

“Oh, Get Over It. I Do This Every Day”: How Ignoring the Specialness of Childbirth Contributes to Experiences of Emotional Distress

Childbirth is a daily event, making it a routine and predictable part of social life. For many people, childbirth is also a profound life-changing experience, as it incorporates previous life experiences, creates new identities, and alters relationships in significant ways. However, the nuance required to see childbirth as not only a regular event but also a special life experience is missing in many considerations of childbirth. Ignoring the specialness of childbirth contributes to experiences of emotional distress in childbirth. This article shares excerpts of four women's birth stories and demonstrates the need for more nuanced understandings of birth to from those involved in assisting women in childbirth. This article draws on data from a study of fifteen women in Atlantic Canada who gave birth in hospitals and who identified as having experienced emotional distress in childbirth. Feminist narrative inquiry and analysis were used to interview and analyze the birth stories shared by the participants. The stories shared demonstrate that women understand the daily and routinized approach to birth dominant in healthcare settings, yet they did not experience childbirth as a routine event. The rupture between the mundane routinization of birth and the transformative and unique experience of giving birth contributed to the distress the participants experienced during childbirth. The women interviewed for this research called on those who work with women during childbirth to be more appreciative of the unique space childbirth claims as both a regular and special experience.

Childbirth is a daily event, making it a routine and predictable part of social life, and for many people, childbirth is also a profound life-changing experience (Bachman and Lind; Lundgren; Thomson). However, the nuance required to see childbirth as not only a regular event but also a special life experience is missing in many considerations of childbirth. Additionally, there is a growing

body of evidence suggesting many women experience childbirth as a significantly distressing (Beck et al.; Czarnocka and Slade; Creedy et al.). This study demonstrates how ignoring the specialness of childbirth experiences contributes to emotional distress in birth. It draws on data from a study of fifteen women in Atlantic Canada who identified as having experienced emotional distress in childbirth, and shares excerpts from four women's birth stories. The article demonstrates the need for more nuanced understandings of birth from those involved in assisting women in childbirth.

Distress in Childbirth

Research often represents distress in childbirth as trauma, posttraumatic stress disorder (PTSD), or posttraumatic stress symptoms; it typically focuses on individual factors associated with birth. These factors include (1) descriptions of the woman giving birth, such as being poor (Fottrell et al.), having a preexisting mental illness (Czarnocka and Slade; Söderquist et al.), and personal coping style (Van Bussel et al.); (2) qualities of the birth experience itself, such as emergency procedures (Adewuya et al.; Söderquist et al.); and (3) the woman's internal experiences during childbirth, such as her thoughts, emotions, and interpretations about childbirth (Beck, "Birth Trauma"; Dale-Hewitt et al.). The dominance of an individualized and psychological view of distress, and its conflation with trauma and with PTSD, is evident in the focus of many research papers. Much effort is spent assessing the credibility of subjective experiences of distress—reducing women's experiences to symptom checklists and matching these against the diagnostic criteria for PTSD (Ayers et al.; Czarnocka and Slade; Soet et al.; Wijma et al.). Although there is agreement that one third to over one half of women report subjective experiences of trauma and/or distress in childbirth (Alcorn et al.; Beck et al.; Creedy et al.; Czarnocka and Slade), the accepted rate for childbirth-related trauma falls between 1.5 and 5.6 percent (Ayers et al.; Creedy et al.; Czarnocka and Slade; Fairbrother and Woody; Ford et al.; Söderquist et al.; Zaers et al.).

Some diagnostically oriented research relies on women's subjective reports of distress as a deliberate countering to the way in which women's experiences are silenced in the general childbirth literature; such research argues for better treatment of women in childbirth and for postpartum psychological treatment. See for example, Beck's "Birth Trauma" and "A Metaethnography". Other studies have taken a different approach to examining experiences of distress in childbirth by deliberately centring the subjective experiences of the participants without filtering women's voices through the mesh of psychological language and diagnostic categories and by focusing on experiences of distress in childbirth (For example, Chadwick et al.; Moyzakitis). This project falls

within this category of interest and analysis, and thus centres distress rather than trauma as a core concept.

