Women's experiences of the process of recovery from birth trauma:

A grounded theory

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This guy's walking down a street when he falls in a hole. The walls are so steep, he can't get out. A doctor passes by, and the guy shouts up, "Hey you, can you help me out?". The doctor writes a prescription, throws it down in the hole and moves on. Then a priest comes along, and the guy shouts up "Father, I'm down in this hole, can you help me out?". The priest writes out a prayer, throws it down in the hole and moves on. Then a friend walks by. "Hey Joe, it's me, can you help me out?" And the friend jumps in the hole. Our guy says, "Are you stupid? Now we're both down here". The friend says, "Yeah, but I've been down here before, and I know the way out".

Leo McGarry, The West Wing (written by Aaron Sorkin)

Abstract

This study aimed to explore women’s experiences of the process of recovery from birth trauma. A meta-synthesis of the literature identified this as a gap in existing knowledge. Seventeen mothers were recruited online and participated in interviews. A feminist social constructionist grounded theory methodology was used to collect and analyse the data. Seven categories were constructed from the data. These were: making sense of trauma, healing through connection, receiving care, reclaiming power, living with the trauma in the past, and recovery as a journey. A theoretical model was proposed. The findings are discussed in relation to existing theories of recovery from trauma, postnatal distress, and mental health recovery more generally. The study carries important implications for maternity practitioners and healthcare managers, and those supporting women to prepare for birth, as well as in the postnatal period.

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Introduction

Background

Approximately 700,000 women give birth in the UK every year (Office for National Statistics, 2018). The birth process is often challenging, and the woman can be in a physically and emotionally labile state, reliant on those caring for her to support her and her baby safely through the process. As such, women are at risk of psychological as well as physical trauma. Around a third of women report that they found childbirth traumatic (Sawyer & Ayers, 2009; Soet, Brack, & DiIorio, 2003), whilst 10% describe significant long-term distress triggered by a traumatic birth (Ayers, 2004). Severe trauma, as defined by those meeting diagnostic criteria for post-traumatic stress disorder (PTSD) is experienced by an estimated 4% of women postnatally, an increase of 0.7% compared with women meeting criteria in pregnancy (Dikmen-Yildiz, Ayers, & Phillips, 2017). Prevalence is much higher in women whose babies are premature or stillborn (Engelhard, Van Den Hout, & Schouten, 2006). It is estimated that perinatal mental health difficulties cost £8.1 billion per birth cohort, with the majority of this cost attributed to long-term negative outcomes for the child such as poor educational outcomes, social care, and criminal justice costs (Bauer, Parsonage, Knapp, Iemmi, & Adelaja, 2014). As part of the Five Year Forward View for Mental Health, an additional £365 million was allocated to expand services to try to meet the mental health needs of perinatal women (NHS England, 2016). Understanding what resources are needed is a priority.

Phenomenology

Trauma and PTSD

Post-traumatic stress disorder, or PTSD, was first conceptualised in the Diagnostic and Statistical Manual of Mental Disorders Volume III (DSM-III) (American Psychiatric

Association, 1980) but trauma reactions have been recognised for a long time (e.g., 'shell shock' in soldiers in the First World War). In the current iteration of the DSM (DSM-5), PTSD is characterised by avoidance, arousal, re-experiencing, and negative changes in thoughts and mood following exposure to actual or perceived threat of death, serious injury, or sexual violence to the self or a loved one (American Psychiatric Association, 2013). Diagnostic criteria have changed as psychiatric classification systems have been revised.

However, rather than being considered a psychiatric disorder, or a sign of something going 'wrong', post-trauma experiences can be understood as the consequences of the brain's normal response to an event that threatens the integrity of the self, or that of a loved one. Neuropsychological research supports the theory that trauma symptoms arise as a result survival mechanisms invoked in response to a severe threat to the self. During a traumatic experience, the brain prioritises survival mechanisms (e.g., fight, flight, freeze) over integrated processing of emotional, sensory, and rational information, leading to fragmented memories that are predominantly sensory and affective in their nature (Van der Kolk & Fisler, 1995). Brain scans have shown that during 'reliving' of the experience, the parts of the brain involving rational thought, language, sense of self, and time, show low levels of activity (Van der Kolk, 2014). The unprocessed memory of the experience lacks a quality of having taken place in the past, and can lead to a sense of ever-present threat. This may lead to hyperarousal. Flashbacks, nightmares, and intrusive thoughts about the event can be understood as the brain's attempt to process the experience. Avoidance strategies, including dissociation, serve to protect the person from triggering distressing flashbacks, connecting with emotional pain that may threaten the integrity of the self, and possible further harm. Such strategies may be triggered by thinking about the event, or reliving the event through flashbacks and nightmares. These post-trauma experiences are considered a normal part of recovery following trauma, and most resolve themselves over a period of months (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992).

The experience of trauma may alter one's perception of inherent trust that the world is broadly predictable, and therefore safe. Being able to plan and make sense of our lives depends on this as our foundation of existence (Ratcliffe, Ruddell, & Smith, 2014). Trauma is believed to fundamentally distort a person's sense of time; a sense of existential death, a severing of the self in relation to others, and an inability to perceive the future as open to possibilities leading to a 'sense of foreshortened future' (Ratcliffe et al., 2014).

Sociocultural influences such as support and stigma may relieve or heighten the threat to the self, and can impact on the course of trauma (Herman, 1992). Trauma, like all psychological phenomena, differs depending on the person.

Cognitive model of PTSD

Ehlers and Clark (2000) proposed a cognitive model of PTSD, suggesting that enduring distress following a traumatic event was indicative of an individual processing the event in such a way as to experience an ongoing sense of serious threat. For this to happen, they suggested that the person must appraise the event and/or its perceived consequences in an extremely negative way, and have a disturbed autobiographical memory of the event, such that the memory is incomplete, incoherent, and not integrated with the person's other memories. Avoidance strategies are hypothesised to prevent the assimilation of new information about the event that may reduce the fear associated with it and assist sense-making, perpetuating trauma. This theory complements understandings about neuropsychological processes underlying trauma responses.

Birth trauma

Much of the birth trauma literature tends to focus on the psychiatric construct of postnatal PTSD. Importantly, the events stipulated by the DSM-5 as qualifying a person for a diagnosis of PTSD (threatened or actual death, serious injury or sexual violence) do not apply to some women, who report that the trauma lay in the stripping of their dignity (Beck, 2016). ‘Post-traumatic stress’ is often used to describe the trauma reaction, regardless of severity. The term ‘birth trauma’ is generally accepted to refer both to women meet PTSD diagnostic criteria as well as those who don’t (Ayers, Joseph, McKenzie-McHarg, Slade, & Wijma, 2008).

A conceptual review of the birth trauma literature defined birth trauma as *“The emergence of a baby from the body of its mother, in a way which may or may not have caused physical injury. The mother finds either the events, injury or the care she received deeply distressing or disturbing. The distress is of an enduring nature.”* (Greenfield, Jomeen, & Glover, 2016, p. 257). This is the definition used in this study, as it does not restrict the distress triggered by the birth event to a narrow understanding of ‘post-traumatic stress’, but rather encourages a more tentative conceptualisation of psychological responses to trauma. This is important, as a woman’s experience of childbirth is inextricably intertwined with her wider life experiences.

Women who have experienced trauma prior to a traumatic birth, such as childhood abuse or rape, are known to be at an increased risk of experiencing birth trauma (Ayers, Bond, Bertullies, & Wijma, 2016). A diathesis-stress model of birth trauma has been suggested as a way of understanding the phenomenon (Ayers, 2004), incorporating the role of factors that leave women more vulnerable to trauma, events during birth, and maintaining factors such as poor support, unhelpful coping strategies, and other stresses.

In considering the societal context of birth trauma for women in most parts of the world, it is important to name that most women give birth within patriarchal societal and healthcare systems. Patriarchy refers to a system of society in which power is held and controlled by men. Patriarchy influences society at every level, including systems of knowledge, what is considered ‘moral’, or ‘right’, as well as societal structures, such as the workplace and the family. It is impossible to isolate birth trauma from a woman’s wider experiences and context. It is important to consider the role of patriarchy in addition to individual and interpersonal factors and processes in women's lives during the perinatal period, and how it may affect their experience of birth and motherhood.

Experiences of trauma, including traumatic births, are reported in the wider perinatal literature, for example, by women experiencing postnatal depression (PND) (Patel, Wittkowski, Fox, & Wieck, 2013), and postpartum psychosis (PP) (Engqvist, Ferszt, Åhlin, & Nilsson, 2011; Glover, Jomeen, Urquhart, & Martin, 2014; Robertson & Lyons, 2003). Many women diagnosed with postnatal PTSD also report PND (Stramrood et al., 2011).

Considering mental health more widely, trauma, particularly in childhood, is linked with subsequent diagnoses including psychosis or schizophrenia (Read, van Os, Morrison, & Ross, 2005), eating disorders (de Groot & Rodin, 1999), bipolar disorder (Etain et al., 2010), and borderline personality disorder (Zanarini, Williams, Lewis, & Reich, 1997), to name a few.

It is important to consider the wider role of trauma in distress which may not be constructed as a response to trauma. Additionally, changes to diagnostic criteria as the DSM has been updated reflects the fluidity of the concept of trauma. In resisting defining birth trauma solely as a classic trauma response attributable to birth, women's experiences and meaning making of what they identify as birth trauma based on Greenfield et al.'s (2016) definition are placed at the forefront of the research. This study may be construed as having greater ecological validity than studies that strive to categorise distress and exclude those whose experiences do not fit into narrow definitions. It could be argued that this is to the detriment of the construct validity of the topic, but as previously discussed, this is open to challenge anyway.

Systematic review of qualitative birth trauma literature

A systematic review of the literature was conducted to synthesise the qualitative evidence in relation to women's experiences of birth trauma. Five databases were searched via the EBSCOhost search platform (CINAHL, Medline, E-Journals, PsycINFO and PsychARTICLES). Search terms relating to trauma (trauma* or PTSD or PTSS or "post-traumatic stress"), maternity (*birth or pregnan* or puerperal or *natal or *partu* or matern* or delivery), and qualitative data (experience* or qualitative or interview or "focus group") were used. To ensure quality of the research included, only papers from peer-reviewed academic journals were included. The Critical Appraisal Skills Programme guidelines for qualitative research were used to assess the papers (CASP, 2013), and all were deemed to be of sufficient rigour to be included. Non-English language papers were excluded for practical reasons. Traumatic birth experiences relating to baby loss, including stillbirth, miscarriage, abortion, and incarceration were excluded. After full-text review, a further eight articles were excluded, leaving 24 papers. Twenty-two synthesised women's accounts to draw out themes or categories. Two offered descriptive reports of individual experiences (Reid, 2011, and Kendal-Tackett, 2014). All papers were synthesised using a meta-thematic analysis approach. Full details of the search process can be found in Figure 1.

Thirteen themes were extracted. They were: labour and birth out of everyone's control, subjected to the healthcare system, assaulted and violated, the impact of health professionals, factors outside the birth, the terrible toll of birth trauma, coping strategies, changes to self-identity, the importance of narrative, relationship with partner, relationship with baby, the role of others, and subsequent birth. They will be described and discussed in turn.

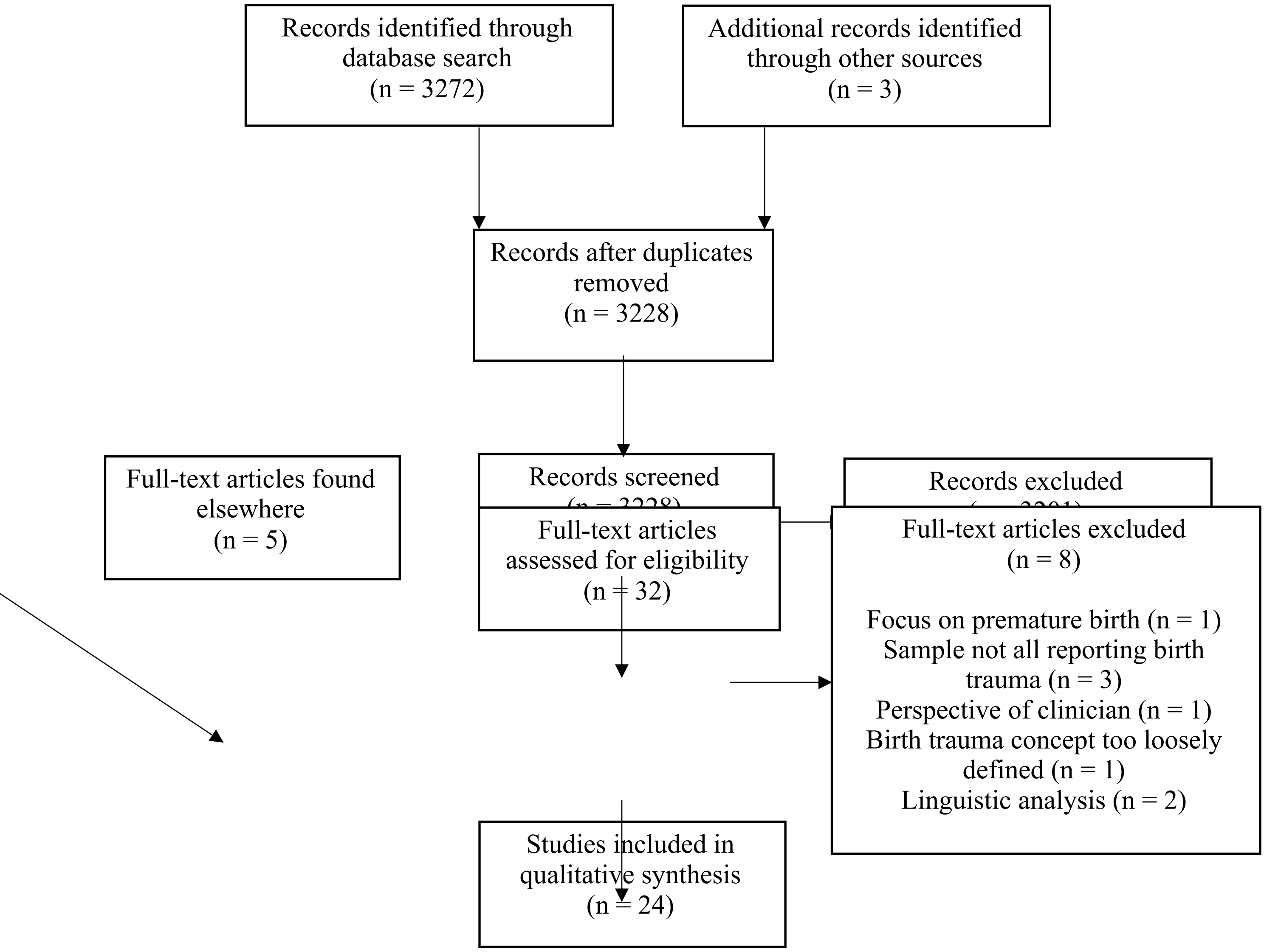

Figure 1: PRISMA diagram detailing the search process

Labour and birth out of everyone's control

Many women described a labour that neither they, their partners, or health professionals appeared to be in control of. Their bodies appeared out of control, as women experienced agonising, unbearable pain (Allen, 1998; Byrne, Egan, Mac Neela, & Sarma, 2017; Nicholls & Ayers, 2007; Reid, 2011; Thomson & Downe, 2008), or haemorrhaging (Beck, 2004a; Iles & Pote, 2015; Reid, 2011): *"I just thought I was going to die. The pain was coming from the roots of my hair, I could feel it keep coming ... eventually it was horrific and there was nothing I could do".* (Allen, 1998, p. 115).

Women's feelings of a lack of control appeared to arise from a lack of information or choice and a sudden, unexpected event (Moyzakitis, 2004). Some women spoke of how their partners were paralysed, or unable to provide support or effect the changes that would have helped the women to feel more in control (Allen, 1998; Beck, 2004a; Reid, 2011): *"I remember my husband trying to tell the anesthetist that I was fearful of a vasovagal attack. The midwife should have been doing that. My husband kept saying, 'My wife, my wife.' He could not remember what to say."* (Beck, 2004a, p. 33).

Women described feeling utterly helpless (Allen, 1998; Taghizadeh, Irajpour, Nedjat, Arbabi, & Lopez, 2014; Thomson & Downe, 2008), and many believed that they or their baby were experiencing serious physical harm, or were going to die (Allen, 1998; Beck, 2004a; Iles & Pote, 2015; Nicholls & Ayers, 2007; Reed, Sharman, & Inglis, 2017; Taghizadeh et al., 2014; Thomson & Downe, 2008): *"Blood came spurting out of me, all over him. That was it for me. I thought he'd ripped the head off. He then swore and said hurriedly, "Get the forceps."...Well, finally out came this baby. I was, by this stage, still stuck in my own private horror movie, visualizing my baby being born dead with half of its head missing."* (Beck, 2004a, p. 33).

As health professionals tried to regain control, women experienced interventions such as forceps or ventouse, episiotomy, or emergency caesarean (Allen, 1998; Beck, 2004a; Byrne et al., 2017; Iles & Pote, 2015; Moyzakitis, 2004; Nicholls & Ayers, 2007; Reid, 2011; Taghizadeh, Arbabi, Kazemnejad, Irajpour, & Lopez, 2015; Thomson & Downe, 2008). One woman described how such interventions terrified her: *"It was all out of my hands, I was* *afraid for me, I was afraid for my baby. I was just afraid that everything was just completely out of control. It didn't feel like a birth, it felt like an emergency operation."* (Nicholls & Ayers, 2007, p. 496).

This theme highlights the perceived powerlessness of women and sometimes professionals during traumatic births. Unable to escape or exert their autonomy, some women dissociated, which some felt was protective strategy against the overwhelming experience of birth (Byrne et al., 2017). Staff attending births may also be traumatised, with serious implications for staff wellbeing and service provision. Midwives reporting signs of trauma have reported events they found traumatic as sudden, unpredictable, and uncontrollable (Sheen, Spiby, & Slade, 2016). They reported a drive to escaping both physically and psychologically, taking time off work or considering leaving the profession in response to trauma (Sheen et al., 2016), with higher reported levels of PTSD symptoms associated with depersonalisation and burnout (Sheen, Spiby, & Slade, 2015).

