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‘dis chord’: one woman’s experience of confronting and understanding the lived experience of birth

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This paper is a collaborative piece written by a midwifery academic and an artist. It presents and interprets a number of mixed media art works created by Caroline Calonder in response to the traumatic birth of her son, and utilises findings derived from Lesley Kay’s doctoral study about birth and birth stories as a means of contextualising, understanding and interpreting the work (Kay *et al* 2017).

In sharing elements of Caroline’s experience, the psychological harm it caused her, and the means she used (and continues to use) to understand, and come to terms with the experience, the paper highlights some of the distressing and harmful sequelae which can arise when a woman’s disembodied experience of birth is accepted as normal and mainstream.

Furthermore, it emphasises the need for health care professionals to actively work towards safeguarding women’s emotional health, and the value of art as a means of confronting and recovering from birth trauma.

There is mounting literature intimating that birth can be the source of clinical levels of psychological distress, and evidence to suggest that between 19.7%–45.5% of women experience a traumatic birth (Soet *et al* 2003, Susan *et al* 2009, Alcorn *et al* 2010, Yildiz *et al* 2017, Dikmen-Yildiz *et al* 2018). The literature tells us that the risk of a traumatic birth experience increases with the use of medical interventions and complications; however, there is also evidence that a ‘normal’ birth may also be perceived as traumatic, owing to *‘a loss of control, perceived threat or physical harm to self or baby, or negative attitudes of healthcare professionals involved in the birth’* (Dikmen-Yildiz *et al* 2018:377).

Post-traumatic stress disorder (PTSD) can affect women who have traumatic birth experiences, with approximately 4% of women meeting the diagnostic criteria for PTSD (Yildiz *et al* 2017). Birth trauma has been defined as:

‘An event occurring during the labour and delivery process that involves actual or threatened injury or death to the mother or her baby... the birthing woman experiences intense fear, helplessness, loss of control, and horror’ (Beck 2004:28).

Trauma experienced whilst giving birth may lead to postpartum mental health problems, including PTSD. It may also alter a woman's sense of self, and disrupt parent-baby bonding and family relationships (Parfitt & Ayers 2009, Fenech & Thomson 2014, McKenzie-McHarg *et al* 2015). The effects of a traumatic birth experience for the woman, baby and family are therefore enormously significant, demanding attention and resolution. This is especially true as childbirth is unlike other potentially traumatic events, in that it is anticipated and generally something which has been readily chosen (Ayers *et al* 2008). Caroline's artworks were 'birthed' some twelve years after the birth of her son, a birth which she forced to the back of her mind, willing herself to 'forget' whilst she concentrated on mothering. Having not had the opportunity to control her birth, Caroline uses her work to take control of the uncontrollable; dramatically representing her story on cartridge paper where the ink, collage and marks made become the narrative. In doing so Caroline reclaims her personal birth story from the greedy clutches of a systemised 'conveyor belt of care' where as a birthing mother she was marginalised and stripped of all power. In using a repetitive and meditative technique, Caroline has started the process of repair, and in doing so, has been able to confront the lived experience of her birth by making it part of her history; something which was denied her at the time as '*the C-section under GA with the 11 lb baby and the PPH*'.

In her PhD study, Lesley revealed that the lifeworld of birth being sustained in stories was one of product and process, concentrating on the stages and progression of labour, with the birth of a healthy baby perceived by many as the only significant outcome. The findings suggest that many women in the United Kingdom (UK) experience birth in a system which normalises technology and the notion of controlling and expediting birth, whilst undermining its cultural and spiritual significance.

Childbirth is a momentous event in women's and families' lives, a time of extreme vulnerability with deep-rooted personal and cultural significance (White Ribbon Alliance 2011). Despite an appreciation of its importance as a rite of passage, and of the potential for the experience to impact on women's emotional and psychological well-being, the priority in clinical care settings is the physical well-being of the woman and neonate. Women's experiences, however, and specifically their experiences of the interpersonal aspects of care, which are potentially a source of empowerment and comfort or a source of damage, are increasingly relevant (Reed *et al* 2017).

Worldwide there is growing recognition that interactions with care providers affect women's emotional well-being as well as their decisions about seeking care in facilities, meaning that

the promotion of respectful maternity care has become progressively more significant to organisations and policy makers (Bowser & Hill 2010, McConville 2014, WHO 2014, Bohren *et al* 2015). Respectful maternity care encompasses women's fundamental rights to dignity; the right to information, informed consent and refusal, the right to privacy and confidentiality and freedom from duress and harm (WHO 2014).

