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# "I was able to take it back": Seeking VBAC after experiencing dehumanizing maternity care in a primary cesarean

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## Abstract

In this article, we present findings from a qualitative narrative analysis that examined the pregnancy, primary cesarean, and subsequent birth experiences of women in the United States. Using a maximal variation sampling strategy, we recruited participants via social media and networking to participate in semistructured interviews. Twenty-five women from diverse backgrounds and geographic locations across the U.S. participated, eight self-identified as racialized and seventeen as non-Hispanic, White. Data were analyzed iteratively using Clandinin and Connelly's approach to Narrative Inquiry. Across their narratives, participants described their experiences of maternity care that were either generally negative (dehumanizing care) or positive (humanized care). They further described how their experiences of dehumanizing or humanized care impacted their decision-making for subsequent births, mental health, relationships with the healthcare system, early parenting birth satisfaction, and family planning. Findings suggest that regardless of ultimate mode of birth, what was most important to women was how they are treated by their maternity care team. We suggest practice changes that may improve the experience of maternity care for primary cesarean and subsequent births, especially among those made marginal by systems of oppression.

### Keywords

Respectful maternity care; Vaginal birth after cesarean; Birth experience; Quality maternity care; Cesarean birth; Health equity; Narrative inquiry



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Declaration of competing interest

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## 1. Introduction

The processes of pregnancy, labor, and birth are major life experiences, incorporating both physiologic and psychological processes (Larkin, Begley, & Devane, 2009). Experiences during this period are influenced by multiple tiers of context (i.e., personal, social, environmental, and policy) and may impart life-long influence on a childbearing person and their family (Larkin et al., 2009). The World Health Organization states that service-users' experiences of maternity care are of equivalent importance to the quality of the clinical care provided (Bohren, Tunçalp, & Miller, 2020; Tunçalp et al., 2015; World Health Organization, 2016, 2018a, 2018b). Respectful maternity care is an integral aspect of high-quality care (Miller & Lalonde, 2015; White Ribbon Alliance, 2011) and can improve service-users' experiences and address health inequities (World Health Organization, 2018b). Women and childbearing people who experienced higher quality, more person-centered maternity care have more positive experiences of childbirth, are less likely to report maternal or newborn complications, or to screen positive for depression (Coo, García, & Mira, 2021; Karwan Fares & Mirkhan Ahmed, 2021; Sudhinaraset, Landrian, Golub, Cotter, & Afulani, 2021). In contrast, a negative care experience can create a feeling of distrust toward caregivers (Fries, 2010) and result in distress in the maternity care clinician-patient relationship (Oparah, Arega, Hudson, Jones, & Oseguera, 2016).

One in three individuals across the United States (U.S.) gives birth by cesarean (Osterman, Hamilton, Martin, Driscoll, & Valenzuela, 2022) and each year, approximately 600,000 individuals with a history of cesarean birth experience a subsequent pregnancy and birth (Basile Ibrahim, Kennedy, et al., 2020). To improve the quality of care for those with a history of cesarean, it is essential to understand and learn from the experiences of service users. Despite pregnancy and birth after cesarean being a relatively common occurrence, that has been well-studied in other settings (Keedle, Schmied, Burns, & Dahlen, 2019, 2020, 2022; Lundgren, Begley, Gross, & Bondas, 2012, 2019; Munro et al., 2017; Nilsson, van Limbeek, Vehvilainen-Julkunen, & Lundgren, 2015), little is known about experiences of service-users in the unique U.S. healthcare setting. Learning from service-users is the first step in identifying interventions that may be implemented to improve the overall quality of the maternity care experience, regardless of planned mode of birth after cesarean. The purpose of this study was to examine in detail experiences of pregnancy, primary cesarean, and birth after cesarean among a group of U.S. individuals who were interested in having a VBAC. Specifically, we aimed to describe participants' experiences and to identify consumer-led priorities for improving care options among U.S. service users experiencing cesarean birth and a subsequent birth.

The authors recognize that people with a diverse range of gender identities are capable of pregnancy and birth, and we generally strive to use language that is inclusive of this diversity. In this article, we elected to use the terms "woman/women" and "maternity care" most commonly because that best represents how the participants in this study identified. We chose to use the term "racialized" to describe our participants who would be coded as a race or ethnicity other than White, non-Hispanic because it captures the notion that the ways in which they interact with others is based on a socially-imposed racial/ethnic identity rather

than an identity that they have the ability or opportunity to define for themselves (Hochman, 2018; Ontario Human Rights Commission, n.d.).

## 2. Materials and methods

### 2.1. Study design

We conducted in-depth analyses of narratives collected as the primary qualitative portion of a mixed-methods study exploring contemporary experiences of pregnancy and birth after cesarean across the U.S. Detailed study methods and preliminary results have previously been reported (Basile Ibrahim, Vedam, Illuzzi, Cheyney, & Kennedy, 2022; Basile Ibrahim, Knobf, et al., 2020). In brief, following Institutional Review Board approval (Yale University IRB protocol #2000021384), an online, self-administered questionnaire was created, validated with 20 women who had given birth within the previous 5 years, and distributed via the Qualtrics platform (Provo, UT). Individuals with a history of cesarean who experienced a subsequent birth in the U.S. within the prior 5 years were invited to participate. Recruitment graphics were posted on social media platforms by administrators of peer-led birth advocacy groups (Improving Birth, n.d.; International Cesarean Awareness Network, n.d.) and shared by group members. In addition to collecting birth history and demographic information, the questionnaire asked participants if they were interested in sharing their experiences in an individual interview with the first author. Sixty-eight percent (n = 1166) of questionnaire participants volunteered to share their stories in an individual interview and an additional 22% (n = 371) declared that they were “maybe” interested in sharing their stories.