Subjected to the healthcare system

Women spoke about feeling that the needs and agendas of the staff and hospital system were prioritised over their own. This included being subjected to interventions driven by a risk-averse culture (Beck, 2004a). Some women reported being threatened with child protection services, and their reluctance to acquiesce to interventions at the wishes of staff was met with what some called 'dead baby threats' (Reed et al., 2017; Taghizadeh et al., 2015), like this woman: *"...Being bullied into interventions with such wording the following: 'Do you want a dead baby?'..."* (Reed et al., 2017, p. 5).

They described being physically forced into the lithotomy position to give birth (Moyzakitis, 2004; Nicholls & Ayers, 2007; Reed et al., 2017), and treated like learning opportunities for trainee medics and nurses, without being asked for their consent (Nicholls & Ayers, 2007; Reed et al., 2017). A lack of continuity of care in the system meant that the women and staff didn't know each other (Iles & Pote, 2015; Nicholls & Ayers, 2007; Thomson & Downe, 2008). In private healthcare systems, some women reported that their births were scheduled to accommodate their obstetrician's personal life (Reed et al., 2017). One woman, who had planned a home birth but had to transfer to hospital due to complications with the baby's heart rate, told of being accused by an obstetrician of deliberately setting up the scenario so she could sue him (Kendall-Tackett, 2014). Some women felt that the environment had contributed to their trauma, likening the hospital to an abattoir or a morgue (Nicholls & Ayers, 2007; Taghizadeh et al., 2015; Taghizadeh et al., 2014). Stretched resources meant that there were no beds available (Reid, 2011), and that staff were too busy to explain or reassure women (Allen, 1998; Taghizadeh et al., 2015). Poor communication resulted in them feeling abandoned and alone (Allen, 1998; Beck, 2004a; Iles & Pote, 2015; Nicholls & Ayers, 2007; Taghizadeh et al., 2015). They felt helpless and powerless in the face of the hospital machine and professionals who held the knowledge and power (Beck, 2004a; Moyzakitis, 2004; Taghizadeh, Irajpour, & Arbabi, 2013): *"I felt as if I was a little lamb, when I went to the delivery ward, it seemed to me that I had handed everything over to them so that they could make any decision they wanted."* (Taghizadeh et al., 2013, p. 5).

Some felt that their care was ultimately unsafe (Beck, 2004a; Nicholls & Ayers, 2007): *"I remember believing that the labor and delivery team would know what was right and would be there should things go wrong. That was my first mistake. They didn't and they weren't! I strongly believe my PTSD was caused by feelings of powerlessness and loss of control of what people did to my body."* (Beck, 2004a, p. 33). After birth, some women reported that there was no postnatal support (Iles & Pote, 2015).

Mothers who gave birth in a highly patriarchal society described explicit structural subjugation of their wishes, e.g., their husband was asked to give consent for a caesarean (Taghizadeh et al., 2015).

Healthcare systems were perceived by many women as denying their bodily autonomy. It has been argued that medical systems are the product of men's understandings and views of the world, and that during labour and birth the woman is subordinate to the patriarchal medical system (Chertok, 1969). The hospital staff hold the power over women, often legitimised by the threat of injury or death to the baby (Kitzinger, 1992). The lithotomy position women are encouraged adopt best suits the hospital staff, but may exacerbate women's feelings of vulnerability, and has been found to elevate a woman's risk of suffering perineal tears (Gottvall, Allebeck, & Ekeus, 2007).

Assaulted and violated

For some women, their experience of giving birth was one of being assaulted and violated (Beck, 2017; Beck & Watson, 2008; Byrne et al., 2017; Kendall-Tackett, 2014; Moyzakitis, 2004; Nicholls & Ayers, 2007; Reed et al., 2017; Taghizadeh et al., 2015; Thomson & Downe, 2008): *"Don't feel I gave birth and had a baby on that day I just felt I went into a room and was just assaulted."* (Thomson & Downe, 2008). They described procedures being done to them without their consent, without anaesthesia, and use of physical force or pain to coerce them (Moyzakitis, 2004; Nicholls & Ayers, 2007; Reed et al., 2017; Taghizadeh et al., 2015).

They used metaphors linked to butchery, e.g., 'treated like a piece of meat' to illustrate the dehumanising nature of their care (Moyzakitis, 2004; Nicholls & Ayers, 2007; Taghizadeh et al., 2015; Thomson & Downe, 2008). Some women felt it was akin to being raped (Beck, 2006; Moyzakitis, 2004; Nicholls & Ayers, 2007; Reed et al., 2017): *"Every birthday is no longer the celebration of the child but is really an anniversary for the rape. Rape day. My son was conceived from love and born out of rape."* (Beck, 2006, p.381). After birth, the sense of violation continued for some as health professionals 'grabbed' their breasts to facilitate breastfeeding (Beck & Watson, 2008).

Kitzinger (1992) noted that women often use the language of rape, abuse, assault, violence, butchery, dirt, and detritus to describe their traumatic birth experiences, which was echoed in the language used by women reporting birth trauma. There is evidence that such interpersonal trauma may have a significant impact on staff too. Research suggests that where midwives perceive interpersonal trauma during birth (as opposed to events during birth that may be considered objectively traumatic e.g., emergency caesareans), this may be more likely to lead to higher levels of distress and trauma symptoms in staff (Leinweber, Creedy, Rowe, & Gamble, 2017). There is currently no qualitative research exploring birth trauma in staff.

The impact of health professionals

Interactions with health professionals played an important role in women's experiences of having a baby (Allen, 1998; Beck, 2004a; Byrne et al., 2017; Iles & Pote, 2015; Kendall-Tackett, 2014; Moyzakitis, 2004; Reed et al., 2017; Taghizadeh et al., 2015; Thomson & Downe, 2008), with some naming this as more important than the objective facts of the birth (Reed et al., 2017). The manner and attitudes of the staff were named as contributing to the trauma, with reports of staff behaviour as cold, clinical, rough, disparaging, dismissive, intimidating, patronising, and arrogant (Beck, 2017; Byrne et al., 2017; Iles & Pote, 2015; Moyzakitis, 2004; Nicholls & Ayers, 2007; Taghizadeh et al., 2015; Thomson & Downe, 2008): *"She [the doctor] was cold, she seemed very resentful that she was called out of her bed at six o'clock in the morning to do the job. She didn't say anything personal to me. Nothing, just 'right, lets stitch this' and examined me."* (Nicholls & Ayers, 2007, p. 497).

Women commonly reported not being listened to by staff, their embodied knowledge denied, or their wishes not complied with (Allen, 1998; Beck, 2004a; Byrne et al., 2017; Moyzakitis, 2004; Nicholls & Ayers, 2007; Peeler, Stedmon, Chung, & Skirton, 2018; Reed et al., 2017; Thomson & Downe, 2008):*"Hospital staff did not listen to me, didn't trust me to know my body. Dismissed me as a first time mother who was over reacting. In actual fact I dilated from 0 to 6 in just over an hour. The hospital midwives told me that I was just feeling the period pain associated with early labour and induction…"* (Reed et al., 2017, p. 4).

Poor communication with women was attributed to lack of staff empathy as well as lack of time (Taghizadeh et al., 2015). Some felt they were treated as if their requests for information were a nuisance or an affront to the staff (Byrne et al., 2017). Some women internalised health professionals' responses to their questioning or resistance, blaming themselves for 'knowing too much' or having 'unrealistic expectations' (Byrne et al., 2017). There was a sense of betrayal as expectations of staff as kind, caring, and compassionate were shattered by the reality: *"I was screaming in pain, I'll never forget this midwife, I was screaming, I'll never forget her saying: "Don't be silly now! Pull yourself together" (sternly). All I wanted was some reassurance, I'll never forget her words and I was astonished by that…"* (Moyzakitis, 2004, p. 11).

Some found themselves in open conflict with health professionals (Byrne et al., 2017; Nicholls & Ayers, 2007; Taghizadeh et al., 2013). Some reported being lied to and threatened by staff (Reed et al., 2017; Taghizadeh et al., 2015). Postnatally, one women described being silenced by a health visitor who tried to impose the label of postnatal depression on her (Iles & Pote, 2015).

Conversely, some women reported that receiving good care helped to minimise their trauma (Byrne et al., 2017; Iles & Pote, 2015; Moyzakitis, 2004; Thomson & Downe, 2010). Feeling listened to and cared for by health professionals during Birth Afterthoughts sessions and subsequent maternity care were important in facilitating and supporting women through these experiences (Bailey & Price, 2008; Beck, 2004b; Thomson & Downe, 2010). Doctors who failed to ask about mothers' physical and emotional wellbeing after birth could result in treatment being delayed, where avoidance led to women being unable to raise issues themselves (Byrne et al., 2017).

These findings support previous research about of the importance of perceived staff support on women's anxiety and sense of control during childbirth, and subsequent PTSD (Ford & Ayers, 2009, 2011). The impact of health professionals' behaviour can endure for many years (Forssén, 2012).

Factors outside the birth

Women's previous experiences and expectations were felt by many women to have influenced their trauma. Expectations of a smooth, positive birth was mentioned by some women as a factor, as they found these expectations shattered, particularly where they had previously had uneventful births or had extensively prepared (Allen, 1998; Byrne et al., 2017; Iles & Pote, 2015; Moyzakitis, 2004; Nicholls & Ayers, 2007): *"I kind of feel like it's my own fault for kind of feeling empowered like I wouldn't have felt like all my power was taken away from me, if I hadn't felt empowered in the first place."* (Byrne et al., 2017, p. 7).

Expectations that staff would be caring and supportive, and the subsequent sense of betrayal when these were not fulfilled was also reported (Moyzakitis, 2004). Some women stated that their trauma began in pregnancy (Taghizadeh et al., 2014). Other women reported that previous experiences of sexual abuse and rape intruded upon their experience of giving birth (Reed et al., 2017) and breastfeeding (Beck & Watson, 2008): *''When I placed my baby to the breast, it triggered flashbacks of my abuse as a child.''* (Beck & Watson, 2008, p. 234).

Some women described being reminded of other traumas, including the death of a family member, and previous traumatic births (Allen, 1998). Others described other stresses in their life as contributing to their trauma, including existing health problems, relationships with partners, and financial worries (Peeler et al., 2018; Taghizadeh et al., 2015).

These findings are consistent with a meta-analysis which found that being a first-time mother, depression in pregnancy and a previous history of trauma was a major risk factor for postnatal PTSD (Ayers et al., 2016). The lack of attention paid to emotional distress by antenatal classes has been cited as shaping expectations that are mismatched with the reality of parenthood (Glover et al., 2014; Mauthner, 1997). One study found that women and carers' expectations of birth too often do not match the reality, with most first-time mothers significantly underestimating the likelihood of intervention and physical injury (Shub, Williamson, Saunders, & McCarthy, 2012). Rather than attributing mismatched expectations to incomplete or misleading information given by classes and societal messages, women often blamed themselves for trying to equip themselves with knowledge about childbirth beforehand (Byrne et al., 2017). Social mentality theory (Gilbert, 2009, 2015) offers a framework for understanding self-criticism as stemming from evolutionary survival processes related to living in social groups. Within patriarchal societies, women, and new mothers in particular, are placed in a submissive position, and their safety and survival in society is dependent on men. Internalising blame may be a survival strategy to ensure that they do not challenge the dominant power of patriarchy and risk being ostracised.

The terrible toll of birth trauma

Women described being left with flashbacks, nightmares (Bailey & Price, 2008; Beck, 2004b; Beck, 2006; Beck, 2016, 2017; Beck & Watson, 2008; Byrne et al., 2017; Iles & Pote, 2015; Taghizadeh et al., 2014), strong feelings of anger (Allen, 1998; Ayers, Eagle, & Waring, 2006; Beck, 2004b; Beck, 2006; Beck, 2017; Beck & Watson, 2008; Iles & Pote, 2015; Peeler et al., 2018; Reid, 2011), and severe anxiety following their traumatic birth (Allen, 1998; Beck, 2004b; Beck, 2006; Beck, 2016, 2017; Kendall-Tackett, 2014; Reid, 2011; Thomson & Downe, 2008). They reported feeling numb and detached from the world (Allen, 1998; Ayers, Eagle, et al., 2006; Beck, 2004b; Beck, 2006; Beck, 2016, 2017; Beck &

Watson, 2008; Moyzakitis, 2004). Birth trauma disrupted relationships between women and their partners, babies, other children, family, and friends (Allen, 1998; Ayers, Eagle, et al., 2006; Beck, 2004b; Beck, 2006; Beck, 2016, 2017; Beck & Watson, 2008; Iles & Pote, 2015; Kendall-Tackett, 2014; Moyzakitis, 2004; Nicholls & Ayers, 2007; Reid, 2011; Taghizadeh et al., 2013; Thomson & Downe, 2008). Trauma could also impede breastfeeding (Beck & Watson, 2008; Iles & Pote, 2015; Taghizadeh et al., 2013).

Women grieved for the loss of the birth they had imagined, the loss of their self-identity, for the memories they were unable to create due to general anaesthesia, for happy times with their babies that they lost due to being trapped in a fog of trauma, and for the future children they felt unable to have (Ayers, Eagle, et al., 2006; Beck, 2004b; Beck, 2006; Beck, 2017; Reid, 2011). Some women reported feeling depressed (Ayers, Eagle, et al., 2006; Bailey & Price, 2008; Iles & Pote, 2015; Kendall-Tackett, 2014; Moyzakitis, 2004; Taghizadeh et al., 2013), or described becoming enveloped in darkness (Beck, 2016). Some reported experiencing suicidal thoughts and urges (Beck, 2004b, 2016). Women spoke about teetering on the edge of an abyss, or likened their experience to trying to stay afloat in stormy seas (Beck, 2016). Many spoke of feelings of guilt that they had ‘failed’ their babies during birth, that they had not been emotionally available to their children (Beck, 2006; Beck, 2017; Reid, 2011), and guilt at taking their anger out on loved ones (Allen, 1998). Some attacked themselves for having ‘failed’ at birth (Iles & Pote, 2015; Kendall-Tackett, 2014), and then attacked themselves for having feelings about this, telling themselves to ‘suck it up’ (Kendall-Tackett, 2014). Others described a sense of having been robbed of what they felt should have been ‘normal’ joyful experiences of motherhood and described trauma as thick layers of pain and torture around their heart (Beck, 2016): *“I know the agony of a woman faced with death at the time of birth. There is no greater pain, no deeper pain. My heart was tortured by layers of trauma.”* (Beck, 2016, p. 81).

Some reported ongoing problems such as pain and incontinence (Ayers, Eagle, et al., 2006; Beck, 2004a; Iles & Pote, 2015), whilst others experienced stress-related health problems (Beck, 2006; Beck, 2017). Some women reported a loss of trust in their own body to do what it was supposed to (Allen, 1998), or felt disturbed by a sense it had been damaged (Taghizadeh et al., 2014). The uncontrollable embodied nature of trauma was also named (Beck, 2006). Contributing to ongoing emotional pain for some was the avoidance of talking about it to anyone or seeking help because they feared that their baby would be taken away (Ayers, Eagle, et al., 2006; Iles & Pote, 2015). Pain, trauma, and a fear of getting pregnant impeded sexual intimacy (Allen, 1998; Ayers, Eagle, et al., 2006; Beck, 2004b; Nicholls & Ayers, 2007; Taghizadeh et al., 2013; Thomson & Downe, 2010). Some developed a fear of childbirth so severe that their plans for further children were often delayed, or scrapped altogether (Allen, 1998; Ayers, Eagle, et al., 2006; Iles & Pote, 2015; Peeler et al., 2018; Reid, 2011; Taghizadeh et al., 2013; Taghizadeh et al., 2014), and this appeared to perpetuate their sense of current threat (Iles & Pote, 2015): *"I am frightened to death of having another baby. Terrified. The whole – even the thought of getting pregnant makes me feel sick."* (Iles and Pote, 2015, p. 250).

The anniversary of the birth was often difficult, with some women reporting it got easier with time, and others not, with a consensus that the first anniversary was the worst (Beck, 2006; Beck, 2017). Many felt that they regressed in their recovery around the anniversary (Beck, 2006; Beck, 2017). Some experienced disturbed sleep in the weeks before (Beck, 2006; Beck, 2017), and reported numbness, detachment, sadness, grief, increased stress and incidence of panic attacks, and physical stress-related symptoms (Beck, 2017). Their children's birthday was something to be survived, and many struggled to celebrate, but felt obliged to hide their emotions from others, particularly their child, which triggered feelings of guilt (Beck, 2006; Beck, 2017). They dreaded their children growing old enough to understand what birthdays were and developing expectations of celebration (Beck, 2006).

The enduring nature of distress was named (Thomson & Downe, 2010), and some experienced resurfacing signs of trauma as totally unpredictable (Beck, 2006; Beck, 2017): *"…So PTSD can be like an octopus and its tentacles can take hold at any time. Its punishment is weird, wily and crippling. Your life is NEVER the same again. It can take hold at any time."* (Beck, 2006, p. 388). Some described feeling psychologically scarred for life (Thomson & Downe, 2010).

The devastating impact of birth trauma on many aspects of women's lives underlined the importance of understanding the processes by which a traumatic birth may trigger enduring distress. Where the mother links the baby with the trauma, avoidance of the baby-as-trigger has much greater implications than avoidance of other triggers. Increased vigilance is normal in mothers of newborn babies (Leckman et al., 2004), and first-time mothers may struggle to distinguish this from trauma-related hypervigilance. This may impair women's ability to identify it as a sign of trauma, which may leave them feeling they 'should' be managing it, impeding help-seeking. Recognising that something is wrong has been highlighted as a key barrier to help-seeking in women experiencing postnatal depression (Cooke, Smith, Turl, Arnold, & Msetfi, 2012; McIntosh, 1993; Slade et al., 2010).

