‘Women’s experience of traumatic childbirth: An interpretative phenomenological analysis’

Carly Ivy Sandercombe

A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Professional Doctorate in Health Psychology

Faculty of Health and Social Sciences, University of the West of England, Bristol

September 2020

Word Count: 26,279

Abstract

Background: It has long been recognised that women may experience trauma as part of the birth process. Up to half of women worldwide report their birth as traumatic, therefore further investigation is a priority. Previous research has focused on women diagnosed with Post-Traumatic Stress Disorder (PTSD) or Postnatal Depression (PND) with a lack of focus giving women without a diagnosis a voice as to why they experienced trauma during childbirth. This study provides an explorative and in-depth understanding of women who experience trauma as part of the birth process who do not have a diagnosis of PTSD or PND.

Methods: Participants were recruited on Facebook and interviews were conducted on Skype. Interpretative Phenomenological Analysis (IPA) was used to explore their subjective experiences of childbirth.

Participants: Six women who had given birth in the last two years, subjectively defined their birth as difficult/traumatic, aged eighteen or above, currently lived in the UK, and did not have a diagnosis of PND or PTSD participated.

Findings: Three superordinate themes were identified: 1) Birth experience as loss which explores participants' feelings of loss which include; loss of fantasy birth, loss of control, and loss of self; 2) Birth as near death which encapsulates the feelings of terror experienced by participants during and after childbirth; 3) Fear of not getting "it" right in the eyes of others which represents an underlying fear of doing something wrong during and after childbirth.

Conclusion: Findings show that for these women there were many factors that contributed towards childbirth trauma which highlights the importance of mothers' subjective birth experience. Women would benefit from better education systems helping prepare them for the realities of childbirth. Health Psychologists can work alongside maternity services to help provide better antenatal education and screening, and care and communication during labour and following birth.

Acknowledgements

I would not have been able to complete this thesis without the help and support of numerous people who have all contributed to its creation and to them I would like to express my gratitude.

First of all, I would like to thank my supervisors' Dr Tim Moss and Dr Toni Dicaccavo for all of the help, support, feedback and guidance they have given me throughout this journey. Their shared interest and passion for my research has been invaluable to me and their continual encouragement has kept me motivated even during times when I have struggled.

I need to say thank you to all my family and friends who have been by my side during this time and watched my progress from the very beginning, almost ten years ago. My mum and dad, my sister Kirsty, and brothers Mark and James who are always there at the end of the phone to listen to me and motivate me. In particular, my sister whose own birth story inspired to undertake this research project. Their continual belief in me and words of encouragement have kept me grounded and for that I am extremely grateful.

A special thanks to my husband, Dan. My deepest gratitude goes to you, you have been by my side and held my hand during not only the good times throughout this process but also the most difficult times. You have shown me patience when I have been at my most stressed and felt like giving up and you have always believed that I could do this. You have supported me emotionally and financially and without your support none of this would have been possible. Your confidence in me has encouraged me to always keep going so thank you.

Lastly, thank you to all the women who took part in this research and for trusting me with your deeply personal stories and taking time out of your busy lives to take part in interviews. Without your openness and trust in me this research would not have been possible, and I hope that this research honours your experiences.

Table of Contents

Chapter 1

Introduction and Literature Review

Rationale for research

My interest in the area of traumatic birth stemmed from my own birth experience back in 2004 when I gave birth to my Son. My labour was not something that I had imagined and in the following days and months I felt 'traumatised' by what I had gone through. I had expectations before the birth that I now realise were perhaps unrealistic and this led to a feeling of disappointment and regret at not being able to have the 'natural' birth that I had envisioned. As I started my journey to becoming a Health Psychologist my interest in this area grew and I was hearing more and more stories of women who had given birth and had felt a sadness because what they had experienced was not what they had been expecting. Through providing psychological therapy through my work as an Assistant Psychologist I spoke with women who were experiencing depression and sometimes signs and symptoms of Post-Traumatic Stress Disorder (PTSD) following giving birth to their child/children. Sometimes help was not sought for years following their birth and this led me to believe that these women were being perhaps being excluded from support and leading them to develop psychological difficulties. I was fortunate that I was able to work with these women and provide support in the form of evidence-based psychological interventions, such as Cognitive Behavioural Therapy (CBT) to help them to recover and come to terms with their birth experiences. Working with these women fuelled my desire to explore this area further and by doing so I hope to fill some of the gaps in the literature and provide recommendations as to how to best support these women following their traumatic birth experiences.

Systematic Review

Although evidence of psychological trauma following childbirth is compelling and there many interventions used to reduce postnatal psychopathology including Eye Movement Desensitization and reprocessing (EMDR) Therapy, debriefing, antidepressants, Interpersonal Therapy (IPT) and Cognitive Behavioural Therapy (CBT) (Dennis & Creedy, 2013) there is little high-quality evidence to support the effectiveness of these interventions. However, cognitive behavioural therapy (CBT) is the recommended treatment for depression and several studies have been conducted looking at its effectiveness, however few have specifically looked at its effectiveness at treating postnatal psychopathology in women who experience trauma as part of the birth process. Therefore, a systematic review (Appendix J) was conducted by the researcher that looked at the effectiveness of CBT interventions for women who had experienced a trauma as part of the birth process. Results from the systematic review found that although CBT treatments could be effective at treating postnatal psychopathology in this population the literature in this area was extremely heterogeneous making conclusions difficult to reach. Further, little information was found with regards to what experiencing birth as traumatic meant to this population and what the women found to be helpful or unhelpful during this time. It is therefore necessary to identify treatments applicable to this patient population and more investigation is needed. Additionally, within the literature there is an assumption that finding birth process as traumatic can result in postnatal depression (PND) or post-traumatic stress disorder (PTSD), however there may also be less visible psychological consequences following a traumatic birth that need to be explored. There have been numerous studies looking at women who have had a traumatic birth and the majority of the current research focuses on symptoms of PTSD, however, women are also vulnerable to postnatal psychological disorders such as depression, anxiety, and attachment disorders (Brockington, 2004). For example, 16% may have anxiety disorders compared to 2% that develop PTSD (Ford & Ayers, 2009) and these women are underrepresented in the current literature. It was therefore decided by the researcher that the aim of this research would be to gain a more in-depth insight into understanding women who report experiencing birth trauma as part of the birth process by taking on a qualitative approach to contribute to the current

literature and broaden our understanding of whether women feel that their needs are being met when they give birth.

It is argued that for women who experience trauma when giving birth, the best intervention is to prevent birth trauma in the first place so that PTSD does not develop. In addition to providing safe care, the basic skills that all healthcare professionals are taught need to come to the forefront with every mother, for example to be caring and to communicate effectively (Beck, 2004). Thus, it is hoped that this research will provide more knowledge about women's experiences of traumatic childbirth which can have a number of implications for healthcare and health psychologists during and after childbirth such as, how to effectively help women and provide the appropriate support and dealing with difficulties to ameliorate the impact of birth trauma. This research will differ from past research that has tended to focus on women with a diagnosis of PTSD. For example, key researchers in this area, such as Susan Ayers, have largely focused on the effects of PTSD and fear of childbirth in relation to PTSD (Ayers, 2007). However, this research is of a more quantitative nature and there is a lack of focus on giving women a voice in which to explore and give insight of how their experience of giving birth has impacted on their psychological health and has contributed to it being perceived as traumatic. It has long been recognised that some women who have reported the birth process as traumatic go on to develop psychological problems (Bailham & Joseph, 2003) therefore this research will include women who have not received any formal diagnosis of postnatal psychopathology, such as PTSD, as women without PTSD symptoms are currently under-represented in the research on traumatic births.

Research Aims

The research aims of this thesis therefore are to provide an explorative understanding of women's experiences of having a birth that they describe as being difficult or traumatic. It further aims to provide an insight of how this may have impacted their psychological health. By giving these women a voice, this research will seek to fill the current gap in the literature that has previously focused heavily on women with a PTSD diagnosis and research using quantitative methodology.

Lastly, this research aims to provide an understanding of the participants' individual, subjective experiences and provide valuable insights for the field of health psychology as well as healthcare practitioners working in the field of maternity care services that will benefit the hundreds of thousands of women who give birth in the UK each year.

Theoretical framework

As a Stage Two Trainee Health Psychologist the theoretical framework of the researcher stems from Health Psychology models and theories such as the biopsychosocial model (Suls & Rothman, 2004). The biopsychosocial model posits that health is shaped by biological, social, psychological, and cultural processes (George & Engel, 1980). Applying this model to illnesses such as heart disease, cancer and depression has gleaned fruitful insights in understanding how psychosocial stress affects immune and inflammatory processes. The physiology of birth involves an interplay between hormones such as cortisol and oxytocin which are known to be affected by socioemotional factors. Thus, existing theories on pain, stress, and social support can be applied to birth. For example, fear and stress can exacerbate the pain of labour, and social support and self-efficacy may reduce it. Additionally, hormones known to influence the progression of labour, such as oxytocin and cortisol, are also linked with psychological phenomena. It is also argued that although there has been a mass of research focusing on psychological functioning during pregnancy and the postpartum period, few studies have examined the psychological experience of childbirth itself (Saxbe, 2017).

The biopsychosocial models differ from traditional medical models, such as the biomedical model, which adopts the notion that all symptoms, including that of pain, are expressions of a discoverable disease process and that there is a definitive connection between pathological changes and clinical features. However, this belief has become the major criterion for discovering disease in Western societies and does not consider behavioural, psychological, and social factors. Clinicians therefore seek out the underlying cause of a symptom by stripping down the body into separate identifiable elements and then search each

element to find an abnormality. Thus, the biomedical approach argues that there is a predictable relationship between change in bodily structure and a person's complaint. When the model is applied to clinical pain it asserts a predictable and linear relationship between identifiable tissue damage and the report of pain, and thus assumes a neurobiologically hard-wired connection between the site of damage and the brain. Therefore, if there is no damage site there must not be any pain, if the pain cannot be localised, the patient's report of pain is at best doubted and at worst not believed. In effect, this privileges the ostensibly objective view of the clinician, which necessarily excludes the sufferer's expertise of their lived experience of pain. This defaults to either dismissal of the patient's complaint or to an inference of "psychogenesis" by the clinician (Quintner et al., 2008, p. 825). Further, qualitative paradigms can offer researchers the opportunity to develop an idiographic understanding of participants, and what it means to them, within their social reality to live with a particular condition or be in a particular situation (Bryman, 1988). Therefore, it can facilitate an understanding of the complexity of biopsychosocial phenomena and thus offers exciting possibilities for health psychology practice (Harper & Warner, 1993). Thus, by approaching this research from a biopsychosocial perspective the participant's whole experience can be captured, not solely their pain, but other factors that may have contributed to the birth becoming a traumatic event. For example, a painful, frightening, or traumatic birth may contribute to women's postpartum distress and contribute or even cause symptoms of depression, anxiety, and PTSD. In contrast, social support and self-efficacy may reduce the discomfort of labour, ease postpartum recovery and help women to adjust to their new lives as mothers.

Thus, to capture women's experiences of having a traumatic birth an Interpretative Phenomenological Analysis (IPA) approach (Smith, Flowers & Larkin, 1996) will be used. IPA will be used to guide analysis as this method is considered to be the most successful at exploring participant experiences with the detailed examination of participants' lived experiences, the meaning of these experiences, and how these are made sense of by participants (Smith, 2011). More discussion as to why IPA was the chosen method of analysis is discussed in more depth in the methodology section within chapter two.

Literature Review

The following literature review firstly explores the historical literature of birth trauma including; how care has evolved since the early 20th century, how women described giving birth historically, the emergence of natural birth vs medicalised births debate, and the psychiatric view of trauma and how it has progressed over time in relation to childbirth. It then outlines the current statistics around traumatic births and defines what is meant by the term 'traumatic birth' and its impact on women's psychological health and the impact it can have on not only the women themselves but their infants and families. The literature review ends by highlighting what support is currently recommended for women who have experienced birth process as traumatic and what support is available for women. By conducting a literature review the researcher demonstrates a critical understanding of the current state of knowledge in the field of traumatic birth.

Historical literature

Investigations looking at trauma during birth and labour date back to as early as the mid-20th century. For example, the literature analysing trauma in mid-twentieth century hospital births describe women typically giving birth in hospital under heavy sedation causing an anaesthetic state referred to as twilight sleep (Michaels, 2017). Scopolamine and morphine were combined to medicate women in labour, and this left many women disappointed with their birth experience (Michaels, 2017). Twilight anaesthesia is an anaesthetic technique where sedatives are used to induce anxiolysis (anxiety relief), hypnosis, and anterograde amnesia (inability to form new memories). Patients are not unconscious but during surgery or other medical procedures are under what is known as a twilight state/sleep. The patient is relaxed and sleepy can follow simple instructions by a doctor and is responsive. However, twilight anaesthesia causes the patient to forget the surgery or procedure and the time right after (Capdevila & Choquet, 2008). Research conducted by Kartchner (1950) interviewed women who experienced twilight sleep during their labour who described feeling a fear that whilst giving birth they had acted in undignified ways such as crying and thrashing about through the drug induced haze. Other women described unmanaged pain

and gruff treatment during labour that left them feeling distressed and disempowered. Further, from the late 1940s through to the 1980s some women were starting to reveal stories of pain and disappointment and feelings of feeling unsupported and uncared for in their greatest moments of vulnerability (Michaels, 2017). Their narratives of trauma in birth revolved around three main themes: abandonment, cruelty, and fear. However, the rise in the late 1960s and early 1970s of the women's liberation movement saw women fighting for a different way of giving birth and resisting traditional pharmacological pain relief became a signifier of women's power and strength. The women's liberation movement, largely based in the United States but also seen in Europe, sought equal rights and opportunities and greater personal freedom for women. The movement coincided with and can be recognised as part of the second wave of feminism whereby women proved less ready to accept their birth trauma as the product of their own psychological shortcomings. Under the sway of second wave feminism, they pushed back against care they defined as inhumane in both conventional maternity care and in natural childbirth. These experiences of birth trauma led directly to the movement for more natural childbirth practices, which pushed for a less interventionist approach than conventional maternity care offered at the time. Supporters sought to avoid the use of pharmacological pain relief that was widespread for middle class, white American women, and their British and French counterparts. Further, reforms in the 1970s saw the introduction of mother-centred and family-centred care, and midwifery made a comeback in the US after having been driven to the brink of extinction. Both in the US and Europe hospitals began to allow fathers into the labour and delivery room and maternity wards were redesigned to provide birthing suites. These changes in hospital-based maternity care were part of women's ongoing quest to eliminate trauma in birth for mother and baby. However, the literature argues that the unchecked pain that sometimes followed a less interventionist approach could also be psychologically damaging to women and these accounts of suffering from both medicalised and natural births were identified not just in the United States but also across Western Europe (Michaels, 2017).

Natural birth versus medicalised birth

In the 1980s and beyond medical innovations and shifting values were starting to erode the appeal of natural childbirth. Epidural anaesthesia was becoming more popular, as it allowed most women to give birth painlessly whilst still being awake and aware, the very thing they sought in natural childbirth (Michaels, 2017). Two polarised camps emerged debating the best way to give birth. Advocates for natural childbirth emphasise the satisfaction and gentleness of their approach and generally support midwife-led, family-centred maternity care. They argue that it is the regimented routines of hospitals that disempower women, exacerbate pain, and incite trauma. However, advocates for in-hospital, anesthetised birth emphasise the damage that long labours can inflict on mothers and their babies. It is argued that the medical establishment tends to focus more on the physical outcome of birth for mother and child, with the quality of the birth as an effective experience being only a secondary concern. These priorities in the physical outcomes of patients are evident in the fact that less than one percent of articles on birth trauma prior to 2017 addressed the topic from a psychological perspective (Simpson & Catling, 2016). However, despite this inattention, advocates of the medicalised model highlight that severe, untreated pain in childbirth can lead to psychological trauma (Tuteur, 2016). Central to these debates is the line between pain and suffering. After the health of mother and baby, labour pain is the biggest concern of women, their partners, and caregivers. Writer, researcher, lecturer, doula, and normal birth advocate Penny Simpkin argues that medical staff promise little or no pain when their medications are used during labour. Further, hospital departments are designed with the key goal of eliminating pain, complete with numerous interventions and protocols to keep the pain medication from causing harm. However, staff believe that pain equals suffering, and this belief is conveyed to women and their partners, and instead of offering support and guidance for comfort, they offer pain medication. Further, if this is the only option available to women then they will take it (Simkin & Hull, 2011). Simpkin (2011) observes “the definition of trauma comes very close to the definition of suffering” (p. 167). Pain can be differentiated from suffering as suffering captures the affective quality that sometimes, though not always accompanies pain. People suffer when pain becomes unbearable, not by the body but by the mind. Thus, childbirth provides a uniquely problematic context between pain and suffering. For example, physician

Eric Cassell (1998) states that there is a direct relationship between pain and suffering whereby the greater the pain the greater the suffering. But childbirth is more complex as pain can be extremely severe but can also be considered uplifting, thus the perceived meaning of pain can influence the amount of medication used to control it. Individuals inject important meaning into the pain of childbirth that for some mitigates the suffering and can even transform it into an emotion of a completely different nature. Therefore, advocates of natural childbirth find meaning of the kind that Cassell describes in the pain during labour and birth. However, proponents of the medicalised model see only senseless suffering that could be alleviated through modern medicine. They describe natural childbirth to a root canal undertaken with no anaesthetic. However, it is argued that research cannot end this debate between natural verses medicalised birth because the polarisation it produces is too powerful (Keirse, 2010; Dahlen, 2011). Advocates for the medical model of birth argue that medicine replaces risky natural processes with technological practices that are better because they introduce human control into the birth process (Mansfield, 2008). However, proponents for natural childbirth object to the interventional bias of contemporary obstetrics (Moscucci, 2002). Additionally, scholars have also analysed nature-society world views associated with natural childbirth, which is seen as actively rejecting the medical model (Cosan, 2001; Thompson, 2005). Thus, medicalised and natural childbirth constructions of childbirth contradict each other (Kurtz, Davis & Browne, 2019). For example, the medical model sees society as improving on nature, while the natural model rejects medical intervention and aims to return to nature (Mansfield, 2008). It appears that there is no ‘in between’ with women choosing a ‘side’ regardless of whether having a natural or medicalised birth is what is best for them or their child.

The psychiatric view

Trauma as a psychological category has a long and complex history that has gradually led towards our present understanding and is evident in the language people use (Michaels, 2017). He asserts that locating in historical records what is identified today as trauma in birth is extremely complex and thus difficult. PTSD only became an official psychiatric diagnosis when it was included in the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1980).

Before this, a variety of terms were used by medical personnel to describe what is understood as its symptoms, such as Kartchner's, an American Psychiatrist, descriptions of his patients' recurring nightmares. There was, to some extent, a shared vocabulary of trauma but psychiatrists and physicians varied the emphasis and inflections. It took twenty years before PTSD was recognised as being potentially relevant to the experience of childbirth. This is believed to be due to the view that birth is normal, natural, safe, and routine for most women and these beliefs have contributed to the medical community's failure to hear some women's attestations of profound suffering. It was only in the early twenty-first century that maternity care researchers began to apply this diagnostic lens to birth experiences and only in the last decade has there been an insurgence of medical research on PTSD and childbirth. However, despite this influx of research and reforms in care women are still experiencing trauma during birth and labour today.

Traumatic birth statistics

Birth experience is multidimensional and there are many factors that can have an impact on a women's physical and mental health. These include fear for self and the infant, medical interference, perception of personal performance, type of delivery, as well as cultural expectations and environmental factors (O'Donovan et al., 2014). Between 20% and 48% of women worldwide report their birth as traumatic (Beck, 2004; Ford & Ayres 2011). For example, Soet, Brack and Dilorio (2003) found that 34% of women reported having a traumatic hospital birth. Furthermore, the experience of having a traumatic birth is unsurprisingly not isolated to one country, but seems to be a worldwide phenomenon, with research on the subject being carried out in the UK, Australia, Canada, the USA, Europe and the Middle East (Beck, 2004; Beck et al., 2011; Boorman et al., 2014; Denis, Parant, & Callahan, 2011; Elmir et al., 2009; Ford & Ayres, 2011; Ionio & Di Blasio, 2014; Taghizadehet et al., 2014).

Defining traumatic birth

Childbirth is a complex life event associated with both positive and negative psychological responses. It is viewed as a common event in society which can mean that it is seen by most people as 'normal' (Ford & Ayers, 2011). Thus, it can

be difficult to understand how it can be classed as a traumatic event for some women and it is suggested that diagnosing PTSD in these women could result in over-pathologising emotional reactions to a seemingly normal event (McNally, 2009). Birth trauma is a subjective experience making it difficult to define in generic terms (Simpson & Catling, 2016). It is therefore described as a personal judgement of a woman's global birth experience that indicates personal satisfaction with the birth process and outcome (O'Donovan et al., 2014). Further, traumatic birth can take place in varying contexts and for many varying reasons, but it is based on the perception of the women experiencing the trauma (Beck, 2004).

What makes a birth experience traumatic?

However, a small number of pregnancies and births do involve events that most people would agree are potentially traumatic, such as stillbirth, life-threatening complications, or undergoing medical interventions without pain relief. It can therefore be assumed that women experience trauma from births that involve surgical intervention, however women can also experience trauma due to previous sexual abuse or assault, pain during first stages of labour, feeling powerless and negative interactions with medical professionals (Soet, Brack & Dilorio, 2003). Additionally, women who have a seemingly normal birth may feel traumatised by aspects such as believing they or their babies will die, feeling violated by intimate examinations, or perceiving hostile or negative attitudes of people around them (Elmir et al., 2010). Thus, to understand traumatic birth, it is important to consider what factors comprise and influence a women's perception of the birth as a whole (Simpson & Caitling, 2016). It is argued that birth experience is multidimensional and can be impacted by a number of factors including; fear for self and the infant, medical interference, locus of control, perception of performance, type of delivery, ability to achieve prior expectations, adaptability when birth expectations are not met, cultural and environmental factors (Sorensen & Tschetter, 2010). Further, it has been found that birth experience is greatly affected by the Quality of Provider Interactions (QPI) which is defined as a care providers verbal and non-verbal behaviours relating to meeting the patient's stated and implied needs, as stated by the patient (Sorensen & Tschetter, 2010). For example, when women perceive their care provider interactions as negative or unsupportive these are considered

low QPI and is correlated to women's experiences of perinatal trauma symptoms and depression. Additionally, perceived low QPI with care providers during labour and birth were found to affect women's long-term memories of negative and traumatic birth experiences (O'Donovan et al., 2014). Thus, it is argued in the literature that although giving birth may appear uncomplicated to care providers, such as doctors and midwives, women can still find the event traumatic if she loses a sense of control or dignity which can arise from hostile or disrespectful interpersonal reactions (Ford, Ayers & Bradley, 2010; Borg Cunen, McNeill & Murray, 2014). Ford and Ayers (2011) have also found evidence that interpersonal interactions with healthcare providers during labour and birth can negatively impact on birth experience. In their research they identified perinatal hot spots that were associated with women reporting their births as negative or traumatic. The category containing the largest number of hot spots in their research was interpersonal difficulties with healthcare providers whereby women most frequently reported feeling ignored, unsupported or abandoned. These women also had the highest levels of anger and conflict which resulted in symptoms of PTSD, avoidance, distress, and impairment. Other intrapartum hot spots that were identified included obstetric events or complications such as emergency caesarean section, neonatal complications, and feelings of a lack of control or intrapartum dissociation. In addition to intrapartum hotspots, antenatal risk factors have been found to influence birth experience. For example, Boorman et al., (2014) state that women who perceive the world as unsafe are more likely to report their birth as traumatic, suggesting a pre-existing mental health morbidity or a prior traumatic event. They identify risk factors for a traumatic birth to include a pre-existing mental health disturbance, primigravidae and caesarean section. The authors noted that while a planned or unplanned caesarean section could be predictive of experiencing a birth as traumatic, only 30% of women who required an emergency caesarean reported their birth as traumatic. They believe that this indicates that other factors may be involved or are influencing their experience of birth as a traumatic event (Beck, 2004).

Birth trauma and impact on psychological health

When childbirth is experienced as traumatic it can have a negative impact on a woman's postnatal emotional wellbeing (Bastos et al., 2015). Negative impact can

include fear for self and the infant, medical interference, perception of personal performance, type of delivery, as well as cultural expectations and environmental factors (O'Donovan et al., 2014). Intense negative responses towards themselves and others and developing dysfunctional coping strategies to cope with flashbacks and nightmares related to their birth have been recorded (Fenech & Thompson, 2014). Furthermore, when women experience birth process as traumatic it can potentially have enduring and lifelong effects for women with regards to their physical and mental health (Greenfield, Jomeen, & Glover, 2016). For example, in the UK, approximately 30% of women define their birth as traumatic and many go on to develop anxiety, depression, postpartum depression (PPD) or PTSD (Slade, 2006; Ayers, 2014). Simpson and Catling (2016) also found that women who reported their births as traumatic felt a profound sense of loss in relation to their experience of birth, motherhood, ideal family and/or sense of self. A range of other symptoms were also reported including sexual dysfunction and intimacy issues, difficulties forming positive attachment with their infant, disruption to family life and suicidal ideation. Another theme that has been identified is a fear of childbirth or secondary tokophobia, which was associated with women deciding not to have any further pregnancies or electing to have a caesarean for future births.

Postpartum Depression (PPD)

Symptoms of PPD start within the postpartum period and can persist during the first year following a traumatic birth (Austin, 2010; Wisner, Moses-kolko, & Sit, 2010). Symptoms of PPD include anxiety (Austin, 2010; Wisner, Moses-kolko, & Sit, 2010), severe nervousness, fear of being alone with the infant, and loss of control (Beck, 1993).

A large study conducted in the UK found that the negative impact of maternal depression on mother-infant relationship led to insecure-attachment style, impaired mental health in the first 5 years of age (Austin et al., 2010; Murray et al., 2010; Murray et al., 1999), low self-confidence and childhood IQ (Murray et al., 1999), inhibited growth and social interactions (Feldman et al., 2009), more baby crying and colic (Paulson, Dauber, & Leiferman, 2006), and high anxiety at the age of 13 years (Halligan et al., 2007). Additionally, it was found that due to the negative mood in mothers and limited interactions they do not have a good

understanding of having a baby and therefore it can take up to three months following childbirth to attach to the baby (Leigh & Milgrom, 2008). Research also shows that few women with PPD receive professional help due to a reluctance in seeking treatment (Terry, Mayocchi, & Hynes,1996).

Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder (PTSD) is characterised by three classes of symptoms: re-experiencing the event through flashbacks, nightmares, and intrusive thoughts; avoiding reminders of the event; and hyperarousal, e.g. being overly alert, jumpy, and irritable (American Psychiatric Association, 2000). There are numerous of models of PTSD in the literature used to enhance our understanding of PTSD that include neurobiological, animal, and cognitive. For example, neurobiological models tend to focus on symptoms but although argued to be important does not capture the brains total response to traumatic events (Ursano et al., 2007). Animal models for PTSD have also played an important role in advancing our understanding of the disease process as well as recovery, resilience, and possible therapeutic targets. However, it is argued that animal models rarely consider that not everyone has a traumatic response following a traumatic response (Ursano et al., 2007). Another model proposed by Ehlers and Clark (2000) is a cognitive model of PTSD that is widely used in the formulation and treatment of PTSD in adult populations. The model suggests that a sense of current threat is produced by negative cognitive appraisals both during and after the traumatic event. This threat, in conjunction with a fragmented and poorly integrated traumatic memory, can be unintentionally triggered by situations that resemble some aspect of the traumatic event. PTSD is then maintained through unhelpful cognitive and behavioural strategies such as thought suppression and reminder avoidance strategies. These strategies are used to control the sense of threat/symptoms; however, they can directly produce symptoms and/or prevent change in negative appraisals or the nature of trauma memory. There is evidence that supports the utility of the cognitive model in understanding and treating PTSD in adults but the qualitative difference between childbirth and what we traditionally consider to be a traumatic experience (for example, threat to life during war) needs to be considered when evaluating its applicability to this population. Another cognitive theory, Dual representation theory, was proposed by Brewin et al.,

(1996) and is based on multiple memory systems. According to this theory, memories of a personally experiences traumatic event can be of two distinct types, stored in different representation formats: verbally accessible memory (VAM) and situationally accessible memory (SAM). However, it argued that although research into PTSD following childbirth is increasing and risk factors are becoming clearer, a strong theoretical basis (Brewin & Holmes, 2003) in the literature is lacking and therefore there is limited understanding of the postnatal factors that may help to maintain traumatic stress responses.

PTSD was first listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 (American Psychiatric Association [APA], 1980) and Vietnam War veterans were the first individuals to be identified as experiencing PTSD. For a diagnosis of PTSD, THE DSM-III criteria required an event considered beyond the range of usual human experience. Presently, the DSM-IV gives an expanded view of what constitutes an extreme traumatic stressor and the definition has been broadened to include “direct personal experience of an event that involves actual or threatened death or serious injury, or a threat to the physical integrity of self or others” (APA, 1994, p. 424). However, the DSM-IV does not specifically identify childbirth as an example of an extreme traumatic stressor (Beck, 2004). To date, most research around childbirth has concentrated on the prevalence and causes of postnatal PTSD. However, diathesis-stress approaches to mental health emphasise that whether a woman develops chronic postnatal PTSD is influenced by pre-existing vulnerability and beliefs, the events of birth, and postnatal factors such as additional stress, support, and the meaning attached to the events of birth and symptoms (Ayers, 2004). Research supports this approach and suggests that postnatal PTSD is associated with a previous history of trauma, history of psychological problems and events during birth such as type of delivery (Ayers 2004). When applying PTSD to childbirth it is important to differentiate between PTSD (where diagnostic criteria is met), appraisal of birth as traumatic, and a traumatic stress response. Appraisal of birth as traumatic is when women consciously label their experience of birth as “traumatic” although they may not have any psychopathology associated with it. A traumatic stress response is where women have re-experiencing and/or avoidance symptoms, particularly in the first six weeks, but do not fulfil all the diagnostic criteria for PTSD (Ayers, 2004).

Research shows that PTSD can affect women who have experienced trauma during the birth process, with approximately 4% of women meeting the diagnostic criteria for PTSD following a traumatic birth (Yildiz et al., 2017). Further, the rates of traumatic birth and PTSD may also be more prevalent in low and middle-income countries (Fisher et al., 2012). Several studies have attempted to identify aspects of childbirth associated with Post-Traumatic stress (PTS) symptoms; however, findings are inconsistent. For example, some studies link assisted vaginal delivery (forceps) and emergency caesarean section to related symptoms of PTS (Creedy, Shochet, & Horsfall, 2000; Maclean, McDermott & May, 2000; Soderquist, Wijma & Wijma, 2002). However, other studies have found no relationship between the type of delivery and subjective distress (Skari et al., 2002) or PTS symptoms (Ayers, 1999; Czarnocka & Slade, 2000). Other factors, such as pain and medical interventions have been associated with appraisal of birth as traumatic but not with the development of PTS symptoms (Soet, Brack & Dilorio, 2003). Thus, evidence for the effect of birth events is inconsistent and there is accumulating evidence that an individual's perception of a health event is more important than the objective severity in determining a traumatic response (Tedstone & Tarrier, 2003).

Beck et al., (2011) examined the risk factors for the development of postpartum PTSD. They found that women who had unplanned pregnancies, had no health insurance, were pressured to have their labour induced or use epidural analgesia in labour, had a caesarean section, did not breastfeed as long as desired, had less partner support postpartum and developed increased physical problems after birth were found to be at increased risk of developing PTSD symptoms in the postpartum period. Additionally, Denis, Parant and Callahan, (2011) found that a lack of coherence between the actual birth event and the anticipated birth, excessive feelings of loss and control, previous experience of trauma and the type of postnatal care the women received also increased the risk of developing postnatal PTSD. Ford and Ayers (2011) also found that a lack of control during labour was a risk factor for developing PTSD. They found that women with a history of trauma were particularly vulnerable to the effects of low support levels and particularly if they underwent high levels of obstetric intervention. Research suggests other risk factors associated with PTS symptoms in the postpartum period include depression during pregnancy and the number of interventions

during labour and birth, however the association between obstetric intervention and PTS symptoms in general has been argued to be weak (Beck, 2004).

Birthplace in relation to birth trauma has also been studied. Stamrood et al., (2011) conducted a cross sectional study that looked at the impact of place of birth on rates of postpartum PTSD. They found no evidence of a difference in PTS symptoms between women planning to give birth at home and women planning a hospital birth but found that women who gave birth in either secondary or tertiary hospitals were more likely to report their births as being worse than expected or traumatic. Higher scores for PTS symptoms were also reported for women who were transferred from home to hospital during labour, experienced severe labour pain, had high risk pregnancies, were induced and women who either had an emergency caesarean section or instrumental delivery.

In addition to birthplace and intrapartum events being linked to PTSD, predicting PTS symptoms has been studied. O'Donovan et al., (2014) conducted a prospective longitudinal study in Australia that surveyed 933 women in the antenatal period. They examined predictive factors of birth-related trauma and development of postpartum PTSD and found fourteen variables that significantly differed between women who developed postpartum and those who did not. Seven of these variables were related to previous traumatic events that the participants had experienced. Therefore, the authors concluded that the most important predictive factor in the development of postpartum PTSD was a prior traumatic life event.

PTSD following birth is associated with adverse outcomes in women such as a greater risk of depression (Shahar et al., 2015), problems with parent-infant relationship (Davies et al., 2008), and marital difficulties (Ayers, Eagle & Waring, 2006), which are likely to prolong and impede recovery. A meta-analysis of 50 studies that looked at the risk factors for PTSD after birth found that antenatal depression, fear of childbirth, prior PTSD, negative birth experience, lack of support and postpartum depression contribute to the susceptibility of birth related PTSD (Ayers et al., 2016). Among the studies that have been conducted there are reports that there is a decline in the prevalence of PTSD over time suggesting that some women recover during the first months after birth (Haagen et al.,

2015).However, other studies have found the persistence or exacerbation of PTSD symptoms across time and specify chronic PTSD (Alcorn et al., 2010; Zaers, Waschke, & Ehlert, 2008). New-onset PTSD cases following a traumatic birth have also been observed (Alcorn et al., 2010). These studies indicate a substantial variation in PTSD outcomes among women who experience a traumatic birth (Dikmen-Yildiz, Ayers & Phillips, 2018).

Research conducted by Dikmen-Yildiz, Ayers and Phillips (2018) identified four longitudinal trajectories of PTSD after birth: resilience, recovery, chronic PTSD, and delayed PTSD. It is argued that PTSD risk and recovery are highly dependent on social phenomena (Charuvastra & Cloitre, 2008) as evidence suggests that support can buffer the effect of stress and that interpersonal traumas are linked to poorer outcomes than non-interpersonal traumas (Kessler et al., 2005). For example, a meta-analysis of risk factors for PTSD following a range of traumatic events found that the strongest predictor of PTSD symptoms was a lack of support (Brewin, Andrews, & Valentine, 2000). Additionally, research on PTSD following childbirth has found similar evidence for a link between social risk factors and PTSD. Studies that have examined women's perceptions of care and support during birth have found associations between PTS symptoms and poor interaction with medical personnel (Soet, Brack & Dilorio, 2003), inadequate intrapartum care (Creedy et al., 2000), low staff and partner support (Czarnocka & Slade, 2000), feeling poorly informed and not listened to (Czarnocka & Slade, 2000), inadequate contact with staff (Wijma, Soderquist, & Wijma 1997), and low perceived and desired support or help (Cigoli, Gilli, & Saita, 2006; Maggioni, Margola, & Filippi, 2006). Evidence also suggests that support during birth may have a greater effect on women's emotional response than the severity of events (Ford, Ayers, & Wright, 2009). For example, experimental studies have suggested that there are better physical outcomes for both mother and baby, less pain, higher maternal satisfaction with the birth experience and less depression after birth when additional support during birth is provided (Hodnett et al., 2003; Sauls, 2002). This is supported by research conducted by Ford, Ayers, and Bradley (2010) who investigated the application of a cognitive model to PTS symptoms following childbirth and explored the addition of social support to the model. Results supported the hypothesis that early postnatal social support explained longer term

symptoms of PTSD and postnatal social support appeared to be more influential in determining symptoms than Post-Traumatic cognitions.

Women who experience a traumatic birth are predicted to develop PTSD, however they are more likely to develop depression and postpartum psychiatric problems (Gill et al., 2008). Research has identified that one of the differences between Post-Traumatic stress and postpartum depression (PPD) is that depression can be developed without a sudden traumatic event in the mother and it is not necessarily the result of giving birth, although perinatal complications can be one of the risk factors (Blom et al., 2010).

