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Giving voice to my childbirth experiences and making peace with the birth event: the effects of the first childbirth on the second pregnancy and childbirth

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Abstract

This autoethnographic study describes the author's waterbirthing experience to evidence the relationship between fear of childbirth and communication with, and support from, healthcare professionals and the medical process during labour and delivery. The study provides a rereading of the author's experience, which demonstrates how the traumatic consequences of a first childbirth influenced the experience of a second pregnancy and childbirth. This account indicates how lack of training and inadequate communication by medical staff can lead to traumatic childbirth experience. The study enhances understanding of womens' transition to motherhood with implications for practice, education and research of midwives and other medical providers.

Keywords

autoethnography, childbirth, fear of childbirth, medicalization, waterbirth

Introduction

The experience of childbirth is viewed both in the literature and by mothers as a significant transition that involves physical and emotional changes in the mothers and relational changes inside the family. This experience is considered a complex, multidimensional and subjective experience (Larkin et al., 2009). Moreover, in many cases the birth event is considered a very engaging moment for the couple and is often a source of realization of a shared project and lived in a positive way from a psychological perspective. However, even if this moment is considered one of the most positive transitions in a woman's life, in some situations, it can be transformed into a traumatic event (Cipolletta, 2016). Women often, during labour and childbirth, feel alone and unsupported. The busyness of the hospital units precludes women-centred care, both in early labour and in the period following the birth (Larkin et al., 2012). Moreover, even if this transition is surrounded by positive emotions as underlined by Isbir (2013), the feeling of fear associated with childbirth is considered a universal feeling that is passed through the narratives of other mothers or related to previous experiences. Bydlowski (2004) considers this fear an ancestral fear. However, in certain situations, the fear may be due to contingent conditions, such as having a positive outcome to the BRCA test (Rania and Migliorini, 2015), in which the fear of being able to get sick and not being able to see their child grow can lead women to live with this feeling or choose not to become mothers. Moreover, as highlighted by Melender (2002), women can face different fears associated with the experience of pregnancy and childbirth, such as pain of childbirth, child's and mother's well-being, healthcare staff, family life, motherhood, vaginal delivery and caesarean section.

Here the author discusses the various different origins of the fear of childbirth, which include negative stories from

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other mothers, to alarming information and for multiparas to their previous negative experiences. The negative stories and experiences are associated, for example, with induction, augmentation, instrumentation and caesarean delivery, feeling of no control of one's body and situation, lack of information of what happens and difficulty in communicating with the staff. All of these aspects can lead women to perceive this idealized experience as traumatic.

A recent meta-ethnography of women's perceptions and experiences of a traumatic birth (Elmir et al., 2010) identified six themes related to this issue: 'feeling invisible and out of control', 'to be treated humanely', 'feeling trapped: the reoccurring nightmare of my childbirth experience', 'a rollercoaster of emotions', 'disrupted relationships' and 'strength of purpose: a way to succeed as a mother'. Moreover, the authors underline that mothers have not had the opportunity to declare their feelings and their state, and healthcare professionals are often not aware of the needs of women during labour and birth.

Another source of fear related to childbirth is the lack of support by professional-care, partners or relatives, particularly immigrant mothers that give birth far from home (Migliorini et al., 2016a) and face motherhood in a foreign country (Migliorini et al., 2016b; Rania et al., 2015a; Rania et al., 2018a; Rania et al., 2018b; Rebora and Rania, 2017).

In recent decades, to reduce the fear of pain during labour, various practices have spread, including mindfulness (Dhillon et al., 2017), which can also reduce anxiety and depression both during the perinatal and postnatal periods. In fact, childbirth fear is related to lower labour pain tolerance and worse postpartum adjustment, and a mindfulness approach can reduce the fear of pain and symptoms of both chronic and acute pain (Duncan et al., 2017). Mothers that have used mindfulness-based childbirth education during the prenatal period have improved their childbirth-related appraisals and their psychological functioning. Moreover, Fenwick et al. (2013) tested the efficacy of midwife-led psycho-education counselling to review birth expectations, distressing elements of childbirth and discuss negative childbirth events. The results included an improvement in women's resilience, confidence and a sense of competence.