The literature suggests that care providers' actions and interactions may be more influential than medical intervention or type of birth in experiences of birth trauma (Alcorn *et al* 2010, Reed *et al* 2017). This is worrying as the number of women disclosing psychological trauma during birth is escalating, with one explanation being that these women have been subject to negative interactions (Reed *et al* 2017). The *Maternity Matters* report states that involvement and dignity are central values of good quality care (Department of Health (DH) 2007). A dignity survey undertaken by the charity Birthrights demonstrated a mixed picture of maternity care in the UK; overall, respondents reported feeling respected during their births, but significant differences in choice and respectful care were reported depending on type and place of birth (Birthrights 2013).

All childbearing women need and deserve safe, high-quality and respectful care which protects their autonomy and their right to self-determination, and which enables them to feel positive when childbearing and making the transition to motherhood (White Ribbon Alliance 2011). There is evidence that whilst care providers in facility settings may consider their actions and interactions to be routine, women may experience them as traumatic, the argument being that disrespectful practices have become so normalised and pervasive that care providers are unable to recognise them (Bohren *et al* 2015, Forster *et al* 2016).

The first work in Caroline's series is called '*dis chord*'. In this piece Caroline seeks to make the 'history' or factual account of her birth into her own very personal story of birth, a story she can move forward with into the future. Significantly the letters making up the caption '*my his story*' are made up of newspaper print; Caroline has used the typeface of the everyday generic story to 'write' her own unique birth story. The landscape of Caroline's birth included being induced for post-dates, a 'failed' ventouse, an ineffectual one-sided epidural, a general anaesthetic and a postpartum haemorrhage. Capturing her own story is important as after her general anaesthetic Caroline was unable to be 'present', to participate, and to make decisions about her care. In this situation her partner became the principal protagonist of the story; his feelings and anxieties, the necessity for him to make decisions, including the need for a blood transfusion, and the responsibility he felt in caring for his son, was something he experienced and inevitably retold.

In this situation Caroline's story was overwhelmed and suppressed and 'his story' became paramount. In any situation where something is repressed or subjugated it inevitably struggles to break free, and Caroline's story started to 'erupt' many years later in the context of her marriage breakdown. Inspired by Miro's ink on paper series, Caroline let the dark red bloody ink take its own form on the page and in doing so established an outlining composition which formed the visual context for her story. The tones of the red and blue ink give a sense of the haemorrhaging of her story and a suggestion of its urgency and resonance. The title of the piece is a play on words: cord as in umbilical cord supporting the physical relationship of the mother baby dyad, and chord as in a musical chord, seeking to be harmonious but at times becoming discordant and jarring. The cord is essential in maintaining the symbiotic mother and baby relationship and there is an expectation that even when it is cut the relationship will continue to be synchronous and 'in tune'. In this piece Caroline rewrites her story, recognising her triumph as a mother and starting from the moment that she first breastfed her son, this was her experience and 'moment' of birth.

[PLACE ARTWORK 1 SOMEWHERE WITHIN TEXT]

In this image, the baby can be seen rooting for the breast. The image of the baby was appropriated from a photogram called 'Invocation' made by Adam Fuss in 1992. Significantly, Caroline chose this image of a baby as the title and the original print suggests the presence of something otherworldly, spiritual or godly. A small A4 size piece, Caroline describes the work as relating to '*the size of my hands and face*'; intimate, personal and as such intensely her story. The work has a certain naivety about it, being something of a catharsis, with its emotional content and the story it tells taking precedence over its form. '*Sammy's motorbike*' was the second in this series of works ('Sammy' alluding to the anaesthetist involved in Caroline's care). This piece is more focused, concentrating on the caesarean section itself, the issue of consent and Caroline's experience of a postpartum haemorrhage. The title evokes the sensation Caroline felt as the operation took place. During the procedure Caroline felt a sense of powerlessness, she felt disorientated and unsafe; feeling as though she might slide off the table and likening the operator's actions to someone riding through her abdomen on a motorbike. More specifically the sensation of a bike wheel stuck in a rut in a muddy field, wheels spinning furiously and the mud, or in this case blood, splashing and spraying onto its surrounds. The process of haemorrhaging is captured with violent crimson and orange reds, shinier in some places and more translucent in others. Not able to visualise the haemorrhage herself, Caroline imagined the blood as pooling, glistening,

bubbling and all-encompassing. The blood seems to have a geographical landscape all of its own, taking its own course but ultimately shaped by the wheels of Sammy's motorbike.

