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A Spiritual Journey of Trust During Multiple Childbirth by Caesarean Section

Peer Review Article

Amanda Norman

University of Winchester, UK
Amanda.Norman@winchester.ac.uk

Abstract

This autoethnographic study explores the author's caesarean section experience to evidence spirituality and trust associated with a multiple childbirth through a caesarean section. The reflective account also indicates how spirituality can influence trust during and post childbirth. By appreciating and further understanding the broader notions of spiritual health surrounding childbirth practice, connected healthcare and trusted relationships between midwives and other healthcare providers could further promote woman-centred care and reciprocal relationships. Together with the narratives of women's spiritual experiences of childbirth in health research and training programmes, a synergy between spirituality and trust can be integrated to support meaning-making about childbirth.

Keywords

Autoethnography, caesarean section, spirituality, narrative, childbirth, trust

Introduction

Every birth is unique, and as Belanger-Levesque et al (2016) consider, it is a multidimensional event, with Cox (2022) evaluating it as a 'rite of passage' or transitioning phase to motherhood throughout history, irrespective of where and what form it takes. What distinguishes a multiple childbirth, according to Piontelli (2002), is that irrespective of how the twins are delivered, it tends to be a predominately impersonal and public event with numerous personnel attending. As Farmer (1996) confirms, this is often because multiple pregnancies are medically termed high-

risk throughout pregnancy to childbirth. As Chervenak et al (1995) points out, predominately unfavourable vertex presentation contributes to perinatal loss or morbidity if, as Chauhan and Roberts cited in Piontelli (2002: 52) conclude, instrumental delivery or caesarean section sections are not performed. However, Piontelli (2002) recognised that if the presentation of the mode of delivery and weight of both babies are accurately predicted through foetal monitoring, then vaginal births could be a viable option rather than administering a caesarean section. Women, as highlighted in Piontelli's study (2002), seek to avoid such complications from the outset, opting for a caesarean section, even though, as Hofmeyr et al (2015) confirm, there is insufficient evidence to support significant benefits in the routine use of planned caesarean section unless presenting with a pre-determined complex pregnancy. Ryding et al (2015) concluded that a severe fear of childbirth might also increase the likelihood of women preferring an elective caesarean section. Therefore, a lack of positive anticipation and fear for the impending childbirth remains an important dimension associated with women choosing and those needing an emergency caesarean section. Takács et al (2019) evaluated that one way of overcoming the fear of childbirth was to recommend attending antenatal classes or counselling during pregnancy. A more recent notion from Belanger-Levesque et al (2016) is that all women have some form of spiritual needs that professionals can meet to support mothers throughout childbirth. These included developing relational aspects of trust and respect, hope, letting go and making meaning throughout the experience. However, Crowther and Hall (2018) found that spiritual health and trust are seldom included as part of a maternal support package. As Wojtkowiak and Crowther (2018) concluded in their study, there is little evidence. According to Hall and Taylor (2004), birth in the twenty-first century should be considered meaningful and significant, not just in terms of survival, but as King agrees (1989), also with women's spiritual wellbeing and flourishing personal and collective wellbeing. Oladapo and Gulmezoglu (2018) in their review about positive childbirth experiences, in the WHO intrapartum guidance (2016) also acknowledged that childbirth is not only about surviving but also about professional and personal, trusting care to enable a woman and her baby(s) to reach their full potential and flourish.

The association between fear of childbirth and spiritual awareness through trusting relationships is, therefore, worthy of discussion (Hall, 2006). Carver and Ward (2007) align with this approach, including the value of trust for forming and enhancing personal and professional relationships. Attending to spiritual needs was historically integral to healthcare, but with developing technological interventions during childbirth, the care is increasingly viewed through a medical lens in England. In the eighteenth century, in England, Fox (2022) evaluated that the definition of 'natural' during labour was when there was no necessity for any assistance. Prolonged labour often included summoning a more experienced midwife with experience in surgical appliances to aid the delivery of the baby in a bid to save the mother. Whilst not specifically referring to spirituality, Fox (2022) accounted for the emotional and bonding relationships between female families during childbirth as well as the moral codes of behaviour and the social constructions of health care by trusted midwives in local communities. This correlated with Crowther and Hall's (2018) definition of spirituality, which, in the twentieth century, is defined as a shared human quality that establishes who a person is. Spirituality, as defined by Swinton and Pattison (2010), is therefore fluid, various and imprecise, attached to faith and religion or more focused on relational presence and transformative. The acknowledgement of spirituality can lead to outcomes such as peace of mind, self-fulfilment, and alleviation of suffering. Whilst these were evident in Fox's (2022) birth stories, the modern-day conundrum is spiritually supporting women and meeting their health and safety needs when receiving a medical intervention, a caesarean section. Consequently, King and Koenig (2009) deemed spirituality to be diminishing as a relevant concept in healthcare, with cultural care variations considered but not significantly influential to specialist healthcare approaches or discourses between patients and professionals. However, recent studies (Belanger-Levesque, 2015; Calister et al, 2010; Crowther and Hall, 2015) have revealed that spirituality, specifically in England, is beginning to re-surface in the twenty-first century as a way of meeting mothers' diverse needs during childbirth to reach their full potential and flourish. Lundgren and Berg (2007) reflected on the role of the contemporary