Another practice used to reduce the fear of pain during labour is waterbirthing, which has also widely spread in recent decades. However, there is no scientific evidence to support the use of waterbirth. There are still few studies, with small samples with a naturalistic observational approach, and often, the results do not agree. Several authors (Nutter et al., 2014) suggest that waterbirth is associated with high levels of maternal satisfaction and with pain relief during the experience of childbirth and may increase the likelihood of an intact perineum. Moreover, waterbirth is associated with decreased incidence of episiotomy and severe perineal lacerations and may contribute to reduced postpartum haemorrhage. Instead, data indicate no difference in maternal or neonatal infection rates. However, an analysis of systematic reviews, case reports and guidelines from professional organizations suggest minimal benefit of underwater birth to the mother and no benefit to the infant (Simpson, 2013). In particular, in the United States, underwater birth is not supported by the guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (2016), which are also placed on the Association of Italian Gynaecologists (AOGOI) website. As appropriately concluded by Simpson (2013), based on these findings, underwater birth requires more rigorous study. In fact, giving birth in water is not a natural process; therefore, it is necessary to have convincing evidence to consider it as a recommended intervention technique. It can be an opportunity for the woman, but they need to be informed regarding the risks and benefits. In this article, I present my two experiences of waterbirth that can be used to improve on the poor qualitative studies in this field.

Furthermore, as affirmed by Reisz et al. (2015), the literature has mostly compared women who deliver vaginally versus those who undergo caesarean section, but few studies have addressed how the traumatic consequences of the first childbirth can influence a second childbirth. The attempt of this study is to overcome this gap to help pregnant women prepare for childbirth, healthcare professionals prepare for those pregnant women and birthing staff but also to allow myself, through the narration, to reread my experiences of birth and make peace with the birth event with a systematic review of the two experiences, emphasizing the critical aspects that can become a source of reflection for those who work in this area of health.

Autoethnography approach

Autoethnography is a methodology that seeks to connect personal experience to cultural processes and create potential for greater depth and understanding of the issue (Liggins et al., 2013). As argued by Ellis et al. (2010), this approach to research and writing allows authors to describe and systematically analyse (graphy) personal experience (auto) to understand cultural experience (ethno). Moreover, Ellis (1991) underlines that the introspection technique, such as autoethnography, is a valid method to access private experiences that would be inaccessible with other qualitative and quantitative tools, particularly when a researcher wants to explore emotional or personal experiences. Autoethnography has origins in the post-structuralist paradigm and was used in the studies in which the researcher is a member of the group considered in the study (Ellis and Bochner, 2000). The autoethnography approach openly challenges the neutrality concept of the researcher, in which the separation between researcher and participants is a structural element of the research itself. In autoethnography, however, the subjectivity and the emotions of the researcher and his point of

Table 1. Significant extractions from my personal diary.

Period during pregnancy	Quotes
Week 16	– 'These days I had so much nausea, sometimes I seemed to feel some small movement, a flickering light as if suspended in the air and doing somersaults!'
Week 17	– 'These days were a bit difficult: every morning at 4:00 I was awake, I felt your small movements as light as butterfly wings but this new feeling made me uneasy and did not make me sleep again!!'
Week 19	– 'We cannot wait to see you and find out if you are a boy or a girl, so we will finally begin to prepare the layette!'
Week 25	– 'This morning I felt you moving… then I put your dad's hand on my belly and for the first time he could feel you too, what a thrill!!'
Week 28	– 'We have assembled the cradle and while Dad was mounting it, you started moving, maybe you understood how much love we have preparing your arrival'.
Week 31	– 'I continue to have a hard belly, the gynaecologist put me on rest for a week, you are growing well, it seems you have beautiful long legs and a nice tuft of hair'.
Week 37	– 'This is my first week on maternity leave even though I continue to work a little bit from home. You are growing, now you move every night, I think you are starting to be a bit tight, we cannot wait to meet you. Daddy keeps dreaming while trying to take care of you with not always positive results: it seems that the diaper will get on your head!'
Week 38	– 'We are approaching the date of delivery, the anxiety of childbirth is increasing, I will be able to birth you, we will go beyond the due date, so many questions without an answer'.

view become relevant dimensions of the research itself. Autoethnography, through personal experience, can share, expand the knowledge and inform the research and the practice into a context of similar experiences (Marshall, 2008). In fact, this method allows researchers to inform the professional through his storytelling and experience in a deeper way, involving the skilled reader but also the inexperienced readers emotionally and scientifically to increase knowledge. The development in recent decades of narrative medicine practices, such as autoethnography, encourage medical staff to experience new methods with which to understand the patients' perspectives (Charon, 2012). Autoethnography, indeed, as underlined by Bonaquist et al. (2012) builds from reflective processes of narrative medicine.