Coping strategies

Women employed different strategies in an attempt to manage their feelings. These can be categorised as either avoidant or approach coping strategies. Many women used avoidance and distraction to help them cope (Allen, 1998; Beck, 2006; Iles & Pote, 2015). This included avoiding thinking about what had happened (Iles & Pote, 2015; Peeler et al., 2018), avoiding reminders of the birth (including their baby) (Ayers, Eagle, et al., 2006; Iles & Pote, 2015) and avoiding social contact (Allen, 1998; Iles & Pote, 2015; Taghizadeh et al., 2013; Thomson & Downe, 2008). Some found themselves unable to tolerate being around mothers who had not experienced a traumatic birth (Beck, 2004b). Women reported adopting a regimented routine and keeping busy to avoid ruminating about the birth (Ayers, Eagle, et al., 2006; Iles & Pote, 2015). On the anniversary, some threw themselves into organising and hosting a party to distract themselves (Beck, 2006). Others used perfectionism and food restriction in their efforts to control and avoid anxiety (Ayers, Eagle, et al., 2006; Beck, 2006; Beck, 2017; Iles & Pote, 2015):*''…suddenly I had stupid standards and it wasn't going to be right.''* (Ayers, Eagle, et al., 2006, p. 393).

Others actively worked to focus on positives (Allen, 1998; Iles & Pote, 2015), or to enjoy their child's birthday celebrations (Beck, 2006). Some women tried to compartmentalise their feelings and experiences, including trying to cognitively separate their child from the birth (Beck, 2006; Beck, 2016; Iles & Pote, 2015):*"started looking at – trying to find a way for me to recognise [baby] as a little baby and not just the product of something that had been painful and upsetting. And actually try and start to separate [baby] from that, from those events."* (Iles & Pote, 2015, p. 247).

Approach coping strategies were perceived as more helpful in promoting recovery, and often involved giving time to think, feel, and process their experiences. They included seeking both emotional and practical support from partners, family, friends, and professionals, (Allen, 1998; Peeler et al., 2018; Reid, 2011), allowing themselves to remember (Allen, 1998) and grieve (Beck, 2006; Beck, 2017):*"But underneath that I felt a need to 'mourn' something. After everyone had gone to bed, I lit a candle and read my doula's write-up about the birth."* (Beck, 2006, p. 387). Self-care, which incorporated taking time for themselves and prioritising their own wellbeing, was also perceived as important for recovery (Allen, 1998; Beck, 2006). The importance of self-care in recovery has also been reported in the PND and PP literature (Engqvist & Nilsson, 2014; McGrath, Peters, Wieck, & Wittkowski, 2013; Williams, 2013).

Avoidance is a key diagnostic criteria of PTSD (American Psychiatric Association, 2013; World Health Organisation, 1992), and is theorised to perpetuate distress within cognitive models of PTSD (Ehlers & Clark, 2000). Psychological avoidance is facilitated and enabled by both subtle and overt silencing from others and wider society. However, it may at times be adaptive. Mothers may not wish to risk placing themselves in such a vulnerable position, and may need to prioritise their capacity to look after their baby rather than getting in touch with their feelings. Additionally avoidant strategies, including denial and seeking alternative rewards, have been found to promote psychological growth following childbirth (Sawyer & Ayers, 2009; Sawyer, Nakić Radoš, Ayers, & Burn, 2015), indicating that simply constructing avoidance as unhelpful is too simplistic. Compartmentalising appears to be another complex strategy which could be constructed as avoidant, but may be helpful. The alternative is holding contradictory feelings about the same thing simultaneously, which presents trauma survivors with a challenge. Attempts to cognitively separate the baby from the trauma mirror the work in parent-infant psychotherapy (Lieberman, Silverman, & Pawl, 2000).

Allowing time to reflect and get in touch with painful feelings, was felt by some women to be a helpful part of recovery. There appears to be some theoretical overlap between models of bereavement and trauma. The grief work hypothesis states that confronting the loss is necessary for processing grief (Freud, 1917). However, critiques observe that avoidant strategies may be adaptive (Stroebe, 1993), as reported above. Findings relating to both and avoidance and approach coping strategies would appear to suggest that both can have helpful functions, as is put forward in the dual process model of grief (Schut & Stroebe, 1999). Within Ehlers and Clark's model, connecting with the trauma and pain would likely have assisted women in processing their experiences, allowing the integration of new and old information about the birth and its meaning. Greater understanding of the relative benefits of avoidant versus approach coping strategies in birth trauma would be helpful in guiding recovery.

Changes to self-identity

Changes to self-identity was one of the most commonly reported aspects of birth trauma, and incorporated different stages of birth trauma and aspects of self-identity (Ayers, Eagle, et al., 2006; Beck, 2004b; Beck, 2006; Beck, 2016, 2017; Beck & Watson, 2016; Byrne et al., 2017; Iles & Pote, 2015; Moyzakitis, 2004; Peeler et al., 2018; Reid, 2011; Taghizadeh et al., 2014; Thomson & Downe, 2008; Thomson & Downe, 2010): *"Obviously you never forget… I have not been the same person since that at all."* (Moyzakitis, 2004, p. 11).

Some women felt they had their selves stripped from them or 'ruined' as they were objectified during birth (Beck, 2004b, 2017; Thomson & Downe, 2008). During birth, some described a loss of sense of existence (Beck, 2016; Taghizadeh et al., 2014). Others reported dissociating, which was perceived as a strategy to protect the integrity of the self (Beck, 2004a; Byrne et al., 2017; Moyzakitis, 2004; Thomson & Downe, 2008). Some spoke of how they were left feeling incomplete somehow (Ayers, Eagle, et al., 2006; Beck, 2004b), describing themselves as 'broken', 'empty', 'dead inside', or with 'parts missing' (Beck, 2006; Beck, 2016; Beck & Watson, 2016; Thomson & Downe, 2010).

Some women reported difficulties with their identity as a mother, from low self-efficacy and self-esteem (Ayers, Eagle, et al., 2006; Beck, 2006; Reid, 2011), to not feeling like a mother at all (Beck, 2006). Some spoke about feeling they had 'failed' as mothers to give birth without assistance or to carry their baby to term, and tried to prove themselves as mothers (Beck & Watson, 2008; Iles & Pote, 2015). Where women experienced a subsequent positive birth, some reported feeling 'whole' again, 'complete', or described reconnecting to parts of themselves they had lost. They spoke of feelings of pride and accomplishment, which boosted their confidence and self-esteem (Thomson & Downe, 2010). Successful breastfeeding had a similarly positive impact on women's self-identity (Beck & Watson, 2008; Byrne et al., 2017). Women described reconnection and restored faith in their bodies, and many pursued breastfeeding doggedly, determined to 'atone' for the birth (Beck & Watson, 2008): *"Breastfeeding became my focus for overcoming the birth and proving to everyone else and mostly to myself that there was something that I could do right. It was part of my crusade, so to speak, to prove myself as a mother"* (Beck & Watson, 2008, p. 233). The decision not to breastfeed or to stop earlier than recommended was difficult, but could be empowering (Beck & Watson, 2008).

Some felt the experience of birth trauma had made them a lot more self-aware of both their strengths and limitations (Iles & Pote, 2015). Others described reconstructing a new, stronger sense of self that was quite different to their previous selves, reporting increased resilience, self-awareness, empathy, and assertiveness (Beck & Watson, 2016): *"I was broken. Now I am unbreakable."* (Beck & Watson, 2016, p. 268).

Feminist perspectives provide a useful framework for understanding women's experiences of giving birth and becoming a mother in a modern Western patriarchal society, and the impact of this on their emotional wellbeing. Motherhood is construed by society as an integral part of being a woman (Ussher, 1989). Society's views on motherhood are powerful and often contradictory: it is seen as inherently joyful and fulfilling, yet mothers are also cast as 'just a mother', with other aspects of their self-identity and previous life swamped by motherhood (Weaver & Ussher, 1997). Women find themselves unable to meet the contradictory expectations, and are judged by others and by themselves (Weaver & Ussher, 1997). For mothers experiencing birth trauma, those who are able to mask their distress are likely to lack a sense of cohesive self-identity. Those more severely disturbed may be unable to project an image of coping, let alone joy and fulfilment, and may feel a huge disconnect or sense of failure with how they 'should' be. Within the patriarchal society's vision of what constitutes a 'good mother' is an unassisted vaginal birth without pain medication, followed by breastfeeding; women experiencing birth trauma are often unable to meet one or both of these ideals. A woman's experience of birth trauma is therefore intertwined with her relationship with herself and the societal discourse around motherhood.

To date, the birth trauma literature only identifies experiences linked to birth and breastfeeding as restoring a positive sense of self-identity; the impact of other events and activities is unknown. The evolution of self-identity in mothers with experience of birth trauma is therefore an area warranting further investigation.

The importance of narrative

Gaps in memory about the birth itself was reported (Iles & Pote, 2015; Peeler et al., 2018), with some women unsure of whether flashbacks they experienced were events that had really happened (Bailey & Price, 2008), and others left with a sense of not having given birth at all (Thomson & Downe, 2008). Women were left unable to make sense of their experiences (Allen, 1998; Bailey & Price, 2008; Iles & Pote, 2015; Kendall-Tackett, 2014; Moyzakitis, 2004; Peeler et al., 2018; Thomson & Downe, 2010). Many spoke about 'needing to talk' about the birth, (Bailey & Price, 2008; Beck, 2004b, 2016; Byrne et al., 2017; Moyzakitis, 2004), and ruminated about it in an attempt to understand what had happened (Beck, 2006; Beck, 2016; Reid, 2011). On the anniversary, women reported clockwatching and recalling what had happened at that time on that date (Beck, 2006; Beck, 2017), as if compelled to use the time to anchor their narrative. Women craved validation of their suffering from those around them (Allen, 1998; Beck, 2004b; Beck, 2006; Beck, 2016), but instead sometimes found themselves silenced: by people tiring of their need to talk about it (Beck, 2004b, 2016), by a resistance to 'put a damper' on the joyful narrative of the arrival of a new life into the world (Beck, 2004a), and by societal pressure to be coping (Allen, 1998; Byrne et al., 2017; Iles & Pote, 2015): *"I was so devastated at people's lack of empathy. I told myself what a bad person I was for needing to talk. I felt like the Ancient*

Mariner doomed to forever be plucking at people's sleeves and trying to tell them my story which they didn't want to hear." (Beck, 2004b, p. 221).

A narrative that thinking, talking or writing about what had happened would make things worse or at best be futile deterred some women from revisiting their experiences (Byrne et al., 2017; Peeler et al., 2018). Such silencing or avoidance of talking about their experiences helped maintain their distress (Allen, 1998), whereas talking about it was generally perceived as helpful (Byrne et al., 2017; Iles & Pote, 2015; Taghizadeh et al., 2015).

For some women, focusing on the outcome of having a healthy baby helped them to give meaning to what had happened and give their story a more positive narrative (Iles & Pote, 2015). The narrative that what had happened during birth was not their fault, e.g., by the framing of their experience as sexual assault, was also helpful (Byrne et al., 2017; Kendall-Tackett, 2014), whereas making sense by blaming themselves appeared unhelpful (Iles & Pote, 2015).

Meeting with a midwife to go through their maternity notes could assist women in making sense of what happened (Allen, 1998; Bailey & Price, 2008; Iles & Pote, 2015; Peeler et al., 2018). It could also provide a counter-narrative to self-blame for the birth (Bailey & Price, 2008; Iles & Pote, 2015; Thomson & Downe, 2010).

Validation of their experiences during debriefing process was valued (Bailey & Price, 2008; Thomson & Downe, 2010). If this didn't happen, some took the matter further, which was reported as retraumatising if the complaint was not upheld (Beck, 2004b). For others, maternity notes represented a more objective, trustworthy, or at least alternative perspective on what happened (Bailey & Price, 2008; Iles & Pote, 2015; Peeler et al., 2018). A subsequent birth, even if intervention was still needed, could provide a powerful narrative to counter feelings of guilt and self-blame about the traumatic birth (Thomson & Downe, 2010): *"I think having X [second child] has made me realise that it [first birth] wasn't my fault,* *there is nothing that I could have done any further than I did do."* (Thomson & Downe, 2010, p. 107).

Those who integrated birth trauma within a narrative of leading to personal and professional growth and development following birth trauma saw their experience as having a positive impact on their lives (Beck & Watson, 2016). A narrative that God had given them the experience of birth trauma for a greater purpose was felt to be a divine gift: *"I now believe that I was made for a purpose."* (Beck & Watson, 2016, p. 269).

Narratives of women who experienced birth trauma were important. They included both making sense of the events surrounding the birth, in addition to their wider story of motherhood, and as such impacted on self-identity. As traumatic memories are often fragmented, chronologically distorted, and often incomplete, creating a coherent narrative following trauma was often a challenge. Coherence was named as important: coherence of the memory of the event helped women to make sense of what happened, whilst coherence in women's narratives about themselves as good enough mothers was vital for their existential survival.

Peeler et al (2018) posit that the creation of a coherent narrative takes place through re-structuring of memory, which allows women to view themselves differently, whilst Iles and Pote (2015) speculate that it enables women to begin to move on from their experience. Iles and Pote (2015) note that postnatal experiences such as pain and breastfeeding were integrated into women's narratives of birth. They suggest that women's postnatal experience creates an 'emotional lens' through which previous experiences, including the birth, are viewed. This may also be true of other experiences which women felt contributed to birth trauma, but it is likely that those related to motherhood are most salient at this time.

Women deemed by health professionals to have suffered a traumatic birth are often referred to the hospital's own midwifery debriefing sessions (Ayers, Claypool, & Eagle, 2006). The literature regarding the efficacy of midwifery debriefing in reducing signs of depression or post-traumatic stress is mixed (Rowan, Bick, & Bastos, 2007; Sheen & Slade, 2015), although many women value the opportunity to discuss the facts of their birth (Bailey & Price, 2008). There are difficulties in the literature with evaluating such sessions, however, as psychological debriefing sessions, which used to be offered within 72 hours of the birth, and 'Birth Afterthoughts' services, which tend to occur weeks or months later, have in the past been equated (Bailey & Price, 2008). Such sessions may assist women to 'fill in blanks', or better understand the rationale for interventions and the sequence of events, and thus support the development of a coherent birth narrative.

Silencing through internalised societal expectations about what pregnancy, birth and motherhood 'should' be like, can also impede recovery, by preventing women from creating a coherent narrative of themselves as good enough mothers. Feeling heard and validated is important in the development of a positive, coherent narrative (Beck, 2004b). Evidence from the literature regarding child sexual abuse (CSA) survivors indicates that silencing can perpetuate distress (Foster & Hagedorn, 2014). Women may be silenced through their perceived 'failure' to give birth 'properly', and its impact postnatally may be difficult to reconcile with idealised images of maternal 'success' (Weaver & Ussher, 1997). Societal expectations of motherhood may also lead women being silenced through fear of negative responses (Iles & Pote, 2015). Women often report feelings of invalidation being triggered by being told that all that matters is a healthy baby (Beck, 2004a; Iles & Pote, 2015; Kitzinger, 1992), or by a sense that they need to 'move on' (Beck, 2004b).

Women may also find themselves silenced by an inability to find the words to describe their experiences; a woman may only be able to explain in medical terms what has happened to her (Kitzinger, 1992), which may be inadequate in conceptualising her experience, thus impairing the construction of a meaningful narrative. One woman spoke of only being able to make sense of her experiences when a friend reframed her treatment during birth as sexual assault (Kendall-Tackett, 2014). Healthcare professionals are often reified, particularly in the UK, where the NHS tends to be perceived as an “all compassionate healer of the sick” that must not be criticised (Fulcher, 2018). Systemic factors, such as lack of time, continuity of care, and lack of services may also contribute towards silencing, with healthcare professionals not asking women about distress, or women not feeling able to disclose (Button, Thornton, Lee, Shakespeare, & Ayers, 2017).

Being denied knowledge with which to construct alternative understandings of experiences is termed epistemic injustice (Fricker, 2007). Examples of epistemic injustice occur throughout women’s reports of birth trauma. Women’s embodied knowledge is denied by health professionals during labour and birth, and again when their experiences are dismissed as ‘normal’ when they raise concerns. This process, in which health professionals placing a lower value on patients’ knowledge than their own has been identified as a form of testimonial injustice in healthcare Kidd and Carel (2017). They note that the status of the patient’s knowledge may be further downgraded based on prejudices held about them. In this way, gender as well as other characteristics, such as ethnicity and socioeconomic status may intersect with the patient role to disempower women of their own knowledge. Women experiencing birth trauma often encounter another form of epistemic injustice: hermeneutical injustice. This refers to the process by which a person or group is denied access to knowledge or ways of understanding (e.g., concepts) that would assist them in making sense of, or creating a coherent narrative of their experiences. The lack of awareness of the phenomenon of birth trauma and active resistance to the idea that women may be traumatised by birth, as well as the dominance of psychiatric constructions of distress as disorders are ways in which women experiencing birth trauma may be subjected to hermeneutical injustice.

Relationship with partner

Women’s relationship with their partner was frequently discussed. Most commonly reported was the disruption to their relationship with their partner caused by birth trauma

(Allen, 1998; Ayers, Eagle, et al., 2006; Beck, 2006; Iles & Pote, 2015; Kendall-Tackett, 2014; Nicholls & Ayers, 2007; Peeler et al., 2018; Taghizadeh et al., 2013). They described not feeling that their partner understood their distress, which left them feeling alone (Ayers, Eagle, et al., 2006; Peeler et al., 2018; Taghizadeh et al., 2015). Others described their partner's frustration at the enduring nature of their distress (Allen, 1998). Women reported anger towards their partners about this lack of empathy, their behaviour during the birth, (Allen, 1998; Ayers, Eagle, et al., 2006) or more generally took their feelings of anger about what had happened to them out on their partner (Allen, 1998):*"I do tend to be very angry towards him, which he does find very difficult."* (Ayers, Eagle, et al., 2006, p. 394-395).

Others described how important their partner's support was during birth (Iles & Pote, 2015), whilst others noted that disagreements about what had happened could lead to arguments (Ayers, Eagle, et al., 2006). Many women described a negative impact of birth trauma on sexual intimacy (Allen, 1998; Ayers, Eagle, et al., 2006; Kendall-Tackett, 2014; Nicholls & Ayers, 2007; Taghizadeh et al., 2013; Thomson & Downe, 2010). Reasons for this included a loss of self-esteem, being consumed by trauma, or being triggered (Ayers, Eagle, et al., 2006; Kendall-Tackett, 2014; Nicholls & Ayers, 2007): *"There isn't room for anything else in a relationship when you are going through that… It destroys any intimacy you have in your relationship."* (Nicholls & Ayers, 2007, p. 500).