### 2.2. Data collection

Among the participants who volunteered to be interviewed, interview participants were invited based on maximal variation sampling, a form of purposive sampling in which diverse individuals are chosen because they might hold different perspectives or experiences that could inform the central phenomenon (Creswell & Clark, 2011). To increase transferability, efforts were made to interview participants with diversity of race/ethnicity, geographic location, urban and rural residency, levels of education, income, and insurance status, and who received care from a variety of types of maternity-care providers, including midwives, obstetricians, and family practice physicians. Individual interviews took place between November 2018 and March 2019, within 5-years of participants’ most recent birth experience.

Participants gave online consent during the questionnaire portion of the study and additional verbal consent was obtained prior to starting each interview. Data was collected through in-person interviews (n = 2), and telephone interviews (n = 23). Interview participants received a $10 gift card. Concurrent data collection and analysis was conducted, and as further areas of exploration were identified, interview guides were adjusted. Recruitment of further participants was guided by the data analysis to ensure maximal variation of experiences of the sample and interviewing continued (n = 25) until concept saturation was achieved (Nelson, 2016).

### 2.3. Data management and analysis

Interviews were audio-recorded, and professionally transcribed verbatim. The interview transcripts were analyzed using Atlas.ti versions 8 and 9 by two analysts with expertise in qualitative research methods (BBI & HPK). As this was primarily a study of experiences, Clandinin and Connelly's Narrative Inquiry guided analysis and interpretation of birth narratives. Clandinin and Connelly posit that life experiences are important, and that narratives of significant life events are central in identity formation, as well as in interpretation of past experiences (Clandinin & Connelly, 2000; Clandinin, Caine, Lessard, & Huber, 2016).

After multiple readings and re-readings of each transcript, coding of all interviews was completed in multiple phases. First, attribute coding (Saldana, 2009) was applied to each narrator describing their demographic characteristics. Next, descriptive, and in vivo codes were applied to capture salient themes described by the narrators. Seven interviews were coded and discussed by both analysts until consensus on central themes was reached; then a code book was created and used to guide analysis of the additional narratives. The remaining interviews were then coded by the primary analyst alone (BBI). Memos identifying elements of Clandinin's three dimensional spaces of narratives: temporality, space, and interaction (Clandinin et al., 2016) were drafted for each narrative. Clandinin and Connelly posit that experience is temporal (Clandinin & Connelly, 2000), and given that each participant had at least two birth experiences when interviewed, temporality was especially important in interpretation of narratives because the experiences of the first (cesarean) birth informed participants' decision-making and interpretation of their experiences of their subsequent pregnancies and births.

### 2.4. Reflexivity and methodological Rigor

As data collection and coding continued, field notes and reflexive and analytic memos were created. A research log was completed at each research team meeting and at the conclusion of each data analysis session. After completion of coding, the networking function in Atlas.ti was utilized to create network maps between codes and to evaluate patterns and themes among the narratives. Regular meetings of the research team occurred to discuss the analysis and networks and connections among the codes, and to continue the reflexive process.

**Trustworthiness.—**Efforts were made to increase trustworthiness through credibility, dependability, confirmability, and transferability (Shenton, 2004). In this study, credibility was enhanced with careful documentation of study procedures, activities, and decisions in research memos, and a detailed audit trail was documented. Dependability was enhanced using multiple data sources (questionnaire data and interviews), maximal variation sampling, sampling to saturation, member checking, and concurrent data collection and analysis. Confirmability was enhanced through the audit trail and member checking. Transferability was enhanced by maximal variation sampling. Reflexivity was also used from the outset to document biases to prevent them from overdetermining interpretation of the data (Creswell, 2013). The international research team was comprised of researchers from diverse geographic, professional, and demographic backgrounds such that multiple perspectives could be integrated allowing for a more nuanced and polyvocal interpretation of findings.

## 3. Results

Semi-structured interviews were completed with 25 participants of diverse self-identified race/ethnicity, geographic distribution, parity, provider type, and birth outcome (Table 1). Participants with racialized identities (Black, Indigenous, Latina, and other People of Color) represented 32% of the sample. Most participants had a parity of 2 or 3 (72%) and 8 participants had a parity of 4 or greater (maximum parity 7). Twelve participants (48%) had a vaginal birth after their primary cesarean (VBAC); eight gave birth in-hospital and 4 at home. Nine participants (36%) had an unplanned repeat cesarean after laboring (labor after cesarean, LAC) and 4 (16%) had a planned repeat cesarean. Pseudonyms are used to protect participants' privacy and confidentiality. Racialized participants described more overtly negative experiences with the healthcare team during their primary cesarean and subsequent births. Thus, to highlight the differences in experiences by race/ethnicity, we have included each participant's self-identified race/ethnicity after each quote, along with details about their birth.

### 3.1. Lived experiences of care: positive or negative with little in between

Participants' overarching experiences of maternity care were described as either positive or negative, with few mixed or ambiguous assessments of treatment. Positive care experiences were conveyed through expressions such as: "they treated me like a person", "I felt seen" and "I felt heard". We have termed such care *humanized care*. Conversely, negative experiences were often described using some version of the following words: "I didn't feel like a person," "I didn't feel like my voice mattered," "I didn't feel seen," and "I did not feel cared for." We have termed such descriptions *dehumanizing care*. One participant described humanizing and dehumanizing care experiences when comparing her two birth experiences. While her primary cesarean was described expressly as "dehumanizing," the way she was treated during her second cesarean contrasted sharply:

> The first time [primary cesarean], I described it as when animals are sent to a processing plant, and they're slaughtered. That's what I felt like … It was just a process that was happening to me. I wasn't involved in the process. Whereas the second time, I felt like I was a part of it. And it was recognized that I was a person that was having this process, not something that was just being processed.
>
> (Maricela, birth 2, cesarean after LAC, Afro-Latina)

Participants' experiences of care were the central theme in their narratives, much more so than, for example, their ultimate mode of birth (Fig. 1). When a woman strongly desired a VBAC and expended significant effort to secure the opportunity to try for one, if she felt respected and heard by her care team, even a pregnancy ending in an unplanned cesarean was described as a positive experience. Blythe captures this well in her narrative of her second birth, when she had an unplanned repeat cesarean after laboring with the support of her obstetrician:

> He [obstetrician] goes, "Okay, this is still our plan. We're still doing delayed cord clamping. We're still doing skin to skin. We're still keeping a piece of the umbilical cord. We know our plans. Are you ready?"

