Exploring the 'good' birth: What is it and why does it matter?

Abstract

This article explores the relationship between childbirth and mothers' psychosocial experience of motherhood, through the lens of the 'good' birth. Case histories of eight mothers were selected and written up from research on birthing and risk in an East London locality; these were mothers who had reported an experience of a 'good' or 'great' birth (Simkin, 2006). The aim was to see what they had in common. Three core themes were identified. Firstly, whether as a consequence or a cause of their birthing experience, and most likely both, the mothers were identified as having strong personalities or 'ego's'. Secondly, they had all experienced respectful care. Thirdly, they had experienced a transition to motherhood (Oakley, 1980) that was unambiguous and lacking in tension. Not all of these women had 'natural' births. The conclusion discusses the implications of this for further research and the way childbirth is managed in the UK and beyond.

Keywords: Psychosocial, Respectful care, Risk, Motherhood, Medicalisation

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A core assumption of this article is that there is a need to investigate the relationship between a woman's experience of childbirth and her experience of motherhood. Another assumption is that those involved in the medical management of childbirth—midwives, obstetricians, doulas and so on—are interested in the longer term outcomes for women who give birth. There is an important need, it is argued, to connect the somewhat diverse fields of midwifery, medicine, and the psychosocial, to understand childbirth as a physical, psychological and emotional process, and one that holds sociocultural implications (van Teijlingen, 2005; Reiger and Dempsy, 2006); for example, the emotional and psychological health of the mother after giving birth (Oakley, 1980; Talbot 2014a; 2014b), her sense of adjustment to motherhood (Thomson et al, 2011), and child development (Emerson, 2001).

Narratives of birth

So far, the weight of this story has been carried by narratives of trauma; for example, the growing prevalence and long-term impact of instrumental births, caesarean sections and self-reported trauma during childbirth on women's emotional and psychological health (Fenech and Thomson, 2014). This is perhaps rightly so, given concerns about the escalation of medicalised births (Illich, 1995; Oakley, 1980; Martin, 2001; Rothman, 2014).

What constitutes a 'good' birth?

What is missing is an account of the 'good' birth, which carries multiple and conflicting meanings but could yield insight for the analysis of birthing and motherhood. Telling the story of the good birth is critical in order to reflect on birth trauma from a different perspective, to give a voice to women who have had what they would describe as good births, and for midwives who, according to Scamell and Alaszewski (2012), feel so enmeshed in risk-management practices that they are no longer able to articulate what constitutes a normal birth. The story of childbirth and its importance for women is a neglected one in sociology and feminist thinking (Oakley, 1980; Oakley, 1986), and the story of the good birth, in particular, remains untold, at least in research narratives. This article aims to redress that balance.

Interpretations of what a good birth is are shrouded in ambiguity. The medical model posits it as one free from maternal and infant mortality (Freemantle et al, 2009). The natural childbirth movement proposes that a good birth is a 'normal' one; that is, vaginal and free from unnecessary medical interventions (National Childbirth Trust, 2010). The 'dignity in childbirth' perspective argues that the good birth is one where the women's choices, autonomy and personhood are respected, regardless of levels of medical intervention (Bowser and Hill, 2010; Birthrights, 2013; McConville, 2014). Similarly, Simkin (2006) posits the good birth as one that involves physical health, adherence to medical and ethical protocols, and where the woman feels respected, empathised with, and supported; that is, there is attention to her 'emotional wellbeing' (Green et al, 2003; Simkin, 2006: 5). She adds another definition, the 'great' birth; natural, free from excessive pain and fear, and where the women felt empowered.

Why does this matter?

Available research indicates that how women give birth has physical, psychological and emotional implications for their identity as mothers, and for their relationships after the birth (Oakley, 1980;

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Simkin, 1991; Simkin, 1992; Birthrights, 2013; Fenech and Thomson, 2014; Talbot 2014a; 2014b). In general, high levels of medical intervention and procedures are associated with greater levels of depression and post-traumatic stress disorder — experiences that remain with women long after the birth (Simkin, 2006). Good births, however, matter because they pose the following important questions:

- How is it is that a minority of women escape feelings of trauma (Oakley, 1980)?
- Is there anything we can understand from their experiences?
- Has having a good birth influenced their experience of motherhood?

