A Critique of the PTSD Definition of Trauma from a Woman's Perspective

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For my parents,
who through example taught me that
anything is possible.

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ABSTRACT

This study was conducted in light of several feminist texts that have critiqued the diagnostic criteria for posttraumatic stress disorder in the DSM-IV-TR. These texts have argued that the current criteria, particularly Criterion A, are gender-biased and exclude many of the kinds of life events that are unique to women. This study sought to conduct an in-depth exploration of life events that do not meet the DSM-IV-TR's Criterion A but that nevertheless precipitated all of the other manifestations of PTSD. For the purpose of this study, two gender-specific traumatic events were selected, namely childbirth and miscarriage or stillbirth.

A feminist and phenomenological approach was taken and the study was formulated as a critique of the DSM-IV-TR diagnostic criteria of PTSD. The research question was formulated as follows: **Should the Criterion A definition of a traumatic event be expanded to include any experience that an individual defines as traumatic?**

A semi-structured interview was conducted with three participants complying with the specific population criteria. The interviews were transcribed and analysed through qualitative data analysis processes. The research methodology and analysis processes needed to be adapted due to the phenomenological nature of the research study.

A comparison between the symptoms presented by the participants and the diagnostic criteria of PTSD, revealed that all three participants complied with all the DSM-IV-TR criteria except for Criterion A(1) and therefore could not be formally diagnosed with PTSD. It was also revealed that the women's experiences and reactions to the traumatic events were very similar, especially the fear caused due to feeling out of control. Therefore it was concluded that the essence of the traumatic experience was loss of control.

The research question was positively answered, because it was concluded that each individual experiences events differently due to internal perceptions and the individualised meanings which are allocated to the event. Therefore the Criterion A definition of a traumatic event should be expanded to include any experience that an individual defines as traumatic.

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CHAPTER 1: GENERAL ORIENTATION OF STUDY

1.1 INTRODUCTION

A diagnosis of PTSD is made only when a client's symptoms comply with the specific diagnostic criteria as stipulated in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM, a handbook that consists of listings and descriptions of psychiatric diagnoses, was developed and compiled by the American Psychiatric Association (APA) (APA, 2000). The DSM is an important tool used by therapists as a guideline towards making diagnoses. It is important to note that the development of the DSM was intended as a means of classifying mental disorders, and should not be used as a rule. Therefore it is important to remember that when using the DSM the therapist should remain open minded and flexible. There are six diagnostic criteria according to the text revised fourth edition of the DSM, the DSM-IV-TR (APA, 2000), the first of which (Criterion A) stipulates the nature of the traumatic event.

The Criterion A definition of a traumatic event is very specific. Research suggests that there are gender-specific traumatic experiences that do not meet Criterion A. This suggestion is explored further through this study. For the purpose of this study the focus will be on two gender-specific traumatic events, namely childbirth and miscarriage or stillbirth.

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This study, therefore, will take the form of a critique of the DSM-IV-TR diagnostic criteria of PTSD, with specific reference to women's experiences of gender-specific traumas that do not meet the requirements of Criterion A. It will be argued that these traumas, which are located in women's social environments and thus of interest to social work, can be experienced as sufficiently traumatic to trigger the onset of PTSD symptoms.

It is my opinion that the current formulation of Criterion A disregards women's experiences, thereby marginalising women. Social work has a long history of concern for marginalised and oppressed groups, with an increasing emphasis on feminist epistemology. Therefore I have adopted a feminist lens on the topic.

In this chapter the research question is stated and the research problem is explained. An outline of the research methodology is provided and problems experienced throughout the

research process are discussed. Feminist theory, which is used as basis of this research, is briefly defined and discussed in this chapter, as well as other themes relevant to this study. Further discussions on these topics follow in chapter 2.

1.2 MOTIVATION

In my opinion the exclusion of gender-specific traumatic events from the Criterion A definition of a traumatic event marginalizes women. Because of social work's longstanding concern with marginalization of minority groups such as women, this research, and others like it, are necessary to create awareness surrounding this issue.

It is my intention that the awareness regarding this issue generated by this research might improve the competence of clinical social workers, social workers and therapists when dealing with women presenting with PTSD symptoms, but who do not comply with Criterion A. Professionals working in the therapeutic field will be more competent, because this research will not only promote awareness, but also provide recommendations regarding assessment, diagnosis and management of these women.

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1.3 PROBLEM STATEMENT AND RESEARCH QUESTION

In 1983 Post Traumatic Stress Disorder (PTSD) was introduced into the psychiatric diagnostic system as a result of the efforts of US Vietnam veterans (Cloitre, Koenen, Cratz & Jakupcak, 2002). Although PTSD may have started as a disorder of men, research has shown that women are twice as likely as men to develop the disorder (Nutt & Ballenger, 2003).

There are six diagnostic criteria for PTSD according to the DSM-IV-TR (APA, 2000). The focus of this study is on Criterion A's stipulations regarding the traumatic event. According to Criterion A, a traumatic event must involve "actual or threatened death or serious injury, or a threat to the physical integrity of self and others" (APA, 2000, p. 467).

There is however, an increasing body of research (Cloitre et al., 2002) that suggests that there are experiences that are traumatic for individuals which do not meet Criterion A. This is particularly so for women, who are more vulnerable than men to interpersonal trauma and gender-specific events such as childbirth and miscarriage or stillbirth. As a result,

PTSD may be under-diagnosed among these women, because their experiences do not meet the requirements of Criterion A.

This study, therefore, will take the form of a critique of the DSM-IV-TR diagnostic criteria of PTSD, with specific reference to women's experiences of traumas that do not meet the requirements of Criterion A.

The research question is as follows: **Should the Criterion A definition of a traumatic event be expanded to include any experience that an individual defines as traumatic?**

1.4 GOALS AND OBJECTIVES

The goal of this research study is to obtain an in-depth understanding of the experience of gender-specific traumatic events such as childbirth and miscarriage or stillbirth. This in-depth understanding would assist me in conceptualizing the essence of the experience. For example, I anticipated that the study would help me in forming an understanding of why the experience of childbirth was experienced as traumatic, and why this traumatic experience resulted in the development of PTSD in some women.

The following objectives were formulated in order to reach this goal:

- To undertake a literature study regarding PTSD, trauma, gender issues and feminist theory.
- To undertake a literature study specifically focussing on the Criterion A issue.
- To conduct qualitative unstructured interviews with women exposed to a gender-specific traumatic event (for example childbirth and miscarriage or stillbirth). The aim of these interviews is to obtain an in-depth understanding of the subjective experience of these traumas that do not meet the Criterion A definition.
- To document results and make recommendations regarding assessment, diagnosis and management of individuals presenting with PTSD symptoms, but who do not comply with Criterion A.

1.5 RESEARCH METHODOLOGY

1.5.1 RESEARCH DESIGN

The research is based on an interpretive qualitative approach. The conceptualization behind this decision is discussed in chapter 3.

Because of the in-depth nature of the study the study is phenomenological in nature. Moustakas (cited in De Vos, Strydom, Fouché & Delport, 2002) explains that through the phenomenological approach the experiences will eventually be reduced to a central meaning or the essence of the experience. The product of this research is a description of the essence of the experience being studied (De Vos et al., 2002).

The methods and strategies used are explained broadly in the research methodology chapter (chapter 3).

1.5.2 POPULATION

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The study was target group specific and the population was defined as follows:

- Female participants.
- The women were exposed to a gender-specific traumatic event not specified or included in Criterion A.
- The event occurred more than one month, but not longer than six months prior to the interview.
- The woman presented with symptoms of PTSD (other than Criterion A).

1.5.3 SAMPLE

The sample comprised three participants. The small sample size is justified by the phenomenological nature of the study. One participant (participant 1) was referred to me by a social worker working in the Greater Johannesburg area. Participant 1 referred me to Participant 2. Participant 3 was referred to me by a Gynaecologist also working in the Greater Johannesburg area, with the consent of the patient.

Participants were not screened based on race or age and complied with the population criteria. Convenience sampling was used, because it is not the intention of this study to generalise the results to the population.

1.5.4 DATA COLLECTION

Data were collected through a qualitative semi-structured interview (De Vos et al., 2002), conducted with the participants at least one month after the traumatic event. An interview schedule was compiled, to be used as a guideline during the interview, and questions were formulated based on the literature review. The main objective of the interview was to gather as much information as possible relevant to the women's experience of and response to the gender-specific traumatic event (Olin & Keatinge, 1998).

1.5.5 DATA ANALYSIS

Data analysis was done simultaneously with data collection. This allowed me to adapt my approach and method constantly, optimizing data collection and understanding. This method also enables the researcher to gather trustworthy data (Merriam, 2002).

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Each interview was tape-recorded and transcribed into written text. The text was then divided into smaller parts, and these smaller parts were analysed. Throughout the process I was focussing on specific themes that described in detail the participants' experience of the gender-specific traumatic event, linked to the resultant PTSD symptoms. This enabled me to recognize and identify the essence of the traumatic event.

1.6 PROBLEMS EXPERIENCED

The recruitment of suitable participants was a time consuming and drawn out process. Based on the feedback received from some of the therapist, it seemed that they did not agree with my critique of the DSM-IV-TR. Other therapists seemed reluctant to refer patients, based on a lack of understanding of the goals of my research.

1.7 THEORETICAL PERSPECTIVE

When research is exclusively aimed at the examination of women's experience of a specific event and ultimately recognises the importance of the examination it could be said that a feminist approach to knowledge building is taken (Hess-Biber & Yaiser, 2004). This study is conducted from a feminist approach based on social work feminist theory. Freeman (cited in Robbins, Chatterjee & Canda, 1998, p. 94) defines feminist theory as "a mode of analysis that involves specific ways of thinking and of acting, designed to achieve women's liberation by eliminating the oppression of women in society".

Viewing human existence from a feminist point of view means to continually criticize one's social context. The aim of this critique is to deconstruct the discriminatory aspects of our social environment. Simultaneously feminist theory promotes a holistic view on the interrelationships between material, social, intellectual and spiritual facets of life (Robbins et al, 1998).

Basing this research on a feminist framework enables me to be more aware of issues and differences. This approach also heightens my awareness around the question of social power, resistance to scientific oppression and the commitment to social justice (Hess-Biber & Yaiser, 2004), which complies directly with the general values of social work. A more detailed overview of social work feminist theory is provided in chapter 2.

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1.8 DEFINITION OF TERMS

1.8.1 TRAUMA

'Trauma' is often the term used to refer to both the event and the distress experienced by the individuals involved. Technically, however, the word 'trauma' refers only to the event (Briere & Scott, 2006). The DSM-IV-TR (APA, 2000, p. 463) defines trauma as "…involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity, or witnessing an event that involves death, injury, or a threat to the physical integrity of another person, or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (Criterion A2)".

1.8.2 POST TRAUMATIC STRESS DISORDER (PTSD)

PTSD is a formal psychiatric disorder. Being exposed to a traumatic life event could lead to the development of certain symptoms characteristic of PTSD. These symptoms include fear, feelings of helplessness, persistently re-experiencing the event and attempting to avoid being reminded of it (APA, 2000). The DSM-IV-TR explains that "PTSD is characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma" (APA, 2000, p. 429). Other symptoms include depression, anxiety and cognitive difficulties. These symptoms last for longer than a month and if important areas of the individuals' life (family relationships and work) are significantly affected, a diagnosis of PTSD can be made (APA, 2000).

Nutt and Ballenger (2003, p. 65) define PTSD as "an anxiety disorder precipitated by exposure to an event which involves actual or threatened death or serious injury, or threat to the personal integrity of self or others that cause intense fear, helplessness, or horror".

1.8.3 GENDER-SPECIFIC TRAUMA

Gender-specific trauma refers to a traumatic experience that can only be experienced by one gender. For example childbirth is a gender-specific trauma, because a man cannot physically experience childbirth.

1.9 <u>CONTENT OF CHAPTERS</u>

CHAPTER 1: ORIENTATION TO THE STUDY

In chapter 1 a description of the study is given, including the motivation, problem statement and research question. The goal and objectives of the study, as well as the strategies, approaches and methods that were implemented to reach the goal, are set out through a brief overview of the research methodology. Also included in the research methodology are the criteria of the population and description of the sample used. The data collection and analyses methods are briefly discussed. Problems experienced while conducting the study are identified and discussed in this chapter. Finally the key terms are identified and defined.

CHAPTER 2: LITERATURE REVIEW

In chapter 2 the fundamental theory, feminist theory in social work, as well as other themes and concepts briefly mentioned and defined in chapter 1 are discussed. A feminist approach is taken, because this study focuses on issues specifically relevant to women. Two gender-specific traumatic events are identified for the purpose of this study, namely childbirth and miscarriage or stillbirth. Both of these gender-specific traumatic events are defined and discussed in this chapter.

CHAPTER 3: RESEARCH METHODOLOGY

In chapter 3 the research process is discussed in detail, in order for the reader to conceptualise the process and my line of thinking. The research problem, question, goals and objectives are clearly stated in this chapter. The research design and strategies are discussed, as well as the research population and sampling strategies. The data collection process is mapped out, as well as the data analysis process and strategies.

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CHAPTER 4: PRESENTATION AND ANALYSIS OF DATA

The results of the data analysis process are reported in detail in this chapter. The results are interpreted in terms of the theoretical perspective presented in chapter 2.

CHAPTER 5: RECOMMENDATIONS AND CONCLUSIONS

In the final chapter of this report recommendations regarding the topic are made based on the findings of the study. Recommendations for further research of this topic are also made. Finally, I explain what conclusions I came to based on the findings of this study.

1.10 CONCLUSION

Research has shown that women are more likely than men to develop PTSD (Nutt & Ballenger, 2003). Unfortunately differential diagnosis of PTSD still reflects a tendency to overlook the traumatic nature of interpersonal violence (Cloitre et al, 2002) and other gender-specific traumas such as childbirth. Childbirth and miscarriage or stillbirth are the gender-specific traumatic events chosen to be the focus of this study.

I am concerned that misdiagnosis of PTSD in these situations may result in ineffective treatment. This study therefore strives to obtain an in-depth understanding of the essence of these gender-specific traumatic experiences that may lead to the development of PTSD in some women.

A feminist approach is taken to form the study as a critique of the DSM-IV-TR diagnostic criteria of PTSD, with specific reference to women's experience of gender-specific traumas that do not meet the requirements of Criterion A.

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CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Striving to reach the objectives stipulated, a literature study focussing on PTSD, trauma, gender issues and feminist theory was undertaken of local and international literature. It was concerning to find that there was no useful local literature relevant to the topic of PTSD relating to gender issues.

In this chapter the theory, themes, concepts and references briefly mentioned and defined in chapter 1 are discussed. This broad discussion will enable the reader to conceptualize my point of view regarding the specific issue being investigated. To fully appreciate the magnitude of the issue the reader needs to be adequately equipped with knowledge of PTSD and the diagnostic criteria as set out by the DSM-IV-TR (APA, 2000).

As I have taken a feminist approach to the research study, the entire study was viewed through a feminist lens. Feminist social work theory is discussed later in this chapter.

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Because of the limited size of the study only two gender-specific traumatic events were chosen as the focus of the study, namely childbirth and miscarriage or stillbirth. Both of these gender-specific traumatic events are discussed and defined in this chapter.

2.2 THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM)

2.2.1 DESCRIPTION AND HISTORY

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a handbook developed by the American Psychiatric Association (APA). The DSM consists of listings and descriptions of psychiatric diagnoses, similar to the International Classification of Diseases (ICD) manual. Over the years the DSMs have changed and developed at the same rate as the concepts of mental disorder have evolved.

During the early years mental disorders were viewed as various ‘reactions’ to stressors, and were classified accordingly with the development of the DSM-I in 1952. During the late 1960’s psychodynamic theory was greatly accepted among therapists and the development of the DSM-II moved away from the concept of ‘reactions’ and maintained a psychodynamic perspective (Jacobson & Jacobson, 1996).

The classification system we are now accustomed to was only introduced in the 1980’s with the development of the DSM-III. “This was significant because it outlined a research-based, empirical, and phenomenological approach to diagnosis, which attempted to be atheoretical with regard to etiology” (Jacobson & Jacobson, 1996, p. 19). This approach was characterized as the ‘biologic’ or ‘syndromal’ approach to diagnosis. Even with the development of the DSM-IV in 1994, the APA continued with this approach (Jacobson & Jacobson, 1996).

2.2.2 THE CLASSIFICATION SYSTEM

Diagnosis is made based on the multi-axial system. The five-axis classification system was developed to provide a systematic framework for the thorough descriptive assessment of a given patient’s psychiatric condition and overall functioning (APA, 2000). The axes are specified as follows according to the DSM-IV-TR (APA, 2000):

- **Axis I**: Clinical disorders other than a personality disorder and mental retardation, as well as other conditions that may be a focus of clinical attention. PTSD, which is the focus of this study, is diagnosed on Axis I.
- **Axis II:** Personality disorders and mental retardation, as well as prominent maladaptive personality features and defence mechanisms.
- **Axis III:** General medical conditions.
- **Axis IV:** Psychosocial and environmental problems.
- **Axis V:** Global Assessment of Functioning (GAF).

Following or during the clinical assessment the therapist will match the symptoms presented by the client or patient with the diagnostic criteria set out for each disorder in the DSM. Once the symptoms have been matched, a disorder complying with these symptoms is identified. The disorder/s or other medical or environmental conditions and factors are

sorted and classified on the five axes, which form the diagnosis of the patient. Based on this diagnosis a therapeutic intervention will be strategised.