Impact of traumatic birth on women, infants, and families

Birth trauma can have a devastating effect on women and their families. Postpartum PTS symptoms have been linked to negative changes in social and family relationships, including a moderate link between parenting distress, difficulties with mother-child interactions and childbirth related trauma (McDonald et al., 2011). Qualitative studies have also highlighted the extreme consequences that postnatal PTSD can have on women (Elmir et al., 2011; Taghizadeh et al., 2014). For example, Elmir et al., (2011) conducted a meta-ethnographic study reporting women's perceptions and experiences of traumatic birth. Qualitative papers were included that had interviewed women with experiences of traumatic birth. Ten studies were included in the final sample. Eight studies included in the synthesis were designed as in-depth qualitative studies that focused on the experience of birth trauma. Two (Allen, 1998; Ayers, 2007) had a survey design with a larger sample and incorporated a qualitative component using semi-structured interviews. All 10 researchers had collected data from interviews with women, however one study by Nicholls and Ayers (2007), included both women and their male partners. The study conducted by Nicholls and Ayers (2007) aimed to look at the experience and impact of childbirth-related PTSD in women and their partners. Qualitative interviews were used to study six couples whereby at least one partner had clinically significant symptoms of childbirth-related PTSD. Results were analysed using thematic analysis and found several themes including effects on relationship with partner, effects on relationship with child, and quality of care. The authors suggest that PTSD may have a negative impact on the couple's

relationship and the parent-baby bond. However, this study only included participants who had clinically significant symptoms of PTSD and thus individuals who had not been screened for PTSD symptoms but who suffered a traumatic birth may have been excluded. Another study included in the meta-ethnography conducted by Thompson and Downe (2008) aimed to explore the lived experience of, and personal meanings attributed to, a traumatic birth. The authors used an IPA approach based on Heideggerian and Gadamerian hermeneutics. Fourteen women who had experienced a self-defined traumatic birth were interviewed. Results found that trauma was not related to mode of birth but rather to inter-personal relationships with caregivers. It was concluded that their findings exposed commonalities between some descriptions of traumatic birth, and victims accounts of violent or abusive criminal offences, even in cases where the birth was clinically normal. In total the meta-ethnography identified five themes; feeling invisible and out of control, to be treated humanely, feeling trapped: the recurring nightmare of my childbirth experience, a rollercoaster of emotions, disrupted relationships, strength of purpose: a way to succeed as a mother. Women developed emotions of anger, disappointment, and a sense of loss after a traumatic birth and this was overwhelmingly due to the poor and unsupportive care that they received from midwives, nurses, and doctors. They described disconnecting from their partners and infants and experiencing symptoms of depression which included suicidal ideation. The authors also argued that having a traumatic birth not only impacted on the women themselves but also on their infants and children. They noted that women with poor mental health often had poorer cognitive functioning, physical, psychosocial, emotional, and behavioural disturbances, and impaired language functioning. The meta-ethnography gives further insight into what the experience of having a traumatic birth is like and its implications. Qualitative synthesis is increasingly becoming more common and meta-ethnography is one of several methods for synthesising qualitative research and is being used increasingly within health care research. However, it is argued that there are many aspects of the steps in the process that are ill-defined (Atkins et al., 2008). Additionally, although combining the findings of studies using qualitative approaches appears to be a worthwhile exercise, the nature of qualitative research raises challenges for its evaluation and synthesis (Barbour & Barbour, 2003). Key issues include the differing philosophical assumptions underpinning studies within the interpretivist paradigm, such as those drawing on

phenomenological or ethnographic approaches, and whether or how to synthesize the findings of such studies. Concerns have also been expressed regarding the loss of explanatory context when the findings of multiple studies are combined, particularly given the importance of context in the analysis and interpretation of qualitative data. Further, whether and how to critically appraise qualitative studies included in a synthesis is also argued to be problematic. Some authors suggest that this imposes a positivist approach to 'quality' on studies conducted within a very different tradition (Barbour, 2001). However, assembling the findings of multiple primary qualitative studies using a systematic process may have several additional benefits. For example, they may help to generate more comprehensive and generalisable theory; they may add greater breadth and depth to existing systematic reviews of effectiveness by focusing on the views of those towards whom the interventions are directed (Thomas et al., 2004); or they may provide insights into the reasons why interventions succeed or fail (Harden et al., 2004). In doing so, reviews of qualitative studies may usefully inform the implementation of interventions and programmes.

Further support for the findings from Elmir et al., (2011) has come from research conducted by Ionio and Di Blasto (2014) who examined the impact of postpartum PTS symptoms on early mother-child interactions. It was found that women with higher rates of PTS symptoms two months following their birth displayed more intrusive behaviours with their infants during play phases which included reducing typical interaction distances and touching their child more often to try and build a relationship through physical contact. The infants in response to women with higher rates of PTS symptoms showed less interest in nearby objects and more avoidance behaviours that included physically distancing themselves from their mothers. It is noted that this research was limited in that there was a small sample of participants, only 19, however the results emphasised the importance in the early management of postpartum PTS symptoms so that improvements in maternal mental health can be made to reduce the negative impact of these symptoms on mother and infant bonding.

Support services for women who experience birth as traumatic

The need to prevent and protect women from poor mental health is a national priority (Public Health England, 2016). Postnatal debriefing services were introduced in the 1990's as a way of reducing psychological morbidity following a traumatic/difficult birth (Thomson & Garrett, 2019). These services were introduced following key reforms, such as the *Changing Childbirth* report (Department of Health, 1993) which led to maternity services becoming accountable for care quality, and an associated consumer movement whereby women could demand services outlined in government charters (Smith & Mitchell, 1996). Thus, debriefing services offered the promise to help women resolve adverse responses associated with childbirth as well as offering an important risk management tool to resolve complaints and minimise litigation claims (Smith & Mitchell, 1996). Further, a meta-ethnographic literature review conducted by Baxter, McCourt, and Jarrett (2014) found that women valued the opportunity to discuss their birth experience and validate their feelings. However, midwives are not trained counsellors and questions were raised regarding the feasibility of developing appropriate training for midwives to provide debriefing services to women due to the depth of emotional exploration required. Further, postnatal debriefing was originally based on structured psychological interventions such as critical incident debriefing (Mitchell, 1983; Parkinson, 1997) that were designed to reduce psychological adversity following traumatic events, such as natural disasters. However, it is argued that there is a lack of clarity as to what constitutes postnatal debriefing (Ayers, Claypool, & Eagle, 2006). For example, psychological debriefing is highly structured where thoughts, facts and feelings are processed to facilitate emotional processing and prevent PTSD onset (Ayers, Claypool, & Eagle, 2006). However, postnatal debriefing tends to be delivered in a less structured way and there is less clarity in its content. It usually involves a one-off meeting between the woman and a health professional (often a midwife) and usually happens early in the postnatal period. Its aim is to help a woman understand what occurred during her labour and birth (Ayers, Claypool, & Eagle, 2006; Baxter, McCourt, & Jarrett, 2014). There have been several experimental studies assessing the effectiveness of postnatal debriefing interventions on postnatal morbidity. For example, a recent Cochrane review identified seven randomised control trials conducted between 1998-2005 in high-income settings (Bastos et al.,

2015). A wide heterogeneity in the trial designs and low-quality evidence meant that no clear evidence for the effectiveness of postnatal debriefing was found (Bastos et al., 2015). Due to the lack of clear evidence in this area, the current postnatal guidelines in the UK do not recommend formal debriefing and rather that women should be offered the opportunity to talk about their birth and ask questions about their care (Holme, Boullier, & Harrison, 2016). Therefore, considering the link between traumatic birth experience and unsupportive midwifery, nursing and obstetric care, it is argued that maternity health professionals should receive training on the provision of adequate support and effective communication for women during their labour and birth (Bastos et al., 2015).

By highlighting these issues, it is crucial that more research is conducted to explore ways in which to improve the services available to this population. More insight as to what constitutes a traumatic birth is needed and as much of the research conducted to date has looked at women with a diagnosis of PTSD there is a hidden population of women without a diagnosis of PTSD but who still experienced a traumatic birth in which to draw more insight into this issue. Therefore, this research will expand on previous research in this area by providing in-depth accounts of this hidden population of women without a diagnosis of PDD or PTSD who have had a traumatic birth using qualitative methods to allow for the exploration of their individual experiences and give them a voice that can help us to understand how to prevent traumatic births from occurring, provide the appropriate support, and deal with difficulties to ameliorate the impact of birth trauma.

Chapter 2

Methodology

This chapter outlines the methodological foundations of the research. It describes the research aims and design and gives a rationale for the use of the qualitative approach of Interpretive Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009). This is followed by the method used to carry out the research. The final part of this chapter includes a reflection on the researcher's positionality within the research.

Research question

'Women's experience of traumatic childbirth: An interpretative phenomenological analysis.'

Rationale for qualitative approach

Qualitative research is a rich, diverse, and complex field (Madill & Gough, 2008) and is not about testing hypotheses and not generally about seeking comparisons between groups. Rather, it argues it should not be assumed that there is only one correct version of reality or knowledge and instead argues that there are multiple versions of reality, even for the same person, and that these are very closely linked to the context in which they occur (Braun & Clarke, 2013). Qualitative research allows access into people's subjective worlds and meanings and to groups that are often marginalised and often invisible in western psychology, it can 'give voice' to a group of people or issue, provide a detailed description of events or experiences and can be used to develop theory (Braun & Clarke, 2013). Exploring the lived experiences of women who have undergone trauma as part of the birth process is the central focus of this research and therefore is suited to a qualitative approach. Further, qualitative research is more flexible and can allow for the discovery of 'realities' and the creation of knowledge that is translated through meaning making processes, between individuals or through intersubjectivity (Willis, 2001) which is in line with the researcher's social constructionist epistemological position. Additionally, qualitative research is more

suitable for trying to understand people's meanings as it can be open-ended, organic, exploratory, and flexible. It is well suited for under explored areas as it can provide new knowledge and understanding that can be lost using quantitative methods (Braun & Clarke, 2013). Thus, using a qualitative design will allow for a richer and more descriptive understanding of how women's experiences of trauma as part of the birth process may impact their wellbeing, whether they feel that their needs were met and what interventions they believe would have been beneficial for them as well as helping to provide new knowledge in this area. Furthermore, IPA will be used to guide analysis as this method is considered to be the most successful at exploring participant experiences with the detailed examination of participants' lived experiences, the meaning of these experiences, and how they are made sense of by participants (Smith, 2011).

Quality in qualitative research

Yardley (2000) outlines four broad principles for assessing the quality of qualitative research; sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance:

Sensitivity to context argues that IPA researchers begin to demonstrate sensitivity to context in the very early stages of the research process. For example, the act of choosing IPA as a methodology and the rationale for its use, is centred upon the perceived need for sensitivity to context through close engagement with the idiographic and the particular. Sensitivity to context is also displayed through an appreciation of the interactional nature of data collection within interview situations. Yardley states that facilitating a good interview requires skill, awareness, and dedication. For example, to collect good data the researcher must have a good awareness of the interview process, be able to show empathy, put the participant at ease, recognise interactional difficulties, and negotiating the intricate powerplay where research expert meets experiential expert. If a researcher can successfully meet this criterion, they will have shown a good sensitivity to context. Sensitivity to context can also be evident in the final write up as it is argued that good piece of IPA research will be sensitive to the data. A final report will have a considerable number of verbatim extracts from the participants' material that can support any claims that are made giving the participants a voice

in the project and allowing the reader to check the interpretations being made. Further, a good IPA is written carefully and makes interpretations that are appropriate to the sample under investigation. These interpretations are presented as possible readings and more general claims are offered cautiously. Additionally, researchers can also show a sensitivity to context through an awareness of the existing literature and this in turn can be either substantive or theoretical. Substantive relates to the topic under investigation and is theoretical to the underpinnings of the research method itself. In IPA, the relevant substantive literature is used to help orient the study and the findings should always be related to the relevant literature in the discussion.

Commitment and rigour - Commitment is a criterion which again can be demonstrated in several different ways. With IPA there is an expectation that commitment will be shown in the degree of attentiveness that is given to the participant during data collection and the care with which the analysis of each case is carried out. Thus, it is argued that to conduct an in-depth interview using IPA methodology considerable personal and commitment is required of the researcher to ensure that the participant is comfortable and that they are attending closely to what the participant is saying. Rigour refers to the thoroughness of the study, the appropriateness of the sample to the question in hand, the quality of the interview and the completeness of the analysis undertaken. Therefore, a sample needs careful selection so that it matches the research question and is reasonably homogeneous. Additionally, conducting a good interview demonstrated good rigour and commitment. A balance of closeness and separateness needs to be achieved as well as being consistent with one’s probing, picking up on participant cues and digging deeper. Thus, it is important that the researcher engages in training and supervision to ensure that qualitative psychology is done rigorously.

Transparency and coherence - Transparency refers to how clearly the stages of the research process are described in the write up of the study. This transparency can be further enhanced by carefully describing how participants were selected, how the interview schedule was constructed and how the interviews were conducted as well as what steps were used in the analysis. To assess for coherence several questions can be asked such as: Does it present a coherent argument? Do themes fit together logically? Are ambiguous or contradictions dealt

with clearly? Yardley also suggests that coherence also refers to the degree of fit between the research which has been done and the underlying theoretical assumptions of the approach being implemented, the research needs to be consistent with the underlying principles of IPA.

Impact and importance - The final quality criterion is that of impact and importance. Yardley (2000) argues that however well the research is conducted, a test of its real validity lies in whether it tells the reader something interesting, important, or useful.

Why IPA?

Grounded theory focuses on building theory from data and, because of its sociological origins, there is an emphasis on understanding social processes, analysis is organised around key categories (Braun & Clarke, 2013). However, due to the nature of this research that is looking at participant experiences of trauma as part of the birth process this method is not considered suitable. Another qualitative method is that of thematic analysis which is used to identify themes and patterns of meaning across data in relation to a research question (Braun & Clarke, 2013). However, in this instance IPA is considered to be a more suitable approach as it is argued to be an intensive fine grained, idiographic analysis, which prioritises the experiential claims of individuals, provides rich and contextualised accounts that can perhaps flesh out the more general claims described via conventional thematic analysis (Kearney, 2001). Lastly, discourse analysis is a qualitative method used to analyse text that makes interpretations based on both the details of the material itself and the contextual knowledge (Braun & Clarke, 2013). However, IPA considers language in a fundamentally different way from discursive studies. The post structuralist and social/cultural constructionist underpinnings of discursive psychology places an emphasis on the effects of language and discourse and what can be accomplished through talk and text (Willig, 2012). From this perspective, discursive researchers are interested in how people talk about and construct their experiences, however IPA subscribes to a more expressive ontology that views people as existential world-disclosers in a world of situated concerned involvement, rather than epi-stemic world constructors (Yancher, 2015).

Research design

The interview questions focus on the lived experiences of women who describe trauma as part of the birth process. It explores how these women made sense of their experiences and will be inductive in its approach as this allows for the generation of new perspectives and knowledge with no pre-existing hypothesis (Braun & Clarke, 2013).

It was agreed between the researcher and the researcher's supervisor that the sample size in this study would be relatively small, between six and eight women, as recommended by Turpin et al., (1997) as a number suitable for IPA studies conducted for clinical psychology doctoral programmes in the UK. This is because a main concern in IPA is to give full appreciation to each participant's account. Additionally, it is inappropriate to use a large sample size as the aim is to produce in depth examination of certain phenomena and not to generate a theory to be generalised to a whole population. Further, although there is no set rule for the number of participants in an IPA study, the number will generally depend on; 1. The depth of analysis of a single case study, 2. The richness of the individual cases, 3. How the researcher chooses to compare or contrast single cases, and 4. The pragmatic restrictions the researcher is under (Pietkiewicz & Smith, 2012).

My research paradigm

IPA focuses on exploring people's lived experiences and the meanings in which they attach to those experiences (Braun & Clarke, 2013). Phenomenology, one of the theoretical foundations of IPA, is a philosophical approach to the study of experience (Smith, Flowers & Larkin, 2009). It focuses on what the experience of being human is like in all its various aspects, but particularly in terms of things that matter to us and which constitutes our lived world. Many phenomenologists are committed to thinking about how people might come to understand what our experiences of the world are like. One key value of phenomenological philosophy for psychologists is that it can provide us with a rich source of ideas about how to examine and comprehend lived experience. IPA is generally concerned with the 'person in context' or 'being in the world' (Larkin, Watts, & Clifton, 2006). It is

based on the premise that individuals are self-reflective, self-interpretative beings and that we have experiences that we reflect on and attempt to make sense of.

One of the key phenomenological philosophers, Husserl, was interested in identifying the means by which someone may come to accurately know their experience of a given phenomenon and would do so with a depth and rigour which would allow them to identify the essential qualities of that experience. Husserl argued that if this could be achieved then these essential features of the experience could transcend the particular circumstances of their appearance and thus illuminate a given experience for others (Smith, Flowers & Larkin, 2012). Husserl's phenomenology means 'stepping out' of our everyday experience and taking on a phenomenological attitude involves and requires a reflexive move. For example, we can turn our gaze away from objects in the world, and direct it inwards, towards our perception of those objects. Therefore, he states that in everyday life people are so busily engaged in activities in the world that they can be taken for granted. Husserl's work establishes the importance and relevance of a focus on experience and its perception (Smith, Flowers & Larkin, 2012).

Later, Heideggar, Merleau-Ponty and Satre, other key phenomenological philosophers, develop his work further and contribute to a view of the person as embedded and immersed in the world of objects and relationships, language and culture, projects, and concerns. They move us away from the descriptive commitments and transcendental interests of Husserl, towards a more interpretative and worldly focus on understanding the perspectival directedness of our involvement in the lived world - something which is personal to each of us, but which is property of our relationships to the world and others, rather than creatures in isolation. Through the work of these leading figures in phenomenological philosophy researchers have come to see that the complex understanding of 'experience' invokes a lived process, an unfurling of perspectives and meanings, all of which are unique to the person's embodied and situated relationship with the world (Smith, Flowers & Larkin, 2012).

However, IPA also acknowledges that researchers cannot access the world directly and that they also make sense of the participants' world using their own interpretative resources (Braun & Clarke, 2013). Thus, this links the researcher's

phenomenological approach with social constructionism whereby IPA involves a dual interpretative process, referred to as a ‘double hermeneutic’, whereby the researcher is trying to make sense of a participant trying to make sense of their world (Smith et al., 2009). Tuffour (2017) argues that the uniqueness of the qualitative inquiry is its experiential understanding of the complex interrelationships among phenomena and its direct interpretation of events. Thus, there is an emphasis to seek and explore the patterns of unanticipated and expected relationships in cases or phenomena. To achieve this, researchers must exercise their subjective judgement whilst making it visible as to how their preconceptions shape the knowledge produced through personal reflexivity in a form of self-analysis and self-evaluation during the research. Thus, the researcher recognises that her preconceptions can shape the research produced and her influence is discussed through a reflexivity thinking section at the end of this chapter.

Method

Design

In this IPA research a purposive sample of 6 women were recruited to participate in semi-structured interviews. The small number of participants in this study could be critiqued. However, participants were selected on the basis that they could grant the researcher access into their perspectives on the phenomenon under study, having experienced trauma when giving birth. That is, they 'represent' a perspective rather than a population. The primary concern of IPA is to give a detailed account of individual experience. Smith, Flowers and Larkin (2009) argue that the issue is quality, not quantity, and given that human phenomenon is complex, IPA benefits from concentrated focus on a small number of cases. The interviews were video recorded on SKYPE, transcribed verbatim and analysed using IPA (Smith, Flowers & Larkin, 2009).

Ethical approval

Before starting the research, the researcher completed an application for 'ethical review of research involving human participants' which was sent to the Faculty Research Ethics Committee (FREC) for review. The information was then sent to the Chair of the Committee who made a decision based on the information provided. Ethical approval for this research was granted by FREC on the 4th of July 2018 (Appendix A – Ethical Approval).

As this research would be generating personal data, in order to be granted ethical approval, the researcher had to make steps to maintain the anonymity and confidentiality of all participant data collected. Under the EU General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018, which governs the processing of personal data in the UK (The University of the West of England, 2019), the researcher had to ensure that she met these requirements. Although the new legislation has not been specifically designed for research purposes it is important that researchers understand what GDPR means for them and the personal data that is processed during their research. Therefore, the researcher completed an online training programme that was designed to help

businesses and individuals understand the importance of data protection legislation and how to comply with the regulations (Appendix B). This allowed her to become familiar with the requirements, such as how to securely store personal data, ensuring that consent is given for the use of personal data, and how to protect participant anonymity.

Participants

Process of recruitment

The researcher, firstly, used a form of active recruitment whereby researchers approach and interact with specific individuals with the aim of enrolling them in research by visiting a mother and baby group local to her and handing out recruitment flyers. However, this was unsuccessful, therefore a different method of recruitment was required and it was agreed between the researcher and her supervisor to post a recruitment flyer on a variety of parenting groups on the social media platform Facebook (Appendix C – Recruitment Flyer) as social media recruitment techniques have shown effectiveness for hard to reach populations (Gorman et al., 2014). The flyer contained a brief outline of the research study, information about the researcher and the researcher's contact details.

Facebook was chosen as a recruitment tool as it offers a platform for connecting and sharing interests and information whilst also allowing users to maintain physical separation and a degree of anonymity (Gelinas et al., 2017). Further, social media is emerging as a promising way to recruit and identify participants for research (Gearhart, 2015). Using social media for this purpose enables researchers to reach wider segments of the population that may not otherwise be accessible and to target individuals based on personal information and infer their eligibility for particular studies. However, despite its growing popularity as a research tool, there are no specific regulatory guidelines and few resources to guide researchers using this method. This can be problematic as navigating social media recruitment requires applying legal and ethical norms sensitively in a context that researchers may not be familiar with. Therefore, the researcher followed recommendations as set out in Gelinas et al., (2017) paper which

discusses ethical issues and recommendations for using social media as a recruitment tool (Appendix K).

Sampling and participants

Six women participated in this study. The inclusion and exclusion criteria is listed below:

Inclusion criteria

1 – Participants had to have given birth in the last two years.
2 - Subjectively define their birth as having been difficult/traumatic.
3 - Be aged eighteen or above.
4 - Currently live in the UK.
5 – Speak English fluently.

Exclusion criteria

1 – Participants were excluded if they reported a clinical diagnosis of postnatal depression (PND).
2 – Participants were excluded if they reported a clinical diagnosis of posttraumatic stress disorder (PTSD).

This sample was in line with recommendations from Smith et al., (2009) who state that researchers should select participants from a fairly homogenous sample, for whom the research question will be meaningful. The sample was not homogenised beyond this as the researcher did not hold any assumptions about the participants backgrounds or experiences.

Participants ranged in age from 23 to 36, with a mean age of 31, and all identified their birth as being difficult but had not received a diagnosis of postnatal depression or PTSD following the birth of their child. All identified as being white British and were currently living in the UK. They had all accessed higher education, and all were in employment except for one who identified as being a ‘stay at home mother’. All the women were married, except for one who identified

as being single and all had one child except for one who had four. All the women had given birth in hospitals in the UK and self-identified as not having a clinical diagnosis of PTSD or PND.

Table 1
Participants' Demographic Information

Participant Level	Age	No: of children	Marital Status	Ethnicity	Employment Status	Education
Delyth	23	1	Married	White/British	Employed	Higher
Charley	36	1	Married	White/British	Employed	Higher
Julie	35	4	Married	White/British	Unemployed	Higher
Olivia	33	1	Married	White/British	Employed	Higher
Amy	27	1	Single	White/British	Employed	Higher
Sarah	35	1	Married	White/British	Employed	Higher

Data collection

Interview schedule

Semi structured interviews were used to collect the data for this research. Semi structured interviews offer a unique flexibility as although they are sufficiently structured to address specific research questions, they also leave space for the participants to offer new meaning to the topic being studied (Galletta, 2013).

The researcher prepared an interview schedule before the interviews were conducted that contained an opening question, a series of open-ended questions and some closing questions (Appendix G). The aim of developing an interview schedule was so that the researcher could facilitate a comfortable discussion with the participant and thus allow them to provide a detailed account of the experience under investigation (Smith et al., 2009). When constructing the interview guide, a funnelling technique was used as this allowed for more general responses to be given at the start of the interview before moving on to more specific research questions. Smith et al., (2009) recommend that interviews should start with a question that encourages the participant to describe a fairly descriptive event to allow them to quickly become comfortable talking. Therefore, the first question used was "can you tell me about when you found out you were pregnant?",

allowing the participant to describe in depth a descriptive event and become comfortable in the interview setting. Once the interview schedule was developed the researcher received informal interview training with her supervisor. The interview was then piloted with one participant who identified as having a difficult birth and was identified by the researcher as being suitable for the pilot interview.

Interview schedule

Introductions – give consent form and explain study

Question 1 – Can you tell me about when you found out that you were pregnant?
Prompts
How did you feel?
What emotions did you experience?
What surprised you about how you felt?
Was your reaction one that you expected?

Question 2 – Can you describe your experience of giving birth?
Prompts
Before the birth/labour
Who was with you?
How did you feel like when you went into labour?
Were you offered any support during your labour – what type of support?
What did you find helpful during the labour? Do you have any examples?
What wasn't helpful during the labour? Do you have any examples?
What part of the birth process gave you any positive emotions during the labour? Do you examples? Could you say a bit more about that?
Immediately after labour
What did you feel like once you had given birth?
Were you offered any support at this time – what type of support? – Only ask if they raise it.
What kind of support? Did you have to ask for it? Was it spontaneous etc
What did you find helpful once you had given birth? Do you have any examples?
What wasn't helpful once you had given birth? Do you have any examples?
Did you experience any positive emotions following the labour?
When you got home following the birth/midwife left you in sole care of the baby
How did you feel when you arrived home with the baby when you were discharged from hospital?
What was good about this time?
What wasn't good about this time?
Months later
How did you feel about your birth experience during this time?
Now
How did you feel when you think about your birth experience now?
Would you like to have more children?
Closing the interview
Summarise the main issues discussed
Tell me about your (child's name here) now
What do you like about being a mum?
What are your plans for the rest of the day?
Thank them for taking part
Give debriefing sheet

Piloting the interview before data collection commenced enabled the researcher to see how well the questions were received by the participant and whether the questions elicited the responses required to meet the aims of the research (Van Teijlingen & Hundley, 2002). Following the pilot interview the researcher wrote notes on how she felt the interview went, what went well and what had not gone as well as anticipated (Appendix H - Pilot interview notes). One main concern following the pilot interview was that it was fairly brief, thirty-minutes in total, due to some of the participant responses being brief. Therefore, after reflecting on the interview the researcher realised that she had not used her skills as a therapist to the best of her ability and this had impacted on the interview and how the participant responded to her questions. McNair, Taft and Hegarty (2008) state that clinicians can bring qualities such as a genuine interest in others and a respect for their stories. Clinicians have also been trained in a range of skills involving observation and non-verbal communication, and a range of questioning and responding techniques such as open-ended questions. These pre-existing clinical skills are an excellent starting point for the researcher and thus following a reflection the researcher realised that she needed to be more proactive in incorporating her clinical skills into future interviews to encourage participants to elaborate on their experiences and enhance the interviews. These skills included oral gesturing whereby the interviewer responds with emotion to the participants verbal account, through verbal and paraverbal communication, including tone of voice, gesture, and facial expression (Fonagy & Target, 2007). Thus, the researcher became more aware of her tone of voice and facial expressions and amended them accordingly to show more empathy and encourage better responses from participants. Another, clinical skill that was incorporated was where the researcher left pauses when a participant appeared to have finished speaking as this makes space for a participant to ‘tell their story’ and also to process it and make new connections (Fonagy & Target, 2007). Further, after reflecting on the pilot interview the researcher decided to schedule a more ‘informal’ chat with the participant before the interview began. This allowed both the researcher and the participant to become more comfortable and at ease with each other and encouraged participants to discuss their birth experience more easily. Thus, by conducting a pilot interview and reflecting on it after the

researcher became more self-aware and was able to improve the interview process to elicit better responses from participants in future interviews.

The interview schedule was made up of five open-ended questions to elicit responses in the following areas:

- What emotions participants experienced during the different stages of their pregnancies, during pregnancy, during labour, and after labour

- What participants experiences were of giving birth

- What participants believed was helpful/unhelpful before, during, and after labour

Interview process

Skype interviews were offered to participants as well as face to face interviews in a location suitable to the participant. This was to ensure that the participants were interviewed in a reasonably quiet and comfortable setting that was safe for both the researcher and participant. This was particularly important with this sample as they all had young children making it more difficult for them to take time out to travel to a location predetermined by the researcher. Research suggests that having different locations available to participants can increase participation for harder to reach groups (Braun & Clarke, 2013). All the interviews took place via Skype, whereby the participant was in their own home and the researcher in her home office.

An information sheet was emailed to participants prior to each interview, as well as consent, demographic, and debrief forms. Participants were also given the opportunity to ask the researcher questions before the interview began and gave verbal consent to the interview being recorded. Additionally, they were told that they could withdraw from the study at any time, prior to the write-up period, without having to give a reason. Interviews lasted between 35-90 minutes and were recorded using Skype recording software.

Reflections on Skype interviews

Using Skype as an interview method allowed an opportunity to increase participation within this group as they were not limited by geography. Further, as the interviews could be conducted within my own home I did not have to travel and could widen my search for participants. I found that by offering Skype as a form of interview that the participants were more willing to take part in the study. As the participants had young children this can make it difficult for them to travel as childcare has to be arranged. Skype allowed participants to be interviewed whilst in the comfort of their homes, in a less formal location such as an office, with their children present, allowing them to feel more comfortable and take away the need to organise childcare. Participants may also feel a greater sense of control and empowerment during a virtual interview (Braun & Clarke, 2013) as they are in their own environment or an environment chosen by them rather than the researcher. Additionally, participants with concerns about anonymity may be more willing to participate in a virtual interview than a face-to-face one. It also facilitates the participation of shy people and those lacking confidence. People may also feel comfortable disclosing sensitive information in virtual interviews because of partial anonymity. I found that all the participants were open and honest during the interviews and were comfortable discussing sensitive topics such as their labour. However, there were some disadvantages of using this method. There were some technical issues with sound during two of the interviews, sometimes making it difficult to hear what the participants were saying. Additionally, the video files were large and could not be saved onto a Microsoft Word document so had to be saved directly onto the Skype platform which only saves the file for a one-month period. This meant that I had to transcribe each one within a month before they were automatically deleted on the Skype platform. Each interview was transcribed verbatim and all identifiable information, such as names, places were changed to protect participants anonymity. Interview recordings were stored on a password and encrypted computer, only accessible to the researcher, and were deleted once transcribed.

Process of analysis

Analysis was completed following the analytic guide as described by Smith, Flowers and Larkin (2009):

Step 1 - Reading and re-reading - The researcher began by immersing herself in the original data by reading and re-reading the transcripts thus allowing the researcher to gain an understanding of how the narratives were formed during the interviews and become familiar with the participants stories and feelings.

Step 2 - Initial noting - After becoming familiar with the transcripts the researcher made initial notes on the right-hand side of the transcripts and highlighting anything of initial interest. This step examined semantic content and language use on an exploratory level and included notes on anything of interest such as comments, key objects of concern and the meanings of those things for the participants.

Step 3 - Developing emergent themes - The researcher started to analyse the exploratory comments to begin identifying emergent themes and writing these on a separate document. This was completed by focusing, at a local level, on discrete chunks of the transcripts.

Step 4 - Searching for connections across emergent themes - The researcher then began to look for connections across the emergent themes by highlighting connections using different colours. This involved clustering the themes based on similarity through the process of ‘mapping’ how the researcher believes the themes fit together.

Step 5 - Moving to the next case - the researcher moved to the next participant’s transcript and repeated the above process.

Step 6 - Looking for patterns across cases - The researcher looked for connections across the cases asking the questions ‘how does a theme in one case help illuminate another case?’, and which themes are more potent?’.

Copies of analysed transcripts with notes and a table of how themes were developed can be found in appendix I.

Reflecting on researcher positionality

The nature of qualitative research means that the personal values of the researcher can shape the way in which they analyse data sets and the conclusions that they draw. For example, two researchers may interpret the same data in very different ways (Dean et al., 2018). Therefore, it is important that I reflexively acknowledge my positioning within the research by owning my perspective and reflecting on my identity and any influence that this had on my research.

I am a thirty-six-year-old, British born woman of mixed-race origin. I am a Health Psychology Doctorate student and have provided therapy through my employment career to people experiencing psychological difficulties such as anxiety and depression. I am also a mother of a teenage son and underwent what I believed was a traumatic birth in 2004. Due to these shared experiences I can be positioned as an insider researcher (Kanuha, 2000). For example, I share an identity, language, and experiential base with my participants (Asselin, 2003). Although I had experienced a traumatic birth myself, I decided that I would not share this information with the participants during interviews. This was decided as a qualitative research interview is described as ‘a conversation with a purpose’ with the aim of the interview to facilitate an interaction which allows the participant to tell their own stories, in their own words (Smith, Flowers, & Larkin, 2009, p. 57). Thus, I believed that withdrawing this information would allow the participants to focus solely on their own story rather than facilitating or encouraging a conversation between us about traumatic births that would detract from their experience and the focus of this research. Therefore, the only visible similarity that my participants could see and were aware of is that I am a woman, and this may have an impact on their perceptions of me. However, there are differences and similarities in terms of age, marital status, roles, values, beliefs, and our experiences of having a traumatic birth. Therefore, although I may appear to share a similar position with my participants, I hold a hybrid status of both an insider and an outsider. For example, I hold memberships with other groups i.e. academics,

researchers, and therapists which my participants may not, therefore positioning me as an outsider (Dean et al., 2018).

It is argued that starting research as an insider can make the initial research process easier as researchers argue that they are better placed to identify research questions and that their previous knowledge of the field can make them less likely to be misled by participants. Additionally, insider researchers state that having knowledge in an area can make accessing it easier and such access is not just the research itself but the 'real' perspectives of the participants. Further, insider research is believed to bring greater intimacy and openness to research interviews (Acker, 2000; Hodkinson, 2005; Breen, 2007; Humphrey, 2007; Dwyer & Buckle, 2009; Keval, 2009). During interviews I found that all the participants appeared comfortable when talking to me about their births and during interviews I developed an easy rapport with them helping them to talk through difficult experiences. I also believe that some of this 'ease' at which participants 'opened up' to me about their births was due to my previous experience at interviewing people with psychological difficulties. For example, through my training as a therapist I have learnt skills to enhance practitioner/client relationships and utilised these skills during the interviews which also helped the participants to feel comfortable. However, although insider researchers argue that this status allows for richer, thicker descriptions, that provide more detailed accounts of experiences in which the researcher makes explicit the patterns of cultural and social relationships and puts them into context compared with thin descriptions which are argued to be more superficial (Braun & Clarke, 2013) and less accurately reflect a participant's experience. However, it is pointed out that so much may be taken for granted within these experiences that things are left unsaid as 'obvious' that would be fully explained to an outsider (Acker, 2000; Breen, 2007; Dwyer and Buckle, 2009). I certainly found this when interviewing the participants as when discussing their stories, I could at times sense an 'assumption' that they believed that I knew what they meant, this could be because they saw me as a women and possibly a mother, thus assumed I understood their meaning. However, by being aware of this issue I made steps to overcome this by asking them to clarify certain points. For example, I used clarifying questions such as "what do you mean by that?" and "can you describe for me what you mean by that. Additionally, I offered back to the participant the essential meaning as I understood it of what the participant had

said. This was to check that I had understood correctly and resolved any areas of confusion.

Approaching the research from the position as an insider also presents challenges around biases and assumptions (Paechter, 2013). Thus, I had to be aware that I come to my research with my own pre-constructed assumptions about the group in which I am studying (Labaree, 2002). For example, initially I assumed that recruiting women would be difficult as they would not have time to discuss their stories with me as they would have young children to look after. I also believed that they may be reluctant to discuss intimate details of their birth story with someone that they did not know and that there would be a high drop-out rate due to the parenting commitments that they had. These assumptions may have come from my own experiences of being a mother and having limited time when my child was young. It could also have been related to my own anxieties around discussing my birth story with other people. However, I was surprised by the willingness of the participants who appeared keen to be a part of this research. All the participants were reliable, and no one cancelled their interviews. I was also surprised by the ease in which they spoke to me about their birth stories and how they appeared unfazed by the fact that we did not know each other. I developed a good rapport with all the participants during interviews and was happy that they were able to share intimate details of their births with me.

Moreover, as someone who has also experienced birth trauma as part of my birth process, I came to the research with my own views relating to that experience, such as negative emotions regarding midwives and health care professionals in the birthing industry. I had to ensure that I separated my experience from that of my participants and not allow it to shape the questions asked during interviews and my analysis. By being aware of this and reflecting on how my own birth could shape the research I was able to minimise the risk by ensuring that my questions were not designed around my assumptions of what it is like to find giving birth traumatic. Therefore, open questions were used that gave participants the space to tell their own story and not one influenced by my story.

Lastly, throughout my studies I have edged towards a social constructionist viewpoint whereby I believe that meaning-making clearly takes place using certain

kinds of resources (narrative, discourse, metaphor, etc.), and within certain sorts of contexts (interactions such as interviews, and settings such as hospitals). Cultures are, effectively, frameworks for meaning making (Much, 1995). This while IPA's primary purpose may lie elsewhere, with understanding experience, it is inevitably 'always already' enmeshed with language and culture. Thus, our understanding of our experiences are woven from the fabric of our many and varied relationships with others. Thus, this research will incorporate elements of social constructionism as it is interested in how social constructs may influence women's understandings and constructions of their sense making when giving birth.

Chapter 3
Analysis

This chapter presents the analysis of six women who experienced trauma as part of the birth process. Three superordinate themes were identified with nine subordinate themes from the dataset following the application of Interpretative Phenomenological Analysis. The first superordinate theme: Birth experience as loss explores the feelings of loss that were communicated by participants when recounting their births. This theme includes three subordinate themes of: Loss of fantasy birth, Loss of control, and Loss of self. The second superordinate theme: Birth as near death encapsulates the feelings of complete terror that the participants experienced during and after childbirth. Three subordinate themes are included: Fear of death, Detachment, and Resignation. The last superordinate theme: Fear of not getting “it” right in the eyes of others represents an underlying fear of doing something wrong during and after childbirth due to confusion of the messages they received from medical staff and feeling judged by medical staff. This superordinate theme comprises of two subordinate themes: Confusion and Fear of personal failure in the eyes of self or others. An overview of each superordinate theme and subordinate themes, followed by a critical analysis and an interpretation of the meaning derived from the interview transcripts is included.

