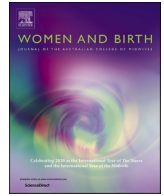


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“Will I ever recover?”, Women’s experiences and perceptions of mental health following pregnancy and birth complications: A qualitative study

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ABSTRACT

Background: Experiencing complications in pregnancy and birth is often associated with poor postpartum health outcomes and can have lasting consequences for women. Understanding women’s subjective experiences of pregnancy and/or birth complications and how they feel such experiences impact their current mental health is essential to better inform supports and resources.

Aim: To explore how women experience and describe their mental health following pregnancy and birth complications in Ireland.

Methods: We conducted semi-structured interviews with 21 women from February to May 2024. Participants were purposively sampled. Eligible women were ≥ 18 years of age and had been between 12 months and 5 years since experiencing a pregnancy and/or birth complication. Reflexive thematic analysis was used to develop themes and subthemes.

Findings: We developed four main themes: 1) ‘Expectations versus reality’ highlighted the disconnect between women’s hopes for pregnancy and birth, and the unexpected nature of their actual experiences. 2) ‘Unresolved consequences’ reflected women’s ongoing psychological and mental health challenges, particularly regarding anxiety and concerns for future pregnancies. 3) ‘Perception of healthcare experiences’ highlighted the importance of effective communication with healthcare providers, 4) ‘Support and systems’ described interpersonal and structural supports, and networks important to women.

Conclusion: Women’s experiences of mental health following pregnancy and birth complications are impacted by multiple factors throughout their pregnancy and birth journey. To improve the mental health experiences of women who have pregnancy and/or birth complications, access to information, resources, and supports at interpersonal and structural levels is needed.

Problem

Pregnancy and birth complications are well-established risk factors for adverse physical and mental health outcomes in the postpartum period.

What is already known

Little attention has been given to women’s lived experiences of mental health in the years following pregnancy and birth

complications, particularly beyond the customary postpartum period.

What this paper adds

This study demonstrates that the mental health impact of pregnancy and birth complications often extends far beyond the immediate postpartum period. Women’s experiences of mental health were shaped not only by the complication itself but also by women’s perceptions of control during birth, communication, and support within the maternity services.

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1. Introduction

Pregnancy and birth are often regarded as positive and life-changing events; however, they can be associated with significant risks for the mother and child [1]. Pregnancy and birth complications have been defined in the context of severe maternal morbidity as ‘any health condition attributed to and/or complicating pregnancy and childbirth that has a negative impact on the woman’s well-being and functioning’ [2,3]. Such complications may lead to severe maternal morbidities and include life-threatening complications such as pre-eclampsia, haemorrhage, thrombosis, miscarriage, and sepsis [4–6]. Recent estimates from the World Health Organization suggest that approximately 260,000 women die from pregnancy and childbirth-related causes each year, and millions more will experience life-threatening complications and their consequences [7].

Previous research has found that women who experience pregnancy complications may report more physical health problems compared to women with healthy pregnancies [8–11]. For example, a systematic review investigating health problems experienced by women in the postpartum period (up to 1 year after birth) reported associations between pregnancy complications and poor maternal outcomes such as chronic postpartum pain, poor sexual functioning, and breastfeeding difficulties [11]. More recent studies highlight the potential psychological impacts of birth complications on women’s health and well-being [12,13]. A cross-sectional study conducted in 2023 reported that approximately two-thirds of women with a history of pregnancy loss exhibited moderate to severe psychological distress after 6 months post-pregnancy loss [12]. Similarly, in a recent systematic review and meta-analysis, women who experienced miscarriage, termination of pregnancy, and preeclampsia reported a higher likelihood of developing posttraumatic stress disorders [13].

There is evidence that negative experiences of pregnancy and birth may result in psychological distress, potentially extending into the postpartum period, with impacts on women’s health, family functioning, and maternal-infant outcomes [14]. Existing qualitative research suggests that women’s perceived lack of support at birth, the birth environment, and perceived poor quality of intrapartum care may contribute to poor birth experiences [15–17]. Evidence from other studies suggests that experiencing complications during pregnancy can have long-lasting effects on a woman’s sense of identity and self-efficacy, with significant implications for overall mental well-being [18–20]. Women’s postpartum health has been closely linked to the quality of pregnancy and birth experiences, and evidence has shown that when postpartum health problems are not addressed, they may exacerbate into long-term health problems in later years [21,22].