As underlined by Ellis et al. (2010), the reliability, validity and generalizability of an autoethnography are in the reader's response to and self-recognition of the material. Self-recognition is helped by writing in the first person, following a highly personalized style that involves the reader more emotionally (Zibricky, 2014). Moreover, the autoethnography encourages the reader to engage in a deeper and meaningful way, better understanding the situation and entering in the emotive world of the researcher and in the issues that he proposes. As claimed by Peterson (2015), autoethnography is based on the assumption that reality is multifaceted and the role of culture and context are crucial in understanding human experience.

This article is based on my own personal experience of women and research; I had two very different pregnancies, labours and deliveries. The aims of this work are to describe and rethink these experiences to make peace with the birth event. I felt that it was important to more deeply investigate my own experience to feel comfortable with myself, but also to share my experience with other women and help them reflect on how the childbirth experience can be significant in the life of a person and can have implications in pregnancies and in following labours and also to encourage obstetricians, midwives and gynaecologists to reflect on these issues. In the following paragraphs, as an autoethnographer, I write my personal stories that reveal my two motherhood experiences from pregnancy to delivery. Furthermore, I critically reflected and systematically analysed my personal experience by using some theoretical frameworks: expectations and fears related to the birth event, the relationships with professionals during the birth event and the sharing of medical procedures, the trauma associated with a problematic childbirth and its consequences in the subsequent pregnancy.

My birth experiences

My first pregnancy and my first baby

My first pregnancy was very peaceful. I worked until the end of my pregnancy with great satisfaction to carry around my child in my belly. This pregnancy was normal with slight nausea during the first months but later proceeded in a physiological way. During the 40 weeks of gestation, I kept a weekly diary in which I reported how I felt, what I felt, what I hoped in relation to pregnancy and birth and the changes in my body. In Table 1, I report some significant quotes that mark some important moments of my pregnancy.

During the birthing class meetings, the head obstetrician had told the women present many things regarding birth, including how to recognize contractions and what procedures to adopt in the moment of birth, such as recording the time between contractions and marking it on a sheet of paper and when they became regular with intervals of 2 minutes,

the woman was to contact the hospital. For breathing during labour, no specific information was given, and we were told that the midwife would have explained methods to us at the time. We also visited the department and the delivery room with all the special equipment, the stool with the hole, the ball on which we could lean on, the pool to give birth in the water, and the rope to hang on.

The big day came. It was midnight on 15 April 2007, and I was still awake with a strange feeling; I cannot explain exactly, but I could not sleep. There was something that was going on in me. Therefore, I went into the kitchen and made myself a nice, hearty breakfast and I told myself, you never know if anything will happen tonight, so I should not fast. Then, I went back to bed and told my husband that something was wrong but I did not understand what. After a while, I fell asleep. In the morning when I woke up, at 8.00 a.m., I went into the bathroom, as is my habit, and I realized that I had lost a transparent gelatinous filament with some blood streaks. I said that it might be the mucous plug of which I had learnt about in the prepartum course. I did not have time to say what happened to my husband as I began to have the first contraction. I took a pen and paper and began to record the times of the contractions. They were immediately regular. I called the hospital, and they told me to go for a check-up. During the car trip, the pain grew ever stronger. At 10.00 a.m., I arrived at the hospital with my husband, I showed my sheet to the midwife where I had marked the duration of the contractions, the only thing I had learnt from the birthing class meetings. In fact, I had been told that the rest would come along.