midwife as being an anchored companion with the mother, a spiritually available person to listen, respecting both their limitations within a trusting relationship so the woman feels secure during the birth process. Furthermore, Crowther and Hall (2015) evaluated that developing spiritually trusting relationships between health professionals and parents during childbirth is significant to positive childbirth outcomes.

Spirituality and Childbirth

King and Koenig (2009) assert the necessity to include spirituality in research and health services provision, considering it an increasingly valuable part of healthcare. However, many professionals remain uncertain about spirituality, either associating it with religion aligning or contradictory to their beliefs. As Crowther et al (2021) assert, spiritual care has become procedural, a tick-box culture, with little time or acknowledgement of spiritual needs. Zinnbauer et al (1999) contended spirituality is an ambiguous concept, and therefore, its meanings and definitions are problematic and contradictory. Many atheists also consider the term "spiritual" as being an inappropriate descriptor for their life experiences because of its association with the supernatural and medieval superstition (Harris 2014:6). In moving away from religious connotations, Elkins (1999) cited in Seltzer (2013) highlighted that spirituality was derived from the Latin root spiritus, which means 'breath', referring to the breath of life. A relevant definition when connecting childbirth and spirituality. Spirituality has, therefore, been defined as enabling the individual to immerse in their feelings of intense sensations, with heightened emotions, referred to as a spiritual experience, such as childbirth Athan and Miller, 2005). An example is the transformative experience described by a mother in labour:

> It was exciting I hardly ate or slept… it lasted for two weeks... I was so happy for having this experience… it means everything (Crowther and Hall, 2018: 76).

Furthermore, Crowther and Hall (2015) also described the mother's labour and childbirth as a form of peak experience, without religious connotations attached and more humanistic. As defined by Stefaroi (2012), within a humanistic approach, this may include an awareness of transcendental unity or knowledge of a higher truth during the experience, leading to a greater sense of meaning and purpose. King (1989: 79) concluded, 'Motherhood is a rich and widely ramified concept linked to biological birth, culturally learned patterns of mothering and expressions of…spiritual insights of human experience'. For some women, a sense of God's presence may be their reality during childbirth, as considered by Mutmainnah and Afiyami (2019) in their study of Indonesian Muslim women's experience towards spirituality, with various childbirth experiences, including those with some medical intervention. This included an acknowledgement that submission to God made it easier to endure pregnancy and childbirth, meaning making through shared spiritual stories enhanced their motivation and confidence towards childbirth. Their faith helped raise their self-confidence during their labour and childbirth. However, for other women, there may be more of an association with a sense of transcendence as they emotionally engage in labour (Fuller, 2001). An example from Callister et al (2001) study highlighted that a Finnish woman suggested that while she was not religious, her birth experience went beyond the physical, and she was able to take an embodied lead and centre herself, listening to her body (p31). By remaining calm and tuned into her body, she navigated her childbirth, taking the lead with the health professionals involved. Sellers and Haag (1998: 339) also suggested spirituality went beyond religion and is 'the centre or core of humanness'. Childbirth, as evaluated by Johnson et al (2007), was considered in many ways a rebirth, transitioning into the new role of motherhood. Another feeling was the power of creation when they gave birth. Crowther and Hall (2018) and Gordon (2019) have provided valuable insights, both from professionals' and mothers' spiritual positions in healthcare and as Spivak et al. (1994) concluded, women in labour regularly and predictably experienced transpersonal shifts, also defined as spiritual awareness.