Research to date has typically focused on birth experiences in the postpartum period up to 12 months after birth [23–26]. While a growing body of research has examined women’s mental health beyond the immediate postpartum period [13,27], qualitative studies specifically exploring women’s perception of their mental health in the years following pregnancy and birth complications remain limited. Understanding women’s subjective experiences of pregnancy and/or birth complications and how they feel such experiences impact their current mental health is essential to better inform supports and resources for women who experience complications. Thus, this study aimed to explore how women experience and describe their mental health following pregnancy and birth complications in Ireland.

2. Methods

This study is reported following the Standards for Reporting Qualitative Research (SRQR) checklist [28], see Supplementary S1. This study was informed by an interpretivist paradigm with a constructionist

epistemology. Constructivism maintains that knowledge is created through social interactions and practices. It also emphasises the mutual construction of knowledge as an interaction between researchers and participants [29]. In this study, we sought to understand how women make sense of their mental health following pregnancy and birth complications.

2.1. Sample and participants

We purposively sampled women who experienced pregnancy and birth complications as previously defined in previous studies, as ‘any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman’s wellbeing’ [2,3]. Additional inclusion criteria included women who were residents in Ireland, aged 18 and over, who were able to provide informed consent and able to interview in English. The sample size for the interview was determined based on data adequacy through iterative data collection, to the point where further interviews did not add any new information to the study’s aim [30]. However, a priori sample size considerations indicated that, for reflexive thematic analysis, between 20 and 30 participants may be adequate [31]. As such, it was expected that at least 20 women would be interviewed to ensure rich data with a broad and diverse sample. In this study, no new themes were identified after the fifteenth interview; however, after discussion with the research team, it was decided to continue data collection to further explore and probe the topics of discussion. Therefore, our final sample included 21 women.

2.2. Recruitment and setting

Participants were recruited through social media platforms, including LinkedIn, X (formerly known as Twitter), Instagram, and Facebook. The study poster was promoted online through the INFANT Research Centre and Let Grow together official websites. In-person recruitment was also conducted through the distribution of posters and flyers at the Cork University Maternity Hospital (CUMH), perinatal clinics, community resource centres, public libraries, and post offices across Cork city. Participants expressed interest in participating by scanning the QR code or link provided in the advertisement flyers or posters. Prospective participants were contacted individually by telephone/email by the lead researcher (EOB) to ensure that they met all inclusion criteria, to explain the purpose and procedures of the study and to answer any questions. If women met the eligibility criteria, they were provided with the study information leaflet, informed consent form, and an interview was scheduled.

2.3. Data collection

Data were collected using online semi-structured interviews conducted from February to May 2024 by EOB. The interview was based on a topic guide reviewed and agreed upon by a public and patient involvement (PPI) advisory group and multidisciplinary research team. The topic guide included questions on women’s experiences of pregnancy and/or birth complications, and impacts of these complications on their current mental health, see Supplementary S2. The median interview duration was 30 min (interquartile range 29 – 40 min), and interviews were audio-recorded. Demographic data were also collected from each participant using a questionnaire before the interview commenced, see Supplementary S3.

2.4. Data analysis

Audio interview files were professionally transcribed verbatim and pseudonymised by an external online transcription service. The transcripts were stored and managed using NVivo Software, version 14 [32]. Reflexive thematic analysis (RTA) following Braun and Clarke’s approach was used to identify repeated patterns within the data [33].

RTA consists of six phases. The first phase involves familiarisation with the data through active listening to the interview recordings and re-reading the interview transcripts. During this phase, EOB made initial notes of thoughts on each interview, mapping these thoughts in a reflective journal. The second phase involves coding of the data. In this phase, EOB initiated inductive descriptive line-by-line coding. The third phase involves generating initial themes, during which EOB categorised similar codes together. The categories generated were grouped into potential themes; however, the theme ideas were broad at this stage. The fourth phase is developing and reviewing themes; in this phase, EOB and KMS discussed and relabelled categories where appropriate to ensure they were objectively interpreted and to minimise potential for bias. The fifth phase is refining, defining, and naming themes. In this phase, EOB and KMS reviewed the themes to ensure the credibility of the data and that the themes and subthemes developed were reflective of the coded data generated in the second phase. All final themes were evaluated and agreed upon by all members of the research team. See the research reflexivity statement in Supplementary S4.

