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Traumatic Birth and Chronology of Losses

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ABSTRACT

This study examines the impact of traumatic birth experiences on parents of children with cerebral palsy. Background: Traumatic births affect 9-45% of women, potentially causing significant psychological consequences. Objectives: To investigate the losses experienced by parents following traumatic deliveries and their impact on family dynamics and identity. Methods: Twenty-four parents (21 mothers, 3 fathers) from diverse backgrounds in northern Israel participated in qualitative interviews analyzed through thematic and narrative approaches. Results: Six domains of loss emerged: idealized birth experience, autonomy during labor, initial bonding, normative family structure, financial stability, and health security. Parents experienced profound identity disruption while navigating between idealized expectations and the reality of raising a child with special needs. Conclusions: Traumatic births create a domino effect that necessitates reconstruction of family life and self-perception. These findings highlight the need for comprehensive support systems for affected families, addressing both immediate and long-term consequences of traumatic birth experiences.

INTRODUCTION

Labor and delivery represent significant milestones in the lives of women and their partners. However, when this event is marked by trauma, for various reasons, it can have both short- and long-term repercussions on the birthing individual, their relationship with their partner, and their future parenting experiences. Traumatic birth is defined as a childbirth experience perceived by the couple as life-threatening to the mother or the baby, and it often evokes feelings of fear, helplessness, or horror (Beck, 2004). According to the American Psychological Association (2013), a traumatic birth is characterized by injuries, serious danger, or the potential for death affecting either the mother or the child. Such experiences can give rise to a spectrum of emotional responses, including distress, intrusive memories, fear, guilt, and shame (APA, 2013; Yonkers et al., 2014; Shaw et al., 2014). The prevalence of traumatic birth experiences varies widely among studies, with estimates indicating that between 9% and 45% of women report their childbirth as traumatic (Ayers, 2004). Understanding the impact and prevalence of traumatic births is essential for providing appropriate support and care to affected individuals and their families.

One significant way trauma during labor impacts couples is through the development of post-traumatic stress disorder (PTSD). To qualify for a PTSD diagnosis, individuals must have been exposed to a traumatic event, which is often a triggering factor for the disorder. However, not everyone who experiences trauma goes on to develop PTSD (Perkonigg et al., 2000; Santiago et al., 2013). Among those who do, there is a wide variation in symptom severity and clinical presentation (O'Donnell et al., 2006; Pai et al., 2017). This variability suggests that both individual differences and contextual factors play crucial roles in shaping post-trauma outcomes.

Given the high prevalence of traumatic childbirth experiences, it is not surprising that PTSD frequently follows, bringing with it significant functional impairments, such as challenges with memory, attention, and executive functioning, alongside self-reported disabilities (Golier et al., 2006; Lambert & McLaughlin, 2019; Qureshi et al., 2011; Schuitevoerder et al., 2013; Scott et al., 2015). This reality opens up multiple avenues for research to explore the connections between traumatic childbirth and the array of losses experienced by parents, encompassing emotional, psychological, social, and familial dimensions. Such investigations can shed light on both immediate and long-term consequences of these distressing experiences.

In this context, we present a thematic summary of interviews with couples who perceived their labor and delivery as traumatic, focusing on the functional impairments they have encountered in the aftermath of these events.

Patients and Methods

This research journey commenced through clinical meetings with parents, both Jewish and Arab, of children suffering from cerebral palsy. FB, a nurse in the pediatric department of a hospital in northern Israel, speaks Arabic as her mother tongue as well as fluent Hebrew. In her role, she has been a witness to the difficulties that parents face during their children's prolonged and repeated hospitalizations, often serving as a "listening ear" for their concerns. Recognizing that these interactions were fleeting and occurred within the confines of her routine workday, FB developed a deeper interest in understanding the experiences and emotions that parents navigate since the birth of their child. Her curiosity extends to how these parents cope in daily life outside of the hospital, the sources of support they rely on, and the moments of crisis they encounter along their journey. We chose to focus specifically on parents of children with cerebral palsy, as FB, in her capacity as a nursing educator, primarily emphasizes the physiological and biological aspects of healthcare. However, she felt compelled to broaden the scope of her research to include the psychosocial contexts that significantly impact the lives of these families.