Distress

Because of the dominance of psychological and medical discourses, the concept of trauma is readily understood (and used) by people in their everyday lives in a such a way that distress is medicalized and individualized, and comes to be understood as individual dysfunction (Burstow; Lafrance and McKenzie-Mohr). Additionally, this conceptualization of trauma comes from a white, Western, and settler perspective, which erases the historical and current trauma of Indigenous peoples, displaced people, and racialized people (Banner; McKenzie-Mohr). This individualized construction of trauma ignores the important political, cultural, and social aspects of experiences and effects of trauma, and also removes the inducement for action ameliorating and eliminating trauma beyond simply symptom reduction (Burstow; McKenzie-Mohr).

Distress was a useful concept for this project; it carries the possibility of incorporating a broader range of experiences than the concept of trauma allows, and in doing so, it denies medical dominance and the resulting pathologization and marginalization. The women who participated in this study did not define or explain their emotional distress as limited to one event or interaction, or one thing gone wrong. Nor did they understand their distress as one diagnosis or set of symptoms or pathology. The participants in this study discussed the distress associated with their childbirth experiences in the context of the entire pregnancy, previous life experiences, thoughts and emotions about potential futures, and various and interlocking aspects of care (or lack of care). Thus, in these childbirth stories, distress was not caused by some thing resulting in feeling some thing. Stories of childbirth distress represented a complex interweaving of events, experiences, interactions, and internal experiences of thoughts and affect.

The Body

Giving birth is an embodied experience; thus, this project is grounded in a material-discursive view of the body, reflecting curiosity about “the day-to-day impact of the discursive construction of experience on material life” (Ussher, “Body Talk” 7). Capturing embodied experiences through research is rife with difficulty. Participants in most research approaches (including this one) must still rely on language—text and talk—to convey their bodily experiences, and a focus on discourse risks removing the body from consideration even in such an embodied experience as childbirth (Chadwick).

In this research, this understanding of embodied telling is reflected in how the text of the stories is shared with the reader. The poetic form of the excerpts represents the embodied storytelling of the participants. The lines of the stories may erupt only to die mid-sentence—sentences may not end but seep into each other, and ideas bleed into each other during the telling. It is important to represent these embodied stories in a way reflecting the subjective action taken in sharing stories, even if this means that the reader is left without tidy sentence structure and neat beginnings and endings (Chadwick). Indeed, this messiness in representation mirrors the messiness of experiences of birth and the way in which birth acts as a site of rupture in neat understandings of body and discourse.

Methodology

Participants for this study were recruited over a one-year period from November 2015 to October 2016. Participants were recruited who had given birth within the last year, were at least sixteen years of age at the time of conception, spoke English, and were able to provide their own consent. Recruitment was undertaken from various formal and informal community organizations (such as healthcare services, family resource centres, community groups representing specific racial and ethnic communities, and local parent and infant play groups) and from word of mouth referrals among participants and among those who became aware of my research through other means.

Fifteen women participated in this research project. Their ages ranged from eighteen to forty-three years old. The women came from a variety of regions across Atlantic Canada, including rural communities, small towns, suburban communities, and urban centres. All women gave birth in hospitals. Participants chose their own pseudonyms to be used with their narratives. Five participants had a preexisting mental health diagnosis (depression or anxiety) that they disclosed to me during the interviews. Nine participants had had older children and/or pregnancies that they mentioned, and six participants were involved with this project as a result of their first pregnancy. All participants were in coupled relationships. Fourteen were in heterosexual relationships, and one participant was in a same-sex marriage. Participants described themselves as ranging from poor to middleclass. All participants identified as white. Excerpts from four of the fifteen participants' narratives are included below.