Table 1- Superordinate themes and subordinate themes

Superordinate Themes	Subordinate Themes
Birth experience as loss	**Loss of fantasy birth** - *"I knew it was going to be hard. I didn't think it was going to be like that."* **Loss of control -** *"Um, and it felt like literally like I had no control over what I was allowed to do. Allowed, like I'm an adult woman that's just had a baby."* **Loss of self** - *"I was just the subject."*
Birth as near death	**Fear of death** - *"I think I kind of felt-thought that I was just gonna die."* **Detachment** - *"I felt like I was in a bubble."* **Resignation** - *"Okay, fine. It is what it is."*
Fear of not getting "it" right	**Confusion** - "*I wasn't kept informed on what's happening with the baby. I wasn't told what would happen to me like where I would go now, what happens next."* **Fear of personal failure in the eyes of self or others**- *"No, it's-it's made me-- So this sounds really weird, I don't want to have a child, I want to go through the pregnancy and birth again. Just get it right just to have that-that feeling of doing it right."*

Superordinate Theme 1 – Birth experience as loss

All participants communicated feelings of loss when recounting their birth stories. This includes a loss of the birth that they had fantasised about, a loss of control, and a loss of self. This theme provides an understanding of the losses felt by participants and how these impacted on their subjective birth experience.

Subordinate theme 1a - Loss of fantasy birth

The loss of fantasy birth conveys the importance of the individual expectations, plans and feelings of mothers as they prepared for childbirth. All the participants expressed the hopes and expectations they had prior to childbirth. When these expectations were not met, or their experiences differed from their fantasy, this led to feelings of disappointment and distress. For example, when expectations of birth do not match the reality women can feel like a failure and that they are somehow at fault.

One expectation or a preference of giving birth that participants expressed was to give birth naturally over a more 'medicalised' birth. When this did not occur a feeling of loss was described. This can be seen in Olivia's statement about having planned a waterbirth at a local birthing centre when she was told she would need to be induced due to high blood pressure and a closed cervix. She explained that although she was not against having a birth that included medical intervention, such as an epidural, she thought the birthing centre was *"much nicer"* and felt *"shocked"* as she had expected to go into labour at home. This left her feeling disappointed at the missed opportunity of having a natural birth as afterwards she stated:

"Definitely, and I also feel that about, um, I definitely feel like a missed opportunity of being able to give birth naturally." - Olivia

Other participants also described a desire to have a natural birth such as Delyth who stated:

“I went in for the induction and um, still had fingers crossed for a water birth and a natural birth and no it didn’t happen.” – Delyth

Additionally, Charley spoke of not having the birth that she had wanted:

“So, I had [BABY] two weeks early but it wasn't the birth I wanted 'cos I dearly, I would have liked a pool, like a birthing pool.” - Charley

In having prepared for a natural birth prior to labour and not being able to meet this goal could have contributed to their subjective experience of birth as being traumatic.

Another loss of fantasy that participants discussed stemmed from their interactions on social media. Through social media platforms a fantasy was formed by the participants through seeing and reading other women’s accounts about their pregnancies, births, and the postpartum period and what this ‘should’ look like. This led to a disparity between what the participants experienced and what they had seen on social media and lead to disappointment when their own birth did not mirror the images on social media. This was expressed by Charley who stated:

“But I think, you know, your-your-your social media, "Oh, I've got a brand-new baby. Look how gorgeous he is and all that," and like full makeup, full hair, looking really good. I was not like that. I didn't even barely-- I barely got dressed for six months.” – Charley

There was also a fantasy about birth that had stemmed from what participants had been told by people they knew, this could be anyone they had contact with from friends, family, and medical staff prior to the birth. Julie described being ‘sold’ a story which referenced overwhelmingly positive emotions and how this was not something that happened to her:

“And I was expecting... so what everyone talks about, like a magical moment where you're like overwhelmed with love. And then some people have said the best be magical or, um, the best thing of their lives. And all I could think of was I

was in so much pain. Um, the pain wasn't stopping, I just couldn't-- I just couldn't really connect to him at all." – Julie

This mismatch between her expected birth, the one that had been described to her, and the actual birth had a profound impact on her functioning afterwards and her ability to connect with her son. This was further echoed in Julie's account who became visibly upset when describing the moment when her son was born:

"Yeah, I knew it was going to be hard. I didn't think it was going to be like that. So, I thought it was all going to be how I expected so I was gonna go into hospital when it just got too painful for me to cope. I thought like gas and air pain relief would-- would work, as it were, at least take off some of the pain. And I thought, you know, I'd only be in really bad pain for like, um, maybe half an hour before I reach second stage labour, and then hour or two it took me to slowly push the baby out. Um, I think the biggest thing that was different was that when he came out, um, and I didn't feel any connection to him whatsoever, [cries softly] sorry." - Julie

These expectations of birth from others were further referenced by Olivia who described receiving messages from friends that she received following her labour:

"Um, so I-I-I kind of then at that point just looked at my phone and, um, I had loads of messages saying like, "Hoping that you're just not replying because you're just so in love with your baby. You must be so happy. You must be over the moon." Um, and I kinda looked at all those messages and like I didn't feel like that at all." - Olivia

Julie also described being sold a fantasy by her friends at church when they described how they had coped during birth and that pain could be beaten through having a positive mind set and the joy that is felt when you meet your baby for the first time:

"I've always seen myself as quite strong mentally. Um, but I couldn't beat it. My mind was not strong enough to deal with that um, and so then that made it feel a lot worse. Sort of al-al-almost like I should be able to mentally, you know, see

contractions as surges, and see it all as a joyful, magical experience that isn't actually too bad. Um, whereas I couldn't see it like that, uh, and that did make it feel a lot worse." - Julie

This loss of the fantasy birth that she had been expecting caused her some distress and could have contributed to her perception of childbirth as traumatic. These accounts highlight a pressure from society that can lead women to expect and want to give birth in a certain way, a fantasy of what birth looks like. Society describes birth as being something that 'should' be one of the happiest days in a woman's life. When it is not this can lead to distress and negative emotions causing the birth to be perceived as a traumatic event. Additionally, the 'fantasy' of a perfect birth starts to slip away once labour begins as other people, such as medical staff, begin to take control of the birth process and make key decisions for the women.

Subordinate theme 1b - Loss of Control

Loss of control describes how the fantasy of giving birth became lost in the process as medical staff began to make decisions for the women about key elements of their birth. This led to women feeling like they were not an active participant in their own births.

For example, Olivia describes how during her labour she started to 'step back' from decision making by remaining silent:

"I just laid there in silence and just waited for them to kind of make this decision on what was gonna happen." – Olivia

Women described having little or no control over their birth experiences and that they were not included in the decision-making process.

Further, participants reported that their opinions and wishes were ignored during their labours. Information from the medical staff was not readily available and women felt like they were 'invisible' indicating the medical staff's failure to consider

them as individuals with a right to make informed decisions about their care. This was evident in Julie's account of her birth:

"A thing I think I mentioned that I didn't, uh, perhaps I didn't mention was about halfway through, um, me pushing in the pool, I asked for an epidural, and the midwife said no, um, and that made me feel again like out of control, um. I asked for an epidural twice actually, and both times she said I didn't need it, um. Again that made me feel a bit like I just-- I was out of control. Pushing when I didn't feel like I should be pushing" - Julie

Amy also described feeling like she was not being listened to and that she had no control over the decision for her to have a caesarean section:

"And prepped me for a C-section. And I said I don't want a C-section." - Amy

Olivia also describes the final stages of her labour where she felt like the midwife was ignoring her:

"As well. Um, and I said to the midwife, at one point I said, "I'm not going to be able to-to push." And she said, "Oh yes, you will." So I just remember thinking to myself, "Okay, you-you don't believe me, but you'll-you'll realise eventually." - Olivia

This battle for control between participants and medical staff led women to feel emotions such as resentment, anger, anxiety, and unease and was also seen following the birth once their baby was born. They expressed feelings of having no sense of autonomy when it came to the care of their newborn. Olivia described feeling that she was unable to make informed decisions about the care of her baby in the following statements:

"Um, and it felt like literally like I had no control over what I was allowed to do. Allowed, like I'm an adult woman that's just had a baby." - Olivia

"I felt like I couldn't be an active part in feeding him or holding him at all." – Olivia

“Like someone else had to hold him on me and I was just kind of laying there like a zombie.” – Olivia

This was further echoed in Amy’s account of visiting her daughter in the NICU:

“Yeah. And that- and that-- Anytime-- Like when- when she was in NICU, um, you couldn't- you know- wouldn't like to pick them up 'cos- 'cos they're attached all to cables. Y-- Um, the nurse has got- pass you the baby. You hold the baby, and then- and then they put the baby back. And it's like you having to ask permission to hold your child or…” - Amy

Because of the lack of control expressed by participants when recounting their birth experience this led to expressions of having no agency as a person and thus a loss of self was also felt.

Subordinate theme 1c - Loss of self

Loss of self describes how participants felt that they were ignored and discounted during their labours. Within the maternity system, women had hopes for inclusion in their childbirth which lead to a loss of agency and individuality through the impersonal system of non-individualised care.

Participants described how they felt disembodied from staff-patient interactions leading to a loss of self. For example, Sarah described feeling like a subject during her labour:

“I was just the subject. I just felt like the subject, and they were interacting between themselves just to make sure of that as well, as it could do at that point. I felt like I was-- I mean I was unconscious most of the time. I felt like I was just like that. They need to, to do what they needed to do. They would speak to me afterward. The registrar-- One of the registrars did come back and apologise and not for speaking to my partner or to me, which it wouldn't have changed how I was at the time.” - Sarah

This feeling like a subject was also described by Olivia:

“And I just kind of remember thinking, cos they took the gown off of me, so I was just now laying there completely naked, like being, having my stomach washed and there was just so many people in the room.” – Olivia

Further, participants expressed wanting to participate in various stages of their labour and childbirth as well as participating in the care of their child once born and be aware of what was happening to them. For example, Charley describes the moment she woke up following her labour:

“And then the next time I came around there was this young little blonde piece milking my nipples for colostrum.” – “Um, yeah, I came around and was just like what's going on or something. I don't know if somebody else had given permission or if I had but wasn't really with it. But it was just a bit of an odd thing to kind of wake up to my husband was stood there looking pretty horrified.” - Charley

The loss of the mother during childbirth is highlighted by the repeated focus on the health of the baby and minimisation of the physical and emotional health of the mother by medical staff. This lack of focus on the mothers’ wellbeing was described by Amy who following an emergency caesarean her daughter was taken to the NICU:

“and then sit with her for about half an hour. Then I'd walk back to my bed, pump again, and then walk back again. And it was just this constant cycle of walking back and walking back. And so for over 24 hours, that is- there's no sleep. There's-- You don't even get to eat 'cos you're- you're away when the food comes, or you're away when you get, uh- when they get the orders” - Amy

This highlights the dehumanising ways in which women were treated during their birth and described a complete lack of acknowledgement of them as people, as though they did not exist. Participants described an absence of engagement between them and hospital staff whereby the staff gave the impression that they were disinterested in the patient to the point of not caring about their physical or emotional wellbeing. A failure to answer mothers questions, speak in a clear and understandable way using English words, not asking for their permission for

therapeutic actions and examinations, and not providing explanations about how and why treatment is done are all factors that contributed to the participants negative emotions.

Superordinate Theme 2 - Birth as near death

This theme encapsulates the feelings of complete terror that participants felt during and after their childbirth leading to a fear of death of themselves and their child. This was followed by a detachment from the birth experience as a way of distancing themselves from childbirth. Lastly, participants described a feeling of resignation regarding what was happening to them.

Subordinate theme 2a - Fear of death

Although the participants knew that giving birth would be painful, the degree of pain shocked some participants and was not something they had expected or had been prepared for. Participants described being extremely scared:

"And it was really scary. I don't know if I've ever been so scared in my life." – Charley

This fear became so extreme that it led to a fear of dying, as seen by Sarah and Olivia who stated:

"I think I kind of felt- thought that I was just gonna die. Not sure. I think it was, if I'm not gonna die, then that's what I want. I was just in so much pain with the doctors..." – Sarah

"Because they said the, I'd actually lost like half of my blood that was in my body." - Olivia

The fear of death that participants described was not only related to themselves but also to that of their babies. For example, in the moments leading to the birth Sarah describes a being told that if her baby is not born quickly then it will die:

“and then there was the registrar telling the other nurses that if-if this doesn't happen quickly then- then she will die.” - Sarah

Charley also describes the moments before her child was born and the fear that she felt at this point:

“lost, like his heartbeat slowed down or it got lost or-or something which was when they decided that I needed to go down and have a C-section. - I was screaming the hospital down. - Um, I was absolutely freaking out.” - Charley

The fear that their babies would die continued following the labour once their children were born. Amy talks of the first moments following the birth and how her child was not breathing:

“And then when [BABY] was born, they took her off because she wasn't breathing.” - Amy

Charley also talks about this moment and her fear for the life of her newborn:

“Um, and because he wasn't kind of put on me. I thought, my God is he alive, is he all right?” - Charley

“Is it dead or-or something of-of that kind of-- It was-- [chuckles] It was almost like he wasn't human.” - Charley

The fear for their children that they felt immediately following their births also continued in the weeks and months after. Charley talks of a real fear for the life of her child continuing once they were home:

“So, because I was just, I was so scared that he was going to die, or-or I was gonna-I was gonna starve him and he was gonna die.” - Charley

These accounts of a fear of death led to a detachment by participants as described in the following subordinate theme.

Subordinate theme 2b - Detachment

To endure the fear and distress felt during childbirth, many participants reported becoming detached as they tried to distance themselves from the pain they were experiencing. This is evident in Julie's description of her labour:

"Um, and, um, and it was about I suppose two hours later, I started to panic, uh, thinking just, "I just can't do this anymore. All right. This has gone beyond what I thought I'd have to deal with and actually, I can't deal with it anymore." Um, but then it's like I have no choice. Um, so it was I started to sort of, um, dread all the contractions and I have to just start distancing myself from it, starting to try imagine I wasn't there. Um, and just 'cos I felt if I just kept on concentrating, I was gonna panic and go into hysterics. I just felt so out of control." – Julie

She was not able to physically leave so instead described trying to mentally distance herself from the experience. Other attempts of mentally distancing oneself from the birth included Julie's attempt at reciting from the bible:

"I started to recite a Psalm from the Bible, um" – Julie

"Um, so I just started to go through them again and again and again. Um, and I think helped that a little bit and I did feel a bit disassociated. Um, and I was trying not to think, "Gosh, this has been going on for ages and I've been pushing really hard." - Julie

Many descriptions described closing their eyes as another attempt to block out what was happening to them:

"Like I just couldn't- I don't know. I couldn't even open my eyes. So, um, and I, um, in a weird way, I guess I did kind of feel like lightheaded. So, uh, I'm kind of euphoric in a way. So I just was kind of laying there like mm-hmm, mm-hmm, mm-hmm to everything they said [laughs]. Um, because I was just like do it, whatever." – Olivia

These accounts suggest that although they were physically present during childbirth they were not emotionally or mentally engaged with the experience and this dissociation and detachment continued for some participants after the birth:

“Well, it- it- it-- It's just because I don't remember a lot. I- I was, um-- I- I was kind of like not detached from her. I just was-- I felt like I was in a bubble, so I- I can't remember things like- like when she crawled, her first word, or anything like that.” - Amy

This impacted on the first moments with their children, for example Olivia describes the first time she held her newborn:

“Like someone else had to hold him on me and I was just kind of laying there like a zombie.” - Olivia

The feeling of detachment from their children directly following the birth is further described by Amy:

“Sorry. No, I just felt a bit detached like I went to see her and I felt nothing.” Okay. I went to see her and it was like- like if you go somewhere and you- say Egypt, you look at a pyramid and you're like, "Well, I've seen the pyramid," and then you walk away”

“I didn't- I didn't feel like it- it was my baby. I just felt like I was looking after a baby. So like if your- it's your niece or nephew. Like how you would treat them. So you would look after them. But there's no deep emotional connection or anything like that.”

And um, so it kind of-- It was like when you visit someone else's baby in the hospital. You- you get there, you look at the baby, and then you- you leave. It…” Well, it- it- it-- It's just because I don't remember a lot. I- I was, um-- I- I was kind of like not detached from her. I just was-- I felt like I was in a bubble, so I- I can't remember things like- like when she crawled, her first word, or anything like that.” - Amy

Olivia also describes the first moments with her baby:

"I didn't get to cuddle him, and um, like I get to feed him, but like I wasn't sort of snuggling with him or anything like that. It was just him being held on me, someone latching him on feeding and taking it and I would kind of be like, you need like I need him taken off of me." - Olivia

It was evident that in some cases the terror they felt caused real distress for participants. Amy described not being able to look back at her daughter's infant months as this triggered the terror felt during her labour and birth:

"I try not to-- Like it's- I mean, it's so-- I don't even look at photos of [BABY] now. Sorry. [Crying]" - Amy

In this case an avoidance of 'looking back' at this time was also linked to feelings of guilt and a continuing sense of detachment following her daughter's birth.

"I can't look at her photos when- other babies of people I don't know. Just because I felt like I wasn't there." - Amy

In these cases, women avoided engaging with medical staff and were hesitant to admit that anything was wrong to what is so often seen in society as a positive life event. This suggests that mothers may struggle alone with their distress following childbirth as there is a reluctance to talk about their negative experience.

Subordinate theme 2c - Resignation

Following the terror and ways they used in which to cope participants described reaching a stage of acceptance and resigned themselves to the situation they found themselves facing.

Olivia describes reaching a stage of acceptance and becoming 'resigned' to what was happening to her during her labour:

“Um, I think that I would have been more disappointed if I hadn't been induced, um, because of like the baby not moving as much and because of high blood pressure, I think at that point I just thought, "Okay, fine. It is what it is." - Olivia

"And I actually didn't care or whatever, what they were doing.” - Olivia

A change in priorities also became apparent in the participants accounts of their birth whereby worries about their own wellbeing transferred to that of their unborn child. This is evident in one account that describes a transference of their worry to that of their unborn child:

“You know, the delivery of the baby is most important. Um, so I didn't really mind, um, or I don't remember minding anyway. I think I just thought, "Well, this like this is just how it's gonna happen now. I won't be going there." And that's just on that was that,” – Olivia

."And all I thought to myself was, he's fine. Like that he's being looked after. He's here. He's fine. I just can't do anything.” - Olivia

A sense of resignation about what participants had been through during their labour was echoed in their accounts afterwards. For example, Olivia talks of reaching a stage of resignation after her birth about having to stay in the hospital:

“Everything's fine and I just kind of accepted my life of living in a hospital” - Olivia

Charley also talks about this period of having to stay in hospital and how she became resigned to this:

“But I, yeah, I didn't dwell on it” - Charley

These participants all had described feeling resigned to what was happening to them during and after their births.

These accounts show that participants felt a real sense of terror during childbirth, fearing for their own and their baby’s lives. To try and cope with this they became

detached from not only the birth itself but also from their children following the birth. These experiences could be contributing factors to their subjective experiences as childbirth being a traumatic event.

Superordinate Theme 3 - Fear of not getting "it" right

When women talked about their birth experiences there was an underlying fear of not getting the birth 'right' and doing something wrong as participants spoke of feelings of confusion due to mixed messages they felt they were receiving and a feeling of being judged by medical staff. These negative emotions impacted negatively on their subjective birth experience.

Subordinate theme 3a - Confusion

Participants described being confused during their labours which stemmed from a lack of continuity of the messages they received by hospital staff. The receiving of these seemingly mixed messages caused participants to feel frustrated and sometimes angry as they did not know what advice to follow. This caused a conflict between the women and staff. For example, Olivia talks of her time in hospital and the differing opinions that she was given:

"Yeah, definitely. Some people, you know, they have different opinions, uh, different midwives have different opinions on things and some people I found really helpful and really nice. Other people I found quite mean." - Olivia

This lack of continuity of care was also described by Charley who talks of having different people in charge of her care throughout her labour:

"It wasn't the same person. Um, I had I think pretty much every single time a different person." - Charley

Additionally, Julie describes becoming confused when she started pushing towards the end of her labour as she was unsure what the midwife required of her due to the conflicting messages that she received:

“Um, so and I was so I was just pushing. And then as nothing was happening, I was sort of thinking, "Well, I don't think I'm fully dilated. Um, why has she asked me to push?" Um, and then at the same time, I was like, "I can't, you know, I'm not gonna argue with her. She's the midwife." And I did just push and it was so painful every time I was contracting as well. I was like, "This has got--" I was in my mind, you're only painful towards the end. So I was like, "It's got to be soon. She must know what she's doing. I must be fully dilated." - Julie

Many of the participants described the medical staff as being ‘too busy’ to explain procedures and what was happening during the birth again leading to confusion regarding what was happening to them during their labours:

“Like. I don't really remember. I think they're just so, so busy, so busy. They haven't got time. They haven't got time to give you the kind of care that you need.” - Charley

Following the births of their children this confusion continued for the mothers as they again describe being given conflicting messages by medical staff as to how they should or should not care for their children:

“Um, and then he would be able to latch and some midwives were like, yes, that's a really good idea. Let me go and get your pump and then someone else would tell them, nope, she can't do that. And I felt really kind of out of control of my own body. Like I had to ask permission about whether I could express milk or not” - Olivia

This confusion is further echoed in Amy’s account:

“Yeah, I was- I was left and then I didn't- I wasn't kept informed on what's happening with the baby. I wasn't told what would happen to me like where I would go now, what happens next.” - Amy

Contradicting information led to confusion on the part of the participants and appeared to add to their distress. Participants described not being given a clear message as to what was happening to them during their labours, what they as

patients needed to do, and lastly how to care for their children following the birth. Due to not being given clear guidance they worried that they would do something wrong and be a failure.

Subordinate theme 3b - Fear of personal failure in the eyes of self or others

All of the participants referred to perceived ‘failings’ during and after birth. For example, there was an innate sense that there was a ‘correct’ way to give birth and look after their children and an ‘incorrect’ way. Giving birth was likened to an important event of profound responsibility in which there are many layers of expectations. A fear of judgement and criticism by hospital staff was apparent in participant accounts and also contributed to feelings that they were doing something wrong and failing in some way. This is expressed by Amy who described moments during her labour wanting to do it ‘right’:

“Just get it right just to have that-that feeling of doing it right.” - Amy

This fear of doing something wrong and being judged continued after her labour and into her stay in hospital:

“No. It's just not having people watching you all the time. It's just the- the bit of freedom to do- just to relax with your child, and then try and work out what the hell you want to do when you get home.” – Amy

“And I- I didn't even feel comfortable touching her, because they were like watching or- um just-- Yeah, it just felt for this first few days that- that-- You know 'cos one- one woman was quite dragony. She was telling me off about other things, and I don't know, she was just a bit.” - Amy

This highlights a common theme described by participants in which they felt judged by hospital staff, leading them to feel uncomfortable when caring for their newborn.

Charley also describes this feeling of judgement by a member of hospital staff when she was looking after her newborn during her stay in hospital following the birth of her child:

"It felt like the old lady kind of looked me up and down, and-and that she kind of looked down on me, and just was quite disapproving of me." - Charley

Multiple ways in which women felt that they had failed were expressed such as not being able to breastfeed their child either immediately following birth or at all. Many of the participants spoke of their disappointment at not being able to breastfeed. For example, women perceived bottle feeding as a 'second best' alternative to the 'correct' way to feed their child, breastfeeding. This led to a sense of regret, disappointment, and shame. Delyth spoke of her difficulty in breastfeeding her baby:

"So, his first feeds were bottles and then he would just never take… the whole time we were in hospital he wouldn't take the breast, I was never able to breastfeed him." - Delyth

Further accounts of feeling judged were described following the labour. For example, Olivia spoke about a visit from her health visitor and how she felt like she was being judged:

"Um, the health visitor came um, to see us and I kind of acted like it was a test. Like felt like everything." - Olivia

"To test us. So, I was like house must be spotless, like you must act like you're the most supportive husband in the world because they are testing us. [chuckles]" - Olivia

Amy also expressed a feeling of being judged by her health visitor during a home visit following the birth of her child.

"Um, so she was different, but-- So anyway, she's, um-- 'Cos my house is clean and tidy, she blamed that on the reason why my milk hadn't come in." - Amy

“She said, um, she looked around my house, and she said, "The reason why your milk hasn't come in is 'cos you're so uptight." - Amy

“Because she just started nursing. Was ill a lot, and um, she came around and she's- she just made me feel like shit again, so I just kind-- It was that as well. That I don't-- Yeah. I don't like the pressure they-- It's not pressure, but it's just them judging or commenting on your parenting. So yeah. Especially…” - Amy

Additionally, there was a perception that they were blamed for their failings by medical staff if something had not gone according to plan.

“I just woke up, um, and then she was weighing him and saying, "Look, he's lost like basically 10% of his body-- Of his birth weight. If he doesn't put on weight in the next 24 hours, he needs to go back to hospital. He is starving kind of thing," which absolutely scared the shit out of me. I was starving my baby. I mean I wanted nothing-nothing less than to do-- Do you know what I mean?” - Charley

“Um, and then she made some sort of comment about, um, not being-- Like not being well enough to look after him. And I was absolutely devastated that she would-- Like a doctor would make that kind of comment, rather than sort of say, you know um-- I don't know, maybe postnatal depression or something, but she basically just said that I couldn't look after him. And I was just mortified. I went to the receptionist and said never ever booked me in with that doctor, ever again. Um, through my tears.” - Charley

These perceived failures are significant as they reveal a vulnerability to feel inadequate as a woman and a mother.

“I think I failed.” - Sarah

Participants wanted to get childbirth right and not fail:

"No, it's-it's made me-- So this sounds really weird, I don't want to have a child, I want to go through the pregnancy and birth again. Just get it right just to have that-that feeling of doing it right."- Amy

This fear of failing highlights another negative cognition that the participants had regarding their childbirth. A pressure to not fail added to the distress that they felt and could be a contributing factor of traumatic birth.

Summary of analysis

This chapter provides an exploration of what women's experiences are of experiencing birth process as traumatic. The first superordinate theme suggests that feelings of loss may lead to women experiencing childbirth as something that is traumatic due to distress when expectations are not met. Particularly, pressures in society fed to women a fantasy birth that was unrealistic. A loss of control was also found to cause women distress whereby they were unable to make decisions about their care and thus felt like they were not active participants in their own births. Additionally, women felt discounted and ignored leading to a loss of self and again contributing to a traumatic birth.

The second superordinate theme, Birth as near death explored feelings of terror described by participants as they feared for not only their own lives but also that of their children either during or after childbirth. To endure this fear, they became detached as a way of distancing themselves from this terror. Finally, they describe reaching a stage of acceptance as to what was happening to them. These negative experiences can be interpreted as contributing to the subjective experience of a traumatic birth.

The last superordinate theme, Fear of not getting "it" right highlighted a fear that the participants had about doing something wrong during childbirth. This was linked to a confusion they felt as they received mixed messages from the medical staff. There was also a belief that they were being judged by medical staff and these encounters left them feeling angry and frustrated. Additionally, participants referred to perceived failings during and after childbirth and giving birth was likened to a profound sense of responsibility where there were many layers of

expectations. The pressure that women felt adds to the negative emotions experienced by the participants again causing distress.

Throughout the themes, there appears to be a sense of expectation felt by the women. This included how they ‘should’ give birth, how they ‘should’ feel emotionally and physically, how they ‘should’ act and if they did not meet these expectations this led to distress. Additionally, the analysis shows that it is not only the labour itself that can be traumatic but also other stages of childbirth including immediately following the birth, and weeks, months and sometimes years after.

Chapter 4
Discussion

This chapter first discusses the findings from this research on women's experiences of trauma when giving birth. It then discusses the implications of this research for the field of health psychology. This is followed by an overview of the limitations of the study, and recommendations for practice. The quality of the research is then examined followed by an evaluation of the research and recommendations for future research. The chapter concludes with a personal reflection from the researcher and the research conclusion.

Women who experience traumatic childbirth

The aim of this study was to explore and provide an in-depth understanding of women who experience trauma when giving birth. Interpretative Phenomenological Analysis (IPA) was used to guide the analysis. The main research question was explored using a series of open-ended questions to elicit responses in the following areas:

- What emotions participants experienced during the different stages of their pregnancies, during pregnancy, during labour, and after labour

- What participants experiences were of giving birth

- What participants believed was helpful/unhelpful before, during, and after labour

Birth experience as loss

The analysis of the participants narratives provides an in-depth exploration of what women's experiences are of experiencing birth process as traumatic. Three themes were presented in the analysis: 'Birth experience as loss', 'Birth as near death', and 'Fear of not getting "it" right'. These superordinate themes and their subordinate themes will be explored in the following discussion in relation to the research question and considering the literature surrounding birth trauma.

The women in this study are part of a wider and largely invisible population within the literature of traumatic birth as previous research has tended to focus solely on women with a clinical diagnosis of PPD or PTSD. The findings revealed that all participants felt feelings of loss during childbirth which contributed to childbirth as being experienced as traumatic. This included a loss of the birth that they had fantasised about, a loss of control, and a loss of self. This theme highlights the subjective nature of childbirth and emphasises the importance of the mother's individual experience. The loss of fantasy birth conveys the importance of the mother's individual expectations, plans and feelings as they prepared for childbirth. All the participants in this study expressed a preference of giving birth 'naturally' over a medicalised birth and when this did not happen contributed to their birth being experienced as traumatic. The finding that having a traumatic birth can be linked to having a medicalised birth is not unexpected as it aligns with previous research by Kjerulff and Brubaker (2017) who found that women who had an unplanned caesarean delivery had the least positive feelings overall about their childbirth, in comparison to women whose deliveries were spontaneous vaginal and instrumental caesarean. Additionally, they found that those women who delivered by unplanned caesarean were likely to feel disappointed and like a failure in comparison to women who had spontaneous vaginal delivery and less likely to feel extremely or quite a bit proud of themselves. Women who scored highly on the First Baby Study Birth experience Scale, used to measure women's feelings following their birth, were significantly more likely to be diagnosed with postpartum depression, less likely to plan to have additional children, and more likely to score below the median on maternal-child bonding as measured on the one-month postpartum interview. The findings from this study also indicate that expectations of childbirth come from interactions on social media and from people close to women, such as friends and family, and these interactions produced a 'fantasy' about how their pregnancies, births and the postpartum period would and should look like. Again, when this fantasy was not achieved women were left feeling disappointed and distressed. Thus, this study provides further insight and expands on previous literature in that it highlights how the expectations that a mother has before her childbirth can impact the birth experience in a negative way as these expectations can be unrealistic. When these expectations do not match the reality women are left disappointed, distressed and often angry and leads them to see their birth as something that was a traumatic event. Society describes

childbirth as something that should be one of the happiest days of a woman's life and this leads to distress and negative emotions when this is not the case.

Participants also reported feeling a loss of control whereby medical staff made decisions about key elements of their birth leading them to feel like they were not active participants in their own births causing participant distress. This suggests that a non-collaborative childbirth may facilitate the development of trauma. The women in this study described how information was not made readily available to them, they felt ignored by medical staff and felt invisible. All participants described feeling like they were not being listened to and had no control over key decisions regarding their care. This loss of control within the maternity care system is consistent with prior research (Thomson & Downe, 2008; Iles & Pote, 2015). Further, a lack of or loss of control has been found in previous studies to be perceived by women as a major cause for experiencing their birth as traumatic (Soet, Brack & Dilorio, 2003; Grekin & O'Hara, 2014; O'Donovan et al., 2014; Ayers et al., 2016; Hollander et al., 2017). The women in this study described the loss of control as leading to feeling resentment, anger, anxiety and unease and these emotions continued following childbirth into the postpartum period as they felt little or no sense of autonomy when it came to the care of their newborn. Thus, this finding expands on previous literature that has focused on the childbirth stage as it also highlights a lack of control following the birth as also being a contributing factor towards childbirth being experienced as traumatic. Thus, it appears from the analysis that it is not only the labour that can be traumatic but also the time afterwards.

Another important finding from this study was that participants experienced a loss of self whereby women felt that they were ignored and discounted during their labours. Within the maternity system, women had hopes for inclusion in their childbirth which led to a loss of agency and individuality through the impersonal system of non-individualised care. This links to previous research that has linked interpersonal events such as being ignored, feeling unsupported and abandoned to interpersonal difficulties such as anger and conflict (Harris & Ayers, 2012). These interpersonal difficulties have been shown to be more likely to lead to PTSD than neonatal complications. The women in this study felt disembodied from staff-patient interactions and described feeling like 'subjects. Additionally, there

appeared to be a repeated focus by medical staff on the health of the unborn child and although necessary, came at the expense of recognising whether the mother was struggling with their emotional and/or physical health. The importance of support during traumatic events is well established in the literature that shows support during labour results in better psychological and physical outcomes (Hodnett et al., 2011). Thus, this lack of focus on the mother's health and wellbeing can potentially facilitate birth trauma as the women in this study were not acknowledged as individuals in need of support during crucial stages of their birth.

Birth as near death

Despite the enthusiasm of mothers prior to childbirth it became apparent from their accounts that they felt a sense of terror during childbirth. They described being aware that giving birth would be painful, but the degree of pain shocked them and was not something they had expected or had been prepared for. Participants described feeling extremely scared during their birth and two of the main concerns described was a fear of dying, either themselves or their child. It is interesting to consider these experiences in light of previous research by Hollander et al., (2017) who themselves found that fear for baby's health/life and fear of own health/life is one of the causes of or contributions to the traumatic birth experience. A fear of death for the participants in this study suggests that a lack of awareness around the realities of childbirth and degree of pain can cause trauma for women. Interestingly, fear of death of the baby continued following the labour and was something that women feared weeks and months after. This finding highlights the importance of continuing psychological care for women following childbirth as they may still be experiencing trauma weeks and months after.

It became evident that to endure the fear and distress felt by participants during childbirth, they detached and distanced themselves from the pain they were experiencing. This is consistent with the literature that has also found that the distress of childbirth led women to disengage with the process leading to surreal and vacant experiences during and following childbirth (Byrne et al., 2017). Participants in this study described trying to imagine they were not present during labour and one participant describes reciting from the bible as a way of distancing herself. However, although dissociation and detachment has been highlighted as

important to the development of non-obstetric trauma (Ozer et al., 2003) the disconnection from the birth is argued to potentially facilitate birth trauma as it keeps the experience of giving birth unprocessed and separated from other autobiographical memories (Ehlers & Clarke, 2000). Although avoidance can be described as personally helpful in that it allows women to carry on, theoretically avoidance of trauma maintains a current sense of threat and thus facilitated the nature of birth trauma (Ehlers & Clarke, 2000). Further, the literature shows that in some cases the detachment they report permeated their relationships with partners and their new infant. Detachment from mother's new infant was something that derived from participants accounts as they described this sense of detachment continuing past the labour and into the moments following, sometimes up to months and even years later. For example, one participant describes still years later not being able to look back at photos of her daughter as it causes her to remember the terror that childbirth triggered. This adds to the literature surrounding attachment and birth trauma which shows a link between disruptions with mother-child bonding as a result of having a traumatic birth (Ayers, Eagle, & Waring, 2006). Additionally, it provides new insight that again the experiences that lead to the subjective experience of birth as traumatic can be linked to not only the birth itself but all stages of childbirth.

Following detachment during childbirth participants describes reaching a stage of resignation and began to accept what was happening to them. Interestingly, there appeared to be a similar change in focus as described in the subordinate theme 'loss of self' where similarly to medical staff participants began to shift focus from their wellbeing to that of their unborn child. This provides crucial insight into women's experiences of trauma as part of their birth as it appears that there is lack of acknowledgement, not just from medical staff but from the mothers themselves, of the importance of their psychological wellbeing being at risk during childbirth.

Fear of not getting "it" right

In addition to the terror felt by participants, they spoke of an underlying fear of doing something wrong during childbirth. It was evident that women became confused during their labour as they described a lack of continuity of the messages they received by hospital staff. The receiving of these seemingly mixed

messages caused participants to feel frustrated and sometimes angry as they did not know what advice to follow. Medical staff appeared to be too busy to explain what was happening during childbirth. This caused a conflict between the women and medical staff and contributed to them experiencing their birth as traumatic. What is interesting is that this confusion continued after the labour and was present afterwards, whilst participants were in hospital with their infants, at home during visits from health visitors and during check-ups. This finding adds new knowledge to previous research which shows that birth experience is greatly affected by the Quality of Provider Interactions (QPI) which is defined as care providers verbal and non-verbal behaviours relating to meeting the patient's stated and implied needs, as stated by the patient. If women perceive their care provider interactions as negative or unsupportive this is correlated with women's experiences of birth trauma symptoms and depression. This can affect women's long-term memories of negative and traumatic birth (Sorenson & Tschetter, 2010). Further, Ford and Ayers (2011) have found that interpersonal interactions with healthcare providers during labour and birth can negatively impact on birth experience. In their research they identified perinatal hot spots that were associated with women reporting their births as negative or traumatic with the category containing the largest amount of hot spots being interpersonal difficulties with healthcare providers whereby women most frequently reported feeling ignored, unsupported or abandoned during labour. These women had the highest levels of anger and conflict resulting in symptoms of PTSD, avoidance, distress, and impairment. Much of the research on traumatic birth generally focuses on labour itself. This research therefore adds a valuable layer to the knowledge of what may cause the subjective experience of traumatic birth as it suggests that negative interactions by medical staff are felt by women in the postnatal period as well as the labour itself.