2.5. Patient and public involvement

A Patient and Public Involvement (PPI) advisory group was involved in developing the interview topic guide and participants' demographic questionnaire for data collection in the study. The PPI group consisted of two distinct subgroups. First, we included three women who were not healthcare practitioners and who had lived experience of pregnancy and birth complications; two of these women had negative experiences associated with these complications. The second group included three healthcare providers, comprising a female obstetrician/gynaecologist, a female perinatal specialist registrar, and a female general practitioner, all of whom were clinically involved in the provision of services and/or support to women who may have experienced complications during pregnancy and birth.

3. Results

As detailed in Table 1, semi-structured interviews were conducted with 21 women, aged 26–43 years (median 37 years). Most women ($n = 17$) were married and living with their partner. Fourteen women were first-time mothers. The most reported mode of birth was

emergency caesarean section.

3.1. Findings

Four main themes were developed from the interview data. The themes describe women's experiences following a pregnancy and birth complication, the consequences of these complications, women's perceptions of healthcare experiences, and support systems at interpersonal and structural levels. The themes and subthemes are described below and summarised in Table 2.

3.1.1. Expectation versus reality

3.1.1.1. Facing the unforeseen. Women in this study perceived their experience of a pregnancy and birth complication as negative and unexpected. Women felt unprepared and frustrated as their experiences were inconsistent with their expectations of pregnancy and motherhood. Complications were perceived as being “out of the blue”. During birth, women expressed that while they had some knowledge of what to expect, they felt unprepared for the complications. Some women had early warning signs of complications, while other women experienced emergencies that developed suddenly. However, both groups of women used words like “difficult” and “afraid” to describe their experiences, suggesting that their expectation of an uneventful birth was disrupted by the onset of a complication.

“I was preparing myself for a vaginal birth, especially because everything had been fine all along. Then, when that happened was very upsetting. I was distraught. I couldn't understand why it had gone so drastically wrong. I just didn't understand how we got to that point,” P2.

“They started to rush me wherever it was that I was going. And I can just remember they were telling me to lie back, hold on, everything is going to be fine, and to be honest, at that point, I don't even know everything wasn't fine” P8.

Table 2
Themes and subthemes.

Themes	Subthemes	Example codes
Theme 1: Expectation versus reality	- Facing the unforeseen - Control and involvement - Postnatal recovery/adjustments	- Disappointment, unmet expectations. - Loss of control, lack of involvement, concerns for the child. - Recovery from instrumental/assisted birth, feelings of blame/guilt.
Theme 2: The unresolved consequences	- Ongoing mental/psychological distress - Lasting physical trauma - Concerns for subsequent pregnancies - Disrupted relationships	- Anxiety, being overly protective, depression and flashbacks - Incontinence, attending physiotherapy, and chronic pain. - Avoidance of subsequent pregnancies, secondary infertility. - Relationship breakdown/separation
Theme 3: Perception of healthcare experiences	- Communication with healthcare providers - The hospital environment	- Not listened to, lack of validation and access to information - Lack of privacy, poor staffing, and waiting times.
Theme 4: Support systems	- Interpersonal supports - Structural supports	- Supports from partners and family, birth advocates for mothers. - Lack of follow-up, reflection/debriefing services, barriers to accessing care.

Table 1
Demographic characteristics of participants ($N = 21$).

Characteristics	n (%)
Age (in years)	<i>Median (range)</i>
At interview	37 (30–43)
Race and ethnicity	
White Irish	19 (90.5)
Others	2 (9.5)
Highest level of education	
Third level	21 (100)
Marital status	
Married and living with a partner	17 (80.9)
De facto relationship	4 (19.1)
Parity	
Primiparous	14 (66.7)
Multiparous	7 (33.3)
Previous miscarriages	
Yes	3 (14.3)
No	18 (85.7)
Birth mode	
Spontaneous vaginal birth	5 (23.8)
Emergency Caesarean section	14 (66.7)
Planned Caesarean Section	2 (9.5)
Year since last pregnancy	
2020	2 (9.6)
2021	5 (23.8)
2022	8 (38.0)
2023	6 (28.6)

3.1.1.2. Control and involvement. Women discussed a sense of loss of control of their bodies and birth experiences, particularly as a result of unexpected medical emergencies. This feeling was discussed as contributing to experiencing high levels of anxiety, panic, and fear. Women expressed that these emotions were further exacerbated due to poor communication and their limited involvement in decision-making processes, which directly affected them. During birth, some women described feeling pressured into procedures/choices that aligned more with the healthcare provider's suggestion rather than their own wishes, invalidating their ownership of their experiences.