In this piece everyday typeface, cut and collaged from a newspaper, is used once again, the characters are carefully placed to create word plays which complement the image and which layer multiple meanings one over the other. The characters in the bottom left-hand corner of the image acknowledge both the powerlessness Caroline felt, as her responses to pain were ignored, as well as her retrospective indignation that she had no voice. The characters at the top of the image in the centre can be interpreted in a number of ways: 'voil' evoking the screen between Caroline and the operator, or the separation between Caroline and her baby; 'voila' the flourish as the baby magically appears; 'viol' the French word for rape, and finally in relation to her physical, emotional and psychological boundaries, the word 'violate'.

[PLACE ARTWORK 2 SOMEWHERE WITHIN TEXT]

In '*Sammy's motorbike*' Caroline continues the process of repair, again relying on a mindful, repetitive technique creating a vulva and a caesarean incision by contouring around the tones in the ink using felt tip pens and a dot-like pattern. The idea of repair is heightened by the use of a further meditative medium, stitching, to visually add another dimension and texture, which also works as an escape, an opportunity to get lost in the process. The image of the baby rooting is seen once again, this time with a beating heart and umbilical cord; Caroline's reason to live, to love and function.

In her work '*The ear-splitting silence...*' Caroline takes a more authoritative stance by giving the image an initial sense of structure. She starts by drawing three curving crossover lines on the paper and in the intersections uses watercolours to create some amoeba-like background forms. In this piece Caroline wanted to establish a sense of the rhythms of the body; for instance, the rhythms of breathing, blood flow, heartbeat and uterine contractions. Caroline conceptualises the idea of the need to monitor the baby's well-being whilst at the same time conveying her fear of both the baby and herself 'flat-lining'.

The next part of the process was to destabilise the structure in an attempt to portray the idea that nothing is guaranteed, concrete or stable. Caroline used a crimson red ink in a pipette, squeezing the ink onto the paper, allowing it to take its own course and effectively relinquishing her control to the ink, much as it had been wrought from her by the institutional medical model. In doing so interesting tones and layers were added to the work. As an artist Caroline remarked this was a freeing process, letting the form of the work speak and as such becoming transactional, a dialogue between her and the image neither having an authority over the other.

In this exchange the image ‘decided’ where the vulva and caesarean incision should be and ‘suggested’ that a fetus rather than a baby should be included. The fetus is pictured with a chain-stitched umbilical cord made using red and blue thread signifying the oxygenated and deoxygenated blood going to and fro. The ear-splitting silence is evocative of a painful and violent situation where the woman is expected to be quiet, to not ‘make a fuss’, is not listened to and where the volume of silence becomes overwhelming.

[PLACE ARTWORK 3 SOMEWHERE WITHIN TEXT]

Interestingly in this work Caroline positions herself in the bottom right hand corner; Caroline is tiny, miniscule in comparison to the fetus and to the volume of blood, she is almost forgotten, inconsequential, making you ask: ‘what value does she have in this situation?’ If you look more closely, though, you can see that Caroline is wearing a bikini and riding a wave; the image claims something more for her than the role of a vessel, she is more than a pregnant woman, something more than a mother, she is a self, a person, she has a personality, a life with likes and dislikes, hopes and fears, she has a story to share and is a being in her own right.

Caroline’s experience is not unusual. In her thesis Lesley found that many of the birth stories being shared stress the inherent ‘dangers’ of birthing and the need for expert and interventionist care. Many of the stories are dramatic, telling of near misses and emergency situations, where women and babies are ‘rescued’ and ‘saved’ by the attending medical team. What is shared is not innocuous, becoming more and more familiar, gaining momentum and authority. The effect being that what is extraordinary (the ‘drama of birth’ described in a story) is made ordinary through familiarity, accommodated, and then made invisible by that accommodation.

The stories tell of, or show birth as managed by, the people and institutions around women rather than by the women themselves. The stories describe, in an almost conformist way, what happened and when, telling of who was there and what they did. They portray stages and interventions (often used to accelerate birth and/or to dispense with pain) rather than fears and feelings and any sense of what birth means to women (Kay et al, 2017). .