Others described being terrified of getting pregnant (Ayers, Eagle, et al., 2006; Nicholls & Ayers, 2007; Taghizadeh et al., 2013; Thomson & Downe, 2010). Women reported feeling unable to give emotionally to their partner (Allen, 1998; Ayers, Eagle, et al., 2006). For some, the strain of birth trauma was felt to have jeopardised, or led to the breakdown of the relationship (Ayers, Eagle, et al., 2006). Despite a predominantly negative picture, some reported that their partners had been very supportive and helpful (Ayers, Eagle, et al., 2006; Iles & Pote, 2015; Nicholls & Ayers, 2007; Peeler et al., 2018; Reid, 2011), but this didn't always ease distress (Ayers, Eagle, et al., 2006). Some women felt that the trauma ultimately strengthened the relationship (Beck & Watson, 2016; Iles & Pote, 2015; Kendall-Tackett, 2014).

Birth trauma often appears to have a negative impact on the couple relationship, but more positive stories have also been reported. As Ayers, Eagle et al (2006) observe, relationships are often strained by the birth of children, but women in the literature attribute many difficulties specifically to trauma. It may be that accounts are influenced by factors such as time since birth, or the impact of the focus of the study on sample recruitment. Research suggests depression may mediate the impact of trauma on the couple relationship (Parfitt & Ayers, 2009). A greater understanding of the processes involved in the development of depression within couples who experience birth trauma is therefore important in better understanding how they may be supported.

Relationship with baby

Women described the impact of birth trauma on their relationship with their baby. Women commonly reported feeling emotionally detached from their baby, particularly in the early moments, months and even years following the birth (Allen, 1998; Ayers, Eagle, et al., 2006; Beck, 2004a; Beck, 2006; Beck, 2016, 2017; Beck & Watson, 2008; Iles & Pote, 2015; Nicholls & Ayers, 2007; Taghizadeh et al., 2013): *"I felt as if there was a wall between this child and myself."* (Beck, 2016, p. 80). Some were left feeling that perhaps the baby wasn't theirs (Beck, 2006; Beck & Watson, 2008).

Some women reported negative feelings towards their baby, rejecting of, or rejected by their baby, and wanting to give it away (Ayers, Eagle, et al., 2006; Taghizadeh et al., 2013). Anger and feelings of blame towards the baby were also reported (Ayers, Eagle, et al., 2006; Iles & Pote, 2015): *"I can remember thinking, you horrible thing, you've done this to me, and what you doing here, you evil child."* (Ayers, Eagle, et al., 2006, p. 395).

Some described feeling scared or even terrified of being around their baby (Allen, 1998; Ayers, Eagle, et al., 2006), which was attributed to feeling unable to cope (Allen, 1998), or to having previously had thoughts about harming or killing the baby (Ayers, Eagle, et al., 2006). Many women reported that these detached or negative feelings towards their baby resulted in a physical avoidance of the child (Ayers, Eagle, et al., 2006; Beck, 2004b; Beck & Watson, 2008; Iles & Pote, 2015; Nicholls & Ayers, 2007; Taghizadeh et al., 2013).

Most reported an improvement in their relationship with their baby over time (Ayers, Eagle, et al., 2006; Beck, 2004b; Nicholls & Ayers, 2007). In contrast, some women reported no difficulties bonding with their baby (Ayers, Eagle, et al., 2006), whilst others described feeling overprotective (Allen, 1998; Ayers, Eagle, et al., 2006; Nicholls & Ayers, 2007). Breastfeeding, for those who could manage it, was experienced as hugely healing for the mother-baby relationship (Beck & Watson, 2008): *"I would cover her up to feed her and hide her little head in the clothing. Not because of dignity, but because I did not want anyone else to see the magic and healing that was happening between us."* (Beck & Watson, 2008, p. 233). For some women, the child's birthday stirred up difficult feelings year on year, and was perceived as a barrier to developing an unbroken positive attachment (Beck, 2006; Beck, 2017).

Research regarding the impact of birth trauma on the mother-baby relationship appears mixed, with one study reporting an association between scores on self-reported PTSD measures and bonding questionnaires (Parfitt & Ayers, 2009), whilst another has not (Ayers, Wright, & Wells, 2007). However, this discrepancy may be due to different bonding measures being used. Parfitt and Ayers (2009) and Williams et al (2016) used the Postpartum Bonding Questionnaire (Brockington et al., 2001), which asks about more diverse bonding experiences (e.g., detachment, wondering whether the child is theirs) whereas the measure used by Ayers et al (2007) focuses on the quality of the bond. One study found an indirect association between PTSD and quality of bond that was mediated by depression (Williams, Taylor, & Schwannauer, 2016). Research has indicated that birth trauma may have long-term implications for child development (Garthus-Niegel, Ayers, Martini, von Soest, & Eberhard-Gran, 2017), but it is a very complex picture, and much more research is needed to better understand how this may unfold in the context of the family system's wider life experiences.

Difficulties in the mother-baby relationship are commonly reported in women experiencing perinatal mental health problems (Brockington, 1996). Women who experienced postpartum psychosis (PP) have described and improving bond over time, as well as the reassurance of seeing the baby develop as supporting recovery (Engqvist & Nilsson, 2014; Heron et al., 2012; Plunkett, Peters, Wieck, & Wittkowski, 2017). Building a positive relationship with the baby has also been reported as important in promoting recovery from PND (Di Mascio, Kent, Fiander, & Lawrence, 2008), and may be used by women as a barometer for their recovery (Stone & Kokanovic, 2016). Better understanding of the role of the baby and the mother-baby relationship in the recovery process from birth trauma may support further development and use of interventions to promote immediate and longer-term positive outcomes for women and their families.

The role of others

People in women's wider networks, including relatives and friends all played a role in women's experiences of birth trauma. Isolation from others or breakdown in relationships was common (Allen, 1998; Ayers, Eagle, et al., 2006; Beck, 2004b; Iles & Pote, 2015; Kendall-Tackett, 2014; Taghizadeh et al., 2015; Taghizadeh et al., 2013; Thomson & Downe, 2008): *"I had forgotten everybody, nobody mattered to me*." (Taghizadeh et al., 2013, p. 5). Some described their trust in others as being shattered (Ayers, Eagle, et al., 2006), whilst others described the strain of talking to people, and of having less capacity to support others with their problems (Allen, 1998): *"'Oh God, you haven't been there so how can you understand'. Their problems seem so trivial, I'm just trying to cope with my own."* (Allen, 1998, p.121). Others found feeling different to other mothers challenging (Beck, 2004b; Iles & Pote, 2015), whereas perceiving similarities felt helpful (Iles & Pote, 2015). Some women described the positive impact of receiving both practical and emotional support (Iles & Pote, 2015; Peeler et al., 2018). Others described how difficult feelings were triggered when friends and family appeared to want to move on or distance themselves from the trauma, (Beck, 2004b, 2017; Kendall-Tackett, 2014). Only in one study did women mention the role that identifying something was wrong, and seeking help played in the course of their birth trauma: telling somebody they were struggling to cope was experienced as helpful, whilst others named that completing mental health questionnaires helped them to realise that others must feel the same (Allen, 1998).

Some women spoke of fostering closer relationships with others following birth trauma, developing intimacy through talking about their experiences with friends, and deepening their relationships with their children (Beck & Watson, 2016). Some fostered new friendships with other women who'd experienced birth trauma, and spoke of wanting to help other women (Beck & Watson, 2016).

Peer support has been reported to be helpful for recovery in the wider mental health literature (Repper & Carter, 2011). It has been found to empower and facilitate the creation of a positive self-identity in both parties (Repper, 2013). Such mutual benefit has been reported by women with lived experience of PP (Doucet, Letourneau, & Blackmore, 2012; Heron et al., 2012; McGrath et al., 2013; Robertson & Lyons, 2003), and PND (Cust, 2016; Jones, Jomeen, & Hayter, 2014). Online peer support has also been reported as helpful by a mixed sample of mothers reporting depression and post-traumatic stress (Moore & Ayers, 2017), but as yet there has been no wider exploration of the role of peer support in recovery from birth trauma.

Support from others in identifying that something was wrong was rarely mentioned, and there was little exploration of women's experience of making sense of trauma, or of help-seeking. Identifying that something feels wrong, and telling someone has been identified as a turning point towards recovery in the perinatal period (Slade et al., 2010). However, many women in the literature report being dismissed, their experiences conceptualised as normal, and therefore not requiring support (Bilszta, Ericksen, Buist, & Milgrom, 2010; Mauthner, 1997). Women who experience birth trauma may experience an additional barrier, as within society there may be resistance to acknowledging its existence. The narrative that women could not be traumatised by birth (as it is an event that most women experience, and have done since the beginning of humanity) was generally held to be true until recently (Ayers & Pickering, 2001).

Additionally, stigma is a major barrier to women seeking support (Button et al., 2017). Fear of having their children removed has also be found to impede disclosure (Boots Family Trust Alliance, 2013; Button et al., 2017). Distress itself has been named as a barrier to accessing and using psychology services (Cooke et al., 2012). However, most of this research has focused on women who primarily identify with having experienced PND. The birth trauma literature suggests that stigma can impede help-seeking and disclosure (Iles & Pote, 2015), but there is little specific information about barriers and facilitators. Further, aside from invalidating experiences in birth reflections sessions, and with friends/family there has been no mention of negative experiences of mental health services, or how women negotiate the help that is offered. Exploration of these issues is therefore warranted.

Subsequent birth

The subject of having further children was a sensitive one, with many describing feeling terrified of having another baby to the extent that they did not plan to have further children (Allen, 1998; Ayers, Eagle, et al., 2006; Iles & Pote, 2015; Taghizadeh et al., 2013; Thomson & Downe, 2010). For those who did, it was a significant event. One woman described panic attacks, disturbed sleep, and thoughts of suicide upon learning she was pregnant (Beck, 2004b).

Some women reported that they first accessed professional support for their trauma in their subsequent pregnancy (Thomson & Downe, 2010). Extensive planning for the subsequent birth was common, as they tried to do everything to protect themselves and avoid repeating the trauma (Beck, 2004b; Thomson & Downe, 2010). Some women described their decision to accept uncertainty was helpful (Thomson & Downe, 2010). Women described feeling more empowered to make choices about birth that put their wellbeing above any potential negative judgements from others (Allen, 1998; Beck, 2004b; Peeler et al., 2018; Taghizadeh et al., 2013; Thomson & Downe, 2010): *"…but umm I didn't have an epidural the first time round, because I didn't like the idea of the drugs being in my body and what it might do to the baby so this time around I said 'No give it to me ...I'm not going through it again.'"* (Peeler et al., 2018).

Many women reported that the subsequent birth had been a positive experience, and those who did often described it as healing or redemptive, regardless of whether they required assistance (Beck, 2004b; Peeler et al., 2018; Thomson & Downe, 2010). *"I think having X [second child] has made me realise that it [first birth] wasn't my fault, there is nothing that I could have done any further than I did do"* (Thomson & Downe, 2010, p. 107). They described feelings of autonomy over their bodies, feeling cared for, and connected to the experience. Following a positive subsequent birth experience, some felt willing to have further children (Thomson & Downe, 2010).

For first-time mothers who would like more children, the prospect of having to give birth again may constitute an ongoing threat to the mother, which may contribute towards the maintenance of birth trauma (Brewin, Dalgleish, & Joseph, 1996; Iles & Pote, 2015). The meaning women ascribe to their trauma, and how that fits with their perceptions of being a mother may impact on the course of their distress (Iles & Pote, 2015).

The meta-synthesis demonstrated that although aspects of recovery have been explored by qualitative research, to date, no studies have attempted to examine processes involved in recovery in-depth.

Recovery

Recovery from trauma

The personal, social, and economic cost of trauma and mental health difficulties more generally means that there is a lot of interest in understanding what helps people to feel better. The concept of clinical recovery focuses on the reduction or elimination of symptoms. However, many argue that this is not the most meaningful way of conceptualising recovery. An alternative definition is offered by Anthony (1993), where recovery is seen as a deeply personal journey that involves changing key parts of self-identity, and living a hopeful, fulfilling life whilst often managing ongoing struggles with mental health. Leamy, Bird, Le Boutillier, Williams, and Slade (2011) developed a conceptual framework of personal recovery from mental health difficulties following a systematic review of the literature. Five key themes emerged from their research: connectedness, hope and optimism about the future, identity, meaning in life, and empowerment (CHIME). Given links between trauma and wider mental health problems, it may be helpful to consider how this framework may apply to recovery from trauma.

Research into recovery from trauma has tended to focus on medication and psychological interventions, and it is this research that has informed guidelines for treatment. The National Institute for Health and Care Excellence (NICE) recommends trauma-focused cognitive-behavioural therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) for people diagnosed with PTSD (NICE, 2018), including postnatal women (NICE, 2014). Both therapies are underpinned by cognitive and neuropsychological theories of trauma. Drug treatments are not indicated as a first-line treatment, as they are considered less effective and less cost-effective than CBT or EMDR (NICE, 2018).

Foa (1997) outlined three cognitive processes believed to be involved in trauma recovery. The first hypothesis suggests that emotional engagement with the traumatic memories is necessary to process and recover from the experience. It does not discuss the potentially adaptive role of avoidant strategies. The second proposes that recovery from trauma involves the organisation of memories and cognitions about the event into a coherent and explicit narrative. This is consistent with Ehlers and Clark's model (Ehlers & Clark, 2000), as well as birth trauma research as summarised in the meta-synthesis. Foa's final hypothesis posits that core schema undergo modification as people integrate their experience into their belief system. However, it assumes a response to an isolated trauma in a life that otherwise has felt safe and may not apply to people experiencing multiple or chronic traumas. All three processes outlined by Foa (1997) are employed in both trauma-focused CBT and EMDR. However, these theories are intrapsychic in nature, which may represent a Western perspective on recovery. They do not comment on the social or cultural context of trauma.

The social context is considered to an extent in Benight and Bandura's social cognitive theory of trauma recovery, which proposes that self-efficacy affects the appraisal of the person's ability to cope with the traumatic event, and may impact on their use of social support (Benight & Bandura, 2004). Conceptually, this theory appears linked to the constructs of empowerment and identity in the CHIME framework (Leamy et al., 2011). However, the theory appears to ignore the influence of sociological and cultural considerations, such as discrimination and structural inequalities experienced by women in patriarchal societies. The likelihood of developing perinatal mental health problems appears linked to socio-economic status (World Health Organisation, 2019). The link between birth trauma and socioeconomic status is less clear. Findings have been somewhat mixed, but reviews of the literature have found that it has little influence in development of postnatal

PTSD (Andersen, Melvaer, Videbech, Lamont, & Joergensen, 2012; Grekin & O'Hara, 2014). It may be that women from impoverished groups do not experience the sense of shattering of an inherent trust in the world if that trust is lacking in the first place. However, samples are predominantly middle-class, so findings have limited transferability.

There is evidence for the role of social support in the course of postnatal PTSD. Brewin et al. (1996) suggest that social support helps people to talk about and process their trauma. Ford, Ayers, and Bradley (2010) used structural equation modelling to explore the predictive validity of Ehlers & Clark’s cognitive model (Ehlers & Clark, 2000). At three months’ postpartum, the model accounted for just 9% of the variance in PTSD symptoms, rising to 16% with the addition of social support. Contrasted with evidence that Ehlers and Clark’s model accounted for 71% of the variance in PTSD symptoms six months after the trauma of an assault, Ford et al.’s findings indicate that other factors and processes influence the course of birth trauma.

Relational processes and the social context are emphasised in Judith Herman’s seminal text on recovery from trauma (Herman, 1992). Empowerment, and the building of new connections both in the survivor’s relationship with the self and with others are posited as necessary for recovery. She proposes that recovery from trauma is non-linear and progresses in three broad stages: an initial phase of safety, which incorporates gaining a sense of safety in the body, and in one’s environment, followed by a phase of remembrance and mourning. This involves making sense of the traumatic experience itself and mourning losses. The final phase is one of reconnection, which involves rebuilding life with a sense of empowerment, with the trauma experience integrated into one’s sense of self. New understandings of the self and the world facilitates building meaningful relationships with others. Herman also notes that many survivors feel empowered to use their new knowledge to benefit others. She observes that recovery is never finished.

One criticism of the recovery literature is its failure to acknowledge the wider social, political, economic and cultural context in which the individual lives (Onken, Craig, Ridgway, Ralph, & Cook, 2007). The role of transcendental, or spiritual feelings in recovery are also little researched. Such feelings of strong connection to something bigger than ourselves is considered in post-traumatic growth, but whether they are a product of recovery or part of the process is less understood.

Post-traumatic growth

Post-traumatic growth (PTG) refers to a process whereby living through significant challenges in life, or trauma, ultimately leads to an experience of positive psychological growth (Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 1996; Tedeschi, Park, & Calhoun, 1998). Conceptually, it refers to a state that goes beyond ‘recovery’ to how a person was pre-trauma, to one where a person feels changed for the better by their experiences. Post-traumatic growth does not eliminate the distress caused by the trauma, but rather co-exists alongside it (Wright, 1989). Cognitively, Calhoun and Tedeschi (2006) posit that a person’s schemas are reconstructed to incorporate both the trauma and any possible future traumas, allowing for an increased capacity to withstand situations that previously led to the schema being shattered. The authors emphasise that changes occur at both emotional and cognitive levels; it is the affective component which gives feelings of positive growth and change such power. There is evidence to suggest that for recovery from life-threatening illness, PTG also occurs at an embodied level (Hefferon, Grealy, & Mutrie, 2009, 2010). Women with birth trauma are often physically injured, and/or report feeling they ‘failed’ at birth (Kendal-Tackett, 2014; Iles & Pote, 2015), suggesting the relevance of embodied PTG to the birth trauma phenomenon, but it has not yet been reported.

Tedeschi and Calhoun (1996) identified five components to PTG. These are changed priorities, closer relationships, personal strength, seeing new possibilities in life, and greater spirituality. In the qualitative perinatal literature, there is evidence of PTG amongst women who experienced PP, PND, and birth trauma (Beck & Watson, 2016; Heron et al., 2012; Karraa, 2013; McGrath et al., 2013; Robertson & Lyons, 2003). Women in these studies report a shattering of sense of self, as well as feelings of disconnection from the self and others, which are all signs of trauma. Women with PND have also reported hypervigilance (Karraa, 2013), whilst feelings of acute fear are often reported by women with PP (Engqvist et al., 2011; Robertson & Lyons, 2003). It should be noted that only one doctoral thesis has reported PTG in women with PND; this was the focus of the study (Karraa, 2013). Information on their perceptions of birth was not collected. There is evidence that PTG may occur for some women following childbirth, and that this may not necessarily be associated with PTSD (Sawyer & Ayers, 2009). Research has also found cultural differences in links between coping strategies, PTSD symptoms, and PTG in a mixed UK/Croatian sample (Sawyer et al., 2015). Processes underpinning PTG, and its role in recovery are therefore unclear, and further research is clearly needed to better understand this aspect of recovery from trauma.