This qualitative-narrative study examines how individuals articulate and describe their emotional, social, and physical experiences while coping with various life events. Narrative research emphasizes the social and cultural contexts that shape these stories, as well as the inherent characteristics of the narratives themselves. Participants' descriptions of their experiences not only facilitate personal meaning-making but also enable them to express their unique struggles, situate their identities relative to others, and reflect on the processes they have undergone. Essentially, the narrative method fosters an interactive engagement between personal life stories, self-identity, and the cultural frameworks that inform their creation (Tuval-Mashiach and Spector-Marzel, 2010:16; Polkinghorne, 1988). The questions posed to the parents are designed to be descriptive and narrative, inviting participants to share their experiences throughout their parental journey with a child diagnosed with cerebral palsy (see Appendix No. 1). This study traces the sequence of significant events associated with cerebral palsy, including the course of pregnancy, the birth process, the diagnosis, the challenges of treatment, and the provision of health services, while also considering daily family life and management.

By employing this qualitative methodology, the research captures the parental, experiential, and emotional perspectives at various stages of navigating different social systems, including the medical, educational, and family systems. Highlighting the distinct voices of parents—each sharing their unique journey while also identifying shared experiences—enables a deeper exploration of the multifaceted meanings of cerebral palsy across varying social and temporal contexts. Ultimately, this study aims to enhance awareness among professionals in the medical field and the public regarding the challenges that parents face when navigating the complexities of raising a child with cerebral palsy. These challenges, often overlooked in existing literature, underscore the need for a more comprehensive understanding of the parents' experiences and the support they require.

The beginning of each parent's story serves as a significant event during the interviews, revealing their choice of what to emphasize and how they organize their narrative. This initial segment provides insight into the trauma experienced by the participants, particularly for those who endured a sudden, traumatic, and unforgettable birth experience. Through these openings, we gain a deeper understanding of the emotional impact on parents as they articulate their journey from that pivotal moment onward. This focus on the commencement of their narratives not only highlights the immediate challenges they faced but also sets the stage for the broader experiences and challenges associated with raising a child diagnosed with cerebral palsy.

Ethical Approval Statement:

At the beginning of each interview, I reintroduced myself, explained the research topic and its objectives, and clarified the structure of the interview—an in-depth, semi-structured conversation allowing participants significant freedom of expression. I emphasized key elements of the informed consent form, including the anonymity and confidentiality of the study, the use of pseudonyms when presenting participants' narratives, and the secure storage of audio recordings. Only my academic supervisor and I had access to the interview materials.
Prior to conducting the interviews, I obtained ethical approval from the Ethics Committee of the Azrieli Faculty of Medicine in Safed Appendix 4). In each case, before the interview, I provided participants with both written and verbal explanations regarding the research purpose and the implications of the informed consent form . I assured the participants of my commitment to maintaining their privacy and confidentiality, explained the use of pseudonyms in their narratives, and clarified that the recorded materials would remain securely stored and accessible only to myself and my supervisor. Verbal explanations were also provided during a preliminary conversation held with each participant prior to the interview.

Participants:

The study included in-depth interviews with twenty-four parents of children with cerebral palsy in northern Israel, consisting of twenty-one mothers and three fathers from a variety of religious and cultural backgrounds. Among the participants, thirteen were Jewish (one mother was religious and the rest were non-religious), four were Muslims, one was Christian, and six were Druze. The interviewees included parents of a five-and-a-half-year-old child with cerebral palsy. Regarding marital status, there were fifteen married couples, three mothers married for the second time, four divorced parents, one widower, and one parent living with a partner. The ages of the parents ranged from 21 to 46 years, with the youngest mother being 21 and the oldest father being 46. The socioeconomic status of the parents was medium-low. Most parents were employed; however, two were independent professionals, while the remaining parents—primarily mothers—were homemakers who supplemented their income with their children's disability allowance.

Data Analysis:

The analysis of the interviews was conducted in two stages. The first stage involved a thematic analysis aimed at sorting and organizing the participants' descriptions, experiences, and explanations. This thematic analysis process comprises four stages (Shakedi, 2010), with each stage building upon the foundation of the preceding one, highlighting the interdependence of the stages. Data analysis took place concurrently with data collection. This continuous interaction between data collection and analysis enabled a dynamic and responsive approach. By analyzing the information immediately after its collection, the researcher could gain insights that informed the development of themes and guided subsequent interviews. This iterative process ensured a deeper understanding of the participants' perspectives and enriched the overall findings of the study.

