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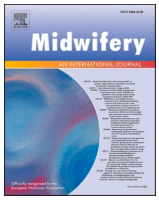

Exploring childbirth experiences through a Salutogenic lens

Dr Giliane McKelvin [a,*], Prof Soo Downe [b], Prof Gillian Thomson [b]

[a] Department of Nursing and Midwifery, Edge Hill University, St Helens Road, Ormskirk L39 4QP, UK
[b] School of Community Health and Midwifery, University of Central Lancashire, Preston, Lancashire PR1 2HE, UK

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ABSTRACT

Women's experiences of childbirth have generally been considered through a pathological lens. Wider sociological arguments associated with salutogenesis stress the need to depict health on a continuum to help understand what constitutes positive health as well as ill-health. Similarly, to fully understand women's experiences of childbirth, it needs to be explored on a continuum, considering salutogenic and pathogenic factors. In this paper we report on qualitative data collected as part of a wider mixed-methods study to describe the continuum of women's different childbirth experiences ('positive' 'neutral' or 'traumatic'). A mixed-method explanatory sequential design was undertaken comprising validated measures and in-depth interviews. Primiparous women who were expecting a healthy term infant were recruited and participated in an in-depth semi-structured interview at 12 weeks postnatal. Thematic analysis was used to analyse the data. Ten women took part in an interview and three main themes were identified. The first theme 'before it all started' showed how stories impacted women, with women trying to 'keep an open mind' or 'accepting and expecting the worst'. The second theme 'arriving at the destination' emphasised the importance of midwifery support through 'continuous compassionate presence' while others reported 'feeling forgotten'. Finally, 'the days that followed' highlighted how women tried to 'focus on the outcome' while others 'wished it had gone better'. This study identified how women's subjective appraisals of childbirth are on a continuum and influenced by several factors including birth narratives and the quality of midwifery care from the early onset of labour. The kinds of experiences associated with reports that the birth was 'neutral' are reported for the first time.

Introduction

The salutogenic theory developed by Antonovsky (1996) was created to explore what helps individuals stay in good health. It conceptualises peoples' capacity for wellbeing in terms of how they experience events and focuses on human flourishing (Downe et al., 2020). Antonovsky viewed pathogenesis and salutogenesis as complementary approaches within a continuum, with health-ease (salutogenic) and dis-ease (pathogenic) at each end of a continuum. He believed that the best way to facilitate health is to understand and address the specific point in the continuum where a particular individual is placed at any particular point in their lives (Antonovsky, 1993). In the context of childbearing, salutogenesis is potentially crucial to promote, respect and protect physiological journeys while addressing the chances of complications without the unnecessary medicalisation of every woman's experience. Within childbirth experiences, salutogenesis provides an opportunity to understand and enable women's potential to experience a transformative event. Perez-Botella et al. (2015), highlight that this approach has rarely been used within maternity research. Nonetheless, positive outcomes have been identified when the salutogenic lens was used in certain maternity care settings. For instance, reframing antenatal education to enable a salutogenic perspective, promoted health instead of enabling medicalised childbearing experiences (Muggleton et al., 2021).

Within the literature, the salutogenic perspective of childbirth experiences (or positive childbirth experiences) is still underreported as research has predominantly focused on a negative, traumatic birth. For instance, while there are multiple reviews and meta-analyses on birth-related trauma (Ayers et al., 2016; Elmir et al., 2010; Fenech and Thomson, 2014; Grekin and O'Hara, 2014; Simpson and Catling, 2016; Yildiz et al., 2017), to date, only one qualitative review on women's lived accounts of a positive childbirth experience has been published (Hill and Firth, 2018) although research in positive childbirth has since started gaining momentum (World Health Organization, 2018). Furthermore, even though individuals differ in where they are on the health/disease spectrum in view of the differences in how they perceive events, childbirth experiences are still dichotomised into positive or

* Corresponding author: University of Bolton, Deane Road BL3 5AB, UK.
E-mail addresses: gm8@bolton.ac.uk (D.G. McKelvin), sdowne@uclan.ac.uk (P.S. Downe), gthomson@uclan.ac.uk (P.G. Thomson).