When I arrived, however, they did not even look at it, which was a disappointment as I had made a great effort to record them. After a while, I was examined by the gynaecologist on duty who verified that I was already dilated to 4 cm. I was so ready to go into the delivery room. The gynaecologist asked me if I wanted to do a waterbirth, and I agreed enthusiastically, because during the birthing class meetings, the midwife had told us that water delivery could be less painful. I was given a room where I placed the baggage with my things and those of the child. I undressed, I put on my shirt and bathrobe and went into the delivery room.

The midwife immediately let me in the pool because I had strong and regular contractions. Shortly after, she broke my water to help me; she said that the expulsion seemed imminent. It was almost 12:00 a.m. My husband went back to the room to retrieve the clothes of our baby while the delivery room was filled with people, two midwives, the neonatologist and other people who I did not understand the usefulness of at the time. In retrospect, I understood that it was a special event: many women were labouring in the water but the moment of expulsion in water was not so common, even though I was in a large second-rate hospital.

At a certain point, a scale came into the delivery room to weigh the child. In short, the whole department was in turmoil. The midwife kept telling me to push even if I did not feel the need, but because it was my first birth and I didn't have any experience of what was to happen, I tried to follow her instructions. Time was passing, but I did not see any progress. I pushed, but I was more and more exhausted, and the expulsion that seemed imminent at 12.00 a.m. was not happening. I kept pushing at the midwife's direction, but I did not feel anything, even the contractions seemed less strong. My daughter's pulse was continuously monitored in the water, and everything seemed fine, but it was not like that and I felt it.

Fortunately, at approximately 2:30 p.m., the gynaecologist passed by listening to my feelings, and he let me out of the pool. I was exhausted, took a shower and lay down on the bed. The gynaecologist finally found that my daughter was stuck in the birth canal; her head was pressing against my sacral bone, and from there, she did not move.

The gynaecologist, having understood the situation, told the midwife to give me the oxytocin to help me, but I, by now, no longer had the strength to push, as I had pushed for hours unnecessarily at the direction of the midwife. At this point, the situation deteriorates; there are exciting moments, and my husband, always present, begins to become excited, as well. The gynaecologist and the two midwives move him away from the bed because they need space, and they decide to help me by performing an episiotomy and trying the Kristeller manoeuvre twice, pushing heavily with their elbows on my stomach to augment movement and allow the birth of my child, but these interventions did not have the desired results. At that point, the gynaecologist told me that they would try again one last time after which they would take me to the operating room for an emergency caesarean section. At that point, I was desperate after all those hours, those pushes and these last excited moments and did not know what to think. My husband read my concern and reciprocated his with his look. I had less and less strength, and at this point, the midwife pushes again with her elbow on my stomach and the gynaecologist pulls the head of my daughter with the vacuum. I had a feeling of sudden emptying with the feeling that no one was available to welcome my daughter and that my concern might fall on deaf ears. Finally, I see it; it is purple, does not cry at once, at least it seems to me but is given Apgar 9. So, all is right, and finally, at 16:00, she was born. She weighed 3250 kg; I am exhausted but I am a 33-year-old mother who is very happy. Somehow, I managed to give birth to my daughter; I had no experience, and no one had given me directions on how to do it, even though I had attended the preparation courses. After giving birth, they have to bring a wheelchair to my room because I do not have the strength to stand up. I revisit the entire night, similar to a movie – the moments spent giving birth to my daughter without being able to close my eyes and being beside my daughter who sleeps blessedly, and she occasionally attempts to eat something.

In the months following the birth, I had to get help to get up or sit down because of coccydynia due to childbirth.

Even today, I have the physical (perineal and coccydynia trauma) and psychological consequences of that dramatic birth in which I was helpless and felt like I could not give birth to my daughter. Nobody explained what happened and everyone decided, almost secretly, without consulting me and giving me full explanations. No one had told me about the potential risks of waterbirth but only the benefits for the mother.