Although the DSM is an extremely helpful tool when diagnosing patients, it has some shortcomings. One of the critiques on the DSM is that its validity was sacrificed in favour of reliability, because it was designed to have high reliability among different raters (Jacobson & Jacobson, 1996).

2.3 SOCIAL WORK FEMINIST THEORY

2.3.1 INTRODUCTION

What we conveniently refer to as 'feminist theory' is, in fact, a diverse collection of theories. In other words, there are many different theories, approaches and perspectives labelled as feminist theory. For the purpose of this study my focus was only on feminist theories directly related to social work practice. For example, I focussed my attention on those theories that guide social workers in honouring our profession's commitment to social and economic justice (Saulnier, 2001). According to Saulnier (2001) these theories include liberal, socialist, lesbian, radical and womanist theories.

2.3.2 HISTORY AND DEVELOPMENT

Social work has been practiced for more than a 100 years, and the history of feminist social work is just as long, as stated by Saulnier, Weil, and Wetzel (cited in Saulnier, 2001). Wise (cited in Saulnier, 2001) lists a couple of examples in order to enhance the credibility of this statement.

In 1917 it was feminist social workers who fought the clash of laws against public drunkenness, since there was no means of supporting women living with husbands that were heavy drinkers. This was a major social problem because it sometimes resulted in domestic violence (Woods, cited in Saulnier, 2001). Within the same period Meigs (cited in Saulnier, 2001) states that Jane Addams, a social worker, was protesting for the voting rights of women. And during the 1930's and 1940's Sophonisba Breckinridge, also a social worker, advocated for women's rights.

The 1960's can truly be marked as an era of remarkable change. Feminism was one of the many liberal democratic developments and changes that emerged during this decade. The feminist movement developed in different ways in key countries, such as America, Britain and other European countries. For example, the student unrest in France (David, 2003) was a key moment in history for feminism. The development of the feminist movement and theory can also be linked to specific political events such as Kennedy's assassination in 1963, which is often associated with the beginnings of the emergence of liberal and social democratic movements in North America. During the same time through the post-war generation the idea of liberation and freedom began to emerge even more (David, 2003).

Through the above mentioned examples it becomes clear when feminist social work and social work started to develop, and still continue to grow and develop. Literature often refers to the first and second wave of feminism and lately also to the third wave in feminism. The first wave of feminist activism, as explained by Payne (2005), was during the late 1800's. During this period the focus was on gaining political and legal property rights for women. The first wave of feminist activism lasted until the 1960's. From the 1960's and onwards the focus changed to inequality of opportunity in work, political influence and the general attitudes towards women in the private sector with regards to interpersonal relationships. This is termed the second wave of feminism.

The third wave of feminism started as early as the late 1980's and throughout the 1990's, and became even more visible during the early 2000's. Bellafante (cited in Gilley, 2005) explains that while the first and second wave of feminism was grounded in research and was completely obsessed with social change, the third wave feminists are focussed on the culture of celebrity and self-obsession. This change or shift to third wave feminism came after young woman realized that contemporary feminism was no longer needed, since the goals they were striving towards, such as equality, had been achieved (Gilley, 2005). This realization forced young women to concentrate on old-new issues such as equality among the races. Third wave feminism is focussed on the voices of woman of colour (Gilley, 2005). A central tenet of third wave feminism, as explained by Gilley (2005), is to celebrate the power and possibilities of contradiction.

2.3.3 OVERVIEW OF FEMINIST THEORY

Saulnier (2001, p. 256) explains that “within feminist theoretical analyses, many distresses experienced by women – and some of those experienced by men – can best be understood in terms of sex-based social and structural restrictions, constrictions, and resource deficits, as these limitations interacts with various other structural and interpersonal constraints”.

It can be stated that feminist theory attempts to protect the individual from certain social and political policies. Feminist theory’s main objective is the promotion of change in social and environmental factors, which may be the cause of problems specifically experienced by woman (Saulnier, 2001).

Dominelli (cited in Payne, 2005, p. 258) defines feminist social work as “practice that starts from an analysis of women’s experience of the world and focuses on the links between women’s position in society and their individual predicaments to create egalitarian client-worker relationships and address structural inequalities”. According to Dominelli (cited in Payne, 2005), working from a feminist point of view also allows the social worker to address the needs of individuals involved in social relationships with women, for example men, other women and children. This can be accomplished because of feminism’s holistic manner when dealing with women and their social relationships.

Feminist theory also focuses on providing explanations and the proposing of interventions for intrapersonal and interpersonal concerns of woman, as well as providing a frame of reference when evaluating social and environmental experiences of individuals as well as groups. This framework or perspective can be used regardless of gender. It is important to note that the emphasis on these three factors (intrapersonal, interpersonal and social and environmental experiences) varies with each theory (Saulnier, 2001).

Payne (2005) explains that since feminism was developed by women, working with women in their communities, they strived toward linking their personal and local problems with public or social issues. The implication of this as explained by Payne (2005, p. 258) “is a relocation of social work to recognise that gender neutrality ignores the substantial discrimination against women.” But still this implication can be addressed by simply readjusting personal and professional relationships (Payne, 2005).

2.3.4 CONCLUSION

Feminism is a critical practice theory (Fook, cited in Payne, 2005) and this is why feminist theory in social work guides social workers to focus their attention on means of eliminating misperceptions, sexual inequalities, restrictions and oppression experienced specifically by women (Saulnier, 2001).

2.4 TRAUMA

2.4.1 WHAT IS TRAUMA?

The early introduction of the Cartesian concept of mind and body dualism has resulted in a purely physical concept of human disease. Consequently the possibility that a traumatic experience could cause certain emotional behaviours and physical symptoms in an otherwise healthy individual was denied (Scaer, 2005). In other words, it was seen as a less important condition. Based on this logic, individuals presenting with symptoms of 'shellshock' following World War One were sometimes even accused of faking their symptoms for personal gain (Scaer, 2005).

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Over the years more and more cases of posttraumatic stress emerged, especially after war, and society was forced to re-examine their views on the topic. But still the concept of life trauma was neglected. It was only during the late twentieth century that a large scale of research was produced, largely based on the societal distress experienced during and after the American-Vietnam war. But still behavioural science continued to define a traumatic event "in terms of the horrific extremes of human experience" (Scaer, 2005, p. 2).

According to Scaer (2005) the core diagnosis describing the psychological effects of a traumatic event is PTSD. Scaer (2005) explains that a growing number of behavioural scientists have recognized that the DSM-IV-TR definition of trauma or the traumatic event is inadequate. They explain that the DSM-IV-TR definition does not address the broad spectrum of symptoms of trauma victims. Also the DSM-IV-TR does not take into account the effects of trauma experienced over the course of years (Scaer, 2005).

2.4.2 TYPES OF TRAUMA

Apart from the traumatic events identified in the DSM-IV-TR (APA, 2000), Briere and Scott (2006) list the major types of trauma, such as natural disasters, mass interpersonal violence, large scale transportation accidents, house or other domestic fires, motor vehicle accidents, rape and sexual assault, stranger physical assault, partner battery, torture, war, child abuse and emergency worker exposure to trauma.

2.4.3 GENDER AND TRAUMA

It is not just an assumption that women are more vulnerable than men to traumatic effects. Research (Briere & Scott, 2006) has shown that women are more likely to meet the diagnostic criteria of PTSD in both clinical and non-clinical samples.

The reason for this is mostly because women are more frequently exposed to traumatic events that may result in the development of PTSD symptoms (Briere & Scott, 2006). In other words, the result is not based on the assumption that women are not emotionally equipped to handle stressful events, but that women are more likely to be exposed to traumatic experiences. Women are more likely to be exposed to traumatic experiences mainly due to their physical vulnerability and are therefore often viewed as 'easy' targets for physical, sexual or even emotional abuse.

2.5 POST TRAUMATIC STRESS DISORDER (PTSD)

2.5.1 HISTORY

Matsakis (1996) discussed the fact that evidence of post-traumatic stress disorder (PTSD) had been documented as far back as the ancient Greeks, but it was not called post-traumatic stress disorder (PTSD). Matsakis (1996) used the following examples to prove this statement.

Firstly Matsakis (1996) spoke about the writings of the Historian Herodotus 490 B.C, about an Athenian soldier who became permanently blind after witnessing the death of a fellow soldier, even though he suffered no wounds himself. More examples are that of the great fire of London in 1666. Samuel Pepys wrote of the emotional distress of the survivors: "A

most horrid, malicious, blood fire… So great was our fear…it was enough to put us out of our wits" (cited in Matsakis, 1996, p. 14). Pepys documented that survivors suffered from insomnia, anger and depression for weeks after the fire. Little did he know that he was listing all the common symptoms of PTSD (Bentley, cited in Matsakis, 1996). Jean-Martin Charcot, a neurologist of the 19th century, diagnosed both women who were sexually abused as children and battered wives with hysteria. Based on the symptoms reported, it is a real possibility that these women in fact suffered from PTSD.

According to Kimerling (2002), the conceptualisation we have of PTSD today was developed based on two major groups of clinical observations. Firstly the stress reactions observed among war veterans, termed "war neurosis" and "shell shock". Secondly the reactions of survivors of sexual assault, termed 'rape trauma syndrome'.

Great difficulty was experienced with the treatment of 'shell shock' during and after World War One, since there was no accepted definition of the disorder (Jones & Wessely, 2005). The patients suffered from various symptoms and disabilities, such as fatigue, poor sleep and nightmares. Patients often presented with a variety of somatic symptoms such as palpitations, chest pains, tremor, joint and muscle pains, loss of voice or hearing and functional paralysis (Jones & Wessely, 2005).

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Frederick Mott (cited in Jones & Wessely, 2005), denying the emotional impact of war, argued that the symptoms of the soldiers were caused by the forces of compression and decompression, resulting from an explosion. The compression and decompression in turn led to microscopic brain haemorrhage. He also believed that carbon monoxide released by the explosion might have resulted in cerebral poisoning, causing the symptoms of the soldiers. Mott had no first-hand experience of war and when it became apparent that many of those soldiers presenting with 'shell shock' symptoms had not been close to an explosion, and some not even in combat, he eventually accepted the idea of an emotional disorder.

During the late seventies Robert Jay Lifton, Charles Figley, Chaim Shatan and John Wilson united in their quest to have the psychological impact of trauma recognized. Together they structured their research to form a diagnostic criterion for the disorder then termed 'Catastrophic Stress Disorder' with the sub-category 'Post-Combat Stress Reaction' (Jones & Wessely, 2005). Their aim was to have this disorder included in the

DSM-III under the section on anxiety disorders. Unfortunately this term was not favourable because of political reasons at the time (Young, cited in Jones & Wessely, 2005), and was adapted to Posttraumatic Stress Disorder (PTSD).

PTSD was finally introduced into the Diagnostic and Statistical Manual of Mental Disorders (DSM) during 1983 as a result of the political efforts of American Vietnam war veterans, mental health workers as well as the public policy advocates who worked with them. According to Scott (cited in Jones & Wessely, 2005) PTSD was one of the few politically driven psychiatric diagnoses developed and included in the DSM.

The acceptance of PTSD as a mental disorder into the DSM was extremely valuable, and although PTSD was first recognized because of political views, the result was a major shift in our sense of self and what is right and proper with regards to our emotions. Furedi (cited in Jones & Wessely, 2005) explains that the shift was from a position of only advocating and admiring resilience and/or reticence, to encouraging and valuing emotional display and vulnerability.

Jones and Wessely (2005) state that over the last two decades the use of the concept, the frequency of the diagnoses, and the discussion of trauma and its effect have all drastically increased.

2.5.2 DEFINITION

Being exposed to a traumatic life event or stressor, regardless of any previous psychological problems, could lead to the development of certain symptoms (Sadock & Sadock, 2007). These symptoms are reactions to a single, overwhelming external event or stressor, or series of such events (Matsakis, 1996). A stressor is the prime causative factor in the development of PTSD, as defined by Sadock and Sadock (2007).

According to the DSM-IV-TR (APA, 2000, p. 429), “PTSD is characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with trauma”. Another explanation is that PTSD is an entirely normal reaction to an abnormal amount of stress (Matsakis, 1996).

"Military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents or being diagnosed with a life-threatening illness" (APA, 2000, p. 463-464) are all traumatic events included in the DSM-IV-TR in Criterion A of the diagnostic criteria of PTSD.

Matsakis (1996) explained that although separate words are used for the mind, emotions, and body they are all part of one whole. In that case it is only natural that when trauma occurs, it affects the whole being, not just the mind or emotions. The physical, biological 'parts' of the human being are also affected. Research has indicated that many of the emotionally distressing symptoms of PTSD have a biological basis. In other words PTSD is the after-effects of an event or series of events severe enough to profoundly alter a person's thinking, feelings and physical reactions (Van Der Kolk, cited in Matsakis, 1996).

When PTSD remains untreated other problems may occur, such as clinical depression and addictions such as alcoholism, drug abuse, eating disorders and compulsive gambling.

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2.5.3 DSM-IV-TR DIAGNOSTIC CRITERIA OF PTSD

The DSM-IV-TR (APA, 2000, pp. 467-468) diagnostic criteria of PTSD are as follows:

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
   (2) recurrent distressing dreams of the event.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hyper vigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With delayed onset: if onset of symptoms is at least 6 months after the stressor

2.5.4 CRITIQUE OF DIAGNOSTIC CRITERIA OF PTSD

Since the development of the first edition in 1952, the DSM has received various critiques, and even though it has adapted and evolved over the years, it is still stated that the DSM has some clear shortcomings (Jacobson & Jacobson, 1996).

This study is specifically formed around the critique on the diagnostic criteria of PTSD as stipulated in the DSM-IV-TR (APA, 2000). As stated before, there is a debate around the Criteria A issue. According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders there are six diagnostic criteria, the first of which (Criterion A) stipulates the nature of the traumatic event. According to Criterion A, a traumatic event must involve “actual or threatened death or serious injury, or a threat to the physical integrity of self and others” (APA, 2000, p. 467).

However the argument of various researchers is that there are numerous studies (Cloitre et al., 2002) that suggest that there are experiences that are traumatic for individuals but do not meet Criterion A. Using a feministic approach to this study, my concern regarding this issue is particularly with women and the experience of gender-specific traumatic events such as childbirth and miscarriage. The reason for my concern is mainly that the exclusion of these and other gender-specific experiences from Criterion A definition may result in the misdiagnosis of these women, ultimately leading to an ineffective intervention.

2.5.5 PTSD AND GENDER

According to Cloitre et al. (2002), it is fair to say that PTSD began as a disorder of men. The authors suggest that initially this may have been very positive. They believe that the recognition of the psychological impact of combat on men was successful because of the respect and appreciation the public had for men who went to battle. The recognition of PTSD as a psychiatric diagnosis might not have been so successful had it originally been framed around women and female gender-specific traumas (Cloitre et al., 2002).

This research is framed around the critique on the diagnostic criteria of PTSD, specifically focussing on women. It can confidently be stated that the differences between men and women are far more than simply physical. Most importantly men and women differ in the

way they perceive themselves and their environment. Based on these perceptions they also differ in their values and beliefs and how they measure self-worth.

Because of these different perceptions and frames of reference, men and women experience trauma differently. It is impossible to ignore gender when dealing with the construct of PTSD. Not only is it possible for the biological differences between men and women to cause different results when exposed to trauma, but it may also be the cause of differences in the expression of PTSD symptoms (Tolin & Foa, 2002). The focus of this study however is not on how men and women's traumatic experiences differ, but rather, that there are certain gender-specific traumas experienced by women that are clearly excluded from the Criterion A definition of traumatic events. Gender plays a significant role in the type of trauma experienced by the individual, as well as the context in which it is experienced. Reactions to the event depend on the system of meaning given to the event and the impact it may have on the social environment of the individual (Tolin & Foa, 2002).

Gender differences with regards to PTSD must be explored. According to Cloitre et al. (2002) this is achieved through an examination of the diagnostic criteria itself. The diagnostic criteria are of importance, because it is according to these guidelines that therapists decide which individuals do or do not meet the criteria. Diagnosis is made based on this inclusion or exclusion.

Cloitre et al. (2002) explain that because most combat veterans have been male, and sexual assault survivors presenting in the treatment settings have been mostly female, these early conceptualizations of what we now call PTSD resulted in inherently gendered concepts. It is believed that the construct of PTSD has been shaped by judgments regarding gender from the very beginning. According to Cloitre et al. (2002) the reason given for this assumption is that gender has been implicit, rather than explicit, in the way the construct of PTSD has been shaped.

There is a longstanding concern of professionals based on this conceptualization. The concern is that women are being measured and treated according to a male model, leaving no room for the option that some conditions are manifested differently in women (Cloitre et al., 2002). For example, even though similar symptoms were observed among veterans of combat and victims of sexual assault, different terms were used to define these symptoms. These terms were developed in the mental health sector and from the

advocacy work of sexual assault survivors. The symptoms observed among veterans of combat were termed "shellshock" or "war neurosis", while the symptoms presented by survivors of sexual assault were known as "rape trauma syndrome" (Cloitre et al., 2002).

In the mid-1980's research indicated that sexually assaulted woman developed symptoms identical to those of men who had been in combat. The same symptoms were also recognised in women survivors of childhood sexual abuse (Cloitre et al., 2002). Based on this research, rape and childhood sexual abuse were recognised as Criterion A traumatic events. Unfortunately differential diagnosis of PTSD still reflects a tendency to overlook the traumatic nature of interpersonal violence, as well as the PTSD symptoms associated with these events (Cloitre et al., 2002), resulting in misdiagnosis.