The second stage of the interview analysis involved narrative analysis, which offered a comprehensive understanding of the experiences of parents raising children with cerebral palsy. This approach facilitated the connection of various events and themes highlighted by the parents, framing them as integral aspects of their life journey and their coping strategies. Each narrative element—whether an event, experience, or characteristic—served to complement and reinforce the central message of their stories. Narratives are significant social acts that provide individuals with a voice. As Marzel-Spector (2010) articulates, the use of narrative allows for an exploration of the subjective meanings embedded in the interviewees' accounts. These narratives function like a snapshot of life, portraying the narrators' primary goals, their perceptions of themselves and their surroundings, as well as the elements that bestow meaning upon their lives (Ruth & Kenyon, 1996, as cited in Spector Marzel, 2010; 67).

The narrative analysis aimed to uncover the endpoint (EP) of each story—essentially the purpose, central claim, or message that parents intend to communicate through their narratives. This involved a meticulous reading of each interview, prompting reflective questions like: Why did the narrator choose to describe this particular event? What was the rationale behind the construction of the story in this way? Why did he or she refrain from addressing certain questions? This process of reading required a balance of closeness and distance—immersing oneself in the narrator's perspective while also maintaining a critical distance to discern the overarching messages related to their identities as parents and individuals. Through this method, we sought to illuminate the complexities of their experiences and the narratives they construct around their roles as caregivers.

Findings:

For the parents in this study, representing diverse socio-demographic backgrounds (Appendix 2: Demographic Characteristics), pregnancy was a planned and relatively uncomplicated event. Fertility issues were largely absent, and pregnancy was viewed as an integral part of their envisioned future. A strong emotional and physical bond between parents and the expected infant began developing in the early stages of pregnancy. With the exception of Shoshi, a 33-

year-old Ultra-orthodox Jews woman who opted against fetal anomaly scans due to her unwavering commitment to continuing the pregnancy regardless of findings, all mothers actively participated in managing and monitoring their pregnancies. This involved utilizing either the public health clinic (Tipat Halav) or private gynecologists through their health insurance providers. One participant, Kitty, a 31-year-old Christian woman, reported undergoing a genetic screening test specifically designed for her ethnic group* (Appendix 3: Pregnancy Management and Monitoring). Parents generally anticipate an easy and swift delivery, envisioning the magical moments of that first encounter with their newborn: the placement of the infant on the mother's body, the initial touch, the caress, the warmth, the gaze into the baby's eyes, and the observation of facial expressions. These moments constitute a significant part of their postpartum expectations. However, as described by the participants in this study, the discrepancy between these expectations and the lived reality proved to be substantial.

This section outlines the **central themes** emerging from the research:

Loss of the Idealized Birth Experience

This theme addresses the profound discrepancy between pre-existing expectations and idealized imagery of childbirth and the traumatic reality experienced. Couples suffered a significant rupture in their perception of the idealized birth they had envisioned. Instead of an empowering and meaningful experience, they confronted complex medical emergencies. Mona poignantly expressed this sentiment: "Simply put, it wasn't what I expected. I was prepared for anything, but not this". Mona's husband, Maher, described the birth as a difficult and painful experience. The unexpected nature of the delivery, coupled with numerous medical risks, affected not only his wife but also Maher himself. He stated: "The experience was unbearable; I felt helpless. I approached the staff, informing them of an interruption in the fetal monitor. They dismissed it as a technical issue, claiming it was commonplace and routine. I told them, 'No problem, continue.' Suddenly, the midwife began screaming, as did my wife—there was bleeding. What I witnessed, I will never forget. The midwife abandoned everything, rushing out of the room screaming and crying. The entire team outside rushed in, alerted by the screams and cries. The head physician entered, assessed the situation, and immediately summoned an operating room bed and surgical team. They transferred my wife, bleeding profusely, from bed to a stretcher and finally to the operating room". Similarly, Afaf shared her pain, stating: "We waited for a healthy child; I prepared everything for him—absolutely everything. And suddenly, he doesn't return home with you. As I told you, I expected a rosy life, I anticipated a three-day hospital stay followed by discharge with my baby in my arms. Instead, I was hospitalized for six days and discharged without him. I visited him daily, from nine in the morning until ten at night. Twice, they called to inform us that we were going to lose him! When I went to the neonatal intensive care unit (NICU) to see him, I didn't recognize him; he was severely swollen. The doctors told me he might survive, or he might not. He suffered seizures in the NICU. In the first few days, he received anti-seizure medication; he had high blood pressure and edema throughout his body, including his head".