(Blythe, birth 2, cesarean after LAC, Native American)

In contrast, some women who ultimately had a VBAC but felt that they were treated poorly by their health care team in the process described their birth experiences negatively. Ynez describes an interaction with the obstetrician she selected because he was purportedly supportive of VBAC:

> And he's [obstetrician] like, 'well, I'm offering you to do a C-section right now and we can get this over with.' and I said, 'I made it very clear to you that that's not what I want. There is no medical reason to do it other than the fact that I'm having a slow labor, which is totally normal for most women.' And he's like, 'Nope, if you don't want to agree to what I'm giving you, then I'm dropping you from my care right now. ' And I said, 'well, bye. ' And so, he dropped me from his care. I'm in the hospital laboring with my son and he dropped me from his care. So, he comes back and he's like, 'Well, I'm officially dropping you from my care, but the Laborist that's on-call volunteered and says that he will support your vaginal birth. I wish you good luck and I hope you don't have adverse outcomes' and he left. And so, from there on, it was a happier environment because I didn't have the negativity of him in there telling me that I needed to have a C-section. I labored for 36 hours with my son with the support of an amazing doula … I had a very healthy, very tired, chubby 8 lb. 10 oz boy vaginally … I don't think personally that I want to have any more babies, but if I were to for some reason, have another baby, I would probably want to do a home birth to experience birth in a place where I don't have to fight so hard for people to hear what I want.

(Ynez, birth 2, VBAC, Latina)

Experiences of care were not shaped simply by the ultimate outcome of VBAC versus repeat cesarean, but by multiple interconnecting elements of care that included both *personal interactions* (knowledge, control, expectations), and *social interactions* (communication and specific interactions with their provider and health care team). Each element was described by participants dichotomously, as generally positive, or negative. Experiences of care during their primary cesarean profoundly shaped participants' birth narratives and were described as impacting many aspects of their lives in the present with expectations that they would continue to shape the future (*temporality*), including their mental and emotional health, early parenting experiences, birth satisfaction, and future family planning. These elements and impacts occurred in *situations* relative to participants' ongoing relationship with the healthcare system and played out in various *places* including home, birth centers, and hospitals (Table 2).

Participants experienced humanized care or dehumanized care based on their unique combination of elements of their maternity care experience. When most of the elements were positive, the overall impression was of humanized care. When most of the elements of care were negative, or if one element was extremely negative, especially if they felt mistreated, violated, or trapped, then their overall experience was of dehumanizing healthcare interactions. Below we analyze each element of care first for birth experiences deemed negative or dehumanizing and then for those described as positive or humanized.

Many of our participants had a dehumanizing experience of care during their pregnancy and birth for their primary cesarean. These negative experiences created part of their past portion of the *temporality* as they planned for their subsequent births. Their past experiences motivated them to seek a different experience for their subsequent pregnancy and birth in an attempt to avoid repeating their negative experience. This was accomplished in a number of ways: seeking a VBAC, changing their *interaction* by switching providers or provider types, and/or changing the *place* where their subsequent birth occurred by planning a community birth/homebirth after cesarean (HBAC).

> I had this idea that I did not want to have a hospital birth [for her 2nd birth]. I did not associate good things with a hospital birth and definitely not in the hospital that I had my daughter.
>
> (Ynez, birth 1, unplanned cesarean, Latina)

### 3.2. Dehumanizing care: "I didn 't feel like a person "

In addition to Maricela's description above of dehumanizing healthcare interactions, many other participants described similar negative experiences around communication, knowledge, expectations, and control.

**Communication:** "No one listened"

Negative experiences of communication included feeling as if they were "kept in the dark," that "information was withheld," or that options or procedures were not explained to them. Participants frequently stated, "*they never told me*" or "no *one listened*".

> He [the OB] really brushed me off at my six-week appointment and I was just like, I, I know this is dramatic, but I really felt assaulted. No one explained anything that happened to me. I was recovering from surgery, and I didn't fully understand what happened to me and I didn't understand the reason for it. And so, I would brush it off and brush it off and then like all of a sudden, I would be hyperventilating and crying myself to sleep.
>
> (Haley, birth 1, unplanned cesarean, White)

**Knowledge:** "I didn't know"

When participants felt uninformed or that their questions or concerns went unanswered, they described experiences related to knowledge negatively as "*I didn t know."*

> It was like pulling teeth to get information … we were always updated by the nurse, never the provider, she seemed never to be around.
>
> (Stephanie, birth 1, unplanned cesarean, White)

Some participants felt that they were sometimes discouraged from knowledge-seeking.

> Anytime we had a lot of questions and really wanted to talk with her [obstetrician], she was very curt with us and said things like, 'well, if you're ever sitting out there past the time you're supposed to be in your appointment, this is why,' when we would have more questions than our 20-minute appointment would allow.

(Kaya, birth 2, HBAC, White)

**Expectations:** "It was exactly the opposite of what I wanted"

Perception of care was strongly shaped by whether participants' expectations for labor and birth were met.