One of the most notable gender issues in PTSD is its epidemiology. Although PTSD may have started as a disorder of men, research has shown that women are twice as likely as men to develop the disorder (Nutt & Ballenger, 2003). Willer and Grossman (cited in DePrince & Freyd, 2002) suggested that women and men are treated differently in the mental health system, leading to different diagnoses for similar symptoms. Through a study conducted by Willer and Grossman (cited in DePrince & Freyd, 2002) it was found that males in a Veterans administration psychiatric outpatient clinic were given the diagnosis of PTSD more frequently than women, who tended to receive affective and schizoaffective diagnoses. Willer and Grossman (cited in DePrince & Freyd, 2002) concluded that gender differences in rates of PTSD diagnosis may reflect cultural assumptions about women's mental health and realities. DePrince and Freyd (2002) argue that gender differences in PTSD may also reflect differences in the amount of trauma males and females experience, as well as the type of trauma experienced.

2.6 GENDER-SPECIFIC TRAUMAS

The main focus of this study is to argue that the diagnostic criteria for PTSD specifically exclude certain valid traumatic events, thus leading to misdiagnosis. This is especially true in the event of a gender-specific traumatic event. There are many valid gender-specific traumatic events, but viewing the problem through a feminist lens based on the assumption that PTSD is a 'male disorder', the focus fell on female gender-specific traumas. Striving to ensure the validity of the study, only two gender-specific traumas were

identified as the focus of this study, viz. childbirth and miscarriage or stillbirth, as explained further below.

2.6.1 CHILDBIRTH

Pregnancy, labour and birth are important and powerful events in a woman's life. It is also a period of adjustment for women. When these events are experienced many biological, physiological, psychological and relational factors are all intimately interactive with each other. Most importantly, these events trigger crucial developmental changes in the feminine identity (Cigoli, Gilli & Saita, 2006). Unfortunately it is possible that in some cases the experience of childbirth may trigger a negative response. My focus, and the focus of this study, is on those who respond by developing PTSD, even though a diagnosis of PTSD can't formally be made, since childbirth is not recognized as a Criterion A traumatic event.

A very important point to remember is that the traumatic event may serve as only a trigger for PTSD and not necessarily as the sole cause. This statement is based on the most recent argument from researchers, that it is not just the nature of the traumatic event, but the individual's interpretation of and response to the event that will determine the development of a PTSD reaction (Clement, 1998). Research done by Feinstein and Dolan (cited in Clement, 1998) found that individuals exposed to physical trauma suggest that the greatest influence in determining the outcome is the way an individual initially incorporates and deals with the traumatic event.

It is impossible to determine whether a traumatic event or experience will trigger a post-traumatic response in a given individual. The same can be said of the experience of childbirth. It is impossible to predict whether or not childbirth will be experienced as traumatic and if it may trigger the development of PTSD in the woman involved. Literature stipulates a few common PTSD triggers, which include fear of death or permanent damage to self or baby, severe pain, and feelings of not being in control (Clement, 1998). In a study done by Ryding (cited in Clement, 1998) with 28 Swedish mothers the following factors were identified as causing acute distress during delivery:

- Feelings of helplessness, especially in cases where their pain could not be alleviated.

- Longer or shorter periods of feelings close to death, believing that they were either dying of pain or wishing for death to end the pain.
- Fear of losing control following brief moments of profound loss of control during a late stage of delivery.

Keeping these triggers in mind it could be stated that it is possible that some women may perceive the delivery as violent. Some women experience strong feelings of fear of 'destroying' the baby or fear of being 'destroyed' by the baby (Cigoli et al., 2006). As a result of the link between life and death, profound contradiction, emotional confusion and conflicting behaviours and feelings could be triggered. Cigoli et al. (2006) explain that the experience of intense pain may act as a significant stressor or trigger to the symptoms of PTSD (for example, re-experiencing of the event, increased arousal, and avoidance of stimuli related to the stressful event).

Kitzinger (cited in Clement, 1998, p. 125) suggested that there are similarities between the experience of childbirth and the experience of rape: "…in childbirth as in rape, a woman may be stripped, forcibly exposed, her legs splayed and tethered, and her sexual organs put on display to all comers…". According to research done by Breslau et al. (cited in Nutt & Ballenger, 2003) there is a 49% probability rate of women to develop PTSD after rape. Kitzinger's conclusions were drawn from 345 letters from women concerning their childbirth experiences. Kitzinger (cited in Clement, 1998) studied the letters using discourse analysis as a framework. One major theme emerged from the study, namely the women's use of words such as 'rape', 'abuse', 'assault' or 'violence' to describe their feelings during and after childbirth.

There are specific similarities between the reactions of rape victims and some women after childbirth. These similarities include reports of feeling shocked at first and emotionally numb. Both groups of 'survivors' explain that they experienced a dominant feeling of relief since they have 'survived' (Kritzinger, cited in Clement, 1998).

Another explanation for the reaction of some women toward the experience of childbirth is that childbirth is experienced as traumatic because some women may feel that they are treated like 'machines' that are at constant risk of breaking down (Kitzinger, 2006). Kitzinger (2006) explains this statement further as that birth is turned into an ordeal when women feel that they are treated like products on a factory conveyor belt when giving birth.

These women feel that they are not being cared for as human beings but are like ‘meat on a table’ without any control over what is happening to them. All of the above mentioned feelings serve as triggers, causing the women to suffer from institutionalized violence which is likely to affect the way the woman feels about herself, her baby and her partner.

The feeling of being out of control is one of the most important components which could result in the previously mentioned symptoms. Soldiers are diagnosed with PTSD after being in situations where they were helpless and trapped. Even if they had no physical injuries, they were emotionally scarred. This could also be the case for woman after childbirth. It is a normal reaction to insensitive care when a woman has no choices and no means of escape (Kitzinger, 2006).

Kitzinger (2006) states that research has shown that one in every twenty new mothers can be diagnosed with traumatic stress after childbirth. It should be kept in mind that this result is based only on the reported cases.

The symptoms are often not present immediately after birth, but after a couple of weeks or months feelings of inner turmoil, flashbacks, nightmares and panic attacks may occur (Kitzinger, 2006). As a result many women will avoid getting pregnant again, not being able to imagine having to go through the experience again.

Cigoli et al (2006) conducted a study with 160 women who had vaginal births. Assessments were done within 48 hours after the birth experience. The aim of the assessments was to determine whether or not symptoms of depression or anxiety were present, since these symptoms may predict the possibility of the development of PTSD. The women were assessed again after 3 and 6 months. The results showed that 1.25% of the women participating in the study presented with clinically significant levels of PTSD and at least 28.75 % of the women participating presented clinically significant symptoms for at least one subscale of PTSD. (Cigoli et al, 2006). Cigoli et al. (2006, p. 96) stated that as with regards to PTSD it was “a complex situation, connected both to the inability at perceiving the child as a ‘supporting’ agent during childbirth, and to a strong tendency to ‘desire’ support form partner and medical staff, particularly in relation to the avoidance subscale”. Even so there is strong evidence that it is possible for PTSD to develop in some women after childbirth.

Beech and Robinson (cited in Clement, 1998) drew attention to reports by mothers of prolonged nightmares following childbirth. Moleman (cited in Clement, 1998) described three women who had symptoms of PTSD following childbirth. Ryding (cited in Clement, 1998) found in a study conducted in Sweden that 28 mothers who had previously experienced a traumatic childbirth showed PTS symptoms. Finally, Ballard (cited in White, Matthey, Boyd & Barnett, 2006) in the mid-1990's presented four case studies of women who showed symptoms complying with the DSM-III-R criteria of PTSD as a result of childbirth. This notion that childbirth can precipitate PTSD is also supported by researchers Alder, Stadlmayr, Tschudin and Bitzer (2006).

The occurrence of PTSD following childbirth remains unrecognised because symptoms of PTSD presenting after childbirth are often misdiagnosed as post-natal depression. The reason for this confusion is that some PTSD symptoms are very similar to the symptoms of post-natal depression (White et al, 2006). The misdiagnosing of these symptoms often leading to multiple Axis I diagnoses, could result in an ineffective treatment plan (White et al, 2006). Furthermore, women suffering from PTSD following childbirth often go undetected because this is not a condition that is routinely screened for. A diagnosis of PTSD can't be made because childbirth is not recognized as a Criterion A traumatic event.

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Moleman et al. and Ralph and Alexander (cited in Clement, 1998) debated whether or not a traumatic experience of childbirth, could be classified as a Criterion A traumatic event. They argued that childbirth fitted the DSM-IV criterion of being "a psychologically distressing event that is outside the range of usual human experience" (Clement, 1998, p. 123).

2.6.2 MISCARRIAGE OR STILLBIRTH

Engelhard, Van Den Hout and Vlaeyen (2003) state that even though psychological trauma is usually associated with threatening events that are external to the individual, such as war, interpersonal violence and disasters, there is an increase in the recognition that threatening medical events may lead to similar symptoms. But still miscarriage is not recognised as a Criterion A stressor.

Clement (1998) differentiates between the terms stillbirth and miscarriage as follows: Stillbirth is legally defined as the birth of a dead infant after the 24th week of pregnancy.

Miscarriage is defined as pregnancy loss before 24 weeks of pregnancy. It seems, then, that the distinction between miscarriage and stillbirth is arbitrary – the difference of but one day can cause an entirely different term to be used to label the event. I argue, therefore, that miscarriage and stillbirth are gender-specific events that fall along the same continuum of experience.

After experiencing the gender-specific traumatic event of a miscarriage or stillbirth, women often feel confused as to how they should react or deal with the situation. It appears as if they are unsure whether or not it is appropriate to mourn the loss of their baby. A possible reason for this is because of the ongoing debate about the point in pregnancy at which an embryo can be regarded as a person.

Davidson (cited in Clement, 1998) states that until the 1970's, it was generally considered harmful for a mother to see and hold her dead baby, especially if the baby had been stillborn. Neither was the mother allowed to plan and attend a funeral service. Mothers were advised to forget what had happened, and to try to have another baby as soon as possible. Moulder (1998) explains that miscarriage has been the 'hidden experience', a minor medical event socially unrecognised and kept out of the public domain, even though according to Smith (cited in Moulder, 1998), around one in five recognised pregnancies ends in miscarriage before 20 weeks gestation.

The significance of miscarriage or stillbirth was only recognised during the nineties. No interest was shown towards miscarriage previously, not even from those concerned with health policies or even women's studies. As explained by Moulder (1998) the feminist view on this is that this neglect was based on the assumption that since little can be done to prevent miscarriage or stillbirth there was a lack of attention given to women's experience in a man's world.

Lately women are much more vocal about their feelings and experiences regarding miscarriage or stillbirth. This is extremely valuable since it is only when women who have experienced miscarriage or stillbirth speak out about their experiences that we can truly begin to understand the tremendous impact it has on the woman involved. The voices of women are particularly important because the event tends to be divided up into practical parts in literature – diagnosis, genetic counselling, care in hospital, aftercare, practical information for staff, etc – fragmenting the experience. In this way the experience also

becomes generalized, even though the experience will remain unique for each woman and will have a function involving different factors that is beyond the actual miscarriage or stillbirth event (Moulder, 1998).

Research has shown that even though each experience is unique and individual, there are some central themes that emerge common to most women (Borg & Lasker, Oakley et al., Leroy, Hey et al., and Moulder, cited in Moulder, 1998). Most of the women who have contributed to this literature conceptualise their miscarriage or stillbirth as a significant event, usually as a loss with accompanying grief and mourning. Moulder (1998) points out that the unique features of grief after a miscarriage or stillbirth are focused on the lack of ritual, not knowing who or what is lost, the loss of role and future hopes, the private nature of the loss, helplessness to prevent it, the loss of a part of oneself, the lack of explanation and the consequent feelings of guilt and anger. The reported feelings of helplessness comply with Criterion A (2) of the diagnostic criteria of PTSD.

Research based on the reactions of parents over time has found that symptoms are usually most severe in the first three to six months (Clement, 1998). Jensen and Zahourek (cited in Clement, 1998) found that six weeks after the loss, one-third of mothers had symptoms at the level of clinical depression. LaRoche et al. (cited in Clement, 1998) found that 20% of mothers had 'inappropriate grief reactions' at three months. Forrest et al (cited in Clement, 1998) found that 34% of mothers had scores in the range of psychiatric disorder after six months, and that 49% had significant symptoms of depression or anxiety. All of the above mentioned symptoms are related to PTSD.

Lasker and Toedter (cited in Clement, 1998) explain that symptoms of a more severe form of grief include withdrawal, despair and difficulty coping. These are symptoms associated with PTSD. Normal reactions would be for a woman to feel a lot of sadness, and even weepiness nine months after the traumatic event, but health professionals are concerned when the woman becomes unable to carry out her normal family or work responsibilities due to this sadness, or when she experiences intense anxiety around babies (Clement, 1998). Avoidance behaviour may follow as a result of this anxiety, which complies with the diagnostic criteria (Criterion C) for PTSD. Research shows that up to a quarter of mothers present with clinical significant levels of anxiety up to one year after the loss (Clement, 1998).

Engelhard et al (2003) found evidence that pregnancy loss may result in substantial symptoms of PTSD in some women. Symptoms that were reported included: re-experiencing the traumatic event (for example, intrusive recollections, nightmares, being upset at reminders), avoidance of its reminders and numbing (for example, cognitive avoidance and feeling cut-off from others), and hyper-arousal (for example, irritability and sleeping problems).

Ehlers and Clark (cited in Engelhard et al, 2003) suggested that certain factors could cause women to be more vulnerable to the development of PTSD symptoms after pregnancy loss. They proposed that only once the memory of the traumatic event is placed in context with other experiences can an individual recover from a traumatic event. In other words, the individual will not continue with avoidance strategies, because the negative connotations of the event would have been restructured.

2.7 CONCLUSION

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Through the literature review it was shown that researchers are becoming more aware of the fact that it is not the nature of the traumatic event that causes the development of PTSD, but rather the perception of the individual regarding the traumatic event. PTSD was developed as a male disorder and as a result, according to feminist views, female gender-specific traumatic events were not included as a Criterion A traumatic event. PTSD symptoms shown by women after experiencing a gender-specific traumatic event are often misdiagnosed, leading to an ineffective treatment plan. Therefore the aim of this research will be to draw attention to certain gender-specific traumatic events not included in Criterion A that could lead to PTSD.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research is a scientific process and in order for any research study to be valid, reliable and trustworthy specific steps need to be followed. These steps are determined by the research approach taken, for example qualitative or quantitative.

With this research study an interpretive qualitative approach is followed, therefore it is phenomenological in nature. The research methodology relevant to this unique phenomenological research design is discussed step-by-step in this chapter. The research question, goal and objectives are identified and discussed, based on the theoretical approach. Finally the process followed during data collection and analysis is discussed.

3.2 RESEARCH GOAL AND OBJECTIVES

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The goal of this research study was twofold: Firstly to formulate a strong critique against the DSM-IV-TR diagnostic criteria for PTSD. The critique was supported by identifying the possibility of gender-specific events experienced as traumatic resulting in the development of PTSD. Secondly to obtain an in-depth understanding of the experience of gender-specific traumatic events such as childbirth and miscarriage or stillbirth. This in-depth understanding assisted me in conceptualizing the essence of the experience for example, forming an understanding of why the experience of childbirth was traumatic. This would lead to a further understanding of why this traumatic experience resulted in the development of PTSD.

The following objectives were formulated in order to reach this goal:

- A literature study regarding PTSD, trauma, gender issues and feminist theory was undertaken.
- A literature study specifically focussing on the Criterion A issue was undertaken.
- Qualitative semi-structured interviews were conducted with three women exposed to a gender-specific traumatic event (for example childbirth and stillbirth). The aim

of the interviews was to obtain an in-depth understanding of the subjective experience of these traumas that do not meet the Criterion A definition.

- Results were documented and recommendations regarding assessment, diagnosis and management of individuals presenting with PTSD symptoms but who do not comply with Criterion A were made.

3.3 THEORETICAL APPROACH

Hess-Biber and Yaiser (2004) define this type of study as a feminist study, mainly because it was specifically aimed at exploring women's experiences of female gender-specific traumatic events such as childbirth or miscarriage or stillbirth. The reason for this exploration was to improve awareness within the therapeutic setting for women and thus avoiding the possibility of misdiagnosis (Hess-Biber & Yaiser, 2004). True to the feminist perspective, the study was formed as a critique of the DSM-IV-TR (Hess-Biber & Yaiser, 2004).

As theoretical framework I decided to focus only on social work feminist theory since feminist theory is very broad and overflows with a diversity of ideas. Thus, only the theories that have a specific impact or influence on social work practice were included. The adoption of the feminist perspective enabled me, the researcher, to view the women participating in the study through a more critical lens, while remaining focused on the protection of women in general. This study will potentially contribute to the protection of women by changing the way in which women are viewed within the medical and psychological sphere (Saulnier, 2001). Saulnier (2001) also explains that feminist theory is not only focused on the protection of women, but is also aimed at providing explanations. These explanations are obtained through in-depth investigations into intrapersonal, interpersonal, as well as social and environmental experiences, which are similar to the perspectives of a phenomenological study, like this one.

3.4 RESEARCH QUESTION

True to feministic views this study was formulated as a critique of the DSM-IV-TR (APA, 2000) diagnostic criteria of PTSD, with specific reference to women's experiences of gender-specific traumas that do not meet the requirements of traumatic events included in Criterion A.

