labor and the postpartum period.

Initial data collection focused on the participants' first pregnancy and labor. It was found that the desire for vaginal delivery stemmed from women's belief that it is the natural and preferred method, while some expressed a fear of surgery. Previous research conducted by Zakerihamidi M. et al. with women in North Iran indicated that vaginal delivery is considered a safe and natural procedure, while cesarean section is viewed as an intervention that may lead to increased pain intensity (Kainu et al., 2016). Similarly, a study by Atan SU et al. involving 342 Turkish women revealed that the majority of participants preferred normal delivery for their next pregnancy (Kohler et al., 2018).

Of particular interest in the present study was the finding that 84.6% of women were certain they would have a vaginal delivery. Therefore, factors such as the method of conception, the course of pregnancy, the relationship with their partner, and their mother's mode of delivery were examined. Women who did not consider cesarean section as an option had naturally conceived pregnancies, normal pregnancies, excellent relationships with their partners, and mothers who had positive birth experiences through vaginal delivery. These findings suggest that when a woman is surrounded by a supportive, positive, and safe environment, she is more likely to have a positive outlook. Notably, even women with medical issues during pregnancy or a history of miscarriages expressed a desire for normal delivery, although they were uncertain whether they could avoid a cesarean section.

Regarding the role of the midwife during their first labor, the majority of women who chose a midwife expressed dissatisfaction with the midwifery services provided during labor and breastfeeding. They felt there was a lack of a close and personal relationship, as well as a lack of trust, security, and respect. Similar results have been reported in other studies (Banerjee and Sanyal, 2012; Andrissi et al., 2015; Chipidza, Wallwork and Stern, 2015; Razzaghi and Afshar, 2016; Lewis, Jones and Hunter, 2017). Lewis et al. emphasised the importance of mutual trust between women and their midwives.

Overall, the study highlights the significance of various factors in shaping the birth experience. When stress factors such as loss of control, lack of respect, and inadequate support are present, childbirth can become traumatic. Conversely, regardless of the mode of delivery, a positive birth experience can be achieved when women feel secure, trusted, supported, and actively involved in decision-making. The constant presence of a midwife during labour appears to play a vital role in influencing both the birth experience and the postpartum period.

The study examined various factors related to the birth experience, including the role of birth preparation groups, the first birth experience, the presence of the partner during labour, breastfeeding, and the role of the midwife during labor and postpartum. Regarding birth preparation groups, it was found that approximately half of the women did not participate in these groups because they believed they would have a normal delivery and that the midwife would assist them. For the first birth experience, more than half of the women reported negative experiences, with some describing it as traumatic. These women experienced a lack of control, respect, trust, security, and involvement in decision-making by healthcare professionals. Difficulty with bonding and feelings of depression were reported by women who had a traumatic birth experience. Previous research has also shown that bonding can be more challenging after a traumatic birth experience (Romijn et al., 2016; Simpson et al., 2018; Attanasio, Kozhimannil and Kjerulff, 2019). Studies by Gökçe İsbİr G. et al. highlighted difficulties in transitioning to motherhood (Romijn et al., 2016), while Simpson M. et al. demonstrated the negative impact of post-traumatic stress disorder (PTSD) on the mother, child, and family (Simpson et al., 2018).

The study also found that the presence of the partner during labour was not helpful when they had a passive role and lacked information and guidance. Support from the partner and the woman's mother was positively associated with maintaining breastfeeding (Roostaee et al., 2015). Strong desires to breastfeed were observed regardless of the birth experience. Additionally, changes in the couple's relationship were found to be more associated with the birth of the first baby rather than the birth experience itself.

The study continued with data collection for the second pregnancy and labour. Interestingly, all women who did not participate in birth preparation groups during their first pregnancy chose to participate in them during their second pregnancy. This suggests that women gained information, preparation, confirmation, faith, support, and empowerment through these groups. Studies by Brixval CS et al. and Afshar Y et al. have also shown a relationship between participation in birth preparation groups and higher rates of normal birth, as it enhances a woman's ability to give birth (Brixval et al., 2016; Afshar et al., 2017). Regarding the role of the midwife during the second birth experience, it was found that the midwife provided women with a sense of security, support, calmness, interest, guidance, reassurance, information, and relief, which helped the progress of labor (Homer et al., 2013; Forster et al., 2016; Zhang and Liu, 2016). Even women who underwent a cesarean section did not view their labor as traumatic when a midwife was present. The constant presence of a midwife during labor has been shown to increase women's sense of control in decision-making and the rate of vaginal deliveries (Homer et al., 2013). Studies by Tieying Zhang et al. and Della A. Forster et al. also

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https://doi.org/10.18332/eleftho/166617

demonstrated that continuous midwifery care during labor led to higher rates of normal deliveries, shorter labor durations, and reduced rates of third-stage hemorrhage (Forster et al., 2016; Zhang and Liu, 2016).