The lack of racial diversity among participants is a shortcoming of this study. Although I recruited broadly and included many agencies providing services to racialized groups, only white women responded to call for participants, which may be associated with the very nature of this project's focus and of who was doing the research. As a white woman social worker doing research

regarding childbirth, this project and I may represent risk associated with the historical and ongoing oppression of racialized women, including the particular oppression racialized women experience in their reproductive lives. Whereas white women have a history of being viewed as idealized objects who are the weak and passive vessels that need to be “delivered of” their babies—and who now perhaps want to be seen as central and express agency in “delivering” their babies—the history of reproduction and research into reproduction has been different for racialized women (Ross and Solinger). It may be fair to assume racialized women have been more aware of the surveillance and control upon their bodies and the pathologizing of reproduction through violent social process, such as eugenics, forced sterilization, and the removal of their children (Ross and Solinger). Perhaps many women of colour want (especially white) researchers to leave them alone. Perhaps more attention from researchers and medical practitioners and social workers is not seen as likely to be helpful given the specific histories of their communities. Thus, although this research represents diversity across many types of birth experiences, and across various social locations, it is a study that will not represent racial diversity.

Feminist narrative inquiry and analysis were used during the interview and analysis phase of the research. They enable the co-constructions of knowledges as the researcher moves between data collection and analysis (Brown; Wilson). Researchers using feminist narrative inquiry and analysis as a methodology seek to change power relationships, reject ideas of neutrality and objectivity, and incorporate reflexivity (Morris). A feminist narrative approach allowed for the discovery of the messages and assumptions participants had about childbirth, both dominant understandings as well as challenges to dominant ideas about childbirth and distress in childbirth to surface (Arvay; Barbour; Hydén; Riessman, “Analysis of Personal Narratives”; Squire).

Guided interviews were carried out using general, open-ended questions and prompts. Interviews occurred at the location of the participant’s choosing, often in their own homes, and lasted between forty-five and ninety minutes. Interviews were transcribed, and the resulting written narratives were analyzed for subjugated knowledge as well as for reflections of dominant narratives, with an interest in how participants navigated these realities (Stone-Mediatore). The findings below emerged organically in the interviews and/or after being prompted with the question: “Do you have any advice or messages you would give to those who are going to experience labour and delivery?” and are related to the theme “recognize that childbirth is a regular event that is special.”

Findings and Discussion

Many participants shared that some of their emotional distress was related to feeling as if the specialness of childbirth was ignored by the medical staff involved in their care. The routinization of care associated with the regular medical event of birth felt cruel and inhumane to many of the women who shared their stories. Many births are considered unremarkable and are routine in hospital-based care, but even beyond this, medical emergencies are also regular events in healthcare. The excerpts shared below are taken from the narratives of four of the participants in this study—Morgan, Charlie, Sarah George, and Nella—who experienced birth as a medicalized event. All had unanticipated complications during their deliveries that risked either their lives and/or the lives of their babies. They required intensive medical interventions, for which they were grateful, yet all felt the specialness of their birth experience was subsumed under the routinized medical management of their care. Morgan, Charlie, Sarah George, and Nella reflected on the importance of having their birth experiences treated as special despite (or perhaps in addition to) the specialized medical interventions they received.

Morgan highlighted this thinking, and had advised staff to treat childbirth as a special experience—a special day. She linked the invisibility of the importance of a positive birth experience to gender:

It is just expected, you know, for women to just be, this is part of what you do.

It is part of what you do.

Men can't give birth but it would be nice if there was just a little bit more,

I don't know what the word is, something.

It should be a little bit more important, a little bit more talked about.

My first birth, one of the nurses literally yawned the whole time.

I totally felt like a number.

I thought about reporting her afterwards because I thought, "You just don't do that!"

Morgan's birth experience was associated with a life-threatening complication, and perhaps because Morgan believed she was going to die in childbirth, she linked the importance of empathetic attending to birth as similar to behaving empathically when dealing with death:

And you know, you are lucky to be part of these people's lives in these important times,

whether it is dying, birthing, sickness.