Lastly, perceived failings during childbirth led to the distress of the participants. For example, there was an innate sense that there was a 'correct' way to give birth and look after their children and an 'incorrect' way. Giving birth was likened to an important event of profound responsibility in which there are many layers of expectations. A fear of judgement and criticism by medical staff was apparent in participant accounts and contributed to feelings that they were doing something wrong and failing in some way. Therefore, it appears that despite previous

recommendations for the improvement of interpersonal interactions between medical staff and patients (O'Donovan et al., 2014; Borg Cunen, McNeill & Murray, 2014; Ford, Ayers & Bradley, 2010) this remained largely unchanged for the participants in this study.

Implications for health psychology

This research has highlighted what the women in this study's experiences are of having a traumatic birth and has found important aspects of their births that has contributed to their trauma. Therefore, as a result of this study there are important implications that the field of health psychology needs to consider. For example, health psychology needs to be embedded into the current model of healthcare so that traumatic birth can be prevented or at the very least minimised.

The analysis shows that the mothers in this study had expectations of childbirth that were unrealistic resulting in trauma when the reality of childbirth differed. Thus, Health Psychologists can help to develop better information provided and psycho-educational courses offered that can prepare women for the reality of childbirth. Additionally, the women in this study all expressed a feeling of not being in control due to medical staff making key decisions about their care, they also felt ignored and discounted. Further, women became confused during childbirth and described a lack of continuity of the messages they received and interpersonal difficulties between themselves and medical staff. Thus, for some people it is clear there is a definite need to improve the communication and interactions between medical staff and patients in maternity settings, not solely during labour but also following the birth into the postnatal period. Therefore, Health Psychologists can play a role in auditing maternity services and working alongside them helping them to provide better antenatal education and screening, and care and communication during labour and following the birth. Health psychologists can work with maternity services helping to educate them on the benefits of better patient communication and to manage women's expectations of childbirth. The participants in this study described feelings of terror linked to a fear of death for themselves and their child. They used dissociation and detachment to cope, possibly facilitating trauma. Thus, maternity services would benefit from training to help to keep women present during their labour through encouragement to prevent dissociation and

detachment and assessing emotional wellbeing following their labour. Women's experiences of having a traumatic birth can be better understood by looking at less traditional models of health and illness such as the biomedical model and instead consider the biopsychosocial aspects of health and illness to better understand this patient group. Additionally, Health Psychologists can revise psychotherapy treatments to include aspects of postnatal psychopathology specific to this patient group. Further, screening tools are essential to identify women with impaired functioning or those in need of treatment. Health psychologists can contribute to the development and evaluation of screening tools, ensuring that they are accessible and training in the use of them available. Thus, the range of research and practical skills that health psychologists can offer is extremely useful in applied areas such as this.

Limitations of study

Although this study has provided a rich and detailed body of literature concerning women who have experienced birth process as traumatic it is important to acknowledge and discuss the limitations of the study.

1 - One limitation for which the work could be criticised is the lack of homogeneity in the research sample. For example, women had given birth in different hospitals, came from different socio-economic backgrounds and differed in age. Despite this, sampling was theoretically consistent with the qualitative paradigm and with IPA's orientation (Smith, Flowers, & Larkin, 2009). For example, samples were selected purposively, they had experienced trauma during the birth process, and this could offer unique insight into this experience. Further, much of the variation was able to be contained and many key characteristics were the same, such as all participants lived in the UK, all had no previous diagnosis of PND or PTSD, and all had given birth in the last two years in a UK hospital.

2 - Secondly, it is noted that the population sample was specifically recruited to include women who self-defined their birth process as traumatic and it is noted that their accounts may sit in opposition to other women's less negative and more positive birth experiences. However, by giving voice to the accounts of women who experienced their birth as being traumatic Health Psychologists can help to

ensure that the highest standard of maternal clinical care delivery is provided to all women who give birth.

3 - Thirdly, it is noted that this study did not utilise any Patient and public Involvement (PPI) which in research is considered to be best practice and, in some countries such as the UK, is an essential requirement to receive funding (Gray-Burrows et al., 2018). PPI is defined as involvement in research being carried out ‘with’ or ‘by’ members of the public, rather than ‘to’, ‘about’ or ‘for’ them. This ensures that research is relevant to user needs and therefore more likely to have beneficial impacts (Gray-Burrows et al., 2018). Utilising PPI might have assisted in the early stages of this research process. For example, Larkin and Thompson (2012) state that research populations can be involved in the early stages of an IPA project, in the piloting of interview schedules, or assisting the research team to consider ethical issues. Thus, PPI would have been beneficial for this study and could have helped to mitigate some of the issues that the researcher encountered with regards to recruitment. By involving the research population in the recruitment process, the researcher may have gained more access to participants.

4 - Lastly, another limitation in which this work could critiqued is that the researcher did not undertake a formal method of reflexivity or quality control. For example, the researcher did not use a reflective diary during the research process. Reflexivity is argued to be an important component of qualitative research so that the reader can understand the context in which the research occurs. This is because all qualitative research is contextual and takes place within a specific time and place between two people. It is therefore assumed that who the researcher is can impact on the findings of the study as objectivity is not present (Dodgson, 2019). However, although a formal method was not used, the researcher reflected on her positionality throughout the write up of the study and clearly described the contextual intersecting relationships (e.g., race, socio-economic status, age, cultural background) between her and the participants which is argued to increase the credibility of the findings and deepens the understanding of the work conducted (Berger, 2015). Similarly, the researcher did not undertake a formal method of quality control which can include repeatedly checking participant’s reactions to the interpretations made from their data (Styles, 1993). However,

quality control can also take the form of prolonged engagement and discussion of preliminary interpretations with other investigators (Styles, 1993). Thus, although no formal method of quality control took place in the form of repeatedly checking participant reactions, quality control did take place whereby the researcher repeatedly discussed her preliminary results with her supervisors. Therefore, helping to ensure that her interpretations of the data were sensitive to the participants' stories revealed.

Discussion of implications for practice

The findings from this study can be used to form a basis for future research and policy aimed at reducing and preventing women experiencing trauma when giving birth. Previous research has primarily focused on women with a diagnosis of either PTSD or PND thus is limited. However, the findings from this study illustrate a need for more research on women who have not received any formal diagnosis. This study shows that there are many factors that can lead to birth process being experienced as traumatic and due to a research bias on women with a diagnosis these factors can be overlooked in the literature. As the current literature informs policy and screening there is a need for more research on this hidden population as some women who have experienced the birth process as traumatic are not being screened for postnatal psychopathological difficulties following their births and are therefore not being given the appropriate support. The most widely used screening tool currently used to screen and assess for PND is the Edinburgh Postnatal Depression Scale (EPDS) and this scale is also used extensively in both clinical and research work (Matthey & Agostini, 2017). More research needs to be conducted to design and test the feasibility of a more qualitative measure that is more sensitive to birth trauma could be designed to fill this gap that could be used to inform future research, screening and policy.

Reflexive considerations

I have been interested in the area of traumatic birth since the birth of my Son and that interest had grown over the years through discussions with people I knew who had also felt distress during childbirth. At the start of this journey I felt that traumatic birth was an important area in which to base my research and this has

been confirmed to me following this study. My findings have shown me that women are still experiencing childbirth as traumatic and there is still much work to be done to either prevent or minimise this. Therefore, I feel that my work is a valuable contribution to the current literature as it provides further and in-depth understanding as to what the experiences are of women who have experienced birth process as traumatic. Additionally, I believe that I have been able to answer the original research question: What are women's experiences of having experienced birth process as traumatic?

During the research process I have been aware that my own personal exposure a traumatic birth could shape my findings as I have the shared identity of experiencing a traumatic birth with the participants. Thus, I came to this research with several preconceptions, things that I believe could contribute to a traumatic birth. However, although I shared this identity with my participants, I believe that I have been able to give them their own 'voice' through being aware of my preconceptions and being reflective throughout my research. I made sure that when analysing the data set, I listened carefully to what they were describing so that I did not miss anything that did not fit with my preconceptions. Having said that though, I feel that by sharing the experience of having a traumatic birth helped me to engage with my participants and made me more empathetic to their stories. This in turn made them more comfortable and helped them to 'open up' to me and share their personal stories and I believe this has made the research richer as it includes intimate and in-depth details of these women's experiences.

Additionally, I came to this research from a social constructionist viewpoint whereby I believe that people's experiences are woven from the fabric of our many and varied relationships with others. I was interested in how social constructs may have influenced how my participants viewed their births. I believe that my research reflects this belief as the analysis shows that there are many social constructs that have shaped the participants experiences of having a traumatic birth such as social media and societal expectations of birth.

During the research process I had to be mindful about how listening to women recount their traumatic birth stories might impact on my own wellbeing. I worried that listening to these stories may bring up bad memories from my own traumatic

birth. However, I was surprised that although at times I felt emotional when hearing women recount their distress, I did not feel overly emotional or upset. Instead, I think that it gave me a sense of determination to continue with my research as it emphasised to me the importance of giving these women a voice and I wanted to ensure that their stories were heard.

By critically reflecting on my work I believe that I have been able to evaluate the study's strengths as well as weaknesses. For example, although I am extremely happy with my research and feel that I have done the women in this study justice by telling their personal stories, on reflection I am aware that I am only giving a voice to a small number of women. Although, this study provides an in-depth analysis I believe that the findings could have been different if different groups of women had been interviewed. For example, the women in this study shared several characteristics, they were all from middle-high socio-economic statuses and had accessed higher education. This leads me to believe that they could have come into childbirth with set expectations as to the quality of care that they would receive. Perhaps other groups of women would tell a different story? For example, women from different cultures, women with more feminist ideologies, or women from different socio-economic backgrounds may see their births differently.

Future research

The findings from this study can be used to form the basis for future research and policy aimed at reducing and preventing traumatic childbirth. More research is needed to study the optimal ways in which information and psycho-educational courses can be used to prepare women for the reality of childbirth. Research also looking at communication and training programmes for medical staff would be beneficial. Additionally, more research is needed focusing on the experiences of women who have given birth following their labour into the postpartum period.

Conclusion

The purpose of this study was to give women without a diagnosis of PTSD or PND a voice in which to explore and give insight into their experiences of experiencing the birth process as traumatic. The findings from this study show that for this group of women, who are under-represented in the literature, there are many factors that can contribute towards women experiencing trauma when giving birth and thus highlights the importance of mother's subjective birth experience. Unrealistic expectations of what childbirth should entail led to participant distress when these expectations were not met, a lack of clear communication from medical staff, and the terror that the participant's felt were all contributors towards their trauma. A key finding from this study also shows that these factors were not only present during labour but also the subsequent periods following, such as when they were recovering in hospital and into the weeks, months and even years later. Thus, this research highlights areas in which health psychology can play an important role in helping to minimise and prevent women experiencing trauma when giving birth in the future, such as helping to provide better education for women to help prepare them for the realities of childbirth and playing a role in auditing maternity services and working alongside them helping them to provide better antenatal education and screening, and care and communication during labour and following the birth.

References

Acker, S. (2000). In/out/side: Positioning the researcher in feminist qualitative research. *Resources for feminist research*, *28*(1-2), 189-210.

Alcorn, K. L., O'Donovan, A., Patrick, J. C., Creedy, D., & Devilly, G. J. (2010). A prospective longitudinal study of the prevalence of Post-Traumatic stress disorder resulting from childbirth events. *Psychological medicine*, *40*(11), 1849-1859.

Allen, S. (1998). A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of reproductive and infant psychology*, 16(2-3), 107-131.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (4th éd.). Washington, DC: *Author*.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th éd.). *Washington, DC: Author*.

Asselin, M. E. (2003). Insider research: Issues to consider when doing qualitative research in your own setting. *Journal for Nurses in Professional Development*, *19*(2), 99-103.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: lessons learnt. *BMC medical research methodology*, 8(1), 21.

Austin, M. P. (2010). Classification of mental health disorders in the perinatal period: future directions for DSM-V and ICD-11. *Archives of women's mental health*, *13*(1), 41-44.

Austin, M. P. V., Hadzi-Pavlovic, D., Priest, S. R., Reilly, N., Wilhelm, K., Saint, K., & Parker, G. (2010). Depressive and anxiety disorders in the postpartum period: how prevalent are they and can we improve their detection?. *Archives of women's mental health*, *13*(5), 395-401.

Ayers, S. (1999). *Post-Traumatic stress disorder following childbirth* (Doctoral dissertation, St George's, University of London).

Ayers, S. (2004). Delivery as a traumatic event: prevalence, risk factors, and treatment for postnatal posttraumatic stress disorder. *Clinical Obstetrics and Gynecology*, 47(3), 552-567.

Ayers, S. (2007). Thoughts and emotions during traumatic birth: a qualitative study. *Birth*, 34(3), 253-263.

Ayers, S. (2014). Fear of childbirth, postnatal Post-Traumatic stress disorder and midwifery care. *Midwifery*, *30*(2), 145-148.

Ayers, S., Bond, R., Bertullies, S., & Wijma, K. (2016). The aetiology of Post-Traumatic stress following childbirth: a meta-analysis and theoretical framework. *Psychological Medicine*, *46*(6), 1121-1134.

Ayers, S., Claypool, J., & Eagle, A. (2006). What happens after a difficult birth? Postnatal debriefing services. *British Journal of Midwifery*, *14*(3), 157-161.

Ayers, S., Eagle, A., & Waring, H. (2006). The effects of childbirth-related Post-Traumatic stress disorder on women and their relationships: a qualitative study. *Psychology, health & medicine*, *11*(4), 389-398.

Bailham, D., & Joseph, S. (2003). Post-Traumatic stress following childbirth: a review of the emerging literature and directions for research and practice. *Psychology, Health & Medicine*, *8*(2), 159-168.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: a case of the tail wagging the dog?. *Bmj*, 322(7294), 1115-1117.

Barbour, R. S., & Barbour, M. (2003). Evaluating and synthesizing qualitative research: the need to develop a distinctive approach. *Journal of evaluation in clinical practice*, 9(2), 179-186.

Bastos, M. H., Furuta, M., Small, R., McKenzie-McHarg, K., & Bick, D. (2015). Debriefing interventions for the prevention of psychological trauma in women following childbirth. *Cochrane database of systematic reviews*, (4).

Baxter, J. D., McCourt, C., & Jarrett, P. M. (2014). What is current practice in offering debriefing services to postpartum women and what are the perceptions of women in accessing these services: a critical review of the literature. *Midwifery*, *30*(2), 194-219.

Beck, C. T. (1993). Teetering on the edge: A substantive theory of postpartum depression. *Nursing research*.

Beck, C. T. (2004). Birth trauma: in the eye of the beholder. *Nursing research*, *53*(1), 28-35.

Beck, C. T. (2004). Post-Traumatic stress disorder due to childbirth: the aftermath. *Nursing research*, *53*(4), 216-224.

Beck, C. T., Gable, R. K., Sakala, C., & Declercq, E. R. (2011). Posttraumatic stress disorder in new mothers: Results from a two-stage US national survey. *Birth*, *38*(3), 216-227.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative research*, 15(2), 219-234.

Blom, E. A., Jansen, P. W., Verhulst, F. C., Hofman, A., Raat, H., Jaddoe, V. W. V., ... & Tiemeier, H. (2010). Perinatal complications increase the risk of postpartum depression. The Generation R Study. *BJOG: An International Journal of Obstetrics & Gynaecology*, *117*(11), 1390-1398.

Boorman, R. J., Devilly, G. J., Gamble, J., Creedy, D. K., & Fenwick, J. (2014). Childbirth and criteria for traumatic events. *Midwifery*, *30*(2), 255-261.

Boyd, D. (2010). Making sense of privacy and publicity. SXSW. *Austin, Texas, March*, *13*.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Breen, L. (2007). The researcher in the middle': Negotiating the insider/outsider dichotomy. *The Australian Community Psychologist*, *19*(1), 163-174.

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical psychology review*, 23(3), 339-376.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of consulting and clinical psychology*, *68*(5), 748.

Brockington, I. (2004). Postpartum psychiatric disorders. *The Lancet*, *363*(9405), 303-310.

Bryman, A. (2003). *Quantity and quality in social research*. Routledge.

Byrne, V., Egan, J., Mac Neela, P., & Sarma, K. (2017). What about me? The loss of self through the experience of traumatic childbirth. *Midwifery*, *51*, 1-11.

Capdevila, X., & Choquet, O. (2008). Does regional anaesthesia improve outcome? Facts and dreams. *Techniques in Regional Anesthesia and Pain Management*, *4*(12), 161-162.

Cassell, E. J. (1998). The nature of suffering and the goals of medicine. *Loss, Grief & Care*, *8*(1-2), 129-142.

Charuvastra, A., & Cloitre, M. (2008). Social bonds and posttraumatic stress disorder. *Annu. Rev. Psychol.*, *59*, 301-328.

Cigoli, V., Gilli, G., & Saita, E. (2006). Relational factors in psychopathological responses to childbirth. *Journal of Psychosomatic Obstetrics & Gynecology*, *27*(2), 91-97.

Cosans, C. (2001). The embodiment of birth. *Theoretical medicine and bioethics*, *22*(1), 47-55.

Creedy, D. K., Shochet, I. M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: incidence and contributing factors. *Birth*, *27*(2), 104-111.

Cunen, N. B., McNeill, J., & Murray, K. (2014). A systematic review of midwife-led interventions to address post-partum Post-Traumatic stress. *Midwifery*, *30*(2), 170-184.

Czarnocka, J., & Slade, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology*, *39*(1), 35-51.

Dahlen, H. G. (2011). Home birth: a story of “infinite love and enormous rejection”. *International Journal of Childbirth*, *1*(4), 254-262.

Davies, J., Slade, P., Wright, I., & Stewart, P. (2008). Posttraumatic stress symptoms following childbirth and mothers' perceptions of their infants. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, *29*(6), 537-554.

Dean, J., Furness, P., Verrier, D., Lennon, H., Bennett, C., & Spencer, S. (2018). Desert island data: an investigation into researcher positionality. *Qualitative Research*, *18*(3), 273-289.

Denis, A., Parant, O., & Callahan, S. (2011). Post-traumatic stress disorder related to birth: a prospective longitudinal study in a French population. *Journal of Reproductive and Infant Psychology*, *29*(2), 125-135.

Dennis, C. L., & Dowswell, T. (2013). Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane database of systematic reviews*, (2).

Dikmen-Yildiz, P., Ayers, S., & Phillips, L. (2018). Longitudinal trajectories of Post-Traumatic stress disorder (PTSD) after birth and associated risk factors. *Journal of affective disorders*, *229*, 377-385.

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation*, 35(2), 220-222.

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International journal of qualitative methods*, *8*(1), 54-63.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour research and therapy*, *38*(4), 319-345.

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *Journal of advanced nursing*, *66*(10), 2142-2153.

Feldman, R., Granat, A., Pariente, C., Kanety, H., Kuint, J., & Gilboa-Schechtman, E. (2009). Maternal depression and anxiety across the postpartum year and infant social engagement, fear regulation, and stress reactivity. *Journal of the American Academy of Child & Adolescent Psychiatry*, *48*(9), 919-927.

Fenech, G., & Thomson, G. (2014). Tormented by ghosts from their past': a meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery*, *30*(2), 185-193.

Fisher, J., Mello, M. C. D., Patel, V., Rahman, A., Tran, T., Holton, S., & Holmes, W. (2012). Prevalence and determinants of common perinatal mental disorders in women in low-and lower-middle-income countries: a systematic review. *Bulletin of the World Health Organization*, *90*, 139-149.

Ford, E., & Ayers, S. (2009). Stressful events and support during birth: the effect on anxiety, mood and perceived control. *Journal of Anxiety Disorders*, *23*(2), 260-268.

Ford, E., & Ayers, S. (2011). Support during birth interacts with prior trauma and birth intervention to predict postnatal Post-Traumatic stress symptoms. *Psychology & Health*, *26*(12), 1553-1570.

Ford, E., Ayers, S., & Bradley, R. (2010). Exploration of a cognitive model to predict Post-Traumatic stress symptoms following childbirth. *Journal of Anxiety Disorders*, *24*(3), 353-359.

Ford, E., Ayers, S., & Wright, D. B. (2009). Measurement of maternal perceptions of support and control in birth (SCIB). *Journal of women's health*, *18*(2), 245-252.

Gearhart, J. (2015). Clinical trial recruitment using social media is growing. *Quorum Review*, *5*(1), 1-2.

Gelinas, L., Pierce, R., Winkler, S., Cohen, I. G., Lynch, H. F., & Bierer, B. E. (2017). Using social media as a research recruitment tool: Ethical issues and recommendations. *The American Journal of Bioethics*, *17*(3), 3-14.

George, E., & Engel, L. (1980). The clinical application of the biopsychosocial model. *American journal of Psychiatry*, *137*(5), 535-544.

Gill, J. M., Page, G. G., Sharps, P., & Campbell, J. C. (2008). Experiences of traumatic events and associations with PTSD and depression development in urban health care-seeking women. *Journal of Urban Health*, *85*(5), 693.

Gorman, J. R., Roberts, S. C., Dominick, S. A., Malcarne, V. L., Dietz, A. C., & Su, H. I. (2014). A diversified recruitment approach incorporating social media leads to research participation among young adult-aged female cancer survivors. *Journal of Adolescent and Young Adult Oncology*, *3*(2), 59-65.

Gray-Burrows, K. A., Willis, T. A., Foy, R., Rathfelder, M., Bland, P., Chin, A., ... & Wood, L. (2018). Role of patient and public involvement in implementation research: a consensus study. *BMJ quality & safety*, 27(10), 858-864.

Greenfield, M., Jomeen, J., & Glover, L. (2016). What is traumatic birth? A concept analysis and literature review. *British Journal of Midwifery*, *24*(4), 254-267.

Grekin, R., & O'Hara, M. W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: a meta-analysis. *Clinical psychology review*, *34*(5), 389-401.

Gyure, M. E., Quillin, J. M., Rodríguez, V. M., Markowitz, M. S., Corona, R. A., Borzelleca, J. F., ... & Bodurtha, J. N. (2014). Practical considerations for implementing research recruitment etiquette. *IRB*, *36*(6), 7.

Haagen, J. F., Moerbeek, M., Olde, E., Van Der Hart, O., & Kleber, R. J. (2015). PTSD after childbirth: A predictive ethological model for symptom development. *Journal of affective disorders*, *185*, 135-143.

Halligan, S. L., Murray, L., Martins, C., & Cooper, P. J. (2007). Maternal depression and psychiatric outcomes in adolescent offspring: a 13-year longitudinal study. *Journal of affective disorders*, *97*(1-3), 145-154.

Harcombe, J. (1999). Power and political power positions in maternity care. *British Journal of Midwifery*, *7*(2), 78-82.

Harden, A., Garcia, J., Oliver, S., Rees, R., Shepherd, J., Brunton, G., & Oakley, A. (2004). Applying systematic review methods to studies of people's views: an example from public health research. *Journal of Epidemiology & Community Health*, 58(9), 794-800.

Harper, D., & Warner, S. (1993). Discourse, social constructionism and clinical psychology. *CHANGES-SHEFFIELD-*, *11*, 72-72.

Harris, R., & Ayers, S. (2012). What makes labour and birth traumatic? A survey of intrapartum 'hotspots'. *Psychology & health*, *27*(10), 1166-1177.
Hodkinson, P. (2005). 'Insider research 'in the study of youth cultures. *Journal of youth studies*, *8*(2), 131-149.

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2013). Continuous support for women during childbirth. *Cochrane database of systematic reviews*, (7).

Hollander, M. H., van Hastenberg, E., van Dillen, J., Van Pampus, M. G., de Miranda, E., & Stramrood, C. A. I. (2017). Preventing traumatic childbirth

experiences: 2192 women's perceptions and views. *Archives of women's mental health*, *20*(4), 515-523.

Holme, N., Boullier, L., & Harrison, C. (2016). Postnatal care: a neonatal perspective (NICE guideline CG 37). *Archives of Disease in Childhood-Education and Practice*, *101*(3), 136-138.

Humphrey, C. (2007). Insider-outsider: Activating the hyphen. *Action Research*, *5*(1), 11-26.

Iles, J., & Pote, H. (2015). Postnatal Post-Traumatic stress: A grounded theory model of first-time mothers' experiences. *Journal of Reproductive and Infant Psychology*, *33*(3), 238-255.

Ionio, C., & Di Blasio, P. (2014). Post-Traumatic stress symptoms after childbirth and early mother–child interactions: an exploratory study. *Journal of Reproductive and Infant Psychology*, *32*(2), 163-181.

Kanuha, V. K. (2000). "Being" native versus "going native": Conducting social work research as an insider. *Social work*, *45*(5), 439-447.

Kartchner, F. D. (1950). A study of the emotional reactions during labor. *American journal of obstetrics and gynecology*, *60*(1), 19-29.

Kearney, M. H. (2001). Levels and applications of qualitative research evidence. *Research in nursing & health*, *24*(2), 145-153.

Keirse, M. J. (2010). Home birth: gone away, gone astray, and here to stay. *Birth*, *37*(4), 341-346.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, *62*(6), 593-602.

Keval, H. C. (2009). Negotiating constructions of 'insider'/'outsider' status and exploring the significance of dis/connections. *Independent Research Consultant*, *4*(2), 51-72.

Kjerulff, K. H., & Brubaker, L. H. (2018). New mothers' feelings of disappointment and failure after caesarean delivery. *Birth*, *45*(1), 19-27.

Kurz, E., Davis, D., & Browne, J. (2019). Analysing constructions of childbirth in the media; Moving possibilities for childbirth beyond gender essentialism. *Women and Birth*.

Labaree, R. V. (2002). The risk of 'going observationalist': negotiating the hidden dilemmas of being an insider participant observer. *Qualitative research*, *2*(1), 97-122.

Leigh, B., & Milgrom, J. (2008). Risk factors for antenatal depression, postnatal depression and parenting stress. *BMC psychiatry*, *8*(1), 24.

Maclean, L. I., McDermott, M. R., & May, C. P. (2000). Method of delivery and subjective distress: women's emotional responses to childbirth practices. *Journal of Reproductive and Infant Psychology*, *18*(2), 153-162.

Madden, M., Lenhart, A., Cortesi, S., Gasser, U., Duggan, M., Smith, A., & Beaton, M. (2014). *Teens, social media, and privacy*. Pew Research Internet Project.

Maggioni, C., Margola, D., & Filippi, F. (2006). PTSD, risk factors, and expectations among women having a baby: A two-wave longitudinal study. *Journal of Psychosomatic Obstetrics & Gynecology*, *27*(2), 81-90.

Mansfield, B. (2008). The social nature of natural childbirth. *Social Science & Medicine*, *66*(5), 1084-1094.

Matthey, S., & Agostini, F. (2017). Using the Edinburgh Postnatal Depression Scale for women and men—some cautionary thoughts. *Archives of women's mental health*, 20(2), 345-354.

McDonald, S., Slade, P., Spiby, H., & Iles, J. (2011). Post-Traumatic stress symptoms, parenting stress and mother-child relationships following childbirth and

at 2 years postpartum. *Journal of Psychosomatic Obstetrics & Gynecology*, *32*(3), 141-146.

McNair, R., Taft, A., & Hegarty, K. (2008). Using reflexivity to enhance in-depth interviewing skills for the clinician researcher. *BMC Medical Research Methodology*, *8*(1), 73.

McNally, R. J. (2009). Can we fix PTSD in DSM-V?. *Depression and anxiety*.

McVey, L., Lees, J., & Nolan, G. (2015). Practitioner-based research and qualitative interviewing: Using therapeutic skills to enrich research in counselling and psychotherapy. *Counselling and Psychotherapy Research*, *15*(2), 147-154.

Michaels, P. A. (2017). Childbirth and Trauma, 1940s–1980s. *Journal of the history of medicine and allied sciences*, *73*(1), 52-72.

Mitchell, J. T. (1983). When disaster strikes: The critical incident stress debriefing process. In *Journal of emergency medical services* (pp. 36-39).

Moscucci, O. (2003). Holistic obstetrics: the origins of “natural childbirth” in Britain. *Postgraduate medical journal*, *79*(929), 168-173.

Murray, L., Arteche, A., Fearon, P., Halligan, S., Croudace, T., & Cooper, P. (2010). The effects of maternal postnatal depression and child sex on academic performance at age 16 years: a developmental approach. *Journal of child Psychology and Psychiatry*, *51*(10), 1150-1159.

Murray, L., Sinclair, D., Cooper, P., Ducournau, P., Turner, P., & Stein, A. (1999). The socioemotional development of 5-year-old children of postnatally depressed mothers. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, *40*(8), 1259-1271.

Nicholls, K., & Ayers, S. (2007). Childbirth-related post-traumatic stress disorder in couples: A qualitative study. *British journal of health psychology*, 12(4), 491-509.

O'Donovan, A., Alcorn, K. L., Patrick, J. C., Creedy, D. K., Dawe, S., & Devilly, G. J. (2014). Predicting posttraumatic stress disorder after childbirth. *Midwifery*, *30*(8), 935-941.

Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. *Psychological bulletin*, *129*(1), 52.

Paechter, C. (2013). Researching sensitive issues online: implications of a hybrid insider/outsider position in a retrospective ethnographic study. *Qualitative Research*, *13*(1), 71-86.

Parkinson, F. (1997). *Critical incident stress debriefing*.

Parsi, K., & Elster, N. (2014). Conducting Research on Social Media—Is Facebook Like the Public Square?. *The American Journal of Bioethics*, *14*(10), 63-65.

Paulson, J. F., Dauber, S., & Leiferman, J. A. (2006). Individual and combined effects of postpartum depression in mothers and fathers on parenting behavior. *Pediatrics*, *118*(2), 659-668.

Quintner, J. L., Cohen, M. L., Buchanan, D., Katz, J. D., & Williamson, O. D. (2008). Pain medicine and its models: Helping or hindering?. *Pain Medicine*, *9*(7), 824-834.

Sauls, D. J. (2002). Effects of labor support on mothers, babies, and birth outcomes. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *31*(6), 733-741.

Saxbe, D. E. (2017). Birth of a new perspective? A call for biopsychosocial research on childbirth. *Current Directions in Psychological Science*, *26*(1), 81-86.

Shahar, G., Herishanu-Gilutz, S., Holcberg, G., & Kofman, O. (2015). In first-time mothers, post-partum depressive symptoms prospectively predict symptoms of Post-Traumatic stress. *Journal of affective disorders*, *186*, 168-170.

Simkin, P. (2011). Pain, suffering, and trauma in labor and prevention of subsequent posttraumatic stress disorder. *The Journal of perinatal education*, *20*(3), 166-176.

Simpson, M., & Catling, C. (2016). Understanding psychological traumatic birth experiences: A literature review. *Women and Birth*, *29*(3), 203-207.

Skari, H., Skreden, M., Malt, U. F., Dalholt, M., Ostensen, A. B., Egeland, T., & Emblem, R. (2002). Comparative levels of psychological distress, stress symptoms, depression and anxiety after childbirth—a prospective population-based study of mothers and fathers. *BJOG: An International Journal of Obstetrics & Gynaecology*, *109*(10), 1154-1163.

Slade, P. (2006). Towards a conceptual framework for understanding Post-Traumatic stress symptoms following childbirth and implications for further research. *Journal of Psychosomatic Obstetrics & Gynecology*, *27*(2), 99-105.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review*, *5*(1), 9-27.

Smith, J. A., & Mitchell, S. (1996). Debriefing after childbirth: a tool for effective risk management. *British Journal of Midwifery*, *4*(11), 581-586.

Smith, J. A., Flower, P., & Larkin, M. (2009), *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Soderquist, J., Wijma, K., & Wijma, B. (2002). Traumatic stress after childbirth: the role of obstetric variables. *Journal of Psychosomatic Obstetrics & Gynecology*, *23*(1), 31-39.

Soet, J. E., Brack, G. A., & DiIorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth*, *30*(1), 36-46.

Sorenson, D. S., & Tschetter, L. (2010). Prevalence of negative birth perception, disaffirmation, perinatal trauma symptoms, and depression among postpartum women. *Perspectives in Psychiatric Care*, *46*(1), 14-25.

Stake, R. E. (1995). *The art of case study research*. Sage.

Stramrood, C. A., Paarlberg, K. M., Huis In't Veld, E. M., Berger, L. W., Vingerhoets, A. J., Weijmar Schultz, W. C., & Van Pampus, M. G. (2011). Posttraumatic stress following childbirth in homelike-and hospital settings. *Journal of Psychosomatic Obstetrics & Gynecology*, *32*(2), 88-97.

Stiles, W. B. (1993). Quality control in qualitative research. *Clinical psychology review*, 13(6), 593-618.

Suler, J. (2004). The online disinhibition effect. *Cyberpsychology & behavior*, *7*(3), 321-326.

Suls, J., & Rothman, A. (2004). Evolution of the biopsychosocial model: prospects and challenges for health psychology. *Health psychology*, *23*(2), 119.

Swirsky, E. S., Hoop, J. G., & Labott, S. (2014). Using social media in research: new ethics for a new meme?. *The American Journal of Bioethics*, *14*(10), 60-61.

Taddicken, M. (2014). The 'privacy paradox 'in the social web: The impact of privacy concerns, individual characteristics, and the perceived social relevance on different forms of self-disclosure. *Journal of Computer-Mediated Communication*, *19*(2), 248-273.

Taghizadeh, Z., Irajpour, A., Nedjat, S., Arbabi, M., & Lopez, V. (2014). Iranian mothers' perception of the psychological birth trauma: a qualitative study. *Iranian journal of psychiatry*, *9*(1), 31.

Taylor, H. A., Kuwana, E., & Wilfond, B. S. (2014). Ethical implications of social media in health care research. *The American Journal of Bioethics*, *14*(10), 58-59.

Tedstone, J. E., & Tarrier, N. (2003). Posttraumatic stress disorder following medical illness and treatment. *Clinical psychology review*, *23*(3), 409-448.

Terry, D. J., Mayocchi, L., & Hynes, G. J. (1996). Depressive symptomatology in new mothers: A stress and coping perspective. *Journal of Abnormal Psychology*, *105*(2), 220.

The University of The West of England. (2019). General Data Protection Regulation (GDPR) Statement. Retrieved from https://www1.uwe.ac.uk/about/corporateinformation/datamanagement/gdprstatement.aspx

Thomas, J., Harden, A., Oakley, A., Oliver, S., Sutcliffe, K., Rees, R., ... & Kavanagh, J. (2004). Integrating qualitative research with trials in systematic reviews. *Bmj*, 328(7446), 1010-1012.

Thompson, C. J. (2005). Consumer risk perceptions in a community of reflexive doubt. *Journal of Consumer Research*, *32*(2), 235-248.

Thomson, G., & Downe, S. (2008). Widening the trauma discourse: the link between childbirth and experiences of abuse. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*(4), 268-273.

Thomson, G., & Garrett, C. (2019). Afterbirth support provision for women following a traumatic/distressing birth: Survey of NHS hospital trusts in England. *Midwifery*, *71*, 63-70.

Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: a contemporary qualitative research approach. *Journal of Healthcare Communications*, *2*(4), 52.

Tuteur, A. (2016). *Push back: Guilt in the age of natural parenting*. HarperCollins.
Van Teijlingen, E. R., & Hundley, V. (2001). The importance of pilot studies.

Ursano, R. J., Li, H., Zhang, L., Hough, C. J., Fullerton, C. S., Benedek, D. M., ... & Holloway, H. C. (2007). Models of PTSD and traumatic stress: the importance of research “from bedside to bench to bedside”. *Progress in brain research*, 167, 203-215.

Wijma, K., Söderquist, J., & Wijma, B. (1997). Posttraumatic stress disorder after childbirth: a cross sectional study. *Journal of anxiety disorders*, *11*(6), 587-597.

Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. McGraw-Hill Education (UK).

Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-Hill education (UK).

Wisner, K. L., Moses-Kolko, E. L., & Sit, D. K. (2010). Postpartum depression: a disorder in search of a definition. *Archives of women's mental health*, *13*(1), 37-40.

Yanchar, S. C. (2015). Truth and disclosure in qualitative research: Implications of hermeneutic realism. *Qualitative Research in Psychology*, *12*(2), 107-124.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health*, *15*(2), 215-228.

Zaers, S., Waschke, M., & Ehlert, U. (2008). Depressive symptoms and symptoms of Post-Traumatic stress disorder in women after childbirth. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*(1), 61-71.

Appendices

Appendix A

Faculty of Health & Applied Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD

Tel: 0117 328 1170

UWE REC REF No: HAS.18.05.170

4th July 2018

[redacted]

Dear Carly

Application title: Women's' experiences of having a difficult birth: An Interpretative Phenomenological Analysis (IPA) study

Thank you for resubmitting your ethics application; this was considered by the Committee and based on the information provided was given ethical approval to proceed.

You must notify the committee in advance if you wish to make any significant amendments to the original application using the amendment form at http://www1.uwe.ac.uk/research/researchethics/applyingforapproval.aspx

Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web: https://intranet.uwe.ac.uk/tasks-guides/Guide/writing-and-creating-documents-in-the-uwe-bristol-brand

The following standards conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.
2. You must notify the University Research Ethics Committee if you terminate your research before completion;
3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

Appendix B

NHS
National Institute for Health Research

CERTIFICATE of ACHIEVEMENT

This is to certify that

Carly Sandercombe

has completed the course

Introduction to Good Clinical Practice eLearning (Secondary Care)

January 24, 2018

A practical guide to ethical and scientific quality standards in clinical research

Including EU Directives, Medicines for Human Use (Clinical Trials) Regulations & the Department of Health Research Governance Framework for Health & Social Care, as applied to the conduct of Clinical Trials & other studies conducted in the NHS

Modules completed:

Introduction to Research and the GCP standards
Preparing to deliver your study
Identifying and recruiting participants: eligibility and informed consent
Ongoing study delivery and data collection
Safety Reporting
Study closure

This course is worth 4 CPD credits

CPD

Delivering research to make patients, and the NHS, better

Appendix C

*****OPPORTUNITY TO TAKE PART IN A RESEARCH STUDY*****

Have you given birth in the last two years and experienced what you felt was a difficult labour? If so (and you are aged 18+, do not have a diagnosis of postnatal depression, and live in the UK) I would like to speak to you as part of an interview study about your birth experience.