Personalising and Trusting in Others During Childbirth

Whilst childbirth is considered one of the most significant and positive transitions in a woman's life, Cipolletta (2016) reminds us that it can also evolve into a potentially traumatic and disconnected event. Women can feel isolated and alone and, according to Larkin et al. (2009), often unsupported during childbirth, with hospital care frequently precluding the women's emotions before and after the birth (Larkin et al. 2009). This is compounded when increased medical intervention, including caesarean sections necessary during childbirth. Even when the transition is initially surrounded by optimistic emotions, as underlined by Isbir (2013), an increased feeling of fear can be associated with the lack of women's autonomy and choice when childbirth procedures and operations, including planned and emergency caesarean sections, are carried out. As highlighted by Melender (2002), women can be fearful about various areas regarding their pregnancy and childbirth. This can include matters such as their pain threshold, personal wellbeing, healthcare staff interactions, family life, and the options and outcomes of a vaginal delivery or a caesarean section.

By investing in trusting relationships, a sense of spiritual connection between maternity care professionals can reduce childbirth fears and promote a more positive birth experience for women. O'Brian and Casey's (2021) findings revealed that multiple organisational and relational factors influenced how women could be included in their care and choices. Maternity care professionals trusting in women's choices were considered necessary to enable them to navigate their own emotional, subjective aspects of their care in spiritually meaningful ways as they transition to motherhood. However, many healthcare professionals preferred to focus on the risk and safety during childbirth rather than supporting choice, as evidenced by Coxon et al (2014). Diminished decision-making and lack of trust in mothers, according to Edward (2010), led to a reduced sense of autonomy, culminating in women feeling a lack of self-trust. As discussed by Szerszynski (1999), Beck (1992), and Giddens (1991), modern society does not assume to trust authority, but rather it is actively earned and actively invested in. Wynne (1992) further considers the risk to one's self-identity and trust when involved in relationships of dependency. As a mother faced with unforeseen expert interventions regarding childbirth, the public affirmations of trust can often be masked by deep private distrust of the professionals. This, according to Wynne (1992), results in fatalistic acceptance rather than genuine trust in the childbirth decisions made by professionals. In appreciating an authentic and trusting relationship, connections with the mother need to be made. Therefore, discourses about risk, trust and fear should be sensitive and move beyond what Szerszynski (1999) considers the performances of a 'trusting' role. This extends from how professionals enter the relationships with mothers, colleagues and other healthcare professionals at the institutional level. However, as Piontelli (2002) emphasises, the medical view holds pregnancy and childbirth as a physiological event with risk attached; therefore, technological interventions such as caesarean sections are a way of managing those risks.

In considering a diminished trusting relationship further, Lothian (2012) also found that women's-controlled care focused on managing risk rather than enhancing safety. Consequently, this resulted in women lacking trust and being dependent on professional decisions about childbirth. Kowalcek and Hainer (2012) focused on the relationship between maternal age and the preferred mode of delivery, concluding that women of advanced maternal age also placed significantly higher importance and concern on the perceived risks and criteria to safety and bonding. This could be due to several factors, such as women over thirty-five years having more invasive procedures offered from the beginning of their pregnancy journey, for example, amniocentesis and increased monitoring. Their findings concluded that although early care can reduce such risks and most women, irrespective of age, favoured a vaginal birth, the choice for a vaginal birth, predominantly for women over thirty-five, often resulted in a caesarean section, 45% within this study sample. The age of the women, therefore, contributed to increased concern regarding medical complications, childbirth choices and unplanned childbirth experiences, with

concerns and fears voiced, correlating with Wynne's (1992) notions of fatalistic acceptance of professional decisions. Whilst a small sample, the study's findings further resonated with Elmir et al. (2010), who identified themes connected to women's perceptions and experiences of what they considered a traumatic birth. These included feelings of invisibility, a lack of control in the process, being treated inhumanely and feeling trapped. They also reported feelings of extreme emotions and disrupted relationships. They concluded that many mothers had little opportunity to share their feelings with healthcare professionals.

This situation highlights the lack of awareness and knowledge around spiritual health and trust as part of the dialogue during childbirth experiences. Furthermore, as affirmed by Reisz et al. (2015), much of the literature has generally compared women who deliver vaginal births versus those who undergo caesarean sections, with fewer studies addressing how the consequences of multiple childbirth through a caesarean section can influence the spiritual self of the mother. This study attempts to contribute to the dialogue about spirituality and caesarean section childbirth, as well as raise awareness for healthcare professionals and midwives to prepare for spiritual care. Consequently, it presents outcomes from an autoethnographical inquiry that sought ways of knowing through reflection and transformation.