> The doctor I finally wound up with basically told me that if I adhered to his schedule, he would try to accommodate what I wanted in a gentle c-section, but it had to be this day and it had to be this time … But he confirmed multiple things and none of those happened. And I was just left feeling. I don't even know a word to describe it … trapped, I guess, violated, definitely … I wanted my own music or no music, but he played what he wanted … And he didn't really honor anything in my birth plan. One of the nurses laughed and said 'I've never heard of a gentle c-section. There's no such thing. It's a surgery. It's not gentle' … I didn't want them to clamp the cord. I wanted everything to stay as natural as it could. I wanted skin to skin when she was born, and I was told we would be able to do that and that didn't happen … And I didn't want them to remove the vernix and they cleaned her off immediately. They clamped her cord right away … I wanted to breastfeed her in recovery, but I almost missed my golden hour.
>
> (Ariana, birth 2, scheduled but undesired cesarean, Latina)

**Control:** "I didn't have any control"

Participants described feeling out of control over decision making for their care. This included when decisions were made without informing participants of their options or the rationale behind a decision.

> And so, the doctor came in and looked at the printout and just very calmly said, Okay, there are some dips here. And from what I see, I think he'd do better out than in.' And I was like, 'What do you mean by that?' I was just stunned … and so I was kind of caught off guard and he was like 'I'm going to set something up' and he leaves the room. And so, the nurse is sitting there and I'm just like, 'Is he talking a c-section? He didn't even say it.' And she was like, 'Yeah.' So, I'm like, Okay, I should call my husband.' I was super alone. I didn't know this nurse. It was just totally blowing my mind.
>
> (Haley, birth 1, unplanned cesarean, White)

**Interactions with provider and the healthcare team:** "She made me afraid" and "You could kill your baby"

Interactions with the maternity care provider and healthcare team heavily influenced participants' perceptions of care. The words a provider chose were sometimes perceived negatively as acts of coercion and fearmongering. A mother of five described her care during her first birth after cesarean: "I wasn't thinking, I was just, you know, she made me afraid. And so, I consented to a c-section" (Helen, White). Blythe (Native American) had a similar

experience during her first birth, “Lack of knowledge and fear made it to where I just went, ‘Okay. I guess that’s my only option.’” Moira describes an interaction with her obstetrician regarding consenting to a cesarean during labor.

> I was saying ‘you don’t know, can’t we just try a little bit longer? Can we just wait a little bit longer?’ He [OB] said, ‘If you do, I’m going to be forced to contact CPS [Child Protective Services] because at this point you’re putting your own wellbeing or your own wishes ahead of your child’s wellbeing. And you could kill your baby. She’s dying right now. She’ll probably be dead in 30 minutes if you don’t do this.’ So, I got an epidural and then he said, ‘Something else has come up, I’ll be right back’ … He was telling me this, initially at 7:00 in the morning. It was 11:30 in the morning when we finally went back to do the surgery. And this whole time he told me my baby would be dead in 30 minutes. I [had an epidural], I couldn’t move, I couldn’t do anything. And I thought I had been sitting there for three hours with a dead baby. So, it was just a really weird thing. He was very angry during the c-section, kind of telling me, ‘You know, this would have been easier if we’d done it earlier, or if you just consented earlier.’ But then when she was born, he was fine. He was excited for us. He was so happy, ‘It’s a beautiful girl.’ And that was it. And then he stitched me up and I was done and then he, you know, left. So, it was very bizarre.
>
> (Moira, birth 1, unplanned cesarean, White)

In addition to the emotionally intense time of labor and birth, participants described negative interactions during prenatal and postnatal care. Ynez describes an interaction with an obstetrician to whom she transferred to at 27 weeks after feeling pushed into a cesarean by her initial provider.

> And he’s like, well, you’re a new client so I need to make sure that you’re as far along as they say you are and, um, I do vaginal checks on all my patients with the first visit, and I’m like (sighs) I’m already close to my due date, there’s no need for your hands to be inside of me … I know that I can decline this check. And I said, ‘you can’t just do an ultrasound to see how far along I am?’ And he’s like ‘No, it has to be a vaginal exam and if you’re refusing to do a vaginal exam, it’s as easy as me saying I won’t take you as a patient’ … So, I said ‘you know what, fine, but he [Ynez’s husband] stays in here.’ So, my husband stayed in there and he did a vaginal exam and I felt like sh*t, excuse my language, I felt dirty and, um, he did a vaginal exam only to tell me what the paperwork already said.
>
> (Ynez, birth 2, VBAC, Latina)

While this obstetrician initially agreed to support Ynez planning a VBAC, he ultimately refused to care for her while she was in the hospital in labor. She transferred to the hospitalist on call while in labor and ultimately had a VBAC.

Another participant describes an interaction with her provider that left her feeling that her unplanned cesarean had not been important or memorable to her provider.

> I went in for my 6-week postpartum visit, I remember the office manager said, ‘oh, we’ll make this visit with [provider name] because then you can talk about what

> happened.' So, I went in, and I wanted to talk about what happened, and she said, 'well, I'd have to get my notes and look at them.' She had forgotten all about it by then, which really was a downer for me. So, I just, I didn't feel cared for in that process.
>
> (June, birth 1, unplanned cesarean, White)

### 3.3. Impacts of dehumanizing care experiences

Overall experiences of care were perceived by participants to have significant impacts on them, even years later. Areas of impacts included (1) mental and emotional health, (2) relationships with the healthcare system, (3) birth satisfaction and early parenting experiences, and (4) future family planning.

**Mental and emotional health:** Trauma "I carry with me a brokenness that you crafted on that day"

When participants had a negative experience of care, they often described being traumatized and carrying that trauma forward into their parenting, relationships, and healthcare interactions. The following is an excerpt from a letter that Maricela wrote to her healthcare team as part of her emotional processing between her first and second births. She shared the full letter in her interview.