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traumatic experiences despite a continuum of experiences (including a more neutral experience) being more likely. Exploring the concept of a 'neutral' perspective for childbearing women and birthing people could help provide a more comprehensive understanding of the different ways in which women experience labour and birth, enable transcendental experiences and understand the types of support needed at different stages of the continuum. This approach will enable health care professionals to appreciate and promote salutary factors related to childbirth experiences while continuing to be mindful of risks (pathogenic factors) so that they can be prevented. Therefore, the aim of this study was to explore the experiences of women who subjectively classified their birth as either positive, neutral, or traumatic.

Materials and methods

This paper is part of a larger study that explores women's continuum of childbirth experiences (please see supplementary material for more information). This paper will report on the qualitative strand of a mixed-method study. An exploratory general qualitative inquiry approach to women's experience of childbirth was undertaken. Ethical approval was obtained from the Science, Technology, Engineering, Medicine and Health ethics sub-committee at XX (blinded for review) in November 2016 and the Health Research Authority (Reference: 16/NW/0700) in January 2017.

Women were recruited from a Trust in North West England, between February and May 2017. Eligibility criteria included: a) women expecting their first baby, as it is known that previous birth experiences can influence subsequent experiences (Beck and Watson, 2010; Nilsson et al., 2010); b) expecting a healthy baby, since women who are expecting a baby with any anomaly are more likely to experience increased distress during the pregnancy (Georgsson Öhman et al., 2006; Hsieh et al., 2013); c) have given birth to a live infant, as women who experience a stillbirth or neonatal death will have very different experiences and needs (Downe et al., 2013; Kelley and Trinidad, 2012); d) to be 18 years or older to avoid ethical dilemmas; e) able to speak and understand English since a translator was not available. Women recruited for the larger study ($n = 125$) were all invited to participate in an interview and ten provided their consent to do so. All ten women were asked to subjectively classify their birth as positive, neutral and traumatic. Women were not provided with any definitions of the classifications and it is this self-subjective classification that was used to inform the qualitative methods. Women were given the option of a face-to-face or telephone interview at a convenient time and location to ensure they had choices, however, all women chose a face-to-face interview.

Measures

A semi-structured interview guide was developed to explore their experience in depth while ensuring that a focus on salutary and pathogenic factors can be maintained. The interview questions were informed by a systematic review (blinded for review) and asked women to narrate their birth story focusing on what they experienced and how they experienced it. It asked women why they had self-classified their birth as positive, negative or neutral. Women were also asked to reflect on what influenced their birth experience and how it had affected them. It was ensured that women were asked to explore both positive and negative thoughts further; to not only explore what made the birth challenging but to also explore what supported them through the experience. Interviews were conducted by XX (blinded for review) who had training in the conduct of interviews, was the lead investigator of the study and had no prior relationship with any of the participants. The interviews lasted for as long as women were willing to share their stories and typically lasted between 30 and 60 min with the option of pausing or stopping their interview if women became distressed. Women were also provided with debriefing contact details throughout the study. Interviews were recorded and transcribed verbatim, and a pseudonym was used. Reflective notes were kept by the interviewer (blinded for review) during the interview to record initial thoughts and exhibition of body language by the participants. A reflexive journal was also kept to document assumptions, subjective views and personal beliefs experienced by the interviewer (Ortlipp, 2008) following each interview and this subsequently aided the analysis by reducing the risk of researcher bias.