The research question was stated as follows: **Should the Criterion A definition of a traumatic event be expanded to include any experience that an individual defines as traumatic?**

3.5 RESEARCH DESIGN

Positivist and quantitative researchers view the world as a fixed, single or measurable concept or experience (Merriam, 2002). Qualitative researchers disagree (Merriam, 2002). They believe that reality is constantly changing. Merriam (2002) explains that reality is constantly changing because human beings are cognitive beings. In other words, each individual has her/his own internal or cognitive interpretation of a specific reality, which is constantly changing through the influence of social and environmental interactions (Merriam, 2002).

Based on this notion the application of feminist theory was especially appropriate for this study, since it is built on the notion that knowledge is always situated (Ezzy, 2002). "All knowledge is knowledge from where a person stands" (Ezzy, 2002, p. 20). I implemented an interpretive qualitative approach, since the aim of this research was to obtain an in-depth understanding of the women's internal experience and interpretation of the gender-specific traumatic events (Merriam, 2002). As stated, this research study is based on the notion that each individual applies her/his own interpretation or meaning to a specific reality. As a result some experiences could be traumatic for some individuals, but not for others. It also explains why individuals react differently to similar events, for example developing PTSD after childbirth or not. Through this approach the research question will be answered.

This is not an easy process, however, because the researcher is not excluded from this process (Ezzy, 2002). This means that I too have my own pre-understandings of the event experienced by the women and my personal internalizations will no doubt also have an influence on the interpretation of data. For example, the fact that I have never been pregnant and have very recently married could colour or influence my own engagement with this material. It is for this reason that I needed to be aware of feminist theory, and use this awareness as motivation to be even more attentive to the participants' description of the event as opposed to my own internalizations. In other words, for me to ultimately understand the essence or cognitive structure of the gender-specific traumatic experience

I had to remain objective and limit my personal attitudes and beliefs while interpreting the data. By doing this, my awareness became heightened and I was enabled to recognize the essence of the gender-specific traumatic event (Merriam, 2002).

The aim of this study was to attempt to form an explanation of how simple or singular units of these specific traumatic events could be compiled into complex meanings for the specific women involved (Merriam, 2002); hence the use of the phenomenological approach. It is noted that all forms of qualitative research share a similar goal. It could be said that phenomenology forms the foundation of all qualitative research, but still it is a strategy with its own 'tools' and methods (Merriam, 2002). A phenomenological study is orientated to find the essence of an experience (Merriam, 2002). According to Patton (cited in Merriam, 2002, p. 7) this type of research is based on "the assumption that there is an essence to shared experiences".

The sophisticated philosophical background of qualitative research as we know and use it today was provided by hermeneutics (Polkinghorne, cited in Ezzy, 2002). Ezzy (2002, p. 24) describes hermeneutics as, "the art and science of interpretation". This is a fitting description since hermeneutics also rejects the idea that there is one single 'truth' and agrees that the 'truth' is formed through experience and perceptions (Ezzy, 2002). In other words, the experiences were reduced to a central meaning or, as explained by Moustaka (cited in De Vos et al., 2002), to the essence of the experience.

The product of this research is a description of the essence of the experience of gender-specific traumatic events as experienced by the participating women (De Vos et al., 2002). These experiences were studied to strengthen the argument that these gender-specific traumas are experienced as equally traumatic to those traumatic events included in Criterion A.

Although there are various gender-specific events that could be regarded as traumatic, I decided to focus my attention on only two related gender-specific events, to maintain coherence in the small dataset. This enabled me to focus more accurately on obtaining an in-depth understanding of the women's experiences of these gender-specific traumatic events. The two gender-specific traumatic events chosen as the focus of this study were childbirth and miscarriage or stillbirth. For the enhancement of understanding I strove to place myself in the women's shoes. This was done through naturalistic methods which

included the analysis of conversations and interactions between me and the participants as explained in De Vos et al. (2002). This strategy was utilized mainly through a semi-structured interview with the participants as method of data collection (De Vos et al., 2002).

3.6 POPULATION AND SAMPLING STRATEGIES

Because the research study was target group specific the population was defined as follows:

- Participants were female.
- The women were exposed to a gender-specific traumatic event not specified or included in Criterion A.
- The event occurred more than one month, but not longer than six months prior to the interview.
- The woman presented with symptoms of PTSD (other than Criterion A).

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The sample for the study needed to comply with the specific population criteria therefore convenience sampling was used. It was also not the intention of this study to be generalised to the population. The sample comprised three women (participants). The sample size was guided by the phenomenological approach taken for the study.

Therapists, social workers, gynaecologists and mother-and-baby clinics in the Greater Johannesburg area were contacted as means of recruiting participants. Contact was made telephonically, by e-mail and post. The therapists, social workers, gynaecologists and clinics were informed in writing of the research goal, objectives and criteria of participants. Participants were not screened based on race or age.

Participant 1 was referred by the social worker from Garden City Clinic. P1 then referred me to her friend who suffered similar symptoms (Participant 2). Participant 3 was referred by a gynaecologist based in the Roodepoort area.

3.7 DATA COLLECTION METHODS

Qualitative semi-structured interviews were conducted with the three women. Each experienced a gender-specific trauma (childbirth or stillbirth) highlighted in this research study. Each participant signed a consent form giving me permission to use the information obtained from the interview in my research study. An example of the consent form is included as Appendix A.

A semi-structured interview was used to fulfil the purpose of forming an understanding of the participant's experience as well as an understanding of the individual's internal meanings applied to the experience (De Vos et al., 2002). For this purpose the semi-structured interview was ideal, since it is a comfortable, informal, but in-depth conversation. In other words, it is informal but focussed, and it allowed me to explore the experience with the participant.

The interviews were conducted at least one month after the traumatic event, since the PTSD symptoms should have been experienced for longer than one month to comply with the diagnostic criteria as stipulated in the DSM-IV-TR (APA, 2000).

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There was only one meeting with each participant and interviews lasted for approximately one hour. Because of the qualitative and phenomenological nature of the study, and to ensure that the goal of the interview was reached, seven open-ended questions were included in the interview schedule. The questions were used only as a guideline during the interview, and were based on exploring the woman's experience of the specific traumatic event, to form an in-depth understanding of what was experienced by the woman involved. The questions were formulated as follows (also view Appendix B):

1. Please tell me about your experience in as much detail as possible.
2. Please explain to me the feelings and emotions you experienced at the time.
3. Please explain what it was about this experience that was so traumatic for you.
4. How did you feel afterwards?
5. How long did these feelings last?
6. Do you or did you ever experience flashbacks or have recurring thoughts of the event?

7. Please explain to me how your feelings, as a result of this traumatic event, influenced your relationship with your baby/husband/family.

To ensure that the data collected was preserved, interviews were tape recorded with the permission of the participants.

3.8 DATA ANALYSIS

Qualitative data analysis can be difficult, confusing and time-consuming, but it is also a creative and exciting process (De Vos et al., 2002). During the data analysis process the researcher brings order and structure to the raw data (De Vos et al., 2002). Once the data are organized, the researcher is able to draw meaning from the data and then interpret it to form an understanding in written text for the reader.

De Vos et al (2002) present a strategy to qualitative data analysis based on Creswell's (cited in De Vos et al., 2002) view that the data analysis process and interpretation is represented as a spiral image, or as stated by De Vos et al (2002, p. 340) "a data analysis spiral". De Vos et al (2002) present this process in a linear form, but emphasise that these steps can also move in circles. I included this process because the process I followed during the data analysis is very similar. I used the process presented by Prof. Rex Van Vuuren, clinical psychologist and Academic Dean of St Augustine College, during a workshop on phenomenological data analysis that I attended at the University of Johannesburg on 23 and 30 July 2008. This will be discussed along with the process set out by De Vos et al (2002) that will serve as theoretical basis.

Step 1: Data collection and recording

The data collection process was already discussed earlier in this chapter. Based on Van Vuuren's method, it is important to remember that when exploring an experience as is the case with this study, the data will be presented as a narrative. With this in mind I had to be sure to gather all the necessary data regarding the venue, time, activity and how the participant was influenced physically or what was experienced physically. I had to be aware of my target group and the audience I wanted to reach. I also needed to be consciously aware of my own values and intentions with this research. According to Van Vuuren, it is extremely important to focus on the language used to tell this 'story', since there is significant meaning to the words people use to describe their experiences.

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Each interview was tape-recorded to assist me during the analysis process. The recordings also ensured the trustworthiness of the data.

Step 2: Managing data

Managing data is described as the first step in the data analysis process away from the data collection site (De Vos et al., 2002). During this step data are transformed into written text appropriate to the researcher's specifications. It could be keywords, sentences or entire stories to be analysed (De Vos et al., 2002). According to De Vos et al (2002) there is no specific method that needs to be followed to make the data manageable, as long as the researcher is able to manage the data in such a way that it is organized and easy retrievable. I transcribed the entire interview with my participants for analysis, because I didn't want any parts or words of the participants' explanations to be lost. This also contributed to the trustworthiness of my research.

Step 3: Reading, memoing

The researcher needs to get a feel for the data early in the process of data analysis. When doing a phenomenological study the researcher needs to be able to place herself in the participant's shoes, striving to experience the participant's feelings and emotions. This will enable the researcher to form an in-depth understanding (De Vos et al., 2002). Once the recorded interviews were transcribed, reading and rereading the transcripts assisted me in making the participants' experiences part of my own cognitive processes. Thus I became acquainted with the text, bringing me closer to placing myself in the women's shoes.

The transcribed text was then divided into smaller more manageable parts. Van Vuuren suggests that the data be divided into parts based on a shift in paradigm, for example, where there is a change in emotion or theme. This process is illustrated step-by-step in the next chapter.

After the transcribed text is divided into smaller parts, Van Vuuren instructs that the central meaning of each part is extracted and rewritten in the third person.

Van Vuuren's strategy suggests that the researcher divide the page in two halves, transcribing the original text on the left side, already divided into smaller parts. This allows the researcher to rewrite the text next to the part being analysed, extracting the meaning in reflected form. This process is illustrated in the next chapter. This is done through asking

yourself what the participant was trying to say and then presenting it in your own words. The researcher should constantly reflect by asking if the researcher's own words are doing justice to the first voice. In other words, the researcher should consciously be aware of her/his own perceptions and values to ensure that the meanings are extracted based on the participant's perceptions and not the researcher's.

Step 4: Describing, classifying, and interpreting

According to De Vos et al (2002, p. 344) "category formation represents the heart of qualitative data analysis". During this process the researcher is required to remain aware of the data while also being aware of the undercurrents of social life (De Vos et al., 2002). The goal of this step is to identify themes, recurring ideas or language (De Vos et al., 2002). As also highlighted by Van Vuuren, language used is extremely important in finding meaning. The most important part of this process is to be able to link the individuals and the setting together in order to form a unified understanding (De Vos et al., 2002). This process enables the researcher to identify the central meanings attached to the experience by each participant.

Once the central meanings have been extracted and rewritten from each part, the researcher once again rewrites the extracts as a unit, summarizing the participant's experience in the third voice, in other words in the researcher's own words. This will allow the researcher to form a summarized description of the participant's experience.

When interpreting the data the summarized description of the participant's experience is rewritten once more as instructed by Van Vuuren. This time the researcher adds theory and literature to the process and interprets the text. This process is illustrated in various forms in the next chapter.

Step 5: Representing, visualising

Finally the findings of the research are documented and presented to the reader. According to De Vos et al (2002) the findings can be presented in many different forms, for example, text, tabular or figure form. Another method used is that of comparison, which supplies the reader with a more visual explanation.

Finally all the data collected from all the interviews will be combined and a general conclusion will be formed, in the context of the relevant literature.

3.9 CONCLUSION

It is my conclusion that even though there are specific predetermined steps to be followed when undertaking a qualitative research approach, each methodology will be uniquely different, because of the qualitative, phenomenological nature of the research study. I was able to obtain an in-depth understanding of the women's unique individual experiences because of this unique design.

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CHAPTER 4: PRESENTATION AND ANALYSIS OF DATA

4.1 INTRODUCTION

Analysing qualitative data can be much more complex than analysing quantitative data, mainly because the focus is not on gaining answers, but rather on forming an understanding. In other words, qualitative research's orientation is towards finding meanings and interpreting these meanings (Ezzy, 2002). The interpretive meanings are then presented to the reader in solid descriptive text (Janesick, cited in De Vos, 2004). This however, is one of the main obstacles for qualitative researchers to overcome, since meaning is not seen as an object or a substance, but rather an activity, and therefore meanings are constantly changing (Ezzy, 2002).

Theories are used to guide researchers to view these meanings from different perspectives based on the theoretical approach taken (Ezzy, 2002). To assist and guide me in analysing the data I utilized a feminist approach. Feminist theory is based on the belief that experience is situational and that the analysis of women's experiences in specific situations will reveal a shared experience that will bring about social change (Ezzy, 2002).

Due to the unique nature of this research approach the complete data analysis process is included in this chapter. This enables the reader to follow the analysis process step-by-step, in order to understand how I managed the raw data to eventually present a description of each participant's traumatic experience, as well as the subjective meanings. These meanings were summarized and interpreted guiding the reader to an understanding of what each participant experienced.

4.2 PRESENTATION OF DATA AND DATA ANALYSIS PROCESS

According to the data analysis method presented by Van Vuuren (workshop in 2008), there are a few basic steps to be followed once the text has been transcribed. These steps are explained and presented for each interview as follows:

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4.2.1 STEPS ONE, TWO AND THREE OF THE DATA ANALYSIS PROCESS

STEP 1: Data collection and recording

As explained in more detail in the previous chapter, the data analysis process also begins during the collection phase. Van Vuuren points out that it is important to take note of the specific words used by the participants when describing their experiences. Each interview was tape recorded and supplemented with my field notes.

STEP 2: Managing data

During this step the recorded data was transformed into written text. The entire interview was used for analysis.

STEP 3: Reading and memoing

Once the recorded interview had been transcribed, I read and re-read the text several times. This enabled me to become acquainted with the text and to come closer to placing myself in the woman's shoes, striving to understand what she experienced during and after the traumatic event.

The transcribed text was then divided into smaller more manageable parts, based on a change in paradigm as recommended by Van Vuuren. He instructed that the central meaning of each part is extracted during this step and rewritten in the second voice.

For presentation purposes the first three steps were combined and illustrated in the following table. The transcribed text, already divided into parts, is placed on the left side of the table. On the right side the summarized extracted meanings are presented. Keywords and phrases in the transcribed text are highlighted in blue. Extracted meanings are written in green and meanings extracted with specific significance to me were rewritten in red. This enabled me to have easy access to the significant text when interpreting the data during the fourth and fifth steps.

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INTERVIEW 1

Participant 1 (P1) is a 32 year old Indian female, in a multi-cultural marriage of 21 months at the time of the interview. Her husband is White. P1 and her family reside in Brixton in the Johannesburg area. P1 is a freelance journalist and is extremely career orientated. It was her first pregnancy and their first child. The pregnancy was planned and their baby girl was born in September 2008. She was healthy and there were no complications during the birth. They were discharged from hospital after only three days.

P1: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
RESEARCHER: Please tell me about your experience in as much detail as possible. PARTICIPANT: Let's see what I can remember…OK, we came home and I was incredibly happy, I remember telling my husband how much I was loving being a mother,	After being discharged from hospital Participant 1 (P1) was very happy and excited about being a mother.
And then I was home for about a week and I was fine during the day, but as soon as the sun went down. Have you seen 'I am Legend'? RESEARCHER: Yes PARTICIPANT: Well, it was kind of like that. You know where he and the dog would lie in the bath tub hiding and being terrified. Well, that's exactly how I felt as soon as it got dark and I don't know why, but I was so afraid. I jumped at a door slamming or even if my husband called my name. I was so on edge. I struggled to fall asleep.	After being home for about a week P1 became anxious, specifically at night. She was easily frightened, even by familiar sounds. She experienced difficulty in falling asleep, because of this anxiety.
Eventually my husband commented that I was walking around with my mouth turned down, and he was very concerned about this. I explained that my bad mood was because of my breasts that was hurting from the breastfeeding. It would hurt all the time, and all the other women who has gone through this before will tell me to just feed through it. Well, ok, prior to having the baby I would read about it and think yes, I would feed through it, but I couldn't. So the pain added to it	After her husband commented that she seemed to be unhappy, P1 tried to justify her mood by explaining that it was due to the constant physical discomfort she was experiencing as a result of the breastfeeding.