Methods

Autoethnography seeks to connect personal experience to cultural processes, creating the potential for depth and understanding of the issue raised (Liggins et al. 2013). As argued by Ellis et al. (2010), autoethnography allows authors to describe and systematically analyse culturally contextualised personal experiences. Autoethnography, evaluated by Chang (2008), engages the researcher in a constructive interpretation process (p140). It is interpretive regarding the personal perspective contributions to the data collection and how the analysis is processed. It is constructive because the researcher is transformed during the self-analytical process, connecting the contextual past with the ongoing self-discovery in the present. It acknowledges the subjectivity of the researcher and their interactions with the world around them, reconfiguring and making sense of the previous experience, in this study, childbirth experience by caesarean section (Bowers, 2002). Ellis (2000) underlined that an introspection technique, such as autoethnography, provides a valid method to access personal and emotional experiences generally inaccessible with other qualitative and quantitative methods. It openly challenges the neutrality concept of the researcher, in which the separation between researcher and participants is a structural element of the research itself. The researcher's subjectivity and emotion become the relevant dimensions of the research itself, with their point of view embedded in the research.

Autoethnography can expand knowledge and inform research and practice in the context of similar experiences (Marshall, 2008). Autoethnographers have found that their work's scientific robustness or scholarly value has been questioned, with some reviewers considering autoethnography as being too individualistic. Ellis (2000), a strong proponent of autoethnographic writing, evaluated that by using an autoethnography approach, the researcher was argued to be self-absorbed and indulgent, failing to hypothesise, analyse, contextualize, and theorise. However, Larkin et al (2009) state that by rejecting these criticisms, autoethnography is considered an ethical form of research that prevents researchers from appropriating the voices of others. Instead, it centres the voice of the researchers themselves within the research. This form of research, therefore, does not claim to make generalisations or scientific claims. Rather, it informs the reader through the researcher's personal and emotional storytelling, with deeper experiences conveyed and understood.

As underlined by Ellis et al. (2010), the reliability, validity, and generalisations of an autoethnography approach are the reader's response to and self-recognition of the material. Self-recognition is supported by writing in the first person, following an individualised style to

provoke the reader to be more emotionally engaged towards the data presented. Peterson (2015) evaluated that autoethnography assumes reality as multifaceted, and the role of culture and context is crucial in understanding personal human experiences. By including my personal experience as a pregnant woman with twins and a researcher, I aim to share my experience, highlighting the significance and impact of a multiple childbirth journey via a caesarean section. I critically reflected and systematically analysed my personal experience by using some theoretical frameworks: expectations and fears related to the birth event, the relationships with professionals during the birth event and the sharing of medical procedures. Autoethnographers immerse themselves further into their critique of social and cultural experiences, which runs contrary to traditional modes of silent authorship (Chang, 2008). This offers ways to explore and reflect on personal histories, values, beliefs and lived experiences through constructive interpretation (Peterson, 2015).

Personal Narrative: Experience of Childbirth

As a mother of two children, I felt like a veteran as I embarked on my third. However, I had not expected the journey of a multiple pregnancy to be centred around scans and complications as the months passed. I did not attend the same antenatal classes as I had done with my first, and as an older female felt detachment and disconnect when I visited and had ultrasound scans carried out. The main aim was to check for any problems, and little was said about my delivery options. I had a previous caesarean section, so the complications were presented to me. With some autonomy, I think I agreed this would be the way forward. I do not recall any breastfeeding options shared, and there was little time for conversations about how I felt in myself. My spiritual care was replaced with medical reassurances by the health carers, and physical health, diet, size, weight, and blood pressure took priority. The antenatal care was managed through support staff who did not have any conclusive answers and were careful in advising me I would need to speak to the specialist for anything specific. I did have a midwife, but from previous experiences, these had changed frequently and were not present at the birth. I had not realised how the changes had affected me, but on reflection, I had felt like my personal feelings conveyed had gotten lost in the midwifery changes to my professional care. My trust in sharing how I felt was gone during my third pregnancy. I was met by another professional midwife whose face I did not know and who could only see me briefly.