"With the episiotomy, I was like I don't want this, I don't want this. But they kept mentioning it, and definitely it was one of those things where I thought, am I just being rushed through, am I being on the timer here?" P18.

Women's separation from their babies, often due to the infant's admission to the intensive care unit, was also described as distressing, as women felt they had little control over this. In some cases, women were unable to see their babies and had concerns for their babies' health. Women discussed instances where babies were separated without any prior explanation or updates regarding the baby's progress from the healthcare providers, intensifying feelings of powerlessness and vulnerability for women. Although separation of women from their babies may be a result of women recovering from their own illness, women expressed a strong desire to be present and care for their newborns even when very ill.

"I was nearly animalistic; I would say in terms of my baby being taken away, and it was just the most alien thing I had ever experienced" P17.

"I remember saying to the midwife even, please don't let me die. I don't know where my baby is, like it was really bad" P13.

Women who reflected more positively perceived that they were empowered to make informed decisions during birth. Having an option and being in control is important; women described feeling prepared and more in control when they had a voice in their care and were able to make informed decisions, even in a distressing time.

"The Consultants left it up to me, but kind of led me in the direction of I have two kids at home. It's easier planned for if I have a section and all anyway, so I went with a section the third time" P11.

3.1.1.3. Postnatal recovery and adjustment. Women's experiences of recovering from pregnancy and birth complications varied. Some women experienced a quick recovery, enabling a smooth transition into motherhood. While other women discussed prolonged recovery from major surgeries and injuries. Some women expressed feelings of failure, guilt, and disappointment in their bodies, which they perceived as a psychological response to how they felt that their bodies couldn't function after birth. These women expressed frustration with not being able to look after their new babies independently or return to their 'normal' life because of the complications they experienced. Other women attributed their feelings to the medical interventions they received, especially when they were excluded from the decision-making process.

"I had no understanding about an instrumental delivery and episiotomy and all of that. I was shocked by the level of pain and distress that it caused and the healing and that was quite slow. Even slower than the section, and maybe that's because my expectation was different" P11.

"I think the thing that really gets me is that I feel like my body let me down and I think that's what caused an awful lot of my spiralling afterwards. I feel like my mother and my sister, were able to have like

three vaginal births no bother, and when the important time came, my body let me down". P2

3.1.2. The unresolved consequences

3.1.2.1. Ongoing mental and psychological distress. Women frequently spoke about their psychological and mental health as being compromised long after the complications they experienced. Women expressed that the trauma of their experience continues to influence their mental health, with many women describing ongoing mental health difficulties. These difficulties included flashbacks of the traumatic experience and reliving distressing emotions. Several women expressed feelings of protectiveness over their children, describing experiencing emotional displacement driven by fear of harm that 'something might go wrong'. Women often described these emotional patterns as feeling beyond their control. For several women, the mental health consequences of the pregnancy and birth complications were described as having an enduring impact that persisted for years, and in some instances required ongoing treatment.

"I don't think I'll ever come off anxiety meds now, you know, and she is nearly 6, she will be 6 in May. The stuff that happens during the delivery, the separation, and the not knowing all of that kind of stuff and then that stayed that way, I am still on the medication" P13.

"I was diagnosed with complex grief. I am on antidepressant for two years and attending counselling, and it is all linked to the previous pregnancy losses and a previous loss as well" P6.

3.1.2.2. Lasting physical trauma. In recounting their experiences, women referred not only to their current mental health challenges but also to ongoing physical health issues resulting from their complications. While their overall physical health had improved, some women faced persistent challenges such as urinary incontinence and reduced physical activity. Some women reported physical limitations resulting from their complications, such as restricted movement, managing chronic pain, and maintaining strength, which contributed to feelings of frustration and persistent anxiety. In addition, women discussed the impact of complications on their daily functions, including their disappointment in their reduced capacity to physically care for their children. As a result of their physical health issues, women described seeking professional help and embracing a 'new reality'.