Analysis

Braun and Clarke (2006) thematic approach was undertaken to analyse the interviews which included reading and familiarising oneself with the text, generating initial codes and creating themes, reviewing the themes and finalising them. While it was important to understand women's experience of birth, it was also deemed essential to understand how they felt their birth was influenced by various factors, therefore, this method appeared appropriate. The salutogenic lens (Antonovsky, 1996) aided the analysis by ensuring that salutatory factors were also explored and thus women were also encouraged to discuss positive elements of their journey, no matter what kind of experience they reported. Furthermore, the reflexive journal was used during the initial analysis to minimise bias particularly since the author, as a midwife, had strong views about the potential influences of different childbirth experiences. By being open, honest and transparent, this bias was minimised. Analysis was initially undertaken by (blinded by review) and was shared and refined by all authors. An audit trail was kept highlighting initial interpretations and how these could be a result of author bias. These were discussed within the team and subsequent interpretations were finalised collectively.

Results

All the women that were interested in the interview, were invited and subsequently participated. Ten women participated; four classified their birth as positive, five as neutral and one as negative/traumatic. All women were in a relationship, worked full-time and had an educational achievement above Diploma level. All women reported a White British background except for one woman that was Bangladeshi.

The themes highlighted in this study are presented in three chronological time frames which were identified by the authors following multiple discussions. The themes were presented in this way because it was the manner in which women shared their stories about childbirth, highlighting that their birthing experienced was influenced by events that started many weeks before the birth and for many weeks after. The first time frame 'Before it all started' represented the antenatal period and was heavily influenced by the birth stories that women heard. The second time frame 'Arriving at the destination' highlights women's perspectives and feelings of labour and birth. Here the midwife played a leading role as women explained how they were burdened or blessed with the care they received. The third time frame 'The days that followed' related to how women interpreted their birth and how they coped with their feelings associated with the birth.

Before it all started

This period was heavily influenced by birth stories women heard from the media, family, and friends. Unfortunately, in most cases, women reported only hearing negative birth stories. Lily reports:

> *'I'd only kind of ever heard of births as being traumatic and whenever you see them on the telly they always look so … dramatic and dramatized' (Lily, positive birth).*

The sub-themes were developed from women's response to these stories. Most women chose to *'keep an open mind'* and to do so they endeavoured to stay informed and avoid a birth plan. However, for a few

women, having heard such horror stories, despite trying to keep an open mind, they '*accepted and expected the worst*'.

Keeping an open mind

All the women who reported a positive birth and a few who reported a neutral birth felt that the negative birth stories they heard stimulated a need to keep an open mind so that they could approach birth with a positive attitude. Jessica, and echoed by the other women, reported a need '*to be very positive*' about the birth, to enable more positive outcomes:

> *'I think that was really useful just to think in that way, to be very positive about it rather than building up an anxiety and getting scared about it' (Jessica, positive birth).*

These women understood that birth could be unpredictable and as Anabelle explained:

> '*Problems may appear and I have to be prepared for anything that can happen. I obviously didn't want a C-section but if that was the only way you know to deliver the baby safely then that's fine I wouldn't say no to it, so you know I was open to everything*'.

By keeping an open mind, these women understood that birth could also potentially be positive even if interventions were required, '*you have to keep an open mind because things do not always go according to plan and you have to be prepared*' (Frederica, positive birth). This is because they felt they had a strong understanding of what could happen and, as such, this would help to mitigate against the potential trauma of complications.

To keep an open mind, some women that reported a neutral birth and all that reported a positive birth, felt the need to approach birth '*being prepared and not having too many expectations*' (Anabelle, neutral birth). To ensure they were well informed, these women engaged in reading and birth-preparation classes and hypnobirthing.