This research is being conducted by Carly Sandercombe, a Health Psychology Doctoral Trainee at the University of the West of England and is supervised by Dr Tim Moss and Dr Toni Dicaccavo. This study has received ethical approval from the University of the West of England ethics committee.

The work will involve taking part in an interview lasting approximately 1-hour at a location that is convenient for you. All data will be kept anonymous.

If you would like to take part or would like more information, please contact Carly Sandercombe on [redacted] or email carlyprankerd@hotmail.es

Appendix D

University of the West of England
BRISTOL

What are women's experiences of having a traumatic birth?: An Interpretative Phenomenological Analysis (IPA) study.

PARTICIPANT INFORMATION SHEET

Introduction

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of this research?

The purpose of this research study is to better understand the experiences of women who have had a traumatic birth.

How will the research be done and what will I have to do?

To take part in this research you will participate in an interview that will run for approximately one hour. The interview will involve a discussion about your experience of having a traumatic birth. Each interview will be audio recorded for training purposes. The researcher is not a therapist and cannot provide psychological support, however you will be given a debriefing sheet containing the information of a number of services that are able to provide psychological support should you require it.

Why have I been asked and do I have to take part?

You are invited to take part in this research project as you have identified your recent birth as being traumatic. This research evaluates the experiences that women have following a traumatic birth and it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part and then change your mind you are still free to withdraw any time before January 1st 2019. After this date we will have analysed the data and published a report on it, therefore it will be impossible to remove your data from this publication.

Is this information confidential and held securely, and what will be done with the results?

All the data you provide will be stored in password-protected computer files on an encrypted computer under an anonymous identifier and used on a confidential basis, in line with GDPR regulations. The original questionnaires will be held securely and destroyed three years after the research. The computer data and the resulting analysed data will be held for as long as it retains research value.

Your name will never be included in a publication, and your data will only be used anonymously.

Do you have any further questions?

If you have questions about the research or want to withdraw your data - either now or at some future date - please contact Carly Sandercombe

Carly Sandercombe Carly2.Sandercombe@uwe.ac.uk

Appendix E

University of the West of England
BRISTOL

Consent Form

Women's experiences of having a difficult birth: An Interpretative Phenomenological Analysis (IPA) study.

Please tick

I confirm that I have been provided with information on the nature of this research and have had the opportunity to ask questions.	☐
I understand that my participation in this research is voluntary and that I am free to withdraw at anytime without giving a reason.	☐
I understand that all the information I provide will be treated as confidential and used for research purposes only.	☐
I agree that the data collected from me and about me may be held and processed by the researcher for the purposes of this research.	☐
I understand that I will never be personally identifiable in any report or writeup that stems from this research.	☐
I confirm that I am happy to take part in the above research project.	☐

Name of participant:

Date:

Signature:

Email address:

Appendix F

University of the West of England
BRISTOL

Debriefing Form

If you have any queries about the study or have any further questions please do not hesitate to contact me using the details provided below.

Contact Details:
Carly Sandercombe
C/o Dr. Tim Moss
[redacted]
Tel: [redacted]
E-mail: [redacted]
Or [redacted]

I'd like to take this opportunity to thank you for your contribution to the current study and a sample copy of the findings will be available to you if you choose.

If you do feel you wish to withdraw from the study at any time before the write up of the study is complete, please email myself or Dr Tim Moss, stating your personal ID number.

Some of the statements within the study may have been of a sensitive nature to you or you may have further questions. If so, please do not hesitate to contact any of the services below, who will be more than happy to offer you support and guidance.

Birth Trauma Association (BTA) was established in 2004 to support families who have been traumatised during childbirth. They are parents who wish to support other parents who have suffered and/or witnessed traumatic births. The BTA is the only organisation in the UK which deals solely and specifically with this issue.
Web: www.birthtraumaassociation.org.uk
Email: support@birthtraumaassociation.org.uk
They also have a closed group on Facebook. You can request to join by searching for 'Birth Trauma Association'.

PANDAS- The PANDAS Foundation is here to help support and advise any parent who is experiencing a perinatal mental illness. We are also here to inform and guide family members, carers, friends and employers as to how they can support someone who is suffering.
Phone: 0843 2898401

Web: www.pandasfoundation.org.uk
Email: info@pandasfoundation.org.uk
They also have a closed group on Facebook. You can request to join by searching for 'PANDAS Foundation'.

MIND is one of Britain's leading charities that support people experiencing a mental health problem. They campaign to improve services, raise awareness and promote understanding.
Phone: 02085192122
Website: http://www.mind.org.uk

*You can also call your G.P for advice.

Appendix G

Interview schedule

Introductions – give consent form and explain study

Question 1 – Can you tell me about when you found out that you were pregnant?

Prompts

How did you feel?
What emotions did you experience?
What surprised you about how you felt?
Was your reaction one that you expected?

Question 2 – Can you describe your experience of giving birth?

Prompts

Before the birth/labour

Who was with you?
How did you feel like when you went into labour?
Were you offered any support during your labour – what type of support?
What did you find helpful during the labour? Do you have any examples?
What wasn't helpful during the labour? Do you have any examples?
What part of the birth process gave you any positive emotions during the labour? Do you examples? Could you say a bit more about that?

Immediately after labour

What did you feel like once you had given birth?
Were you offered any support at this time – what type of support? – Only ask if they raise it. What kind of support? Did you have to ask for it? Was it spontaneous etc
What did you find helpful once you had given birth? Do you have any examples?
What wasn't helpful once you had given birth? Do you have any examples?
Did you experience any positive emotions following the labour?

When you got home following the birth/midwife left you in sole care of the baby

How did you feel when you arrived home with the baby when you were discharged from hospital?
What was good about this time?
What wasn't good about this time?

Months later

How did you feel about your birth experience during this time?

Now

How did you feel when you think about your birth experience now?
Would you like to have more children?

Closing the interview

Summarise the main issues discussed
Tell me about your (child's name here) now
What do you like about being a mum?
What are your plans for the rest of the day
Thank them for taking part
Give debriefing sheet

Appendix H

Pilot interview schedule guide:

1. Where and when did you give birth?
2. Can you describe to me the type of birth that you had?
3. When you think of the birth what stands out for you?
4. Do you feel that any questions that you had were listened to and addressed quickly?
5. Did you always have to ask for information or do you feel that information was provided?
6. Were you able to understand the information given to you?
7. Do you feel that staff members communicated with each other?
8. Do you think that anybody noticed your distress/confusion/bewilderment?
9. Did any particular members of staff stand out to you and if you why?
10. Were you offered any psychological support after the birth and if so what type?
11. If were offered support did you find it helpful and if so in what way?
12. What type of support do you feel would have been beneficial for you?
13. What services would you recommend for women in the future who have experienced a traumatic birth?

Researcher reflection from pilot interview

Observations:

The interview was relatively short as the participant didn't expand much on some questions.

The flow of conversation could have been better, maybe the participant wasn't as comfortable as she could have been.

I had to keep looking at my interview schedule to remind myself of questions so didn't maintain as much eye contact as I would have liked.

Changes to be made:

Need more prompts and open questions to put participants more at ease and to encourage them to expand on what they are saying. Will amend script.

Read through and familiarise myself with the transcript before each interview so that I am more familiar with the questions.

Appendix I

Interviewer: So let me know what it does. **Interviewee:** Uh, yeah, it says. **Interviewer:** So, it's recording, yeah? **Interviewee:** Yeah. **Interviewer:** Brilliant. Okay. So, um, the first question then is, can you tell me a bit about when you found out that you were pregnant? Um, yeah. So I thought that I might be pregnant. I waited for the day, I was expecting my period and it didn't arrive. **Interviewer:** Yeah. **Interviewee:** I hadn't bought any tests or anything cos I just kind of thought to myself, "No, it's too good to be true" that I would actually be pregnant. **Interviewer:** Yeah. **Interviewee:** So then when I finished work, I went to TESCO's for, um, two tests and I couldn't even wait to go home. So I went into the toilet. I thought that I was pregnant [laughter] **Interviewer:** Oh, that's so cool. So were you trying? **Interviewee:** Um, yes and no, I suppose. **Interviewer:** Yeah. **Interviewee:** You know, trying as much as if you have unprotected sex, you, you know, might get pregnant. Um, but sort of not exactly. Not like both thinking to ourselves. It will happen straight away or anything, but it actually, **Interviewer:** Um, so how did you feel when you, if you say you went into the toilet, did the test, how did you feel? **Interviewee:** Um, I think weirdly, I, it's almost like I knew before, I knew that I would be pregnant because I just felt like I was, weirdly and, but I also kept saying to myself, "No, like, you're just being silly. Um, the, yeah, I was just, I think I was in shock like a bit, but it gave in to the fact [chuckles] that I was in Tesco's now. Um, so I went outside, phoned my husband and um, said, "I've just done	

a test." And he said, "Oh, what, what is that?" Um, so I told him, and I was kind of now like, now obviously laughing like, the tears in my eyes walking right past the Tesco. **Interviewer:** [laughs] Was it, how are you expected to feel, do you think? **Interviewee:** Um, yeah, I suppose so. I think I was, I was more scared that it was going to be negative because even though I say like, "Oh, we weren't trying or whatever." I think because of the way I fell, I sort of kept thinking, saying, and I was feeling to myself like. "Maybe I am pregnant." Um, so then you know, I was just kind of, I guess overwhelming in a way. **Interviewer:** Yeah. Yeah. A bit of a shock. **Interviewee:** Yeah. Yeah, Well. **Interviewer:** So you, you felt a bit of shock. We're excited as well. Were there any other kinds of emotions around that time? **Interviewee:** Um, I think, I, I, no. I think just, excited and I kind of, just couldn't believe it. Really. **Interviewer:** Yeah. And was that how you expected to feel? **Interviewee:** Um, I think, um, I think the only thing that I'm kind of, the shock and excited. Yes. I think that I couldn't believe it. Maybe, maybe I wouldn't have expected that I kind of, feel like that because it's kind of, you think, well, if you have an, if you're having unprotected sex, what does it lead to? So I think it was just kind of, I just thought, "No, don't be excited cause it won't happen." Then the fact that it actually did, I was kind of like, Huh. **Interviewer:** Yeah, **Interviewee:** That was maybe a bit, uh, a bit unexpected. But I was, maybe it was something unexpected. I was shocked, but I expected that I would be excited. **Interviewer:** Yeah. Maybe a bit of a surprise that it actually happened- **Interviewee:** Yeah.	Shocked and excited.

Interviewer: -so easily [laughs] **Interviewee:** Yeah, I think so. **Interviewer:** Oh, that was really good. Um, okay. So, I think if it's okay we'll go into the actual experience of giving birth. **Interviewer:** So, so if you want to just say it in your own words about what happened. Sort of were you aware when you went into labour? **Interviewee:** So I was, uh, two days overdue. Um, and I went to a midwife appointment, um, and I actually went to my midwife appointment with my mum. Um, she hadn't come before anything. She just happened to come and see me that day. **Interviewer:** Yeah. **Interviewee:** I said, to her, "Why don't you come with me?" Um, and the midwife did all the usual checks, and she was going to do a sweep. When she took my blood pressure it was really high. So she, and she called, um, the maternity unit at the hospital and said to them, you know, that she wanted me to come in and see them. **Interviewer:** Yeah. **Interviewee:** Um, and then she actually did do a sweep then. Um, but she said that my cervix was completely closed. And I was nowhere near labour, even though I was overdue. **Interviewer:** Oh, why? **Interviewee:** So, I went to the, um, hospital. Um. And I think I waited quite a while at this point. So, I was just with my mum still, um. My husband was- I- think I told him I was going to the hospital but he was on his way back from work. **Interviewer:** Yeah. **Interviewee:** Um, and they, I think when I finally saw somebody in triage, um, they said that they were going to get a, I think a consultant to come and see me. And they said you were going to induce me. **Interviewer:** Hmm.	"Finally" – implies waiting a long time/fed up?

Interviewee: Um, and that I wouldn't be leaving the hospital until I had the baby. **Interviewer:** Right. **Interviewee:** But that was quite- **Interviewer:** How were you, how you feeling at this point? **Interviewee:** I think I was really, really shocked because I just expected that I would go into labour at home. Um, and, then obviously I knew about, you know, people get induced if they're overdue and stuff, but I still thought they would induce me. I'd go home and then I'd come back later when I, further along in labour. Um, so they bought, uh, yeah, so I think this was like quite late in the evening. Um, and so yeah, just bought all my things up to the hospital. Um, and I think so, uh, they had to get a trace of the baby and it had to be like a 20 minute straight traces before they could induce me. And for some reason it took a few hours to get that. Um, so they didn't induce me until I think about two in the morning. **Interviewer:** Right. **Interviewee:** Um, they did give me the option to wait until the next morning or just do it then. So I just thought I might as well get it done. Um, **Interviewer:** Yeah. Did they give you a reason why they were inducing you then? **Interviewee:** I thought high blood pressure and for, um, lack of movement of the baby. **Interviewer:** Right. **Interviewee:** Um, so then I, yeah. So, we were just in the hospital then waiting. Um, went to sleep. I think I was in, um, I had to wait 12, no. I think 12 hours and then I was examined. And I don't think much that happened at that point. Um, and then, so it was then going to be at about the 24 hour-point that they would remove that pessary. Um, and I think do maybe a second one, but that happened, um, uh, like I think it was about 11 o'clock. My waters broke. Um, so, yeah, so my waters broke, um, they then obviously removed pessary. Um, and just kind of said to me, "Yeah, you are in labour now. **Interviewer:** What?	Expected something different - wanted to give birth at home. Waiting Fitting story into a neat time scale Communication quite abrupt

Interviewee: Um, that's it. Go get some sleep. Um- **Interviewer:** Okay. **Interviewee:** -after we contractions, like, quite bad contraction straight away. Then- **Interviewer:** Yeah. **Interviewee:** **-so**, I think I probably laid down for about an hour. Um, and then I was just, kind of, walking around and trying to manage the pain, um, and actually being sick as well, walking around on what wasn't a level award so other women were just sleeping, not in labour. Um, [laughs] **Interviewer:** Why were you in labour ward then? **Interviewee:** Because I, um, I think it was because I was just there being induced. I've- because I was in the early stages. I just wasn't in the labour ward. I was just on a- it was a maternity ward, but other women that were there, maybe much earlier in their pregnancies or whatever. **Interviewer:** Right. **Interviewee:** So, I felt a bit sorry for them in a way that I'm now walking around being sick in labour- [laughter] **Interviewee:** -and they're trying to sleep. **Interviewer:** Yeah. **Interviewee:** So, then I think it was about five in the morning or six in the morning, um, when, sort of, I was given painkillers and I think anti-sickness medicine, but I don't remember them making a difference. And then I was examined when the shift changed over. I think it was about five or six in the morning. And they basically said that they- And they monitored, um, my stomach to monitor my contractions. And they said, like, the- how close together my contractions were. I didn't match up with how dilated I was. **Interviewer:** Right. **Interviewee:** So, they then took me upstairs to the labour ward. Um, but the lift was broken so I had to walk there. I remember that was great.	Feeling out of place/self conscious Sarcasm here? Disappointment in service?

Interviewer: Why? There was anybody who was with you? Did anybody help you? **Interviewee**: Joss was with me, and there was a midwife that was like, "We can stop anytime you want." But they told me that I could have gas in there, um, and then an epidural when I go out there, so I was like, "I'm not stopping. Let's go." **Interviewer:** Yeah. **Interviewee:** Um, and they prepared me to have an epidural so that they could, um, give me an oxytocin drip to speed up the labour. **Interviewer:** Right. **Interviewee:** Um, so I was actually really pleased at that point because I always thought that you had to wait for ages before you could have an epidural, and then here they are offering it to me without me even asking. **Interviewer:** Yeah. **Interviewee:** I was quite pleased about that. **Interviewer:** Yeah. **Interviewee:** And- **Interviewer:** So at what point did you decide to-- or at what-- had you any birth plan for an epidural or was that something that you've decided- **Interviewee:** Um, so actually, I wanted to um, have a water birth, um, on the birthing center, which- so I would have um, only had gas and air. I wasn't against having an epidural or anything, but I just wanted to, I just preferred the birthing center. I think it looked much nicer. **Interviewer:** Mm-hmm. **Interviewee:** And it was less busy and just, I preferred that. Um, so I was, that was kind of my motivation that I would not have an epidural because I have a water birth, and then because I've been induced, I couldn't- cos it then became, uh, high-risk labour. **Interviewer:** Mm-hmm.	Expectations not met, had envisioned a different birth. Would have preferred a quieter environment, that choice was taken away due to the high risk labour

Interviewee: So as soon as I knew that I couldn't have a water birth, I was just quite open. Well, and especially the amount of pain I was in straight away of- **Interviewer:** Yeah. **Interviewee:** -going into an epidural. **Interviewer:** Right. So were you disappointed by them or how did you feel I suppose about not having the kind of water-birth and the birth and-? **Interviewee:** Um, I think that I would have been more disappointed if I hadn't been induced, um, because of like the baby not moving as much and because of high blood pressure, I think at that point I just thought, "Okay, fine. It is what it is." **Interviewer:** Yeah. **Interviewee:** You know, the delivery of the baby is most important. Um, so I didn't really mind, um, or I don't remember minding anyway. I think I just thought, "Well, this like this is just how it's gonna happen now. I won't be going there." And that's just on that was that, **Interviewer:** Yeah. **Interviewee:** So yes so I had gas and air, had an epidural and I would say that I then was really happy could've stayed in labour forever. Um, for about probably an hour or so. **Interviewer:** Yeah. **Interviewee:** And then I started feeling really ill. Um, I felt like I had, um, I've was sick quite a lot still. **Interviewer:** Yeah. **Interviewee:** And I-I didn't feel like the epidural was helping me anymore. I felt like I was in so much pain again and **Interviewer:** Yeah. **Interviewee:** And yeah, and I was being sick. Um, and I just had absolutely no energy. Um. **Interviewer:** Yeah.	When in pain the worry about having a water birth became less important, priority was stopping the pain

Interviewee: And they were, so I was just kind of being monitored and given like I think I was given uh, um, a drink to hydrate me and.	
Interviewer: Mm-hmm.	Detached
Interviewee: And um, yeah, I just remember being really hot. Um, and I think I just kind of laid there silently. Um, my mum and Joss were in the room. Um, so my mum was with me as well as I think partner.	
Interviewer: Yeah.	Detached
Interviewee: And they both say that I just laid there with my head back, eyes closed. Um, and I, yeah, I just thought I've had absolutely no energy and my epidural was, um, to be self-administered. So I had to press the button	
Interviewer: Mm-hmm.	
Interviewee: Um, every half an hour. Um.	
Interviewer: Yeah.	
Interviewee: I remember the midwife saying, "Don't press the button unless you can press it, because I was too weak."	
Interviewer: Right.	
Interviewee: Like, so that obviously didn't help that I then couldn't administer an epidural. Um, I think I did kind of press it a couple more times. Um, and then, yeah, I found it just the time. I mean, it didn't seem like it went on as long as it did with felt quite for me weirdly. Um, but I, um, I just kept kind of saying like, "I feel really ill-I feel really ill." They were trying to monitor the baby and, and he would move quite rapidly and then there'd be no, not as much for a long time.	
Interviewer: Yeah.	
Interviewee: So I, um, they, uh, put like a probe on his head so they could monitor him.	
Interviewer: Mm-hmm.	Not being listened to
Interviewee: As well. Um, and I said to the midwife, at one point I said, "I'm not going to be able to-to push." And she said, "Oh yes, you will." So I just remember thinking	

to myself, "Okay, you-you don't believe me, but you'll-you'll realise eventually." So, -	
Interviewer: Right.	No energy to make decisions, just left it up to the midwives, handed over control?
Interviewee: -I just laid there in silence and just waited for them to kind of make this decision on what was gonna happen.	
Interviewer: So how many were with you? Did you have, how many midwives?	
Interviewee: So, I just had one midwife with me, um, the whole time.	
Interviewer: Okay.	Confusion, different people.
Interviewee: Um, apart from, she was kind of cool, other people in for a second opinion and so they would just come and have a look. Um, and things like that and, and different consultants as well.	
Interviewer: Yeah.	
Interviewee: -consultants to come and see me as well because she was a bit worried.	
Interviewer: Mm-hmm.	
Interviewee: Um, and so I just- I remember that, um, you know, people just kept checking me and examining me and giving me different drips., and so I was given an antibiotic drip-	
Interviewer: Right.	
Interviewee: -because they thought that I had, cos I had a high temperature, so they thought that I had an infection.	
Interviewer: Yeah.	Eyes closed – hiding from pain/reality
Interviewee: Um, and so I just remember eventually a consultant came in. I still have my eyes closed at this point.	
Interviewer: Mm-hmm.	
Interviewee: Um, and I just heard somebody say, "We need to deliver the baby uh, in the next five minutes."	
Interviewer: Right.	

Interviewee: Except for I being, you know, not exactly knowing [chuckles] how you can deliver it. I just have to sell it.	
Interviewer: Yeah.	
Interviewee: Get to get the baby out. And she said, "I'm going to give you a cesarean.	
Interviewer: Right.	
Interviewee: And I just kind of, I burst out crying. And she said, "You want this cesarean?" And I was like, "Yes." Um, and so then came in and he looked at the epidural, uh, too, cos he obviously had to talk at that I can have a cesarean.	Scared
Interviewer: Mm-hmm.	Had overlooked mothers pain?
Interviewee: And I just remember him saying, "She hasn't administered it for three hours and 51 minutes."	
Interviewer: Right.	
Interviewee: And obviously then gone that long without administering the epidural at all.	
Interviewer: Yeah.	
Interviewee: Well, I had an even, I mean to me that probably seems like about half an hour. It really didn't seem like it was that long at all.	No real sense of time
Interviewer: Yeah.	
Interviewee: Um, so they taught me, never said to me, take epidural or they stuck stickers over it, plasters over it.	
Interviewer: Mm-hmm.	
Interviewee: Um, they told my husband he needs scrubs and to go and get changed. I said to my mum, you just wait in this room here	
Interviewer: Yeah.	
Interviewee: And they wheeled me out and so yeah, I was wheeled out into an operating room. I mean at this point, I think I was just completely relieved, that it was just going to be over because I didn't even, I was in pain,	Just wanted the labour over

but I didn't even, it wasn't like the pain that was bothering me. **Interviewer:** Mm-hmm. **Interviewee:** It was just how I felt like I just felt horrendous. **Interviewer:** Yeah. **Interviewee:** Uh, and I should-I should actually, when also when the consultant said to me, they're going to deliver the baby, I opened my eyes and there was just loads of people in the room that I kind of have been aware of it. **Interviewer:** Wow. **Interviewee:** So, um, so I was like, "Oh, right, there's loads of people here." Um, so yeah, I went to the operating theater and they were, I remember somebody said to me, "Can you just move over onto that bed there?" I said, "No, I have-I have had an epidural. I can't move." So they were like, "Okay." Um, moved me over. And I just kind of remember thinking, cos they took the gown off of me, so I was just now laying there completely naked, like being, having my stomach washed and there was just so many people in the room. **Interviewer:** Um. **Interviewee:** Uh, I couldn't believe it. And I just, uh, I remember they would say, "We're just gonna do this now. We're gonna do this, and we're gonna do this." And I actually didn't care or whatever, what they were doing. Um, and then, yeah, a couple of minutes later, uh, they just said, oh, I think I heard, uh, a cry. **Interviewer:** Wow. **Interviewee:** They moved the curtain down so that I could see him. **Interviewer:** Yeah. **Interviewee:** And I remember I well, I said to my husband, "As soon as the baby comes out, you need to take a picture of it." [laughter] So he said, "Here's your baby I heard him cry." **Interviewer:** Yeah.	Had been detached previously, was now aware Loss of dignity/vulnerable Stage of not caring, exhausted and wanted the labour over

Interviewee: And I'm, I just, just went, [sigh] kind of crumbled cry and I went, "Take a picture." So he took a picture and it was actually a live picture. So we've actually got a little recording of his first cry as well. Um, and they also said, um, Joss said to me, "It's a boy, cos he didn't know what we were having before." **Interviewer:** Wow. **Interviewee:** And I said a boy. And then he said, "I think he's a boy." [laughs] Um, they took-they took him over. I'm kind of like, look, you're looking him over and everything. **Interviewer:** Mm-hmm. **Interviewee:** And the Midwife said that he needed to go to the special care. Um, and they said to Joss like, "Did he want to go?" And I remember he-he was like, "What should I do?" I was like, "Obviously go with the baby." **Interviewer:** Yeah. **Interviewee:** Because they said the, I'd actually lost like half of my blood that was in my body, um, because **Interviewer:** Why? when did they say that? It's like after-while? **Interviewee:** So, I think well, I-I, I'm not sure, but I think while I was in there, they were kind of saying to me like, you're bleeding a lot." **Interviewer:** Mm-hmm. **Interviewee:** Um, obviously didn't know how much it was at the time. **Interviewer:** Yeah. **Interviewee:** Um, but I actually remember that I had, so I think I obviously had adrenaline when BABY was first born and everything, but then- **Interviewer:** Yeah. **Interviewee:** -really quickly afterwards, I had-had- **Interviewee:** -was to being safe again. **Interviewer:** But why?	Shift from worries about pain/labour to baby

Interviewee: I couldn't lift my head to be sick so I was just kinda turned it to the side and- **Interviewer:** Yeah. [laughs] . And so? [laughter] **Interviewee:** I don't know why I was so sick throughout the whole thing. [laughs] **Interviewer:** Yeah. Yeah. **Interviewee:** I was so bad. Um- **Interviewer:** What kind of emotions were you experiencing at this point because you'd obviously had quite an intense situation where you were- **Interviewee:** Mm-hmm. **Interviewer:** -taking time to theater. **Interviewee:** Yeah. **Interviewer:** And-and then, um, BABY was taken to the special baby unit and then your husband was going with him. How-how did you feel at this point? **Interviewee:** Um, I actually-- I think in-- I-- Before he-- Before that situation- **Interviewer:** Mm-hmm. **Interviewee:** I would have expected that I would be like, "Uh, I want to see my baby. I want him here." But I felt so ill that all I just thought was, he is here. They're looking after him. **Interviewer:** Hmm. **Interviewee:** I-I feel ill is kind of all I, um, felt for actually quite like a long time. Um, so yeah, they, um, they-- Obviously, they had to stitch me up and they were giving me all sorts of different- telling me what they were given me everything. **Interviewer:** Mm-hmm. Mm-hmm. **Interviewee:** That-- Different injections and, uh, things to try and stop the bleeding. Um-	Different emotions to what she expected when he was born.

Interviewer: Yeah. Did you kind of understand what they were saying to you?

Interviewee: I think I did understand, but I didn't care. Like I just-

Interviewer: Hmm.

Interviewee: Uh, yeah. The only way I can describe is just like the least energy I've ever had in my life.

Interviewer: Yeah.

Interviewee: Like I just couldn't- I don't know. I couldn't even open my eyes. So, um, and I, um, in a weird way, I guess I did kind of feel like lightheaded. So, uh, I'm kind of euphoric in a way. So I just was kind of laying there like mm-hmm, mm-hmm, mm-hmm to everything they said [laughs]. Um, because I was just like do it, whatever.

Interviewer: Yeah.

Interviewee: Whatever you need to do. Um, and, um, yeah, I kind of just remember one specific person like talking to me the most and holding the sick bowl and telling me what they were doing. Um, I get that-

Interviewer: Was that a midwife? Do you- do you know?

Interviewee: Um, I think it was, um-- I think he was a-- it was a guy. I think he was a health care assistant.

Interviewer: Right.

Interviewee: Um, um, and that it felt like I was in there for probably like 20 minutes, but actually BABY was born at one minute past six and I didn't leave there until 8:40.

Interviewer: Why?

Interviewee: I was in there for really a long time, but it-

Interviewer: Yeah.

Interviewee: -it didn't feel like it at all. Um, I was with-

Interviewer: And Mr. was-was with you.

Interviewee: -my husband. Yeah.

Interviewer: Yeah.

Interviewee: Um, yeah. So, that was, uh, yeah. So then I after that left, um, and went to a recovery room. **Interviewer:** Mhmm. **Interviewee:** And-And that's where-- So I think if I remember rightly I went into the recovery room first and I think my mum was in there. **Interviewer:** Mm-hmm. **Interviewee:** Um, and then, um, just bought BABY in. **Interviewer:** Wow. **Interviewee:** And-and the midwife like told me how much-- I think, yeah, with the midwife that had been with us all day. **Interviewer:** Yeah. **Interviewee:** Um, she told me how much he weighed, um, and just kind of spoke to us. Um- **Interviewer:** What was that midwife like? **Interviewee:** She was really nice. **Interviewer:** Yeah. **Interviewee:** And- **Interviewer:** In what way? **Interviewee:** She-she, uh, she-she was, uh, really reassuring all day and I mean for some people they might not like this, but I like that she was kind of always asking for a second opinion on things. **Interviewer:** Right. **Interviewee:** And if she wasn't sure and I feel like the-- uh, like she kind of-- Uh, sometimes you hear people that where the midwife is kind of saying to them trying to push them, "Uh you are fine." Blah blah blah. **Interviewer:** Mm-hmm. **Interviewee:** Like as much as I said, but I said to her. I can't do it. And she said, "Oh, no. You will be able to." I-I didn't feel like she and sort of- sort of didn't listen to me. Um, because, uh, you know, a lot of, uh, uh, people I know say when they're first time giving birth that the	Linguistic comment

midwives kind of make them feel like they don't know what they're talking about. Whereas, uh, she-- I felt like she listened to me. She was really reassuring. She's **Interviewer:** Yeah. **Interviewee:** Um, because I think I spent most of the lab- my labour kind of with my eyes closed and head back, but I could just hear her- **Interviewer:** Mm-hmm. **Interviewee:** -thinking with my mum and just, um, and they would kind of just come in and then they'll go. Saying things. And I just, yeah. I just felt reassured by her. I think she definitely did- Again that hospital that I had. [sound cut] **Interviewee:** -that people kind of horror stories and don't-- and will say, "Don't have your baby at that hospital. Um- **Interviewer:** Right. **Interviewee:** But I couldn't fault them. I think it was-- They did everything really well. Um, so yeah. So she then said bye to us and, um, actually, a mid-- the midwife that had walked me up that morning- **Interviewer:** Mm-hmm. Interviewee: -then came back on shift. So she came to kind of- **Interviewer:** Wow. **Interviewee:** -like now meet the baby that she kind of like was here to see me, uh, that morning. **Interviewer:** Yeah. **Interviewee:** And-and then she looked-- she actually got him dressed, um, because I was-- I had like oxygen in my nose. I had- **Interviewer:** Mm-hmm. **Interviewee:** -drips in my arms and things on my chest.	Escaping/detachment

Interviewer: Hmm.

Interviewee: I think it was just everywhere all over me.

Interviewer: Yep.

Interviewee: Um, so and so [crosstalk]

Interviewer: No. Carry on sorry.

Interviewee: Um, so yeah. First of all, um, when I went in there then BABY came in. Um, I held him for the first time properly and had skin to skin.

Interviewer: Right.

Interviewee: Um, and then, um, then my mum said bye to us and she left. And then that other midwife came in, um, and got him dre-- got BABY dressed and stuff.

Interviewer: So you had two midwives. I mean, you said the one in the [crosstalk].

Interviewee: Yeah. Yeah. Yeah. I did.

Interviewer: Yeah. And then she left her shift and then you have the other one who was there for the delivery and then the other one came back?

Interviewee: So yeah. So there was one-one like walked me upstairs to the labour ward. One was then with me for the whole day.

Interviewer: Right.

Interviewee: And then one came back afterwards, basically after the delivery. Um-

Interviewer: Yeah. Um-

Interviewee: Um, so then yeah, which was nice actually to see the same person again.

Interviewer: Mm-hmm.

Interviewee: Um, and, so yeah. Um, I think she, yeah she got him dressed, um, and she helped me, um, try to breastfeed him.

Interviewer: Right.

Interviewee: Which was quite difficult actually because every time, um, they-- I would feel okay, and I've now

been given, um, morphine and all sorts of painkillers as well. I'd feel okay-- [sound cut] **Interviewee:** -all of the energy out of me. **Interviewer:** Right. **Interviewee:** Like I-I couldn't kind of-- I felt like I couldn't be an active part in feeding him or holding him at all. **Interviewer:** Yeah. **Interviewee:** Like someone else had to hold him on me and I was just kind of laying there like a zombie. **Interviewer:** Yeah. **Interviewee:** And yeah, that kind of-- that carried on actually for like most of the night, um, because I didn't have- despite how much blood I'd lost I didn't have a transfusion. **Interviewer:** Right. Okay. **Interviewee:** I think I had, um, um, lots of fluids to kind of like actually like bag after bag of fluid through the whole night. **Interviewer:** Mm-hmm. **Interviewee:** Um, and constant-- I think-- I don't know how often it was, but like the blood pressure cuff they just took my blood pressure every so often and, uh- **Interviewer:** How did you feel a-about that because obviously you'd had the birth and then you said you had loads of tubes coming out of you and- **Interviewee:** Um- **Interviewer:** -fluids going in. **Interviewee:** Like people, uh, like friends and family and everything were texting me because when I- **Interviewer:** Yeah. **Interviewee:** -first had the epidural and everything, I was texting my friends. I felt completely fine.	Not an active participant in her experience

Interviewer: Mm-hmm. **Interviewee:** I was like, "Yeah, I'm in labour, but I'm completely fine. No problem at all." **Interviewer:** Mm-hmm. **Interviewee:** And then obviously where I kind of declined and felt really ill over-- All of a sudden. **Interviewer:** Yeah. **Interviewee:** My friends were like, "Uh, are you okay? Like what's going on?" **Interviewer:** Yeah. **Interviewee:** Um, so I-I-I kind of then at that point just looked at my phone and, um, I had loads of messages saying like, "Hoping that you're just not replying because you're just so in love with your baby. You must be so happy. You must be over the moon." Um, and I kinda looked at all those messages and like I didn't feel like that at all. **Interviewer:** Yeah. **Interviewee:** Um, I, yeah, people saying, "Oh, you must be like ecstatic that the baby's there." And all I thought to myself was, he's fine. Like that he's being looked after. He's here. He's fine. I just can't do anything. Like I felt like I couldn't move, I couldn't like- **Interviewer:** What kind of- **Interviewee:** -like I could hardly open my eyes. **Interviewer:** How-- What kind of emotions were you feeling because of that at that point? **Interviewee:** I think at the time I didn't-- It was almost kind of like, sounds a bit dramatic maybe, but like survival mode that I- **Interviewer:** Hmm. **Interviewee:** -didn't-- I wasn't sad about it at the time or anything. Whereas now I am a bit sad. **Interviewer:** Why? **Interviewee:** And-and like that I didn't get to have skin to skin with him. Even though you know, I don't think now	Detached – no feelings at this point. Didn't feel like she was expected to by her friends. Survival mode?

probably it doesn't make a difference so I don't know why I care, but I just feel like I didn't get to hold him for like a few hours and then-	
Interviewer: Mm-hmm.	
Interviewee: -I didn't get to cuddle him, and um, like I get to feed him, but like I wasn't sort of snuggling with him or anything like that. It was just him being held on me, someone latching him on feeding and taking it and I would kind of be like, you need like I need him taken off of me. Um, but like the whole night, um, is-- so at the time I didn't, I suppose I didn't think or feel anything at the time. Um, but then in hindsight like I feel a bit sad about it even though I actually, I'm sure it doesn't matter. Like I still feed him six months later and have loads of cuddles and stuff, so I'm sure he's not like affected by it, but I, um, yeah, I feel bit disappointed that that happened.	Sense of loss – trying to justify it to herself?
Interviewer: You've realised it's kind of like a lost opportunity?	Sense of disappointment, missing out on these first steps – trying to justify it and ease the sense of loss?
Interviewee: Definitely, and I also feel that about, um, I definitely feel like a missed opportunity of being able to give birth naturally.	
Interviewer: Yeah.	
Interviewee: Um, yeah, I just feel like a bit disappointed. I mean, yeah, I'm sure like if I had actually given birth naturally I wouldn't be like, oh, I'm so glad that happened. But I feel like, yeah, just a bit of like a missed opportunity to kind of just have that experience. Um, yeah.	Disappointed at not having a natural birth.
Interviewer: Um, uh, okay. Um, we'll come back to that as well, I think, in a bit. But so we've looked at your experience of giving birth, So you've spoken about that, sorry. So what about at that time in the hospital then, how long were you in the hospital for after?	
Interviewee: Um, so I was in for seven days afterwards and-	
Interviewer: Oh, no, it's long time.	
Interviewee: Yeah. So, um, because they actually found out after he was born that the infection was group strappy, and so he had to be on two types of antibiotics um, for a week. And so did I as well, but I obviously could have administered mine at home, whereas his were in a drip that he had to have at the hospital. Um, so, but I didn't, even though I knew that he was having those	

antibiotics, I didn't know that that meant we had to stay at the hospital. So, I think it was, it must've been on the Sunday morning. So he was born on Friday night, on the Sunday morning. I had one night in the recovery room, one night on a labor ward, which would, not a labor ward, sorry. You know, a general maternity ward you know for babies. Um, and that night, that night was awful. Everyone else's babies were crying and mine wasn't but because I didn't know, you know, I heard other people's babies crying. So I was constantly looking at him. Um, and then so then I really wanted to go home and on the Sunday morning a doctor came and said to me that I could be discharged and go home. **Interviewer:** Right. **Interviewee:** Um, so I was really excited like told Jess, come on, pack everything up, we can go home. Um, getting really excited, and then um, a doctor, another doctor came, which was, um, a pediatric doctor for BABY and he said, um, oh yes. So these antibiotics that he has, um, and the culture that we've like grown to check, and yes, he does have an effect and that means you can't go home for seven days. Um, so I was a bit like, my God, what. I really didn't want to stay there. Um, but a midwife came and said that they had a private room they could move me to and I could stay there. So they took me there. It was a really nice room, really big. I was really happy, and then another doctor, another midwife came and told me that I couldn't be in that room, um, because I was being discharged. I had to go to a transition ward where the mums aren't under maternity care anymore, but the babies are. So I was then really, really upset. I was told that while, um, friends of ours had come to see us at the hospital, so I think that was now like six of-- upset that we had to go back onto a ward because I hated it and I'd just been given, sort of felt like I just had an opportunity to have a private room. **Interviewer:** Yeah, what was it that you hated. **Interviewee:** I felt like I could cope with staying there for that long if I was in a private room. Um- **Interviewer:** Obviously about than what you didn't like. **Interviewee:** Um, the noise of everyone else. Um, I think was the main thing. Um, I don't know if it was just kind of bad luck or what, but the lady opposite me let her baby cry all night. Um, and even when midwives came, parents said, you want me to take your baby? She would say, "No,	Confusion and mixed messaged from medic al staff.

it's fine," um, and just let her baby cry. So I was like, wait if she is why she would do that. And then there was sort of three of us in the room and the other person who was in the room was, um, a girl that was quite young and her baby actually cried as well all night. But she was really upset that she couldn't console her. So the baby was crying. The mum was crying. Those two babies crying. One mum crying. **Interviewer:** Like you said, that-that BABY wasn't crying? **Interviewee:** No, he wasn't. We had to wake him up to feed him like, um, like every four hours or whatever. So he, yeah, he like, he was asleep. I could have kind of had like four-hour sleep at a time. Um, but I was just awake because everyone else's babies and people were crying, um, and obviously I-I couldn't actually really like move or do much for myself because the C-section was so, so painful afterwards, the recovery. Um. **Interviewer:** So did you have people there to help you on the ward if you couldn't move and- **Interviewee:** So yes. Uh, I did, but for the first night for some reason, I, so yeah, I, for those first few nights decided that I didn't need to ask anyone for help but just do it myself. Um, and um, so yeah, on the first night I just got just to do everything and on the second night for some reason I, even though he never sort of indicated this or anything and says like, of course, I wouldn't have left you. I thought to myself, if he gets really bad night sleep then he'll leave me here and I really didn't want him to leave me at the hospital. **Interviewer:** Yeah. **Interviewee:** I decided I would just do everything myself, take him out of his cot. Even I wasn't meant to lift him and do everything myself. **Interviewer:** Yeah. **Interviewee:** And then you get the next day I was like, I didn't wake you because I didn't want you to leave. He was like, "Why would I leave?". [laughs] **Interviewer:** So they let him stay then because sometimes they don't, do they?	Overwhelming environment Seeking independence? Trying to gain control?