P1: TRANSCRIPTION	**SUMMARISED EXTRACTED MEANING**
and by this time obviously, getting up at night was really painful especially since we have a really high bed. Then we switched to the bottle, and later we realized that the screaming episodes she had during this time was because we didn't phase it out, but I just couldn't breast feed her anymore. I remember that she had a very bad night, and we didn't get any sleep at all. We didn't know what to do. We gave her colic drops and rocked her. Eventually it turned out it was only gas,	They resolved the problem by switching to the bottle. Unfortunately this resulted in discomfort for the baby, causing her to have extreme screaming episodes. Caring for the baby made her feel helpless and out of control.
But my husband's mother who came to help with the baby after I was discharged from hospital, was leaving that morning. So my husband left to take her to the airport, leaving me alone with the baby for the first time,	P1's mother-in-law stayed with them for a while after the baby was born. When she left, P1 was left alone with the baby for the first time.
He came back and came into the room and I was sitting on the chair feeding her. And all of a sudden I just started crying, and crying and I just couldn't stop crying. And I remember feeling that I don't love this little creature…And I didn't, I honestly didn't feel any love for her. I felt responsibility and duty and I just told myself….well I made my bed, now I have to lie in it.	At this time, P1 became extremely emotional and recalled that she didn't have any feelings of love for her baby ('little creature'). She felt only duty and responsibility.
And that was it. I was sitting there holding her and howling. Then I think I had a shower, and while I was showering my husband picked up one of my baby books and started reading about post-natal depression etc. And he phoned my gynaecologist and told him, this is what's happening, and he said: 'Ok, bring her into hospital and we can see what is the best way to treat it'.	P1 had a complete emotional breakdown. She was constantly crying. Her husband realized that she needed help and contacted her gynaecologist, who suggested that she be admitted to hospital.
I was admitted to hospital and the baby went to stay with my sister. They put me on a bunch of drugs and I had counselling. I told the counsellor that we fell pregnant shortly after I stopped taking the pill, and I admitted that I haven't even really adapted to the idea yet.	P1 was admitted to hospital and 'the baby' was taken care of by her sister. While in hospital P1 received counselling, during which she admitted that she didn't expect to fall pregnant so soon after she stopped using contraception.
And I just started working properly for myself. I was doing very well. I had huge projects lined up, and I thought well, I'm pregnant, but it will be fine, but it ended up being…not a difficult pregnancy. I was very healthy, but eventually after three months I had to stop working. I was beyond exhausted. I couldn't even drive my car. Then I started to gain weight, and I am actually a very tiny person.	During this time P1 reflected on her pregnancy and it was revealed that at the time she fell pregnant, her career was just starting to take off. She had to stop working shortly after her first trimester.

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P1: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
And I didn't think about it at the time but it all came out while I was talking to the counsellor at the hospital. What has happened was that my independence have just evaporated right in front of my eyes and I have always been a very independent person. I always lived on my own and did everything for myself, and suddenly I wasn't earning money. I wasn't able to go to work and I didn't even have the energy to have a shower. You know, all of those things. But after all this happened, I realized the pregnancy was not as easy, simply for me, because I wasn't emotionally prepared for what was about to happen.	She experienced the entire pregnancy as difficult, mainly because she felt she had lost her independence. P1 admitted that she wasn't emotionally prepared for the experience.
I wasn't afraid of having a natural birth, but in the end I had a caesarean. A planned one, because my doctor felt since the baby is going to be a normal size baby and I am so tiny, he didn't want to take any risks. And that was fine, although I did cry for a couple of weeks after the decision was made.	P1 was ambivalent regarding having a vaginal birth or a caesarean section. Unfortunately she didn't have a choice in the matter, since the doctor insisted that she have a caesarean section.
On hindsight it was really stupid, but this is what happens if you get caught up in the labour and the birth and romanticise it. And finally I couldn't take it any longer and I talked to myself…I said: 'Listen you have two options, you go with the natural labour and you have an emergency caesarean, or you plan it and you know that you are fine and the baby is fine. And the doctor promised me that he would keep me drugged up to the eyeballs,	After some serious consideration and discussions with her doctor she concluded that having a caesarean section was in the best interest for both her and the baby.
I was concerned about bonding with her if I didn't have a natural birth, but as soon as I could, I picked her up and it was fine.	P1 was still extremely disappointed, because she feared that not birth vaginally would hinder her bonding with her daughter.
But still I was so anxious and unhappy and I just couldn't figure out why. I really thought that after nine months I would pretty much be used to the idea of having a baby and that my life would go back to be very much normal…	After the birth P1 still felt anxious and unhappy and she didn't understand why. She thought she was still getting used to being a mother.
So she was a little more than a month old when I got admitted to hospital and I didn't even mind leaving her. It was like I wanted to avoid anything that reminded me of her as well. But after a while in hospital, I found myself missing her, and wanting to see her. Well, that is pretty much what I can remember.	Being admitted to hospital was welcomed by P1, since she wanted to escape from her situation. She wanted to be away from her baby. She admitted wanting to avoid anything that even reminded her of her baby.

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P1: TRANSCRIPTION	**SUMMARISED EXTRACTED MEANING**
RESEARCHER: Tell me more about the birth itself. Was there anything about the experience that you would describe as traumatic to you? PARTICIPANT: It was...actually everything went quite well, but I constantly had to remind myself that the caesarean was the best option for me.	Even though the caesarean section was a success, she constantly had to remind herself that having a caesarean section was the best option for her and the baby.
The night before I felt quite calm. Even when I went in, I was very calm, but what was very traumatic to me was lying there on the table. I mean it is literally like lying on a crucifix, with your arms stretched out alongside you, and you are hooked up to everything and I felt extremely exposed. It was terrifying. I felt out of control and helpless. At this stage I was thankful that I didn't go with the natural birth, because I don't think I would've been able to deal with everyone looking at my bits…	P1 experienced the birth as traumatic because her body was positioned in such a way that she experienced it as lying on a crucifix. She felt extremely exposed and terrified, because she felt out of control and helpless.
Then everything slowed down a bit and I felt completely removed from the situation. It was like it wasn't happening to me. I was only watching. Then all of a sudden everything started happening, and with a mirror I could see her little head came out, and it was a girl,	During the caesarean section P1 felt totally removed from the situation. Everything slowed down and she felt as if she was watching it happen to someone else.
and I was happy that it was a girl, because my Dad really wanted a granddaughter. I still remember that all I felt at that moment was responsibility and duty. I think I even blamed her for what happened to me, you know for having to go through this terrifying experience.	P1 was happy because it was a girl, because that was what her father wanted. The only feelings P1 experienced were responsibility and duty. She resented the baby for the terrifying experience.
I was so relieved that it was over and that I and the baby have survived,	P1 experienced feelings of relief for surviving the experience.
RESEARCHER: Do you or did you ever experience flashbacks or have recurring thoughts of the birth? PARTICIPANTS: At first I couldn't remember anything about the birth, and I didn't even want to think about it. Then I started to remember some of it, but I still can't remember everything. I just had this overwhelming feeling of being out of control and terrified. And what I do remember is that I felt completely removed from the situation, as if it happened to someone else.	At first P1 had no recollection of the birth, and avoided thinking about it. Eventually she started to remember feeling out of control and terrified, as well as completely removed from the situation.
I did think about it often, but didn't realize it at first. I would have that feeling of absolute terror for no reason and then realize I was thinking of the birth or remembering something that happened.	She often had recurring thoughts about the birth and would relive the feelings of terror, although she still could not recall some of the events.

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P1: TRANSCRIPTION	**SUMMARISED EXTRACTED MEANING**
RESEARCHER: Please explain to me how your feelings, as a result of this traumatic event, influenced your relationships, with your husband, and the rest of your family. PARTICIPANT: It was very hard on my family, especially my husband. But in a way I'm glad it happened, since it made me realize that sometimes my husband understands me better than I understand myself, and that he was there for me. It definitely strengthened our relationship. He really became my rock.	P1 felt that in the end the entire experience had strengthened her relationship with her husband.

INTERVIEW 2

Participant 2 (P2) is a 30 year old White female, residing in Sandton in the Johannesburg area. P2 has been married for a little over three years. She is a successful career woman and had a planned pregnancy with their first child. Their baby boy was born August 2008, with no complications. Baby and mother were perfectly healthy and were discharged after only a few days in hospital.

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P2: TRANSCRIPTION	**SUMMARISED EXTRACTED MEANING**
RESEARCHER: Please tell me about your experience in as much detail as possible, also try to explain the feelings and emotions you experienced at the time? PARTICIPANT: I had, I wanted to have a natural birth because in my pre-natal class they explained how much better it was for the baby, much better, and for the mother. And interestingly, people said things to me like: 'You should have a natural birth and not a caesar, because you have to go through, that trauma to feel competent as a mother. Because most people feel if you have a caesar, you take the easy way out, and to be a mother, you have to be confident.	Participant 2 (P2) wanted to have a vaginal birth, because she heard that it was better for mother and baby. She was also influenced by society's views regarding vaginal birth. She felt that society expected you to suffer in order to qualify to be a competent mother.
And also natural birth is a bonding experience. It was as if people were telling me that I had to suffer in order for me to feel strong and confident as a mother. Anyway, I wanted to do it natural, because I was told it was better.	P2's perception was that by having a vaginal birth you initiate bonding with your baby.

P2: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
But I couldn't because he was breech. He was breech the whole way. Well, the whole way for about 3 or 4 weeks he was breech. And he didn't turn, didn't turn and I really got stuck on trying to get him to turn. I went to reflexology like 3 times a week. I even went to a chiropractor and then my gynae said to me: "Just stop", he's not going to turn, and even if he does turn, it is probably going to be an emergency c-section, and you don't want that. It will be extremely traumatic for me and the baby.	P2 couldn't have a vaginal birth because the baby was breeched. It became an obsession for her to get the baby to turn, really wanting to have a vaginal birth. Eventually her gynaecologist convinced her that the risks were too great and she agreed to have a caesarean section. She wanted to avoid the trauma of having an emergency caesarean section.
So I had a caesarean and in theory I had a relatively easy time of it. Compared to a lot of the women I've spoken to, my birth experience was really easy. There was no complications. There was no ICU. Everything went according to plan. But it was properly the single most traumatic event in my life. You should've actually spoken to me about 2 months ago. Now I have recovered. I can actually talk about it.	There were no complications during the birth, but P2 still defined the experience as the single most traumatic event in her life. The experience was so traumatic that she couldn't even talk about it at first.
I think the things that really got me was how alone, how absolutely lonely it was, I should've had my mother there. I should've had a woman there and I didn't. I had my husband and we had a Doula there. We had a Doula because we were going to have a natural birth and she was my lifesaver. If it wasn't for the Doula, I don't know if I would've gotten through it.	P2 remembered feeling alone. She felt 'absolutely lonely', even though her husband and their Doula (assistant to provide various forms of non-medical support) were there with her. On reflection, P2 felt that she needed to have her mother with her instead of her husband. She felt very strongly about having a woman present when giving birth.
I mean it gotten to a point where we were outside the theatre and I was so…I was never so frightened in my life. I was shaking. I have never experienced emotion like that. Like I was convinced that I was going to die and that the baby was going to die. And I thought that the gynae got it wrong and that he wasn't 38 weeks. That he would be unformed when he came out. And I never felt like that before. Never had I experienced emotions like that. Just terror, absolute terror, I never felt like that before.	Before entering the operating theatre, P2 was extremely frightened. She experienced emotions unlike anything she had ever experienced in her life, 'absolute terror'. Her entire body was shaking. She was convinced that she and the baby were going to die, and if they survived, the baby was going to be unformed.

P2: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
And my husband, as much as he is a lovely man, he couldn't help me in that situation. I think the only person who could've helped me, would've been my mother, or another woman, or someone who had gone through it before. I couldn't even look at him. I was just too terrified and I didn't expect this terror at all. I mean I was actually trying to wheel my trolley away, you know. Luckily we had a great paediatrician. She was really and again a woman, she was really helpful. And we went into the theatre and I was just shaking,	P2 didn't feel that she was getting the support she needed from her husband. She felt that only another woman would have been able to give her the support she needed. At this stage P2 was so terrified, her body was shaking and she was literally trying to escape!
But once I had the spinal I relaxed a bit. But as I was looking around, I got worried because I have low blood pressure, which is madness. I mean, so many other people have it. But I told the anaesthesiologist and I felt like he was just not listening to me.	P2 had certain concerns and got the feeling that the hospital staff, especially the male anaesthesiologist, were not sensitive to her needs.
And the theatre just didn't looked organized like I thought it would. It looked so messy, and everyone looked disorganized, and I felt like they just weren't equipped and organized to help me. And the gynae wasn't there. He was somewhere else doing something else. And then the anaesthesiologist said: 'Ok, let's start'. And I was thinking you can't start, we have to wait for the doctor. And I remember thinking: Why are you people so disorganized and unprofessional?	Brought on by her fear, she experienced the hospital staff as disorganized, unequipped, unprofessional and inadequate to help her.
And the anaesthesiologist just didn't help at all. He was just joking around all the time. And I was not amused, and the Doula was telling him to stop. And by this time I was becoming hysterical. Ja it was quite unexpected. My whole reaction was quite unexpected.	The anaesthesiologist attempted to calm her down by making jokes, but she experienced that as insensitive. Her whole reaction came as a surprise to her, since it is completely out of character. She described her reaction as hysterical. Once again it was a woman who came to her rescue, her Doula, who instructed the anaesthesiologist to stop making jokes.

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P2: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
And then I mean the caesar is really quick, and they warn you about the smells and sounds and so on, and the caesar was really quick. It is actually a really small op and then the baby came out and that was fine. I just couldn't believe it. I mean I was still convinced that he was going to be malformed. It looked like a baby you see in the movies. And it is quite scary, because they hand him to you and you don't know what to do, or how to hold him. All of a sudden you are in the room with your baby now, and once I had the baby, everything was just wonderful and I felt so excited.	P2 described suddenly realising that the caesarean section was a 'small' operation, but still the whole experience was quite unbelievable to her. The caesarean section was successful, but still she was overwhelmed with fear and believed that the baby was going to be malformed. At first, when the baby was handed to her, P2 felt anxious, but soon the fear and insecurity transformed into excitement.
But what happened after that, and what I think is so difficult for women, is the hormonal rush. I mean I think of myself as a relatively rational together person and I was taken out. I mean absolutely flat on the ground, I just cried, I cried, I cried, I would wakeup crying, I was a mess. I had these terrible dreams about the birth, and I was hot and tense and dreaming. And it was all very, very real, although I can't remember any specific details now.	P2 described herself as a rational person, but the hormonal rush that followed the birth completely knocked her off her feet. She was crying all the time and had terrible, vivid dreams about the birth, leaving her feeling hot and tense.
So I didn't get much sleep, and at times I would wake up and I would see him lying next to me in the cot, and I would get this terrible shock. I mean your whole life has changed. You can't comprehend this if you don't have children. I am not sure if I was emotionally equipped to deal with that.	P2 experienced some difficulties in adapting to be a mother. She admitted that she didn't think that she was emotionally equipped to be a mother.
And I think for most women, especially if you have achieved something in your career, you are not used to being so out of control. It's so primal.	Being a very independent woman, it was extremely difficult for her to feel so out of control. She described the situation as 'primal'.
And I really, it was properly the first time I really felt that I needed my husband, because I am actually a very independent woman. And I just needed him to be there for me and he wasn't. Like I'm lying there, I have a catheter, I can't stand, you know what I mean? I can't move really. Actually the pain wasn't so bad, because the op is not so bad. The after effects was much worse, because you have all the after effects just like with natural birth. You've got all the bleeding, all of that, and he just, he wouldn't even hand me my toothbrush.	Again she was disappointed in her husband for not supporting her in the way she expected him to. Especially while she was experiencing the after-effects of the birth.

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P2: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
If I have another child I want my mother there. After this experience, and feeling that my husband didn't respect my needs and feelings, I was ready to leave him. This was how abandoned I felt.	P2's feelings of abandonment by her husband were so intense that she seriously considered leaving him. On reflection she emphasised the importance of having a woman present when giving birth, to support and guide you through the process. She felt that a man would never understand such a female-specific experience.
I think it was very difficult for my husband to see me like that. He kept on asking me: 'What's wrong? The baby is fine. Everything is fine. You guys are healthy. What's wrong?' and I just kept on crying. I was so irritated with him for not understanding. I would get so angry with him. For instance, we would get home from shopping and he would take the baby inside the house, leaving me to carry the shopping bags. It drove me crazy, so I would scream at him. So he withdrew even more, because he couldn't deal with that.	P2 was irritated with her husband for not understanding. On reflection she realized that the situation was difficult for her husband as well. It was impossible for him to understand why she was constantly crying when both she and the baby were healthy.
RESEARCHER: So you definitely felt that this experience put some strain on your marriage? PARTICIPANT: O yes definitely, I was ready to leave him. I can't explain to you how isolated I felt, how abandoned, how absolutely lonely. Ok, but now it is much better, and my husband is a wonderful dad, he is absolutely great.	P2 described her feelings as isolated, abandoned and absolutely lonely.
RESEARCHER: How long did these feelings last? PARTICIPANT: Well at first, I think the big hormone rush went on for about 10 days, which was really big. That was messy, messy. You just feel so distort, but all in all I would say it lasted for about 2, maybe 3 months.	P2 explained that the rush of hormones, leaving her crying all the time and feeling distraught, lasted for about 10 days. Overall, the feelings she mentioned lasted for 2 to 3 months.
Later my mom arrived and my mom was great, because my mom understood what I was going through. And then the baby got sick, and it wasn't an issue. I mean it was just a little bit of jaundice. So we were just discharged from hospital and we went back the next day for a check-up. But I just couldn't cope. I would end up lying on the floor crying. That's how bad it was.	Shortly after being discharged from hospital, the baby developed jaundice. She felt as if she wasn't coping. This feeling resulted in an emotional breakdown.