> Those same providers who took care of me that day are equal contributors to my terrible experience as a first-time mother, which should have been filled with joy, happy and pure love, whereas instead full of uncertainty, inadequacy and sadly a lack of bond between my newborn and myself. This wasn't a short-lived experience. I felt this feeling for almost a year. They affected the way that I cared for, loved, and bonded with my child. I was robbed of the opportunity to have joy in welcoming my son. I was stripped of the elation and the high of immediately meeting my child. Instead, I was in a daze. It wasn't until I was in the recovery room that I got to meet my child, so I don't remember it. This was almost an hour after the delivery. My first time meeting him the nurse pulled my blanket down and shoved his face into my breast. I'll never forgot how barbaric that seemed to me to this day. I'll never forgot how stunned I was and how unkind that made me feel as the mother to this child I had just met seconds before … When I went home, my feelings of inadequacy and uncertainty did not fade. When I held my child, I would cry. When I fed my child, I would also cry. When I changed my child, that, too, made me cry. I cried because I was robbed of the care that I deserved as a woman welcoming her firstborn. I am forever scarred by this experience. It affects me to this day, two years after the fact. It affects me as I grow another human and go through another experience with maternity care at a different practice. It affects my ability to trust providers. It affects my ability to relax and feel joyous about welcoming my second child … I want each and every one of you to know that I carry with me a brokenness that you crafted on that day.
>
> (Maricela, birth 1, unplanned cesarean, Afro-Latina)

Relationships with the healthcare system: Distrust and hospital as unsafe “He told me ‘I’m not asking you anymore, I’m telling you’”

Negatively perceived healthcare interactions often had a powerful and long-lasting impact on the ability of participants to trust healthcare providers in the future. There was also an impact on choice of provider type and birth setting (home, birth center, or hospital) for subsequent pregnancies and births as participants attempted to avoid a repeat negative experience.

> I will say one of the most disappointing things for me … was my female Ob-Gyn who performed my c-section. [She] had a really dismissive tone with me about my hesitation. I had sort of assumed that a female Ob-Gyn would understand why I was hesitant to go straight to a c-section, but she didn’t, and in fact she belittled me a lot, and sort of talked down to me and I avoided going back to an Ob-Gyn for several years … I think if I hadn’t developed a friendship with someone who happened to be an Ob-Gyn in my small town, I certainly wouldn’t have looked into a VBAC because I didn’t really trust Ob-Gyns after that. When I processed my first c-section, I realized that I hadn’t really been very well taken care of.
>
> (Skye, birth 1, unplanned cesarean, White)

**Early parenting experiences:** Difficulty bonding and breastfeeding “They kept taking [my baby] out of the room”

Feelings of detachment and difficulty bonding were reported by many participants. These were often paired with difficulties breast-feeding. Sometimes this was due to separation from their baby—a common occurrence after a cesarean birth in this sample.

> I really struggled. It kind of started in the hospital. The nurses kept taking [baby] out of the room without talking to us and they would keep him away from us for 5–6 hours at a time and it was like ‘OK, we know he’s not breastfeeding back there. You guys are formula feeding him and we only wanted to breastfeed’ … and they were telling me that my breasts weren’t producing any milk. My breasts said ‘you’re lying’ because they were in a lot of pain (laughs). I was leaking non-stop. So, yeah, they kept formula feeding him and they started yelling at us saying we were starving our kid and things like that.
>
> (Kirsten, birth 1, planned cesarean for breech position, White)

**Future family planning:** “We’re done having kids”

Multiple participants expressed that their negative experiences of pregnancy and birth led to the decision to avoid having further children. Even if they desired more children, they could not bear to go through the emotional challenge of another pregnancy and birth after cesarean.

> To try for VBAC after two cesareans I would have to go to the research hospital where we’re living now and that doesn’t seem like a very viable option to have to

> drive an hour for all my doctor's appointments when I have a demanding job in my small town. So, when I look at future births, I just don't even think it's an option to try for a VBAC. When I think about future birth, the idea of having a third c-section is a pretty big reason not to have a third kid.
>
> (Skye, birth 2, undesired cesarean after LAC, White)

### 3.4. Humanized care: "They treated me like a person"

In contrast, when a participant felt heard, listened to, or cared for, they described their experiences of care positively. Again communication, knowledge, expectations, perceptions of control, and specific interactions with providers shaped participants' birth experiences as positive.

> When I was laying there during the surgery, I was crying and it was the anesthesiologist who was looking at my face and he was like upside down looking over me and he was the only person who acknowledged me and put his hand on my face and said, 'don't worry, you're okay.'
>
> (Hannah, birth 1, unplanned cesarean, Latina)

**Communication:** "I had a voice"

In contrast, to when they felt that no one listened, participants described a positive experience when they felt like they "*had a voice*," when they felt heard, or that their thoughts, opinions, and desires were valued and considered by the healthcare team.

> That was the first time I had had anybody who was actually, you know, a comfort and felt like there was someone in the room that was listening to me … [they were] the only person who actually took time to talk to me and treat me like a person
>
> (Monica, birth 4, scheduled repeat cesarean, White)

**Knowledge:** "Knowledge is power"

As participants gained knowledge, they felt more informed and empowered. Feeling informed was strongly associated with positive narratives.

> I didn't know of anyone who had a VBAC … I just did a lot of research and sought out stories. Obviously where it did work, but I also sought out stories where it didn't work because I wanted to know what could happen and the likelihood of it happening or not happening, and their outcomes. But then along the way, I met other people. There was a nurse in my building who was in her fifties, and she had a VBAC with her second child and that was a long time ago … I did a lot of research on my own
>
> (Tess, birth 2, VBAC, White)

**Expectations:** Birth plan and hopes honored

When participants' wishes for their birth were honored, they felt heard and respected. As a result, they were left with a positive perception of care.