Interviewee: Yes, so, um, at this hospital or like the partners are allowed to stay. Um, so yeah, he stayed with us the whole time actually. Um-	
Interviewer: So did you find that helpful having him there with you? Did that make the difference?	Felt vulnerable, didn't want to be left alone
Interviewee: Definitely. I, um, I just needed to kind of that security of him being there, like knowing that okay, I'm okay because he's there. I don't know, kind of, yeah, I just, I think I would have been really upset if he wasn't allowed to stay.	
Interviewer: Yeah.	
Interviewee: And then obviously, yeah, when we were in, we were-we were allowed to stay in the private room in the end, because they decided-- a doctor decided that they wouldn't discharge me, they would just keep me as a patient as well, so that I could stay in the private room, um, with him for a week. Um, and so after the-- those last two nights, I then realised that I could just ring the bell and ask a midwife to come and help me. Um, and so I did that because also they would come and monitor, um, BABY, I think it was every two or three hours. They would in the room, um, and just do observations on him. So they were coming in all the time anyway, so I kind of just be like, oh, can you just pass him to me and I'll feed him now. For the first few days breastfeeding was really easy and then it just became really hard and he couldn't latch properly and stuff, so I, um, was getting really stressed about that. So I would then just ask them, I would kind of just sit there and be like, pass me my baby, latch him on me. Like kind of, it really actually then like used kind of the help that I could get.	Seeking security from her partner
Interviewer: And did you find that they were helpful?	
Interviewee: Yeah, definitely. Some people, you know, they have different opinions, uh, different midwives have different opinions on things and some people I found really helpful and really nice. Other people I found quite mean. Um-	Accepting help
Interviewer: In what way?	
Interviewee: So, it was all really to do with, um, breastfeeding. I, you know, I had, um, so it was quite hard for him to latch on. And my milk came in quite early, so my boobs where really engorged, um-	

Interviewer: Yeah. **Interviewee:** -and therefore it made it just hard of him to latch. I really wanted to just express a bit of milk so my boobs were a bit less swollen. **Interviewer:** Mm-hmm. **Interviewee:** Um, and then he would be able to latch and some midwives were like, yes, that's a really good idea. Let me go and get your pump and then someone else would tell them, nope, she can't do that. And I felt really kind of out of control of my own body. Like I had to ask permission about whether I could express milk or not. **Interviewer:** Yeah. **Interviewee:** Um, kept saying to me, we've got a pump at home. I'll just bring it but kind of it's like, no, they won't let me. I can't, like, I'm not allowed. Um- **Interviewer:** Yeah. **Interviewee:** -and then all of a sudden I just told my mom to bring the pump, I used it. Someone walked in the room while I was using it and said, Oh, you're expressing milk? I said, yeah, I am. And then from then on, it wasn't a problem. **Interviewer:** Yeah. **Interviewee:** Every time I suggested I wanted to do that, people were saying to me, no-no, you can't-you can't. Um, but then it was almost like, as soon as I did it, they then just supported me with that decision, um-- **Interviewer:** Did you find it confusing and the people having different kind of opinions on? **Interviewee:** Definitely. Um, and it felt like literally like I had no control over what I was allowed to do. Allowed, like I'm an adult woman that's just had a baby. **Interviewer:** Yeah-yeah. **Interviewee:** Um, can I do this? Can I do that? **Interviewer:** Yeah. **Interviewee:** Um, whereas as soon as I actually did it, I then kind of felt more empowered again that people	Confusion, not in control of her own body. Permission seeking. Feeling she needed permission. Taking charge/gaining back control

would actually help me then with that decision. So, um, and then just expressed for like 24 hours and get him bottles only. **Interviewer:** Mm-hmm. **Interviewee:** Um, and then that was really-really hard. Um, another midwife said to me, do you know about um, breast shield? It might help him latch, blah, blah. As soon as I bought those, she then helped me all through the night to use them- **Interviewer:** Right. **Interviewee:** um, and that was really-really helpful. Um, because I then use those breast shield's to feed him for four months- **Interviewer:** Yeah. **Interviewee:** -until he decided that he didn't want to use them anymore. And now I just breastfeed him normally, um, for the past two months. So I definitely, as much as I hated the thought of staying at the hospital for a week afterwards, I definitely think it helped so much for me to rest after losing that much blood and having a rest back then. Um- **Interviewer:** Yeah. **Interviewee:** -secondly, um, with breastfeeding I don't-I don't know if I would have been able to feed him if I hadn't been there and had all that help, like constantly for a week. Um- **Interviewer:** So did you feel like they were supportive? **Interviewee:** But once I kind of, once I just kind of made the decision that I was going to do this and it's my choice and I can do whatever I want, then I felt that everyone after that supported me completely. **Interviewer:** And how were you emotionally at that week in hospital? **Interviewee:** Um, I would say the only day that I was like upset was the day that I thought I could go home and then was told that I couldn't, um, like when people, like my uh, mother in law came to visit and stuff and she kind of said like, how are you? And I was like, I don't even want to talk about it cos I just knew I'd get upset-	Becoming defiant, she is taking back control Started to feel empowered now she has control and does not have to seek permission. Linguistic comment - Starting to dismiss advice?

Interviewer: Yeah. **Interviewee:** -and but that day was quite bad. But then actually after that, I feel like I was quite just like, fine, I'm going to be here for a week. That means I can go home next Friday and- **Interviewer:** Yeah. **Interviewee:** -everything's fine and I just kind of accepted my life of living in a hospital. **Interviewer:** Yeah, you felt like this because they were quite clear of how long you were gonna say there for. So they, yeah. **Interviewee:** I knew what the end date was. **Interviewer:** Mm-hmm. **Interviewee:** Um, and that was, yeah, that was really good. Um-	Happy that she took back control and started to make independent decisions.
Interviewer: Yeah. **Interviewee:** -and I kind of like, once I just knew what happens, like I'm in my room on my own, like-like BABY had to go to special care twice a day, um, for his antibiotics. **Interviewer:** Yeah. **Interviewee:** Like if they would take him if we-- you know no one could go with him at the start of the week. I-I couldn't walk that far. Um, so I the jar for my mom, or like if-if they came in and we were asleep at like seven in the morning, they would just take him, bring him back, um, near the end of the week, I then like had more strength and I went with him and um, like, hold him and stuff while he was having it. **Interviewer:** Yeah. **Interviewee:** Um, so yeah, I think once I knew like this is what happens, this is what we do, then I was just fine really. Like I still wanted to go home but I wasn't kind of like, oh, I wish I could go home, wish I could go home cause- **Interviewer:** Yeah.	Acceptance of having to stay in hospital.

Interviewee: -I think, well you just got to get to Friday and then you can go home. **Interviewer:** Yeah. And so they, it seems like they provided quite a bit of practical support instead of taking the baby for you and everything- **Interviewee:** Yeah. **Interviewer:** What about emotional support, did they? **Interviewee:** Um, I think actually like they would have definitely provided emotional support, but- **Interviewer:** Yeah. **Interviewee:** I was either I wasn't, I was, I feel like I was okay. And then if I wasn't okay, I didn't want to tell them, like my mom and HUSBAND are both quite supportive. So I was just like if I was upset, I would like to speak to my mom, speak to HUSBAND, my mum came um, suppose through every day. Um-- **Interviewer:** Yeah, so you have the emotional support from your family? **Interviewee:** Yeah, and-and like, I didn't really want-I didn't really want to tell the midwives if I ever was like having a moment. I just kind of wanted to keep it to myself, like keep it in my family or whatever. Um, I think that's just-that's just personally like how I am really like I feel like I don't, you know, I'm quite happy to be an emotional person or whatever, but I just like to kind of keep it with people that I know and trust rather than- **Interviewer:** Yeah. **Interviewee:** -strangers or whatever. **Interviewer:** Yeah, what about um, so I was just check these aside- **Interviewee:** Mm-hmm. **Interviewer:** -so um, so following that then, so you were allowed home only on Friday. **Interviewee:** Yeah. **Interviewer:** How did you feel when you got home?	Gaining strength as the week went on. Emotional support through family. Reluctant to talk to midwives. Shows a lack of trust in the healthcare professionals?

Interviewee: Um, I was actually very overwhelmed when I got home. **Interviewer:** Really? **Interviewee:** Yeah. **Interviewer:** Yeah, what why? **Interviewee:** Um, so my mom and dad, cos they actually don't live near us, they live like an hour away. So they'd stayed at my house for um, like the 10 days actually that I was in there overall, um, but then the night before I was coming out they went back to there's just too, um, cause I think like my pram was at their house and stuff and I just wanted them to bring it. **Interviewer:** Yes. **Interviewee:** Um, so when we got back they weren't back yet. So they have taken my dog with them as well. Um, so it was just, I was really happy to be home. I wanted to see my dog and everything and they-they bought --when they came back I think I was laying in bed and like the dog came and she saw me on the bed and stuff which was really cute. Um, and then um, my mom had like bought me uh, like it was quite funny. I obviously when I was pregnant I wasn't allowed to eat brie. So she bought me like brie- **Interviewer:** Yeah. **Interviewee:** -and grape stuff cos I really liked. **Interviewer:** Wow nice, yeah. **Interviewee:** So because I was all fine then and then they didn't stay for too long and as soon as my mom and dad and sister left, I then just felt really like overwhelmed. Um, I don't know. I guess it was kind of like a relief of being home- **Interviewer:** Hmm. **Interviewee:** Um, I'm sorry, I was just like cried and just like what's wrong? I was like, I don't know. I'm just home. **Interviewer:** Yeah. **Interviewee:** Um, like, and it kind of felt really nice like this is now, it felt kind of like, now this is, we can just start	Healthcare professionals as strangers.

like uh, life with the baby as a family, like now we're home and everything. Um-- **Interviewer:** Yeah. Like a new beginning for you? **Interviewee:** Yeah, cause yeah I mean in the hospital. Another reason actually going back to what I said earlier, that I wanted to go, but we didn't have an epidural and stuff, you could potentially go home the same day you had the baby. **Interviewer:** Right, okay. **Interviewee:** I really didn't want to stay at the hospital for even one night. **Interviewer:** How come? **Interviewee:** Um, I don't know, I just didn't want to, I just- **Interviewer:** Yeah. **Interviewee:** -wanted to stay in my home. I-I've never stayed in hospital before. I've never had an operation or anything, so- **Interviewer:** Yeah. **Interviewee:** -um, I just didn't want to stay in a ward. I didn't want to have to stay there, I just want it to be in my own bed, my own home, and everything. Um, so in fact, I was there for 10 days. **Interviewer:** Yeah, quite different to what you have originally envisioned. **Interviewee:** Yeah. **Interviewer:** How did you feel after looking back at that, so I mean, cause like you said it was you know your original plan was to go to the birth in Santiago, go home the same day. Um, and then you ended up having a three day labor in hospital for 10 days after the cesarean. How did you feel after looking back at that? **Interviewee:** Now, I think that I'm not at all like scared to stay at hospital. **Interviewer:** Yeah.	Overwhelmed to be home Start their new life Staying in the hospital delayed their new start, felt angry at having that stopped? New and scary experience Missed home comforts/strange new place

Interviewee: Um, yeah I think next time I have a baby I wouldn't be so like determined that I was going to go home the exact same day- **Interviewer:** Yeah. **Interviewee:** -um, because it wasn't, I don't know what I thought would be bad about it, but it actually wasn't that bad. **Interviewer:** Right, you know that's really good. **Interviewee:** Yeah. **Interviewer:** So you-you probably don't have it in number two then. **Interviewee:** Yeah, and actually, funnily enough, people are quite surprised of like if I say like straight away, I'd be like, Oh yeah, I'll still have a another baby. Um, I think at first I was definitely like, I would never ever try and give birth naturally, ever. **Interviewer:** Yeah. **Interviewee:** I, um, my, again, another kind of worst nightmare of mine beforehand would've been that I would go through labor and then have a cesarean anyway. **Interviewer:** Mm-hmm. **Interviewee:** See what happens. So now the fact that that happened at first I was like well, I would just never ever try and give birth naturally. I would just have a cesarean planned, so that I didn't have to go through that again. Um, was-- as six months has going on I think. Now, I possibly, probably would try and give birth naturally again because I think now I think I would see that even if it did result in an emergency C-section, it's not actually the end of the world like- **Interviewer:** Yeah. **Interviewee:** -it wasn't nice, but it wasn't-- Now that six months have gone past it's just kind of-- It's not the end of the world. I'm not like scared for life obviously of C-section. **Interviewer:** Yeah.	Different expectations now

Interviewee: But not like emotionally scared for life by it so-- **Interviewer:** Yeah. **Interviewee:** Yeah. **Interviewer:** That's really good though. It's really positive. **Interviewee:** Mm-hmm. **Interviewer:** It hasn't put you off in any way. **Interviewee:** Um yeah, I mean actually like if I see someone have a C-section on TV, like that kind of makes me feel like emotional because it was just I like I didn't-- It was a horrible experience, but then I still-- Yeah, I'm not like put off of babies. I'm not put off of trying to have a natural labour or anything. **Interviewer:** Yeah. And what about um, so after-- So when you got home and then you were at home with the baby did you um, did you have any support after that? So did you have like a health visitor to come and see you or anything? **Interviewee:** Yeah, so um, yeah. So I think because we've been in the hospital for so long it was then like we've kind of had the first initial visit from health visitors. **Interviewer:** Right. **Interviewee:** So I think it was maybe on like day 10 to like three days after we were home. Um, the health visitor came um, to see us and I kind of acted like it was a test. Like felt like everything. **Interviewer:** Yeah. **Interviewee:** To test us. So I was like house must be spotless, like you must act like you're the most supportive husband in the world because they are testing us. [chuckles] **Interviewer:** Yeah. [chuckles] **Interviewee:** Um. **Interviewer:** And what where they like when they came? **Interviewee:** Not testing us. [laughs] Um, no. They were really nice. Um, yeah. Just normal like, "How are you	Felt tested – judged by health visitor

feeling?" Like, "Do you feel sad, depressed? Are you okay?" Um-- **Interviewer:** So they asked about your emotional welfare then? **Interviewee:** Yeah. Yeah, I think I remember and there was like kind of thing they, they read me and I had to like say different numbers on the chart. And I guess that would be their kind of like quick way to assess if you have any signs of post-natal depression or baby blues or whatever. **Interviewee:** Yeah. **Interviewer:** Um, and then I think I can't remember a couple of more times health visitor came to see us at home. **Interviewer:** Mm-hmm. **Interviewee:** Um, and then after that it was um, just way in in the community going to the clinic. **Interviewer:** Yeah. **Interviewee:** Uh, yeah. Um, so I just did that normal thing. Um, I say when he was like four months with breastfeeding, habit really changed. Um, and I got really worried that he wasn't getting enough milk, so I went to a breastfeeding clinic. **Interviewer:** Yeah. **Interviewee:** And she said to me, "Oh, he's not screaming. Um, so I-I would say he's not hungry." And I was like, "Oh yeah. I think that's true." **Interviewer:** [chuckles] **Interviewee:** But I-I yeah, I don't know about other counties or anything, but but there's loads of help that we could kind of get in the community here. Um, yeah. I kind of feel it makes most of my things as well getting help. **Interviewer:** That's really good. **Interviewee:** Yeah.	Felt pressure to pass this test?

Interviewer: Was there anything that you would change about the whole experience? You think is there anything that they could have improved on or done differently? **Interviewee:** I think they could've given me a C-section earlier in my labor. **Interviewer:** Right. **Interviewee:** Um, I don't think they needed to make me wait that long. That's the-- like I think the only thing I would fault about the hospital. **Interviewer:** Mm-hmm. **Interviewee:** Like experience in care that I had is that like I don't think they needed. I don't. Yeah, I don't think it needed to be that long for like 19 hours. Um-- **Interviewer:** Right. **Interviewee:** I think that they could've done the C-section at like in a day, one o'clock, not making me wait until six that night. **Interviewer:** Yeah. **Interviewee:** Um-- **Interviewer:** Did anyone say anything about that or?- **Interviewee:** No. Um, we did like-- We kind of we're asked to give feedback or whatever. I did like mentioned that um, everything was really good, but I felt like they made us wait too long. Um, and what kind of just makes you think I was a bit-- I don't know why they did make me wait so long. It's that midwife that was actually with me like throughout the whole day, time of my labour. **Interviewer:** Mm-hmm. **Interviewee:** Um, she kept calling for consultants to come and see me which me, makes me think that she thinks that I should've been-- that I should've been delivering the baby. **Interviewer:** Right. **Interviewee:** Um, but they obviously just took ages about it.	

Interviewer: What were the consultants like? Were they um-- Can you remember?

Interviewee: Uh, no. Not really.

Interviewer: No.

Interviewee: I can't even remember the last lady that told me that I was gonna have the baby in five minutes.

Interviewer: All a bit of a blur [chuckles].

Interviewee: Yeah. Uh, I don't want to see. I don't think I opened my eyes for most of it.

Interviewer: Yeah.

Interviewee: Um, yeah.

Interviewer: It sounds like you went through a lot. Um, but also that you kind of contract positively. Do you feel that it was-- So were there-- there was a lot of things that happened. You look on it quite positively. I think.

Interviewee: Definitely. I think like it's one of those things where I'm-I'm sure it's not for everyone, but for me like the more time that goes past away from it, the less like traumatised I feel by it. Because at first I felt very, very traumatised. Um, I found it extremely traumatic to think about it. Um, and like when I was saying when I saw someone have their C-section on TV, like I would feel really kind of overwhelmed and stuff to see that even if it was an emergency or whatever-

Interviewer: Yeah.

Interviewee: -they did. Um, but yeah, now I don't feel that bad about it. I just-- And I think um, I had a lot of

um, like from recovery until I would say about four and a half months um, post-partum. Whereas now that I haven't had pain for like six weeks or something. Even just that short amount of time I feel like I'm just kind of forgetting about it, maybe.

Interviewer: Yeah. Yeah.

Interviewee: Yeah, sort of feel that kind of-- Yeah, so I would say fine-ish about it now.

Interviewer: Yeah. Well, bless you. Yeah, amazing. And now you've got a nice, six-month old baby.

Interviewee: Yeah. Six-months.

Interviewer: Most like.

Interviewee: I guess like the-the outcome was like worth, like all of that so I-I kind of feel like I'm not gonna be like dwelling on it being sad because I would do the same again to have the same outcome so--

Interviewer: So um, what was sad about it then? So that kind of loss of--

Interviewee: I think they-- Yeah, the main thing that I find sad was I didn't held him for so long at first because even though now I'm like I'm sure It doesn't matter.

Interviewer: Yeah.

Interviewee: So when you go to baby classes and stuff they tell you how important it is to have that initial skin-to-skin um--

Interviewer: Yeah.

Interviewee: And how important it is to like breastfeed the baby straight away, have him on your chest, blah, blah, blah. But obviously I didn't see him for like three hours or an hour and a half.

Interviewer: Yeah, well I supposed it's quite difficult because people-- Yeah, you told these things. So you have your birth planned, and then when it doesn't go how you expect it to. Although things might not be possible actually.

Interviewee: And I-- As much as I think like that probably doesn't matter. I-I don’t know what the negative effects on BABY’S relationship with me could possibly be because of that.

Interviewer: Yeah. Yeah.

Interviewee: Now, like they said it's important to have skin-to-skin straight away, and I didn't do it.

Interviewer: Yeah.

Interviewee: Um, but then from the fact that I now breastfed him for six months, I'm like it can't possibly have impacted him [chuckles] negatively.

Interviewer: Yeah.

Interviewee: He's had plenty of skin-to-skin. **Interviewer:** Yeah, that's when he get those so many positive that you can. Well, I'll let-I'll let you go now 'cause you've-- We've been timed for an hour. I know you've got to get back to him, but um, thank you. **Interviewee:** That's all right. I hope that's meaningful. **Interviewer:** Um, I mean are you-are you happy now for me to leave you be? I've given you- **Interviewee:** Yeah, yeah. **Interviewer:** -um the debrief sheet as well. So um, there is the contact numbers and things on the website's exact address. **Interviewee:** Yes. **Interviewer:** So there's some support groups. There's also a GP that you can talk to. So if you do feel um, you know distressed, thinking about in the future you've got those people to go to. **Interviewee:** Yes, fine. Thank you. [laughter] **Interviewer:** We need to let you go now. [chuckles] **Interviewee:** Bye now. **Interviewer:** Um, and yeah no, that's everything. **Interviewee:** Lovely. **Interviewer:** Yeah. **Interviewee:** I hope it was helpful then. **Interviewer:** Yeah, I know it's really helpful, thank you so much. Um, and just let me know anything you need as well. **Interviewee:** Yeah. Definitely. **Interviewer:** We could talk to our staff. **Interviewee:** Lovely. Thank you. **Interviewer:** I might see you soon. So if you need participants let me know.	

Interviewee: Yeah, I will do. Thank you. **Interviewer:** Yeah, all right. Take care and um, I'll see you soon. **Interviewee:** All right. Bye. **Interviewer:** Bye. Bye.	

Initial theme ideas

Invisible
Terror
Failure
Expectations
Control
Acceptance
Loss of self
Invisible
Just a vessel/dehumanised
Trust
Survival mode
Resignation
Not getting it right
Confusion
Frustration
Loss of natural birth
Loss of dignity

Emergent theme	Example extracts
Superordinate theme 1: Trust (process/service) Subordinate themes: Contradictions/confusion Not caring about me Not doing it right/feeling judged	**Contradictions/Confusion** **Olivia:** "Um, apart from, she was kind of cool, other people in for a second opinion and so they would just come and have a look. Um, and things like that and, and different consultants as well." "and then another doctor, another midwife came and told me that I couldn't be in that room, um, because I was being discharged." "Um, apart from, she was kind of cool, other people in for a second opinion and so they would just come and have a look. Um, and things like that and, and different consultants as well." "Yeah, definitely. Some people, you know, they have different opinions, uh, different midwives have different opinions on things and some people I found really helpful and really nice. Other people I found quite mean."

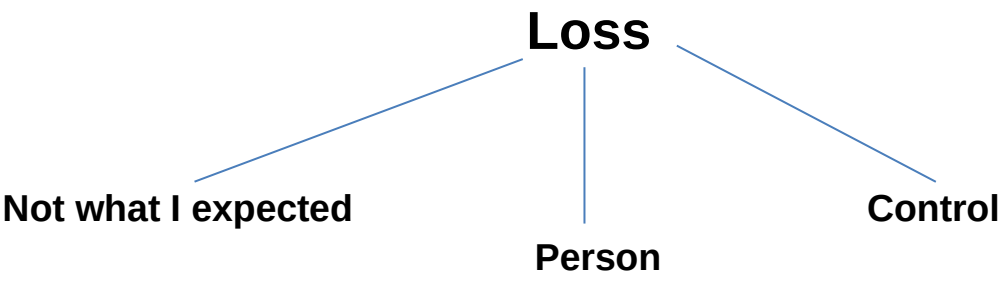
	"Um, and then he would be able to latch and some midwives were like, yes, that's a really good idea. Let me go and get your pump and then someone else would tell them, nope, she can't do that. And I felt really kind of out of control of my own body. Like I had to ask permission about whether I could express milk or not." "Um, kept saying to me, we've got a pump at home. I'll just bring it but kind of it's like, no, they won't let me. I can't, like, I'm not allowed." **Charley:** "Um, I think I'm so out of it. So I don't really know anyway." "It wasn't the same person. Um, I had I think pretty much every single time a different person." **Amy:** "Um, so my sister came back from NICU looking-looking but she couldn't find me. And she found me eventually. And then- and then she went home." "Yeah, I was- I was left and then I didn't- I wasn't kept informed on what's happening on the baby. I wasn't told what would happen to me like where I would go now, what happens next." **Delyth:** "Yeah so a bit of confusion so they thought you were ready to push and then obviously he kept going back up and down…" "To be honest I think I was so heavily drugged at that time everything was fine cos he was taken away, straight away, he wasn't breathing, there was a bit of confusion, there was obviously some point in the delivery where I think things just weren't being communicated or I hadn't remembered it properly." **Julie:** "So when she told me I could push, I was very-- I was a bit confused because I-- she measured me, you know, about an hour ago four centimetres dilated. Um, I thought like she must think I'm now fully dilated; otherwise, she wouldn't ask me to push**."** **Not caring about me** **Olivia:** "As well. Um, and I said to the midwife, at one point I said, "I'm not going to be able to-to push." And she said, "Oh yes, you will." So I just remember thinking to myself, "Okay, you-you don't believe me, but you'll-you'll realise eventually." **Charley:**

	“And then the next time I came around there was this young little blonde piece milking my nipples for colostrum.” “Like. I don't really remember. I think they're just so, so busy, so busy. They haven't got time. They haven't got time to give you the kind of care that you need. Um.” **Amy:** “And I don't know who- who was there in the morning, it was just people. So I was in the side room. It was- it was not like anyone was doing checks as such on me. I had to go and as soon as I could feel my legs again, I had to go and find someone to empty my- well look after the bag-bag of pee because it-“ “No-no one keep me informed, no one telling me what-what I should be doing or what, um, what the process is or anything like that. It was just happens and then your-your left just aside and you couldn't work-work everything out then.” **Delyth:** “and not really knowing what to do, and midwives or the nurses I think they were there but no one was really talking to me, no one was really helping me, and then one came back and said you need to feed him and I said I don’t know how um and she didn’t help me feed him she just gave me a little bottle to give him.” **Not doing it right/feeling judged** **Olivia:** “Um, the health visitor came um, to see us and I kind of acted like it was a test. Like felt like everything.” “To test us. So I was like house must be spotless, like you must act like you're the most supportive husband in the world because they are testing us.” [chuckles] **Sarah:** “No, I kinda just tried to get over it. I think I failed.” **Charley:** “Cos he'd been-- And this wench came over and she said-she said to me, "I hope he's got his clothes on under there." I'm like felt, honestly, I felt disgusted. The fact that I've been, I-I'd been through that awful birth-“ “I just woke up, um, and then she was weighing him and saying, "Look, he's lost like basically 10% of his body-- Of his birth weight. If he doesn't put on weight in the next 24 hours, he needs to go back to hospital. He is starving kind of thing," which absolutely scared the shit out of me. I was starving my baby. I mean I wanted nothing-nothing less than to do-- do you know what I mean?”

	"Um, and then she made some sort of comment about, um, not being-- Like not being well enough to look after him. And I was absolutely devastated that she would-- Like a doctor would make that kind of comment." "It felt like the old lady kind of looked me up and down, and-and that she kind of looked down on me, and just was quite disapproving of me." **Amy:** "do anything. And I- I didn't even feel comfortable touching her, because they were like watching or- um just-- Yeah, it just felt for this first few days that- that-- You know 'cos one- one woman was quite dragony. She was telling me off about other things, and I don't know, she was just a bit." "No. It's just not having people watching you all the time. It's just the- the bit of freedom to do- just to relax with your child, and then try and work out what the hell you want to do when you get home, and-" "That I don't-- Yeah. I don't like the pressure they-- It's not pressure, but it's just them judging or commenting on your parenting. So yeah."
Superordinate theme 2: Loss Subordinate themes: Not what I expected Control Person	**Not what I expected** **Olivia:** "I think I was really, really shocked because I just expected that I would go into labour at home." "I would have expected that I would be like, "Uh, I want to see my baby. I want him here." But I felt so ill that all I just thought was, he is here. They're looking after him." "Definitely, and I also feel that about, um, I definitely feel like a missed opportunity of being able to give birth naturally." **Charley:** "So, I had BABY two weeks early but it wasn't the birth I wanted 'cos I dearly, I would have liked a pool, like a birthing pool-" "But I think, you know, your-your-your social media, "Oh, I've got a brand-new baby. Look how gorgeous he is and all that," and like full makeup, full hair, looking really good. I was not like that. I didn't even barely-- I barely got dressed for six months." **Delyth:** "Umm at the time I didn't feel anyway about it. Afterwards umm I guess disappointed that I couldn't have the birth I wanted but actually, umm I don't think Ali or I would have made it if we had so ultimately it was for the best what happened, which is a bit disappointing given that he was delivered the way he did…" **Control**

	Olivia: "I felt like I couldn't be an active part in feeding him or holding him at all." "Definitely. Um, and it felt like literally like I had no control over what I was allowed to do. Allowed, like I'm an adult woman that's just had a baby." **Person** **Olivia:** "And I just kind of remember thinking, cos they took the gown off of me, so I was just now laying there completely naked, like being, having my stomach washed and there was just so many people in the room. Like someone else had to hold him on me and I was just kind of laying there like a zombie." **Sarah:** "I was just the subject. I just felt like the subject, and they were interacting between themselves just to make sure of that as well, as it could do at that point."
Superordinate theme 3: Survival mode Subordinate themes: Fear of dying How they got through it – became detached	**Fear of dying** **Olivia:** "Um, and I just heard somebody say, "We need to deliver the baby uh, in the next five minutes." **Sarah:** "I think I kind of felt- thought that I was just gonna die. Not sure. I think it was, if I'm not gonna die, then that's what I want. I was just in so much pain with the doctors." **Charley:** "So, because, I was just, I was so scared that he was going to die, or-or I was gonna-I was gonna starve him and he was gonna die." "Um, I had this baby that I was scared was gonna starve and die." **Amy:** "And it was really scary. I don't know if I've ever been so scared in my life." **Delyth:** "So I think it's only after the drugs started to wear off that I started to realise like the gravity of what had happened and um the fact that he wasn't really very well." **How they got through it/detached** **Olivia:**

	“Um, and I think I just kind of laid there silently. And they both say that I just laid there with my head back, eyes closed.” “Um, so I-I-I kind of then at that point just looked at my phone and, um, I had loads of messages saying like, "Hoping that you're just not replying because you're just so in love with your baby. You must be so happy. You must be over the moon." Um, and I kinda looked at all those messages and like I didn't feel like that at all.” **Amy:** “Sorry. No, I just felt a bit detached like I went to see her. Okay. I went to see her and it was like- like if you go somewhere and you- say Egypt, you look at a pyramid and you're like, "Well, I've seen the pyramid," and then you walk away.” “I didn't- I didn't feel like it- it was my baby. I just felt like I was looking after a baby. So like if your- it's your niece or nephew. Like how you would treat them. So you would look after them. But there's no deep emotional connection or anything like that.” “And um, so it kind of-- It was like when you visit someone else's baby in the hospital. You- you get there, you look at the baby, and then you- you leave. It-“ “like just didn't-- Obviously I knew she was my baby. It just didn't feel like it was my baby. Like that's- that's what was inside me. I don't- can't really explain it.” “I can't look at her photos when- other babies of people I don't know. Just because I felt like I wasn't there.” “Well, it- it- it-- It's just because I don't remember a lot. I- I was, um-- I- I was kind of like not detached from her. I just was-- I felt like I was in a bubble, so I- I can't remember things like- like when she crawled, her first word, or anything like that.” **Julie:** “Um, and, um, and it was about I suppose two hours later, I started to panic, uh, thinking just, "I just can't do this anymore. All right. This has gone beyond what I thought I'd have to deal with and actually, I can't deal with it anymore." Um, but then it's like I have no choice. Um, so it was I started to sort of, um, dread all the contractions and I have to just start distancing myself from it, starting to try imagine I wasn't there. Um, and just cos I felt if I just kept on concentrating, I was gonna panic and go into hysterics. I just felt so out of control.” “Um, I think the biggest thing that was different was that when he came out, um, and I didn't feel any connection to him whatsoever, [cries softly] sorry.”