"I am six years later, still wearing nappies. I have no control over my bladder or my bowel. I was seen at five weeks by a physio and then I done months, months of physio, different things in the hospital, but because of the delivery, they damaged me, and I am forever going to be damaged because of that" P19.

"I'm still seeing the physio now; I am privately seeing the physio. She thinks I should be seen in the maternity hospital because this is still a consequence of that birth. Yeah so, I'm still repairing from that birth, you know" P7.

3.1.2.3. Concerns for subsequent pregnancies. The women in this study expressed a range of mixed emotions about subsequent pregnancies. However, every woman reported feeling anxious and worried about the prospect of future pregnancies. Women's feelings ranged from mild apprehension to complete avoidance of future pregnancies. The feeling of fear was related to a strong feeling of insecurity in their ability to carry and sustain future pregnancies, fear of death, and uncertainty about surviving childbirth. For some women, the complications they had experienced led to injuries resulting in a reduced reproductive capacity, which further exacerbated concerns and worries. Women who become pregnant subsequently expressed heightened awareness of risks due to their previous experiences. They discussed how prior experiences

shaped their approach to care and their sustained hopes of having a better birth experience. For example, women who felt they had little control over their previous experience expressed their desire to exert control over their future pregnancies. As such, some women found that a positive subsequent birth experience offered emotional strength.

“But I do think if I hadn’t had another baby, and I hadn’t gone through that; I would still look back on the other birth and be very sad thinking about it. There was a lot of thoughts spiralling what if I did this, what if I did that, if only I had said this, if only I had said that and again thinking it was all my fault” P18.

“I wasn’t as anxious the second time around because I kind of knew what to expect in a lot of things, and I had a really good pregnancy” P17.

3.1.2.4. Disrupted relationships. Women described how experiencing a pregnancy and/or birth complication affected their relationship with their partner and child(ren). Most women acknowledged that the experience of pregnancy and/or birth complications deepened relationships, generated positive emotions, and appreciation of their partners. However, not all experiences were positive. A few women reported a lack of understanding and consideration of their needs from their partners. In some cases, tension arose from feelings of guilt, with women feeling blamed for the complications by their partners. Women perceived these experiences as stressors in their relationship, intensified by emotional distress and, in some cases, ongoing unresolved trauma.

“There was definitely an element of blame as to why this happened. I suppose he had questions around why I didn’t know sooner, why I didn’t give up work, so yeah, there was a lot of kind of... My partner didn’t really understand it at all you know, and why it happened” P15.

In relationships with children, most women in this study described a strong sense of bonding, often attributing the closeness to the shared trauma of childbirth. Women ascribed this intensified bond to their emotional processing of the experience, with one woman describing her experience as shaping her ongoing attachment to her child:

“He wouldn’t go to his daddy, and I don’t know. I think I put it down to his personality, but I think the trauma we both experienced at the beginning must have something to do with it” P14.

3.1.3. Perception of healthcare experiences

3.1.3.1. Communication with healthcare providers. Women expected and considered it important to communicate with the healthcare providers providing their care during pregnancy, labor, and the postpartum period. However, several women reported issues of poor communication with healthcare providers and highlighted the need for clearer information. Many women perceived communication with the healthcare providers as one-sided and passive, especially when raising concerns or describing their symptoms. The most recurring feeling was best described by women as “not being listened to”. During pregnancy, some women felt that their symptoms were dismissed and felt ignored due to the healthcare provider’s failure to acknowledge their difficult experience during birth.

“I definitely felt like I wasn’t really being listened to. I felt trapped, stuck, not knowing how to move out of the situation. I felt like the choices were made for me to say okay, yeah, I’ll go for the episiotomy. You know I have a lot of angst and feelings about that when I think about that labour” P18.

For most women, it was important to understand what happened and, in many instances, women emphasised the value of clear and empathetic communication from their care providers. Some women

described feeling inadequately informed about medical procedures, and even when information was provided, it often felt insufficient. The lack of communication and access to information was particularly challenging for first-time mothers who felt responsible for maintaining a record of what happened during their birth. However, few women expressed feeling confident and well-informed when listened to, engaged with, and perceived those care providers as trustworthy:

“The consultant was excellent, and she gave a lot of time, and you know would have listened. I think the fact that we were listened to by both the bereavement midwife and the consultant was helpful” P10.