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[*] https://www.malpractice.co.il/%D7%A1%D7%A7%D7%A8-%D7%93%D7%A8%D7%95%D7%96%D7%99%D7%9D-%D7%A2%D7%A8%D7%91%D7%99%D7%9D
The provided link details genetic screening recommendations for Arab Israelis, issued by the Israeli Medical Genetic Association, both pre-conception and during pregnancy.

Kitty, who had previously experienced two uncomplicated vaginal deliveries, found herself in a completely different situation with her third birth. She lost the opportunity to experience a normal delivery due to severe medical complications (placental abruption and massive hemorrhage) that necessitated an emergency cesarean section. She recounted: "He was born at 28 weeks. I experienced a sudden placental abruption that caused internal bleeding. I didn't understand what was happening because I experienced severe abdominal pain at home that prompted me to go to the hospital. It took the doctors an hour and a half to understand what was happening to me, and during that time, I was bleeding. A doctor arrived and informed me that something was seriously wrong. The doctor himself rushed me to the operating room without even waiting for a stretcher".

Loss of Autonomy and Control During Labor

This central theme reflects the feelings of helplessness and lack of control experienced by the birthing persons during their traumatic deliveries. Due to the urgency of the situations, they were effectively excluded from decision-making processes concerning their bodies and their fetuses. Their fundamental right to understand what was happening in real-time and to participate in the process was denied. Afaf sharply articulated this, stating: "The doctors debated whether to take me to the operating room or let me deliver naturally. I don't truly know what happened because they didn't speak to me or explain anything. Later, our lawyer discovered they had hidden a fetal monitor strip showing that the baby wasn't receiving enough oxygen in utero. (A deep sigh accompanied by a pained expression). He was born with the assistance of vacuum extraction, which resulted in significant complications—truly significant complications. They couldn't deliver him normally". Kitty experienced significant uncertainty and a lack of control. She was rushed to the operating room without prior preparation, without family support, and without a full understanding of her medical situation: "I went into shock. They took me to the operating room—it was the first time in my life that I'd ever been in an operating room. They took me alone, without anyone accompanying me, and it was truly traumatic. Everything was sudden: 'Do this, do that…". Maher, who had implicitly trusted the medical team and even alerted them to the malfunctioning fetal monitor, witnessed the delivery unraveling moment by moment of loss of autonomy, particularly when the midwife—his anchor in the birthing process—ran screaming and crying from the room, and his wife, bleeding profusely, was rapidly transported to the operating room.

Loss of Initial Moments and the First Bond

This theme centers on the loss of the profoundly significant experience of the initial mother-infant encounter—moments critical for the development of the parent-child bond and secure attachment. Mona described this loss: "After I left the operating room, I sensed the staff's distress. I felt something had happened to the baby, but they didn't tell me. I asked my husband where my son was because I wanted to see him. He said he was fine but that he had aspirated amniotic fluid, but everything was all right, the baby was fine. However, I saw that they were not calm; they kept coming in and out. I asked them what had happened. Had something happened to the baby"? Kitty shared her pain: "Even after the baby was born, I didn't see him. I was hospitalized for three days in recovery because I continued to bleed. I saw the baby after five days, and because I was connected to IV bags, I wasn't allowed to enter the NICU due to the risk of infection". Afaf described: "I saw him when he emerged from my womb, I looked at him, and then they took him away. Mentally, it was incredibly difficult; you know, not seeing your son. They immediately took him to the NICU. It wasn't until the second day that I got up and went to the NICU myself to see him. Moreover, no one told me anything—what, how, why, you know! They didn't explain anything. Today, I have a phobia of that hospital (where I was hospitalized), and I won't go back even to visit someone who is ill. I will never go back there, under any circumstances"!!