Not what I expected

“I think I was really, really shocked because I just expected that I would go into labour at home” – Olivia

“Um, so actually, I wanted to um, have a water birth, um, on the birthing centre, which- so I would have um, only had gas and air. I wasn't against having an epidural or anything, but I just wanted to, I just preferred the birthing centre. I think it looked much nicer” – Olivia

“Um, so I-I-I kind of then at that point just looked at my phone and, um, I had loads of messages saying like, "Hoping that you're just not replying because you're just so in love with your baby. You must be so happy. You must be over the moon." Um, and I kinda looked at all those messages and like I didn't feel like that at all.” – Olivia

“I wasn't sad about it at the time or anything. Whereas now I am a bit sad.” – Olivia

“And-and like that I didn't get to have skin to skin with him. Even though you know, I don't think now probably it doesn't make a difference so I don't know why I care, but I just feel like I didn't get to hold him for like a few hours and then-“ – Olivia

“I didn't get to cuddle him, and um, like I get to feed him, but like I wasn't sort of snuggling with him or anything like that. It was just him being held on me, someone latching him on feeding and taking it and I would kind of be like, you need like I need him taken off of me. Um, but like the whole night, um, is-- so at the time I didn't, I suppose I didn't think or feel anything at the time. Um, but then in hindsight like I feel a bit sad about it even though I actually, I'm sure it doesn't matter. Like I still feed him six months later and have loads of cuddles and stuff, so I'm sure he's not like affected by it, but I, um, yeah, I feel bit disappointed that that happened.” - Olivia

“Definitely, and I also feel that about, um, I definitely feel like a missed opportunity of being able to give birth naturally.” - Olivia

“Um, yeah, I just feel like a bit disappointed. I mean, yeah, I'm sure like if I had actually given birth naturally I wouldn't be like, oh, I'm so glad that happened. But I feel like, yeah, just a bit of like a missed opportunity to kind of just have that experience.” – Olivia

“Well, which isn't how I imagined it to be. I think because I'd perhaps been through so so much-“ – Charley

“But I think, you know, your-your-your social media, "Oh, I've got a brand new baby. Look how gorgeous he is and all that," and like full makeup, full hair, looking

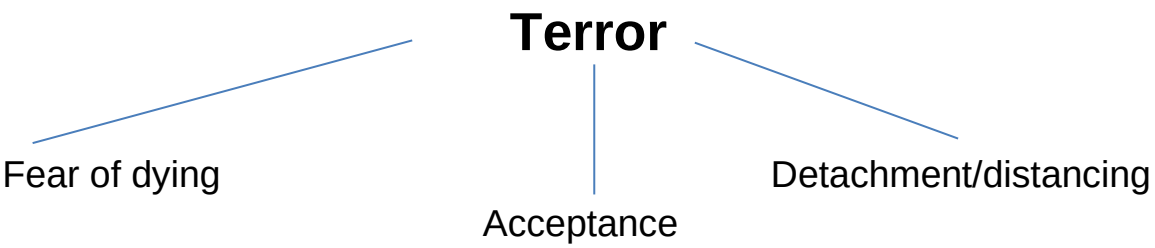
really good. I was not like that. I didn't even barely-- I barely got dressed for six months.” – Charley
“Went in for the induction and um, still had fingers crossed for a water birth and a natural birth and no it didn’t happen.” – Delyth
“Um, I think the biggest thing that was different was that when he came out, um, and I didn't feel any connection to him whatsoever, [cries softly] sorry.” – Julie
“And I was expecting so what everyone talks about, like a magical moment where you're like overwhelmed with love. And then some people have said the best be magical or, um, the best thing of their lives. And all I could think of was I was in so much pain. Um, the pain was stopping, I just couldn't-- I just couldn't really connect to him at all.” – Julie
“It was someone who said that their birth-- their whole birth experience was magical, and-and these pe-- women who are completely in control, and can control the pain through breathing exercises, and all these sort of stuff, and I was like I could've breathed in any way, and I would not controlled that pain.” – Julie
“I've always seen myself as quite strong mentally. Um, but I couldn't beat it. My mind was not strong enough to deal with that um, and so then that made it feel a lot worse.” – Julie

Control

“I felt like I couldn't be an active part in feeding him or holding him at all.” – Olivia
“Like someone else had to hold him on me and I was just kind of laying there like a zombie.” – Olivia
“Um, and it felt like literally like I had no control over what I was allowed to do. Allowed, like I'm an adult woman that's just had a baby.” - Olivia

Person

“And I just kind of remember thinking, cause they took the gown off of me, so I was just now laying there completely naked, like being, having my stomach washed and there was just so many people in the room.” – Olivia – Invisible
“I had all these things strapped onto me” – Charley
“And then the next time I came around there was this young little blonde piece milking my nipples for colostrum.” – “Um, yeah, I came around and was just like what's going on or something. I don't know if somebody else had given permission or if I had but wasn't really with it. But it was just a bit of an odd thing to kind of wake up to my husband was stood there looking pretty horrified.” - Charley



Fear of dying

“I think I kind of felt- thought that I was just gonna die. Not sure. I think it was, if I'm not gonna die, then that's what I want. I was just in so much pain with the doctors.” – Sarah

“And it was really scary. I don't know if I've ever been so scared in my life.” – Charley

I was still kind of absolutely like fight or flight just still panicking but like I-I think I must have been able to breathe because I-I remember “thinking I must stay still because otherwise I might be paralyzed or something.” – Charley

“Is it dead or-or something of-of that kind of-- It was-- [chuckles] It was almost like he wasn't human. It was that- I actually-- I didn't really-- I didn't even know if I cared or not. I just was alive.” – Charley

Detached/Distancing

“Um, and, um, and it was about I suppose two hours later, I started to panic, uh, thinking just, "I just can't do this anymore. All right. This has gone beyond what I thought I'd have to deal with and actually, I can't deal with it anymore." Um, but then it's like I have no choice. Um, so it was I started to sort of, um, dread all the contractions and I have to just start distancing myself from it, starting to try imagine I wasn't there. Um, and just cos I felt if I just kept on concentrating, I was gonna panic and go into hysterics. I just felt so out of control.” – Julie

“Um, and I think I just kind of laid there silently” – Olivia

“Um, and so I just remember eventually a consultant came in. I still have my eyes closed at this point.” – Olivia

" And I actually didn't care or whatever, what they were doing.” – Olivia

“I started to recite a Psalm from the Bible, um” – Julie

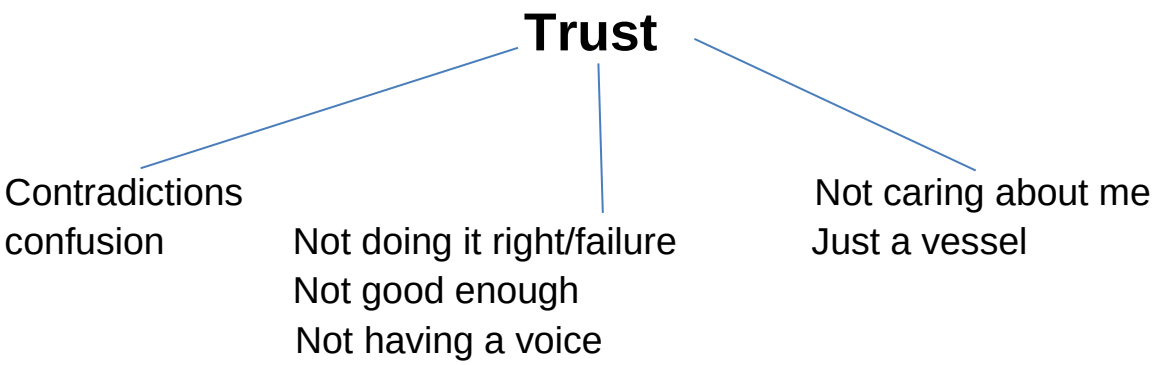
“Um, so I just started to go through them again and again and again. Um, and I think helped that a little bit and I did feel a bit disassociated. Um, and I was trying not to think, "Gosh, this has been going on for ages and I've been pushing really hard.” – Julie

“Um, and I'm out of control." And that's, yeah, cos I think there was one point where there were a few times when I started to cry, um, and I just knew that if I thought about this birth, I was just gonna, yeah, I just wasn't gonna be able to cope. Um, cos I-- I was thinking it's one of the few times in my life where I've been so beyond what I can cope with, but I have actually no choice but to keep on going. That's what's scared was feeling in control.” – Julie

“I think I was feeling, um, I think I was just-- I was just telling myself I have to get this done. I have to do this. Because otherwise, um, it's yeah, I'm just not going to be able to do it. Um, and I think it was just like me trying to just go for it. Um, and so I'm just guessing that I think it was.” – Julie

Acceptance

“You know, the delivery of the baby is most important. Um, so I didn't really mind, um, or I don't remember minding anyway. I think I just thought, "Well, this like this is just how it's gonna happen now. I won't be going there." And that's just on that was that,” – Olivia



“As well. Um, and I said to the midwife, at one point I said, "I'm not going to be able to-to push." And she said, "Oh yes, you will." So I just remember thinking to myself, "Okay, you-you don't believe me, but you'll-you'll realise eventually." – Olivia – Not believing her?

Confusion/Contradictions

“Yeah, definitely. Some people, you know, they have different opinions, uh, different midwives have different opinions on things and some people I found really helpful and really nice. Other people I found quite mean.” – Olivia

“Um, and then he would be able to latch and some midwives were like, yes, that's a really good idea. Let me go and get your pump and then someone else would tell them, nope, she can't do that. And I felt really kind of out of control of my own body. Like I had to ask permission about whether I could express milk or not.” – Olivia – permission seeking?

“Hmm, um, they're just so busy, so, so busy. And the-the-the notes-- 'Cos I really kind of studied them when we got home 'cos they didn't-they didn't add up. They didn't match up. I didn't feel like it was true.” – Charley

“But they sent my sister to go away. So I don't- I don't know. So I didn't get any updates on what was going on with her for”- -Amy

“and then because it is then the morning- following morning it was different staff again.” – Amy

Yeah, I was- I was left and then I didn't- I wasn't kept informed on what's happening on the baby. I wasn't told what would happen to me like where I would go now, what happens next. – Amy

“Um, so and I was so I was just pushing. And then as nothing was happening, I was sort of thinking, "Well, I don't think I'm fully dilated. Um, why has she asked me to push?" Um, and then at the same time, I was like, "I can't, you know, I'm not gonna argue with her. She's the midwife." – Julie

Not caring about me

“I was just the subject. I just felt like the subject, and they were interacting between themselves just to make sure of that as well, as it could do at that point. I felt like I was-- I mean I was unconscious most of the time. I felt like I was just like that. They need to, to do what they needed to do.” – Sarah

“Like. I don't really remember. I think they're just so, so busy, so busy. They haven't got time. They haven't got time to give you the kind of care that you need.” – Charley

“No-no one keep me informed, no one telling me what-what I should be doing or what, um, what the process is or anything like that. It was just happens and then your-your left just aside and you couldn't work-work everything out then.” – Amy (cried at this point)

Not doing it right/failure

“Cos he'd been-- And this wench came over and she said-she said to me, "I hope he's got his clothes on under there." I'm like felt, honestly, I felt disgusted. The fact that I've been, I-I'd been through that awful birth- “like what was she insinuating? Was she-was she insinuating that after I'd had that horrendous time that what me and my husband were going to be-be doing nooky in the bed in a hospital?” –“ I was just, I felt, I was so angry, so angry and I actually cried.” I just thought, "You vile, horrible person." And it-and it really, really upset me, it really made me feel like shit.” – Charley

“No. It's just not having people watching you all the time. It's just the- the bit of freedom to do- just to relax with your child, and then try and work out what the hell you want to do when you get home, and-“ – Amy

“Um, so she was different, but-- So anyway, she's, um-- 'Cos my house is clean and tidy, she blamed that on the reason why my milk hadn't come in.

She said, um, she looked around my house, and she said, "The reason why your milk hasn't come in is 'cos you're so uptight."

I just felt it was rude. It was to- completely uncalled for. Like if- if I've not-- If I'm struggling with milk supply, help me. Advise me. Just like now I know. I'm a bit more educated 'cos I know what they could have advised me-“ – Amy

“No, it's-it's made me-- So this sounds really weird, I don't want to have a child, I want to go through the pregnancy and birth again.

Just get it right just to have that-that feeling of doing it right.

Just being able to hold your baby straight away. Being able to feed your baby straight away.

Just without all the intervention and even if you go through all the pain than sitting just not having a withdrawal-- Not-- And just go through it as naturally as possible.”

Just being able to hold your baby straight away. Being able to feed your baby straight away.– Amy

“-and I-and I was feeling that most of the way through that. I wasn't coping with something that most women could do, uh, because I really didn't really cope well with the labour, like mentally I was not coping.” – Julie

Appendix J

Is Cognitive Behavioural Therapy effect at reducing postnatal psychopathology in women following a traumatic birth?: A Systematic Review

Abstract

Background

In the UK, up to 30% of women experience childbirth as traumatic and many go on to experience postnatal depression (PND) or Post-Traumatic Stress Disorder (PTSD) (Ayers, 2014; Slade, 2006). Whilst there are specific treatments for PTSD, such as debriefing and Eye Movement Desentization and Reprocessing (EMDR) therapy, there are limited treatments that specifically target other forms of postnatal psychopathology such as PND. However, cognitive behavioural therapy (CBT) is the recommended treatment for depression and several studies have examined its effectiveness for treating postnatal psychopathology, however results are mixed and more investigation is needed. In this review, the effectiveness of CBT as a treatment for psychopathology in women following a traumatic birth was investigated.

Method

The trial registers of Psych-INFO, MEDLINE, EMBASE, and Maternity and Infant Care were searched to identify articles published in English up to August 2017. Trials were included if they met eligibility criteria: (1) followed a quantitative design; (2) included a measurement across at least two time points; (3) assessed the effectiveness of a CBT intervention on the outcome of psychopathology in women who had given birth. Quality was assessed using an adapted Cochrane Collaboration Depression, Anxiety and Neurosis (CCDAN) quality rating scale (QRS).

Results

Six trials from five countries (Canada, Sweden, Australia, China and Brazil) were included in this review that met the inclusion criteria. The number of women contributing data to each outcome varied from 34 to 397. Methodological quality was variable, however most of the studies were of low methodological quality. The psychological interventions of Group CBT and Therapy-Assisted Internet-Delivered CBT (TA-ICBT) resulted in decreased symptoms of PND immediately after treatment with significant decreases at 10 weeks follow-up being observed in the TA-ICBT intervention. Reductions in depressive symptoms were observed, although results were mixed, with the longest lasting effects being found up to 12 months post treatment when using Internet-CBT (ICBT). There was limited evidence for the effect of CBT on patients' perceived quality of life (QOL) and anxiety.

Conclusions

There is evidence that CBT is effective at reducing psychopathology in women following birth, however there was limited evidence of its effectiveness following a traumatic birth. Further investigation of CBT for postnatal psychopathology is required utilising larger and more heterogeneous samples, with longer-term follow-up that focus on women who have experienced a traumatic birth.

Introduction

Traumatic birth

Childbirth is a complex life event that is associated with positive and negative psychological responses. When it is experienced as traumatic it can have a negative impact on a woman's postnatal emotional wellbeing (Bastos et al., 2015). Birth trauma is a subjective experience making it difficult to define (Simpson & Catling, 2016). However, it is described as a personal judgement of a woman's global birth experience that indicates personal satisfaction with the birth process and outcome (O'Donovan et al., 2014). Birth experience is multidimensional and there are many factors that can have an impact. This includes; fear for self and the infant, medical interference, perception of personal performance, type of delivery, as well as cultural expectations and environmental factors (O'Donovan et al., 2013). Between 20% and 48% of women worldwide report their birth as traumatic (Beck, 2004; Ford & Ayres 2011). Further, the experience of having a traumatic birth is not isolated to one country, but seems to be a worldwide phenomenon, with research on the subject being carried out in the UK, Australia, Canada, the USA, Europe and the Middle East (Beck, 2004; Beck et al., 2011; Boorman et al., 2014; Denis, Parant, & Callahan, 2011; Elmir et al., 2009; Ford & Ayres, 2011; Ionio & Di Blasio, 2014; Taghizadehet al., 2014).

Postnatal psychopathology

The experience of having a traumatic birth can potentially have enduring and lifelong effects for women with regards to their physical and mental health (Greenfield, Jomeen, & Glover, 2016). For example, in the UK approximately 30% of women experience childbirth as traumatic and many go on to experience anxiety, depression, postnatal depression (PND) or PTSD (Slade, 2006; Ayers, 2014). Although PND can be caused by many factors it is argued that the interplay between the traumatic event and women's perception of threat, combined with strong emotions during labour and delivery is critical for its onset (Ayers et al., 2009; Wijama, Saita & Fenaroli, 2010). PND usually develops within the first six weeks of giving birth and can affect up to 20% of new mothers (Moraes et al., 2006). The most common symptoms include; feelings of guilt, persistent despondency, sleep disorders, suicidal ideation, and loss of libido, appetite and mental function (Pinheiro et al., 2006). Further, Simpson & Catling (2016) found that women who reported their births as traumatic felt a profound sense of loss in relation to their experience of birth, motherhood, ideal family and/or sense of self. A range of other symptoms were also reported including

sexual dysfunction and intimacy issues, difficulties forming positive attachment with their infant, disruption to family life and suicidal ideation. Additionally, following a traumatic birth, women described a fear of childbirth, or secondary tokophobia – a pathological fear of pregnancy, which was linked with making a conscious decision not to have any further pregnancies or to have an elective caesarean for future births. For example, (Gottvall & Waldenström, 2002) found that 38% of women who reported a negative birth experience did not go on to have another child. Despite these findings, the literature on maternal mental health remains relatively under-explored despite the potential long-term impact and consequences for women (Ayers, Wright, & Wells, 2007; Halligan, Murray, & Martins, 2007; Sharp, Haye, & Pawlby, 1995). In the UK and Ireland, it was reported that mental health problems are one of the leading causes of maternal death. For example, in 2009 to 2013, 23% of deaths in women postpartum were caused by suicide or accidental deaths such as substance misuse.

Treatments

Evidence of psychological trauma following childbirth is now compelling and there many interventions used to reduce postnatal psychopathology. Interventions include EMDR therapy, debriefing, antidepressants, interpersonal therapy (IPT) and CBT (Dennis & Creedy, 2013). For example, debriefing aims to reduce any psychological trauma (anxiety, trauma, or depressive symptoms) and prevent the onset of PTSD. However, a recent systematic review by Bastos et al (2015) failed to find any high-quality evidence for the effects of debriefing to inform practice.

Cognitive behavioural therapy (CBT)

CBT and antidepressant medications are considered the most effective treatments for depression. However, in the postpartum period, antidepressants can have a negative effect on the baby through breastfeeding (O'Hara et al., 2000; Pearlstein et al., 2009), thus CBT is recommended by the National Institute for Health and Care Excellence (NICE) for PND (NICE, 2014). CBT focuses on modifying dysfunctional cognitions and maladaptive behaviours and has been proved one of the most effective interventions at improving peri-natal wellbeing (Dennis & Creedy, 2013; Morrell et al., 2009). However, although several studies have looked at the effectiveness of CBT as a treatment for postnatal psychopathology there have been no systematic reviews of the evidence.

Research Aim

It is estimated that the number of women who experience a traumatic birth will rise in the future due to the increasingly complex medical needs of women who are older or obese when they become pregnant (Brace, Kernaghan, & Penney, 2007; Knight, 2008; Roosmalen & Zwart, 2009). Further, PND is a disorder with high prevalence (Moraes et al., 2006; O'Hara et al., 2000) and is becoming a public health problem, it is therefore

necessary to identify treatments applicable to this patient population such as effective, low-cost, short-term strategies that yield long-term results.

Previous reviews have focused on interventions to prevent the onset of PTSD in women who have experienced a traumatic birth, such as debriefing (Bastos et al., 2015). However, these interventions have produced little or no evidence of their effectiveness. Moreover, most women who experience a traumatic birth do not go on to develop PTSD (Ayers et al., 2009) but are more likely to suffer other forms of postnatal psychopathology such as PND and anxiety which can be treated with CBT.

To date many reviews have supported the effectiveness of CBT with depression although none specifically for the effectiveness of CBT at treating postnatal psychopathology in women following a traumatic birth. Thus, this systematic review addresses this evidence gap by reviewing relevant trials that used CBT interventions to specifically reduce psychopathology in women following childbirth.

Method

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and Cochrane Collaboration recommendations were used for the reporting of this review.

Inclusion criteria

Papers were eligible for inclusion if they reported on a quantitative design and included a measurement of at least two time points, assessed the effectiveness of psychological interventions that used any form of CBT on the outcome of postnatal psychopathology, comparing them with any other treatment or a wait-list control and enrolled participants who had given birth in the past. It was decided by the researcher that studies that did not specify whether the birth had been traumatic or the type of delivery experience could be included. This was because any symptoms of postnatal psychopathology could have been related to a traumatic birth whether or not it was stated in the paper and the lack of papers available specifying the type of delivery.

Search methods

For this review a systematic search of Psych-INFO, MEDLINE, EMBASE, Maternity and Infant Care was used to search for potential publications published in English between January 1980 and June 2017. Three groups of search terms were used to search for relevant studies: CBT (CBT, Cognit* behave* therap*); birth (childbirth, traumatic birth, premature birth, caesarean); postnatal psychopathology (depression, postpartum depression, postnatal depression, postnatal psychopathology). Further search methods were employed to ensure a thorough procedure, such as contacting authors for any missing information and reference list searches. Searches were conducted between

December 2016 and June 2017 and were repeated in August 2017 to ensure that newly published research were not missed. All results were imported into RefWorks, duplicates removed, and an initial title assessment was conducted by the author. The abstracts were reviewed and the full text of any relevant studies were kept. Two authors (CP and CG) evaluated the full text of the studies independently to determine whether they met the inclusion criteria, any disagreements were discussed and only included if both authors agreed.

Quality Assessment

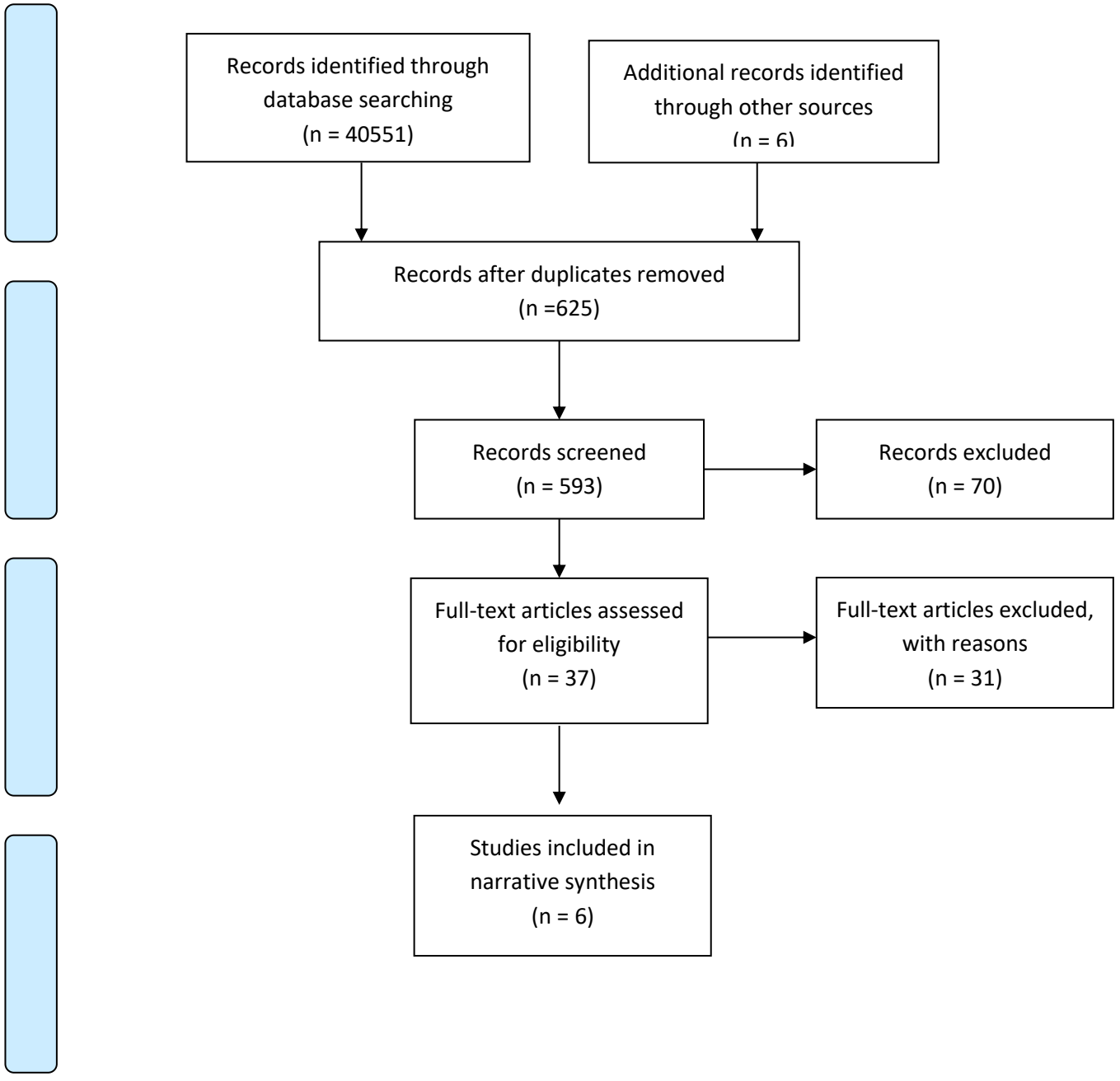
An adapted version of the Cochrane Collaboration Depression, Anxiety, and Neurosis (CCDAN) Quality Rating Scale (QRS) was used to assess the quality of the studies included (Appendix 1). This allowed the researcher to assess the studies for any risk of bias based on different domains of bias including performance bias (blinding of participants and personnel), attrition bias (incomplete outcome data), and reporting bias (selective reporting). The adapted version contained a total of 20 questions with each item allowing a score of between 0 and 2 with a total available score of 40. Studies with a score of greater than 30 indicated high methodological quality.

Data Extraction and Analysis

An adapted version of the Cochrane data collection form for intervention reviews: RCTs and non-RCTs was used to extract data from the studies (Appendix 2). The relevant information extracted included; study characteristics, population description, sample size, methods of recruitment, risk of bias and main results.

Due to the high amount of variation in the studies available, for example the outcome measures used and the types of intervention, a meta-analysis was not possible with the data. Instead, a narrative synthesis was carried out to draw together the evidence and findings of the review.

SMA 2009 Flow Diagram



Data synthesis and appraisal

Included studies

Six trials were included in this review (Ngai et al., 2017; Nieminen et al., 2016; Milgrom et al., 2015; Pinheiro et al., 2013; Pugh et al., 2016; Van Lieshout et al., 2016). There was no disagreement between the author and second reviewer about which trials to include. The data extraction table contains brief descriptions about the interventions, the participants and the results. Following this, a narrative synthesis will summarise the studies.

Table 1

Characteristics of the 6 Included Studies

Study	Study aim	Setting	Sample size and characteristics	Design	Intervention	Length and success of follow up	Outcomes measured	Key Results	Quality score
Nieminen et al., 2016	Analyse the effects of trauma-focused cognitive behavioural therapy (TF-ICBT)	Sweden	56 Women Mean age = 34.6 Swedish	Randomised control trial Control group – waiting-list control with treatment as usual Treatment group – TF-ICBT	Trauma-focused online cognitive behavioural therapy (TF-ICBT) Included exposure components for PTSD following childbirth developed specifically for the project Therapists = 7 MSc psychology students and 1 obstetrician	8 weeks, 93% followed	PTSD – Traumatic Event Scale (TES) PTSD – IES – R Anxiety – Beck Anxiety Inventory (BAI) Depression – Patient Health Questionnaire (PHQ-9) Quality of Life – Quality of Life Inventory (QOLI) Health-related quality of life - EuroQuol Dimensions	After treatment results: Significant reduction in TES (p< .0001) Significant reduction in IES-R (p< .0001) Significant reduction in BAI (p<.004) Significant reduction in BDI (p<.006) Significant reduction in PHQ9 (p< .0001) Significant reduction in QOLY (p<.049) Significant reduction in EQ5D (p< .01)	16

Van Lieshout et al., 2016	Evaluate the effectiveness of a brief group CBT intervention for postnatal depression in a sample of women referred to a specialist perinatal mental health clinic.	Specialist perinatal mental health clinic Canada	34 women Mean age = 32.7 91.2% Canadian born Women were either pregnant or in first 9 months postpartum	Effectiveness study – before and after (pre & post)	Brief group cognitive behavioural therapy Weekly 2-hour intervention (first half core CBT content, second half psycho-education and guided discussion on topics relevant to women with PND)	9-weeks, 83.25% followed	Levels of depressive symptoms – Edinburgh Postnatal Depression scale (EPDS) Depression – Beck Depression Inventory (BDI) Mother-infant bonding – Postnatal Bonding Questionnaire (PBQ) Social support – Social Provisions Scale (SPS) Partner relationship quality – Dyadic Adjustment Scale (DAS) Participant satisfaction (Client Satisfaction Questionnaire (CSQ-8)	After treatment at 9 weeks: Significant difference in EPDS (p= <0.001) Significant difference in BDI ((p= <0.001) Significant difference in PBQ (p= 0.003) Significant difference in SPS (p= <0.001) Significant difference in DAS (p= 0.004) The mean CSQ score was 30.2 (SD = 1.9) out of a possible total of 34, indicating very high levels of patient satisfaction with the group CBT intervention.	18
Milgrom et al., 2015	To compare the relative efficacy of mono-therapy with an SSRI	Women who had recently given birth in	45 women Mean age = 30.1	Randomised control trial	Group cognitive behavioural therapy, sertraline,	24 weeks 12 weeks at weekly	Depression – The Beck Depression Inventory (BDI)	Significant reduction in BDI after week 5 (p= 0.01). However, not	20

	(sertraline), CBT mono-therapy and combined treatment at reducing symptoms of depression and anxiety and t monitor trajectory of depressive symptoms in each group weekly for the first 12 weeks of treatment.	Melbourne, Australia	Had an infant between 2 and 8 months of age		combination of both	intervals (9 sessions for women only and 3 for couples)	Anxiety – The Beck Anxiety Inventory (BAI) Stress – The Parenting Stress Index (PSI)	significant at follow-up. No significant reductions in BAI observed after 5 weeks. No significant reductions in PSI observed after 5 weeks.	
Pugh et al., 2016	To conduct a parallel-group randomised controlled trial to determine the efficacy of Therapy-Assisted Internet-Delivered Cognitive Behavior Therapy (TA-ICBT) for the treatment of postpartum depression.	Women who had given birth within the past year in Saskatchewan, Canada	50 women Mean age = not stated +18 years Gave birth to an infant in the past year	Parallel group randomised control trial	Therapy-Assisted Internet-Delivered Cognitive Behavior Therapy (TA-ICBT) Internet-therapists included 2 Doctoral students in Clinical Psychology	14 weeks 7 modules over 7 weeks	Depression – Edinburgh Depression Scale (EPDS) Depression and anxiety – The Depression Anxiety Stress Scale – Short version (DASS) Stress – The Parenting Stress Index – Short form (PSI-SF) Quality of Life – The World Health Organisation Quality of Life Assessment BREF (WHOQOL-BREF)	A statistically significant change in EPDS scores over time, $F(1,20.99) = 16.23$, $p = .001$. Statistically significant change in EPDS scores at follow-up, $t(14) = 4.13$, $p < .01$, $d = 1.10$. Consistent with primary hypothesis, a condition by time interaction, $F(1, 11.82) = 5.15$, $p = .02$. When compared to the WLC, the TA-ICBT at T2 (controlling for scores at T1) produced lower stress (β = -.41), lower parental stress (β = -.25) and distress	29

								(β = -.41), and better psychological health (β = .34) and environmental quality of life (β = .31).	
Ngai et al., 2017	To examine the effect of T-CBT on HRQoL among Chinese mothers at risk of postnatal depression at 6 weeks and 6 months postpartum.	Chinese mothers at risk of postpartum depression	397 Chinese women Mean age, intervention = 31.1, control = 30.4 Women 1-5 weeks postpartum	Randomised control trial	Telephone-based cognitive behavioural therapy	6 months 5, 30 minute telephone-CBT sessions over 5 weeks	Quality of life - Health-related Quality of Life (HRQoL)	The GLMMs results yielded a significant effect in group-bytime interaction for PCS ($F[2,1147] = 3.58$, $p = 0.028$). The physical component of HRQoL improved significantly more in the intervention group than in the control group between baseline and 6 weeks postpartum (mean difference 1.76 [95% CI, 0.19–3.33]; $p = 0.028$; $d = 0.31$), and between baseline and 6 months postpartum (mean difference 1.89 [95% CI, 0.48–3.30]; $p = 0.009$; $d = 0.39$). The GLMMs results yielded a significant effect of group on MCS ($F[2,1147] = 7.58$, $p = 0.006$). Analyses of between group	30

								contrast demonstrated that the T-CBT group had a higher score on the mental component of HRQoL than the control group at 6 weeks postpartum, but the effect was marginally non-significant (mean difference 1.24 [95% CI, −0.04–2.52]; *p* = 0.057). At 6 months, the T-CBT group had a significantly higher score on the mental component of HRQoL than the control group (mean difference 1.19 [95% CI, 0.09–2.28]; *p* = 0.034; *d* = 0.18).	
Pinheiro et al., 2013	To evaluate maintenance of the effects of models of manualised cognitive	Women who had given birth to babies in maternity wards in the city Pelatos in Southern Brazil	320 women who had recently given birth Mean age, CBT = 26, RCT = 27.5	Randomised control trial	One-to-one cognitive behaviour therapy and relational	12 months 60 days of programme	Anxiety – The Beck Anxiety Inventory (BAI)	A significant reduction in BDI score was observed after the intervention (*p* < 0.05). This was	29

	behaviour therapy and relational constructivist therapy for seven sessions with women with postpartum depression.				constructivist therapy Therapists were Clinical Psychology interns		Depression – The Beck Depression Inventory (BDI)	maintained at follow-up. For the BAI score, however, the reduction following CBT was not significant (t = 3.953; *p* = 0.064).	

Of the six studies, five were described as ‘randomised control trials’ (RCTs). Two studies (Nieminen et al., 2016; Pugh et al., 2016) used a waiting list control design whereby the control group received the same treatment as the treatment group after a set period. Milgrom et al (2015) used a parallel RCT design whereby three treatment conditions were compared; CBT, sertraline, and a combination of both. Ngai et al (2017) used a RCT design where telephone-based CBT (T-CBT) was compared with usual postpartum care. Pinheiro et al (2013) used a RCT design comparing CBT and RCT. One study (Van Lieshout et al., 2016) was described as an ‘effectiveness study’ measuring the impact of a brief group CBT before and after treatment.

Study characteristics

Sample sizes

The number of women included in the studies ranged from 34 to 397.

Setting

Study samples in all trials included in this review recruited participants from high to upper-middle income countries. Thus, findings from this review are only applicable to similar contexts and settings.

Participants

One trial (Ngai et al., 2017) selected participants with a score of >9 on Edinburgh Postnatal Depression Scale (EPDS) and one (Pugh et al., 2016) with a score of >10 on the EPDS. One trial (Van Lieshout et al., 2016) specified that participants had a primary diagnosis of major depressive disorder, although there could be additional psychiatric comorbidities and one (Milgrom et al., 2015) specified a diagnosis of depressive disorder with postnatal onset. Two of the studies did not stipulate a specific diagnosis.

Of the six trials, four (Milgrom et al., 2015; Pinheiro et al., 2013; Pugh et al., 2016; Van Lieshout et al., 2016) did not include any information about the type of delivery participants had experienced. Two (Ngai et al., 2017; Niemen et al., 2016) of the six trials did provide a detailed breakdown in tabular form of the type of delivery experienced by the participants. Most trials excluded participants under the age of 18 years (Ngai et al., 2017; Nieminen et al., 2016; Pinheiro et al., 2013; Pugh et al., 2016) apart from one (Milgrom et al., 2015) who excluded participants under the age of 19 years. Additionally, one trial did not provide information about any age limits being specified (Van Lieshout et al., 2016) but did state there was a mean age of 32.7 years.

Of the six trials, three (Niemen et al., 2017; Pugh et al., 2016; Van Lieshout et al., 2016) did not exclude participants if they were currently taking medication. For example, Niemen et al (2017) only recruited women that if taking medication had been taking the same dose for at least one month and had no intention of changing the dose during the programme. The other

three trials did not accept participants if they were taking any form of antidepressant medication (Milgrom et al., 2015; Ngai et al., 2016; Pinheiro et al., 2013).

Half of trials excluded women who were currently participating in any other form of psychotherapy or receiving psychiatric care (Ngai et al., 2016; Niemen et al., 2016; Pugh et al., 2016). Van Lieshout et al (2016) included women who were seeing a counsellor and/or were taking any form of psychotropic medication. However, the other two trials did not state whether this was an exclusion criterion (Milgrom et al., 2015; Pinheiro et al., 2016).

Interventions

Type of Interventions

The intervention in two trials consisted of an online CBT intervention. For example, Nieminen et al (2016) used trauma-focused online CBT (TF-ICBT) with exposure components for PTSD following childbirth developed specifically for the project. Pugh et al (2016) used an adapted form of Therapy-Assisted Internet-Delivered CBT (TA-ICBT) (Maternal Depression Online) for depression through the Online Therapy Unit for Service Education and Research. One trial used a structured telephone CBT (T-CBT) intervention adapted from a CBT manual (Wright et al., 2006) and modified for PND based on local experience (Ngai et al., 2009). Van Lieshout et al (2016) used a brief group CBT programme consisting of nine 2-hour sessions. The first half comprised of core CBT content and the second-half used psycho-education and guided discussion on topics relevant to women with PND. Pinheiro et al (2013) used a CBT manualised programme constructed according to Beck's proposals and Milgrom et al (2015) followed a manualised, replicable CBT treatment (Milgrom et al., 1999; Milgrom et al., 2005).

Frequency of Interventions

The number of sessions for each trial varied between 5 and 12 and all were conducted at weekly intervals. The shortest duration of treatment was 5 sessions over 5 weeks (Ngai et al., 2017). Pugh et al (2016) carried out 7 modules over 7 weeks, Nieminen et al (2016) carried out 8 modules over 8 weeks and Van Lieshout (2016) carried out 9 sessions over 9 weeks. The longest duration and number of sessions was 12 sessions over 12 weeks with 9 sessions solely for the women and the last 3 for couples (Milgram et al., 2016). One trial (Pinheiro et al., 2013) did not state the number of sessions or how often they were conducted, however the treatment was described as short-term (60 days). Additionally, the timing of each intervention varied between 30 minutes (Ngai et al., 2017) and two-hours (Van Lieshout et al., 2016).

Onset timing of intervention

The interventions in all trials were administered at different points. One intervention took place either during pregnancy or in their first nine-months postpartum (Van Lieshout et al., 2016). Three of trials took place at different points following birth (Milgrom et al., 2015; Ngai

et al., 2016; Pugh et al., 2016). For example, Milgrom et al (2015) commenced treatment between two and eight months postpartum, Pugh et al (2016) commenced treatment up to one year postpartum and Ngai et al. (2017) commenced treatment between 1 and 5 weeks postpartum. Two trials did not mention when the intervention was delivered (Niemen et al., 2016; Pinheiro et al., 2013).

Outcomes

Niemen et al (2016) compared the prevalence of PTSD or PTSD symptoms and the severity of the symptoms (primary outcome) between the treatment group who received TF-ICBT and the waiting list control group who received treatment as usual. Five trails (Milgrom et al., 2015; Niemen et al., 2016; Pinheiro et al., 2013; Pugh et al., 2016; Van Lieshout et al., 2016) examined the prevalence or severity of depression symptoms, two of these included PND as an outcome (Pugh et al., 2016; Van Lieshout et al., 2016). Four trials (Milgrom et al., 2015; Niemen et al., 2016; Pinheiro et al., 2013; Pugh et al., 2016) examined the prevalence or severity of anxiety. Three trials (Ngai et al., 2017; Niemen et al., 2016; Pugh et al., 2016) assessed the prevalence or severity of quality of life (QOL). Two trials (Milgrom et al., 2015; Pugh et al., 2016) assessed the prevalence or severity of stress. Only one study (Van Lieshout et al., 2016) assessed changes in levels of mother-infant bonding, perceived social support, and relationship quality before and after treatment. Additionally, of the six studies, half assessed patient satisfaction (Niemen et al.,2016; Pugh et al., 2016; Van Lieshout et al., 2016).

