Communication and Birth Experiences Among Black Birthing People Who Experienced Preterm Birth

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ABSTRACT

PURPOSE Physically or psychologically distressing birth experiences can influence postpartum health, parenting efficacy, and future pregnancy plans. Communication deficits contribute to negative birth experiences. This qualitative analysis explored themes related to communication and negative birth experiences among Black birthing people who experienced preterm birth.

METHODS We conducted qualitative interviews with non-Hispanic Black, English language–proficient birthing people with Medicaid-insured preterm infants. Interviews were designed to explore experiences with health care access and well-being after birth. Interviews were audio recorded, transcribed, and coded following an integrated approach where we applied a priori codes and captured emergent themes from the data.

RESULTS We interviewed 30 participants from October 2018 to July 2021. Median gestational age at birth was 30 weeks (range 22–36 weeks). Interviews occurred a median of 7 months postpartum (range 2–34 months). Themes emerged related to negative birth experiences and communication: (1) communication gaps during urgent or emergent intrapartum procedures contributed to negative birth experiences; (2) postpartum opportunities to share birth experiences, particularly with peers, sometimes mitigated the psychological consequences of negative birth experiences; (3) participants did not consistently discuss concerns about future pregnancy risk related to negative birth experiences with clinical teams.

CONCLUSIONS Themes from this sample of Black birthing people who experienced preterm birth suggest 3 ways health systems might intervene to improve communication to mitigate the consequences of negative birth experiences. Improvement efforts in these areas may improve postpartum health, future pregnancy outcomes, and long-term health.

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INTRODUCTION

Birth experiences sometimes cause psychological distress, persistent feelings of anger or loss, or depression and posttraumatic stress disorder.[1-4] These negative birth experiences and their sequelae can influence women's ability to care for their newborns and their future reproductive decisions.[2,5-7] Negative birth experiences are associated with patient factors including a history of depression, anxiety, or sexual trauma; community factors including lack of social support; intrapartum factors including emergency procedures, severe pain, and feelings of loss of control; and health system factors including lack of care team continuity, poor communication, and obstetric racism.[1,4,8-10]

In the United States, Black birthing people experience higher rates of maternal morbidity and mortality than birthing people of other races.[10-12] Similar factors contribute to negative birth experiences for birthing people of different races, but Black birthing people experience these factors more frequently.[13,14] In addition, for Black birthing people, negative birth experiences may occur in the context of obstetric racism, a framework for analyzing how obstetric violence and medical racism intersect to generate "beliefs and practices that harm the reproducing Black body."[10,12,15] Obstetric racism may include components of interpersonal racism, such as clinician bias, and structural racism, such as underfunding of facilities serving predominantly Black birthing people.[12,15-17]

Health systems are responsible for ensuring high quality communication between health care teams and patients and families. Communication is one potentially modifiable contributor to negative birth experiences where health systems may have an opportunity to intervene.[9,13,18,19] The objective of this study was to explore perspectives of Black birthing people on ways that health systems could have improved their birth experiences through better communication.

METHODS

This is an analysis of qualitative interviews of low-income Black birthing people in the Philadelphia area. Interviews were part of a larger project exploring adaptation of care management strategies to better support interconception health care access and well-being after preterm birth, a period with substantial unmet health care needs.[20-23] (See Supplemental Appendix for additional details of the larger project.)

Setting and Participants

Qualitative interviews were conducted with birthing people who had preterm, Medicaid-insured infants. We defined preterm as birth at <34 weeks gestation or at 34-36 weeks with a known modifiable risk factor (eg, high blood pressure). This definition was developed with a goal of focusing on perspectives of birthing people who were aware they had risk factors for future adverse pregnancy outcomes or increased follow-up needs after birth. Participants were English-language proficient and sought infant care at 1 of 3 primary care sites affiliated with an academic pediatric health system (Supplemental Appendix). Potentially eligible participants were identified from pediatric electronic health records. There were no inclusion criteria related to race, but for this analysis we included only participants reporting Black race. This study was reviewed by the Institutional Review Board at our institution and was considered exempt.

Interviews

The initial interview guide, informed by Self-Determination Theory, focused on experiences with health care, health care access, and health priorities after birth, and what the health care team did, or could have done, to support postpartum people.[24] The interview guide did not specifically ask about birth experiences, birth trauma, or obstetric racism.