Loss of the Idealized and Normative Family

This theme reflects the shattering of the idealized and normative family perception in the aftermath of the traumatic birth and its long-term consequences. Mona expressed this by saying, "I had dreams of seeing him sitting, crawling, standing, but instead, I live in fear". This insight demonstrates the conflict between imagined motherhood and a reality that has become challenging due to the infant's vulnerabilities. Afaf described the rupture in these words: "You know, we waited for a healthy child; I prepared everything for him—absolutely everything—and suddenly, he doesn't return home with me". The birth of Salah led to a total collapse of the idealized family image. The home environment, intended to be a space of family intimacy and warmth, underwent a dramatic transformation, becoming a quasi-medical unit. When I visited Afaf's home, I saw how the domestic space had become a makeshift hospital. They transformed their large bedroom into a treatment room for their son, bringing in equipment from the hospital. Upon entering the room, I felt as if I were in an intensive care unit. The loss of family normalcy is also manifested in the absence of the most basic parent-child interaction, as Afaf painfully describes: "He doesn't move, doesn't move his hands, doesn't smile at me. I talk to him constantly, but he doesn't smile, doesn't give me any response at all. Since the birth, he's been in the same condition; he's always in bed; he doesn't do anything; he just sleeps all the time". Instead of a vibrant and joyful family life, Afaf and her partner found themselves cut off from the outside world, as she testifies: "Really, really, 24 hours a day, I care for him. His father and I have disconnected from the outside world; the most important thing being that he's okay". Thus, in place of the idealized family they envisioned, a reality of an isolated family unit emerged, confined to a domestic space transformed into a medical facility, their lives dictated by the child's complex medical needs.

The loss also encompasses the dramatic change in family lifestyle and traditional parental roles. Kitty recounted: "I couldn't return to work because it would have been at the expense of my husband and my other children, who require significant investment. Their brother was born prematurely and with many problems. I chose to forgo my career as an accountant, but concurrently, I witnessed Sharbel's progress; I don't offer empty excuses for staying home, as I intend to return to my career later. I returned to a part-time position on my own terms because my aunt (who owns the business) is considerate of my situation".

Loss of Financial and Employment Stability

This theme describes the economic and employment consequences of the traumatic births on the families. Afaf and her partner lost their ability to maintain a regular work schedule. The private business they ran closed due to the need for intensive care for their son. As Afaf stated: "Until we transitioned to home peritoneal dialysis, which we don't control properly. The catheter gets blocked, or the gastrostomy[†] tube dislodges. We don't have specific days when

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[†] A gastrostomy tube (G-tube) is a catheter inserted into the stomach through the abdominal wall. It's used when, due to various health or other reasons, food, fluids, and medications cannot be delivered through the upper digestive system—the mouth and esophagus—allowing for their administration as needed via the G-tube.

we're at home. I could go to the hospital at any moment. Now I'm home, and in an hour, I might not be, so it's impossible to work".

Maher and Mona found themselves in a very difficult family and financial situation. Maher stopped working and faced financial hardship, relying on allowances and family support. He shared: "I didn't work for two and a half years. I'm 24/7 at home caring for my wife and son (who suffers from severe cerebral palsy, is now five years old, walks with a walker, can't climb stairs, doesn't speak, still uses diapers, doesn't eat orally but through a gastrostomy tube, and moves between home and the hospital). I received a meager disability allowance of 2500 shekels and had to borrow money from my brother and friends to buy medicine for my son".

Kitty described the complex decision: "I couldn't return to work because it would have been at the expense of my husband and my other children, who require significant investment... I chose to forgo my career as an accountant, but concurrently, I witnessed Sharbel's progress; I don't regret staying home at all, and I intend to return to my career later".

Loss of Health and Existential Security

This theme addresses the erosion of basic security stemming from the significant risk to the life of both mother and child. Kitty experienced a life-threatening medical condition: "I woke up after three days; I would wake up and fall back asleep. Both my arms were connected to different blood sources; my hemoglobin level reached three grams per milliliter. They left me in the recovery room; I had a condition of disseminated intravascular coagulation".

Afaf described forty days of uncertainty regarding her son's survival: "I was hospitalized for six days and was discharged home without him. I would go to visit him every day, every day from nine to ten at night. Twice they called to tell us that's it, we were going to lose him!!! When I went to the NICU to see him, I didn't recognize him; he was very swollen. The doctors told me he might survive, and he might not. In the NICU, he had seizures. In the first few days, they gave him anti-seizure medication; he had high blood pressure and edema all over his body, including his head".

For forty days, Afaf lived in uncertainty, wondering whether her son would live or die—forty days between life and death. When I asked her how she managed to function during those forty days and what sustained her, she replied: "I had faith that everything would be alright. Initially, I believed everything would work out with God's help. My husband, of course, was always by my side and never left me. So were my parents and his parents. I definitely received emotional support from our community".