3.1.3.2. The hospital environment. Some women expressed dissatisfaction with the quality of care they received in the hospital and often referred to the hospital environment as ‘traumatic’. Some women felt their personal needs were overlooked, neglected, and described intense feelings of loneliness, abandonment and psychological vulnerability. A significant concern was a lack of privacy and a perceived absence of dignity in healthcare facilities, which women associated with heightened distress. For instance, women who experienced pregnancy loss described not being provided with a private space. One woman discussed being informed of her loss in a shared space, surrounded by other women who had just given birth to babies. Another woman described the emotional distress and discomfort she experienced during a general medical examination, and procedures were performed in the presence of unfamiliar individuals without consent or explanation.

“Nobody told us who these people were, and I’m quite a private person, and the idea of having an audience of people around that area is already very difficult” P20.

“The care that I got that day I’ll never forget, it was awful, even sitting in the same clinic side by side with women who are pregnant when you are experiencing pregnancy loss is not a very nice experience. It was very traumatic, and I found that really difficult and often it was the only option” P1.

3.1.4. Support systems

3.1.4.1. Interpersonal supports. Women in this study described interpersonal supports they received and needed throughout their experience before, during and after childbirth. While few women identified instances where their emotional and information needs were unmet, most women described receiving high levels of emotional and physical support from partners and family members during and after birth. Women highlighted the importance of having a birth partner or advocates, and many women shared that having birth advocates other than their partners, such as a birth doula or a friend with lived experience of complications, was more effective for advocacy during birth. Similarly, peer groups and community organisations were important for providing support and additional resources to women; however, some women reported a lack of such peer groups/support networks within their communities. Online support groups, for instance, those providing support for women who experienced stillbirth or neonatal loss, were also discussed as useful support networks.

“I also participated in online support with an organisation called “A Little Lifetime”. So, they have a pregnancy after loss support group, so I attended a couple of meetings with them” P10.

Women also described more formal support services in terms of support from the healthcare providers. However, experiences differed substantially. Few women felt they received support from midwives and nurses involved in their care; however, this was not the case for all women in this study. In terms of emotional support, some women expressed their frustrations over the lack of proactive counselling services, debriefing or follow-up supports, which left them struggling to

understand and cope with their experiences. However, other women reported actively adopting information-seeking behaviours by seeking out information or availing of a midwife before leaving the hospital, and found them helpful in processing their birth experiences.

“So, I met the most amazing midwives who took the time to kind of speak to me and hear me and actually respond to me as a new mum who needed emotional and practical support and thinking about them just made the world of difference to me you know” P7.

“We went and done the birth reflections, they brought me back to the scene of the crime, as I do say they brought me back to the delivery ward, and now I found that beneficial” P14.

3.1.4.2. Structural supports. Women identified several structural support needs they felt were important to improving maternity care and their overall experiences. These included timely access to tailored pregnancy-related information, educational resources about birth, and signposting to available supports. Women expressed the need for greater awareness among pregnant women about instrumental births other than the commonly known caesarean section. Concerns about staffing in the hospitals and under-resourcing in the maternity hospitals were also voiced. Several women highlighted the need for extended follow-up care, especially for women who experienced more severe complications. Women perceived their postnatal follow-up as insufficient and, in some cases, ended abruptly as per the standard six-week postnatal policy in Ireland. For example, one woman expressed her frustration with being discharged after six weeks, despite ongoing mental health needs.

“There was this really strange policy or procedure because it was just over the six weeks, I was like disconnected from the original service, like discharged. And because of that, even though I was only five days, we had to start the referral process all over again. So, I was really struggling with a lot of things mentally” P20.

4. Discussion

To our knowledge, this study is one of the few qualitative studies to examine women's longer-term mental health experiences following pregnancy and birth complications in Ireland. Overall, women's experiences of mental health following pregnancy and birth complications were influenced by perceived feelings of control, engagement with healthcare providers, and access to formal and informal supports, structures and resources.

In this study, the expectation of a healthy pregnancy for many women was abruptly disrupted by the diagnosis of a complication, consistent with findings reported by Ray et al [34]. . Notably, the majority of women in this study (76.2%) gave birth by caesarean section (CS), with 66.7% of these women experiencing emergency or unplanned CS. Our findings suggest that, rather than the mode of birth itself, unexpected interventions and deviations from women's birth expectations may have contributed to feelings of loss of control, sense of fear, and unmet expectations. These findings align with previous research suggesting that unplanned delivery modes may negatively shape birth experiences, particularly when women perceive events as unpredictable or inadequately communicated [35]. These experiences may act as key mechanisms underpinning psychological distress, where perceived loss of control may contribute to subsequent adverse mental health outcomes [36–38]. On the other hand, women who perceived themselves as being in control, particularly during childbirth, described their experiences as positive and empowering. This aligns with previous conceptualisation of control during childbirth, which encompasses shared decision-making, access to information, personal security and physical functioning [38].