You know, you are lucky to be part of that.

Feel blessed to be part of that and focus on that.

It is also to be influencing in a positive way even if someone is dying then any medical professional that comes into that situation should be impacting it in a positive way.

Charlie also experienced life-threatening complications during her delivery, and also linked birth and death. She is a veterinarian, and as such, she spoke about the importance of staff being sensitive to the needs of people undergoing routine yet emotionally challenging life events:

And I know that when you do something every day,
it becomes normal to you
but like, I would never go in to a client where I was euthanizing their
animal.

...

And be like, "Oh get over it, I do this every day."

...

I would never even dream of...

Because it is part of their family and they are saying goodbye and it is like,
just because it is something I go through every day and have to deal
with,

it doesn't make it any less important.

You've chosen, you've chosen a profession where this is what you are
doing.

Charlie had advice for those caring for birthing women as she combined both the concern for women with the recognition of childbirth as a meaningful experience:

I want people to recognize
that it is a pretty huge experience for every woman that is going
through childbirth

and everybody might have different needs [pause]

and to really talk to them and see what they need in that situation.

You know what I mean?

And be there for them.

It is like, don't just stick them in a room and you know,

You know, don't tell them that they are not technically in labour,
we don't want to hear technicalities.

You know what I mean?

Like reassure them what they are going through is normal yet it is still
huge.

Do you know what I mean?

In this story, Charlie searched for some synthesis between the polar views of the childbirth as a routine yet special experience. Her frequent use of “you know what I mean” indicates that what she was trying to express is not easily put into words because it disrupts the binaries that have come to define childbirth (Devault). Charlie’s comments reflect her view of birth as a medical event (which was Charlie’s experience as she developed HELLP syndrome¹). They reflect her search for a way in which she could maintain her status as person rather than patient and for a way in which staff could resist the neoliberal pressures to treat birthing women as objects on a healthcare assembly line (McCabe).

Similarly, Sarah George experienced medical complications during birth, and her baby required specialized care in the NICU. She also experienced distress as a result of having the specialness of her birth experience invalidated by the medical team’s behaviour. She experienced being repeatedly ignored despite having been in one of the most vulnerable positions a person can be in—spread-eagled with feet in stirrups. The medical staff then took her baby to the NICU and dealt with other labouring women on the unit. Her advice mirrored Morgan’s; she begged staff to remember the woman is an important person in need of care:

To that person that is delivering [the babies], it’s like another [day]
and that made me so mad.

“You are like the twelfth woman to deliver tonight.”

I’m like, “I don’t care if I’m the twelfth person to deliver.

This is your job.

I am just as important as the first person that delivered and you need
to make an effort.”

I can’t believe they left me on that table, and she was like,

“If you need anything call, push the buzzer.”

I am like, “I’m bleeding to death here and I am not going to be able to
push the buzzer lady.”

The anger in Sarah George’s story demonstrates the indignities and inhumanity she experienced as she was forgotten and abandoned on the delivery table.

Finally, Nella had similarly reasonable advice for those working with women during childbirth: find a way to treat women and childbirth like they are special and important.

I think for practitioners,
I think people who have been doing it for a very long time
are very comfortable with what they are doing
and sometimes I think this with a lot of different professions,

but what they are doing might be the first time for the person who is laying on the bed having the baby and it is a very, like you said, special experience.

To them, it is just, you know, one more delivery but to, I don't know, I don't know how to say it, like, don't forget about that part of it.

Their part of it, yes, definitely, is to deliver the baby and maybe that is where a doula comes in to play.

You know, maybe I should have a doula.