Methodology

The research that forms the basis of this article consists of 28 semi-structured qualitative interviews with women who had children under 5 in Walthamstow (north-east London). The interviews aimed to explore mother's feelings about risk-taking in their children's lives, and whether this bore any relationship to their earlier feelings about their pregnancy and childbirth. As such, the interview explored relationships between pregnancy, childbirth and experiences of being a mother. Also important were the women's narratives about themselves, their identities and views of their own personalities and life experiences. Naturally, research of this kind must bear in mind the multi-causal nature of journeys to motherhood (Oakley, 1980).

The open-ended nature of the conversations and their person-centred orientation towards the mothers' narratives of their history of motherhood (Miller, 2005) brought these to the fore. The Open University's Human Research Ethics Committee granted ethical approval for the research. The sample was mainly recruited from local online networks, specifically a Facebook group for local parents and Walthamstow Parents Online, while a number were distant acquaintances. These were very active groups with a reasonable broad social base, so suitable for a small exploratory study. Volunteers were initially sent an information sheet and consent form and, after analysis, were sent two reports of the research findings (Barbour, 2001).

From the initial sample of 28, the author selected eight women who described themselves as having a 'good', or even a 'great' birth; the other 20 had described themselves as having traumatic or difficult births (Simkin, 2006). Each of the women have been given pseudonyms for the purposes of this article. All of the women could be described as broadly 'middle-class', although not necessarily affluent, and most were white, with the exception of one woman who was originally from India. The sample was too small to ascertain whether the social composition of the eight women was in any way meaningful. Further research would be needed to examine its relevance. While these women did not necessarily identify as being culturally alternative, most of them had 'dabbled' in alternative therapies during their pregnancy and read about alternative birthing methods. Some of the women worked after the birth, and some were stay-at-home mothers, although this did not appear to influence how they mothered.

In order to examine any potential causation and understand what constitutes a good birth, the author reworked the data into case histories; previous analyses had been based around thematic coding. It was also possible to handle the data in this way because of the small sample size. This article does not claim to provide the definitive answer to what makes a good birth, or whether those who have had a good birth have 'social' characteristics in common. More research with larger sample sizes would be needed in order to gain insight into this. However, this article does aim to use the limited data to open up questions for further thinking and research.

The births

The births described were diverse but, on the whole, were all seen as positive. These accounts will be provided in this section.

Ankel

When Ankel went into labour, it initially felt to her like indigestion. She had a midwife-attended birth and gave birth within 2 hours of arriving at hospital. Her mother was also at the birth and stayed with her for 5 months after her baby was born. Breastfeeding had been very painful for about 8 months, but she said that she had been able to cope because of help from her partner and mother.

Barbara

Barbara said she had an easy birth and although she had planned a homebirth, bad weather had caused support staff delays so she was transferred to hospital. Once she arrived at the hospital, she managed to find an emotional and mental space in which to gain some control. She ended up having a water birth, which she described as 'empowering'. Her daughter had tongue-tie so breastfeeding was difficult at first.

Rachel

Rachel had type-1 diabetes and, as such, her birth

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was medically managed from conception to birth. Her daughter was birthed by caesarian section at 36 weeks. She described her birth as good because of the level of non-judgmental and non-stressful support she had received from medical staff.

Katy

Katy had an older son and two younger twins. With her first, she resisted an induction and gave birth naturally. With her twins, she was 'lucky' enough to be managed by a consultant who had a non-interventionist approach to birthing multiples. She therefore also gave birth to them naturally.

Natalie

Natalie had given birth twice, and both labours were induced with gel. The first labour lasted 2.5 hours and the second lasted 40 minutes. She explained her good birthing experiences as being a function of the speed of the births (although had said the second was a little too quick) and her ability to assert what she wanted.

Enrica

Enrica gave birth twice. The first labour started in a birthing centre but she was transferred to the labour ward because of the length of time the labour was taking; the second took place in the birthing centre. Both births were supervised by the same midwife and had a doula present. Enrica had difficulties with some staff as well as a difficult journey to the birthing centre with her first baby; however, she made a strong connection between being in control, determining who was useful to her and who was not, and having a 'good' birth, which meant that her interpretation of the events were, on the whole, positive.