Afaf gave full expression to her emotional experience. She needed the close presence of someone who understood, recognized, and was with her in her distress—her husband. Her husband offered a warm shoulder, a listening ear, and embracing hands to receive her grief and sorrow. Afaf and her husband coped with the experience of losing a healthy baby; they supported each other both emotionally and practically. Her beloved husband shared her sorrow, which led to the restoration of harmony in her inner world; Afaf's fears and distress diminished.

Maher described the post-traumatic emotional and physical consequences experienced by Mona, manifested in sleep disturbances, dependence on sleeping pills, difficulty bonding with the child, lack of function and activity, fears, and depression: "Judah's crying and screaming in the middle of the night terrify her, causing her to relive the screams from the delivery room; she is still traumatized by the birth. Sadly, many things remind us of the traumatic moments we experienced. At this stage, she's not thinking about getting pregnant, not thinking about having more children—five and a half years have passed. She wants to and doesn't want to. She wants to but is afraid. Afraid of what she went through, afraid it will happen again, afraid of many things, even though I constantly reassure her. I want him to have a sibling to support him after we're gone". For him, the post-traumatic experience of the birth manifested as heavy smoking, hair loss, sadness, and helplessness.

Loss of Self-Identity

This theme addresses the loss of self and personal identity following the traumatic birth process and the tumultuous situation that followed. The mothers found themselves in a constant struggle between the desire to be a "good mother" and the complex reality. Mona expressed this when she said, "I didn't have the strength to get up, to help him, as every mother should". These feelings of inadequacy and failure profoundly impacted their self-perception as women and mothers. Maher focused on the gap between the early expectations and images of parenthood and the reality imposed on the couple. He emphasized the rupture in their perception of the future, both family and personal: "Our whole lives turned upside down, all our plans, everything we had planned in life—everything changed since I've been caring for my wife and child. Only after three years did she (Mona) start feeding the child slowly, gradually approaching him and holding him. She's in a difficult mental state; she continues to take tranquilizers and sleeping pills to sleep through the night".

The intensive care required for their severely disabled child created a significant upheaval in Afaf's mental state. She describes a metaphorical sense of confinement—"stuck inside a ball"—reflecting the trap that has formed in her life. The fragility of Salah's health and the need for around-the-clock care created a reality of social isolation and confinement at home, with their entire life revolving around his bed. Afaf experienced herself as different from "other people"—she doesn't work, doesn't go on outings, and isn't able to fulfill her desire to expand her family due to the imposed mental instability. Her deep mental distress is repeatedly expressed throughout the interview, as she repeatedly emphasizes the devastating consequences of her son's condition on her mental state—"mentally, it destroyed us".

DISCUSSION

The fragility of life is somewhat analogous to a domino game. When we put domino bricks to stand, one after another, seeking to create a chosen form, we strive to contain it, shape it, and balance the pieces to prevent them from falling, aiming for the desired structure. This form, which we sought to create, is disrupted when a rogue domino brick, whether intentionally or not, falls, toppling the others that, moments before, stood in perfect order. Similarly, the path, direction, and form the parents in this study sought, hoped, and yearned to shape in their lives—to order and manage their foundational elements, to build their family, their careers, and their future—is altered in one fragile moment, the moment the birth becomes complicated. The foundational elements of the previous form, of the hoped-for family, of the imagined life, shatter; they can no longer exist. Now, the process of creation and rebuilding must begin anew.

This study describes the disintegration of parental expectations as experienced by parents of children with cerebral palsy. This process unfolds within the context of collective social consciousness and socialization within Israeli society, which sanctifies the values of family and fertility. These values are embodied in pro-natalist policies and the medicalization of pregnancy, which, on the one hand, encourage the birth of healthy infants while preventing genetic defects and diseases, but on the other hand, create an illusion of control or predictability regarding the future health of the unborn child. This embodies overlooking a crucial stage that can alter the whole situation: the birth itself and the birthing experience. Parents in this study experienced a stark contrast between the pre- and during-pregnancy control and prediction of fetal health and the idealized image of their future family, and the reality that unfolded through traumatic births. The expectation of an easy, swift birth, including the magical moments of the first encounter with the infant, is shattered by various complications during labor, both physical (placental abruption, premature rupture of membranes) and systemic (lack of a skilled and professional team during emergencies, incorrect decision-making). These complications resulted in traumatic experiences and physical and emotional scars for the parents, as well as losses experienced both during and after the traumatic birth. Losses experienced during the traumatic birth include: loss of a safe and positive birthing experience; loss of the initial mother-infant bond; loss of the feeling of motherhood; loss of certainty regarding the infant's survival; returning home without the infant; loss of the healthy child; loss of the mother's mental health; and loss of daily functioning. Losses experienced after the traumatic birth include: loss of the healthy family; loss of employment; loss of the previous life; loss of the joy of life; and loss of the distinction between home and hospital.

