Birthing Failures: Childbirth as a Female Fault Line

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ABSTRACT

In a qualitative study, 119 women completed an online, open-ended survey about their childbirth experiences. In response to the question, "What ways, if any, did you experience failure?," 65% of women identified feelings of failure. Overwhelmingly attributing the failures to themselves, participants reported that they experienced failures of mind, body, action/inaction, representing "what I feel," "who I am," and "what I did or didn't do" and leading some participants to conclude that they were "less of woman," "less of a mother," or ultimately failed the baby. Such perceived failures can be unintentionally perpetuated by a system that neglects to address the complex experiences and interpretations of birthing women. Helping women anticipate and process the psychosocial and emotional aspects of the birth experience may serve as a protective factor against women internalizing perceived failures as their own, and preventing long term consequences of such feelings. The findings of this study highlight the importance of assessing women's personal experiences and interpretations of childbirth during the prenatal phase to address expectations and increase preparedness.

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INTRODUCTION

Women evaluate their birth performance as an important, if not the most important,element of their childbirth experience; pleased when they do well and disappointed when they felt they have not (Mackey, 1995). Women tend to remember their birth experiences for a lifetime. Despite the fact that birth is a critical biopsychosocial and spiritual event in many women's lives, women's interpretations and meaning making of childbirth experiences are not well studied. This qualitative study explored narratives on how women were impacted by their birth experiences, specifically eliciting experiences of power, accomplishment, disempowerment, and failure, and the meaning women derived from their experiences, with the aim of better understanding women's lived experiences. These findings suggest that experiences of failure are far more common and complex than previously reported in the literature.

Women evaluate their birth performance as one of the most important, if not the most important component of their childbirth experience; pleased when they do well and disappointed when they felt they have not.

Even in supposed "normal" births, women reported themes of failure, often internalizing the failure as a reflection of some personal failing. Standardization and efficiency within birth systems contribute to the internalization of failure for women who fall short of the system requirements and their own expectations.

LITERATURE REVIEW

Health-care providers recognize that to enhance maternity care women's expectations and experiences of childbirth must be taken into account (Hollins Martin, 2008). Although research supports the value of women's choices regarding some aspects of the childbirth experience, birthing women and clinicians tend to agree that the outcomes of both mother and baby are highest priority (Kingdon et al., 2009). Yet women's impressions of their childbirth experiences extend beyond issues of safety and health. The meaning that women assign to birthing-related events is as important as the events themselves (Allen, 1998). Evaluating women's birth experiences elucidates women's perceptions of a significant biopsychosocial and, for many, spiritual event (Schneider, 2010). An experience that has lasting effects on the birthing woman (Halldórsdóttir & Karlsdóttir, 1996), childbirth may represent a peak emotional experience (Blum, 1980; Colman & Colman, 1971; Leifer, 1980; Tanzer & Block, 1976), a rite of passage (Davis-Floyd, 2003), a shift in self-concept (Benedek, 1959; Parratt & Fahy, 2003), and the onset of a new stage of development (Benedek, 1959). Thus, how a woman experiences and interprets the birth event may shift her very perception of herself (Ayers, Eagle, & Waring, 2006; Schneider, 2010).

Women with perceived prior reproductive "failures" are susceptible to fearing that they will "fail" at birth as well (Reynolds, 1997). Distress in childbirth is often associated with feelings of helplessness and a sense of being out of control over the events and one's own behavior (Allen, 1998). Such distress can persist well into the postpartum period for women who avoid thinking about the birth experience and who do not wish to acknowledge that they are not coping (Allen, 1998). Although discussing and acknowledging distressful birth experiences helps women process their experiences, women may not feel comfortable voicing their distress out of fear that their concerns will not be taken seriously (Moyzakitis, 2004).

Women's negative birth experiences affect women's well-being (Waldenström, 2004). Personal feelings and self-perceptions change after birth. After negative experiences, women report feeling inadequate, unwhole and generally not good about themselves (Ayers et al., 2006). In a meta-ethnographic study of 10 published studies on women's perceptions of traumatic childbirth experiences, across at least 2 studies (see Beck, 2004 and Ayers et al., 2006) women reported feeling angry at themselves for not speaking up during their birth experiences and for submitting to unwanted medical procedures (Elmir, Schmied, Wilkes, & Jackson, 2010). Elmir et al. (2010) also note that women who reportedly felt a sense of "failing" their baby compensated by working hard to form bonds with their babies (see Ayers et al., 2006; Beck & Watson, 2010).