Nella spoke to the importance of attending to the woman in the room who is living through a very physically and emotionally overwhelming and challenging experience. It is helpful to have someone in the room dedicated to telling the labouring woman what is happening to her body and to the baby:

Yeah, or just like so that somebody could, even one of the nurses, if they weren't all really busy to stand there and say, "Okay, the baby is out, the baby is good, we are going to take him over and clean him up."

You know.

...

Yeah, that's all. I don't need a lot. Just a little bit. Right?

...

That's it.

It seems as if Nella has given up on the idea that women can be cared for and that birth can be viewed as special in the hospital-based system she experienced, which suggests that caring for a labouring woman's emotional needs is outside the duties of the physician (belonging instead to the doula). Indeed, Nella wondered if the way to ensure women and birth are seen as special is to hire a doula to care for them while the medical team cares for their baby. She was seemingly resigned to the idea that caring for birthing people is not the role of medical professionals.

Okay, it is not the doctor's job to console me.

Right? The doctor is here purely for his or her job of delivery this baby, that is not their job to make me feel happy inside.

The excerpts above point to the vulnerability women experience during birth. The highly emotional nature of birth combines with physical vulnerability to position women as needing care and sensitivity as they navigate this important life event and experience.

Conclusion

Narratives are stories told by people that reflect perspective (who is telling the story), context (the larger environment in which the story is told and the storyteller is situated), and frame (the outlook of the storyteller, including ideas related to culture and background) (Andrews; Riessman, “Narrative Analysis”). The childbirth narratives shared by the participants reflect an experienced-based view of narrative, which allows for shared creation of meaning through the act and interaction of telling and hearing stories (Squire et al.). In their stories, narratives move beyond serving as a way to disseminate knowledge about birth, and become a way of making meaning and creating new knowledges about birth as a special experience. Feminist approaches to research, including feminist interviewing and analysis, recentre subjugated knowledges and experiences. The feminist approach to narrative inquiry and analysis used in this project allowed the powerfully disruptive messages in women’s birth stories to surface; these messages interrupted and talked back to the public narratives about birth and about childbirth distress. This methodology and the narratives produced encourage us to see those who give birth as more than simply birthing bodies—as full people who should also have rights, access to services that meet their needs, and choices in how they have their pregnancies and deliveries. It also allows us to see the importance of reconceptualizing birth as both a regular event and a special experience.

The childbirth stories told by Morgan, Charlie, Sarah George and Nella allow us to show how the individualized, pathological, and event-based views of birth and distress lead to an insufficient framing of distress in childbirth. These women all had serious, sometimes life-threatening, complications during their birth experiences, yet it was not these complications per se that caused them the greatest distress; equally troubling was the erasure of birth as a special and transformative experience. Some women wondered if the lack of awareness of birth as a special experience is linked to the more general and gendered invisibility of women, their work, and their needs in society. Morgan illustrated this analysis when she said “it’s just expected ... this is part of what you do.” Participants’ birth narratives also indicate how the routinization of care feeding into this decentering of women was a source of distress for participants. Charlie was made to feel that because birth is a routine and routinized event in healthcare, her birth experience was no longer important. In sharing her story, her phrasing of this attitude—“Oh get over it. I do this every day”—highlights how her sense of birth as important was dismissed. Sarah George’s story calls attention to the way in which understanding birth as a time-limit event contributes to the mistreatment of women during this special experience. Once she had delivered her baby, the hospital care team seemed to treat birth as over; they left Sarah George alone, exposed, bleeding,

and vulnerable while they attended to her baby and other birthing women. Nella could also see the routinization of care, as she saw the demands this placed on healthcare teams. In a pragmatic and forgiving way, she advocated for women to be treated with just a little bit of respect and care: “I don’t need a lot. Just a little bit. Right?” She recommended that doulas should provide women/mother-centred care if the medical care team cannot. Understanding the demands placed on medical teams, she sees this as a reasonably accommodating middle ground.

