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Factors related to a negative birth experience – A mixed methods study

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ABSTRACT

Objective: this study aimed to explore factors associated with a negative childbirth experience including descriptions from women themselves.
Design: we performed a mixed methods study based on data from the Norwegian cohort of the Bidens study, including a total of 1352 multiparous women. Quantitative information was analysed in addition to thematic analysis of 103 free-text comments provided by women with a prior negative childbirth experience.
Key findings: the total prevalence of a negative birth experience was 21.1%.

A negative experience was associated with fear of birth (AOR: 5.00 95% CI 3.40–7.23) and a history of abuse (AOR 1.34 95% CI 1.01–1.79) in multivariate analysis. Women who indicated they were para 2 were less likely or report a negative childbirth (AOR 0.66 95% CI 0.46–0.94). Three major themes were identified: 'complications for mother, child or both', 'not being seen or heard'; and 'experience of pain and loss of control'. The majority of respondents reported experiences of unexpected and dramatic complications during childbirth. Further, several of the respondents felt a lack of support, that they had not been treated with respect or included in decisions regarding their birth. A minority described pain and loss of control as the main reason for their negative birth experience.
Conclusions and implications for practice: comments by the women show that they were unprepared for complications and inadequate care during birth. The feeling of not being seen or heard during childbirth contributed to a negative experience. Midwives can use the information gained from this study to prevent negative birth experiences.

Introduction

Childbirth is an important life event (Larkin et al., 2009) and considered to be one of the most significant experiences in a woman's life (Hall and Wittkowski, 2006). Most women remember their birth positively and describe it as an experience that enabled them to grow and feel empowered (Thomson and Downe, 2010; Waldenstrom et al., 2004). However, some women describe their birth as a negative experience (Waldenstrom et al., 2004). Instead of feeling empowered, they may feel disconnected, helpless and have a feeling that their body failed them (Rijnders et al., 2008; Waldenstrom et al., 2004). A negative birth experience may have short and long-term impact on women's well-being (Garthus-Niegel et al., 2013; Simkin, 1991). Factors that positively or negatively influence the birth experience include expectations of the forthcoming birth, information, complications, care and communication, feeling of control and perception of pain (Hildingsson, 2015; Nilsson et al., 2010; Simkin, 1991; Thomson and Downe, 2013; Waldenstrom et al., 2004). The woman's subjective interpretation of the birth experience is not necessarily related to actual adverse events (Storksen et al., 2013). If a woman felt safe and well taken care of during the birth process, the overall experience may be positive despite any serious complications (Garthus-Niegel et al., 2014;

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Lavender et al., 1999). On the other hand, a woman who has had an uncomplicated birth, may consider it a negative experience if she has not felt safe and cared for (Garthus-Niegel et al., 2014).

Studies have shown that 5–20% experience their childbirth as a negative event (Rijnders et al., 2008; Smarandache et al., 2016; Waldenstrom et al., 2004). A negative birth experience is associated with post-traumatic stress syndrome (Garthus-Niegel et al., 2014; Waldenstrom et al., 2004), wish for a caesarean section in subsequent deliveries (Storksen et al., 2015), an increased risk of post-partum depression (Bell and Andersson, 2016). It can impact breastfeeding (Brown and Jordan, 2013) and the mother and child relationship (Elmir et al., 2010). A negative experience can cause or increase fear of childbirth (Storksen et al., 2013) and affect the planning of future pregnancies (Gottvall and Waldenstrom, 2002; Slade et al., 1993). Thus, the effects of a negative birth experience may be costly both on a personal and societal level.

Both quantitative methods and qualitative interviews have been used to examine women's birth experiences (Harris and Ayers, 2012; Larsson et al., 2011; Lavender et al., 1999; Lundgren, 2005; Nilsson, 2014; Rijnders et al., 2008; Simkin, 1991; Waldenstrom et al., 2004). The studies have been performed in different periods after birth, right after and months or years after (Simkin, 1991; Storksen et al., 2013; Waldenstrom, 2003). What women remember from birth seems to be quite accurate even years after the experience (Simkin, 1991; Tomeo et al., 1999). Though, it is suggested that the overall assessment of the birth experience can be modified (Waldenstrom, 2003). Not because of memory loss, but when women have the opportunity to think about the experience over time, opinions may change (Waldenstrom, 2003). Simkin used a qualitative design and examined the long-term impact of birth in a group of 20 women (Simkin, 1991). She found that women's memories were vivid and deeply felt 15–20 years after they gave birth (Simkin, 1991). Waldenström et al. found in their cohort study of 2 428 women that 47% made the same assessment regarding pain one year after birth compared to two months after and 60% made the same overall assessment of the birth experience in the same time period (Waldenstrom, 2003). Using data from the Bidens study, a population based cohort of pregnant women, we were able to examine factors related to a previous negative birth experience using both quantitative and qualitative data. To our knowledge this has not been done in previous studies.