Esme

Esme had given birth in a house in the country surrounded by her family. She described it as 'idyllic', because she had an easy birth, in familiar surroundings, with a supportive family.

Janet

Janet had a 20-minute labour in an in-hospital birthing centre, where because of the different rules that apply to such centres, she and her husband were both able to spend their first night together. She said that her labour had been quick, not too painful, and that the surroundings had helped her and her husband feel relaxed and rested.

The births of these women were very different in terms of location, duration, levels of medical intervention, pain and so on. So what makes all of them good births? Three key findings have emerged from this analysis:

- Personality interacts strongly with the kinds of births women had, or with how they interpreted their experiences. The women in this sample described themselves as confident, independent-minded and strong-willed and/or strongly motivated by ideas of wanting a birth free of medical intervention. There was one exception to this (i.e. Rachel), which the article will go on to explore in greater depth
- Respectful care and social support were essential to having a good birth
- The kinds of birthing experiences these women had was connected, in their narratives, to their experiences of being a mother.

Personality and 'ego'

Seven out of the eight women sampled described themselves as either having strong personalities and/or having been convinced by a strong ideological position on birthing, either by reading or via the influence of their families.

Ankel had read the book, the *Gentle Birth Method* (Motha and MacLeod, 2004), which she felt had influenced her easy birth. She also said that while she appreciated the advice of her mother, she made up her own mind about how to approach mothering.

Barbara had very strong views about childbirth. These were influenced to some degree by her mother who had one very medicalised birth and three natural births but had difficulty bonding with her baby from the medicalised birth. Barbara was determined to have a homebirth and described herself as strong-minded and independent, having a very different view of risk from the medical profession:

> ***'I see it as very risky, to me, to just put my body in someone else's hands, without them knowing what I'm capable of, or what I think, what I would choose in certain circumstances.'***

Katy had resisted an induction with her first labour, even though she had high blood pressure. As she said of herself:

> ***"cos I'm a bit like that' and 'I'm a bit bloody minded.'***

Katy commented frequently on her strong personality as having a strong connection to her birthing experience and her experiences as a mother.

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Natalie, while she had two inductions, had quick births with both. As she says of the speed of the births:

'In my mind I was willing them out'.

During her births, she had been quite directive with medical staff, which she put down to her personality:

'I'm quite direct, if I don't like something, I tell it as it is'.

Enrica, while less assertive in her personality (although opinionated), had been motivated by a fear of the consequences of a medicalised birth. She read the writings of Ina May Gaskin and 'did lots of yoga' to 'psyche herself up'. Esme had found her birth 'empowering' and located her feelings about birth in the support of her ethically similar and supportive family, particularly the women:

'The women are more significant in my family...there's a lot of fairly strong female characters who have all travelled with their kids and got on with their lives with their children'.

Finally, Janet described herself as having a very relaxed pregnancy, birth and period of motherhood, which she put down to her personality, which was to:

'enjoy the moment and roll with the punches ... things don't tend to faze me too much',

and her upbringing:

'I've never felt lacking, you know ... I've had a wonderful upbringing, wonderful parents ...'

Illich (1995), in his concept of iatrogenesis, argues that the problem with the increased levels of medical intervention is that it corrodes the ego; in other words, our ability to cope internally with pain and suffering. Similarly, Foucault (2003) argues that medical science shapes identity by treating the body as a distinct object and a site of disciplinary power; his perspective captures how the medical gaze can be disempowering. This theme is captured by Oakley (1980: 98), who argues that, 'the medicalisation of childbirth has changed the subjective experience of reproduction altogether, making dependence on others instead of dependence on self a condition of the achievement of motherhood'.

These ideas, together with the findings reported within this article, reveal birth as intrinsically bound with ego and personality. In the 'good' births described, the women all expressed feelings of strength, power and solid senses of self and of the kinds of births they wanted, whether because of their upbringing or via their critical reading.

Of course, it is unclear whether their births were influenced by their sense of personal strength, or whether their 'good' birth was empowering following on from Breen's (1975) theory that birth experiences are developmental. However, it is likely to be both; that is, their birth experiences were influenced by, and also consolidated, their sense of self.