Over half of the women (most who reported a positive birth and a few who reported a neutral or traumatic birth) knew other mothers who had been disappointed when the birth had not been as anticipated, as Maggie explains; '*my friends were distraught when their birth didn't go as planned, so I did not want one*'. As such, they actively avoided creating a formal birth plan. These women felt it was unwise to become fixated on certain expectations for an event which was mostly out of their control. Instead, they chose to be more flexible and to '*trust in the professionals*' as Jennifer explained:

> *'I didn't have a full birth plan.…people used to say that I should have a birthing plan you know and I was like, you never know what might happen, so you just have to trust in the professionals and [pause] and do what they advise' (Jennifer, traumatic birth).*

Accepting and expecting the worst

For a few women who had a neutral birth, listening to the 'dramatic' childbirth stories meant that they felt they had to prepare themselves for the same experience. Katherine '*expected it* [birth] *not to go to plan*' because this was the norm for other women:

> *'I just accepted that's how it would be because I feel like everyone's got a bit of a story like that something went [pause] went the way it shouldn't have done' (Katherine, neutral birth).*

While some women wanted to keep an open mind, they could not seem to move past their negative expectations. This was reflected by Alice who said:

> *'I prepared myself mentally I think, just…it [caesarean section] was just in the back of my mind just because my mum had them' (Alice, neutral birth).*

Arriving at the destination

This time frame encompasses labour and birth and how women felt they were looked after and supported. The midwife played a significant role in all the women's accounts. The sub-themes in this section concern how women valued the '*continuous compassionate presence*' and being reassured and supported by a midwife. In the final sub-theme however, some women reported '*feeling forgotten*' as they felt misunderstood and unsupported by their midwife.

Continuous compassionate presence

The importance of the midwife's continued presence throughout labour and birth was vividly captured by all the women who experienced a positive birth. This continuous presence was reported to have made '*the whole process a lot easier*' (Lily, positive birth) even in situations where they had not met before. Women spoke of how the midwives, '*didn't leave the room at all*' (Federica, positive birth), and felt that they did not need to '*put a brave face*' (Lily, positive birth).

Jennifer who categorized her birth as traumatic also became very emotional when speaking about how her midwife helped her:

> *'She'd help you to find that little bit that you'd been missing [pause]. She touched me actually [crying, deep breath]. When I think about her I get quite emotional' (Jennifer, traumatic birth).*

All women who had a positive birth and a few who had a neutral birth spoke of how the midwives helped them achieve a sense of control. For instance, Antoinette who had a neutral birth identified how the midwife helped her manage the situation:

> *'I think that there were times where I felt out of control but then [my husband] and the midwife especially were able to bring me back to being in control through my breathing … I think that really helped' (Antoinette, neutral birth).*

The sense of control was perceived to be particularly important for women as they acknowledged that in most cases labour and birth were often out of their control, and how the support and guidance of the midwife helped them regain some control over their bodies. '*Being able to completely trust in the midwife, helped me relax and by letting go, I felt more in control' (Anabelle, neutral birth).*

Feeling forgotten

In contrast, some women disclosed distressing accounts of receiving little or fragmented support from the midwives. Some women who reported a neutral birth and the woman who reported a traumatic birth expressed their disappointment when midwives did not listen to their needs or left them alone for long periods when they needed them. This was particularly felt when women were going through the induction process and were left alone. Maggie expressed how '*she* [the midwife] *just left me*' and how, '*it was a very difficult time for me*'. During the induction period, all women who reported a neutral birth reported how dismissive midwives were of their pain. Katherine who was induced and who quickly went into labour and became fully dilated while still in the induction bay reported:

> *'they [the midwives] were dismissive of it. I was under the impression that, that was only the start of things but actually, it was the end of the end things' (Katherine, neutral birth).*

The days that followed

This time frame captures women's reflections of the birth in the initial days and weeks that followed. The sub-themes highlight how some women had elements of '*disappointment and wishing it had gone better',* however, others were able to '*focus on the outcome*'.