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P2: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
And I spoke to my mother and said: 'Well this is it, he got jaundice, he is sick...' and then my mother said: 'You are not a bad mother, it is completely normal'. And that seemed to calm me down, because she was like, no, it is normal.	Her mother seemed to have a calming effect on her, because her mother, as a woman, understood her situation.
RESEARCHER: Do you or did you ever experience recurring thoughts of the birth itself, and of the terror you experienced? PARTICIPANT: Yes, it was just too terrible. Like I mentioned before, I had these terrible dreams about the birth. And I wrote a lot of what I felt down. I kept a diary, because I realized that it was a very big thing for me and that seemed to help a lot.	P2 explained that she experienced terrible recurring dreams about the birth. She realized that the experience was quite significant to her, and kept a diary as a way of dealing with it.
And then the next stage was that our child screamed the whole time. He screamed for the first five weeks. That was hectic. It was like survival stuff, I didn't sleep at all. He would start screaming at about six in the evening until about midnight, then have a little sleep and then he would wake up and scream again, I mean he was either asleep or screaming. This made me feel completely incompetent,	The baby went through a phase when he was constantly crying, for about 5 weeks. This caused P2 to be sleep deprived, and she eventually started to doubt her abilities as a mother.
I mean if you are used to doing something in an office, you see a problem and you identify a solution, but with the baby, I just didn't know what was wrong. I mean, what is the problem and nothing was wrong, and I just couldn't fix it. He was just crying and screaming. And I started asking myself, why is he screaming so much. What have we done wrong? That was really difficult.	Being a very independent, career orientated woman, P2 felt completely confused, because the situation wasn't manageable. She often referred to a work related problem which you can manage because it can be identified, but with the baby she couldn't identify the problem. This situation made her feel out of control and helpless.
My mother, when she arrived, said to me: 'If you can't cope, we can take him and that was like such a relieve. Because after I came out of hospital, I kept on saying to my husband: 'We have to go back to the hospital. And he was like: 'Why?' And I would say: 'We have to take him back, this was a mistake', the minute I got home I felt that it was a mistake. We shouldn't have children. I didn't know what I was thinking. Did I even really want to have children? I felt it was a mistake and we have to reverse it, and of course you can't. And he just kept saying to me: 'We can't take the baby back. He didn't come from the hospital, he came from us'. And I just couldn't get that into my head. I was completely irrational I just wanted to take him back.	P2 revealed that she felt it was a mistake to have a baby, and that she was not suited to being a parent. She was completely irrational and insisted that they take the baby back to the hospital, unable to comprehend that the baby didn't come from the hospital.

P2: TRANSCRIPTION	**SUMMARISED EXTRACTED MEANING**
And I was thinking of leaving both of them. Really I was. I just wanted to get away from them, which of course again was completely irrational. But when my mother said that to me, it was like a wave of relief, I had a way out if I needed it...	P2 was so desperate to escape her situation, that she even considered leaving both her husband and baby. Her mother presented her with a solution by offering to take care of the baby if she felt she wasn't able to. The idea of 'having a way out', calmed her down.
I was just completely overwhelmed. I also think society puts a lot of pressure on you. Like for instance, you have to breastfeed and I mean it is not that easy, I remember [the baby] just refused to take my breast at first. And the sister would come in and say: 'No! What is wrong with you?' And I could feel my husband looking at me like he was saying: 'What is wrong with you? You are such a bad mother.' And again I feel I needed my mother or another woman from my family to be with me and guide me. Someone who have experienced it herself before.	P2 admitted feeling completely overwhelmed. It was her perception that society placed a lot of pressure on women to instantly know how to handle the baby. She used breastfeeding as an example. She experienced breastfeeding very difficult at first, and because of this felt her husband and the nurse were thinking of her as a bad mother. Again she mentioned that she needed a woman, specifically her mother to guide her through the process.
RESEARCHER: Please explain to me how your feelings, as a result of this traumatic event, influenced your relationships, with your baby/husband/family. PARTICIPANT: My baby is 5 months old and I can honestly say that I have only recently started to bond with him, like in a honest, intellectual and emotional level. I mean, of course he was my baby and would look after him. That was a given. I didn't think about throwing him out the window or anything, but I am only recently starting to appreciate him. And even though that first day when we got home my main objective was just to get to know this little person. But the way he was looking at me was like: 'I want to go back'. And I was feeling, 'Yes, I also want you to go back! 'I kept on' feeling that this baby was just looking at me like: 'Who are you and where am I?' he looked completely terrified.	P2 admitted that this traumatic experience had delayed her bonding process with her baby. She perceived her baby as if he was asking to be taken back to hospital. She really wanted to take him back.
But I can honestly say that I have really grown through this experience. Just to mention one thing is that I am much more patient. I had to accept that I can't control everything!	P2 felt that she had grown emotionally through the experience. She used the fact that she had accepted that she can't control everything as an example.

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P2: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
RESEARCHER: Is there anything else you feel you need to share with me about you experience? PARTICIPANT: Again the operation itself was very scary for me, because I was awake and I was being cut open. It was horrible. Again it was singularly the most terrifying experience of my life, and I really didn't expect to be so scared!	P2 once again stressed that the birth experience was the single most terrifying experience of her life. Her reaction took her by surprise, but being awake while being cut open was absolutely horrible to her.
RESEARCHER: Why do you think the experience was so traumatic for you? PARTICIPANT: Because it is completely unnatural. I mean you shouldn't be awake and be cut open. It is like brutal, very brutal. I mean every operation is kind of barbaric, but at least you don't know about it, you know. The first day after I felt, wow, that was terrible. It was really very, very unsettling to me on a very deep level. I mean to be cut open while I was awake and be aware of it.	P2 explained that she experienced the birth event as traumatic mainly because of the epidural caesarean section. She felt being cut open while awake was unnatural, brutal and extremely unsettling at a very deep level.
RESEARCHER: Do you think if you had a natural birth it would have been better for you, I mean less traumatic. PARTICIPANT: No not at all. I actually think it would've been worse. I've heard the stories and believe me. I'm glad I didn't have to go through that.	Even though the caesarean section was experienced as extremely traumatic, P2 felt that having a vaginal birth would have been even more traumatic.

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INTERVIEW 3

Participant 3 (P3) is a 25 year old African female, married for a year and residing in Roodepoort in the Johannesburg area. P3 had a stillbirth when she was 28 weeks pregnant. It was her first pregnancy and it would have been their first child. The pregnancy wasn't planned, but they were extremely excited about the prospect of having a baby.

P3: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
RESEARCHER: Please tell me about your experience in as much detail as possible. PARTICIPANT: Well, I was about 28 weeks pregnant and this is what is so confusing to me. I had a very healthy pregnancy. I mean there were no complications. I was healthy and the gynaecologist was very happy with the baby's development. I had an appointment with the Gynaecologist on the Thursday for a scan, and everything was perfect. The baby's heartbeat was strong and everything. We were so excited after the visit!	P3 was 28 weeks pregnant, and up to this point it was a very healthy pregnancy. On their last visit to the gynaecologist he confirmed that it was a girl.

P3: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
But then, the baby was very busy. Always, she was always busy. The doctor confirmed that it was a girl that visit. Anyway, she was very busy. I was always aware of her moving around. When I woke up the Saturday morning I couldn't feel her moving. It was strange, but at first I wasn't worried. But I couldn't feel her moving the whole day. Then I got really worried and my husband phoned my doctor. He told my husband to take me to hospital immediately.	P3 explained that the baby was very active and she could feel her moving all the time. Then, on the Saturday morning when she woke up, she could not feel any movement. At first she was not worried, but when the baby did not move for that whole day, her husband contacted the gynaecologist and she was immediately admitted to the hospital.
I think at this stage on some level I knew it wasn't normal and that I was going to lose my baby, but I couldn't admit it to myself. So I was worried, but I still had hope. At the hospital they did a scan and told us that there was no heartbeat, and I just didn't understand what they were telling me....Then it hit me...My baby was dead.	At the hospital, P3 and her husband received the confirmation that there was no heartbeat. P3 realised with a shock that her baby was dead.
I kept on saying that it can't be true, and that it didn't make sense, because everything was fine. She was fine and healthy,	At first P3 refused to believe that her baby was dead.
I wanted to know what went wrong, but the doctor explained to me that there was no way for them to determine the exact cause. This was extremely hard for me to deal with...You know, not knowing what went wrong. I kept going through the last couple of days in my mind, trying to figure out what I did wrong.	P3 found it extremely difficult to accept, especially since nobody could explain to her exactly what had caused the death of her baby.
My heart was broken. It was our first child and just like that 20 years and more of our future dreams were shattered.	She was completely heartbroken over the loss of her baby and of all their future dreams.
I needed to have a reason. I needed to know if it was my fault. I even blamed my husband for a while. I felt he should've taken me to the hospital sooner, even though the doctor assured us that it wouldn't have made a difference.	She felt she needed to have an explanation. She needed to know if there was something she could have done to prevent it. She even blamed her husband for not taking her to the hospital sooner, but the doctor assured her that it wouldn't have made a difference.
RESEARCHER: What about this experience would you describe as traumatic to you? PARTICIPANT: Not knowing what went wrong. That in itself was extremely traumatic to me, because I needed to be sure that is wasn't my fault, that I didn't kill my baby...	She experienced the stillbirth as traumatic. Firstly, since there was no reason given for the stillbirth, and secondly because she felt that it may have been her fault.
Anyway, even more traumatic than that was to give birth to my dead baby! You know they don't do a caesarean when your baby dies inside of you, you have to give birth to it naturally.	The fact that P3 had to give birth to her dead baby vaginally was experienced as extremely traumatic.

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P3: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
it was horrible. I mean I didn't have any pain because they gave me an epidural. But I felt completely exposed, not just physically but emotionally as well. I felt so helpless,	She didn't experience any pain, but she felt exposed physically and emotionally. She was horrified and felt completely out of control and helpless.
I didn't want it to go through with it, because then it would be true and final. I can't explain why I felt like that. And it was so final. Any hope that I had of them maybe making a mistake was gone.	Giving birth made her baby's death undeniably real and final.
I wanted to have a natural birth ever since I discovered that I was pregnant. I was so excited about it. I always viewed it as a woman's privilege to bring her children into the world in such a miraculous way. But this was torture feeling the contractions and knowing that I am in labour and that I am giving birth to my baby, my dead baby. It was torture. I just wanted it to be over. I wanted to be alone. I wanted to mourn my baby, my little girl.	P3 always wanted to give birth vaginally, but she experienced it as torture to give birth to her dead baby. She desperately wanted it to be over. She wanted to be alone to mourn her baby.
RESEARCHER: Was your life in danger at any stage? PARTICIPANT: No. Well, obviously miscarriage has got its risks to the mother, but I was in good hands and the doctor didn't seem to think that I was in any immediate danger.	Even though a stillbirth can be risky to the mother, P3 explained that her life was not in danger at any stage.
RESEARCHER: How did you feel afterwards? PARTICIPANT: Like I said, I couldn't wait to get to my room and be alone so that I could mourn my baby. But once I got to my room, I felt nothing. I know it sounds terrible, but I really didn't feel anything. I wasn't sad, I wasn't angry, I just didn't feel anything,	Once P3 was alone and free to mourn her baby in private, she didn't feel anything – not sad, not angry, nothing. She was completely numb.
And then my family arrived and they were all crying and upset, and all of a sudden I found myself comforting them. I was concerned about my husband because he hadn't said anything since the doctor told us that the baby was dead, I was afraid that he was pulling away from me, and I needed him.	At this stage the only feelings P3 experienced were concern for her husband. She was afraid that he was withdrawing from her.
But still the whole time I was in hospital, I felt no emotion at all. I convinced myself that it was because I have accepted what had happened and that I was ready to move on.	She rationalized her lack of feelings and emotions to the belief that she was ready to move on.

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P3: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
It was only once I got home, that I really thought about what happened. And I think that was the first time I really realized that she really was gone. I came home from the hospital alone and not with her, as I have dreamt. I felt completely alone and empty. I can't explain to you how empty I felt, physically and emotionally empty. I went upstairs to the room we had prepared for her and I couldn't make myself go in. I closed the door and it was as if it didn't exist.	Once at home, P3 was confronted with the reality of her baby's absence and death. She described feeling physically and emotionally empty. She couldn't manage to enter the baby's room. Instead she closed the door and denied its existence.
I avoided talking about her, even with my husband. I know he lost his child too, but I just didn't feel connected to him anymore. If someone else brought it up I would change the subject. I didn't want to be reminded of her or of what had happened. I just wanted to move on with my life as if it never happened.	P3 felt detached from her husband and couldn't even bring herself to share her feelings with him. She actively avoided anything that would remind her of what had happened.
RESEARCHER: Do you or did you ever experience flashbacks or have recurring thoughts of what happened? PARTICIPANT: Yes I still do. Like I said, I tried very hard to forget and move on with my life. But no matter what I did, every time I would find myself anxiously thinking about those couple of days before the miscarriage. I would go over it in my mind step by step, thinking and rethinking everything I did, everything I ate, trying to find something that I did wrong, that might have caused the miscarriage.	P3 had recurring thoughts of the days leading up to the stillbirth, playing it over and over in her head. She evaluated her own behaviour, attempting to find some kind of an explanation, or to determine whether or not she was to blame. This thought left her feeling anxious.
Sometimes I couldn't even sleep. I would just go over those days in my mind, but it is better now. I still think about it, but not as often and I'm sleeping much better.	The recurring thoughts caused her sleep pattern to be affected.
RESEARCHER: How long did these feelings last? About 6, maybe 8 weeks. Then my doctor referred me to a counsellor. I only just started my sessions, but it seems to be helping.	These feelings and recurring thoughts lasted for at least 6 weeks.

P3: TRANSCRIPTION	SUMMARISED EXTRACTED MEANING
RESEARCHER: Please explain to me how your feelings, as a result of this traumatic event, influenced your relationships, with your husband and the rest of your family? PARTICIPANT: It definitely had a terrible impact on my relationship with my husband. I feel like it drove us apart. And I know it is my fault, because I wouldn't allow him to talk to me about what happened. I just couldn't. Also at this stage I am still terrified of falling pregnant again, so I don't allow him to touch me. Hopefully the therapy will help me to overcome this fear, and help us to reconnect.	The experience had a negative effect on their marriage, especially since she didn't want to discuss the stillbirth. Their sexual relationship was also affected negatively, due to her fear of falling pregnant again.

4.2.2 STEP FOUR OF DATA ANALYSIS PROCESS

STEP 4: Describing, classifying and interpreting

Van Vuuren explains that once the central meanings of each part are extracted the researcher must summarize and rewrite these extracts as a unit. When rewriting these meanings it is done in the third voice, in other words, in my own words. This assists me in forming an understanding of the woman's experience. The result is a summarized description of each participants' experience.

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INTERVIEW 1

P1 experienced her entire pregnancy, including the birth, as traumatic, because she felt out of control. This was firstly because, even though it was a planned pregnancy, she didn't expect to fall pregnant so quickly. She admitted to not being emotionally prepared for the experience. Adding to the experience of not being in control was the loss of independence, especially since she had no control over the decision to have a caesarean section. She was simply told that it would be a better option for her and the baby. Even though she believed it really was the better option, she was extremely disappointed. It was her perception that a mother bonded with her baby through vaginal birth. Later she admitted that having a caesarean section didn't interfere with their bonding at all.

The birth event itself was experienced as extremely traumatic by P1, mainly because she felt extremely exposed. She described experiencing it as if she was lying on a crucifix, about to be crucified. She explained that this was a 'terrifying' experience, because she felt out of control, trapped and helpless. The feelings of terror caused her to feel removed from the situation, as if it was happening to someone else. Once it was over, P1 experienced

feelings of relief, because she had survived. P1 explained that she even resented the baby, because she had to go through that terrifying experience. Shortly after the event P1 had no recollection of what happened during the birth.

After being discharged from hospital, P1 felt extremely happy and excited about being a mother. After a couple of days she started to remember fragments of the birth event, but she was still unable to recall specific details. She remembered that these fragments would trigger the dominant feelings she experienced during the birth event. These feelings included feeling out of control and experiencing extreme terror, causing her to relive these feelings. These feelings of terror were often experienced at nighttime. She compared her experience to the fear experienced by Will Smith in the movie 'I am Legend'. These feelings left her feeling anxious with an exaggerated startled response. Due to this anxiety and startle response P1 experienced difficulty falling and staying asleep.

Because P1 didn't understand these feelings, she didn't discuss them with her husband. Eventually when he mentioned to her that he had noticed that she seemed unhappy, she explained that her bad mood was due to the difficulties she was experiencing with breastfeeding. Their solution was to switch to bottle-feeding, but still her anxiety didn't subside and her mood didn't improve. She explained that she might be tired because the baby was crying constantly. It was only when she was alone with the baby for the first time that she identified her true feelings. She felt duty and responsibility, but no love towards the baby, or 'little creature' as she referred to the baby. This realization resulted in a complete emotional breakdown about one month after the birth of the baby. She was then admitted to hospital.

P1 explained that she welcomed being hospitalized, mainly because she wanted to escape the baby and everything that reminded her of the baby.

INTERVIEW 2

P2 desperately wanted to have a natural birth, but unfortunately this wasn't possible since the baby was breeched. Even though there were no complications, and P2 admitted that the caesarean section was a minor procedure, she still continuously referred to her birth event as the single most traumatic experience in her life.

Even before entering the operating theatre, P2 was overwhelmed by unexplainable terror. She was convinced that neither she nor the baby was going to survive the caesarean section. Adding to her anxiety was the idea that even if they survived, the baby was going to be unformed. She believed the gynaecologist made a mistake and she wasn't 38 weeks pregnant yet. The psychological terror she was experiencing affected her physically. P2 explained how her entire body shook uncontrollably. She described feeling absolutely terrified, helpless and trapped, to the extent that she physically tried to escape by trying to wheel her bed away.

When taken into the operating theatre, she felt completely out of control and helpless. She felt that the hospital staff were not sensitive to her concerns. According to her standards, the theatre seemed untidy and disorganized. This caused her to perceive the hospital staff as incompetent and unequipped to help her. These observations added to her anxiety and at this stage P2 described her behaviour as hysterical.