Respectful care

Three of the women who described themselves as having 'good' births did not mention the nature of their care at all during the interviews. They were all women who had very short births, which seemed to suggest that it was the lack of intimate association with medical care owing to their short labours or the fact that they had a homebirth, which accounted for their positive experiences. It is also possible to assume that their medical care had been good and/or unobtrusive and, therefore, comment was not necessary.

There were four other examples where women did comment on their medical care. Barbara said she had to be taken to hospital from her planned homebirth 'kicking and screaming'. However, once she arrived at the hospital, she calmed down, was left to her own devices, got the water birth she asked for at the last minute, and had a good birth, which she described as an 'empowering experience'. She had been able to communicate with her midwife about how the labour was progressing and what was going on with her.

Katy had felt she needed to fight medical opinion with her first labour, to resist an induction. She commented more extensively, however, on her second positive experience with medical care, when she was pregnant with twins. She had been able to move from a consultant who was suggesting all kinds of procedures, to one who advocated non-intervention unless it was strictly necessary.

Natalie had two inductions, but felt in control and that medical staff had listened to her. Enrica had some negative experiences once she was transferred to the labour ward. She described, for example, a consultant coming in with ten students and a 'bossy' midwife by whom she reported she was manhandled. The hospital had also lost notes

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and blood test results, extending her stay beyond her wishes. However, she also had a good midwife and doula who both calmed her down and made her feel in control.

Rachel's birth had been highly medicalised because of her diabetes. She did not describe herself as being particularly damaged because of it, however, nor did she feel she was a particularly strong person. However, possibly because of her diabetes, her expectations may have been very different from those of the other mothers and, furthermore, her medical care had been supportive, reassuring her that she was doing everything right. It is possible, therefore, that there is room for medical staff to allay feelings of guilt and personal failure arising from having a traumatic or difficult birth. In the one example of a good birth where there was a high degree of medical intervention, staff had, according to Rachel, worked to allay feelings of conflict that may have arisen from this.

The results confirm the 'dignity in childbirth' perspective (Bowser and Hill, 2010; Birthrights, 2013; McConville, 2014), that it is not so much about the absence or presence of medical care (whether the birth is natural or medicalised), but rather the tone and practices of the care that matters. Communication and respect for autonomy seems key. Childbirth is not something that can be envisaged as being 'done to' women as the medical model suggests. It is one in which the women should be equal partners, where medical care is supportive and empathetic, and where there is an understanding that birth is an emotional process (Simkin, 2006).

Experiences of motherhood

All of the women, bar one, seemed to feel at ease with their new transition to motherhood (Oakley, 1980) and spoke of adjusting very quickly to its demands. Another way of describing this is that they felt relaxed and 'bonded' with their baby or child. While women who have experienced trauma and postnatal depression often refer to negative feelings such as feeling like a failure, not bonding with their babies, finding everything a struggle and anxiety (Fenech and Thomson, 2014), these negative feelings were not present in the women who felt they had experienced a good birth.

Of course, establishing causation between an experience (the birth) and its aftermath (motherhood) is a fraught exercise in the context of the prevalence of the scientific method in medicine and medical sociology. Nevertheless, it would not be far-fetched, and indeed it is arguably important, to posit an intuitive response here: that is, to claim that being 'in control' of one's birth and carrying it through successfully would enable positive feelings of confidence in one's body and sense of self, which would translate into the way these women feel about being mothers (Oakley, 1980; Wolf, 2001). Examples of this sense of confidence were found in the interviews with all eight of the women. For example, Barbara referred to her birth as an 'empowering experience'. Natalie felt extremely confident about her births, saying 'I've done it, and on gas and air'. Esme also said she felt her birth had been 'really empowering'.

So how did those women who had experienced a 'good' birth talk about their experiences of motherhood? Ankel seemed surprised that the author asked her about how her birth had prepared her for motherhood as, for her, there were no dilemmas to consider in this regard. She enjoyed her time with her daughter; indeed, so much so that she didn't go to many playgroups or other organised activities. She had integrated her own life and activities with her daughter's (e.g. joint cleaning, shopping), and described herself as a responsive mother, relying on some reading, but mainly her own instincts, in relation to her responses to her daughter. As already noted, however, her mother had stayed with her for 5 months after the birth, which she felt had helped her considerably.