Despite the increased awareness of the significance of the birth event on women, there remains a disparity between how health-care providers and the women themselves view and "evaluate" the birth experience. Health-care providers may portray traumatic birth experiences as "routine" (Beck, 2004). Whereas, women with so-called "normal" birth experiences may experience them as traumatic (Beck, 2004, 2009; Reynolds, 1997; Thomson & Downe, 2008). Likewise, in a context where there is little attention to the birthing women's psychological needs, women may experience more difficulty reconciling the hospitalization and medical treatment, than the actual birth experience (Baker, Choi, Henshaw, & Tree, 2005). It is not uncommon for child-birthing women to "suffer from institutionalized violence" (Kitzinger, 2006, p. 4) because of how they are treated within hospital settings.

The aim of this paper is to report on the themes that emerged in the narrative responses to the question, "In what ways, if any, did you experience a sense of failure?," explore their potential meanings to and impact on birthing women, and examine the implications for birthing practitioners.

METHODS

Following Institutional Review Board approval, women who had given birth within 3 years of the study were recruited online through postings sent to a national network of childbirth educators, doulas, midwives, doctors, and nurses, identified through online resources, and derived from a national contact list from the National Summit for the Health and Humanity of Pregnant Women. A snowball sample technique was employed and recruitment information was posted on Listservs, and in email newsletters. Employing a purposive sample, female

participants who were 25 years and older, had given birth within the 3 years prior to participating in the study, and had a minimum of a high-school education were invited to participate in an online survey consisting of 26 open- and closed-ended questions. The age criteria were selected to exclude adolescent birth experiences, which would potentially confound the data.

Open-ended responses were coded line-by-line using an open-coding, axial coding and grouped into meaningful categories, representing themes (Glaser & Strauss, 1967). Words and statements written by participants provided in vivo codes. An inductive approach was used for identifying and tracking emergent themes. To enhance the credibility and trustworthiness of the data, researcher biases were tracked and negative cases were identified throughout all stages of the study. Peer review and member checking was conducted in the later stages of the data analysis. A second coder coded every 10th survey and variations and consistencies in coding were identified and reviewed until an agreement was reached over the designation of final themes.

The final sample consisted of 119 participants, most of whom were married, Caucasian women. Forty percent of the sample was 35 years of age or older, and 38% was primiparas. Seventy-five percent of participants had a minimum of a college education, while 36% of participants also completed graduate school. Nearly half of the sample was employed while the household income level of participants varied widely, with the highest number of participants (23) falling in the $50,000–$74,999 bracket. Except for one participant, all participants resided in the United States, with 28 different states represented. The states most represented were Connecticut (14%), North Carolina (13%), Virginia (9%), New York (9%), Massachusetts (7%), California (6%), followed by Florida (4%), Utah (4%), and Pennsylvania (4%). During their most recent birth experience, 52% of participants used an obstetrician, while 38% utilized a midwife. Nearly 75% of the women birthed in a hospital, while approximately 20% birthed at home. The remaining 5% of participants gave birth in a birth center. Ninety percent of the sample gave birth to a healthy baby and 25% of the women underwent cesarean surgeries. Eighty-four percent of the women attended childbirth classes. Of the 119 women who responded to the survey, 65% identified experiences of failure in their childbirth experiences. Approximately 10% of the women who identified failure noted that their sense of failure had less to do with the actual childbirth and instead attributed failure to inability or difficulty with breastfeeding, lack of attachment to the baby, experiences during pregnancy, and inability to advocate with their pediatrician.

RESULTS

The narrative responses to the question, "In what ways, if any, did you experience a sense of failure?" revealed multiple ways in which failure was experienced by 65% of participants. Birth emerged as an event, and even "job," of profound responsibility in which there were multiple layers of expectations. In this context, women identified themes of failure in mind, body, and action/inaction. In other words, women identified failure in areas of, "what I feel,""who I am,"and "what I did/didn't do." The meaning of these perceived failures is significant as they reveal birthing women's vulnerability to feeling inadequate as a woman and mother. For some women, such feelings of failure were synonymous with "failing the baby," and reportedly complicated the beginning relationship with and attachment to the baby. Failures occurred not only during the birth itself, but also during the immediate postpartum period with breastfeeding and bonding. Ultimately, a continuum of failure with varying degrees and assigned meanings emerged from the data, underscoring the need to more clearly understand the context and intervening variables that contribute to feelings of failure, as well as the internalization process of these failures.