> In that hospital, they had not frequently had moms holding babies while they were stitched up, but they weren't opposed to it. I asked them, 'Can I see her? Can I have her?" And they did go ahead and rub her down and do scores on her and things, but then they brought her right over to me. And I remember, well, first I remember the joy of actually seeing one of my babies right away. The anesthesiologist commented to me, he was like, 'Wow, your heart rate and your blood pressure and everything; this is the most beautiful, the most perfect numbers that you can have. I'm going to make sure that I suggest this because with that baby, what that baby does for your body makes what we're doing easier.'
>
> (Monica, birth 4, scheduled repeat cesarean, White)

**Control:** "I got to choose"

Participants described their experiences positively when they felt that they had a say in their care or were informed about their choices or rationale for their care.

> So, the c-section was actually wonderful. It was such a healing experience compared to my first one. I don't know if it's because I was older. I don't know if it's because I was at a different practice, a different hospital. But they were so respectful to me, and my wishes and they were so kind and so supportive of the fact that this really sucked and that I had tried [labored] for so long. But in the end, it was my choice … the OB was involved at that point and he was like, 'if you want to go on for a couple more hours, the baby's heart is totally fine.' So, that was really healing for me because I was able to take it back. Like, it was my experience, and I was able to make that choice.
>
> (Annie, birth 2, cesarean after LAC, White)

**Interactions with provider and the healthcare team:** "He made me feel like I could take on the world"

When participants perceived that they were in a collaborative relationship with their provider and healthcare team, many interactions were empowering and very positive for the participants.

> I went to his [obstetrician] office. I remember I wrote down like 20 questions, all of my concerns … You know, all the things. I just rattled all this out to him. And he said, 'You can totally do this. Don't wony.' I remember walking out of that appointment feeling like, I mean I cried of course, but I felt like I could take on the world. He made me feel like I could take on the world. It was amazing.
>
> (Sabrina, birth 3, VBAC2, White)

### 3.5. Impacts of humanizing care

Many of our participants successfully avoided repeating the negative experiences of their primary cesarean. Experiences of humanizing care had positive impacts on participants' emotional health, their relationships with the healthcare system, their birth satisfaction, and their hopes and desires to continue to grow their families.

**Emotional Health:** Healing

When a woman had a positive experience in a subsequent pregnancy and birth, i.e., when she felt cared for and treated well it was extremely healing. This was described by many participants, both those who had VBAC and repeat cesarean births.

> [Midwife] told me oftentimes if you have a good subsequent birth, it really helps heal the trauma of the other birth, and I would say that was 100% true for us, at least for me. I no longer have all of the weight of that trauma of the C-section because the second birth was just perfect for us.
>
> (June, birth 2, HBAC, White)

**Relationship with the healthcare system:** Empowerment "Just knowing what you're capable of is the most important part"

A positive experience can create a sense of empowerment for birthing women. Again, the ultimate mode of birth does not create this feeling of empowerment; it stems from the sense that the birthing woman's personhood and autonomy was respected and valued by the healthcare team.

> I can't even, I can't even describe. I just, I felt on top of the world. I felt like I could do anything. I felt empowered. I felt supported. I learned so much about myself because for nine months I had to fight so hard for myself and in my whole life I've never fought that hard for myself … And, so, by doing that, I was proud to show that my bodyworks. I'mnot broken. I'mnot 'failure to progress.' That'sjusta term that is still given to women by impatient doctors as an excuse to move forward with whatever they want … So, after, you know, working through my whole labor and delivery, I'm healed, I'm happy and I'm proud. I know that I can do it. I know other women can do it. So, that's what I feel after. I felt like you couldn't tell me I can't do anything. I felt like I could take over the whole world.
>
> (Ynez, birth 2, VBAC, Latina)

**Birth satisfaction—**Even when the ultimate mode of birth was different to what was planned or desired, when a woman felt treated with respect and autonomy, she recalled the birth with a high level of satisfaction. This is in stark contrast to those participants who had a VBAC but felt that they were mistreated or disrespected during their experience.

> The entire staff at [hospital] was amazing. The whole time during labor and delivery I felt heard and respected. With each step the midwives took, they explained my options and allowed me to make the decision that I wanted. They were not in a hurry to get the baby out. I knew I could trust them completely. Even the anesthesiologist was wonderful. And every nurse. They just have amazing staff there. They gave me time to process and grieve even during the labor, when things didn't go how I wanted. When we decided to have the c-section, I knew better this time. I knew I needed to process. Last time I was whisked away too quickly, and for no good reason, since it was not an emergency, and sobbed the whole way to the OR. This time, I asked to be left alone with [husband] and [doula] for a while. I had

> [husband] come sit on the bed and hold me while I cried and let out all the things I was feeling. It was so good to have that time beforehand to process the surgery before it happened. I had the opportunity to *try*. I know I did everything within my power to make a VBAC happen … I have no regrets and wouldn't do much differently if I could. I didn't feel laughed at. I didn't feel like they thought I was silly for trying, or like they were looking down on me or questioning my decisions.
>
> (Cynthia, birth 2, unplanned cesarean after LAC, White)

**Future family planning:** "I know now that I can do it, so I want to do it again"

Participants who had a positive and healing birth after cesarean, regardless of their ultimate mode of birth, often felt empowered to attempt another pregnancy and birth after cesarean. Some participants felt that now that they had a provider whom they trusted, they were safe to experience another pregnancy and birth after cesarean.