Four female researchers (author A.M. and 4 others) conducted the interviews. Interviewers had professional experience in maternal-child health programs, including neonatal intensive care unit (NICU), home visiting, and newborn primary care research, and had qualitative research training (Supplemental Appendix). They had no prior relationship with participants and introduced themselves as research employees with the health system. Participants were recruited via telephone and interviews occurred in person or by telephone. Interviews were private, though in some cases infants or young children of participants were present. Participants were asked to complete a demographic survey at the end of the interview. This survey included questions on race and ethnicity given that interpersonal and structural racism can be barriers to health.[17,25] We continued interviews until we reached data saturation. Participants were offered gift cards to offset the burdens of participating in research. Interviews were audio recorded and transcribed by a professional transcription service.

Analysis

We used NVivo software version 12.0 (QSR International) for analysis and followed an integrated approach for coding transcripts.[26] We began coding with an a priori codebook reflecting constructs that informed interview guide development; for example, autonomy and health behavior. As coding progressed, we captured emerging themes in a grounded approach to assess content not represented in our a priori assumptions. The themes that we focus on here, related to birth experiences, were emergent themes in our analysis. As these themes emerged, we sought additional theoretical frameworks to interpret our findings, including Reproductive Justice, a human rights framework that contextualizes reproductive rights within the intersectional experiences of birthing people.[27]

Coding was completed by 2 nursing students, a public health student, a pre-medical student, a physician, and 1 of the interviewers (a research coordinator). All coders (authors E.G., G.J., A.B., A.M. and others) had training in qualitative research. Coders were orientated to the project and underlying theories (Supplemental Appendix). All transcripts were double coded and reviewed for consistency. Differences in coding were resolved through discussion and functioned as opportunities to clarify the coding scheme.[28] To further ensure consistency across coders, 1 person coded at least 2 interviews with each other coder.

Interviewers, coders, and other members of the study team met to debrief impressions and discuss revisions to the interview guide or code book. After meetings, we circulated memos related to clarifications and changes. Debriefing meetings and memos were intended to promote reflexivity.[29] Coders and interviewers differed in professional expertise, race, ethnicity, and personal experience as parents or with health care, which we considered a strength in interpretation of the data. Participants did not review transcripts or provide feedback on findings.

RESULTS

We identified 99 potentially eligible participants through pediatric health record review. We were unable to reach 31 people, 6 explicitly declined participation, and 29 expressed interest, but never scheduled or completed an interview. We interviewed 3 participants who did not report Black race, who were excluded from the analyses reported here.

These results reflect findings from 30 participants who reported Black race and non-Hispanic ethnicity (Table 1). Interviews occurred from October 2018 through July 2021 and lasted a mean of 37 minutes (range 18 to 55). We describe 3 themes related to communication and birth experiences. In

Table 1. Characteristics of Sample

Characteristics	Mean (range) or No. (%) Participants n = 30
Black race	30 (100)
Non-Hispanic ethnicity	30 (100)
Age, y	28 (18–42)
Infant age at interview, mons	11 (2–34)
Gestational age at birth, wks	28 (22–36)
Educational attainment	
<High school	5 (17)
High school	15 (50)
Some college	7 (23)
Bachelor's or graduate degree	3 (10)
Participant relationship with infant's biologic father	
Married or live together	10 (33)
Don't live together, parents in a relationship	12 (40)
Don't live together, father involved with child	4 (13)
No relationship	4 (13)

addition, we report on a theme related to birth experience and future pregnancy plans, to provide context on 1 theme related to communication about future pregnancies. These themes were all emergent themes in our analysis.

Intrapartum Communication

In discussing birth, participants highlighted poor communication during emergency procedures. One participant told us about an emergency procedure, saying:

> "That was one experience I could say the doctors kept me all the way out of the loop… They said we got to get an emergency cesarean…. I just was in all this pain… I'm like, "Wait. Am I about to die? I don't know what's going on." (Participant 18)

Another participant reported her experience during an emergency caesarean stating,

> "I'm back here shaking and scared and crying, I didn't know what was going on, it's just like, it's a lot things that scared me about that day."

This participant went on to suggest designating a team member to focus on communication and emotional support during emergency intrapartum procedures.