As I sat and waited for my allocated midwife, I wondered if I would be able to share my fears. As I entered the room, a young midwife sat before me with slick, tied-back hair and a small figure. To me, she had little visible lines of an experienced life on her face, an assumption I know I had made in that first meeting. It may be more about my own feelings, perhaps, being 42 years old and heavily pregnant. She took my blood pressure and then suggested that a caesarean section certainly didn't have to be the outcome and that a natural birth could be possible with twins. I remember looking at her with a mix of frustration and annoyance as she mentioned a couple of studies she had read in relation to multiple natural births. Natural always made me think I was proposing or previously experienced something unnatural, the trust between us widening and distancing. I recall wondering whether she had given birth herself and how much emphasis was placed on a vaginal birth from her recently completed training. I try to feel calm and think positively, as it is her job, and she is trying to present me with options. From my experience in trying to convey the emotions of helplessness and my achievements of having two healthy children already from previous life-threatening childbirth experiences seemed too much to say and far too dramatic. So, I say nothing and allow her to chat about processes to come. I think about how I feel about her comments and consider that perhaps I play a minor role as 'patient' in her story, an unfamiliar face with little to offer or need in terms of being her patient within our relationship.

Childbirth number three: At the hospital, I physically prepare for my caesarean section. I wash my hair, brush it, and then tie it back in preparation, unsure when I may get another chance to attend to my appearance. I follow the procedures of not eating, being checked, and arranging my home items around my bed. I talk to my family on the phone, go through moments of excitement, and

then calm. I have been in a few days pre-labour, and the decision to have the caesarean section was brought forward with my blood pressure high. Ultimately, I had little and no voice in what and how I chose to give birth, relying on advice and agreeing rather than making independent decisions. Once again, a medical procedure to be undertaken …. I do not think of what may go wrong but rather visualise the positives of having my babies soon; my spiritual self is calm and mindful. I recall my previous feelings of love for my daughter and how the process was calm and magical. I feel it will be similar…. I am focusing on my spinal block as the ritual of the spine injection commences…I am unduly anxious about the injection that it will not be a success. I feel it is a premonition perhaps and vocalise this to the staff who laugh and reassure me it is nerves, and I am worrying unduly…. Unfortunately, as I observed the long needle and was asked to roll my back, absurd when you are huge and scared. It took four painful attempts, 'roll your back', they bark as they try again, and the no-nonsense medical voices prevail, but I feel a lack of trust and connection … Once achieved, I am quickly moved to an operating bed in preparation – my legs tingling and now accepting the rest is beyond my physical control. I must allow the professionals to take responsibility for me and my babies; I must trust them. I remain calm and enthusiastic. The staff speak all around me but not to me. My husband sits near, talks to me, and I am asked if I need more medication every so often; the anaesthetist talks in a calm manner, and here I feel calm….one baby is in an awkward position, and the room is filled with an atmosphere of tension and abrupt voices. I am not spoken to, and calls are made from the phone fixed to the wall. I close my eyes and breathe slowly. I focus on the voices familiar to me and breathe. The collective group of medical professionals continue to talk all around me…. The crash team are notified. I lie and wait, unable to move or take the lead in my own body or thought to the next step… the babies arrive one by one. They are shown to me, held by the midwives, fed by the midwives, and removed by the midwives. Busy and procedural came to mind… kindness was needed…I trust they know what they are doing with my babies….

I feel a sense of awe and euphoria with my childbirth event successfully finished, but also a feeling of helplessness and removed from the present. Residing in the tension between the overwhelming feelings. I was not asked much about the babies or myself, and I felt my spiritual health could have been included. I connect in part to the mothers who felt childbirth was a spiritual experience but also to the complexity and anxiety around medicalised childbirth and the attitudes towards me because of this. I failed to have a sense of euphoria, more of a bubbling gratitude they had arrived in this world.

I was taken to a recovery room, and one of my babies was already there, but one had been taken to emergency care as a precaution. I was told in a casual, busy manner, perhaps deliberately so as not to worry me…I felt emotionally fragile at the news, responding as such. During the subsequent hours, I am left alone to rest and recover with my husband by my side. I look at my one baby and listen to the midwives as they come in and out of the room, chatting about their shifts and what they will be doing during the weekend. Eventually, a nurse comes over and asks if I would like to be cleaned and washed. I agree and remain numb; my thoughts and physical body are not aligned.