My second pregnancy and my second birth

Three years after the first pregnancy, my husband and I decide to have another child, even though the memory of the traumatic birth was still highly present, but I have the desire to be a mother again and to enlarge the family by giving my daughter a brother or sister. It never makes me question the possibility of undertaking a new pregnancy. I immediately get pregnant, and even before carrying out the pregnancy test, I am aware that I am expecting a baby. I immediately notice some changes in my body, imperceptible from the outside but of which I immediately notice (delay of a few days of menstruation, breast enlargement, nausea). In this second pregnancy, I am more aware of the changes that my body would have faced in the following weeks, but it distinguishes itself and differs from the previous one because after a few weeks I have to leave my job because of severe nausea and continuous, unmanageable and alienating vomiting. I spend all of the weeks of this endless pregnancy lying on the couch without being able to do anything; every slight movement causes me to vomit, and I lose several pounds, especially in the first months, because I cannot keep down anything. I cannot take care of my daughter, and the most complete emptiness accompanies my days. I am discouraged and very sad. After the fourth month, even the hope that the nausea will pass vanishes. I continue to vomit until the time of delivery, an experience that is very difficult to deal with; I still do not know how I managed to overcome it.

The 40 weeks of gestation passed slowly unlike the previous pregnancy in which I had worked so hard and up to the eighth month. This time, the months seemed endless and the countdown was not just to know the baby I carry in my womb but above all to put an end to this malaise that accompanies me day and night. Sometimes I seem to go crazy, and I am afraid that my body has changed so much that the vomiting will continue even after giving birth and that I will remain so forever. The gynaecologist tries to give me some medicine to make me feel better but they do not do anything. At a certain point, she proposes hospitalization, but I do not feel like abandoning my daughter. She is already suffering in seeing me in this condition and my removal would be even more negative.

Needless to say, in this second pregnancy I am not able to write in any diary, and my life has stopped and no longer runs. It proceeds slowly, punctuated by the exits to go to medical appointments. Despite everything, the pregnancy is proceeding for the best, and I keep telling the gynaecologist that I want to do a caesarean because I do not feel like facing a birth similar to the previous time, when I felt helpless, unable to do the right thing and without strength. The gynaecologist does not comply with my requests but leaves me free until the end to decide how to give birth. Until the end, I prepare all the documentation and do the exams as if I would have a caesarean section. However, something internally pushes me to do a natural childbirth again and, despite what happened, I again choose the same hospital to give birth.

This time, the fateful day arrives; it's a Saturday morning, the 15 May, and this time, I see a grey stain with red streaks while going to the bathroom. There are still 10 days until my due date. I call the hospital, and the gynaecologist tells me to go for a check-up, similar to the previous time. I arrive at the hospital already dilated 4 cm; it is 10:00 am, similar to the previous childbirth. I meet the same gynaecologist of 3 years before; this familiar face reassures me a lot because without his interventions who knows what would have happened 3 years before. This reassures me, and according to him, being the second pregnancy, I would have given birth with him before the end of his shift. He asks me if I want to give birth in the water; I was a little hesitant but after some hesitation, he fully explains to me what can happen. I consent to try again this second time. However, more aware of my body, I decide to enter the water only after having had a good half-hour of strong contractions to avoid slowing down labour due to the warmth of the water, similar to the previous time, up to the point of not hearing them anymore.

When I feel ready, I decide to enter the pool. It is approximately 12:00, and the contractions are getting closer and stronger. With me, there is my husband who tries to make himself useful with some massage, a midwife to whom I tell the previous birth story and who takes care of me explaining what happens and suggests what to do, and a fantastic specialized midwife who continues to be close to me holding my hand. This time I feel truly cared for, welcomed and listened to in my anxieties and fears of not making it. I feel that I am in charge of myself and aware of the choices that I am making. This time, the midwife asks me if she can break the waters and I decide positively after having been reassured on the usefulness rather than passively endure, as the previous time, an unmotivated choice and made only to help me.

Finally, I feel pressure and I want to push, a feeling never felt in the previous childbirth, and after three pushes my son's head comes out. At that point, I ask to help him out because I am afraid of drowning and because I think I cannot do anything anymore. I am told that I will have the desire to push again and so it happens after a while. For me, it is as if it was the first delivery. I feel for the first time the sensations in which the child leaves the birth canal. In the previous delivery

in which a vacuum was used, everything had been different. I had been pulled out of the child, and I expected this, this time, too. Instead, I feel as if I am the mistress of my body and still full of energy; this second time I let him out alone. Afterwards, he was leaning on my stomach, and incredibly, he moved towards my breasts. It was a beautiful and unforgettable emotion. My love, my baby, weighed 3250 g, similar to his sister, and was born at the same time, 3 years and a month after. In the following hours, I could move without problems, enjoy this second birth and appreciate the natural birth in water. I could also make peace with myself and all my incapacities that I had attributed to the first delivery. I appreciated the medical staff who had assisted me and accompanied me during those hours. Without their support, I could not have overcome the fears induced by the first experience; they attempted to understand and lovingly let me overcome the fears.