Recovery from perinatal distress

In the perinatal mental health recovery literature, there is clear support for both Leamy et al.'s conceptual framework of recovery from mental health problems (Leamy et al., 2011), as well as Herman's phases of trauma recovery (Herman, 1992). This period is characterised by challenges of navigating changes in relationships, and of making new connections, particularly with the baby. Making connections with other mothers has been identified as a more variable experience by women discussing recovery from postnatal distress. Whereas the meta-synthesis found that disconnection through invalidation or judgement from other mothers was unhelpful, peer support in PP has been cited as valuable in recovery (Jones et al., 2014; McGrath et al., 2013). It is thought that sharing experiences with peers may also assist in the process of making sense of experiences, and of assimilating the experiences of being a mother with mental health difficulties into a new, positive self-identity (Heron et al., 2012; McGrath et al., 2013). Modelling recovery in peer support may also engender hope (Beck, 1992; Berggren-Clive, 1998).

Reconstruction of self-identity is a challenge for all first-time mothers, but creating a positive new self-identity may be a particular challenge for mothers experiencing perinatal distress. Mental health stigma in society may appear incompatible with the concept of being a ‘good mother’. Loss and subsequent recovery of self was identified in the meta-synthesis by women experiencing birth trauma, and has been also named in the PP literature (Robertson & Lyons, 2003). Peer support has been named by women reporting PP as supporting them with this process (Doucet et al., 2012; Heron et al., 2012; Robertson & Lyons, 2003).

The perinatal literature also supports the importance of empowerment in recovery from PP, PND, and birth trauma, with peer support, volunteering for research (Beck, 2005; Heron et al., 2012; McGrath et al., 2013; Plunkett et al., 2017), and breastfeeding (Beck & Watson, 2008) all named as empowering activities.

The role of finding meaning in life to recovery may be a more complex issue within in the perinatal period. Many women speak about how becoming a parent gives their life a new sense of meaning, and this does not appear to protect against becoming distressed. Finding meaning in women’s experience of birth trauma was clearly important, however, and the meta-synthesis found that many women appeared compelled to try to make sense of it. However, finding a new meaning in life has also been reported in the wider perinatal literature (Beck & Watson, 2016; Heron et al., 2012; Karraa, 2013; McGrath et al., 2013; Robertson & Lyons, 2003), and may be linked to posttraumatic growth. Developing a greater understanding of processes relating to PTG in the perinatal period may be important in better understanding recovery from trauma.

Conclusion

Theories and research relating to recovery from trauma, and from wider mental health difficulties appear to be supported by the perinatal literature. However, there are considerable gaps regarding birth trauma, its unique challenges, and the impact of the wider social context on recovery. The context of experiencing birth trauma within a patriarchal society is widespread. The additional challenges to relationships and identity faced by women in the perinatal period highlights the importance of researching recovery from birth trauma in its own right. This is a new area of research which has significant implications for how we support women experiencing birth trauma.

Research Aim

The aim of the study was to explore women's experiences of the process of recovery from birth trauma.

Method

Overview

To explore in-depth women's experiences of recovery, a qualitative approach using semi-structured interviews to gather data was employed. Participants were women who self-identified as having experienced birth trauma, and who subjectively felt that they had recovered, or taken significant steps in the process of recovery. The social constructionist grounded theory approach was used to collect and analyse data as this allows an in-depth exploration of women's own perceptions and is suitable for generating emergent theories. Women's stories were explored from a feminist standpoint. This chapter will outline the epistemological stance of the research, the rationale for the design, and describe how the grounded theory approach is embedded in all stages of the research. It will describe the sample and procedures in recruitment and the interviews and lay out the analysis procedure. Ethical issues will be considered, and steps taken to minimise any potential harm will be described.

Design

A qualitative design was chosen to explore in-depth women's experiences of the psychological process of recovery from birth trauma. Qualitative research can provide rich, detailed information and is particularly suited to research exploring people's views and experiences.

A social-constructionist grounded theory design (Charmaz, 2006) was employed, as this approach is appropriate for research exploring processes, and enables the development of new theories. The social-constructionist approach reflects the researcher's own epistemological stance. Semi-structured interviews were chosen as the means of data collection as they allow an in-depth exploration of a person's own unique perception of a psychological process. Focus groups were not considered as a means of data collection in order to provide absolute privacy and confidentiality to participants, particularly as the topic of the research related to the very personal and sensitive experience of recovery from birth trauma. Data collection and analysis were undertaken simultaneously to facilitate the grounded theory principles of theoretical sampling and data saturation.

Epistemology

The research was approached using a feminist social constructionist epistemological stance. The social construction of gender is a central premise of feminist research (Barnes, 1999). This epistemological position is considered appropriate for research into birth trauma, as childbirth and motherhood are personal experiences unique to women, but moreover, in this country (and most others) take place within the context of a patriarchal society.

Consideration of this topic from a feminist standpoint is therefore useful in order to better understand experiences of women within the societal context in which those experiences occurred. Kitzinger (1992) notes the power imbalance between women and the patriarchal medical context in which most births occur. This power imbalance has been articulated by women in the birth trauma literature. Furthermore, from pregnancy through parenthood, women's parenting decisions are judged by society regardless of their choices. For example, working mothers and stay-at-home mothers are both derided and celebrated (Johnston & Swanson, 2003). Women are told that 'breast is best', yet breastfeeding in public is often disapproved of, and continuing to breastfeed beyond 12 months is often viewed as strange or disgusting (Vares, 1992). Mothers are placed in a double bind and find themselves unable to 'win'.

Social constructionists reject the notion that there is one objective truth that can be discovered. They argue that a person constructs their understanding of the world through interactions with others, and that a person's society and culture has a huge influence on how they see the world.

Language is viewed as shaping thought; how we conceptualise and attach meaning to experiences is determined by the language available to us (Vygotsky, 1964). Social constructionism is built on the concept of symbolic interactionism, which "assumes society, reality and self are constructed through interaction and thus rely on language and communication" (Charmaz, 2006, p.7). Rather than mechanistic beings mindlessly reacting to stimuli, humans are active, thinking beings, their own interpretations of the world influencing their interactions with it.

In using a social constructionist standpoint, this research recognises that it will be presenting an analysis of women's experiences of birth trauma within the UK. This will not only be affected by the different objective experiences that the women have had compared to women from non-Western cultures, e.g., Western healthcare, but the meaning of these experiences as constructed through their interaction with Western societies and cultures. Likewise, within the sample, there is likely to be variance in experiences and the meanings attached to them, as the notions of culture and society may extend to micro-cultures within e.g., families, social groups, and communities. This research therefore acknowledges that it is unlikely to be transferable to non-Western cultures. However, it may provide an understanding of recovery from birth trauma against which women's experiences in other cultures may be compared, and some similarities may exist.

Within the UK, dominant societal narratives frame distress as something that has gone wrong within a person. They are labelled as having a 'disorder' of some kind, which can be treated with medication and therapy. The societal context is not considered (Kitzinger, 1992). This reflects neoliberal ideologies and structures, where the person is viewed as autonomous, and ultimately responsible for their wellbeing, regardless of circumstance. These ideologies minimise the role of others, and of socio-cultural factors in shaping a person's self-image and self-identity.

In research exploring other manifestations of perinatal distress, such as PND and PP, women regularly speak about wanting to live up to the societal ideal of a 'good mother', their fear of being a 'bad mother', and the role that stigma and judgement from others plays in the course of their mental health (Button et al., 2017; McGrath et al., 2013; Moore, Ayers & Drey, 2016). These socially constructed narratives of parenting may be internalised by women, influencing women's experiences of motherhood and mental health. To be able to explore women's experiences of the process of recovery from birth trauma it is therefore appropriate to use a methodology that takes a feminist social constructionist viewpoint.

Grounded theory

Grounded theory was originally conceived by Glaser and Strauss (1967) as a systematic qualitative research methodology that posits that it is possible to develop new theories from qualitative data rather than analysing data in the context of existing theories to deduce testable hypotheses. Informed by a positivist stance, viewing scientists as discoverers of knowledge, it uses a systematic analytic process that seeks to ensure that emerging theories are grounded in the data. Classic grounded theory advocates that adopts an inductive approach whereby the researcher should ideally know as little about the topic as possible. Data collection and analysis occur simultaneously to allow further exploration of emerging theories. Central to grounded theory is the constant comparative method, whereby data is continuously compared against other data to facilitate the development of the researcher's understanding of the phenomenon.

Social constructionist grounded theory

A key difference in the social constructionist approach to grounded theory is the premise that researchers are not objective discoverers of data and theories, but play an active role in the world that is studied, and construct the data and theories drawing on their own experiences (Charmaz, 2006). Rather than advocating the notion that the researcher should know as little as possible about the topic being explored, the social constructionist stance acknowledges that the researcher will always bring their own knowledge and experiences to the research, and that an understanding of the area being studied will be co-constructed with the participants. Henwood and Pidgeon (2003) argue that a constructivist approach is needed to align the systematic rigour of grounded theory analysis with its interpretive nature. The literature was reviewed at the beginning of the study, with the topic guide informed by the literature. Additional literature was reviewed as analysis progressed, as part of the constant comparative aspect of the method.

Research position

The researcher is a 38 year old, white, British, middle class, childless woman with a background of working primarily in child and adolescent mental health services in both England and New Zealand, including five years in a private hospital for young people with eating difficulties. In addition to this, she also worked on research projects in the fields of perinatal mental health and collaborative mental health nursing. For the final six months of the thesis, she worked in a Community Perinatal Team. These experiences contributed towards the researcher developing an understanding of recovery both in the non-perinatal, child/adolescent as well as the perinatal, adult context. Finding a voice, expressing feelings, developing an understanding of their experience, being understood and validated by others, and being able to work towards recovery with support, and at one's own pace are some of the key aspects of the researcher's understanding of recovery at the outset of the project. Turning points, and 'moments of hope' were also thought to be important for gaining strength and resilience, and building confidence in taking new steps towards recovery. More specifically, experience of working with young people experiencing eating difficulties contributed towards an understanding of the role of systems, such as family, friendship groups, and group identities in recovery, and of the power of role models and shared expertise gained through lived experience. The theorised impact of societal expectations on the development of eating problems also lay the foundations for the researcher's feminist social constructionist stance. Young people admitted to the clinic were overwhelmingly middle or upper middle class, white, and female. Their interactions with society, how they interpreted their world and themselves as participants in the world appeared to impact on their experience of their emotional difficulties and their recovery. The researcher is also a feminist and perceives the world through this lens. Accordingly, the role of societal expectations of women, and mothers specifically, has a strong influence on the researcher's understanding of recovery from perinatal mental health difficulties.

Patient and public involvement

Patient and public involvement was carried out in two stages. Firstly, six mothers whose youngest child was under five years of age advised on the development of the recruitment advert, the PIS, the recruitment procedure, and the website. They advised on language, helping to ensure that the information provided was understandable, sensitively conveyed, and comprehensive enough for women to be able to make an informed choice about participating. They also considered ethical issues in the research. Their views on images used on the materials were sought. They were also asked about their own knowledge of recovery from birth trauma, and their responses helped to inform the topic guide. Secondly, the topic guide was discussed in-depth and finalised with a lived experience expert in birth trauma who works in NHS perinatal services. Ethical points to consider to minimise potential participant distress during interviews were also discussed.

Participants

Sample Size and Sampling Method

It was estimated that a sample size of 15-20 would be likely to provide sufficient data for the study. Previous qualitative research into birth trauma using the same methodology has employed samples between 7 and 20 (Allen, 1998; Bailey & Price, 2008; Iles & Pote, 2015), so this goal was felt to be prudent. To try to achieve a sample of women whose perceptions of the severity of their trauma response varied across a spectrum, recruitment materials explicitly stated that women did not need to have been diagnosed with PTSD to participate. The intention prior to recruitment was to use theoretical sampling, with women selected for interview according to the likelihood of them being able to provide information to further inform emerging theories (Glaser & Strauss, 1967), based on the demographic information collected. However, this was not practicable due to the limited diversity of those consenting to participate. A community sample was used, with women recruited online.

Sample

Seventeen women consented to participate and completed interviews. A further three women consented but the researcher was unable to arrange an interview. Information was not collected regarding why women did not ultimately participate. Three further women enquired but were not eligible due to their traumatic births occurring more than ten years ago. Demographic details of participants are reported in Table 1.

Recruitment procedure

Participants were recruited online, via the Birth Trauma Association website, as well as via social media (Twitter and Facebook). Women who clicked on a link in the advertisements were directed to the project website, which contained full details about the project, including a Participant Information Sheet (PIS) that was available to download as a PDF, as well as a contact form which enabled them to log their interest in the project. They were also given the option of emailing, texting or phoning the researcher directly.

Eligibility criteria

Women were eligible to participate if they were over 18 years of age and self-identified as having experienced psychological birth trauma (diagnosis of post-traumatic stress disorder [PTSD] not necessary), and felt that they had either recovered from the psychological trauma or had made significant progress in their recovery. Original eligibility criteria stated that between six months and five years must have elapsed since the traumatic birth. The rationale behind the selection of these time boundaries was to try to ensure that enough time had elapsed since the birth for women to have made progress in their recovery, both for ethical and research design purposes. The maximum elapsed time-point of five years was originally chosen so that women's memories were reasonably recent, to allow sufficiently in-depth exploration of their experiences. After approximately one week of recruitment, it became clear that it would be sensible to increase the time cut-off to 10 years, as two women had contacted the researcher reporting their traumatic birth occurred 5-10 years previously. They had had a subsequent child and noted that birth trauma contributed to the long gap between the births of their children. It was considered that in order to recruit women with a greater diversity of experiences, as advised in research employing grounded theory (Charmaz, 2014), a compromise on the time cut-off would be appropriate. Women needed to be residing in the United Kingdom at the time of the interview to be eligible to participate. This decision was taken to ensure that proper safeguarding and signposting could take place. Additionally, women needed to be able to speak English well enough to have a conversation with the researcher about their experience of recovery from birth trauma, as well as complete a written questionnaire. Women who had received non-PTSD diagnoses either prior to or following the birth, or had a PTSD diagnosis that pre-dated the birth were not excluded from the study. Women who had experienced the death of their baby, either through stillbirth or neonatal death were excluded from participating, due to the different emotional challenges and societal contexts of those experiences (Badenhorst & Hughes, 2007). Although some studies exploring birth trauma exclude participants whose babies spent more than 24 hours in special or intensive care (e.g., Iles & Pote, 2015), the decision was made not to exclude women on this basis. Many women whose births are perceived as traumatic receive emergency interventions due to foetal distress in labour, and as such, a significant proportion of the babies born to women reporting birth trauma receive significant and prolonged medical care. Excluding these women with the goal of isolating the experience of birth trauma from the influence of other life experiences, was felt to be ultimately unachievable. Inclusion of these women may also support further understanding of the diversity of women's experiences of birth trauma. The decision to exclude formal diagnosis with PTSD as a prerequisite for participation was made for various reasons. Diagnostic categories are a socially constructed method of grouping together experiences, that view certain experiences of distress as conceptually different from others. In order to receive a diagnosis, distress must exceed a certain level, or significantly impact on functioning. Judgements that are made not by the person, but by the ‘expert’ health professional. The term ‘disorder’ is also a value judgement that denotes that something has ‘gone wrong’ within the person, rather than the person responding in understandable ways to exceptional situations (Kinderman, Allsopp, & Cooke, 2017). Invalidation of people’s experiences can compound distress (Linehan, 1993; Naso, 2008), and so the decision to set the criteria according to self-identification of distress was in part an ethical decision too.

Additionally, many women who experienced birth trauma and who may well have met the criteria for diagnosis may not have sought professional help from services. Most research into psychological trauma and recovery outside the perinatal literature focuses solely on those who have sought help and received a psychiatric diagnosis. As many women who experience birth trauma may not meet seek formal support, meet diagnostic criteria, or present in a way considered to be characteristic of a trauma response, it will be important to consider the impact on women of both receiving a diagnosis and not receiving a diagnosis. At present, many women with birth trauma fall through gaps in care (Greenfield et al., 2016). Additionally, it is often assumed that receiving professional treatment always has a positive impact on recovery, but stories of iatrogenic harm are common (Crawford et al., 2016). It is therefore important that efforts are made to include people with a range of experiences in research into mental health recovery.

Ethical considerations

As previously mentioned, decisions about eligibility criteria were informed in part by ethical considerations. Ethical approval for the study was obtained from the University of Essex School of Health and Social Care Research Ethics Committee (reference 17003). Patient and public involvement was used to inform development of recruitment materials, topic guide, and interview considerations to place participant experience at the heart of the research. Due to the potentially distressing nature of the topic, women were encouraged to consider their own needs when making the decision about when may be a suitable time for the interview, to consider their schedule after the interview, and what they might find most helpful should they find the experience distressing. Additionally, all prospective and actual participants were signposted to both professional services and informal peer-support at every stage of the process including on the website, PIS as well as following the interview, if this was indicated. Support options were provided for birth trauma and other perinatal mental health difficulties. The participants were given the opportunity to discuss their experience of the interview itself immediately afterwards, and via telephone at a later time. If the researcher suspected that the participant would benefit from seeking support, this was conveyed gently to the participant, with appropriate signposting given.

Confidentiality of information was respected throughout. Participant anonymity was maintained by assigning women a participant number after recruitment, which was used to label the data pertaining to each woman. Pseudonyms were used in dissemination of the data, and any information that could potentially identify any person or service was redacted during transcription. Data was stored in locked or password-protected files and devices to which only the researcher had access. Transcription was carefully carried out by the researcher, to minimise the reinterpretation of data during transferral from audio to written media. A copy of the interview transcript and initial analysis was given to each participant to ensure that the meaning of their account had been interpreted as they intended; feedback was welcomed to inform analysis. Following dissemination of the research, data will be archived and destroyed in accordance with University policies.