Once she had the epidural, P2 calmed down, but still experienced the caesarean section as extremely traumatic. She described it as being unnatural, brutal and deeply unsettling to her on a very deep level. She emphasized that it was unnatural to be awake while being cut open.

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The events that followed the birth not only added to the traumatic experience, but also caused P2 to realize just how deeply the event had affected her psychologically. Adjusting to motherhood and trying to deal with these intense emotions left P2 feeling out of control once again. This was especially traumatic, since she saw herself as an accomplished, successful and very independent woman. Feeling out of control, helpless and vulnerable caused her to feel detached from her husband. For the first time in their relationship she desperately needed her husband's support. She felt that she wasn't getting any support from him, mainly because she did not believe and still does not believe he understood what she was experiencing.

P2 continuously stated that she felt that she needed a woman with her during the birth process, because a new mother needed the guidance, reassurance and support of a woman who had experienced childbirth before. In her opinion a man would never be able to fill this role. That is why she is determined to have her mother, rather than her husband, with her during her next childbirth experience.

She was so disappointed by this perceived lack of understanding of her husband that she seriously considered leaving him and the baby. She used words such as isolated, abandoned and absolutely lonely to describe her feelings at the time.

Various factors added to P2's emotional distress and confusion. Firstly there was the hormonal rush that lasted for about 10 days after the birth. Then the baby was diagnosed with jaundice. The baby also cried non-stop for about five weeks and she felt misunderstood by her husband. This left P2 sleep deprived and exhausted, adding to her confusion and causing her to doubt her competence as a mother. P2 described her cognition and behaviour as completely irrational. She was desperate to escape her situation. She felt having the baby was a mistake and told her husband that they needed to take the baby back to the hospital to reverse the mistake. At the time she was unable to comprehend that the baby did not come from the hospital. She even projected her feelings of insecurity towards the baby and perceived the baby's behaviour as being afraid of her and wanting to return to hospital.

It was the recurring dreams about the birth itself that finally made her realize that she experienced the birth as extremely traumatic, 'the single most traumatic experience of my life'. She explained that she remembered that the dreams she had about the birth were extremely vivid, leaving her feeling tense and hot. Afterwards she was unable to recall any exact details of the dreams.

Through reflection it was her perception that the experience was emotionally growing, although she also admitted that it delayed the bonding process between her and her baby. She only recently started to bond with him.

INTERVIEW 3

P3 was 28 weeks pregnant when she realized that something was seriously wrong, because she couldn't feel the baby move. At the hospital her fears were confirmed, when she was told that the baby had no heartbeat. P3 found this unbelievable and confusing especially since the gynaecologist confirmed a few days prior that she and the baby were both very healthy.

Even though her life wasn't in any immediate danger, she experienced the event as extremely traumatic, especially the uncertainty of the cause of the stillbirth. She

desperately needed an explanation. She needed to be assured that she was not responsible for the death of her baby. She described feeling completely heartbroken.

Adding to the trauma of losing her baby was the experience of having to give birth to her dead baby. Although she didn't experience any pain, she felt physically and emotionally exposed. She used words such as 'horrible and 'torture' to describe the event. P3 explained that the experience was emotional torture, mainly because of her own perceptions and expectations. She romanticized the vaginal birth process, but was disillusioned by giving birth to a dead baby.

The stillbirth event left her extremely traumatised and desperate. Her only desire was to be left alone to mourn her baby. P3 explained that once she was alone she felt nothing, no sadness, no anger...nothing. Eventually she was distracted by comforting the other family members. She was also concerned about her husband's reaction and behaviour.

Once P3 had been discharged from hospital and returned home, she was overwhelmed by a flood of emotions. She explained that the dominant feeling was emptiness, physically and emotionally. The feelings were so intense that she felt the best way to deal with it was to actively avoid anything that reminded her of the baby. She acted as if the baby's room did not exist, and even avoided conversation about the baby. Admitting that it was selfish of her, she couldn't bring herself to discuss her loss with her husband, because she felt detached from him.

P3 admitted having recurring thoughts of the stillbirth, more specifically of the days leading up to the traumatic event. She obsessed over every detail trying to determine a cause or at least some kind of an explanation, for her baby's death, leaving her feeling anxious. These symptoms lasted for at least six weeks after the stillbirth.

P3 felt that the traumatic event definitely had a negative effect on her relationship with her husband. She took full responsibility and admitted that this was due to her inability to discuss the stillbirth with him. She was also terrified of falling pregnant again, so avoided any sexual contact with her husband.

4.3 INTERPRETATION OF DATA

Once a summarized description of the participant's experience has been formed, the text needs to be rewritten once more, according to Van Vuuren. This time the researcher uses clinical terms while adding theory and literature to process, analyse and interpret the text.

My goal with this study was actually twofold. Firstly, I strove to form a strong critique against the gender-excluding DSM-IV-TR diagnostic criteria for PTSD. The critique was supported by determining the possibility of gender-specific events experienced as traumatic resulting in the development of PTSD. To achieve this goal, I needed to show that there are gender-specific events that do not meet Criterion A but still precipitate PTSD. Secondly I also strove to form an understanding of the woman's experience through forming a description of the essence of each traumatic experience. To achieve this goal, I needed to show what it was in these events that was capable of precipitating PTSD

In order to reach these goals, and to present it effectively, I had to be creative in the completion of this step. That is why I completed this step in two parts. In Part 1 (4.3.1) I compared the summarized description of the participants' experience with the symptoms set out in the diagnostic criteria of PTSD as stipulated in the DSM-IV-TR (APA, 2000). Therefore a comparison between the experience and symptoms described by the participants and the diagnostic criteria was made and justified, to address the first goal. In Part 2 (4.3.2) a summarized clinical description was given of each participant's experience, focusing on the essence of their traumatic experiences, to address the second goal.

4.3.1 PART 1: DSM DIAGNOSTIC CRITERIA

INTERVIEW 1

DSM-IV-TR DIAGNOSTIC CRITERIA	PARTICIPANT 1
A. The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror.	P1 did not meet Criterion A(1), as the birth did not, in fact, expose her or her baby to the threat of death or injury. In accordance with A(2), however, P1 described feeling terrified, exposed and helpless during the birth event. It was her experience and perception that she was lying on a crucifix, about to be crucified.
B. The traumatic event is persistently re-experienced in one (or more) of the following ways: (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).	In accordance with B(1), P1 explained that she often experienced recurring thoughts about the birth event, which caused her to relive the feelings she had experienced. In line with B(3), she would become overwhelmed with feelings of being out of control and of extreme terror.
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following: (2) efforts to avoid activities, places, or people that arouse recollections of the trauma (3) inability to recall an important aspect of the trauma (6) restricted range of affect (e.g., unable to have loving feelings)	In accordance with C(2), P1 described that she blamed the baby for this traumatic experience. Later when she was admitted to hospital she was relieved because she wanted to escape (avoid) the baby and everything that reminded her of the baby. In line with C(3), shortly after the birth, P1 had no recollection of the events that occurred during the birth and was still unable to recall some specific details. Complying with C(6), P1 was unable to form any loving feelings towards the baby.
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following: (1) difficulty falling or staying asleep (5) exaggerated startle response	In accordance with D(1), P1 experienced difficulty falling and staying asleep. In line with D(5), P1 described experiencing an exaggerated startle response especially at night time.

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DSM-IV-TR DIAGNOSTIC CRITERIA	PARTICIPANT 1
E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.	In accordance with E, P1 explained that she started to experience these symptoms shortly after being discharged from hospital. She was re-admitted to hospital because of the same symptoms one month later.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	Complying with F, P1 experienced clinically significant distress in her social, occupational and personal areas of functioning

Based on this comparison, P1 complies with the minimum requirement of each criteria except for Criterion A where she complies with only one, viz. A(2). Both Criteria A(1) and A(2) need to be present in order to make a diagnosis of PTSD.

INTERVIEW 2

DSM-IV-TR DIAGNOSTIC CRITERIA	PARTICIPANT 2
A. The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror.	P2 did not meet A(1), as the birth event did not, in fact, expose her or her baby to the threat of death or serious injury. In accordance with A(2), however, P2 described the birth as the single most traumatic event in her life. P2 described experiencing intense fear, feeling out of control and completely helpless.
B. The traumatic event is persistently re-experienced in one (or more) of the following ways: (2) recurrent distressing dreams of the event.	In accordance with B(2), P2 described experiencing recurring extremely vivid and disturbing dreams about the birth. Unable to recall exact details of the dreams now, she described feeling anxious, hot and tense whenever she had such a dream.
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following: (5) feeling of detachment or estrangement or estrangement from others (6) restricted range of affect (e.g., unable to have loving feelings) (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)	In accordance with C(5), P2 explained feeling detached from her husband and baby, using words such as feeling isolated, lonely and abandoned. In line with C(6), P2 explained that she didn't have any loving feelings towards her baby, and only experienced feelings of duty and responsibility. In accordance with C(7), P1 did not believe that she, her husband and her baby had a future together. She felt abandoned by her husband and she believed having the baby was a mistake.

DSM-IV-TR DIAGNOSTIC CRITERIA	PARTICIPANT 2
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following: (1) difficulty falling or staying asleep (2) irritability or outbursts of anger	Complying with D(1), P2's sleep pattern was disrupted. She experienced difficulty in staying asleep due to the disturbing dreams about the birth. In accordance with D(2), P2 experienced irritability, mainly aimed at her husband. These feelings of irritation often resulted in outbursts of anger.
E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.	In accordance with E, P2 explained that, apart from the initial hormonal rush that lasted about 10 days, the other symptoms lasted for two to three months.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	In line with F, P2 experienced clinically significant distress.

Based on this comparison P2 complies with the minimum requirement of each criteria except for Criterion A where she complies with only one, viz. A(2). Both Criteria A(1) and A(2) need to be present in order to make a diagnosis of PTSD.

INTERVIEW 3

DSM-IV-TR DIAGNOSTIC CRITERIA	PARTICIPANT 3
A. The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror.	P3 did not meet A(1). Her life was never in any immediate danger, neither did she experience any pain. In accordance with A(2), however, P3 experienced feelings of helplessness and horror.
B. The traumatic event is persistently re-experienced in one (or more) of the following ways: (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	In accordance with B(1), P3 described experiencing recurring thoughts of the stillbirth event, or more specifically, of the days leading up to the event. These thoughts triggered the re-experiencing of her anxiety and feelings of helplessness. In accordance with B(5), P3 explained that exposure to internal or external cues that reminded her of the event, caused her to re-experience the feelings of helplessness and horror she experienced during the stillbirth event.

DSM-IV-TR DIAGNOSTIC CRITERIA	PARTICIPANT 3
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following: (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma (2) efforts to avoid activities, places, or people that arouse recollections of the trauma (4) markedly diminished interest or participation in significant activities (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)	In accordance with C(1) and C(2), P3 explained that she was unable to enter the baby's room. P3 avoided any stimuli that might trigger her feelings by locking anything of the baby's in the baby's room. She closed the door and acted as if it didn't exist. She would also actively avoid any conversations regarding the stillbirth or the baby. In line with C(4), P3 experienced markedly diminished interest in any form of marital activities with her husband. In line with C(7), P3 explained that she was reluctant to fall pregnant again due to the fear of reliving this experience. She did not expect to have any children in future.
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following: (1) difficulty falling or staying asleep (3) difficulty concentrating	In accordance with D(1), P3 explained that she experienced difficulties in falling asleep. In accordance with D(3), P3 explained that she became obsessed with determining the cause of the stillbirth.
E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.	In line with E, P3 explained that after experiencing these symptoms for more than six weeks, her doctor referred her to a counsellor. Although there was some improvement, P3 was still experiencing some of the symptoms at the time of the interview.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	Complying with F, P3 explained that through the active avoidance of conversations regarding the baby and stillbirth, she excluded herself from social interactions with friends and family. The belief that she would suffer a miscarriage or stillbirth again caused her to fear falling pregnant again, resulting in the avoidance of any form of sexual activity.

Based on this comparison P3 complies with the minimum requirement of each criteria except for Criterion A where she complies with only one, viz. A(2). Both Criteria A(1) and A(2) need to be present in order to make a diagnosis of PTSD.

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4.3.2 PART 2: THE ESSENCE OF THE TRAUMA

A summarized clinical description of each participant's experience, focusing on the essence of their traumatic experiences, follows.

INTERVIEW 1

P1 explained that she actually experienced her entire pregnancy, and finally the birth event, as extremely traumatic. I believe the essence of her traumatic event was the experience of being out of control, because P1 is a very strong minded, intelligent and independent woman. This theme constantly repeated itself throughout P1's experience.

First of all, even though the pregnancy was planned, she admitted that she never expected to fall pregnant so quickly; falling pregnant was out of her control. Due to her physical reaction to the pregnancy, she was unable to drive and eventually had to give up working much sooner than she anticipated; again it was out of her control. P1 attached great value to her independence, especially coming from an Indian culture where woman are often dominated. Due to circumstances out of her control, being unable to drive her car or go to work made her feel as if she had lost her independence.

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The decision to have a caesarean section or giving birth vaginally was another example of her loss of control. The gynaecologist suggested that because of her tiny physical build it would be safer for both her and the baby to have a caesarean section. P1 was extremely disappointed, especially since she viewed giving birth vaginally as a bonding experience between mother and baby. She could not control this decision.

Once inside the operating theatre, P1 described feeling, terrified, exposed, helpless and out of control. She had the perception that she was lying on a crucifix waiting to be crucified. This perception had an extremely violent connotation, because crucifixion is one of the most violent ways of execution. In other words, not only did she perceive that she might die she also perceived it as a very violent death in the form of execution. In other words, she was waiting to be executed.

Once the procedure was completed and the baby was born without any complications, P1 expressed feelings of relief, because she survived and did not suffer a horrible, extremely violent death, such as crucifixion.

Thus, apart from the repeating theme of feeling out of control, triggering a negative response to the pregnancy and birth experience, P1 also perceived the birth itself as extremely violent by drawing a connection between her physical position and waiting to be crucified. It is possible that she experienced the entire pregnancy as a form of punishment by the baby. This could also be why she expressed resentment towards the baby for having to live through such a traumatic experience.

INTERVIEW 2

P2 described the birth of her son as the single most traumatic event in her life, even though there were no complications. It is my understanding that there may have been various factors contributing to this event being experienced as traumatic.

P2 was extremely aware of her role in society and of what she thought society expected of her as a woman and a mother. For example, she was extremely disappointed when she was unable to have a vaginal birth, because it was her perception that society views having a caesarean section as 'taking the easy way out'. In other words, it was her perception that society expects you to suffer in order to qualify as a competent mother. After the birth event she referred to society expecting a woman to immediately know how to be a mother and she used breast feeding as an example.

Another factor adding to the experience being traumatic was the sense of losing her independence and feeling out of control.

P2 experienced the birth event itself as extremely traumatic. It was her perception that both she and the baby were going to die. This perception triggered overwhelming feelings of terror in P2. She felt so completely helpless and out of control that she physically tried to escape by trying to wheel her bed away from the operating theatre.

Once inside the theatre, the feelings of being out of control increased, adding to her feelings of terror and helplessness. She perceived the hospital staff as insensitive to her needs, disorganized and unequipped to help her. This perception might have added to the experience of the epidural caesarean section as the most traumatic element of the entire experience, as opposed to general anaesthesia.

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Try to imagine yourself in her position. She was terrified of dying or of the baby dying, being out of control feeling trapped and unable to escape. Then she had an epidural paralysing her from the waist down, leaving her even more trapped, helpless and out of control. Now imagine her lying there with all of these negative, terrifying thoughts and feelings and being cut open while being fully awake. P2 interpreted the caesarean section as 'brutal' and 'unnatural'.

Adding to the birth event being experienced as traumatic was P2's perception that she was misunderstood. It made her feel absolutely alone and abandoned. It was her interpretation that when a woman gives birth, she should have another woman present who had experienced childbirth before. It was her perception that the presence of an older woman, preferably a family member, would make the experience less traumatic. The woman could provide guidance and support which a man could not.

This was clearly illustrated in her translation of the events. For example, she perceived her husband as unsupportive. The anaesthesiologist also a man, made jokes in an attempt to calm her down, but P2 interpreted his behaviour as unprofessional and insensitive to her needs. She explained that the Doula and female paediatrician calmed her down and ordered the anaesthesiologist to stop with his jokes.

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INTERVIEW 3

After 28 weeks of her pregnancy P3's baby was stillborn. Her life was in no immediate danger, but she described her experience as extremely traumatic. Not only did she have to deal with the loss of her baby, but she was forced to give birth to her dead baby vaginally. This experience shattered all of her precious expectations and perceptions of giving birth vaginally as being a privilege and an honour. She was horrified with the birth experience and describes it as 'emotional torture' and 'horrible'.

The entire experience made P3 feel helpless and out of control, because she was unable to prevent the death of her baby. She also described feeling exposed physically and emotionally, and being trapped with no means of escape.

This feeling of being out of control is an important factor in causing women to suffer from institutionalized violence. In this case, it is my conclusion that the perception of violence and safety may very well be the essence of P3's traumatic experience.

Being inside a womb is often related to being safe, but P3's baby died inside her womb. This unexplained violence of her baby dying inside her body and then being forced to give birth to her baby's dead body is the essence of P3's traumatic experience.
I conclude this as the essence because P3 explained that she desperately needed an explanation as to what had caused her baby's death. She needed to be assured that she was not responsible for her baby's death.