In summary, the interviews with the parents revealed that all had anticipated a normal delivery; however, to their dismay, the birth became complicated, deteriorating into a traumatic experience that left lasting scars on the mothers. This traumatic birth affected all the mothers mentally. Furthermore, the narratives consistently highlighted the systemic challenges within the healthcare system, characterized by a constant shortage of staff at all levels, from nurses to senior physicians.

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Appendix No. 1: The Interview

1. Tell me about yourself...
2. How it all began...
3. Tell me about your pregnancy experience (were there any emotional or physical difficulties)?
4. Tell me about the birth experience (were there any emotional or physical difficulties)?
5. Can you tell me about your child?
6. Can you tell us how you knew that your son or daughter has cerebral palsy, what the signs are, tell us about the diagnostic process, how long it took to diagnose the disease, to whom you were referred?
7. How did you deal with the child's diagnosis, who did you contact, what did you do (do you have a social support network)?
8. Tell me about the treatment process, what difficulties you encountered regarding the accessibility of the treatment and the bureaucracy.
9. Tell about the gap between expectations and reality in the parenting process.
10. What would help you cope with your child's treatment process?

Appendix No 2: Demographic characteristics of the interviewees

The age of the child with CP	Number of children	Religion /Origin	Practice	Marital status	Age	Number of Interviewees
3	4	Jewish	hire	married	38	1
8	3	Jewish	farm worker	divorcee	51	2
6	2	Druze	an assistant to her daughter	divorcee	34	3
6	3	Christian	accountant	married	37	4
5	2	Muslim	hairdresser	married	37	5
5.5	4	Muslim	housewife	married	41	6
12	5	Jewish	office worker	Married	55	7
6	3	Jewish	housewife	married	30	8
8	3	Jewish	Paramedic	married	35	9
8.5	2	Jewish	special education teacher	married	40	10
10	3	Jewish	housewife	married for the second time	36	11
9	2	Jewish	Cosmetologist	divorced + Spouse	39	12
8	2	Jewish	teacher	married	43	13
16	2	Jewish	farmer	widower	50	14
5.5	3	Druze	Housewife	married	40	15
5.5	1	Druze	Housewife	married	36	16
5.3	1	Druze	housewife	married	27	17
5.3	1	Druze	electrician	married	38	18
6.9	2	Druze	housewife	Divorced twice	47	19
6	2	Muslim	Independent	divorcee	42	20
3.5	3	Jewish	housewife	married	35	21
4.5	1	Jewish	office worker	partner	43	22
11.5	2	Jewish	dental hygienist	married	46	23
6 months	2	Druze	housewife	married	26	24

Appendix No. 3: Pregnancy Management and Monitoring

hospitalization time	birth complications	birth week	pregnancy follow-up	tests during pregnancy	religious background/ ethnic	name and age of the child	parent's name	
Month – Pollution due to premature water loss	Emergency cesarean section Umbilical cord prolapse	30	Gynecologist follow-up at the HMO	Nuchal translucency Fetal protein Early Systems Review	Jewish Secular	T. 3 years	S. 43 years	2

URL: http://dx.doi.org/10.14738/bjhr.1206.19562.