Context

According to the narratives (designated by individual participant number), managing a profound sense of responsibility, performing a job, and meeting expectations are important aspects to the birthing context. To one participant, birth represented an "unimaginable burden" (P 119) that could not be passed off to anyone else. As another participant described,

> *I couldn't get anyone to understand how I felt and if I failed, then I failed. No one else would have. It felt like a huge responsibility being pregnant, making sure you ate right, paid attention to kick counts, exercised, etc. In some ways, I couldn't wait for the babies to be out so that both of us could care for them, that it wasn't all on me. (P 102)*

Birth represented a job that had to be done. As the same participant described, "I am thankful beyond words. . .that I did my 'job' getting them out to others in a healthy way" (P 102).

Successful execution of the "job" of birth was subject to intense scrutiny by participants, and in part due to how tightly one held on to "self-imposed expectations" (P 35) for where, when, and how one would give birth. Whether a general critique, "I don't think I did a very good job" (P 77) based on doctor doing "almost everything to get her out" (P 77), or expectations for a "natural birth" not being met, women mostly attributed failure to some fault of their own. In other words, they had not properly done their job. As one participant who experienced a vacuum birth noted, "With my first, my experience was that I failed the tradition of birthing normally" (P 27).

Not surprisingly, the type of birth represents another important contextual factor that triggered feelings of failure. The following participant experienced an emergency cesarean surgery.

> *Absolutely I experienced a sense of failure. I was really devastated to have gone through two days of labor to then have an emergency C-section. It was horrible. . .While I thankfully did not suffer from depression after my son was born, I certainly did cry quite a bit in those first couple of weeks. (P 18)*

Managing one's expectations with the reality of the birth experience emerged as a crucial task. As one participant shared,

> *The fact that I had to have a C-section after wanting so badly a natural birth. I think that's something that people don't tell you enough when you are pregnant with your first (perhaps they do and you don't hear it, or perhaps they don't tell you because they don't want to burst your bubble)—but NOTHING goes as planned. The birth doesn't go as planned, bringing home the baby doesn't go as planned, they don't sleep like you had planned. . . So, I definitely felt a sense of failure in that I couldn't deliver vaginally. (P 65)*

Highlighting personal failure, the following participant attributed much of the failure to herself.

> *My first birth felt like a failure because I had planned to deliver at home and needed a transfer to the hospital for epidural and Pitocin. I had a lot of self-imposed expectations and an inability to relax and let the process unfold. I felt like I was not "tough" enough. (P 35)*

Actions

While medical interventions, such as use of pain medications, vacuum birth, premature birth, and cesarean surgeries, were intervening variables directly impacting the birth experience, most women wrote that the failure was not having had the intervention, *per se,* but rather their actions, or *inactions*, that may have triggered the need for the intervention. Participants failed at what they set out to do. As one participant noted,

> *I failed to find the right provider. I failed to completely push (the baby) out in their given time, I failed to refuse the epis[iotomy] when he was on my perineum, I failed to use upright pushing positions on my own, I failed to fight for the natural delivery of my placenta, I failed to go home early on after my "check." I failed because I let their protocols dictate my son's birth. (P 39)*

Multiple participants identified the use of pain medication as a failure, writing, "I broke down and got Nubain" (P 33), "I gave into the urge to use pain medications" (P 61), "I asked for the drugs" (P 56). As their language suggests, there is an implicit assumption that the need for such medications indicates a perceived weakness. The use of pain medications was also tied to one's "mental resources." As another participant described,

> *Though I did not plan to have a natural birth, I still sometimes think I should have tried to do it naturally. But, when the time came to decide—epidural or not—I must thought to myself, 'I don't know if I have the mental resources to do this myself.' (P 26)*

Or, as another participant identified, failure was "that I had an epidural and a cesarean. I feel like I wimped out" (P 77). As one woman noted, the decision to use or not use pain medication in childbirth had further ramifications. "I felt less of woman for not being able to tough it out" (P 61).

The use of pain medications was not just a symbol of personal weakness for some participants, but also signified a key entry point to further interventions, compounding feelings of failure and vulnerability.

With birth one I felt like a failure when I opted to get the epidural. Even the MEAN CRNA quipped that maybe I could get a refund on my birthing ball. If I had my wits about me, I would have punched him! But I was desperate and feeling so helpless, I let him talk to me that way. I should NEVER have gone to the hospital when I did. It was a slippery slope of giving in little by little until I was almost to the point of having a C-section. Thank God, I didn't. I've since reconciled the differences between my ideal birth and what actually happened, but for a few hours after my son was born, I couldn't help but feel like I had been let down. (P 94)

Another participant described how the series of interventions impacted her ability to bond with her baby.