Informed written consent was obtained prior to the interview, and verbally confirmed at the time of interview. Participants were also reminded of their right not to answer follow-up questions asked after the interview had taken place, and when these were asked verbally, verbal consent was also sought. Participants were explicitly informed of their right to stop the interview at any time, take a break, or withdraw their data from the study entirely.

Materials

A photo-sized advertisement was used for advertising the study on social media (Twitter/Facebook). The brief copy used in this advertisement was also used on the Birth Trauma Association website. These advertisements contained links that directed interested women to the study website, which contained more comprehensive information about the study (the PIS). This was also available to download as a PDF file, and a hard copy was sent to potential participants in their information packs. The PIS detailed what participation would involve, considerations for the women in terms of timing and preparation (for example, women were encouraged to think about their schedule and caring responsibilities, particularly after the interview, to promote self-care). It also included how to take part, ethical considerations and legal information. The website signposted women to a range of professional and informal support options and included a photo and brief biography of the researcher, as well as information on how to make contact.

A consent form was used, which asked women to provide contact details and confirm that they had read and understood the PIS.

The interview was left as open as possible to allow the data to be generated by the participants rather than being asked to answer lots of directive questions. However, a topic guide was used to prompt exploration of areas or themes if they were not spontaneously spoken about by the participant. These topics arose from reviewing research in the perinatal and general mental health recovery literature as well as online blogs and posts on Twitter written by women about recovery from birth trauma and perinatal mental health difficulties in general. Topics included the role of the baby, sleep, family and friendships, as well as experience of services. The topic guide was co-created with a lived experience expert.

Procedure

Recruitment took place online via the Birth Trauma Association website as well as via social media between March and November 2018. Although permission was obtained to advertise on the Netmums website, this was not necessary due to the success of recruitment through other sites. Women who clicked on the link to find out more information about the study were directed to the project website. All women who contacted the researcher to express their interest in taking part were sent an information pack containing the PIS, a consent form, and a pre-paid reply envelope. On receipt of the consent form, the researcher contacted women to screen for eligibility, give women the opportunity to ask any questions they had about the study, ascertain ongoing willingness to participate, and arrange a mutually suitable date, time and location or medium for the interview. Wherever possible, requests for in-person interviews were met, although this was not always possible due to geographical distance. In one instance, it appeared that the interview did not take place following receipt of consent due to scheduling difficulties of a face-to-face interview. Two interviews were conducted in-person, 10 via telephone, and five via videocall. Technical issues prevented one call being conducted via videocall, so it took place over the telephone with the participant's agreement.

Before the interview, women were given the opportunity to ask any further questions prior to starting and were reminded of the steps being taken to assure their confidentiality. They were also reminded of their right to take a break or stop the interview at any time, withdraw their consent, or decline to answer questions. Verbal consent to participate and proceed with the interview was also obtained. Interviews were audio-recorded using a passcode-protected digital voice-recorder.

Interviews began with the question 'Could you begin by telling me a bit about your experience of recovery from birth trauma, starting from whichever point you feel it began?'. Subsequent questions remained open and were mainly used to explore experiences mentioned by the participant in more depth, although the topic guide was used as a prompt to explore any areas not spontaneously spoken about. These main interviews lasted between 53 and 164 minutes.

Following the interview, women were reminded that further questions may arise as new topics or ideas warranting further exploration were elucidated by other participants – their verbal consent to do this was received at this stage (written consent received at the start of the study). Their preferred method of communication was noted. They were reminded that they would be sent a transcript of the interview with the initial analysis, to provide the opportunity to check that the codes reflected their intended meaning. Transcripts were sent out following focused coding (see ‘Data analysis’ section for more details), along with a request to ask follow-up questions.

Follow-up questions were posed to women either over the telephone or via email, depending on their preferred method of communication. If the telephone was used, verbal consent to record was obtained at the beginning of the call and they were reminded that the same ethical considerations as during the main interview applied. Ten participants responded to requests to pose follow-up questions. Eight of these participated in an interview (including one who sent written responses). These varied in length from 9-31 minutes.

Audio-recordings were stored in a password-protected folder on a password-protected laptop. Field notes containing pertinent details about the interview, and other reflections were taken. They contained no identifying information. A reflective diary documenting the researcher’s thoughts about birth trauma and recovery was used throughout the project.

Data analysis

Transcription

Interviews were transcribed by the researcher. The process was undertaken with the consideration that transcription is to some extent a re-interpretation of the data (Cook, 1990) held in mind. Transcription was an iterative process, with much of the interview listened to multiple times in short segments during the initial stage to transcribe the interview as accurately as possible from the start. Initial drafts were checked again by listening to the interview in full to ensure it conveyed the conversation as closely as possible. Italics were used to denote words emphasised by the interviewee, and pauses and non-word utterances were noted.

Grounded theory methodology

The social constructionist grounded theory method advocated by Kathy Charmaz (2006) was used to analyse the data. Analysis took place towards the end of data collection, with follow-up interviews used to explore topics emerging from the analysis further with participants where possible.

The constant comparative method

Central to grounded theory is the constant comparative method (Glaser & Strauss, 1967), which was employed throughout the analysis. This describes a process whereby comparisons between data and other knowledge are made at each stage of the analytic process. For example, data relating to similar incidents discussed in different contexts during an interview may be compared to find similarities and differences in how they were experienced and understood. Statements about experiences or incidents highlighted by more than one participant may be compared. Similarly, where codes define an understanding of an action, process or belief that differs from the researcher's, these may also be compared. As theories begin to take shape, they are compared with existing, related theories and examined to consider what new aspects or dimensions they bring. The comparisons with the researcher's own beliefs about the process highlight the importance of researcher reflexivity throughout the process, and of keeping a reflexive diary throughout the study. This methodology helps to bring awareness to the researcher of different truths held by people about their experiences in the world, casting a critical lens upon preconceived notions and their impact on the analytic process. Using reflexivity as data within the analytic process is a crucial aspect of the social constructionist grounded theory methodology.

Initial coding

Line-by-line coding was the first coding stage of the analysis. This helps to ensure that coding progresses grounded in the data, and it can help the researcher to 'step back' a little from the data to enable a more critical stance towards the views expressed by participants (Charmaz, 2006). Each line of data in the transcripts was coded, with attention focused on the actions within the data. During this stage, the wider context of the participant's response was also held in mind, to ensure that the implicit actions and meanings in the data were also reflected in the codes. In vivo codes, terms used by the participants that appeared to carry significant meaning, were flagged as distinct codes. This was done to facilitate adherence to the implicit meaning in what the participant was conveying, to ensure that this was not lost through transformation of their account into other codes.

Focused coding

Following initial coding, focused coding took place, which considered larger chunks of data. The most common initial codes were examined to see whether they could explain larger portions of data. This process was done using word processing software. At this stage, transcripts were sent back to participants to give them an opportunity to consider whether the codes bore fidelity to the intended meaning of the data. Minor corrections to vocabulary in one transcript were made by one participant. No participants suggested any changes to the codes.

Synthesis of codes into clusters of codes, and eventually categories took place using NVivo 12 software (QSR International Pty Ltd, 2018). These were then reviewed and assessed for adequacy in explaining the data. This was an iterative rather than linear process. Experiences of shared events, such as anniversaries and subsequent births were compared to develop understanding of processes occurring in these contexts. As coding progressed, new conceptual ideas arose, and earlier data, including the researcher's preconceptions, were reconsidered through these new conceptual lenses.

Theoretical coding

Possible relationships between the categories developed during focused coding were explored with the aim of developing an understanding of how the categories fitted together, and to develop theories relating to the processes being explored. The data and the developing theories were compared with relevant existing theories to facilitate understanding of the data, and whether these differed. Their propensity to bring new dimensions to the understanding of the process of recovery from birth trauma was considered. A position of *theoretical agnosticism* (Henwood & Pidgeon, 2003) was adopted using reflexivity to help ensure that the researcher's preconceptions about existing theories were considered as part of the process, and that all concepts remained grounded in the data. An awareness that wanting data to fit with favoured theories may result in data being 'forced' into categories, helped to minimise the risk of this.

Memo-writing

Memo-writing was used throughout the study to develop and refine ideas and conceptual links between the codes, and was key to the development of theoretical categories following focused coding. Memos can help to spark theoretical creativity and facilitate the researcher in exploring theoretical saturation of a category (Henwood & Pidgeon, 2003).

Extensive memos were written as part of the constant comparative method, comparing within and between different levels of data, from raw data, to codes, and categories. Memos were also used to create links with other research findings and theories where comparisons could be drawn. Questions pertaining to codes and categories were noted to facilitate understanding of the data, and to consider whether the codes constituted a good fit with the data.

Theoretical sampling

Theoretical sampling involves ‘seeking and collecting pertinent data to elaborate and refine categories in the emerging theory’ (Charmaz, 2006). Unfortunately, in-depth analysis did not happen alongside data collection, so participants were not selected according to any particular characteristics that suggested they may be able to contribute new information to inform category development. Participants were women who responded to the advertisement and arranged interviews. However, following initial analysis, follow-up questions were posed to those who responded to the receipt of their transcript and confirmed willingness to answer further questions. Novel information and perspectives that arose in the course of the interviews were explored with subsequent participants.

Data saturation

Data saturation was defined as having gathered enough data to form comprehensive, fully rounded categories that afforded a clear conceptualisation of the data. Theoretical saturation was achieved in so far as can be claimed with the 17 participants who took part; this will be discussed later with regard to theoretical sampling.

Results

Participant demographics

Participants were predominantly white and well-educated. All were cisgender and married or cohabiting in heterosexual relationships. The mean age of participants was 37 years old (SD = 3.4 years). At the time of the main interview, women's traumatic births occurred between 17 months and 8 years previously and the mean time elapsed since their traumatic birth was 4 years (SD = 2 years). Where more than one traumatic birth was reported, the most recent one has been recorded. A small majority of women had two children. All were traumatised by their first birth except one, and one woman reported that her second birth had been more traumatic than her first traumatic birth.

Three women completed consent forms and demographic questionnaires but did not ultimately arrange an interview. Their mean age was 35 years old (SD = 1 year) and the mean time elapsed since their traumatic birth at time of recruitment was 23 months (SD = 11 months). Data gathered from women who completed demographic questionnaires and consented but did not participate in interviews indicated that participants were on average two years older, and their traumatic birth had occurred on average approximately two years less recently than those who did not participate. Full demographic details of participants can be found in Table 1.

Table 1. Participant demographics

Pseudonym	Years since traumatic birth	Age	Ethnicity	Relationship status	Qualification level	Number of children
Natasha	1	30	Black Caribbean/ mixed other	Married	Undergraduate	2
Holly	2	39	White British	Cohabiting	Doctorate	1
Sian	4	38	White British	Married	Undergraduate	1
Dominique	4	34	White British	Married	Undergraduate	2
Chloe	5	34	White British	Married	Doctorate	2*
Jenny	3	34	White British	Married	Postgraduate	1
Angela	4	39	White British	Married	Postgraduate	2
Stephanie	7	33	White British	Married	A level or equivalent	2
Fiona	2	37	White Irish	Married	Doctorate	2
Elizabeth	8	40	White British	Married	Postgraduate	2
Melissa	2	35	White British	Married	Doctorate	1
Jane	3	39	White British	Married	Postgraduate	2
Niamh	6	42	White Northern Irish	Married	Postgraduate	2
Orla	3	40	White Northern Irish	Married	Postgraduate	1*
Sophia	3	43	Greek	Cohabiting	Postgraduate	2
Natalie	3	37	White British	Married	Undergraduate	1
Katherine	7	36	White British	Married	Postgraduate	2

*Gave birth to another child in between main interview and follow-up interview

Analysis

Social constructionist grounded theory analysis of the data generated seven theoretical categories and 25 focused codes. These are summarised in Table 2.

Making sense of trauma

Realising something was wrong

For most women, the first step towards recovery came with the realisation that the birth had had much more of an impact on them than they had initially thought, or that they had been in a state of denial. Some women recognised immediately that they had been traumatised by the birth, whereas for others this process took longer. Many women described not being able to distinguish their distress from the assault on their psyche and bodies of having just given birth to what was, for the majority of women, their first child. Having no sense of what was 'normal' for a first-time mother led to them attributing what they were feeling to part of being a new mother.

"I was aware that having a newborn baby ... was exhausting, and I knew I'd been through a lot, and so I thought it was just my body's way of recovering… I thought the flashbacks were more sort of daydreams, like I'd be sat there, and suddenly I'd be in theatre. And I, I thought it was just that my mind had wandered, because I was so sleep deprived, because I had a newborn, and I'd lost so much blood." (Jane)

Physical pain from birth injuries and breastfeeding problems contributed to the mess of embodied experience. Other stresses also contributed to their distress, such as the baby having

Theoretical categories	**Making sense of trauma**	**Healing through connection**	**Receiving care**	**Reclaiming power**	**Living with the trauma in the past**	**Barriers to recovery**	**Recovery as a journey**
Focused codes	Realising something was wrong	Connecting with the self	Professional support	Feeling empowered	Being a changed person	Silencing	The nature of recovery
	Creating a coherent narrative	Connecting with others	Support from family and friends	Getting closure	The hangover	Invalidation	Noticing recovery
	Internalising to externalising	Connecting with the world	Self-care	Acceptance		Not getting the right support from services	Managing the challenges of trauma
	Being validated	Connecting with time				Not getting the right support from elsewhere	
						Sleep	
						Physical ill-health	

Table 2: Theoretical categories and focused codes

an undiagnosed milk allergy, and conflict with, as well as illness of family members, which muddied the picture further.

"... and it took a really long time to, to notice... that... I was in panic mode... But because you have nothing to compare it to you kind of go 'Oh, I'm sleep-deprived. It's nothing out of the ordinary. Who wouldn't be, you know, a bit anxious because, I've got things to be anxious about', so... yeah." (Niamh)

The severity of the trauma response itself also appeared to engulf women in the experience, to the extent that two women, both of whom worked with trauma professionally, did not recognise that they were traumatised. Some women spoke about the role of narratives around birth as impeding their recognition of trauma, such as the notion that an 'everyday' event that women have been doing for millennia, in which nobody died, could not possibly be traumatising.

"I didn't even really know but she said it was birth trauma, you know and it sounded like that was what I was experiencing, and that was really, um, that was a really strange feeling to have I sort of, like I felt really silly actually, um like I was going like, 'How can I be traumatised? We were both okay. We were fine', and 'This is something that women go through all the time'". (Fiona)

Denial also played a role in impeding identification. Women spoke about just wanting to 'get on with it', and shut the birth out of their minds, with a sense that to indulge the notion of birth trauma was a threat to their self-identity.

For several, the dominance of PND as '*the* postnatal mental health problem' in public awareness, led them and health professionals to consider this, but they quickly realised PND did not ‘fit’. Many reported that it was a health professional that identified PTSD, but others noted that their symptoms were not picked up. This was attributed to health professionals’ lack of awareness about birth trauma and PTSD, the picture being obscured by anxiety and distress about the baby’s wellbeing, or the sanitising, minimising language women used to describe their birth that hid its traumatic nature. For women who had lived experience of previous mental health problems, this helped them to identify what they were experiencing, whilst two women noted that their husbands’ experience in the military helped them to identify trauma. Realising something was wrong often came in the form of uncharacteristic emotionality or ‘breakdown’ and often led to seeking professional help, but for some, help was only sought a long time after they had identified birth trauma, or not at all. Fears of regarding having their children removed, stigma, invalidation, and confidence in healing naturally deterred women from help-seeking.

Creating a coherent narrative

Many women were left with an incomplete memory of the birth due to dissociation or having their cognition impaired due to pain or medication. Being unable to create a coherent narrative of the events of the birth left them unable to make sense of what had happened, or understand the decision-making of the health professionals, and left them struggling to move on from the experience. Most described discussing the birth with a midwife or consultant, usually as part of a Birth Afterthoughts service run by the hospital. Being able to go through their notes, discuss the facts of the birth, understand the sequence of events, the reality of the risk to herself and/or her baby, and reasons for interventions was reported to be helpful. Where the couple attended sessions together, women felt this was helpful for their partner too.

“*…it was sort of also helpful to find out bits that I’d, we’d both forgotten about things that had happened. Um, just aspects of… actually what happened to me and to the baby, decisions that* *were made, cos I think we hadn't, I think <husband> thought that he'd remembered it all but he hadn't… it went on for so long."* (Holly)

A few women reported problems getting answers from the hospital, either through notes being lost, the consultant leaving, or defensiveness, which left them living with uncertainty. One woman noted how their partner helped them to understand what had happened. 'Re-living' the experience during EMDR or a subsequent birth was also reported to have jogged memories, helping women to construct a fuller picture.

After creating a coherent narrative of birth, women then described the task of creating a coherent narrative of their experience with birth trauma. Many noted that it was only now they felt mostly recovered, often having made sense of their experiences with the help of therapy, that they felt able to piece everything together.

"I've gone through the initial heartbreak of having to put into words um, all these various conflicting thoughts and emotions, and I've- and through this process of my own therapy I've been able to get the narrative straight in my own head, and like make sense of it to myself and then verbalise it, and that's been really important…" (Angela)

Internalising to externalising

Most women initially internalised responsibility for the traumatic birth and subsequent difficulties, such as problems breastfeeding. This was facilitated by internalised narratives of how birth and the early part of the baby's life 'should' be, which went unchallenged and were often reinforced by the care received.

"I haemorrhaged extremely badly, during the birth, um… and the, one of the things I can pinpoint, so I wasn't, um, I wasn't really able to breastfeed afterwards, and there was just this

whole 'Breast is best', all I was getting was this continuous messages, like 'Try harder. Do more', they, and nobody said 'You've basically lost half your blood. It's really unlikely you're going to be able to feed your baby, because... you need to rebuild all your stores'. But instead of that, there was no personalisation, so you know, I then just thought I was failing my baby." (Niamh)

Women who also blamed their babies, and/or did not get the support they needed often became depressed. Speaking to other mothers helped women to identify that they were not alone in feeling they had received poor care, and to uncover subjugated narratives about birth and motherhood, which helped them to externalise responsibility.