The aim of this study was to explore factors associated with a negative birth experience among Norwegian women.

Method

Design

A mixed methods evaluation, consisting of quantitative and qualitative data from the Bidens cohort study was conducted.

The Bidens study

The Bidens study was a six-country (Belgium, Iceland, Denmark, Estonia, Norway, and Sweden) cohort study of unselected pregnant women recruited between March 2008 and August 2010 (Schei et al., 2014). The main aim of the Bidens cohort study was to assess the association between a history of abuse and mode of delivery (Schei et al., 2014). A total of 7 200 pregnant women who consented, subsequently completed a questionnaire and allowed for the extraction of specified data on delivery from their medical notes. The study is described in previously published papers (Lukasse et al., 2014; Schei et al., 2014). The 68-item questionnaires included several validated instruments measuring fear of childbirth, abuse and depression translated into the required languages by a native speaker. This study used self-reported data from 1352 multiparous women in the Norwegian sample. In Norway women, after attending routine ultrasound, received the questionnaire by mail and returned it by mail. Non-responders were sent one reminder and the response rate was 50% in Norway. Table S1 in the Supplementary material describes the Norwegian study sites.

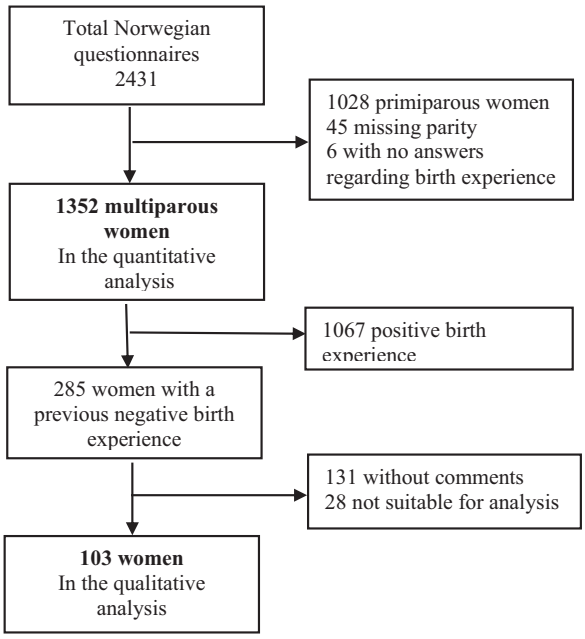

Fig. 1. Inclusion and exclusion process.

Negative birth experience

Women were asked questions about their first and their last childbirth and they could assess whether the birth was an entirely positive experience, an entirely positive experience but with negative elements, an entirely negative experience but with positive elements or an entirely negative experience. Women who answered that the previous birth had been 'an entirely negative experience' or 'an entirely negative experience but with positive elements' were in the negative birth experience group. There was space for the women to write about the experience or add additional comments to the questionnaire. The qualitative data in this study consists of comments from multiparous women who had indicated a negative birth experience. Fig. 1 shows the inclusion/exclusion process.

Covariates

All covariates were a-priori selected based on previous research and availability. All covariates were self-reported by the mother. Age was recoded into four groups: < 25 years, 25–30, 31–35 and ≥ 35 years. Parity was based on how many children women indicated they had given birth and recoded into para 1, para 2 and ≥ para 3. Education was coded at three levels: elementary school (9 years), high school (fewer than 13 years), and college or university. Marital status was coded as married/cohabiting, single or other. Economic hardship was investigated by asking women how easy it would be for them to pay a large bill (23 500 Norwegian kroner, approximately 2700 Euro) within a week, based on the countries' consumer price index levels for 2007. The answering option "very difficult" was defined as experiencing economic hardship. A history of any abuse was defined a positive answer to having experienced emotional, physical or sexual abuse as an adult or child. Women who indicated, that they had no one to confide in beside their partner were categorised as not having social support. The Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) measured fear of birth (Wijma et al., 1998). A W-DEQ score of ≥85 was defined as having a severe fear of birth (Wijma et al., 1998). Depression was