4.4 PRESENTATION AND INTERPRETATION OF COLLECTIVE DATA

Van Vuuren explains that the final step of the data analysis process is to combine all the descriptions of the different experiences. This will assist me as the researcher to determine central themes and meanings. Literature and theory are also included during this step to justify these meanings.

All three participating women experienced a gender-specific event as traumatic. According to Scaer (2005) a traumatic event is defined based on the horrific extremes of human experience. These events included childbirth and stillbirth. Both participants who had given birth had caesarean sections. This was not of their own choice, but circumstances forced them to have caesarean sections rather than giving birth vaginally. It was noted that because both women were very strong independent women they experienced not being able to control the decision as a loss of independence. Other factors added to this feeling. For example, in P1's case it was not being able to drive anymore very early in her pregnancy. She experienced this loss of independence as traumatic.

P1 described her entire pregnancy as traumatic and admitted that she was not emotionally prepared for the experience. P2's feelings of loss of independence only came after the birth when she was in physical discomfort and emotionally vulnerable. All three participants experienced the childbirth event as extremely traumatic. They described feeling exposed, terrified, out of control and helpless. These descriptions comply with the descriptions given by the women participating in Kitzinger's (2006) studies describing their birth experiences. Kitzinger (2006) explains that these feelings during childbirth may serve as triggers for the development of PTSD. These triggers may cause these women to suffer from institutionalized violence bound to affect the way the woman feels about herself, her baby and her partner.

Experiencing feelings of helplessness and terror complies with Criterion A(2) of the diagnostic criteria of PTSD, as set out in the DSM-IV-TR (APA, 2000). P2 was overwhelmed with feelings of terror. She described her feelings as being terrified, out of control and helpless, even before entering the operating theatre. She described feeling so completely helpless and out of control that she physically tried to escape by unsuccessfully trying to wheel her bed away from the operating theatre. Similarly, soldiers were diagnosed with PTSD after being in situations where they were helpless and trapped, even if they had no physical injuries. Kitzinger (2006) explains that this may also be the case with woman during childbirth, where they feel trapped with no means of escape. P3 had a similar experience while she was in labour with her dead baby. She felt out of control for not being able to prevent the stillbirth (Moulder, 1998) and completely trapped, leaving her desperate to escape.

Kitzinger (2006) explains that the experience of being out of control is one of the main reasons for the experience of terror by the woman involved, even though her life is not in danger or being threatened. This was exactly the case with P2. She felt completely out of control because she experienced the operating theatre as unorganized and untidy. She also experienced the hospital staff as unprofessional and not being sensitive to her needs. She felt she was not being heard, and that she had no control over what was happening to her. Kitzinger (2006) explains that childbirth is experienced as traumatic when the woman involved feels that she is not being cared for as a human being, but simply as a product on a conveyer belt; in other words, she is not being heard and she has no control over what is happening to her.

Cigoli et al. (2006) found that some women may perceive childbirth as violent. Both women experiencing childbirth found the process to be violent. P1 found her physical position disturbing. She described feeling as if she was lying on a crucifix, waiting to be crucified, and feeling relieved after surviving this ordeal. This response is similar to the response of rape victims (Clement, 1998). P2 experienced the caesarean section as extremely violent. She used words such as ‘unnatural’ and ‘brutal’ to describe her feelings. She described the idea of being awake while being cut open as deeply unsettling. The perception of childbirth being violent may also lead to strong feelings of fear of dying, or of the baby dying (Cigoli et al, 2006). Just before entering the operating theatre, P2 was overwhelmed with fear that neither she nor the baby was going to survive, and even if they survived, she was convinced that the baby was going to be unformed. It is my opinion that

P3's experience was the most violent of all three. Having her baby die inside her body, and then giving birth to the dead baby, may be experienced as extremely violent.

As a result, emotional confusion and conflicting behaviours and feelings were triggered (Cigoli et al, 2006) and were noticed shortly after the birth. P2 described feeling misunderstood by her husband, causing her to feel detached from their relationship. She described feeling isolated, lonely and abandoned. These feelings comply with Criterion C(5) of the DSM-IV-TR diagnostic criteria for PTSD (APA, 2000).

All three of the participants reported experiencing recurring thoughts or dreams of the event. In all three cases these recurring thoughts, re-experiencing of feelings and dreams caused their sleep pattern to be disturbed. All three experienced difficulty in falling or staying asleep, complying with criteria B(2) and D(1) of the diagnostic criteria of PTSD according to the DSM-IV-TR (APA, 2000).

All three participants experienced symptoms of numbness and avoidance of reminders. P1 and P2 wanted to escape from their babies, mainly because they were living reminders of their traumatic events. P3 wanted to avoid objects or conversations reminding her of the loss of her baby. At the time of the interview P3 was still terrified of the idea of falling pregnant again. This fear caused P3 to actively avoid sexual contact with her husband.

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This also links to the symptoms of numbness or feeling 'cut-off' from others (Engelhard et al, 2003). P3 felt cut-off from her husband and P1 and P2 felt cut-off from their babies. They were unable to experience any loving feelings towards them. They only experienced a sense of duty and responsibility. These symptoms comply with criteria C(5) and C(6) of the diagnostic criteria of PTSD in the DSM-IV-TR (APA, 2000).

The symptoms reported by all three women lasted for more than one month (Criterion E) and caused clinical significant distress in their social functioning.

4.5 CONCLUSION

Based on the nature of the research design it was necessary to have a unique data analysis strategy. The strategy used was based on the guidelines set out by Prof. Rex Van Vuuren. I had to be creative in order to analyse the data effectively. Because the strategy

was very creative, the entire process was included in this chapter. This enabled the reader to follow the process and understand why certain conclusions were made.

Among the emerging themes of the collective experience of trauma were the feelings of helplessness and loss of control, which I concluded as the essence of the traumatic experiences.

In the next chapter the interpretations of the participants' experiences will be used to form a conclusion to the study and to answer the research question.

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CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Dealing with a very complex topic, various aspects needed to be included and explored in order to form conclusions. Being a feminist study, these aspects were not only explored, but also critically evaluated. Therefore there are some aspects of this study that can be labelled as unique. For example, the data analysis process needed to be adapted in such a way that the internal meanings each participant allocated to their gender-specific traumatic event could be extracted, while allowing the reader to visually follow this process. Another aspect of this research study that distinguishes it from other similar studies was that the aim of the study was not only to show that trauma is experienced differently by each individual, but also to form an understanding of the essence of the traumatic experience, specifically for women experiencing a gender-specific event.

Through the careful analysis of the data as presented in chapter 4, an in-depth understanding of each participant's experience was formed and central meanings regarding the experience of a gender-specific traumatic event were extracted. These understandings and central meanings were combined, and a unified summary was formed. This summary was compared to the relevant literature in order to form a conclusion to the study. This also provided an answer to the research question.

I agree with the famous quote of Arthur Block that "A conclusion is simply the place where someone got tired of thinking." Although I did form a conclusion regarding this specific research study, there are still many aspects of this topic that need to be explored. These aspects are, however, beyond the scope of this minor dissertation. Therefore I make recommendations for further research on this topic, as well as recommendations on how to use these research findings in practice.

5.2 CONCLUSION TO FINDINGS

Social workers in South Africa work in an extremely diverse community, dealing with various social problems. One of the most important lessons learned in social work is to remember that each culture may experience a problem differently. We should constantly

be aware of this and respect our clients regardless of our own perceptions. This is why I felt extremely fortunate to have participants from different cultures participating in this study. Because of their cultural diversity, it was a wonderful opportunity to compare the experience of trauma in the three different cultures. It was even more fascinating to discover that regardless of cultural background, all three women's experience of trauma was very similar.

All three women were exposed to a gender-specific event (childbirth and stillbirth); events that only women can experience. These gender-specific events were experienced as traumatic by all three, even though these events, excluding the stillbirth, are not normally perceived as traumatic. All three women reported feeling out of control, helpless and terrified. All three of them were confronted with violence or death in some form. P1 compared her experience to being crucified or waiting to be crucified. P2 was convinced that either she or the baby was going to die during the birth. She also experienced the caesarean section as brutal and unnatural. P3's experience involved the actual death of her baby. This was experienced as extremely violent, because her baby died inside her. Although it may even be argued that P3's experience does comply with the Criterion A definition of a traumatic event, the essence of her trauma was *delivering* her dead baby and the uncertainty of what *caused* the death, rather than the actual loss of her baby.

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Being privileged to have such a diverse group of participants, I was able to draw the conclusion that the experience of trauma is a universal experience, such as love and anger. Expressions of these experiences may differ. Personal internalized understandings of these experiences may even differ. But the feelings or emotions regarding these experiences remain the same across the cultures.

This brings us back to the research question: **Should the Criterion A definition of a traumatic event be expanded to include any experience that an individual defines as traumatic?**

Based on the research findings, the answer to the research question is without a doubt **yes.** It is extremely important to understand what your client defines as traumatic, because what one individual experiences as traumatic may be experienced as positive by another individual. For example, the women participating in this research study defined their childbirth experiences as traumatic, based on various internal interpretations and

perceptions of the event. Other women I have spoken to informally, who also experienced childbirth by caesarean section, experienced the complete opposite. They described their experiences as absolutely wonderful and they felt calm, relaxed and excited. This observation made it clear that it is possible for two individuals to respond entirely differently to the same experience.

Other research studies on this topic have shown that the experience of an event as traumatic is based on the individual's internal perception or meanings formed regarding the experience. Merriam (2002) states that all humans are cognitive beings, meaning that each person has her/his own internal or cognitive interpretations of a reality or event, but these interpretations are constantly changing, due to the influences of our social environments. Therefore, each individual has got her own definition of trauma or what may be perceived as a traumatic event.

In this study this was illustrated clearly through the experiences of the two women who experienced childbirth by caesarean section. In both cases it was a planned caesarean section. They had their own gynaecologists present and their husbands. The caesarean sections were done in private hospitals and neither of them experienced any medical complications, and both the mothers and the babies were healthy. Despite all of this, they both defined the experience as extremely traumatic, felt out of control and even experienced the situation as life threatening, even though objectively there was no actual threat to their integrity or life.

One of the main themes that were presented continuously by the participants and during the literature study was the feeling or experience of being out of control. This feeling of being out of control, or even just the fear of being out of control, may lead to the experience of other gender-specific events as traumatic as well. For example, a routine gynaecological examination, or even having a routine mammogram, may leave the woman feeling exposed, violated and out of control. Sexual discrimination is another event that can leave a woman feeling out of control and experiencing the event as extremely traumatic.

Moving away from gender-specific events I even want to argue that the experience of having anaesthesia and undergoing surgery may be experienced as extremely traumatic, because the individual is completely out of control of what is happening to her/his body.

Women may, however, be more susceptible than men to this being experienced as traumatic, mainly due to society's perception that women are more vulnerable to different forms of abuse and exploitation.

It is my understanding that women experience gender-specific events as traumatic due to the feeling of loss of control. The cause of this reaction is directly related to women's history of being oppressed and previously disadvantaged. Even though today's women have equal rights, we are still constantly fighting a battle in society to prove ourselves at least equal to men. Women are therefore much more vulnerable when faced with a situation we perceive as being out of control or involving a loss of our independence.

Based on this observation, I conclude that, regardless what the facts of the circumstances of the event are, whether or not an event is experienced as traumatic by the individual involved is greatly dependent on the individual's perception and internalized definition of the event.

Even in the case of P3 whose baby was stillborn, the experience was extremely traumatic; but this trauma was apparently not due mainly to the loss of her baby, but because she felt out of control not being able to prevent the loss of her baby. Her initial perceptions of childbirth were also violently shattered and she felt that she was deprived of an explanation. It may be argued that P3's experience was, in fact, extremely traumatic because she lost her baby, but it seems that it was the trauma experienced for not having an explanation to the death of her baby that caused her to develop PTSD symptoms. This kind of trauma is not included as a Criterion A definition of a traumatic event.

In my opinion, this conceptualization is extremely important for any social worker or therapist, because once a social worker or therapist is open to this possibility, it will enable them not only to understand the client better, but also to improve the client-therapist relationship, enforcing trust between the two parties. Based on this statement, a number of recommendations can be made.

5.3 RECOMMENDATIONS

5.3.1 RECOMMENDATIONS FOR PRACTICE

It is recommended that all social workers should become acquainted with the symptoms of PTSD and be aware of its occurrence, specifically after the experience of a female gender-specific traumatic event. This is important since the occurrence of PTSD, especially when misdiagnosed, may lead to various social problems, such as child abuse, spousal abuse, neglect or abandonment of children, substance abuse, etc.

Social workers will be able to evaluate the situation more extensively if they are aware of the possibility of PTSD being the cause of these various social problems and are able to identify the essence of the traumatic event. All possible causes should be included and then her/his intervention plan should be designed according to these findings. For example, if, when dealing with a case of child abuse, the social worker finds that the mother is suffering from PTSD following childbirth, she will adapt the intervention plan accordingly. If PTSD is the underlying cause of or a significant contributor to the mother's abuse of her baby, the social worker could conclude that the baby is in no long-term danger. Therefore, if necessary, the child may be removed from the mother's care for only a short while, or for only as long as it is necessary for the mother to receive the necessary care and treatment for PTSD. This will enable the social worker to reunite the family once the mother's treatment has been successfully completed. This approach is true to social work's goal of keeping the family together.

Being empowered through knowledge based on this research study and others like this, the social worker will be able to form an effective intervention plan, including the referral of the client to other professionals, when necessary. For example, the client could be referred to a psychologist where a formal diagnosis is needed, to a clinical social worker for therapy, or to a psychiatrist where medication may be needed.

I also recommend that the social worker referring the client to any of the above mentioned professionals should write a detailed referral report highlighting the symptoms and stating that PTSD may be the cause. The social worker may even include resources such as this research study and other relevant literature. Following this course of action will not only

promote awareness, but also contribute to the competence of social work practice and promote other professions' perceptions of our profession.

5.3.2 RECOMMENDATIONS FOR RESEARCH

I also recommend that social workers continuously expand their knowledge base of different types of disorders, specifically aimed at women. I recommend that women's needs should be prioritised and that there should be a constant quest to understand these needs, especially since women were formerly disadvantaged. This prioritising could contribute to the empowerment of women thereby promoting social change.

Through research and self-study social workers will be able to improve their service delivery when dealing with dysfunctional families and other social problems. The following recommendations are made for further research on this topic to create awareness with social workers in the field, as well as other professionals:

- Social workers should constantly criticize our social environment, using feminist studies as a theoretical lens. Through this objective evaluation of our social structures, existing and future problems will be identified. Through research of these topics, awareness will be raised, which in return will lead to the development of protocol for improvements and the necessary adaptations will be made.
- More extensive research needs to be done determining the statistics regarding the prevalence of the development of PTSD following gender-specific events. This type of research will create awareness of the gendered nature of trauma, making gender impossible for health professionals to ignore.
- Phenomenological research studies need to be undertaken, exploring the essence of the experience of other gender-specific events not included in this study.
- Equally important is the critical analysis of other diagnostic reference text books to ensure that women are not being excluded from other diagnostic criteria.

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5.4 PERSONAL REFLECTION

Completing this study was an interesting and exciting journey for me personally. Implementing a phenomenological approach and basing the research study on feminist theory was a very emotional and eye opening experience. Being a woman myself, it encouraged, and even at times forced me to look within myself and challenge my own perceptions and ideas surrounding this topic of female gender-specific events, such as childbirth and miscarriage or stillbirth. I became immensely aware of the psychological impact that these events may have on women.

5.5 CONCLUSION

To ensure the trustworthiness of this study, specific data analysis steps were formed to complete the research study. These steps were formed based on the unique nature of this research study. The reader was enabled to visually follow these steps as they were set out clearly in chapter 4. The entire process remained true to the phenomenological nature of the research study. The aim of the research study was not only to find an answer to the research question, but true to social work feminist theory on which the research study was based, also to form a critique of the DSM-IV-TR diagnostic criteria of PTSD.

The research question was answered and it was found that there are similarities in the experience of trauma across cultures. It was also concluded that whether or not an event is experienced as traumatic, is dependent on the individual internal cognitions regarding the experience. Therefore it is stated that the DSM-IV-TR should be adapted to include traumatic events defined as traumatic by the individual involved.

Recommendations for further research on this topic were made, as well as other disorders specifically aimed at women. This will promote the empowerment of women in the social, medical and psychological spheres.

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APPENDIX A

CONSENT FORM

I ________________________________ hereby give consent to Lizette Gründlingh (researcher) to include any information given by me as true in her research study regarding the possibility of developing PTSD after childbirth, although not included as a Criterion A traumatic event according to the DSM IV TR. I also declare that I was informed that the research study will be formulated as a critique of the DSM IV TR, based on feminist theory.

________________________ ________________________

Signature Date

APPENDIX B

INTERVIEW SCHEDULE

INTRODUCTION: I would like to ask you a couple of questions regarding your experience of childbirth/stillbirth. Please try to answer all the questions in as much detail as possible. The information gathered will be analyzed and interpreted, to form an in-depth understanding of the essence of your experience. This understanding will assist me in formulating a critique against the DSM-IV-TR, which excludes feminist gender-specific traumatic events from the Criterion A definition of trauma in die diagnostic criteria of PTSD.

1. Please tell me about your experience in as much detail as possible.
2. Please explain to me the feelings and emotions you experienced at the time.
3. Please explain what it was about this experience that was so traumatic for you.
4. How did you feel afterwards?
5. How long did these feelings last?
6. Do you or did you ever experience flashbacks or have recurring thoughts of the event?
7. Please explain to me how your feelings, as a result of this traumatic event, influenced your relationship with your baby/husband/family.

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