Disappointment and wishing it had gone better

In the postnatal period, all the women who reported a neutral or traumatic birth discussed factors which disappointed them. Their disappointment ranged from the lack of consistent support, to interventions they had endured. Katherine needed her husband after the birth, but since he had not been allowed to stay and no one else helped her in the postnatal period, she was desperate to go home:

> *'I just said to the midwife I'm much better off … at home rather than stay here where you're so busy and I feel like I'm just getting forgotten about in the room on my own.' (Katherine, neutral birth).*

Jennifer talked about how her induction contradicted everything that was spoken about during pregnancy and how she had been unable to relax because the environment did not allow it, with the lack of privacy negatively influencing her experience:

> *'you're put in a ward with all the women and all you've got is a curtain between all of you…everything is unfamiliar. Having procedures done and shouting out in pain and this one [other patient] … she did laugh at me when I groaned in pain which I won't forget' (Jennifer, traumatic birth).*

Some women normalised their disappointment and accepted what they needed to endure for the safety of their baby. However, they also wished things could have gone differently. Maggie explains why her normal birth was taken away from her:

> *'It [normal birth] was taken away for his [son] safety. I wish I was allowed to push longer but [if] it was for his health then it doesn't bother me' (Maggie, neutral birth).*

Women who reported a neutral or traumatic birth also felt that their disappointment was attributed to the staffing problem that the National Health Service was facing. They did not blame the individual staff members when they encountered fragmented support, or when they were left alone for long periods. Jennifer reported that midwives were '*under a lot of pressure, that there aren't enough of them basically'* (Jennifer, traumatic birth).

Despite these women attempting to rationalise the lack of care they received and the disappointment they felt, they still reported self-blame when they spoke about what happened. Women wondered about what may have happened if they had behaved and acted differently. Annabelle regretted the lack of time she spent with her baby after the birth and blamed herself for it, '*I always thought it was kind of my fault that we lost that connection in the beginning'* (neutral birth). Alice also reported a sense of guilt for managing her pain with an epidural. She discussed in detail how she felt that it was her fault that she needed a caesarean section:

> *'Was I a bit of a wimp for choosing the epidural? I did feel like, this slight feeling that decisions I've made had impacted on how the birth progressed' (Alice, neutral birth).*

Focusing on the outcome

Once their baby was born, no matter what had happened during the birth, the majority of women focused on the outcome and the fact that they and their baby were both healthy and safe. It was noticeable that women who reported a positive childbirth experience became much more emotional when they shared the moment they met their newborn. Jessica describes the '*surreal'* moment she experienced when she met her baby:

> *'When I saw him for the first time, [crying] it was it was surreal, but it was like that's [pause] that's my baby I'm a mum now it was very strange and wonderful. It was like recognizing him [laughs and cries] but he was also a stranger… it was just so beautiful' (Jessica, positive birth).*

Every woman who experienced a positive birth described the moment they met their baby in a positive and at times transcendental manner in spite of the difficult birth, pain, or fears they experienced. The same surreal experience of meeting their baby for the first time was not expressed by those who had a neutral or traumatic birth:

> *'I didn't have that overwhelming kind of [pause] happiness when she arrived because I guess…because it just felt like such a surgical procedure…' (Alice, neutral birth).*

Nonetheless, most women, as reflected by Antoinette below, tried to look past the fact that the birth was not experienced as anticipated and focused on the outcome, '*the means to an end'* instead:

> *'The thing that makes it positive is the outcome for me. It's definitely the kind of the means to an end' (Antoinette, neutral birth).*

The element of pride post-birth was strong for women who had a positive experience. Lily described herself as a '*superhero'*. Jessica became very emotional during the interview. She recognized that often women do not achieve what they want, and, as such, she was both proud and also '*felt very lucky'* that she was able to achieve the birth she wanted. Women who reported a neutral birth acknowledged that their birth experience was not wholly positive. Anabelle who had been disappointed with the level of interventions that she had to endure explained how '*once I had the baby none of that [the interventions] mattered for me*' (Anabelle, neutral birth). The more they reflected on their birth and their ability to focus on the good outcomes such as the arrival of a healthy baby, women's birth experiences appeared to carry a smaller burden on their emotional wellbeing even though this appeared more significant for some than others. With a very proud tone Maggie explains how she '*wasn't very positive about it, but now I am a little bit more positive'* (Maggie, neutral birth). Antoinette also explained how she is more positive about her experience now despite how difficult it was:

> *'I guess looking back now yay it was all quite positive. Yeah it was [pause] it was difficult. It was [pause] the hardest thing I've ever done I think in my life [pause] but in the grand scheme of things I think the…I think the being a mum takes over' (Antoinette, neutral birth).*

Discussion

This study aimed to explore the experiences of women who subjectively classified their birth as either positive, neutral, or traumatic. By taking a salutogenic approach, primarily by refuting the idea that birth experiences can only be dichotomous (i.e. either positive or traumatic), an understanding of the potential for more neutral birth experiences is presented. Nonetheless, the explorative nature of this study will warrant further research. The qualitative themes highlight how women were influenced by birth stories, the quality of the care provided by midwives during labour and birth, and the impact that different birth experiences had on women.

In line with the findings of Fenwick et al. (2015); Sheen and Slade (2018) and, Thomson et al. (2017) this study illustrates the negative messages that surround childbirth. Women hear birth stories via the media and personal networks, which ultimately can have a detrimental impact on their expectations and experiences (Luce et al., 2016). However, this does not mean that women should necessarily be discouraged from sharing their negative or traumatic birth experiences. When women choose to publicly share their traumatic experience, it can initiate a healing process (Baker and Moore, 2008; Hoyt and Pasupathi, 2008). Blainey and Slade (2015) found that whilst women found it emotional to share their story online, they wanted to understand and make sense of it while also helping others by showing them that they are not alone. Das (2017) also reports that sharing traumatic birth stories can be 'cathartic and therapeutic' (pg.5). However, these authors also highlight how women express concerns about how their stories will be perceived by others. As such, while women should not be discouraged from sharing their story due to its associated personal benefits (Baker

and Moore, 2008; Blainey and Slade, 2015; Das, 2017; Hoyt and Pasupathi, 2008) there is still the need to ensure women are aware of the potential risks of sharing such stories, both for themselves, and for pregnant women who may be hearing them. Encouraging more women to share positive stories may also mitigate against the rhetoric of birth as a dangerous event that is currently prevalent (Fisher et al., 2006). As identified in this study, positive birth stories have the potential to offer hope and encouragement for women (Leventhal, et al., 1998).

The most important element to achieving a positive birth expressed by women in this study was midwives' support during labour and birth, particularly their continuous presence. This finding supports the *Better Births* (England, 2017; NHS England, 2019) vision and recommendation for continuity of care. The importance of continuous presence appears to have been translated into practice over the past decade as surveys in the UK report that the numbers of women who report being left alone during labour or shortly after giving birth has reduced from 22 % (Care Quality Commission, 2018) to 7 % (Care Quality Commission 2022). Contrastingly, midwives and their attitudes and actions were associated with more negative experiences. In this study, women who felt unsupported during induction and labour did not report a positive birth. Some recognised that staff were overworked and unable to provide the kind of support they needed. This finding is in line with those of Aune et al. (2014) who found that midwives were unable to provide continuous presence due to inadequate staffing and being required to care for multiple women during labour (Pace et al., 2022) suggesting that more still needs to be done to support women during labour.

In the current study, women reported dissatisfaction with the induction process; none of the women who had an induction reported a positive birth experience but rather experienced a neutral or traumatic birth. The findings resonate with a recent meta-synthesis (Coates et al., 2019) that explored women's experiences of induction. This study revealed that women felt they had a lack of ownership, felt unprepared and out of control during induction (Coates et al., 2019). Moreover, a key finding from Coates et al's work, which strongly resonated with the insights from the current study was the lack of support women received during the cervical ripening phase of the induction and their sense of loneliness. Similar to the findings by Coates et al. (2019) women reported feeling alone and abandoned, yet at the same time, they knew that midwives were very busy and felt embarrassed to disturb them. These findings highlight the need to identify the induction of labour phase as an equally important and key influencing factor for women's experiences as any other stage of labour.