I got an epidural. I had to have a vacuum delivery. I was unable to care for my baby during my recovery. I struggled deeply with these things, because I so wanted to have a "natural birth" and to experience "birth-bonding." (P 95)

The use of medications was also significant in women's narratives regarding the need for cesarean surgeries. Seven participants attributed the need for cesarean surgeries to their choices regarding the medications. As one participant wrote, "I felt if I hadn't had the epidural maybe it would have gone differently" (P 28). Another participant shared, "If only I had the epi(dural) earlier, I would have been able to push him out" (P 100). Several women also mentioned their ambivalence using Pitocin. One noted that she was "pressured into Pitocin" which lead to an epidural (P 70). Another participant wrote,

After the C-section. I hated that I felt I had "let" this happen. I agreed to be put on Pitocin. I was not as well-read as I had thought. I was too trusting. I was too overwhelmed with the excitement that I was going to meet my baby. I knew as they were wheeling me down to the operating room that my next baby would be a VBAC. (P 5)

Inaction

In contrast to participants who perceived their actions as a failure, a subgroup of participants identified their inaction, or passivity, as a failure. For at least one participant, who had a cesarean surgery, being a "good patient," also meant being passive.

I was disappointed that I was not able to give birth to my son. I felt that I failed to give him an uncomplicated entrance into the world. . . I also felt that I failed in speaking up for myself and my son because I was trying to be a good patient. I feel I should have been focused on being a good mother. (P 59)

This experience led this participant to conclude, "I feel that I have yet to experience childbirth" (P 59). Although another participant stated that she identified failure with her first birth "because it was so passive" (P 33), she viewed her experience less as failure and more as "regret" for "agreeing to be induced. . .not insisting that the monitor was wrong" (P 33). She wrote, "They made it sound like I had no choice. But I had lots of choices, I just didn't realize it at the time. . .overall it felt like the birth happened to me, rather than I did something" (P 33).

Another participant similarly reflected on her failure in advocating for herself and the baby.

I felt a sense of failure in that I wasn't able to control all of the "little things" at the hospital after my second birth. There were some very specific things I wanted to happen, but the "baby fog" prevented me from being able to respond quickly and my husband was in a baby fog, too, so he didn't catch them either. It is disappointing that the staff in the maternity units at these hospitals just assume that you want the cookie cutter birth and they don't ask for permission to do anything, they just do it. I knew that was probably going to happen going in with my second birth, but I still wasn't able to stop them from cutting the cord right away and scrubbing the daylights out of the baby. . .(P 116)

The inactivity also reflected a tension between listening to oneself and following the lead of one's medical providers.

I felt awful that I listened to the doctor and not my body. I knew that women have been having babies for millions of years and it shouldn't be that hard for me to follow suit. Yet somehow, I convinced myself that 8 years of college made her all-knowing. I was wrong and in the next pregnancy I will listen to what my doctor has to say and take everything to heart but listen to what my body says as well. (P 84)

Personal Failure

Given the narratives of women who poignantly described their personal failure even in the contexts

of flawed systems, it is not surprising that some women specifically described physical, emotional, and spiritual failure within the childbirth experience.

Body Failure. Women experienced the body failing, and were confronted with feelings of betrayal and estrangement from themselves. As one participant described,

> *. . . I felt like my body didn't work right. My OB said to me once that there are some women who don't "open up" unless they have an epidural. I really didn't want to have one, but I did not progress after hours of hard labor. Once I got the epidural, my cervix opened and my labor progressed, each time. I felt like I had done all the things I was supposed to do pregnant. [I] worked out, did prenatal yoga, practiced relaxation breathing and using a focal point. Nothing worked. I stayed at 5 cm for HOURS until I got the epidural. For some reason, my cervix does not move easily. So, it felt like my body was out of my control, which is not something I am used to. I am a fairly active person and have always done sports and been very athletic. At these times, I could not do what I had done so often in the past, which is to feel like I had some sense of what my body was doing. (P 102)*

Failure took place both before and after birth, leaving a participant who had "medical complications and postpartum depression" (P 112) to conclude,

> *I had a placental abruption and was put on bed rest, which made me feel like a failure. My body wouldn't start laboring. My son wouldn't latch and breastfeeding was very frustrating. I just felt like I had failed in every way. (P 112)*

Identifying one of the more long-range consequences, she shared, "I didn't feel like a good mother for a long time" (P 112).