				Extended Systems Overview				
4 days	Urgent cesarean section – amniotic fluid deficiency The fetus does not move	30	Follow-up at the Family Health Station	Nuchal translucency Early Systems Review	Druze Secular	N. 6 years	S. 28 years	3
week	Urgent cesarean section – placental abruption that caused bleeding	28	Follow-up at the Family Health Station Gynecologist follow-up at the HMO	Nuchal translucency Fetal protein Early Systems Review Late Systems Review Genetic Disease Carrier Test Hematologist Consultation	Christian Secular	S. 6 years	K. 31 years	4
3 days	Natural birth – placental abruption	27	Gynecologist follow-up at the HMO	Nuchal translucency Fetal protein Early Systems Review Extended Systems Overview	Muslim Religious	R. 5 years	L. 32 years	5
3 days	Natural Birth	37	Gynecologist follow-up at the HMO	Nuchal translucency Fetal protein Early Systems Review	Muslim	A. 5.5 years	S. 43 years	6
4 days	Cesarean section The surgical scar of the previous pregnancy ruptured and placental abruption	41	Follow-up at the Family Health Station	-----------------	Religious Jew	Y. 12 years	S. 33 years	7
4 days	Vaginal bleeding Pregnancy Rest Cesarean section	26	Follow-up at the Family Health Station	Nuchal translucency Fetal protein Early Systems Review Extended Systems Overview	Jewish Secular	L. 6 years	Y. 24 years	8
3 days	Natural Birth	40	Don't remember	Don't remember	Jewish Secular	Y. 8 years	L. 36 years	9
week	Sudden natural birth	26	High-Risk Pregnancy	Nuchal translucency	Jewish Secular	D. 8.5 years	A. 32 years	10

			Clinic Follow-up Gynecological follow-up at the HMO	Early Systems Review Late Systems Review				
3 days	Natural birth, placenta opened therefore after induction and balloon	38	Follow-up at the Family Health Station Pregnancy Maintenance Slowed intrauterine growth	Nuchal translucency Fetal protein Early Systems Review Late Systems Review	Jewish Secular	E. 9 years	L. 25 years	12
4 days	Cesarean section – there was no opening	42	Follow-up at the Family Health Station Gynecologist follow-up at the HMO	Nuchal translucency Fetal protein Early Systems Review Late Systems Review	Jewish Secular	T. 8 years	Y. 35 years	13
3 days	Natural Birth after induction	40	Follow-up at the Family Health Station Dietitian Follow-up – Gestational Diabetes	Nuchal translucency Fetal protein	Religious Druze	S. 5.5 years	S. 35 years	15
month	Giving petocin – uterine rupture, uterine bleeding, emergency surgery	37	Follow-up at the Family Health Station	Nuchal translucency Fetal protein Early Systems Review Extended Systems Overview	Druze Secular	J. 5 years	M. 27 years M. 38 years	17 18+
week	Cesarean section – slowing down the pulse	40	Follow-up at the Family Health Station Gynecologist follow-up at the HMO	Nuchal translucency Extended Systems Overview	Druze Secular	Y. 6 years	F. 47 years	19
5 days	Planned cesarean section Amniotic fluid deficiency	32	Follow-up at the Family Health Station Pregnancy Rest – 3 Months	Nuchal translucency Fetal protein Early Systems Review Extended Systems Overview	Muslim Religious	B. 6 years	S. 42 years	20
9 days	Emergency cesarean section Premature water drop	38	Gynecologist follow-up at the HMO	Nuchal translucency Fetal protein Early Systems Review Extended Systems Overview	Jewish Secular	B. 4.5 years	H. 43 years	22

week	Cesarean section – premature contractions and developed fever – infection	26	Follow-up at the Family Health Station High Risk Pregnancy Clinic Follow-up	Nuchal translucency Fetal protein Early systems review – private due to a high-risk pregnancy Late system review – not enough	Jewish Secular	N. 11.5 years	T. 46 years	23

Appendix No. 4: Ethics Committee Approval

The Azrieli
Faculty of Medicine
Bar-Ilan University

Wednesday, June 2, 2021

Dr. Limor Maodad Danon
Ms. Faida Barazi
Faculty of Medicine
Bar-Ilan University

Dear Dr. Danon and Ms. Barazi,

I am pleased to inform you that the Ethics Committee of the Faculty of Medicine in the Galilee at Bar-Ilan University has approved the implementation of your research. This approval is conditional upon compliance with the following requirements:

(a) Ensuring participant confidentiality as outlined in the submitted research protocol.
(b) Obtaining signed informed consent from all participants, using the most recent and approved version of the consent form submitted to the committee. It must be clearly explained, both in writing and verbally, that participation in the study is entirely voluntary.
(c) No participation of minors or other special populations is allowed.
(d) Recruitment of participants must not take place within medical institutions, as such institutions fall under the sole jurisdiction of the Helsinki Committee.

This approval is valid for two years from the date of issuance.

Approval No.: 05-2021

Sincerely,
Dr. Miri Bentwich
Chair, Human Research Ethics Committee
Faculty of Medicine, Bar-Ilan University
cc: University Ethics Committee