In the present study, women who had difficulty breastfeeding their first child were successful in breastfeeding their second child or had a longer duration of breastfeeding. The role of the midwife was found to be supportive and helpful for breastfeeding as well (Schmied et al., 2011; Renfrew et al., 2012; Homer et al., 2017; McKellar, Fleet and Dove, 2018). Retrospective analysis by Homer CS et al. showed that the presence of a midwife increased the rates of initiating and continuing breastfeeding (Homer et al., 2017). A metasynthesis by Schmied V. et al. emphasized the importance of human-centered care in breastfeeding (Schmied et al., 2011). Additionally, a qualitative study by McKellar L. et al. demonstrated that constant midwifery care improved breastfeeding rates (McKellar, Fleet and Dove, 2018).

Furthermore, a comparison between the first and second birth experiences was made regarding the sense of pain, caring for the baby, bonding, and the emotional state postpartum. Women who had vaginal deliveries experienced lower intensity and duration of pain. Studies by Hardy-Fairbanks AJ et al. and Kainu JP et al. showed that cesarean sections were associated with greater intensity and duration of pain, with consistent pain being more common one year after a cesarean compared to a vaginal delivery (Hardy-Fairbanks et al., 2013; Kainu et al., 2016). The lower intensity and duration of pain in women with vaginal deliveries appeared to help them with movement, caring for the baby, and breastfeeding (Pereira, Souza and Beleza, 2017; Petrou et al., 2017; Kohler et al., 2018). Kohler S. et al. compared the quality of daily life postpartum between women with vaginal deliveries and cesarean sections and found that women with vaginal deliveries had better quality of life in terms of movement, self-care, sense of pain, daily activities, and discomfort even 30 days after labor. This better quality of life persisted even one year after labor compared to women who underwent a cesarean section (Petrou et al., 2017; Kohler et al., 2018). Positive birth experiences and positive emotions such as joy, pride, self-confidence, empowerment, happiness, integration, and satisfaction were associated with a better emotional state postpartum compared to the first child. Chen HH. et al. found that cesarean sections were associated with a greater possibility of stress symptoms one year after labor compared to vaginal deliveries (Chen et al., 2017). Modarres M. et al. also identified the mode of delivery as an important factor in post-traumatic stress disorder (PTSD) after labor (Kohler et al., 2018).

For women who had a cesarean section with their second child, lower intensity and duration of pain were reported. They did not view the cesarean section as a traumatic experience but mentioned feelings of sadness and disappointment. However, the sense of respect, honesty, support, and effort from the support team (midwife-doctor) helped them have a better emotional state postpartum. In a supportive environment where a woman feels secure, trusted, and respected, regardless of the mode of delivery, the birth experience tends to be positive. However, Shorten A. et al. identified the mode of delivery as a major factor influencing maternal satisfaction and postpartum health, while Dunn EA et al. found greater maternal satisfaction after vaginal deliveries (Dunn and O'Herlihy, 2005; Shorten and Shorten, 2012).

CONCLUSIONS

The experience can be traumatic when factors such as loss of control, lack of respect, lack of informed consent, a hostile environment, and lack of support are present. However, regardless of the mode of delivery (cesarean, vaginal delivery, vaginal delivery with interventions), the birth experience can also be positive when a woman feels secure, trusts, receives support, and participates in decision-making. Birth preparation groups play a supportive role by providing information, support, faith, and empowerment to women.

The study also examined the role of midwives in the birth experience and postpartum support. The constant presence of a midwife, who establishes a closer and more personal relationship with the woman, was found to be supportive, aiding in labor progress, and contributing to a positive birth experience. Midwives also played a supportive role in the initiation and continuation of breastfeeding. Support from the partner and the woman's mother also played a significant role in breastfeeding continuation.

Although the sample size of the study has limitations, it provides valuable information for healthcare professionals to evaluate and redefine the provision of care. This is crucial because the birth experience impacts not only the woman but also the partner, the couple, the relationship with the child, and the entire family.

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CONFLICTS OF INTEREST

The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none was reported.