As others have argued, (Callister; Palladino; Schiller) listening to and learning from birth stories from the perspective of those giving birth are necessary to understand where the flaws in the current system lie and how to mitigate the harm done within the current system. Paying attention to the experiences of those who have given birth is part of the movement to expand reproductive-rights discourse beyond simply the right to not give birth (through contraception and abortion). It extends concerns to the right to have children and to have reproductive needs and concerns addressed in a more all-encompassing framework (Hayes-Klein; Ladd-Taylor; Schiller; Smith).

Ignoring the needs of women to have the specialness of their childbirth experiences recognized contributes to their emotional distress in childbirth. Participants experienced childbirth differently and outside of the polarized understandings of birth as regular or special. The women interviewed wanted to be seen as deserving of medical care and personal attention in their birth experiences; they also wanted their experience of giving birth to be seen and treated as a special and transformative part of life.

Endnote

- ¹ “HELLP syndrome is a life-threatening pregnancy complication usually considered to be a variant of preeclampsia. Both conditions usually occur during the later stages of pregnancy, or sometimes after childbirth” (Preeclampsia Foundation).

Works Cited

- Adeyuya, A. O., et al. “Post-Traumatic Stress Disorder after Childbirth in Nigerian Women: Prevalence and Risk Factors.” *BJOG: An International Journal of Obstetrics & Gynaecology*, vol. 111, no. 3, 2006, pp. 284-88.
- Alcorn, K. L., et al. “A Prospective Longitudinal Study of the Prevalence of Post-Traumatic Stress Disorder Resulting from Childbirth Events.” *Psychological Medicine*, vol. 40, no. 11, 2010, pp. 1849-59.
- Andrews, Molly. “Learning from Stories, Stories from Learning.” *Explorations in Narrative Research*, vol. 6, edited by Ivor F Goodson et al., Springer

- Science & Business Media, 2013, pp. 33-41.
- Arvay, M. J. "Doing Reflexivity: A Collaborative Narrative Approach." *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*, edited by L. Finlay and B. Gough, Blackwell Publishing, 2003, pp. 163-75.
- Ayers, Susan, et al. "Posttraumatic Stress Disorder after Childbirth: Analysis of Symptom Presentation and Sampling." *Journal of Affective Disorders*, vol. 119, no. 1-3, Dec. 2009, pp. 200-4.
- Bachman, Debra Honig, and Regina Furlong Lind. "Perinatal Social Work and the High Risk Obstetrics Patient." *Social Work in Health Care*, vol. 24, no. 3-4, Apr. 1997, pp. 3-19.
- Banner, Francine. "'She Was Just a Chechen': The Female Suicide Bomber as a Site of Collective Suffering in Wartime Chechen Republic." *Critical Trauma Studies: Understanding Violence, Conflict and Memory in Everyday Life*, edited by Monica J Casper and Eric HR Wertheimer, Kindle Edition, NYU Press, 2016, loc. 708-1177.
- Barbour, Rosaline. *Introducing Qualitative Research: A Student Guide to the Craft of Doing Qualitative Research*. Sage Publications, 2008.
- Beck, Cheryl Tatano. "A Metaethnography of Traumatic Childbirth and Its Aftermath: Amplifying Causal Looping." *Qualitative Health Research*, vol. 21, no. 3, 2011, pp. 301-11.
- Beck, Cheryl Tatano. "Birth Trauma: In the Eye of the Beholder." *Nursing Research*, vol. 53, no. 1, 2004, pp. 28-35.
- Beck, Cheryl Tatano, et al. *Traumatic Childbirth*. Routledge, 2013.
- Brown Wilson, Christine. "Developing Community in Care Homes through a Relationship-Centred Approach." *Health & Social Care in the Community*, vol. 17, no. 2, Mar. 2009, pp. 177-86.
- Burstow, Bonnie. "A Critique of Posttraumatic Stress Disorder and the DSM." *Journal of Humanistic Psychology*, vol. 45, no. 4, 2005, pp. 429-45.
- Callister, Lynn Clark. "Making Meaning: Women's Birth Narratives." *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, vol. 33, no. 4, 2004, pp. 508-18.
- Chadwick, Rachelle J. "Embodied Methodologies: Challenges, Reflections and Strategies." *Qualitative Research*, vol. 17, no. 1, 2017, pp. 54-74.
- Chadwick, Rachelle J., et al. "Narratives of Distress about Birth in South African Public Maternity Settings: A Qualitative Study." *Midwifery*, vol. 30, no. 7, 2014, pp. 862-68.
- Creedy, Debra K., et al. "Childbirth and the Development of Acute Trauma Symptoms: Incidence and Contributing Factors." *Birth*, vol. 27, no. 2, 2000, pp. 104-11.