"Um, and I think… quite a bit of that was because I had prepared for, like a hypnobirthing approach, and I'd um, felt that that had, felt that kind of like I had failed at that, or that had failed me. So I was quite preoccupied, with thoughts around, like having failed. But I think as I probably spoke to… more, other mums who'd had difficult births, and also felt like that, that probably helped as well." (Melissa)

Women also spoke about the power of understanding that their distress was a mental health difficulty rather than an unchangeable part of themselves in giving them hope and motivation to get better. Awareness that dominant narratives around birth and motherhood subjugated awareness of common experiences, and understanding the mechanisms involved in this, tended to protect women from, or ease distress. Identification of their baby's distress as a health problem rather than anger towards the mother, or being a 'rubbish mother', also helped to ease distress.

Externalising responsibility to the hospital or to hypnobirthing tended to reduce guilt, and often led to anger, which could be motivating and facilitate recovery to a point. Where the hospital refused to acknowledge responsibility, this could lead to women questioning themselves and blaming themselves again. Externalising the causes of distress whilst simultaneously feeling powerless to effect change could exacerbate distress.

"I think, had I not done hypnobirthing I probably would've been screaming and shouting a hell of a lot more during my birth… but because I was trying to… be calm and centred and just go, 'This is a process, breathe through it', I don't think the staff were alerted to the trauma that I was in. So I think the anger that I feel has helped me try and seek answers and fix things, however having said that, having been through all that and still being told 'but nothing's changed, nothing's different, if you give birth again there's very little we can do for you to guarantee that this doesn't happen again, or that you'll get help sooner', then that's really disempowering." (Sian)

Where babies had been injured during birth, having no certainty about the cause left women struggling to process and resolve their distress.

Being validated

Women spoke about the healing power of empathy and validation in helping them to move forward. Being diagnosed with PTSD was felt by most to be helpful in acknowledging their distress as severe, both to themselves and others, and confirm that their experience had been traumatic. Some of the women who had not sought professional help or been diagnosed felt in retrospect that it would have been helpful for these reasons.

"And so, that was part of my problem with the mental health thing I was a bit like 'Is it? Am I? Do I deserve this? And then for her to go 'Well yes, you have post-traumatic stress disorder'. 'Oh! Okay'. And that was a massive thing for me. I was like 'Oh, thank God for that' like. It

sounds really stupid with mental health, but like 'Oh, it's not me. It's not something that I could have stopped happening, if I'd been a bit stronger'." (Katherine)

One woman, who did not receive a diagnosis, felt that it would have been helpful in making sense of the severity of her trauma in comparison to others' experiences. Where the woman was obviously in great distress, or had experienced an objectively awful birth, they reported that validation from friends and family was more forthcoming. Others' anger at their treatment during birth was also helpful in helping them to feel justified in their distress.

Healing through connection

Connecting with the self

Reconnecting with the self, with regard to their feelings, thoughts, and their body was important in facilitating recovery, firstly in making sense of what they were experiencing, and secondly in guiding them in getting better. Connecting with others and engaging in the outside world without their children, including returning to work, supported them to reconnect with their sense of self, away from their role as a mother.

"…going back (to work), it was, it was just so refreshing, because I was <name of participant> again, I wasn't mum, I wasn't <name of child>'s mum, and it helped hugely…" (Stephanie)

Yoga and mindfulness practice helped them to develop insight into their feelings, which then helped them to understand their needs, take action to help themselves, and have confidence in their decisions.

"I went to a mindfulness… programme… (It) revealed to me that… I had more stuff going on, and, became much more aware of... what I was going through in my head... So that actually

probably set me on the path to thinking that the birth was more central to what was going on... So that was maybe one of the windows that opened me down to the pathway of recovery." (Niamh)

Many of the women spoke about the role of exercise in reconnecting them with their bodies, and rebuilding trust in the body they felt had failed them. The role of exercise in reclaiming their body as their own was also named. A return to physical health following injury or illness also helped to restore women's sense of self-identity.

"I'd always kind of been very, very fit… and I think once when I was so ill, um, it was a huge shock to me, I kind of felt like my whole body had failed me… um, so I think the physical exercise kind of.. helped me, first of all feel like my body was working again and, I'd also kind of get to like it again, cos I think I'd kind of felt quite disconnected from it." (Chloe)

The importance of being free from things that they felt were not 'them', was also named by a woman who worked to come off medication quickly, and another who had a hysterectomy to abolish the threat of remaining cancerous cells following a molar pregnancy.

Connecting with others

Connecting with other people appeared to be one of the most powerful facilitators of recovery. Empathy, kindness, willingness to bear witness and listen were all invaluable to women. Some spoke about feeling more connected to their partners following the experience, which was often traumatic for the men too.

"And then now, he gets me through the moments… when I… need to talk about it. And he does that by… just focusing entirely on the conversation. Um, and he's always been brilliant at that, but in these moments he knows, just how important it is for us to be there, be present." (Natalie)

Relationships with health professionals were important in facilitating making sense of experiences and feeling safe enough to re-live and process their trauma. Many women spoke about working with at least one health professional whom they felt genuinely cared about them and collaborated with them on their care.

"I mean certain health professionals during the birth were amazing and really kind and I think that's… helped me more than anything… just connection, connection with other people… other mums who I've met…" (Holly)

Continuity of care was important in facilitating good relationships. Sharing the experience of having children was particularly important to women, and that included both friends and health professionals.

Feeling a sense of community with others was felt to be helpful, and many women spoke about feeling solidarity with other mothers and connecting with a sense of shared 'normal' maternal experiences. Building relationships with other women who had also experienced birth trauma was particularly helpful in making sense of their experiences, normalising, and reducing isolation and feelings of shame, as well. One woman noted she had observed societal changes in recent years regarding the stigma of maternal distress, which she attributed to seeing more and more women share their experiences on social media. She noted the importance of understanding she was not alone in helping her to realise she was not a 'bad mother'. Social media facilitated peer support, particularly for one woman who was also a midwife, who found it particularly difficult initially to openly identify as having birth trauma due to stigma. Peer support also allowed women to use their experience to help other women, which felt beneficial.

(On Twitter) "I was able to talk to um… other women who had experienced the same, who had come out the other side of it. And it was just a nice opportunity to just get everything out and say exactly how I felt and not be afraid of... afraid of saying something that other people might go 'crikey that's a bit intense'… because these people understood and when I noticed myself getting better, I was then able to share some light with them through their sort of darkness if you like and that was very beneficial…" (Jane)

Some of the mothers spoke about moving away from friends and family or returning home. Moving away increased isolation and facilitated social avoidance. Returning home was felt to be helpful, but could be challenging as old relationships had to be reconstructed.

Women's connection with their babies was also felt to be healing. However, women commonly encountered difficulties early on, including feeling resentful following the ordeal of birth and sometimes breastfeeding, overprotectiveness, and detachment. Some also reported that their babies were angry or 'difficult', which was attributed sooner or later to the baby having experienced trauma in birth, or lactose intolerance or allergy; once these difficulties were resolved, reduced distress in both helped bonding to progress.

"Once she was in a place where she wasn't so distressed, she began to blossom. She's just been incredibly healing…" (Niamh)

Many described feeling guilty for have not given the baby the start in life they'd wanted, including experiencing enforced separation from the baby due to the either the mother or baby's illness. Guilt often existed alongside a fierce love for their baby. Guilt often drove women to feel they had to ‘make up’ for the birth with exclusive breastfeeding. Successful breastfeeding supported bonding, but where difficulties led to women blaming either themselves or their baby, this exacerbated problems. As babies developed and became more interactive, women reported the relationship improving.

“When I started getting interaction from her, and, and started getting things back from her, that’s when it started to heal a bit…” (Orla)

Feeling reassured that the baby had not been harmed helped them to move forward. Connection via a sense of joint survival was also reported.

“I remember when he was about... he was probably three months old and we were round at my friend’s house, she was, she was an NCT friend with another baby… and he was just uh, being really… charming basically, smiling at her… and I just got sort of realised that he was a really confident child by nature, and that was really helped me, like, he’s alright, we’re alright um, and I think we just always kind of got on well, you know… and I think he’s helped me to realise that he’s survived it therefore, I can kind of put it behind me a bit better.” (Holly)

Connecting with the world

Women described recovery progressing as they reconnected with life outside the home. This was often challenging in the early weeks and months due to the demands of looking after the baby, and the exhaustion that went alongside it. Connecting with the outside world helped women to reconnect with their sense of self, particularly when they were able to do this without their baby, and undertake meaningful activities they’d previously enjoyed.

"I had my first night away since having my daughter… myself & two friends travelled to <name of city> by train, had a night on the town and stayed in a hotel overnight – it was also fun, reconnected me with the rest of the world, my own self (not just the mummy)." (Fiona)

Returning to work was often felt to facilitate reconnecting to that part of their self-identity, and often provided a sense of self-worth, as well as being a welcome distraction. Experiencing life beyond the home could also facilitate women achieving some distance or sense of perspective regarding their own difficulties.

"I think my job gives me a lot of perspective, and I think not, just being with your child, your world starts to revolve around them and becomes quite narrow, so that, being able to get perspective on your own… challenges, was really helpful." (Melissa)

Connecting with time

Connecting with a sense of time was important. Women connected with time through mindful connection with the present and their babies, through routine, and through anniversaries of significant dates, including birthdays. Connecting with time, including anniversaries facilitated reflection, which could connect women with their feelings and help to process them. Those women who connected anniversaries with the birth spoke about structuring their reflection according to the clock, and what was happening at that time, on the same date a previous year. Connecting with difficult emotions on anniversaries tended to wane with the passing of each year, as the child got older, and birthdays became more about the celebration of the child.

"Her first birthday, I really struggled… Obviously, the day, the older she's got, the easier it's got, because the day is now about her." (Katherine)

Anchoring themselves and the child in time appeared to help women to notice recovery and child development, feel the trauma was in the past, and brought with it a sense of survival.

"(as) you start to see them develop that then kind of connects you much more into the here and now and, you start to focus on what's... um, your relationship in the present and your baby in the present and how things are now and you start to kind of look to the future and it becomes quite exciting…" (Chloe)

One woman named that connection with time also facilitated the belief that 'this too shall pass', giving hope for recovery. For women whose babies were injured during birth, having faith that their distress would pass, and focusing on the here and now was a greater challenge as they worried about the impact of disability on their child's life.

Receiving care

Professional support

Caring, attentive, reliable, and competent health professionals who got to know the woman and collaborated in planning her care were integral to recovery, particularly with regard to care in a subsequent pregnancy and birth.

"I'm gonna have a planned caesarean, and the hospital, this hospital system up here is sort of much more, is much more personal, like I get the same midwife for every appointment and, um, I feel like they understand what happened last time… and I'm sort of under a consultant and it feels much better managed, whereas last time it was quite chaotic… yeah so I think it's helping actually…" (Holly)

Many women reported that there was one health professional who was pivotal in providing them with the support that often they didn't even know they needed.

"The… kind of, bright light in all this was that I had the best midwife I've ever, well she's just the best human being, I've ever met. She was a community midwife… She was with me from the moment I booked in. She was the kindest human being." (Katherine)

Getting the right therapy was important, particularly when women got the approach and the time they felt they needed. Paying privately facilitated this.

"…it was only when therapy started and they kind of diagnosed… post-traumatic stress um… and that therapy began that I thought, okay this is going somewhere um, positive eventually and that I could see like you know, the proverbial light at the end of the tunnel." (Jane)

GPs were instrumental in facilitating access to appropriate support. Medication was generally felt to be helpful. Midwives and consultants who were professional and non-defensive in Birth Afterthoughts sessions helped to make this experience beneficial.

Support from family and friends

A helpful support network provided the woman with time, patience, space to talk, validation, and helped them to externalise responsibility for the birth and other difficulties, as well as providing practical support. Many women spoke about working as a team with their partners.

"(I'm) just very thankful to have had him and him being the parent that I couldn't be at that time, cos he kind of took on both roles… he still doesn't understand it, he doesn't, but he, he's very good about it." (Stephanie)

Where loved ones could help women meet theirs and their children's needs, and do so in a way women experienced as helpful rather than intrusive, this was invaluable.

"Whereas, I was her daughter, I was her priority, and so yeah, she was much more aware of it. And she was just kind and caring, didn't ask me about it, but she was always there." (Natalie)

It didn't appear to matter where women got support, and they could tolerate loved ones not understanding if they received adequate support elsewhere. Where partners struggled to understand or were less emotionally available, their stoicism, loyalty and willingness to provide practical support was helpful.

Self-care

Women spoke about the importance of tending to their own needs, which was facilitated by having space to reflect, gain insight, and connect with their feelings. This took the form of trying to look after themselves with rest, diet, exercise, and time spent with their partner and friends, carving out time for themselves to engage in meaningful activities away from their children.

"I try to cycle, rather than take the car, so if I do go, you know for any meetings, carve out some quiet time for me. And I play the piano, when, if I get the chance…" (Niamh)

Exercise (yoga, running and boxing in particular), was felt to be cathartic. Women also spoke about protecting themselves from difficult or triggering situations when feeling vulnerable, including deciding not to breastfeed, pushing for a caesarean in a subsequent birth, and avoiding challenging interactions with people who didn't understand.

"I thought, I've been through the worst experience, there's no way I'm gonna unsettle this baby for anyone. She can get her nutrients from Actimel. I'm quite happy with that (laughs)." (Natasha)

Sacrificing money to stay at home, or reduce working hours was also helpful. Some spoke about developing self-compassion in their recovery, which facilitated them to prioritise their own needs and make mistakes without redress.

Reclaiming power

Feeling empowered

Women spoke about many different ways in which they empowered themselves, or were empowered by others. CBT empowered women to have autonomy over their symptoms.

"I found it (CBT) much more helpful than the face-to-face one-on-one counselling, because I was kind of given, giving coping mechanisms and things to take away with me to try and change my thought processes… Which was good for me, it was something I could do myself rather than just having the, the chat." (Stephanie)

One woman, who had never run before the trauma, described how running a half-marathon had consolidated her sense of physical and mental strength. Others named that yoga had similarly benefitted them:

"…going to do a yoga session… was irreplaceable. And… it helped me build strength in my body and in my mind." (Sophia)

Actively working towards recovery, and achieving goals was also empowering. Being empowered by health professionals to achieve the subsequent birth they wanted, be it a VBAC (Vaginal Birth After Caesarean), or most commonly, a caesarean, was helpful.

"…but at the actual birth, the consultant wasn't there and the midwife team just let me do what I want really which was really huge for me, so they let me push longer than I was supposed to and I think had they not done that, it could've turned out very differently. So yeah it was a big thing." (Chloe)

Knowledge, although usually helpful, was sometimes a double-edged sword, particularly with regard to knowledge about attachment and child development, which tended to exacerbate anxiety and guilt about the impact of their difficult start together. Effecting changes in practice at the hospital following a complaint was also empowering. Women also named feeling empowered by being able to meet their children's needs, including breastfeeding.

Getting closure

Getting closure on what happened was important in supporting women to accept what happened and move on. Birth Afterthoughts sessions, investigation reports, and formal complaints were routes to achieving closure. For some women, simply understanding the events of birth was enough to get closure on the matter. Where hospitals acknowledged shortcomings in care, no women pursued the matter further. Where this didn't happen, most women fought for acknowledgement or an apology, which they got.

"(They) rewrote the report, and met with me, and changed the grading, (from low) to moderate harm, and, for me that was enough to see that then, that they had acknowledged that this wasn't an everyday occurrence, that this wasn't just someone going in and um having the outcome they didn't want… Um, so… after that, um, I felt that the report was kind of put to bed in a way, and I was able then to start on my road to recovery again." (Jane)

For many, a subsequent birth in which they experienced elements they didn't manage to get the first time, such as a calm birth, immediate skin-to-skin, and being able to breastfeed, was felt to be incredibly healing. Being able to give thanks to health professionals who had helped them through their birth trauma or subsequent recovery also appeared to be important in helping women to achieve closure.

"Well that senior anaesthetist (who had intervened helpfully in the first birth) was my anaesthetist from the start this time, so it was so weird like, it kind of felt like total closure, you know. I saw everybody, and got the opportunity to thank him, and we were talking to him all the way through the operation, it was just that I walked away from the whole experience going 'That's it. Fine. Closed. Yeah', and it was really helpful." (Orla)

Acceptance

Accepting what happened in the birth and the baby's early life was a huge task for women, and appeared necessary in helping them at different stages of recovery. Some found the task of accepting they had been traumatised difficult, often when they felt that to do so would tarnish them with stigma or failure in some way. Accepting that they had been traumatised appeared to be the first step towards recovery. Accepting that their trauma necessitated them reducing stress in their life, including reducing socialising and stepping back from their career, was another task for some women.

"...I think just being mindful of your own needs so, um, for me that was about, you know, once I'd spotted it, slowing down and just sort of, taking time to just, do nothing and being okay with doing nothing." (Natasha)

It appeared particularly difficult for women to accept the events of birth when they were unable to get closure, for example when they were left with memory blanks, their questions weren't answered, or they were not able to get an apology or effect changes to protect others from similar harm. However, this was a reality for some, and most focused on the fact that they and their child had survived to help them move forward.

"I'm at a place where I think, 'Yeah I'm acceptable, I've accepted it, it's okay. I know I'm never going to get an apology." (Jenny)

Bonding, and seeing their baby thrive facilitated their acceptance of what had happened, helping them to see that the future held other possibilities.

"I think it (bonding) helped, yeah, because of ultimately you know, we wanted to have children and, when you're thinking along those lines you want to love your child and all the rest of it, so I think it kind of... it put that... it was... a point in time that was there and I have to accept that, but it doesn't have to define how our relationship would be in the future." (Dominique)

Living with the trauma in the past

Being a changed person

Women who felt that they had mostly recovered from birth trauma described feeling like a changed person. They noted that they were more assertive, and felt stronger, more resilient. They spoke about feeling greater empathy and compassion towards others, curiosity about the human condition, and a strong connection with a sense of shared humanity.

Um, but… it's made me a stronger human being in the long run. It's made me more compassionate. It's made me more, I want to reach out to people and help them. (Katherine)

They were driven to help others, which they did through volunteering, fundraising for charity, seeking to effect changes in maternity care, sharing their experience to reduce stigma and raise awareness of mental health difficulties, participation in research, and peer support.