My body is responding and reacting to the environment while my head is full of thoughts about the new lives I have produced and the uncertainty of their future during this day. Their future in the short term and long term is unknown to all, and I have to accept what will be… in a spiritual but not Godly way…

The nurse cleans the yellowy-orange stains that encase my lower body. She is gentle in her manner, and I believe she is gentle in her approach. I question her medical role to myself. How many times does she undertake this ritual with unknown women post-operation? She doesn't speak a lot but asked if I would like toast and a drink, and her presence is calming. She talks about my babies, and I feel a sense of being valued for the first time since I attended the operating room. She explained why my daughter had gone to special care. Once again, I put my trust in the professional, perhaps not by choice, in where she has gone. I would like to see them both at that moment, but I resign to wait until I am told. The trust resolved to acceptance, and I feel I am suspended in time as I recover physically

from the birth. I will keep their hats and wristbands as a symbolic remembrance of the day…. It was a spiritual period, and I was very much in the present, moment to moment. I did not pray or call on God. Rather I appreciated and accepted the situation. I would have liked to be listened to and interacted with more though….

Discussion

The process of narrative inquiry of my childbirth experience expanded upon storytelling and involved critical reflection with personal information whilst making connections between the experience and the cultural context (Connelly and Clandinin, 1999). A Neoliberalist ideologically informed perspective suggests that the process of reflective practice may 'hollow out' learning and therefore be viewed as being restrictive and simply a confessional narrative (Chang, 2008). However, Moloney (2006) asserted that the narrative conveys insights into the connection between childbirth and spirituality (Callister, 2010; Rosato et al. 2006). 'Birth stories offer a powerful and rich source of data. Greater emphasis needs to be accorded to a valuing of women's stories as data' (Carolan, 2006: 66). Understanding spirituality in childbirth is therefore nested between the existing literature and my own culturally contextualised childbirth journey to becoming a mother. My autoethnographical narrative was framed by Chang's (2008) 5 themes to organise my data findings. It was a useful approach to drawing on personal key themes, culturally contextualised in my experience of childbirth. In producing this model, it enabled me to reflect on my position.

1. Proverbs
2. Rituals
3. Artefacts
4. Values
5. Mentors

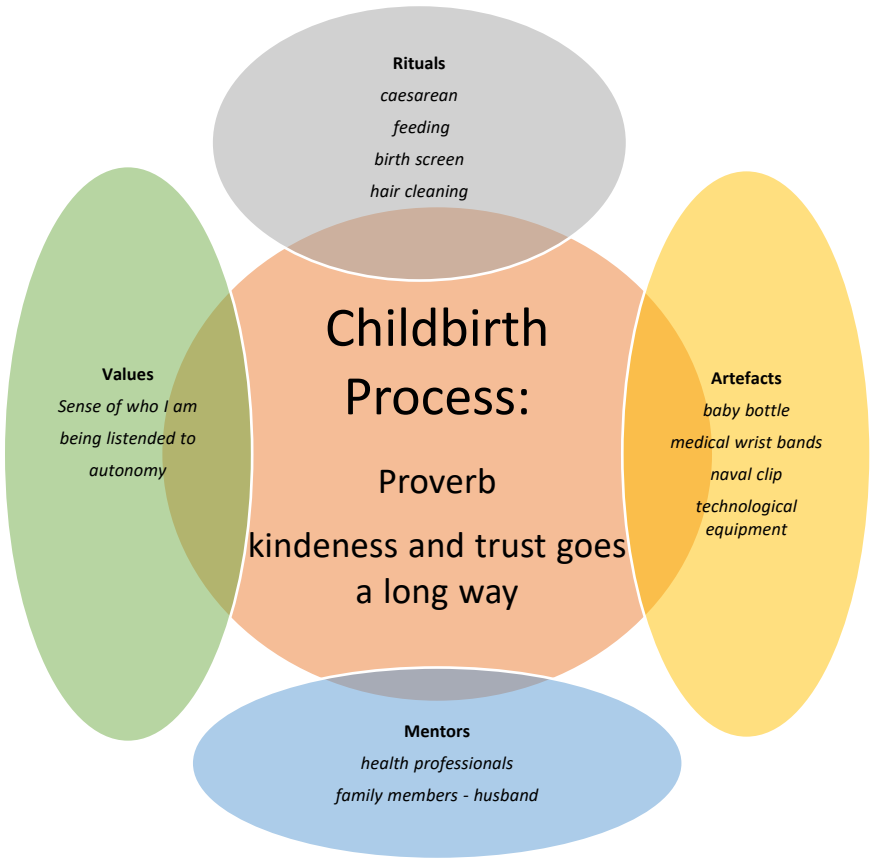

Figure 1: Reflections on themes during my personal experiences of childbirth and post-delivery adapted from Chang (2008: 76)