> "At least have a nurse sitting on the side of the patient, especially in an emergency c-section, let the mother know what's going on. We're already scared. It's birth. We're already in pain. At least let us know what's going on. That would ease our mind." (Participant 15)

Postpartum Communication as an Opportunity to Process Birth Experiences

Participants told us it was important to share their birth experiences to make sense of them and highlighted benefits from talking about these experiences, particularly with peers. One participant told us,

> "When I've tried to ask for help, it was more like it was shunned a bit. My mom will help me… with all the physical things that [my baby] needed. But when it came down to me, I didn't really address my inner person problems... The trauma of having a baby. It's not like I needed a pity party, but it's more like I needed some kind of, you could do this... You can handle it… I didn't feel like I was getting that." (Participant 29)

This participant disclosed that she was receiving counseling, but that other people in her situation would also benefit from "a parenting club… just for self-help and self-care."

Some participants reported opportunities for this type of communication in the hospital or through social media. As one participant said,

> "Going to the support group and talking to the other parents, I think that helped a lot and talking to the social workers, and the nurses… We were all basically going through the same things, and it was easier talking to the NICU moms than to talk to anyone else." (Participant 16)

However, not all participants were able to access support groups. One participant told us,

> "No one told me about support groups for me after I had my daughter come home, but I just recently found a support group on Facebook… They have been really helpful for me just hearing other peoples' stories." (Participant 27)

Some participants told us about behavioral health services they had received since their pregnancy, however no participants linked this directly to helping them process or overcome negative feelings associated with their birth experience.

Negative Birth Experiences and Future Pregnancy Plans

Participants reported that negative experiences during pregnancy and birth led them to reconsider future pregnancies. One participant said,

> "I don't think I'm having no more kids… it hurt so bad." (Participant 18)

Another participant, who had experienced multiple pregnancy complications told us

> "I don't want to have any more kids… just all the complications of the pregnancy, I mean to deal with or chance it again." (Participant 2)

In describing factors that led to future pregnancy preferences, participants specified psychological stress, physical safety, pain, and the impact of their pregnancy on employment and social needs. Regarding physical safety, one participant reflected on her experiences across multiple pregnancies.

> "This pregnancy determined that really, this is my last baby. Just the fact that I ended up developing pre-eclampsia again, and then I had to have another early baby, and then the fact that in my last pregnancy I almost died, and with her, I almost died." (Participant 16)

Focusing on pain and employment, another participant reported,

> "I don't think I want any more… The pain, and just the whole process, just going to the doctors so frequently, missing work, and getting stuck with a needle [every week for my condition]…, it was just a lot to deal with." (Participant 10)

Another participant focused on stress, stating,

> "I decided on my own [to get my tubes tied] because I couldn't take no more of them stressful pregnancies." (Participant 7)

Participants also worried that another pregnancy could have worse outcomes. One participant told us,

> "I wanted to have another baby… but when [my baby] was in the NICU… I was on Instagram looking at other people that had babies early and I saw how not all but some, they had problems and [my baby] doesn't have no problems… I don't think I will want to, you know, go through that again and the baby not as lucky as [my baby]." (Participant 1)

Communication About Birth Experiences as Part of Future Pregnancy Planning

Some participants explicitly told us that they had not discussed their concerns about future pregnancies with clinical teams. For example, one participant told the interviewer,

> "You're the first one to actually ask me [how I'm thinking about future pregnancies]… I think I will probably bring that up with my doctor… going back and thinking about my c-section, oh my god, seriously. I wouldn't wish that on my worst enemy… it just scared me." (Participant 15)

Another participant told us,

> "I wanna have more kids and I wanna have kids close in age but… I'm scared that it might be a premature baby again, I might be in the hospital for a month again… no I haven't really talked to anybody about it really." (Participant 25)

One participant highlighted a potentially treatable problem as a reason to decide against future pregnancies, saying,

> "I'm not planning on getting pregnant again… because I get real sick because I'm anemic and I got low iron." (Participant 11)

When asked if she had discussed these concerns with her clinical team, she told us she had not.

One participant reported discussing future pregnancy risk with the clinical team, but only during the intrapartum period. This participant told us,

> "For the future, it's very scary…. It's just a lot that I think about…. The doctors, when they came in the room and told me I had to have my baby, they told me that my next one would be high risk, because I've got induced, and had a preemie." (Participant 5)

It did not appear that she had revisited this topic with her health care team.