Emotional Failure. Like the body, a woman's emotional state and fortitude, was a source of perceived failure. One participant noted, "How I felt so out of control emotionally while I was pregnant" (P 101), and another wrote, "I was not calm during my birth. I wanted to be more collected, but I truly lost it for an hour or two. . ." (P 113). In the following two excerpts, an in vivo narrative of "I could have done better" emerged. For example,

> *As in my nature, I felt like I could have done a better job both times. I could have been less scared the first time and more relaxed the second time" (P 114). "I felt I could have 'done it better,' been more prepared and not be so emotionally depleted. (P 14)*

Participants also questioned their ability. For example,

> *Though I did not plan to have a natural birth, I still sometimes think I should have tried to do it naturally. But, when the time came to decide—epidural or not—I just thought to myself, "I don't know if I have the mental resources to do this myself." (P 108)*
>
> *Maybe in the way I handled the pain. I keep on thinking sometimes that it is my attitude that made me feel so much pain. (P 58)*

Spiritual Failure. Demonstrating how experiences of failure may be pervasive to other aspects of the self, one participant noted failure in her faith.

> *I thought there had to be something wrong with me, either with my body or with my faith. My body wasn't fit enough or I didn't have enough faith [in] God that He would pull me through the pain. (P 57)*

Failed the Baby

Some participants reported that they failed their babies based on how their bodies responded to pregnancy and birth, and based on decisions they had made. For several participants, feelings of failure resulted from giving birth prematurely. One participant shared, "I couldn't deliver a healthy baby" (P 17). Another participant described not only feeling her body had failed the baby, but also noted that decisions she did not fully agree with were made on her behalf. She shared,

> *The failure for me was seeing my preemie in the hospital hooked up to wires, when I had to leave the hospital but she had to stay. I still feel like my body failed her. . .it couldn't sustain her through the full term. If it were up to me, I wouldn't have been induced. . .I would have kept her in as long as I could. The doctors and my husband wouldn't allow it because my kidneys were no longer functioning due to preeclampsia. (P 88)*

Some participants reported that they failed their babies based on how their bodies responded to pregnancy and birth, and based on decisions they had made.

Another participant viewed her daughter's premature birth as a failure resulting from the decisions she made in pregnancy. Like some other participants, her relationship to God was interconnected with her interpretation of events.

> *With my daughter, the first one, I did feel like I failed her by having her so early. My diet was horrible (pizza, ribs, chocolate), and I did not get enough rest. My bed rest was okay but not perfect. I felt like God was punishing me for something by having to watch her suffer for 8 weeks in the NICU. (P 51)*

Several participants disclosed that they also experienced failure in feeling attached, and loving their babies. For example,

> *I suppose I felt like a failure in a sense about not feeling attached to my babies at first. They seemed like such strangers to me. (P 119)*
>
> *I experienced a sense of failure after the birth when my baby was not able to breastfeed because of an oral defect. This led to severe postpartum depression where I again experienced a feeling of failure because I didn't love my baby as I felt I should. I felt like a fake mother without love for her child. (P 44)*

Deriving Meaning from Failure

Participants were critical of themselves noting that they could have done a better job, should have had different emotional responses, were not strong enough, and somehow "let" unwanted events happen. Women's birth experiences impacted women's sense of worth and ability as women and as mothers, highlighting the importance of knowing the meanings women construct from their experiences.

> *With my first birth, I felt like I failed because I gave into the urge to use pain meds. If I had just held out he would have been born hours earlier. In some ways, at the time, I felt like less of a woman for not being able to tough it out. With my second birth, for most of the time, I felt like a failure. Not being able to go into labor all the way on my own somehow seemed like it was my fault. My partner (who was having personal issues at the time) reinforced this with comments and their (sic) attitude. When my daughter was born, the fact that she wasn't breathing, and was having complications, also seemed as if it was somehow a failure on my part. I felt let down, sad, somehow less of a woman for not having the "perfect" birth. (P 61)*

Women's birth experiences impacted women's sense of worth and ability as women and as mothers, highlighting the importance of knowing the meanings women construct from their experiences.

The following participant recognized the contradiction between the health-care providers' interpretation of the birth and her own internal experience.

> *In my first birth, I experienced failure when I lost control during contractions. I experienced failure when I listened to the nurses tell me discouraging lies. I experienced failure when I accepted the epidural because I didn't want it. The written details of my first birth are so easy and great that everyone around me thought it was fantastic except for me. I felt this false sense of achievement that made me want to crawl under a rock. I was humiliated and disgusted for handing over my birth to someone else. I felt that it was the hospital or doctor's accomplishment, not mine. I felt that I failed as a mother and as a woman. This failure extended into my first years with my firstborn child. It touched everything I did. (P 25)*

Also alluding to the disconnection with her baby and her providers, the following participant reflected on the impact of not wanting her baby.