- Czarnocka, Jo, and Pauline Slade. "Prevalence and Predictors of Post-traumatic Stress Symptoms Following Childbirth." *British Journal of Clinical Psychology*, vol. 39, no. 1, 2000, pp. 35-51.
- Dale-Hewitt, Vanessa, et al. "Patterns of Attention and Experiences of Post-Traumatic Stress Symptoms Following Childbirth: An Experimental Study." *Archives of Women's Mental Health*, vol. 15, no. 4, 2012, pp. 289-96.
- Devault, Marjorie L. "Talking and Listening from Women's Standpoint: Feminist Strategies for Interviewing and Analysis." *Social Problems*, vol. 37, no. 1, 1990, pp. 96-116.
- Fairbrother, Nichole, and Sheila R. Woody. "Fear of Childbirth and Obstetrical Events as Predictors of Postnatal Symptoms of Depression and Post-Traumatic Stress Disorder." *Journal of Psychosomatic Obstetrics & Gynecology*, vol. 28, no. 4, 2007, pp. 239-42.
- Ford, Elizabeth, et al. "Exploration of a Cognitive Model to Predict Post-Traumatic Stress Symptoms Following Childbirth." *Journal of Anxiety Disorders*, vol. 24, no. 3, 2010, pp. 353-59.
- Fottrell, Edward, et al. "Risk of Psychological Distress Following Severe Obstetric Complications in Benin: The Role of Economics, Physical Health and Spousal Abuse." *The British Journal of Psychiatry*, vol. 196, no. 1, 2010, pp. 18-25.
- Hayes-Klein, Hermine. "Human Rights in Childbirth." *Human Rights in Childbirth at Women Deliver 2016*, 19 May 2016, www.humanrightsinchildbirth.org/womendeliver2016/. Accessed 25 Aug. 2018.
- Hydén, M. "Narrating Sensitive Topics." *Doing Narrative Research*, edited by Molly Andrews et al., 2nd edition Kindle edition, Sage, 2013, p. loc. 5145-510.
- Ladd-Taylor, Molly. "Mother's Right Are Human Rights: Reflections on Activism and History." *Journal of the Motherhood Initiative for Research and Community Involvement*, vol. 5, no. 1, 2014, pp. 21-34.
- Lafrance, Michelle N., and Suzanne McKenzie-Mohr. "The DSM and Its Lure of Legitimacy." *Feminism & Psychology*, vol. 23, no. 1, 2013, pp. 119-40.
- Lundgren, L. "The Meaning of Giving Birth from Long-Term Perspective for Childbearing Women." *Qualitative Research in Midwifery and Childbirth: Phenomenological Approaches*, edited by Gill Thomson and Soo Downe, Routledge, 2011, pp. 115-32.
- McCabe, Katharine. "Mothercraft: Birth Work and the Making of Neoliberal Mothers." *Social Science & Medicine*, vol. 162, 2016, pp. 177-84.
- McKenzie-Mohr, Suzanne. *Out from and beyond Trauma: Women's Experiences of the Process from Rape to Living Well (NR55394)*. 2008, search.proquest.com/docview/304403047?accountid=12378. Accessed 25 Aug. 2018.