Building on previous studies [39,40], our study findings provide evidence for enduring distress not only immediately following the complications, but also for persistent and lasting impacts extending up

to five years postpartum. Women described a variety of ongoing consequences, including ongoing mental distress, physical distress, and concerns for future pregnancies. These findings are consistent with those of Daly et al [41], who reported that women may experience physical health morbidities over an extended postpartum period. The reported use of anxiety and antidepressant medications noted among a few women in our study further demonstrates ongoing mental and psychological health problems years after the birth experience. In addition, while the extended postpartum time period in this study offered a deep exploration into the enduring nature of women's experiences beyond the typical postpartum period [42], the persistence of distress over several years suggests that for some women, these experiences may remain unresolved, potentially shaped by ongoing physical morbidities, uncertainty about subsequent pregnancies or limited access to psychosocial supports and resources. These experiences may contribute to a high sense of vulnerability, as highlighted in previous qualitative studies [43, 44].

Healthcare providers' understanding of women's needs is important in deciding how to support them. In this study, involvement in the decision-making process and access to information were described as factors that mattered most to women. While women's experiences of engaging with healthcare providers were not universally negative in this study, women's narratives of not being visible or heard were similar in many instances. This is consistent with findings from two studies that reported that poor communication with healthcare providers is detrimental to mothers' pregnancy and birth experiences [45,46]. Furthermore, while informed consent may represent a challenge in certain emergencies, consent may not be obtained before performing a procedure [47]. Our findings demonstrate that women may feel unsafe when consent is not implicitly sought during an unplanned intervention or clearly explained. According to the Wittmann-Price Theory of Emancipated Decision Making in Women's Health Care (EDM Theory), it is important to women that their health concerns are acknowledged and understood by their care providers [48]. This theory emphasises person-centred care and shared decision-making between women and healthcare providers, highlighting the importance of collaborative and socially responsive maternity care [48].

Together, the findings in this study highlight the need for appropriate support for women who experience pregnancy and/or birth complications in line with Ireland's National Maternity Strategy [49]. Women in this study described the need to access information, including informal debriefing and reflective discussions, rather than structured psychological interventions. In line with the findings from two previous studies [50,51], women in this study, who engaged with/were provided formal psychological supports, found them beneficial in understanding their experiences and regaining control. On the other hand, evidence from other research [52,53] indicates that formal debriefing may be unhelpful or even harmful in certain situations. Therefore, it is important to differentiate between formal and informal interventions provided within maternity services to ensure that women who require more intensive support are referred to qualified mental health providers.

4.1. Implication for practice

These findings underscore the need to build capacity to support healthcare providers in delivering person-centred care, including tailored longer-term screening and structured psychological follow-up beyond the first year postpartum. It is crucial to develop interventions that target this critical one-year window in order to interrupt trajectories of potential long-term consequences [54]. Furthermore, findings from this study have important implications for trauma-informed and sensitive person-centred practices during childbirth. Traumatic birth experiences are not only shaped by medical outcomes, but also by how care is experienced, communicated, and delivered [34]. Increased investment in perinatal mental health services and the availability of resources for healthcare providers may facilitate support for women following

pregnancy or birth complications [55]. In addition, integrating trauma-informed care into routine obstetric practices may benefit not only clinical outcomes but also women's longer-term psychological health. Practices such as respectful communication, acknowledgement of women's birth needs, and sensitivity to individual vulnerabilities may help reduce the risk of negative or traumatic birth experiences [56,57]. Importantly, supporting women to engage with maternity care with realistic expectations through antenatal education before potential complications arise may help women prepare for possible challenges [58,59]. However, effectively implementing educational services or conveying this realistic risk may be complex.

4.2. Strengths and limitations

This study was enriched by the PPI advisory group, which reviewed the data collection guide, strengthening the study's design and data collection procedures. Furthermore, this study attempted to reach a wide audience and not just in a single setting study, by conducting recruitment with gatekeeper organisations; INFANT Research Center and Let's Grow Together.