Barbara, similarly, felt comfortable with her role as a mother and liked just 'hanging out' with her daughter. Barbara was the main carer for her daughter, who did not go to nursery until she was three; so external support was not evident here. As she said, 'just being with your child is good enough'. Katy also described herself as being comfortable with her children and trusting her instincts, rather than reading too much. She felt it was important not to intervene or interfere too much with her children's autonomy. Katy also had little support in raising her children, as the main carer. Natalie, like all the others considered so far, said she felt relaxed about being a mother and felt comfortable with her children. While she did read parenting manuals, she tended to trust her instincts more. In contrast with Barbara and Katy, but like Ankel, she had wide networks of support, drawing on her same-sex partner, the biological father and his partner, and a local same-sex, parenting group.

In line with emergent patterns of responses, Enrica said she was very relaxed about being a mother, and 'felt quite able to read her children's signs and quite able to act on instinct.' Esme

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commented quite extensively on identity issues. Prior to becoming a mother, she had not really craved motherhood but after the birth, had felt 'really comfortable in a positive way, not as I'd anticipated.' Janet stated directly that her birth experience had helped her sense of confidence and adjustment as a mother; she was less tired, and went through those milestones of negotiating the world with her child early on. She was relaxed about being a mother, and enjoyed her time with her child. She credited her positive outlook on life for this, as well as her good upbringing. Out of these three, only Esme commented that she had good levels of support from her extended family.

Rachel, by contrast, seemed less relaxed and comfortable about her mothering; although she said she was flexible in her approach to parenting, and had plenty of family support, she was also the main wage earner and, therefore, the bulk of child-rearing responsibility had fallen to her partner. In the interview, she cried when reflecting on her daughter going to school, and suggested she regretted not being more present for her daughter. Her family circumstances seemed to overshadow her feelings about being a mother, rather than being a direct response to her childbirth experiences.

Regardless of how one views matters of causation and whether, like in Oakley (1980), an attempt is made to link birthing experience with one's transition to motherhood, the mothers who had good births expressed a palpable absence of tension in their own identities and in their relationships to their children. It may be that there is a complicated causal interaction between their own upbringing, their psychological health prior to giving birth, how these factors played into their experience of childbirth, and their identities as mothers. However, perhaps it is less important to firmly identify causation, than note the narratives that have emerged here and, as a consequence, more clearly consider childbirth as a psychosocial, as well as physical, event.

Conclusion

With all the women considered in this article, with the exception of Rachel, the story of their births is one of strength, success and confidence. Whether as a consequence of their good birth, or as an a priori condition for having one, the women expressed a strong ego-sense. Further, their births had, in the main, been characterised by respectful care (Bowser and Hill, 2010; Birthrights, 2013; McConville, 2014), and this included Rachel who had a very medicalised birth for reasons that were unavoidable. Indeed, perhaps this is why her birth was 'good'; there were no 'what ifs' or possible alternative outcomes. Lastly, the women commented on how their good births had made them feel empowered. Further, whether one regards this as causal consequence or coincidence, that they felt confident and relaxed as mothers, that they trusted themselves, and enjoyed their time with their children.

The weight of the psychosocial story that should be considered a core aspect of childbirth has been borne by discussions of childbirth trauma and the psychological consequences of it (Fenech and Thomson, 2014). Yet, there is much to be learned about the good birth, not just in terms of its definition (Simkin, 2006), but in terms of the emotional, psychological, life history, sociocultural and institutional preconditions for it. The author hopes this article will make a small contribution towards advancing knowledge and practice in this area. **BJM**

Key points

- There is as yet an untold story about the relationship between childbirth experiences and a woman's experience of motherhood, particularly with respect to 'good' births
- Understanding what a good birth is can tell us much about how to manage childbirth, particularly its psychosocial content
- This research found that women who had good births described themselves as having strong personalities or 'egos', which gave them a sense of being in control of their labours
- The women who had good births had experienced 'respectful care'
- The women who had good births, with one exception, felt relaxed and bonded with their babies

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