A new finding in this study relates to those who defined their birth as neutral. Women who had a 'neutral' experience looked back on the events of birth with a sense of disappointment as they highlighted dissatisfaction with the care they received or the events that occurred. However, most women who had a neutral birth sought for, and, eventually, found, positive meaning from aspects of their labour birth, and from motherhood. Despite this evidence of emotional recovery, it is worth noting that all women who experienced a neutral birth, expressed disappointment, particularly as dissatisfaction with childbirth is associated with an increased risk of postnatal depression (Urbanová et al., 2021). These insights raise questions about using 'satisfaction' scales to assess labour and birth experiences as they do not allow for nuances to help understand that one may be satisfied with one aspect of care but dissatisfied with another (Mocumbi et al., 2019). Accepting 'satisfaction' or 'dissatisfaction' as a measure of wellbeing may therefore miss both deep trauma and profound happiness – both of which matter in terms of ensuring that maternity services recognise, respond to, and optimise maternity experiences.

Recommendations for practice and research

The findings highlight the importance of ensuring that media accounts of childbirth are balanced. This could be achieved by working with influential individuals to de-sensationalise childbirth in the media and support women to share their positive birth stories. As midwifery support during labour can enhance maternal experiences, the induction processes, policies and guidelines need to be reviewed to ensure that the same support is provided. This study has also highlighted areas that need further exploration which includes a deeper understanding of the role that the media has in shaping expectations and to explore neutral birth experiences further to enhance our understanding of this new concept. It also highlighted that assessing birth experiences using terms which can be deemed neutral such as 'satisfaction' may not be the right measure for care planning purposes. Of great importance, is the need to explore this concepts further due to the exploratory nature of this study.

Strengths and limitations

A strength of this study relates to the salutogenic approach taken and acknowledging that some women may identify their birth as neutral. This work highlights potential complications when women are asked whether they are satisfied with childbirth as women may potentially have experienced distress requiring support as was evidenced in this study. A reflexive journal was kept throughout this study and interpretations were shared and discussed within the research team to enhance the analysis process and to reduce researcher bias. The interviews were also conducted 12 weeks following the birth, thereby allowing time for women to process their emotions and response towards the birth. However, key limitations are present and this is primarily related to the exploratory nature of this study and the very small sample size present and a lack of diversity within the sample making the transferability of the findings limited without further data especially since very few women reported either a traumatic or neutral birth. Since this is the first study to report on women's experience of a neutral birth, it is difficult to determine how transferable the reported findings are. The same applies to the lack of diversity present, highlighting the need for to replicate the study in different demographics.

Conclusion

This study has provided insights into women's different birth experiences, namely positive, neutral and traumatic birth. While the study is limited by a small sample size it offers insights into factors that influence women's different experiences of childbirth and the implications of such in the postnatal period. Societal representations of childbirth have a key role to play in shaping women's birth experiences; with messages of fear, horror and pain dominating the media. High-quality midwifery care continues to play a central role in ensuring women achieve a positive birth experience: but poor, dismissive or absent midwifery support is profoundly distressing for women. Good quality care includes ensuring that women receive the care and support they need during the early phases of labour (and especially when undergoing induction of labour).

These findings emphasise how birth experiences can be experienced at extreme ends of the positive/negative continuum, but in reality they are usually more nuanced, depending on a range of factors. Further research is needed to deepen understanding of the birth continuum, and especially the psychosocial implications when women report their labour and birth as 'neutral' or 'satisfactory'.

Ethical Approval

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CRediT authorship contribution statement

Dr Giliane McKelvin: Writing – review & editing, Writing – original draft, Project administration, Methodology, Formal analysis, Data curation, Conceptualization. **Prof Soo Downe:** Writing – review & editing, Supervision, Methodology, Formal analysis. **Prof Gillian Thomson:** Writing – review & editing, Supervision, Resources, Methodology, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

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