This is reminiscent of the mechanised metaphor of birth where the hospital is portrayed as a ‘factory’, the woman’s body as a ‘machine’ and the baby as a ‘product’ (Davis-Floyd 2001:56). Care managed in this way sees women objectified, distances the health professional from the woman, invests power in the health professional rather than the woman and ignores consequences for the maternal-newborn pair (Wendland 2007). In this ‘vision’ women, who are each unique and in no way ‘standardised’, are expected to conform to the standard and,

amongst other things, make consistent progress in labour, keeping time along with '*the arbitrary clock*' which has dominated maternity care since it was conceived in the 1950s by Friedman (Simonds 2002:565). If women do not keep to time as dictated by the clock then they are seen as '*deviant*' and as having failed in some way (Simonds 2002:565). Following the clock and thinking about childbirth in a calculative way does not encapsulate the complexity of birthing or the needs of women and their bodies. Moreover it can be seen as '*unyielding*' and '*without feeling*', something which is not conducive to effective and satisfying care of the childbearing woman (Pierson 1998:166).

In '*Little hats*' Caroline continues her series, depicting her experience of a 'failed' spontaneous delivery and a 'failed ventouse'. The work illustrates her lack of agency in the birthing process; she no longer exists as an individual, instead she is merely part of the escalating induction process, another part of the production line. The babies (taken from depictions shown in medical journals) have also lost their identity and their very humanness; they are objectified prizes to be won by the medical team. The babies' only sense of identity comes from their bruising, tiny watercolours collaged onto their diagrammatic, yet still vulnerable, heads. The umbilical cords are 3D, cross stitch, invested with love and care at Caroline's hands as she attempts to bring them to life, supplying them with oxygen as her blood, heart and soul begins to pulsate through their outlined bodies.

In this piece, Caroline seems to be questioning: when does the baby become entitled to her/his humanness, at what stage do her/his human rights begin to be respected? When do caregivers begin to take care of the babies' psychological/emotional well-being? In the work there is a sense of fear, for her and for the babies but there is also a sense of hope. Caroline is frightened for these babies, as they are suctioned and savagely pulled from the security of her body, their mother's bodies. In the work she depicts her son's velvety head as badly bruised, swollen and cut, and she grieves for his trauma, for her trauma and disempowerment. This was not what she wanted for him or for herself. But then Caroline takes control. She takes the babies out of the medical journal, and she takes her baby out of the operating theatre, putting them all in a beautiful, calm, green landscape with blossoms and breasts to nurture them. Taking the green of the landscape, Caroline stitches into the spine of the mother and towards the babies. Taking the orange from their bodies into the landscape — the babies and landscape become one, they are safe. The multi-coloured areas are vulvas or caesarean section incisions, they are rhythmic and there is a sense of harmony bestowed on them by the surrounding landscape. The collaged hands in the bottom right-hand corner are Caroline's hands, there to carefully guide the baby to safety. Despite being fractured and flawed,

Caroline is strong enough to bring the diagrammatic babies, and her baby, safely into the world.

[PLACE ARTWORK 4 SOMEWHERE WITHIN TEXT]

The opportunity for every birth to be understood as a unique lived experience, as something otherworldly, infused with joy and specialness for the individual woman and her family, rather than merely as a process resulting in the birth of a healthy baby, is significant to all of us. Women and their bodies are not merely resources tasked with producing young, rather each individual woman is physically embodied as a self in a unique world personalised to her own '*lived context*' and each woman has the ability to exercise agency in childbirth as in every other facet of her life (Marcum 2004:315).

In their study of childbirth trauma relating to care provider actions, Reed *et al* (2017) conclude that it is essential to address interpersonal birth trauma at '*a macro and micro level*', suggesting that service development and provision must be '*underpinned by a paradigm and framework that prioritises both the physical and emotional needs of women*' (Reed *et al* 2017:17). The danger of not addressing interpersonal birth trauma and of not protecting the '*transcending significance*' of birth is that we will be left with nothing more than the '*physical husk*' of ourselves (Kitzinger 1978:133) and with the majority of women experiencing what Wolf describes as '*ordinary bad births*' (Wolf 2002:122).

Despite these arguments, and the policy drivers calling for perinatal mental health services, service delivery is sparse and inconsistent (Bauer *et al* 2014). Going forward more needs to be done to develop and standardise services, including improvement of mental health education for midwives and other health professionals involved in caring for women throughout the childbearing continuum. This will go some way to help in the prevention and management of the harmful sequelae associated with maternal perinatal PTSD (Cook *et al* 2018).

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