> *I felt like a failure through her entire pregnancy. I knew I didn't want that baby, and I told a few people how I felt, but, I softened the words. I made it up to be a mild feeling that I was dealing with and would overcome. Inside myself, I knew it was more intense than I was letting on. I didn't want to go to the hospital. I didn't want her to be born. I felt like a horrible person. I mean, I was a mom of two already. She wasn't the one asking to be in that position. . .with a mother who regretted her birth. I think this overshadowed my entire labor. (P 89)*

The birth experience resonates over time. As one participant wrote, "My birth story turned from every woman's dream to my worst nightmare that I still carry with me" (P 63). She described her feelings of failure:

> *I did not see the C-section as a failure; even though I did hope for a natural birth. My goal was a healthy baby—she was in distress so I know I made the best*

decision to go forth with the C-section. I felt I failed because of my response during the surgery and after. I did not feel like a mother at the time. I also feel like a failure because it still haunts me. I wish I would not have had the epidural and I wish I could have better advocated for myself through the process. For example, when the midwife and I were not "connecting" (she was busy with another birth and often left for extended periods). I should have insisted that a second midwife be called (there were three in the service and I knew the other two intimately). I feel like a failure to my daughter, because maybe she would not have had to go through the distress in the first place if I made different decisions related to the epidural. (P 63)

Perhaps, one of the most serious consequences of such births is the complete dissociation of the woman from the actual birth. Comments such as "I felt birth happened to me rather than I did something" (P 33), "I feel I have yet to experience childbirth" (P 59) give reason to why other participants shared, "[the baby] belonged to the hospital and not to me," (P 27) and that the birth was "the hospital's accomplishment, not mine" (P 25). Unfortunately, this dissociation carried over to the baby, as participants made such statements as, "I was unable to care for the baby during recovery" (P 95), and "I felt that in early days I failed to provide one of the basic needs for my son by not being able to breastfeed" (P 59). As one participant noted the inability "to have 'instant bonding' was devastating" (P 21). Another participant who experienced medical complications and postpartum depression shared, "I didn't feel like a good mother for a long time. . .breastfeeding was frustrating and I just felt I failed in every way" (P 112).

Finally, internalizing these perceived failures may have consequences to the relationship with the child. As one participant wrote, "I feel like a failure to my daughter, because maybe she would not have had to go through the distress in the first place if I had made a different decision about the epidural" (P 63). This mother further noted that once her baby was born she "did not feel like a mother at that time" and wished that "I could have better advocated for myself through the process" (P 63).

Changing Perceptions of Failure

Several participants noted that their perceptions of failure changed over time. Reviewing these narratives provides insight into processes that may help mitigate the internalization of failure. Two participants noted that the passage of time allowed for a certain degree of objectivity. "Yes, since I had to have C-sections I did feel like a failure. Especially after my first child was born. It took me a long time to get over that but now I have no regrets" (P 69). And, "At first I thought I had failed at having a Hypnobirth after my first child. . .but after a few months I was able to be more objective" (P 52).

For other participants, a reframing of the experience as "best for the baby," or choosing to highlight the accomplishments over the feelings of failure, provided a buffer against initial feelings of failure. As one participant noted,

I felt with my first that I failed in having a natural birth. That for a long time bothered me. I have since come to a place in my life where I realized that the C-section was the best thing for the baby. (P 79)

Another participant who identified a sense of failure from a "second-degree tear" wondered how she could have avoided it. "But that was minor compared to my accomplishments" (P 21). Another participant also reframed her original sense of failure. She noted she did not feel failure, "except when I lost my first baby. That wasn't anyone's fault. I think I tried to determine if I was to blame at first, but ultimately, I wasn't. So, it wasn't a failure, it was a loss" (P 37).

Other participants noted a shift in the feelings of failure when they accepted their need for assistance and gained another perspective. One participant wrote, "I felt like that [failure] when I got my epidural but in all honesty, that pain is too much for me and I don't see that as a failure to get some meds" (P 117). Another participant shared,

When I was going through all of the pain, was only 7 cm dilated and the nurse asked if I wanted to get an epi, I first reacted like "oh, no, I'm a failure." But then I soon got over that 'cause I figured I wanted to have the energy to push. . . (P 23)

Or put another way by another participant,

I have struggled with that sense of failure for needing intervention in the birth. But overall, I do get a feeling that after all that I went through it doesn't matter. I got the help I needed when I needed it. . . (P 18)