> I feel like that [respectful care] changes someone's idea of fertility and/or parenthood for their whole life. You know what I mean? If I had had a third section, I would have just had them do a tubal ligation, but like, that's it. I can't, I can't do this a fourth time. I wouldn't want to, but because I got to do that vaginal delivery, it kind of changes my whole outlook on where my family goes and what our future looks like.
>
> (Moira, birth 3, VBA2C, White)

## 4. Discussion

We describe the experiences of primary cesarean birth and pregnancy and birth after cesarean for a diverse group of women across the U.S. Our findings highlight that how a person is treated during their pregnancy and birth experiences has long lasting impacts on their recollection of care, their health, and the health of their families (Fig. 1). Women who had a negative birth experience described struggling to breastfeed and bond with their infants and postpartum mental health challenges such as symptoms of depression and trauma/PTSD. Multiple participants who experienced dehumanized care described a postpartum distrust of the healthcare system that impacted their health system utilization for years after a negative birth experience. Our findings echo the range of experiences of women planning a VBAC in Australia (Keedle, Schmied, Burns, & Dahlen, 2022).

Women who experience a cesarean birth, especially an unplanned or unanticipated cesarean, have increased rates of birth trauma and lower satisfaction with their birth experiences (Benton, Salter, Tape, Wilkinson, & Turnbull, 2019). In the VBAC in Australia Survey, 69% of women stated their previous caesarean was a traumatic experience (Keedle et al., 2020). Although almost every participant had an unplanned primary cesarean, the racialized women in our sample more commonly described overt mistreatment and disrespectful care and traumatic birth experiences than their White counterparts. This is similar to other studies of experiences of maternity care of women from marginalized communities in the U.S. (Altman et al., 2019; Basile Ibrahim, Kennedy, & Combellick, 2021; Chinkam et al., 2023; McLemore et al., 2018; Nguyen et al., 2022; Vedam et al., 2019). It has been noted

that experiences that seem harmless or mundane to healthcare providers are sometimes traumatic to birthing women (Beck, 2004). For a small yet significant number of women, their traumatic childbirth experiences are associated with a diagnosis of posttraumatic stress disorder (Beck, Gable, Sakala, & Declercq, 2011). Many of our participants described posttraumatic stress symptoms related to their birth experiences.

Negative experiences and mistreatment during maternity care are impacting long term health outcomes for women and their families. Negative or traumatic birth experiences are associated with higher rates of maternal mental health complications including postpartum depression and anxiety (Coo et al., 2021) and posttraumatic stress disorder (Beck & Casavant, 2019; Reed, Sharman, & Inglis, 2017). Birth trauma/posttraumatic stress disorder has been implicated in decreased maternal-infant bonding (Kjerulff, Attanasio, Sznajder, & Brubaker, 2021) which was described by many of our participants. Additionally, negative and traumatic experiences create a feeling of distrust that may result in decreased postpartum follow-up (Attanasio, Ranchoff, & Geissler, 2021) and lower utilization of healthcare in general (Gadson, Akpovi, & Mehta, 2017; Hemphill et al., 2023; Nguyen et al., 2022; Oparah et al., 2016), something that was also described by a number of participants. Further, a negative birth experience has impacts on future family planning as those who have a traumatic or negative birth experience are likely to have fewer subsequent children (Gottvall & Waldenstrom, 2002), which is consistent with our participants' experiences.

In the survey arm of this study (n = 1711), having a midwife provider was associated with a 3.5-fold increased likelihood of experiencing more respectful and autonomous maternity care (Basile Ibrahim et al., 2022). The experiences of midwifery care of our interview participants were similarly positive. Those who were cared for by midwives generally felt like respected, collaborative partners in their care. These experiences are in alignment with those reported in other studies in the U.S. and Australia (Basile Ibrahim et al., 2021; Keedle et al., 2020; Vedam et al., 2019). Midwifery models of care are associated with high-quality care in support of normal, physiologic birth, including VBAC (Renfrew, McFadden, et al., 2014) and high levels of respect, a focus on communication and information sharing, and lower rates of intervention (Avery et al., 2018; Renfrew, Homer, et al., 2014; Renfrew, McFadden, et al., 2014). The person-focused and collaborative midwifery model of care embodies many core components of respectful, person-centered maternity care (White Ribbon Alliance, 2011; World Health Organization, 2018a) described by the Quality Maternal and Newborn Care framework (Kennedy et al., 2016; Renfrew, McFadden, et al., 2014). Midwifery models of care have also been shown to improve health and birth outcomes for women and infants (Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017; Nove et al., 2021). Policies increasing access to midwifery models of care, through improved integration of midwives into the health care system (Vedam et al., 2018), improved reimbursement for midwifery care and community birth, and licensure that allow midwives to practice at their full scope may improve quality of maternity care (Carlson et al., 2019; Neal et al., 2019).

Black women have the highest cesarean rate in the U.S. (36.3%) (Osterman et al., 2022). Despite these high rates of intervention, Black women have the poorest maternal and infant birth outcomes (Hoyert, 2021; Kozhimannil, Interrante, Tofte, & Admon, 2020;

Womack, Rossen, & Hirai, 2020). They also most frequently report mistreatment and disrespect in their maternity care (Basile Ibrahim et al., 2021, 2022; Vedam et al., 2019). Improving quality of maternity care for racialized women from preconception to postpartum, is critical to reducing maternal and infant health inequities (Harper, Dugan, Espeland, Martinez-Borges, & McQuellon, 2007; Howell, 2018; Johnson, 2020). Further research should investigate associations between discrimination, lower quality of care, and physiologic changes such as allostatic load (Sonderlund, Schoenthaler, & Thilsing, 2021) and epigenetic alterations (Jawaid, Roszkowski, & Mansuy, 2018; Leimert & Olson, 2020) that may be putting marginalized women at increased risk of poor health outcomes. Further, interventions to improve the experience and quality of maternity care should be developed with the communities they are intended to serve so that they may be better received and more effective at improving outcomes (Altman, McLemore, Oseguera, Lyndon, & Franck, 2020; Stanley et al., 2020).