Discussion

During my second experience, I noticed immediately that my body had changed; as discussed by Duden (2005), new technologies have led women to move away from the experience of their body, but in my experience, this was true only in the first pregnancy experience when women are not aware of their changes, and they rely on objective tools to understand what happens.

My second pregnancy was marked by an intense fear of not being able to manage the birth that had resulted from a pregnancy consisting of constant nausea and vomiting that would occur as soon as I stood upright. Consistent with previous research (Nilsson et al., 2010), I was invaded by the feeling of not being able to do, of having had an incomplete birth experience. During the second delivery, in fact, I expected that after my son's head was out that the midwife would take him out because with my first daughter, the vacuum was used. This experience had left me with the feeling of impotence and incompleteness. In fact, with the vacuum, I felt emptied without the awareness of having acted in the first person. The fear that such a situation could reoccur has blocked me throughout the pregnancy as if my body unknowingly rejected the birth event even if the child had been wanted and desired. Nilsson et al. (2010) emphasized that the intense fear of childbirth is deeply influential and can be related to suffering and birth trauma.

As Melender (2002) appropriately states, it is important during pregnancy to listen to the feelings of women in relation to pregnancy and childbirth to be able to explain these fears and discuss them with competent staff and, therefore, help the parturient to face them in a serene way. In particular, the author underlines that the primiparas or multiparas with previous negative experiences, as was my case, should be more carefully listened to and prenatal paths oriented to these aspects should be discussed.

As affirmed by Bowers (2002), women should be informed before delivery on what could happen in the delivery room so that they do not develop unrealistic perceptions. Prenatal education is important to inform future mothers; give them information about labour, breathing and relaxation techniques. The nurse, midwife and setting can support mothers to construct a realistic vision. All these steps had not been done in my experience, and I was unprepared for what would happen to me.

Nobody had explained to me that labour in the water was less painful but it could also slow down the contractions and that there could be risks for the child. I discovered this last aspect by reading the literature for this article. I was not informed of this issue in either childbirth. Clarifications of the actions and operations that are made, on the progress of labour, on physiologic progress, and on the problems that must be faced should always be made explicit and not only upon the request of the woman (Bowers, 2002). In particular, Reisz et al. (2015) underline that during labour, medical staff should give women complete and accurate information, especially when they are undergoing medical interventions, including unforeseen manoeuvres such as episiotomy, Kristeller manoeuvre, the use of a vacuum or unplanned caesarean section. Unfortunately, in my first labour, these aspects were partly missing, including the relational dimension, such as the continuity with the midwife who left because the shift had ended.

Moreover, the strong medicalization of the first childbirth with poorly explained manoeuvres and the perception of little support by the midwife during delivery, perhaps dictated by the urgency of birth, as there began to be a foetal suffering, led me to relive that experience with anxiety and fear that was resolved only with the second birth in which the climate was entirely different. In comparing the two experiences, I can highlight how in the second experience, I had a greater awareness of my body and how it could act. Having a midwife and a specialist midwife who never abandoned me and always provided me with explanations of what happened and what would happen in the following phases allowed me to feel welcomed and supported in my fears. This physical closeness, with the specialist midwife holding my hand, and emotional closeness, words of comfort, joking when necessary contributed to a positive and relaxing atmosphere. In the literature, in fact, women have emphasized the importance of continuous, individualized support during childbirth (Van der Gucht and Lewis, 2015). In addition, the midwives need to share responsibility, be intentionally and authentically present, and create an atmosphere of calm serenity in a mutual relationship with the mothers to improve the quality of the woman-midwife relationship (Morano et al., 2018; Thelin et al., 2014).