However, some limitations were noted in this study. First, we restricted the inclusion criteria to women who could be interviewed in English. Although this was necessary to ensure accurate communication and adherence to the study interview guide, this may have restricted participation among women with limited English proficiency. Subsequently, recruitment in this study relied on social media posts and voluntary participation, which may have implications for the equity and inclusivity of the results. Women who participated may have had strong or ongoing mental health experiences, potentially limiting the representativeness of the sample and the transferability of the study findings. Second, although the recruitment approach actively sought to recruit participants from lower socio-economic areas, the women in this study were predominantly white Irish women, married or in a relationship, and were all third-level educated, which may restrict the generalisability of our findings beyond the sample included in this study. Further research is warranted among women from ethnic minority backgrounds, as marginalisation, forms of disadvantage, and cultural stereotypes may impact experiences of pregnancy and birth complications [60]. Third, women reflected on experiences occurring between 12 months and up to 5 years postpartum. The passage of time may have influenced recollections, with women's accounts and perspectives potentially evolving or being shaped by subsequent experiences. Future research could explore how perceptions of mental health following pregnancy and birth complications evolve since the time of birth. In addition, most women in this study described some type of obstetric complications during pregnancy and/or childbirth, suggesting that women who found pregnancy traumatic for reasons other than a medical complication may have been excluded from the study. However, as the focus of this study was on complications, we are confident in our eligibility criteria. Finally, while our study was conducted after the COVID-19 pandemic, participants' experiences focused on the pandemic period, which may have influenced their experiences.

5. Conclusion

The findings in this study showed that women expressed a range of emotions upon receiving a diagnosis of a complication during pregnancy and birth. These women reported substantial information needs and shared that effective communication from healthcare providers was essential and impacted their perceptions of control. Women in this study reported ongoing mental and psychological distress, including concerns for subsequent pregnancies. Women emphasised the need to improve the communication skills of healthcare providers and service delivery to implement continuity of maternity care models. Women also required easily accessible information to increase health literacy about their own or their baby's health complications. Further research should be

directed towards a diverse and inclusive sample of women, and additional qualitative research on longer-term consequences following the experiences of maternal morbidities. Ultimately, by increasing support for healthcare providers and addressing barriers to resources for healthcare providers, we can optimise support for women's experiences of pregnancy complications and potentially improve maternal health outcomes.

Authors' contribution

Elizabeth Bodunde: Conceptualisation, Methodology, Investigation, Formal analysis, Data curation, Writing – original draft, Writing – review & editing. **Fergus McCarthy:** Supervision, Writing – review & editing. **Karen O'Connor:** Supervision, Writing – review & editing. **Ali Khashan:** Validation, Supervision, Writing – review & editing. **Karen Matvienko-Sikar:** Methodology, Validation, Supervision, Formal analysis, Data curation, Writing – review & editing.

Ethical approval

Ethical approval for this study was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals, Ref number: ECM 4 (a) 24/10/2023 & ECM 5 (6) 07/11/2023 & ECM 3 (aaa) 05/12/2023. Participants provided written informed consent before study participation. Women were made aware that participation was voluntary, whereby they could decline to partake in the study at any time. They did not receive any remuneration for taking part. All methods were carried out in accordance with relevant guidelines and regulations.

Author declaration

I, Elizabeth Bodunde, declare on behalf of myself and the other authors, Ali Khashan, Fergus McCarthy, Karen O'Connor, and Karen Matvienko-Sikar, that the article is the author(s) original work. The article has not received prior publication and is not under consideration for publication elsewhere. That all authors have seen and approved the manuscript being submitted, titled "Will I ever recover?", *Women's experiences and perceptions of mental health following pregnancy and birth complications: A qualitative study*. That the author(s) abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives

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Declaration of Generative AI and AI-assisted technologies in the writing process

AI was not used in the preparation of this work.

Declaration of Competing Interest

The authors declare no known competing interests, including financial interests.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at [doi:10.1016/j.wombi.2026.102234](https://doi.org/10.1016/j.wombi.2026.102234).

Data availability

While study data were pseudoanonymised for the purposes of this study, participants may still be potentially identifiable from transcripts due to their lived experiences. The authors are not therefore sharing the data from this study in line with the ethical approval and consent granted.

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