DISCUSSION

The variation and complexity of participant responses indicate that failure is a relevant and impactful experience to birthing women. Failure is not only experienced with traumatic births, but also, as these findings suggest, exists on a continuum; depending on how a woman makes meaning and interprets her birth experience. For some, failure may be experienced by not having the "perfect" birth, while for others failure may be experienced because of having a series of medical interventions. These results indicate that far more women, even those birthing healthy babies, may experience and internalize a sense of failure than the literature has previously suggested. The women in this study were predominantly older, White, well-educated women with access to resources, and may reflect a potential bias of this population being predisposed to internalizing a sense of failure. This sample may have also had a higher predisposition to desiring "natural births," perhaps being more vulnerable to feelings of failure when medication or other interventions were used. The results clearly indicate a need for further research exploring perceived experiences of failure in childbirth with diverse groups of women.

The participants in this study identified with feelings of failure and overwhelmingly attributed these failures *to their own doing* and internalized the failure as reflecting some flawed aspect of themselves; vastly underestimating the influence that systems, culture, and social standards for birthing may have on their experiences. The narrative data reveal that birthing women in this study attributed stressful experiences and outcomes to their own actions, behaviors, thoughts, and even flaws within themselves. "Haunted" by questions about their abilities and having a nagging sense that they "could have done it better"; these women were vulnerable not only to the systems in which they birthed, but also to their own personal interpretations of their birth experiences.

The discrepancy between care providers and birthing women's interpretations of birthing events is evident in these findings, and is similar to the discrepancy noted in other studies (Beck, 2004; Elmir et al., 2010; Hunker, Patrick, Albrecht, & Wisner, 2009; Redshaw, 2008; Thomson & Downe, 2008). Even participants who are critical of the system in which they birthed are prone to blaming themselves for not advocating properly or for being too concerned with being a "good patient." Remaining passive in a perceived hostile environment is a strategy used by participants in this study. Submission into a more passive patient role is consistent with prior research in which women "perceived that clinical professionals held expert, authoritative status over childbirth and women's bodies" (Thomson & Downe, 2008, p. 271).

Fractured relationships with caregivers may lead to women feeling unacknowledged by health-care professionals and the emotional aspects of birth rendered invisible (Thomson & Downe, 2008). Women may view themselves as a "player" in the event and may agree to unwanted procedures "in an attempt to protect themselves from further adversity" (Thomson & Downe, 2008, p. 271). While Thomson and Downe encourage the dissemination of women's traumatic birth stories, this study suggests that even birth stories which may not be clinically defined as "traumatic" can reveal similar themes. These findings suggest that women's experiences of failure in their birth experiences may be more common and complex than previously thought. Consequently, health-care providers must resist assuming that a healthy baby and mother is enough to protect women from intense and potentially far-reaching feelings of failure.

The experiences of failure in childbirth psychologically impact women who conclude that they failed at being a mother and being a woman. The inability to achieve one's own expectations also compounds one's sense of failure. Through their narratives, the participants perceived failure in their roles and actions, but more deeply in who they were as mothers and women. These results suggest that research identifying the ways in which birth failures may contribute to women's perceptions of their own changing identity, sense of worth as women and mothers is highly recommended. The relationship of perceived failure and postpartum depression and attachment challenges needs further exploration, as well as the protective factors that may mitigate feelings and internalization of failure.

LIMITATIONS

This sample represents a very small segment of the overall population and the results are clearly not intended to be generalizable. The demographics of this study revealed some major demographic differences from a national study completed around the same time (see Table 1). Sampling decisions, such as

TABLE 1.
Comparison of Beyond the Baby Demographics and Listening to Mothers II Statistics (valid percentages reported)

Data Item	Beyond the Baby (%)	Listening to Mothers II[c] (%)
Birth attendant		
Doctor	52.5	92
Midwife	38.1	8
Other		
Mother's age		
18–24	[a]	28
25–29	23.1	27
30–34	36.8	25
35–39	29.1	14
40–45	10.3	6
46–50	0.9	not reported
Mother's education		
High school	100	44 (HS or less)
Some college	15.3	28
College graduate	33.9	20
Postgraduate	41.5	8
Mother's race[b]		
Caucasian	93.3	63
African American	2.5	12
Hispanic	1.6	21
Asian and other	7.6	4
Number of times giving birth		
One	38.7	33
Two	36.1	38
Three or more	25.1	29
Method of birth		
Vaginal	75.4	68
Cesarean	24.6	32

[a]Individuals under 25 years. [b]Participants given option to check off more than one category. [c]Declercq, Sakala, Corry, and Applebaum, 2006.

age of the participant, and years since previous birth, limited the scope of participants and unintentionally may have attracted an older, more educated, and less racially diverse participant pool. Recruitment efforts through a national childbirth conference, and other national Listservs, may have unintentionally attracted respondents whose birth choices are outside of the cultural norm of the United States, thus soliciting a higher number of women than the average population using midwives, engaging in homebirths, or possibly having higher expectations for "natural births." Some respondents also shared that they work within the birth arena, as doctors, nurses, doulas, and midwives.