- Morris, Teresa. *Social Work Research Methods: Four Alternative Paradigms*. Sage Publications, 2005.
- Moyzakitis, Wendy. "Exploring Women's Descriptions of Distress and/or Trauma in Childbirth from a Feminist Perspective." *Evidence Based Midwifery*, vol. 2, 2004, pp. 8-14.
- Palladino, Hallie. "Motherhood's Opening Chapter: Birth Stories as Performance and Counter Performance across Dueling Media Platforms." *Journal of the Motherhood Initiative for Research and Community Involvement*, vol. 6, no. 1, 2015, pp. 107-120.
- Preeclampsia Foundation. "HELLP Syndrome." 2016, <http://www.preeclampsia.org/health-information/hellp-syndrome>. Accessed 3 Sept. 2018.
- Riessman, Catherine. "Analysis of Personal Narratives." *Research in Social Work*, edited by Anne Fortune et al., 2nd ed., Columbia University Press, 2013, pp. 168-91.
- Riessman, Catherine. "Narrative Analysis." *The Qualitative Researcher's Companion*, edited by Michael Huberman, Sage, 2002, pp. 471-86.
- Ross, Loretta, and Rickie Solinger. *Reproductive Justice: An Introduction*. University of California Press, 2017.
- Schiller, Rebecca. *All That Matters: Women's Rights in Childbirth*. Guardian Books, 2015.
- Smith, Andrea. "Beyond Pro-Choice versus Pro-Life: Women of Color and Reproductive Justice." *NWSA Journal*, vol. 17, no. 1, 2005, pp. 119-40.
- Söderquist, Johan, et al. "The Longitudinal Course of Post-Traumatic Stress after Childbirth." *Journal of Psychosomatic Obstetrics & Gynecology*, vol. 27, no. 2, 2006, pp. 113-19.
- Soet, Johanna E., et al. "Prevalence and Predictors of Women's Experience of Psychological Trauma during Childbirth." *Birth*, vol. 30, no. 1, 2003, pp. 36-46.
- Squire, Corinne. "From Experience-Centred to Socioculturally-Oriented Approaches to Narrative." *Doing Narrative Research*, edited by Molly Andrews et al., 2nd edition Kindle edition, Sage Publications, 2013, p. loc. 1279-823.
- Stone-Mediatore, Shari. "The Power of Stories." *Reading across Borders: Storytelling and Knowledges of Resistance*, edited by Shari Stone-Mediatore, Palgrave Macmillan, 2003, pp. 1-16.
- Thomson, Gill. "Abandonment of Being' in Childbirth." *Qualitative Research in Midwifery and Childbirth: Phenomenological Approaches*, edited by Gill Thomson and Soo Downe, Routledge, 2011, pp. 133-52.
- Ussher, Jane. "Are We Medicalizing Women's Misery? A Critical Review of Women's Higher Rates of Reported Depression." *Feminism & Psychology*, vol. 20, no. 1, 2010, pp. 9-35.

- Ussher, Jane. "Body Talk': What Does This Mean?" *Body Talk: The Material and Discursive Regulation of Sexuality, Madness, and Reproduction* [Kindle Edition], Routledge, 1997, pp. 1-8.
- Van Bussel, Johan, et al. "Childbirth Expectations and Experiences and Associations with Mothers' Attitudes to Pregnancy, the Child and Motherhood." *Journal of Reproductive and Infant Psychology*, vol. 28, no. 2, 2010, pp. 143-60.
- Wijma, Klaas, et al. "Posttraumatic Stress Disorder after Childbirth: A Cross Sectional Study." *Journal of Anxiety Disorders*, vol. 11, no. 6, 1997, pp. 587-97.
- Zaers, Stefanie, et al. "Depressive Symptoms and Symptoms of Post-Traumatic Stress Disorder in Women after Childbirth." *Journal of Psychosomatic Obstetrics & Gynecology*, vol. 29, no. 1, 2008, pp. 61-71.