Proverbs = Kindness and trust were significant because these two areas made a difference to the care and bridged the natural experience of the medicalised experience. It reduced the fear of childbirth and the detachment of those delivering their job role with little emotional investment. This can be common when circumstances arise, and medical attention supersedes what is typically considered a 'natural' vaginal birth.

Rituals = The rituals of brushing my hair were symbolic in terms of my autonomy as a woman before birth. The cleansing ritual was an experience out of my control, and knowing I would be, waist down, temporarily paralysed. It also felt like a regular activity in something that was out of the ordinary. Similarly, arranging the bedside cupboard where I knew I would be residing temporarily. The ritual of the spinal block and the caesarean section itself were rituals in that I had to place my trust and spiritual self in the professionals as I was physically rendered helpless.
Artefacts = The symbolic artefacts were the blue birthing shield, the babies' feeding bottles supplied and their hats and bands. These were treasured keepsakes, a remembrance of the transformational experience.
Values = This was a personal aspect of the narrative: Who am I, and what do I have to say? In an underrepresented area, I had little autonomy and was seldom listened to by professionals. Those who did listen were highly valued and an extended part of my own feelings of value towards myself.
Mentors = The few health professionals who guided me in my care. Irrespective of the outcome, they were the mentors of my pregnancy journey and subsequent childbirth, guided by their expertise. Moments of spiritual connectedness such as achievement of the birth, cleansing, being at one and accepting the experience for what it was.

Through the analysis of the data, I identified that the method provided direction and was useful as a holistic way of understanding and navigating adversities through childbirth. Interpretations were made at multiple levels as experiences unfolded, and support was needed within the broader subject of trust.

Consistent with previous research (Nilsson et al. 2010), I had the overwhelming feeling of having had an incomplete birth experience, a natural rite of passage had become a medical intervention, fearful of the outcome and therefore sensing a detachment from mind and body similarly considered by Priddis (2015). Martins (2018) also concluded many women portrayed childbirth as natural when it was vaginal, viewing it as a transformative rite of passage into motherhood. They signified the experience as a celebratory act of creation. One woman equated her childbirth with empowerment and self-affirmation, describing the experience as an intimate moment between her baby and herself. She discussed the experience as mind-opening, self-defining and creative. They noted all the women in their study alluded to or mentioned a desire to have a vaginal birth and connected the act with the ability to participate in the creation of birthing their baby. The ability to deliver their child with minimal medical intervention and, therefore, choice held meaning for these women beyond the outcome of the birth of a healthy child and became a key factor in influencing their transition to motherhood as a spiritual experience.

In contrast, not having a natural birth impacted the meaningfulness of this experience with expressed disappointment. Whilst concerned about the outcome of childbirth and trying not to respond to the changing circumstances with fear, I, too, shared a similar experience of disempowerment, having felt cheated of a vital and defining experience. I, as Wynne (1992) stated, accepted my fatalistic acceptance rather than genuine trust in the childbirth decisions

made by professionals. This experience left me with a mixture of feelings of helplessness and incompleteness after birth. Only years later, I accepted and reflected on the experience philosophically and spiritually, with emotion but less fear. Nilsson et al. (2010) emphasised that the intense fear of childbirth is deeply influential, and as Melender (2002) appropriately evaluated, it is important during pregnancy to listen to the feelings of women about pregnancy and childbirth, including the form it takes. To be able to explain these fears and discuss them with healthcare professionals is supporting spiritual health. As affirmed by Bowers (2002), women should be informed before delivery about what could happen in the delivery room so that they do not develop unrealistic perceptions. Pre-natal education, including caesarean section, is important to inform future mothers. The healthcare specialists can then support mothers in constructing a realistic vision with trusted, realistic options. More recently, attention has been given to what is termed the natural caesarean section, with emphasis mirroring vaginal birth practices, including immediate skin-to-skin contact with the baby and opportunities to observe the baby being born. As Smith et al. (2008) confirms, this empowers the mother with feelings of having accomplished childbirth rather than it being something happening to them. As a mother with little autonomy or choice, I already had feelings of mistrust before having the caesarean section, which then led to higher levels of anxiety and fear and risks around procedures such as the spinal block, being unable to request to be cleaned or being informed about the health of the babies.