Not all women are willing to understand what happens and to participate actively in the event; some prefer to be guided. However, the midwife's responsibility is to understand the needs of every single woman to be able to support her in the best way. As Cipolletta (2016) discussed, midwives can support women with their presence and proximity, providing information and suggestions on what the parturient must do during labour and delivery.

Furthermore, according to Cipolletta and Sperotto (2012), although the hospital organizational model in which

I gave birth to my children is centred on the humanization of care and patient-centred service, in my experience and in the experience of the women in this area of study, these approaches are not perceived.

Conclusion

An autoethnographic study such as this one has both advantages and limitations. The first limitation is the subjectivity of the researcher; as underlined by Peterson (2015), 'while other qualitative methods ask researchers to hide behind a "veil of objectivity", the application of the knowledge gained through the transition from objective to involved party can enrich the research and enhance its validity' (p. 231). However, the critical reflections in the autoethnographic approach remain the researcher's interpretations of what was experienced. As with any qualitative research and in particular the case-type study, similar to this one, the reflections presented in this article are limited because they are intended to offer a deep understanding of one person's experience. The use of an interpretive methodology that places the researcher at the centre of his or her own research may not seem suitable within the medical sciences (Farrell et al., 2015).

Despite these limitations, however, there are several potential advantages. This narrative can enhance the field of medical education and practices in the delivery room. Autoethnography allows researchers to study aspects of the human experience that an external researcher could not observe through the critical reflections, experiences, feelings and emotions of the autoethnographer. Accordingly, professionals may be able to improve interactions with patients, developing a more humane and effective medical practice.

This autoethnography therefore has the potential to offer a powerful tool for advancing the understanding of the expectations and fears related to childbirth, the relationship with professionals during the birth event and the sharing of medical procedures, the trauma associated with a problematic childbirth and its consequences in pregnancy and in subsequent births.

Although the generalizability of these studies is limited, autoethnography studies can reveal novel insights of reflections for professionals, midwives and gynaecologists. This study could better consider the patients' perspective, see events through their eyes and consequently develop greater empathy, better understand their needs, and have a more positive influence on the quality of midwives and gynaecologist activities in the delivery room. In fact, writing in the first person could reduce the distance and improve readers' understanding of the problems faced by women during the delicate period of pregnancy and during the time of labour and birth. Liggins et al. (2013) note that the autoethnography approach has enormous potentials; it can engage researchers and readers both emotionally and cognitively and also stimulate critical thinking. Experimenting with these readings of autoethnographic experiences could fill those neglected aspects during training courses for clinical practice, above all focusing on techniques and human and relational aspects that are so important for the outcomes of medical practice itself. The reader is engaged through the evocation of emotion and the stimulation of reflection that could enhance her or his relational competence in better understanding the patients' situation. With the reading of autoethnography, one gains access to private experiences that are unlikely to be made public but can become agents of change through the critical reflection that the autoethnographer proposes and which the professional reinterprets through his experience and training.

A transformative emancipatory approach (Priddis, 2015) guided this article; the autoethnography, which builds from reflective and critical processes of narrative medicine approach, allowed me to describe the events by laying the foundations for overcoming the traumatic events present in the first delivery and during the second pregnancy and also allowed me to encourage midwives and gynaecologists to think about their medical interventions to promote more respectful care during childbirth. In fact, in this writing process, I was able to experience unexpected emotional and reflective challenges that changed my vision of the events. However, I hope that my autoethnography, although not easy to tell, can sensitize the operators and enrich their knowledge on what women experience during the transition to motherhood. The delivery room is a place that remains forever in the experience of every mother. Moreover, as well as in other health professions, delivery room professions need specialized technical skills as well as interpersonal communication style (Bowers, 2002; Rania et al., 2015b; Rania et al., 2018c).

This study, being an autoethnography, raises a number of opportunities for future research, both in terms of qualitative research in general and relating of this topic. Although autoethnography as a research method can be a difficult technique for inexpert researches to use, however, it is an important method to explore this delicate issue and deepen these important themes. These results, particularly linked to the delivery room and to the relationship with the different actors involved, should be related, in future research, to the other positions of the professionals involved.

In sum, the implication of this study is to provide a new focus for care during pregnancy and childbirth and, above all, help women rework what has happened after a potentially traumatic birth.

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