This report is also based on answers to one question in a larger study exploring the ways that women may feel changed from their birth experiences. As such, questions about failure and accomplishment were used to offset each other. At the time of this report, data analysis reflects emergent themes yet to be analyzed in connection to specific birth demographics. Comparing birth demographics with participant responses to the question would provide a more detailed analysis. Moreover, no definition of "failure" was provided to participants and was subject to each participant's interpretation. Women were not asked to define their birth experiences, as traumatic or otherwise. Consequently, the degree to which the identified "failures" were experienced as traumatic remains unknown. Likewise, participants may have used this question as an opportunity to express some of the more negative aspects of their birthing experience, without necessarily viewing it as a failure. No mental health history or data was collected as part of this study, leaving any connection between experiences and perceptions to prior history, or postpartum depression unknown. In addition, given that some responses fit multiple categories of failure, judgments and interpretations were invariably made about how to best categorize the response. Access to the participant's complete narrative helped inform these decisions.

IMPLICATIONS FOR PRACTICE

Assessing a woman's experience of the birth is important. However, exploring how she interprets her abilities, her overall experience, and how she makes meaning of the birth is essential. Even births that "look good on paper" may embody a sense of failure for the birthing woman. Given that the women in the study were more likely to have homebirths, and use midwives than the general population, it may be that they had higher expectations for a "natural birth," thereby contributing to the sense of failure if they experienced medical intervention. However, this does not explain why the birthing women in this study tended to identify the failure as their own. Attributing failures to herself, the birthing woman may be able to preserve her sense of the health-care environment as a benign and neutral place. If she is to carry the responsibility for a perceived failure, then she may paradoxically experience a renewed, and perhaps illusory, sense of control. Blaming herself unconsciously liberates a woman to consider the ways that she may change circumstance or change herself. This is consistent with the literature that suggests many women do make changes in their subsequent birth experiences (Beck & Watson, 2010; Waldenström, 2004; Reynolds, 1997). However, health-care providers and the systems in which they

work may perpetuate this myth and ultimately benefit from women assuming the "failed" aspects of birth experiences.

These findings underscore the importance of exploring women's expectations for and perceptions of her birth experience, while acknowledging her interpretations of failure. It is only until we can encourage and support women in sharing all aspects of their experiences—both joyful and profoundly disappointing—that birthing women will feel that that the whole of their experiences is being recognized and supported. We know from some of the participants that this personal sense of failure may remain unvoiced and hidden. As Kitzinger (2006) notes, "A woman who is distressed often thinks she must keep it a dark secret. No one wants to hear about her feelings of panic and failure. She believes she is different from all other mothers" (p. 2). Encouraging these discussions and helping women see how they may have internalized failures will bring healing to the woman hiding the complexity of her experience. These findings suggest that birthing women, particularly with the first birth, may benefit from childbirth preparation that explores expectations, fears, and self-concept prior to giving birth, thereby possibly mitigating the internalization of failure. Health-care providers must also be willing to recognize and acknowledge the complexities of women's perceptions, while being open to mining women's experiences and interpretations for meaning following birth.

Providing women with opportunities to express aspects of their experience that are less than favorable, even in normal births, will allow for the expression of feelings that may have otherwise gone into hiding and been internalized as a personal failure. As reported by Allen (1998), women who have had traumatic birth experiences will only continue to experience distress if they are not given an opportunity to cope with the experience. Childbirth educators and health-care providers are in a unique position to explore with women the potential meanings embedded in the birth experience and to help women anticipate a range of feelings and experiences. They may also work within their systems to address the ways in which the system may promote factors that increase women's experiences of failure.

CONCLUSION

The results of this exploratory study suggest that the concept of failure is highly relevant to participants of this study. Their narratives reflected a myriad of ways in which women may interpret having failed aspects of childbirth, even with healthy outcomes. As several participants revealed, these personal interpretations of events can profoundly impact an individual's self-concept as a woman and mother. Moreover, these interpretations and values may influence how a woman experiences the development of the relationships with her child. Health-care providers are in a critical position to assist women in preparing for, experiencing, and exploring their experiences of childbirth.

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