Crowther and Hall (2015, 2021) suggest that midwives should acknowledge women's religious beliefs and be aware of their own personal spirituality to better facilitate and support their patient's spiritual care. They should, therefore, appreciate the multidimensional aspects of childbirth and be able to support their patient's spirituality even if it is different to what they practice themselves. Assessment of childbearing women may include the question about spirituality that will help provide better care during pregnancy and birth. One of the main areas I reflected on was the number of midwives I encountered but also the lack of investment from pregnancy to the impending birth and post-birth. I knew the professional encounters would be transient relationships and therefore felt discouraged from revealing my inner feelings about childbirth, knowing in my mind I would not see them during or after the birth. As a high-risk pregnancy, I was monitored closely by the hospital by a range of professionals, which I now later consider was part of my own anxiety and fear as well. This revealed how I felt about the care I received and the physicality of my embodied self. In the literature, women have emphasised the importance of continuous, individualized support during pregnancy and childbirth (Van der Gucht and Lewis, 2015).

Furthermore, midwives need to share responsibility, be intentionally and authentically present, and create an atmosphere of calm serenity in a mutual relationship with the mothers to improve the quality of the woman-midwife relationship (Morano et al. 2018). As Cipolletta (2016) discussed, midwives can support women with their presence and proximity, providing information and suggestions on the actions of the mother during their labour and delivery. Tending to childbearing women's spiritual health needs in this way may improve their health care. Callister (2010) evaluated that alongside the focus on medical records, women should be given the space to be able to express their personal feelings about their spirituality during childbirth, creating personal meanings for them. This resonated with my experiences of overwhelming helplessness during childbirth and heightened awareness to remain strong through the process and connect with the environment. Whilst it was a highly medicalised childbirth journey, I still felt a sense of wonder and emotions as I delivered each baby, observing them through my numbness but paradoxically in heightened alertness and feeling, responding where I could.

Conclusion

An autoethnographic study such as this one has both advantages and limitations. The critical reflections in the autoethnographic approach remain the researcher's interpretations of what

was experienced. As with any qualitative research, the reflections presented in this article have their limitations because they are intended to offer a deep understanding of one person's experience. The use of an interpretive methodology, according to Farrell et al. (2015), places the researcher at the centre of their own research and may not seem suitable or offered as a source of contributing to knowledge within the medical sciences or healthcare services.

Despite these limitations, however, there remain several potential advantages. This narrative can enhance the field of education and practices in the delivery room. More importantly, it reaches out and touches people through the sharing of lived experiences from mothers as well as healthcare professionals, including midwives, who can relate to these experiences. Autoethnography allows researchers to study aspects of the human experience that an external researcher would not be able to observe through the autoethnographer's critical reflections, experiences, feelings, and emotions.

This autoethnographic study has the potential to offer a powerful method for advancing the understanding of the spiritual dimensions of childbirth experiences and care as well as the trust and fears related to caesarean section sections. It, therefore, highlights the relationship with professionals during childbirth and the sharing of medical procedures, childbirth interventions and their consequences in pregnancy and in subsequent births.

Autoethnographic studies reveal novel insights of reflections for health professionals, including midwives. This study exclusively considers the way in which the de-naturalisation of childbirth, in discourse, has consequences for the experience of mothers, impacting the type of care needed as well as offered, as well as treatment issues that might be encountered. Viewing events through a first-person viewpoint provides a way of understanding needs and their influence on the quality of activities and communication in the delivery room. With autoethnography, there is access to private experiences that are unlikely to be made public but can become agents of change through the critical reflection that the autoethnographer proposes and which the professional reinterprets through his experience and training. This study, therefore, aims to provide a new focus for care with mothers throughout a caesarean section, with multiples.

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ORCHID iD

Amanda Norman https://orcid.org/0000-0002-5210-216X

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Author Biography

Amanda Norman is a Senior Lecturer at the University of Winchester, UK. She is the author of *Historical Perspectives on Infant Care and Development (Bloomsbury)* and *From Conception to Two Years: Development, Policy, and Practice (Routledge)*. Her research primarily focuses on infant care and alloparenting within and beyond the domestic home, with publications in professional and peer reviewed journals.