Some participants expressed awareness that risk factors for adverse birth outcomes may be modifiable at the individual level, without indicating where they had obtained this information. One participant suggested that people who had experienced pregnancy complications should:

> "Be careful with your next baby. Try to do things a little different. Try to switch it up… it's very important, for your health and your baby's health." (Participant 5)

Another participant was more specific, saying,

> "I wanna lose weight before I get pregnant again because in the beginning of my pregnancy, I was considered high risk… I don't want that to be a factor at all when I'm pregnant again." (Participant 6)

DISCUSSION

This qualitative study of Black birthing people highlighted communication during the intrapartum and postpartum periods as a strategy to reduce negative birth experiences or mitigate their consequences. These findings confirm and extend prior work from the United States and internationally that identified communication deficits and emergency procedures as contributors to negative birth experiences and found negative birth experiences influence future pregnancy planning.[9,13,18,19] Reproductive justice frameworks advocate for structural changes to inpatient birth settings, to allow all individuals the opportunity to determine optimal conditions under which they birth.[10,27,30] Our findings support 3 ways health systems might work toward optimal conditions by improving communication.

First, participants noted communication lapses during emergency procedures, and one participant suggested a dedicated team member to offer updates and emotional support to birthing people during emergencies. This suggestion is consistent with practices in pediatric settings where code teams may include a role focused on communicating with parents or caregivers during the code.[31] Second, health systems should offer birthing people opportunities to discuss their experiences with clinical teams and particularly with peers. Importantly, these opportunities should be welcoming to all families. Third, postpartum discussions around contraception or planning for future pregnancies should include discussions of birth experiences. These conversations may offer support, provide education about risk factors and treatment options during future pregnancies, and address uncertainties, supporting autonomous and informed reproductive planning. These conversations may need to happen more than once as people process experiences over time, and certainly should not be limited to the intrapartum period. Given that anxiety and fear result in a more negative birth experience, these conversations may help improve subsequent experiences of birth.[32]

Identifying opportunities for improved communication does not ensure improvements will take place. Prior work has suggested health systems could improve communication between reproductive health care teams and patients through better anti-bias training, or changes to clinician scheduling to increase time with patients or continuity with a single clinician.[18] We are unaware, however, of communication interventions that have empirically demonstrated improved birth outcomes. Health systems also have opportunities to prevent negative birth experiences from occurring in the first place. Offering prenatal education on potential complications of childbirth can provide a sense of control during birth.[33] Health systems could also improve intrapartum support by welcoming and incorporating doula models of care.[34]

This study focused on Black birthing people with a history of preterm birth. Our findings may not represent perspectives of birthing people of other races or those who had uncomplicated pregnancies or different types of complications. We consider the focus on populations with particularly high rates of adverse pregnancy outcomes to be a strength of the study.

This study did have several limitations. First, we did not design this study to explore negative birth experiences or racism. When negative birth experiences were described, interviewers offered empathy and validation, but did not probe, in part to avoid retraumatizing participants. Relatedly, our interview guide was not designed to probe for racism as a potential cause of negative birth experiences. Second, our study was conducted at a single institution and may not reflect perspectives from other settings, particularly non-urban settings, or perspectives of people who do not regularly interact with pediatric care. Third, in most cases there was not racial concordance between participants and interviewers, which may have influenced how experiences were described.[29] Fourth, participants reported these experiences to us at single time point 2–34 months after birth. We could not ascertain whether births were experienced as described or whether the intervening months amplified, diminished, or changed the valence of those experiences.

In conclusion, this sample of Black birthing people who experienced preterm birth suggested 3 ways for health systems to improve communication. Findings suggest health systems could improve communication during emergency intrapartum procedures, better ensure postpartum opportunities to share birth experiences in welcoming environments, and promote ongoing conversations about future pregnancy risks. Implementing suggestions from Black birthing people may help address racial inequities in maternal care quality, promoting positive birth experiences and environments of healing.

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Key words: African American; birth trauma; Black; Black birthing people; interconception care; intrapartum care; negative birth experience; preconception care; reproductive justice; health communication; postpartum care

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Supplemental materials

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