### Limitations.

This study has several limitations. Given the sample size, which is appropriate for a narrative inquiry study, the diversity of experiences falls short of the wide variety of experiences of women and childbearing people across the U.S. Further, as the retrospective interviews took place after the subsequent birth, narratives of all birth experiences are filtered through the current mental state of the narrator and may not reflect their experiences in real time. Additionally, since this was a study of individuals who were interested in VBAC, the experiences of primary cesarean may have tended to be more negative than for individuals who did not consider VBAC or elected to schedule a repeat cesarean.

## 5. Conclusions

While pregnancy and birth are a relatively short period in an individual's lifetime, experiences during this liminal phase can have intergenerational, lifelong impacts. Providers and members of the healthcare team should be mindful that interactions and interventions that they perceive as routine, unremarkable, or benign are often not perceived as such by women who will only experience them a handful of times in their lives. Although various aspects of pregnancy and birth may be out of the control of any one individual, taking the time to listen to women and explain the rationale for why something needs to be done and respecting the humanity and autonomy of birthing women is fully within the control of each member of the healthcare team. In order to improve the quality of care for all women and birthing people, it is essential to provide humanized care to each person every day.

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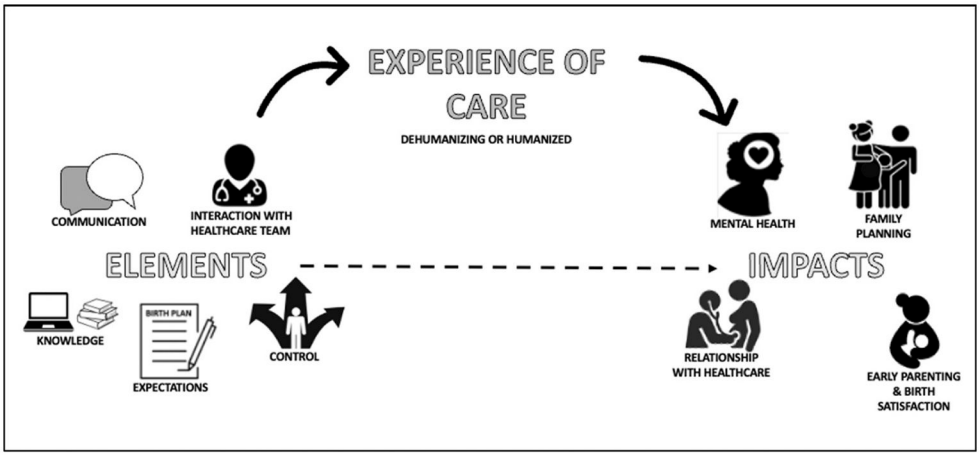


**Fig. 1.**
Elements and impacts of lived experience of maternity care.

## Table 1

Narrative analysis participant demographics.

| | Total *N* = 25 (%) | Racialized *n* = 8 (32) | White *n* = 17 (68) |
|---|---|---|---|
| **Parity** | | | |
| 2 | 16 (64) | 7 (88) | 9 (53) |
| 3 | 2 (8) | 0 (0) | 2 (12) |
| 4+ | 6 (24) | 1 (12) | 5 (29) |
| **Race/ethnicity** * | | | |
| Black | 4 (16) | 4 (50) | 0 (0) |
| Latina | 4 (16) | 4 (50) | 0 (0) |
| Native American | 1 (4) | 1 (13) | 0 (0) |
| White | 17 (68) | 0 (0) | 17 (100) |
| **US region of residence** | | | |
| Midwest | 6 (24) | 1 (13) | 5 (29) |
| Northeast | 5 (20) | 2 (25) | 3 (18) |
| South | 7 (28) | 2 (25) | 5 (29) |
| West-Interior & Southwest | 5 (20) | 2 (25) | 3 (18) |
| West-Coastal | 2 (8) | 1 (13) | 1 (6) |
| **Negative first cesarean experience** | | | |
| Yes | 17 (68) | 7 (88) | 10 (59) |
| No | 4 (16) | 1 (12) | 3 (18) |
| Maybe/neutral | 4 (16) | 0 (0) | 4 (24) |
| **Primary provider for 1st birth after cesarean** | | | |
| Midwife | 11 (44) | 4 (50) | 7 (42) |
| Obstetrician | 14 (56) | 4 (50) | 10 (59) |
| **Mode of birth for 1st birth after cesarean** | | | |
| Vaginal birth after cesarean (VBAC) | 12 (48) | 3 (38) | 9 (53) |
| Hospital-based VBAC | 8 | 2 | 6 |
| Homebirth after cesarean (HBAC) | 4 | 1 | 3 |
| Unplanned cesarean after laboring after cesarean | 9 (36) | 3 (38) | 6 (35) |
| Planned repeat cesarean | 4 (16) | 2 (25) | 2 (12) |

VBAC- Vaginal birth after cesarean, HBAC- Home birth after cesarean, *one participant identifies as Black and Latina and is recorded under both but only counted as one individual in the total *n*.

**Table 2**

Themes within the three-dimensional space of narrative structure.

| INTERACTIONS | | TEMPORALITY | | | PLACE |
|---|---|---|---|---|---|
| **Personal** | **Social** | **Past** | **Present** | **Future** | **Situation** |
| Knowledge | Communication | Previous birth experiences | Early parenting | Future family planning | Place of birth |
| Control | Interaction with healthcare team | Birth experiences of family and friends | Birth satisfaction | | Interaction with healthcare system |
| Expectations | | Past experiences with healthcare system | Mental health | | Family context |