Risk of bias in included studies

Allocation

Overall, there was low risk of allocation bias. Two of the trials (Niemen et al., 2016; Pugh et al., 2016) used methods that seemed to result in sufficient sequence generation (online random allocation). For example, Niemen et al (2016) conducted randomisation using an online true-random number service conducted by a person not involved in the project. Two of the studies (Milgrom et al., 2015; Ngai et al., 2017) used permuted blocks randomisation to reduce the chance of imbalances across important baseline characteristics between the control and intervention groups. However, one study (Pinheiro et al., 2013) described using an opaque, closed envelope containing a card with the name of one of the two interventions. This was conducted by a member of the team who was involved in the study possibly introducing selection bias. Van Lieshout et al (2016) did not use any form of random allocation as this was an effectiveness study with no control group.

Blinding of participants and personnel (performance bias)

There was a high risk of performance and information bias because blinding was not possible for treatment providers or participants due to the nature of the interventions included in this review. Thus, none of the included studies, apart from one, were free from

performance bias. For example, Ngai et al (2017) minimised the risk of bias by blinding their research assistants to the treatment assignment. Of all the studies, only Pugh et al (2016) briefly discussed unblinding issues stating in their discussion “It was not possible for the study therapists and participants to be blinded to the treatment assignment.”

Incomplete data outcome assessment (detection bias)

All the studies, except for one, provided detailed information of the levels of attrition. For example, Milgrom et al (2015) did not provide any participant characteristics about the percentages of women who did not complete the treatment, instead they stated, “The women completed an average of 10.6 of the possible 12 sessions and all completed at least half of the sessions”. In Niemen et al’s 2016 study the levels of attrition were high with 54% completing all 8 weeks of treatment in the treatment group and 28% completing all 8 sessions in the control group. Some trials reported the potential systematic differences between the women who completed treatment and those who withdrew. For example, in the Van Lieshout (2016) study women who dropped out were significantly older (U=26.5, p=0.024) and reported more social support (U=19.5, p=0.011). Pugh et al (2016) reported that although 60% of participants completed treatment some data was missing and no reasons were given. However, they used a longitudinal mixed model which uses all data on each subject and is unaffected by randomly missing data to account for this. None of the other studies provided any information about whether they had issues with missing data and how this was accounted for.

Other potential sources of bias

Most studies did not report any significant baseline imbalances between the intervention and control groups after randomisation. However, Van Lieshout’s (2016) study examined pre to post change scores in the absence of a control group and did not restrict the participants’ ability to see their mental health counsellor or physician outside of the group. By not randomly allocating participants to treatments and allowing them to seek outside treatment there is the risk of selection bias and pre-treatment differences that could have affected results.

There were potential cases of underpowering due to small sample sizes. For example, in Niemen’s study (2016) 80 participants were needed to detect a between-groups effect size of .70 (Cohen’s d) with 80% power, however only 51 participants were analysed at the end of treatment. Additionally, in some trials, there were large numbers of eligible women who declined participation. If the women who did not participate were systematically different from those who did, this could have resulted in study bias and therefore limit the generalisability of the study results.

There were several confounding factors that could also have impacted results. For example, in half of the studies large numbers of participants were reported as taking some form of

psychotropic or anti-depressant medication. Thus, medication could have been partly responsible for any improvements in the psychological functioning of participants.

Prominent findings/Results

The following section firstly reviews the primary outcome measures from the included studies followed by any secondary outcomes that were assessed. Secondary outcome measures were included in this review as it was felt that this could add to the current literature around the effectiveness of CBT at treating postnatal psychopathology in women following labour.

Trauma

There is good evidence that CBT can be effective at treating PTSD using a short-term TF-ICBT. However, the evidence came from one study (Niemen et al., 2016) that was low in methodological quality. They found a significant reduction in the presence of PTSD symptoms after 8 weeks of TF-ICBT ($p< 0.001$) and significant reductions in self-reported symptoms of posttraumatic stress symptoms ($p< 0.001$).

Postnatal depression

There is good evidence that CBT is effective at treating PND in the short-term (after 9 weeks), however there is no evidence to support its effectiveness long-term. For example, two of the trials (Pugh et al., 2016; Van Lieshout et al., 2016) directly measured the impact of CBT on PND, however the delivery of the CBT intervention differed across both studies and the results were mixed. Van Lieshout et al (2016) reported a clinically significant decrease in PND symptoms after 9 weeks of a brief group CBT treatment ($p<0.001$) and a large effect size ($d= 1.97$). However, the study was limited in its methodological quality, with a lack of control group, high drop-out rate and the participants ability to seek other psychological treatments at the same time as well as taking psychotropic medication all of which could have impacted results. Further, the effects of the intervention were not measured after treatment ended thus it is unknown whether these improvements were sustained in the long-term. However, the study does suggest that a brief group CBT intervention can be effective at reducing postnatal depression in women following childbirth in the short-term. Further, there is good evidence that brief TA-ICBT is effective at treating PND with affects being maintained at follow up. For example, following a 7 week TA-ICBT programme Pugh et al (2016) reported a statistically significant change in PND at 10 week follow-up, $t(14) = 4.13$, $p < .01$, $d = 1.10$.

Depression

Overall, there is mixed evidence for the effectiveness of CBT interventions when treating depression, with some moderate evidence that reductions are maintained or improved over a follow-up period post intervention up to 12 months. However, the majority of evidence shows that improvements are only maintained up to 12 weeks. For example, all the trials,

except one, reported significant decreases in depression symptoms after treatment. Two of the three trials measuring the outcome of depression found a significant decrease in depressive symptoms. Van Lieshout et al (2016) reported a clinically significant decrease in depressive symptoms after 9 weeks of brief group CBT ($p< 0.001$) and a large effect size ($d= 1.89$). Milgrom et al (2015) also reported a significant reduction in depression after the initial 12 weeks of group CBT treatment ($p< 0.001$), however reported that scores fell into a minimal range immediately post-treatment. They reported that despite the non-significant result after 24 weeks it was near significance and the effect size was large ($\eta p^2 = .21$). These results indicate that group CBT therapy is effective at reducing depression in the short-term however reductions may not be sustained long-term. There is also evidence that brief ICBT is effective at reducing depression in women following birth. For example, Pinheiro et al (2013) reported a significant reduction in depression ($p< 0.05$) after 60 days of one-to-one CBT treatment and results were maintained at 12 months follow up. However, none of the studies were high in methodological quality and contained a moderate-high risk of bias which could have impacted on results. For example, many had small numbers of participants, lack of blinding and were under-powered.

Anxiety

There is moderate evidence that CBT is effective at reducing anxiety, however no evidence was found for its long-term effectiveness. For example, half of the studies measured the outcome of anxiety (Milgrom et al., 2015; Niemen et al., 2016; Pinheiro et al., 2013), all of which contained a moderate-high risk of bias, with one significantly reducing anxiety following treatment and one significantly reducing anxiety following treatment but not at follow-up. For example, Niemen et al (2016) found significant reduction after 8 weeks of TF-ICBT, however it was not stated whether this reduction was maintained over time. Additionally, Milgrom et al (2015) found a significant difference in anxiety after 12 weeks of group CBT, $F(1,41) = 8.65$, $p= 0.007$, $\eta p^2 = 26$ but not after treatment ended at 24 weeks suggesting that it may be effective in the short-term reduction of anxiety.

Quality of Life

There was moderate evidence of the effectiveness of CBT on the outcome of QOL. For example, of the three trials measuring quality of life (Ngai et al., 2016; Niemen et al., 2016; Pugh et al., 2016), two did not find any significant effects at the end of treatment. Further, these trials were of low methodological quality and contained a high risk of bias which could have impacted on their results. However, Ngai et al (2016) reported significant differences in quality of life scores both components of the HRQoL after treatment of T-CBT and this trial was of high quality with low risk of bias. Although two of the studies reported no significant effect of CBT on quality of life there is some high-quality evidence of a beneficial effect of T-

CBT on women's HRQoL during the early postpartum period that was maintained at 6 months postpartum.

Stress

Two of the studies (Pugh et al., 2016; Milgrom et al., 2015) measured the outcome of stress and observed lower levels in the treatments groups, however these did not reach statistical significance and the studies were considered to include a moderate risk of bias. Therefore, the evidence suggests that CBT does not significantly reduce stress in women following labour.

Other outcomes

There was moderate evidence that brief group CBT and TA-ICBT can be effective at treating other forms of psychopathology. For example, Van Lieshout's (2016) study measured the outcomes of mother-infant bonding, perceived social support and relationship quality. They reported statistically significant improvements on all study outcomes. Further, the intervention produced gains that corresponded to large effect sizes on the social provisions scale (SCS) that measured perceived social support (d = 0.93), and moderate effect sizes on the postpartum bonding questionnaire measuring mother-infant bonding (d = 0.57) and on the dyadic adjustment scale (DAS) that measured partner-relationship quality (d = 0.340). Additionally, Pugh et al (2016) assessed dysphoric mood, fear and autonomic arousal, and general nervousness and agitation using the Depression and Anxiety Scale – Short Form (DAS). However, no significant differences between the treatment group and wait-list control were reported. Additionally, these studies lacked methodological quality which could have impacted results.

Patient satisfaction

Half of the studies assessed patient satisfaction with all reporting high levels post treatment. For example, Niemen et al (2016) assessed acceptance of the intervention using closed and open-ended questions at follow-up and stated that majority in both groups found the programme helpful for their problems (83.3% in the treatment group and 82.4% in the control group). This provides strong evidence that CBT is an acceptable treatment for women with postnatal psychopathology.

Discussion

This systematic review conveys mixed findings of the effectiveness of CBT interventions at reducing postnatal psychopathology in women following birth.

Overall, there did not appear to be a trend in favour of the type of CBT intervention. For example, results found moderate evidence that brief TF-ICBT is effective at reducing PTSD symptoms, depression, anxiety and improving QOL in women following a traumatic birth, although it was unknown as to how long these improvements lasted as there was no follow-up. Additionally, brief group CBT interventions were effective at reducing depression in

women following labour after 9 weeks of an intervention, however it was unknown if these results had a lasting effect. Further, the group interventions were not effective at reducing stress. One-to-one CBT interventions yielded significant reductions in depression and these improvements were observed at 12 months follow-up, though the intervention was not effective at significantly reducing anxiety after treatment or at follow-up. However, the evidence needs to be interpreted with caution as only one study was of high methodological quality. This study used a T-CBT intervention for the outcome of QOL, however no significant improvements were found at 6 months follow-up. Additionally, there were only a limited number of studies within this review that directly measured the impact of PND following birth. However, these did provide evidence of a reduction in PND, one following a brief 9-week group CBT intervention and one following a brief 7-week TA-ICBT intervention. However, there was limited evidence of the lasting effects of these improvements. Evidence was also found for effectiveness of brief-group CBT interventions for the treatment of mother-infant bonding, perceived social support, and relationship quality following a brief group CBT programme.

Thus, the results from this review, although mixed, support previous evidence that CBT can be effective treatment at reducing some forms of postnatal psychopathology, such as depression and PND, in women following birth, however there is limited evidence of the long-term effectiveness of such treatments and a lack of high-quality studies.

Study limitations

Of the six studies included in this review, only one was high in methodological quality. For example, all the others had several methodological limitations. These included a lack of allocation concealment, lack of blinding and incomplete outcome data. Therefore, when assessing each outcome, much of the information was based on studies with unclear or sometimes high risk of bias making the estimate of the effect of CBT as a treatment for psychopathology weak. Additionally, different formats of CBT were used within the studies making it difficult to determine the types of CBT treatment that are most effective at treating postnatal psychopathology. There was also a lack of information available detailing the type of birth experienced by participants and whether they were considered ‘traumatic’. Further, the study samples in all trials were from upper-middle to high income countries thus results are only applicable to similar contexts and settings.

Future research

Additional well-designed trials of CBT for postnatal psychopathology are required with larger, more diverse samples, that include longer-term follow-up times. Additionally, more studies that include women who have identified as having a traumatic birth are needed to address the question of whether CBT is an effective intervention at treating this population.

Recommendations for practice

This review found only a limited number of high-quality studies providing evidence that can be considered to inform practice, with research conducted to date being too varied to provide consistent evidence to support a positive effect for CBT in the treatment of postnatal psychopathology in women following a traumatic birth. However, there was some evidence of the effect of short-term, manualised treatments of CBT, that included PTSD or PND components on women with a diagnosis of either PND or PTSD. Although the quality of evidence was low, the studies did show that some CBT treatments can be effective at reducing psychopathology and that participants were highly satisfied with the treatment. Therefore, CBT needs to be considered by healthcare practitioners when identifying which specific treatments to use when working with this population. Thus, women who show symptoms of depression following a traumatic birth should be offered some form of short-term, manualised CBT that include PTSD or PND depression components as an intervention to help reduce these symptoms and prevent further mental health problems from occurring.

Strengths and limitations of the current review

The strengths of the present review include the consideration of a variety of postnatal psychology outcomes that include anxiety, stress, quality of life, patient satisfaction measures and the use of a standardized quality assessment tool. The systematic narrative approach allowed for flexible comparisons to be made for studies that used a wide variety of measures, designs, implementation of interventions, and follow-up periods. However, a limitation of the current review was a lack of information within the included studies about the types of birth experienced by the participants and whether they had been considered 'traumatic'. Therefore, it is unclear whether results can be generalised to women who have experienced a traumatic birth.

Conclusion

Despite the limitations of this review it does provide evidence that different forms of CBT can be effective at reducing psychopathology in women following birth, however there was limited evidence of its long-term effectiveness specifically following a traumatic birth. Further investigation for CBT for postnatal psychopathology is therefore required utilising larger and more heterogeneous samples, with longer-term follow-up that focuses on women who have experienced their birth as being traumatic.

References

Ayers, S., Wright, D.B. and Wells, N. (2007) Symptoms of Post-Traumatic Stress Disorder in Couples After Birth: Association with the Couple's Relationship and Parent–baby Bond. *Journal of Reproductive and Infant Psychology* [online]. 25 (1), pp. 40-50. [Accessed 26 May 2017].

Ayres, S. (2014) Fear of Childbirth, Postnatal Post-Traumatic Stress Disorder and Midwifery Care. *Midwifery* [online]. 30 (2), pp. 145-148. [Accessed 25 May 2017].

Bastos, MH, Furuta, M, Small, R., McKenzie-McHarg, k and Bick, D. (2014) Debriefing Interventions For the Prevention of Psychological Trauma in Women Following Childbirth. *Cochrane Database of Systematic Reviews* [online]. [Accessed 11 May 2017].

Beck, C.T. (2004) Birth Trauma in the Eye of the Beholder. *Nursing Research* [online]. 53 (1), pp. 28-35. [Accessed 25 May 2017].

Beck, C.T., Gable, R.K., Sakala, C. and Declercq, E.R. (2011) Posttraumatic Stress Disorder in New Mothers: Results From a Two-stage U.S. National Survey. *Birth* [online]. 38 (3), pp. 216-227. [Accessed 25 May 2017].

Boorman, R.J., Devilly, G.J., Gamble, J., Creedy, D.K. and Fenwick, J. (2014) Childbirth and Criteria For Traumatic Events. *Midwifery* [online]. 30 (2), pp. 225-261. [Accessed 25 May 2017].

Brace, V., Kernaghan, D. and Penney, G. (2007) Learning From Adverse Clinical Outcomes: Major Obstetric Haemorrhage in Scotland. *Bjog: An International Journal of Obstetrics & Gynaecology* [online]. 114 (11), pp. 1388-1396. [Accessed 25 May 2017].

Denis, A., Parant, O. and Callahan, S. (2011) Post-Traumatic Stress Disorder Related to Birth: A Prospective Longitudinal Study in a French Population. *Journal of Reproductive and Infant Psychology* [online]. 29 (2), pp. 125-135. [Accessed 25 May 2017].

Dennis, C.L., Creedy, D.K. (2013) Psychosocial and psychological interventions for preventing postpartum depression. *The Cochrane Database of Systematic Reviews* [online]. (2). [Accessed 07 July 2017].

Elmir, r, Schmied, V., Wilkes, L. and Jackson, D. (2010) Women's Perceptions and Experiences of a Traumatic Birth: A Meta-ethnography. *Journal of Advanced Nursing* [online]. 66 (10), pp. 2142-2153. [Accessed 25 May 2017].

Ford, E. and Ayres, S. (2011) Support During Birth Interacts with Prior Trauma and Birth Intervention to Predict Postnatal Post-Traumatic Stress Symptoms. *Psychology and Health* [online]. 26 (12), pp. 1553-1570. [Accessed 25 May 2017].

Goncalves, O. F. (1997) Cognitive narrative psychotherapy: The hermeneutic construction of alternative meanings. In: Mahoney, M.J., ed., (1997) *Cognitive and constructive psychotherapies*. New York: Springer, pp. 139–162.

Gottvall, K. and Waldenström, U. (2002) Does a Traumatic Birth Experience Have an Impact on Future Reproduction?. *An International Journal of Obstetrics & Gynaecology* [online]. 109 (3), pp. 254-260. [Accessed 05 February 2017].

Greenfield, M., Jomeen, J. and Glover, L. (2016) What Is Traumatic Birth? a Concept Analysis and Literature Review. *British Journal of Midwifery* [online]. 24 (4) [Accessed 25 May 2017].

Halligan, S.L., Murray, L., Martins, C. (2007) Maternal Depression and Psychiatric Outcomes in Adolescent Offspring: A 13-year Longitudinal Study. *Journal of Affective Disorders* [online]. 97 (1), pp. 145-154. [Accessed 26 May 2017].

Ionio, C. and Di Blasio, P. (2014) Post-Traumatic Stress Symptoms After Childbirth and Early Mother–child Interactions: An Exploratory Study. *Journal of Reproductive and Infant Psychology* [online]. 32 (2), pp. 163-181. [Accessed 25 May 2017].

Knight, M. (2008) Preeclampsia: Increasing Incidence But Improved Outcome?. *American Journal of Hypertension* [online]. 21 (5), p. 491. [Accessed 25 May 2017].

Milgrom, J, Martin, P.R. and Negri, L.M. (1999) *Treating Postnatal Depression: A Psychological Approach for Health Care Practitioners*. Chichester: Wiley.

Milgrom, j, Negri, L.M. and Gemmill, A.W. (2005) A Randomized Controlled trial of psychological interventions for postnatal depression. *British Journal of Clinical Psychology* [online]. 44 (4), pp. 529-542. [Accessed 08 August 2017].

Moraes, I.G.S, Pinheiro, R.T., Silva, R.A., Horta, B.L., Sousa, P.L. and Faria, A.D. (2006) Prevalˆencia Da Depressao p´os-parto e fatores associados [Prevalence of postnatal depression and associated factors]. *Revista De Sa´ude P´ublica* [online]. 40 (1), pp. 65-70. [Accessed 07 July 2017].

Morrell, C.J, Warner, R, Slade, P, Dixon, S, Walters, G, Paley, G, Brugha, T. (2009) Psychological interventions for postnatal depression: cluster randomized trial and economic evaluation. *Health Technology Assessment Journal* [online]. 13 (30). [Accessed 10 June 2017].

NICE, *Antenatal and postnatal mental health: the NICE guideline on clinical management and service guidance*. Available from: https://www.nice.org.uk/guidance/cg192. [Accessed 27 June 2017].

Ngai, F.W., Chan, S.W.C. and Ip, W.Y. (2009) The Effects of a Childbirth Psychoeducation Program on Learned Resourcefulness, Maternal Role Competence and Perinatal Depression: A Quasi-experiment. *International Journal of Nursing Studies* [online]. 46 (10), pp. 1298-1306. [Accessed 08 August 2017].

O'Donovan, A., Alcorn, K.L., Patrick, J.C., Creedy, D.K., Dawe, S. and Devilly, G.J (2014) Predicting Posttraumatic Stress Disorder After Childbirth. *Midwifery* [online]. 30 (8), pp. 935-941. [Accessed 25 May 2017].

O'hara, M.W., Stuart, S., Gorman, L.L. and Wenzel, A. (2000) Efficacy of Interpersonal Psychotherapy For Postpartum Depression. *Archives of General Psychiatry* [online]. 57, pp. 1039-1045. [Accessed 07 July 2017].

Pearlstein, T., Howard, M., Salisbury, A. and Zlotnick, C. (2009) Postpartum Depression. American *Journal of Obstetrics & Gynecology* [online]. 200 (4), pp. 357-364. [Accessed 07 July 2017].

Sharp, D., Hay, D.F. and Pawlby, S. (1995) The Impact of Postnatal Depression on Boys' Intellectual *Development. Journal of Child Psychology and Psychiatry* [online]. 36 (8), pp. 1315-1336. [Accessed 26 May 2017].

Simpson, M. and Catling, C. (2016) Understanding Psychological Traumatic Birth Experiences: A Literature Review. *Journal of the Australian College of Midwives* [online]. 29 (3), pp. 203-207. [Accessed 25 May 2017].

Slade, p (2006) Towards a Conceptual Framework For Understanding Post-Traumatic Stress Symptoms Following Childbirth and Implications For Further Research. *Journal of Psychosomatic Obstetrics & Gynecology* [online]. 27 (2), pp. 99-105. [Accessed 25 May 2017].

Taghizadeh, Z., Irajpour, A., Nedjat, S., Arbabi, M. and Lopez, V. (2014) Iranian Mothers' Perception of the Psychological Birth Trauma: A Qualitative Study. *Iranian Journal of Psychiatry* [online]. 9 (1), pp. 31-36. [Accessed 25 May 2017].

van Roosmalen, J. and Zwart, J. (2009) Severe Acute Maternal Morbidity in High-income Countries. *Practice & Research Clinical Obstetrics & Gynaecology* [online]. 23 (3), pp. 297-304. [Accessed 25 May 2017].

Wright, J.H., Brown, G.K., Thase, M.E. and Basco, M.R. (2017) Learning cognitive-behavior therapy: An illustrated guide. *American Psychiatric Pub*.

Appendices

Appendix 1: The adapted CCDAN QRS for assessment of study quality

1. Objectives

0= objectives unclear

1= objectives clear but main outcome not a priori

2= objectives clear and main outcome a priori

2. Sample size

0= <50 per group

1= 51-100 per group

2= >100 per group

3. Duration of trial and follow-up

0= <3 months

1= >3 months and <6 months

2= >6 months

4. Power

0= not reported

1= mentioned without details

2= details of calculation provided

5. Method of allocation

0= unrandomized and likely to be biased

1= partial or quasi-randomized with bias possible

2= randomized allocation

6. Concealment

0= not done or not reported

1= partial concealment reported

2= done adequately

7. Description of treatment

0= main treatments not clearly described

1= inadequate details of main or adjunctive treatments

2= full details of main or adjunctive treatments

8. Source of subjects, representativeness of sample

0= source of subjects not described

1= source of subjects but unrepresentative

2= source of subjects plus representative sample

9. Diagnostic/inclusion criteria

0= none
1= diagnostic criteria or clear inclusion criteria
2= diagnostic criteria and specification of severity

10. Record of exclusion criteria, exclusions, refusals
This supplemental material has been supplied by the author and has not been edited by Annals of Family Medicine.
0= criteria and number not reported
1= criteria or number not reported
2= criteria and number reported

11. Description of sample demographics
0= little/no info (only age/sex)
1= basic details (marital status/ethnicity)
2= full description (socio-economic status/clinical history)

12. Adherence /attendance for therapy
0= not assessed
1= assessed for some experimental treatments
2= assessed for all experimental treatments

13. Record of number/reasons for withdrawal by group
0= no info on withdrawals by group
1= withdrawals by group without reason
2= withdrawals and reason by group

14. Outcome measures/use of validated instruments
0= outcomes not described clearly
1= some outcomes not clearly described
2= outcomes described and valid/reliable

15. Group comparability and adjustment in analysis
0= no information on comparability
1= some information with adjustment
2= sufficient information with adjustment

16. Inclusion of withdrawals in analysis (ITT)

0= not included or reported

1= withdrawals included by estimation of outcome

2= withdrawals followed up and included in analysis

17. Results presented with data for re-analysis

0= inadequate presentation

1= adequate

2= comprehensive

18. Appropriate statistical analysis

0= inappropriate

1= mainly appropriate

2= appropriate and comprehensive

19. Conclusions justified

0= no

1= partially

2= yes

20. Declaration of interests

0= No

2= Yes

Appendix 2: Adapted version of Cochrane data collection form

Data collection form

General Information

Report title *(title of paper/ abstract/ report that data are extracted from)*	*Internet-provided cognitive behaviour therapy of posttraumatic stress symptoms following childbirth – a randomized control trial*
Report ID *(ID for this paper/ abstract/ report)*	Nieminen et al., 2016
Date form completed	26/07/2017
Name/ID of person extracting data	Carly Prankerd
Study author contact details	K. Nieminen, Faculty of Medicine and Health Sciences, Unit of Medical Psychology, Department of Clinical and Experimental Medicine, Linköping University, Linköping, Sweden.

Study Eligibility

Study Characteristics	Eligibility criteria	Eligibility criteria met? Yes	No	Unclear
Type of study	Randomised Controlled Trial	x☐	☐	☐
Participants	Women who had experienced a traumatic birth	x☐	☐	☐
Types of intervention	Trauma-focused online Cognitive behavioural therapy (TF-ICBT)	x☐	☐	☐

Types of comparison	Treatment as usual Waiting list control	x☐ ☐ ☐
Types of outcome measures	Severity of PTSD Depression General Anxiety Quality of life Completion rates Treatment satisfaction Adherence	x☐ ☐ ☐
INCLUDE ☐ Include EXCLUDE ☐		
Reason for exclusion		

Population and setting

	Description *Include comparative information for each group (i.e. intervention and controls) if available*
Population description *(from which study participants are drawn)*	Women who had experienced traumatic childbirth
Sample size	N=56
Setting *(including location and social context)*	Sweden

Inclusion/exclusion criteria	i-Having self-reported posttraumatic stress symptoms ii-At least 18 years of age iii-having access to a computer and the Internet iv-Being able to read and write in Swedish v-Not being pregnant vi-Not having problems requiring more urgent care vii-Not currently participating in psychotherapy viii-Not currently having a serious problem that would be better treated with psychiatric care ix-If having medication, having taken the same dose for at least one month, with no intention to change dose during the course of the programme x-Minimum three months since the traumatic delivery	
Method/s of recruitment of participants	Via project-specific website. Advertisements were placed in national daily newspapers. Information was also spread on social media (Facebook, Twitter and/or some blog sites) and via local TV stations and on public service radio. An email newsletter was sent to all Gynaecologists and midwives in charge of antenatal clinics in Sweden to inform the staff to encourage patients to register directly on the homepage.	
Informed consent obtained	☐ ☐ ☐ Yes No Unclear	Yes
Total number randomised	56	28 – treatment group 28 – waiting list control
Age	Mean age = 34.6	
Race/ethnicity	Not stated	
Withdrawals and exclusions	Treatment – 4 Control - 9	

Methods

	Descriptions as stated in report/paper	
Aim of study	Analyse the effects of trauma-focused guided Internet-based cognitive behaviour therapy for relieving posttraumatic stress disorder (PTSD) symptoms following childbirth.	
Total study duration	8 sessions over 8 Weeks	
Ethical approval needed/ obtained for study	☐ ☐ ☐ Yes No Unclear	Yes – Regional Ethical Review Board of Linköping approved study

Results

Measures	Results
PTSD – measured by Traumatic Event Scale (TES) **PTSD – measured by IES-R** **Depression – measured by Beck Depression Inventory (BDI-II)** **Anxiety – measured by Beck Anxiety Inventory (BAI)** **Depression – measured by Patient Health Questionnaire-9 (PHQ-9)** **Quality of Life – measured by The Quality of Life Inventory (QOLI)** **Health-related quality of life – measured by EuroQol Dimensions (EQ5D)**	The between-group effect size (ES) was d = .82 (p < .0001) for the IES-R. The ES for the TES was small (d = .36) and not statistically significant (p = .09). A small between-group ES (d = .20; p = .02) was found for the PHQ-9. The results from pre- to post-treatment showed large within-group ESs for PTSD symptoms in the treatment group both on the TES (d = 1.42) and the IES-R (d = 1.30), but smaller ESs in the control group from inclusion to after deferred treatment (TES, d = .80; IES-R d = .45). In both groups, the treatment had positive effects on comorbid depression and anxiety, and in the treatment group also on quality of life. The results need to be verified in larger trials. Further studies are also needed to examine long-term effects.

Appendix 3 – Data collection form from second author

Data collection form

THE COCHRANE
COLLABORATIONS

1. General Information

Report title (title of paper/ abstract/ report that data are extracted from)	randomised controlled trial [illegible]
Report ID (ID for this paper/ abstract/ report)	
Date form completed	26/8/17
Name/ID of person extracting data	C Goodwin
Study author contact details	Nicole.

2. Study Eligibility

Study Characteristics	Eligibility criteria	Eligibility criteria met? Yes No Unclear
Type of study	RCT	YES
Participants	50 women who had given birth in last year K-Score	YES
Types of intervention	[illegible]	☑ ☐
Types of comparison	Waitlist	YES
Types of outcome measures	EPDS, TAQ, DAS 5, CEQ, PSI-SF, WHOQOL-BREF	YES
INCLUDE EXCLUDE	INCLUDE	

Reason for exclusion	

Population and setting

decided not to participate

	Description Include comparative information for each group (i.e. intervention and controls) if available	
Population description (from which study participants are drawn	50 women who had given birth in last year and scored +10 on EPDS	
Sample size	ASSIGNED TO 2 GROUPS	
Setting (including location and social context)	SASKATCHEWAN CANADA	
Inclusion/exclusion criteria	• 18 + • CAN/CAN WRITE LOCAL • LIVE IN SASKATCHEWAN • ACCESS TO COMPUTER + INTERNET • SCORE OF 10 OR MORE ON EPDS • CONSENT TO NOTIFY PHYSICIAN OF PARTICIPATION NOT RECEIVING OTHER PSYCHOTHERAPY • STABLE DOSE OF MEDICATION FOR PAST MONTH • NO PAST OR PRESENT PSYCHOSIS / BIPOLAR OR CURRENT SUICIDE PLAN OR INTENT	
Method/s of recruitment of participants	NOTIFICATION OF PHYSICIANS, PRENATAL PUBLIC POSTERS / INFO CARDS, INTERNET INTERVIEWS.	
Informed consent obtained	Yes No Unclear	
Total number randomised		
Age	Mean age =	STATED – NEED TABLE
Race/ethnicity		
Withdrawals and exclusions		responded + 6 excluded 2 didn't meet EPDS recent meds change

3. Methods

	Descriptions as stated in report/paper	
Aim of study	DETERMINE EFFICACY TA ICBT TREATMENT	
Total study duration	UNCLEAR least 3 months	
Ethical approval needed/ obtained for study	Yes No Unclear	

4. Risk of Bias assessment

See Chapter 8 of the Cochrane Handbook

RESULT 4144...

Confounding factors	SMALL SAMPLE ABSENCE OF ACTIVE
	CONTROL DEMOGRAPHIC SELF REPORT GROUP MEASURE – A FACES
Quality score	

5. Results

Measures	Results
Anxiety, Depression + Parental	Statistically reduction TAICOS group.

Appendix 4 – PICO model used to guide research question

The PICO Model

•**P**atient, Population, Problem

- Women who have recently given birth
- Women who have recently experienced a traumatic birth

•**I**ntervention

- Cognitive behavioural therapy (CBT) Including; online, face-to-face, internet, telephone

•**C**omparison

- Usual postpartum care
- Control group
- No comparison

•**O**utcomes

- Improvements in postnatal psychopathology including; postnatal depression, depression, anxiety and stress

Appendix K

Gelinas et al., (2017) define social media as “any internet based applications that permit users to construct public or semi-public profiles and create and maintain a list of other users (friends) with whom they may share content and participate in social interactions and networking” (p. 3). They argue that although social media recruitment is governed by the same foundational norms that govern the more traditional analogue recruitment, its interconnected nature provides a new and potentially unfamiliar context in which these principles can be applied to. Thus, this new context demands the sensitive application of these norms and the recognition that their operational implications may differ from traditional contexts. They state that the most salient ethical considerations that need to be considered fall into two main categories: respect for privacy and other interests of social media users and investigator transparency.

Respect for privacy is grounded in the foundational norms of respect for persons and beneficence. For example, being able to maintain a personal sphere of sovereignty where individuals can govern themselves effectively (i.e., autonomy), is crucial for their wider wellbeing, given the harm that can occur when sensitive personal information is taken, used, or shared without consent and as such individuals have the right to control sensitive personal information about themselves, including their private health information. In the context of social media recruitment, respect for privacy is of particular importance due to the amount of personal information available online and the ease with which it can be accessed. Although, much of the personal information available online has been made public voluntarily it has not been shared by social media users for the advancement of generalisable knowledge, or even health purposes, but rather for social connectivity and personal expression. Moreover, perceptions of whether a venue is public or private may vary (Taylor, Kuwana & Wilfond, 2014). Posting material for social networking purposes, often within limited public communities, is different from intending for it to be available to the public in general or researchers. In addition, empirical research has shown that social media users often lack knowledge of how to manage privacy settings and fail to grasp the full extent to which they render information shared over social media publicly available (Boyd 2010; Madden et al., 2013). This may result in a

“disinhibition effect” (Suler 2004, p. 188; Swirsky, Hoop & Labott, 2014) that leads social media users to act in ways that they would find embarrassing and avoid if they knew the public or researchers were observing. For example, a social media user, not realising that their privacy settings permit people other than their family and friends to see their posts, may describe intimate and vulnerable details of their experience with an illness that they would not want the public to see. In general, social media users may not comprehend the range of possible uses, risks, and harms of posting potentially sensitive personal information online (Taddicken, 2013; Parsi & Elster 2014). Therefore, researchers should handle personal information responsibly, even if it has been made widely available, by minimising the chances of individuals suffering embarrassment, loss of dignity, or other harms due to social media recruitment methods. Researchers should never disclose sensitive information to others without the participant's explicit permission or engage in online interactions that would allow others to infer sensitive information about participants or potential participants, even if that information has already been made publicly available in a different context. Lastly, to considerations of privacy, researchers have an obligation to be mindful of the values, mores, and potential vulnerabilities of those they approach on social media (Gyure et al., 2014). It is possible to be respectful of privacy but nonetheless approach and communicate with different online communities in ways that are offensive or insufficiently sensitive to their condition. While researchers have similar obligations in offline recruitment, the quickness and ease of online communication, the physical distance between researchers and investigators during online interactions, and the fact that many social media users may not expect to be approached by researchers over social media make sensitivity to the interests and vulnerabilities of potential participants particularly important when recruiting over social media. These recommendations were followed by the researcher. For example, to handle personal information responsibly the recruitment flyer posted on Facebook stated that if people were interested in taking part in the researcher to contact her directly via telephone or email. Further, if people responded directly onto a visible Facebook platform they were redirected by the researcher via private message. This ensured that there were no visible online interactions containing personal or sensitive information about any of the participants to ensure that these ethical obligations were met.

The second ethical consideration when using social media platforms as a recruitment tool is investigator transparency. The importance of transparency is argued to be grounded primarily in respect for persons, which, outside of exceptional circumstances, demands researcher truthfulness and honesty when interacting with research volunteers. It also serves a dual function by promoting public trust in the research enterprise, which is needed for research to flourish. Transparency requires researchers engaged in recruitment activities to be truthful and honest when describing the aims, details, risks, and benefits of studies. In the context of social media recruitment, the demand for transparency has further implications. The first stems from the fact that certain social media venues, such as online patient support groups, may require users of the site to have certain characteristics as a condition of joining and participation. An online patient support group for breast cancer survivors, for example, may require members to be breast cancer survivors themselves, or to be a close family member of a breast cancer survivor, in order to join the site. Since researchers may lack the relevant characteristics, these sites may often be technically closed to them. Transparency in this situation requires investigators to avoid deception and refrain from fabricating online identities to gain access to these online communities, instead seeking access through alternative mechanisms, such as asking for explicit permission from a moderator or site administrator, as is discussed further in the following. The researcher was given permission to post her flyer on various Facebook platforms by the page administrators ensuring that there was no deception regarding her research aims and objectives. Another issue related to transparency concerns the obligations of researchers to proactively disclose their presence on social media when collecting information for recruitment purposes. Information gathering can often be conducted relatively easily and without the knowledge of social media users, but there is a distinctive concern about whether activity of this sort may be insufficiently respectful of social media users—counting as cases of researchers “creeping” or “lurking” on a site where users reasonably expect that such activity will not occur and to which social media users could justifiably object. The question is whether, or under what conditions, investigators must alert social media users to their presence and purpose when viewing and collecting the personal information of strangers. Therefore, the researcher solely posted the flyer and did not engage in any form of information gathering from these

sites and the only information for this research was gained from participants who had taken part in the study and signed a consent form.

The information sheet (Appendix D) contained a brief overview of the purpose of the research, how the research would be conducted and what was required of the participants, research aims, confidentiality, consent and withdrawal, and researcher contact details. Individuals who expressed an interest in the study were contacted via telephone and provided with a brief overview of what the study entailed and if they stated that they wanted to participate were then emailed an information sheet, consent form (Appendix E) and a debrief sheet (Appendix F). A suitable day, time and location for the interview was then arranged with those who were happy to participate. After changing the method of recruitment, the researcher was successful in recruiting participants relatively easily and quickly.