"…that's why I like, wanted to be involved in this study too. It's like trying to actually shine a light, cos there's so like there's so, there's not enough information about out there, about any of this stuff…" (Fiona)

Some described how their priorities in life had changed, where they placed a greater value on nurturing important relationships and protecting their and their family's wellbeing.

"But yeah, I think I am different in some respects like... yeah. I'm still like happy and still quite like bubbly, but I've definitely let go of things that I just don't feel are purposeful, or I don't really take much shit anymore, from anyone (laughs). Um, and I probably had, had a lot more acquaintances as friends, whereas now I just have a small group of friends that I know are quality." (Natasha)

The hangover

Most women reported that the process of recovery was ongoing. Some reported ongoing anger that they had been subjected to a traumatic experience they felt could have been prevented. Some described ongoing hypervigilance and anxiety. Persistent feelings of guilt and self-directed anger for their hostile or detached feelings towards their child, and worry about the potential impact of birth trauma on the child were common.

"Um, I still feel guilty to this day actually that… I didn't love him, to start with um... worry, that somehow, he'll know in the future, I mean if he asks me in the future I'll be honest but like, worry that some psychological damage has been done to him which'll come out when he's a teenager or something (laughs) um, it's a hard, it's a hard feeling to deal with, I would say, even now." (Dominique)

For a couple of women an ongoing sense of trauma was reflected in the language they used, as they switched between talking in the present and past tense. Ongoing feelings of sadness and loss for the wished for start to life that they felt they'd been deprived of was also named. Women worried about their child finding out about their traumatic entry into the world. One woman, who feared that the complications she experienced during birth may be hereditary, spoke about dreading having to tell her child about it. Such worries were linked to concern that their child may feel responsible for the trauma. Being unexpectedly triggered was also reported as an ongoing challenge, and an uncomfortable envy of women who had the experiences they were denied was common.

"You're supposed to have a… vaginal delivery, and that- I guess I slightly… mourn those birth experiences that people have where you breathe the baby out and it's all beautiful and it's in water and there's whale song and. There's actually a girl that I was really good friends with,

and I can almost not talk to her anymore because she had four, really lovely births and I, I think it's alright now the kids are a little bit older, but at the time I was so jealous like, 'That's not bloody fair, is it?'." (Katherine)

Some women remained silenced from speaking about their birth, and welcomed the opportunity to talk about their experiences at length in the research interview. One woman spoke about feeling that her trust in others to keep her and her children safe had been forever shattered. The midwife faced the unique challenge of having to work in the place the trauma happened, in addition to working with people who remained hostile that she had challenged their attempts to minimise her experience.

"I was kind of left with this hangover, what I termed a hangover of anxiety from it where um, I'm sort of hypervigilant at work, around these people, and it's not a very… it's not a very nice place to kind of be in, as somebody having to deal with that, on uh, you know three days a week, which is what I then returned to work as. But it is what it is." (Jane)

Barriers to recovery

Silencing

Feeling silenced from talking about their experiences was very common, and served to prevent women from making sense of their trauma and seeking support. From the start, some women spoke about being made to feel they should 'put up and shut up' by health professionals, and the subsequent lack of interest and services to support their recovery. This led them to assume that the difficulties they were experiencing were just 'what all mothers go through'. Women were silenced by friends and family being unable to understand, bear, or know how to respond to the nasty reality of what had happened to them and their baby, or the darkness of their subsequent trauma. They observed that people (health professionals especially), were only really interested in the baby.

"…it felt like a bit of a selfish luxury… (to talk about emotional trauma with other mothers) no one professionally in my whole experience of both being pregnant, the birth, and post-pregnancy, ever gave us any time to think about ourselves. All the questions were, about the baby, and then they kind of said 'And are you okay', and that was kind of it. So it was a closed question. There was never any time for us." (Natalie)

Some described not wanting to scare women who had not yet had children. One woman noted that being unable to coherently describe what had happened or find the language to convey the horror silenced them, and impeded others from empathising. Some women felt compelled to put others' distress before their own so as not to burden, worry, or exacerbate others' distress, and muted themselves. Most of the women also named feeling silenced by dominant narratives around birth, for example, that birth *is* painful and difficult, and romanticised stories of immediate bonding and the 'perfect birth' as attainable through doing hypnobirthing 'right'. Internalised failure and feelings of shame about the birth, as well as the taboo around birth trauma and mental health also silenced women from discussing their experiences.

"I didn't want to talk to anyone about it, I think I – I didn't realise it at the time but in retrospect I think I felt quite a lot of shame about... for some reason I think I felt responsible… for what had happened…" (Chloe)

Invalidation

Most women described feeling, or being made to feel unjustifiably traumatised by their experiences around the birth. Narratives around birth trauma being the fault of the woman for having unrealistic expectations of birth, or that or the idea that ‘all that matters is a healthy baby’ served to make women feel they had no right to feel as they did, and made them feel ungrateful and self-indulgent.

“…you see this quite a lot in the articles about this topic, and it’s ‘Well what have you got to complain about? It’s not like your baby died.’ Well no, you know, she didn’t die. But it was still bloody awful, you know?” (Orla)

Some described being invalidated by health professionals, as their experiences of their body in labour or recovery did not ‘fit’ the textbooks. Invalidation through health professionals’ defensiveness in Birth Afterthoughts sessions or complaints proceedings was often retraumatising. Invalidation served to silence women, encouraged them to internalise the birth and subsequent difficulties with the child as their own failure, and impeded them from making sense of their experiences and being able to externalise responsibility.

“…they just sort of, minimised and belittled my whole experience and I think that had.. that was really hard. That made me feel like I’d made up the trauma, or I’d made up the problems and maybe I was catastrophising everything…” (Sian)

Not getting the right support from services

Failure on the part of health professionals and systems to support women prevented them from understanding their experiences, silenced and invalidated them, and impeded their recovery. Many of these difficulties were attributed to a lack of awareness about birth trauma, and its impact on breastfeeding and the baby. Women described being referred to inappropriate, inadequate levels of support and psychological intervention.

(Describing low-intensity telephone CBT from IAPT) "I was much more interested in 'Well why has this happened?', and 'What's going on?' to get me to this point, than just, 'Let's learn to deal with having a panic attack', because I thought 'Well actually I want to not be having panic attacks'. And I think I tried to share that with the, the counsellor, and that kind of didn't really fit the, the model, and it was 'That's not really what we're here for'." (Elizabeth)

Some faced barriers to accessing therapy, such as long waiting times, incompatibility with work schedules, difficulties sourcing childcare, and a lack of flexibility and understanding from services regarding missing sessions. They described 'tick-box' support from health visitors and in one instance a mental health professional, who appeared blinded by their ability to function. They reported that health professionals appeared to have little interest in their or their husband's mental or physical wellbeing, and were only concerned about the baby's physical health.

"…no one professionally in my whole experience of both being pregnant, the birth, and post-pregnancy, ever gave us any time to think about ourselves. All the questions were, about the baby, and then they kind of said 'And are you okay', and that was kind of it. So it was a closed question. There was never any time for us." (Natalie)

Most, but not all women were asked to complete the Edinburgh Postnatal Depression Scale (EPDS). For most, who weren't depressed, this didn't fit their experiences. Those who had become depressed, easily evaded detection by ticking the 'right' answers. There appeared to be a dearth of understanding and services around pelvic injuries, with women reporting a lack of specialist physiotherapy services, being told to ‘go away and do your pelvic floors’ (no women reported receiving adequate support for pelvic issues). The lack of continuity of care postnatally from the health visiting service mirrored women’s experiences with midwifery care antenatally, and echoed their sense of fragmentation. It prevented them from building relationships with health professionals where they may have felt safe to disclose problems, and meant staff were unable to detect changes in their presentation. Lack of time in appointments was also named as a barrier.

“I feel both GP (sic) and health visitors are… working… in a routine way that is not really letting them get involved with people, and trauma needs people who get involved with you.” (Sophia)

Defensiveness of staff in Birth Afterthoughts sessions could be retraumatising if women responded with internalising, or otherwise filled them with rage and sometimes hopelessness. A few women weren’t offered a Birth Afterthoughts session at all. Problems accessing notes was also reported by three women. Two women noted that systemic issues with categorisation of births into either ‘successful vaginal delivery’ or ‘not’ seemed incapable of accurately capturing their experience and risk in a subsequent birth, exacerbating their anxiety about having more children. Three women, who experienced life-threatening events in labour and birth reported having to fight to get the answers and support they needed to ensure their own safety in their subsequent pregnancy and birth. All those who identified experiencing depression in addition to trauma noted that they felt this was because they did not get the support they needed for their trauma. Approximately half of those interviewed named what they’d experienced as the systemic devaluing and gaslighting of women’s experiences perinatally as a direct product of living in the patriarchy.

Not getting the right support from elsewhere

Some women described not having the right support from their family, friends, and work. Women who had little or no family nearby, or whose families didn't understand why they were upset, and felt they should just 'get on with it', felt isolated.

"There was, there was no support, there was no sense of 'Gee <name of participant>, and <name of husband>, what a thing you've been through, you've almost lost your baby, you must, you must feel awful. We'll give you all the emotional support you need. We'll be nice to you, even when you're horrible and say nasty things, or when you're stressed'. No, I didn't get that. I got... sulky silences, and, um... and then a lot of drama and trauma around my dad's um, illness." (Angela)

A couple of women, who had also recently moved, spoke about how their husband's work took them away from home for significant chunks of time when their baby was small, making them feel very isolated and unsupported. Some women noted that their partner's own distress acted as a barrier to offering the emotional support the women needed. Others described protecting their partner from their darkest thoughts. Women reported 'well-meaning' comments from friends and family, that angered or exacerbated their distress. Lack of understanding from work in accommodating their trauma was felt to have contributed towards relapse and depression. One woman, a midwife, reported an apparent resistance on the part of colleagues to acknowledge trauma, and a refusal to refer her to Occupational Health for support, for fear of losing a staff member to sick leave.

"…even though they knew that I was returning to work, there wasn't anyone, and you know, knowing that I was returning to the place in which it happened. There wasn't any support, there wasn't any, 'Okay so how can we make this easier for you?'" (Jane)

Inflexible patriarchal work structures meant that some women had to give up their job:

"…their attitude really was 'You take it or leave it. This is the only job we can find for you now… 'Don't ask us to bend over any further about working four days a week or three days a week'." (Angela)

Privilege, British cultural etiquette, and the busy nature of others' lives were also felt to be a barrier to others offering support.

Sleep

Sleep was named as a hugely important and underestimated contributor to wellbeing. Many women faced disturbed sleep caused by multiple factors: from hypervigilance, rumination, nightmares, their baby's feeding regime, and their baby's poor sleep, which was attributed to either undiagnosed lactose intolerance or the trauma of the birth. Lack of sleep impeded women from being able to make sense of and process their feelings and experiences as well as impeding physical recovery.

"I wasn't able to sleep, and I wasn't able to think, and I wasn't able to do things… usefully." (Katherine)

Nearly all women articulated that once they started getting more sleep, which often coincided with a reduced feeding regime or stopping breastfeeding, things started slipping into place and they began to feel better. They noted that having the cognitive capacity to reflect made a huge difference in being able to make sense of their experiences, know what they needed to do to feel better, take action to help themselves, and connect with the knowledge and hope that things would change with time.

"…the sort of panicked flashbacks stopped… and the stress of it and the anxiety and all those different things… I'd say that that all stopped by about five months I don't know why, but it just did maybe also by about five months the sleep deprivation's have calmed down a bit, you're getting into a bit of a routine with your baby so you actually have some time to actually reflect and look after yourself…" (Sian)

Physical ill-health

Physical pain, illness, and exhaustion all impeded recovery. Some women articulated that they did not feel their recovery began until they felt physically recovered. Prolonged pelvic pain, severe tearing, episiotomy wounds, and recovery from pregnancy-related illnesses and blood-loss were all named as impacting on women's wellbeing. Physical ill-health reduced their capacity to talk about and reflect on their experiences.

"I think once the physical experience, physical pain had gone, it was after that that I began to be able to talk about what happened… with my husband." (Natalie)

Two women articulated that silencing around 'normal' physical recovery following birth meant that they had no idea that what they were experiencing was not normal, and so help-seeking was delayed or did not happen at all.

"I had just assumed… that that's what it was like, after you have a baby. And at no point, in anything I'd come across or read, did it say 'You shouldn't still be in pain at this point'." (Katherine)

One woman noted the irony that being in hospital for a long time after birth had impeded her physical recovery as she had been unable to sleep for any sustained periods due to the noise and constant checks. Physical recovery was associated with a return to feeling like their old selves, motivated women, and facilitated their participation in activities outside the home.

"I'd gone from being extremely fit… to being not able to go up the stairs… and once I was able to um, I remember being able to get to the end of my road with a pram and that was quite a big thing for me and then I started feeling a little bit like um.. I might be able to kind of focus on something else, maybe to get myself back a bit, um reminded me of how I was before, cos I think it had become a bit all-consuming…" (Chloe)

Recovery as a journey

The nature of recovery

Women reported very different experiences of the course of recovery from birth trauma; they variously described re-living symptoms, rumination, guilt, low self-esteem, self-worth, and self-efficacy, anger, anxiety, and low mood. Some reported their presentation moving from depression to anxiety, or from flashbacks to anger. Two women noted the co-existence of happiness and trauma. The early postnatal period was often characterised by women simply trying to survive and 'hold it all together'. Coping was felt to be qualitatively different from recovery. Some described 'turning points'. These tended to be what women felt to be key times when they had come to realise something important, which then motivated and catalysed their recovery.

"I remember, just looking at his (eldest child's) wee feet going 'Oh my god, like, I have missed the last three months of your life'… and having this kind of mixed like, feeling awful about it,

but also going, like, I'm not going to miss any more, so that was… it was a big turning point for me." (Fiona)

Many described recovery as a sense of living with the trauma, rather than being ruled by it, which was facilitated by a sense of survival. Many women spoke about the multifaceted nature of recovery, and they struggled to pull apart the influence of different experiences on wellbeing. Women described recovery as a process, which ebbed and flowed over a period of months and sometimes years, and was generally felt to be ongoing. Interestingly, two women had not previously constructed their experiences as 'recovery' until reading about the study, illustrating the role of social interaction and language in how we make sense of our experiences.

"I was interested, when I saw your project because…I'd never thought of… my journey being a recovery until I saw those words put together and I thought 'that makes total sense, this is what's happened to me'… there's a sense that it's finished, but it happened, it's a bit like you know you, like having been an alcoholic, you know… you are no longer an alcoholic, but that has stayed with you… it's part of your existence and that's kind of how I feel with this." (Angela)

Noticing recovery

Women spoke about noticing changes in their psychological and physical health as they recovered. Women who had experienced significant physical ill-health due to complications in birth described feeling encouraged by physical steps towards recovery.

"I ended up with a prolapse… and I had a hysterectomy, um, four months ago. So going back to yoga, two weeks ago, feels like a real step forward." (Niamh)

Positive changes motivated women to keep going, or to work harder to make more progress. They noticed a reduction in re-living symptoms and in emotionality when exposed to reminders of the birth, and in needing to talk about it.

"Um, and, it's only recently… I've met some new mums, and I do playdates with this one mum, and this is going to sound really silly, it's amazing, I haven't actually told her about <name of child>'s injury. I haven't felt the need to offload to her and to tell her about it. Um, whereas, pretty much anybody and everybody who, who's spoken to me about <name of child>, knows about it." (Jenny)

Those who'd had CBT also noticed recovery as they developed a sense of mastery over their symptoms. Some women, who had felt detached or depressed, noticed a return of playfulness and feelings such as joy or excitement. Cognitively, some women reported realising that they were able to think and reflect, or noticed a return of creative thought. Only one woman reported setting herself goals to facilitate recovery.

"…I couldn't even read a news story, I was just staring at things so that was like, you know part of, part of when I went for that coaching, facilitating thing, that was part of what I wanted to do… I wanted to get back a place where I can read, think again, so that was like, I had like wee targets where I would read for like, an hour a day or something, you know, build it up…" (Fiona)

Women reported noticing feeling less anxious, less irritable, and less guilty as they recovered. Coming off medication and a willingness to get pregnant again were also named as milestones. Anniversaries were a time when these changes were often noticed, as women compared the extent to which they felt preoccupied or emotionally vulnerable with previous years.

Managing the challenges of trauma

Women spoke about navigating and having to overcome multiple challenges in their recovery, some of which were ongoing. The things that they felt they needed to do to survive or make themselves feel better, such as breastfeeding to ‘make up’ for the birth, building up emotional walls to protect themselves, or working whilst still very unwell, were double-edged swords that simultaneously impeded recovery. Other double-edged swords included sharing their experiences to help others, therapy, and pursuing an apology from the hospital. With regard to making a formal complaint, women often found the process an emotional rollercoaster. For those who did not get an acknowledgement of responsibility from the hospital, they faced the task of moving on, whilst feeling an ongoing sense of injustice. For the majority of women, their traumatic birth was their first birth, and they wanted more children, so were left with facing the prospect of going through another birth. Some women named the challenge of having to celebrate the most traumatic event in their life every year. A couple of women articulated the task of recovery as integrating often seemingly contradictory feelings, or holding onto both the good and bad.

“...I could be mourning a child every birthday, rather than… celebrating a child every birthday. And this is the… awful fragmentation, because you are doing both at the same time. It’s like, I’m simultaneously so… grateful that that day ended up the way it did, and so… traumatised by the way it went. You end up with these two conflicting emotions, clashing all the time. And, it sends you mad. It’s very hard to process that cos they’re both true, simultaneously.” (Katherine)

Their relationship with gratitude presented an another, ongoing challenge to manage. Feeling grateful for their and their baby's survival promoted acceptance and connection with humanity and the wonder of life on earth. However, it also contributed to self-invalidation, as they compared their experiences with women whose babies were seriously disabled as a result of birth or stillborn.

'…for me it still feels like it's an indulgence to… go back there. He survived, and I survived, and lots of people firstly can't have children, that want them, and lots of people get as far as we got, and their children don't make it. You know <child> had sepsis, so he was a very poorly bunny. So for me, it feels like, just need to be grateful, rather than… looking back all the time.' (Natalie)

Some women described compartmentalising their experiences to cope with the fragmentation, for example, by separating the trauma experienced on the ward from the helpful counselling sessions that took place in a nearby room, or refusing to use their child's name when talking about the traumatic time in the hospital.

Grounded theory model

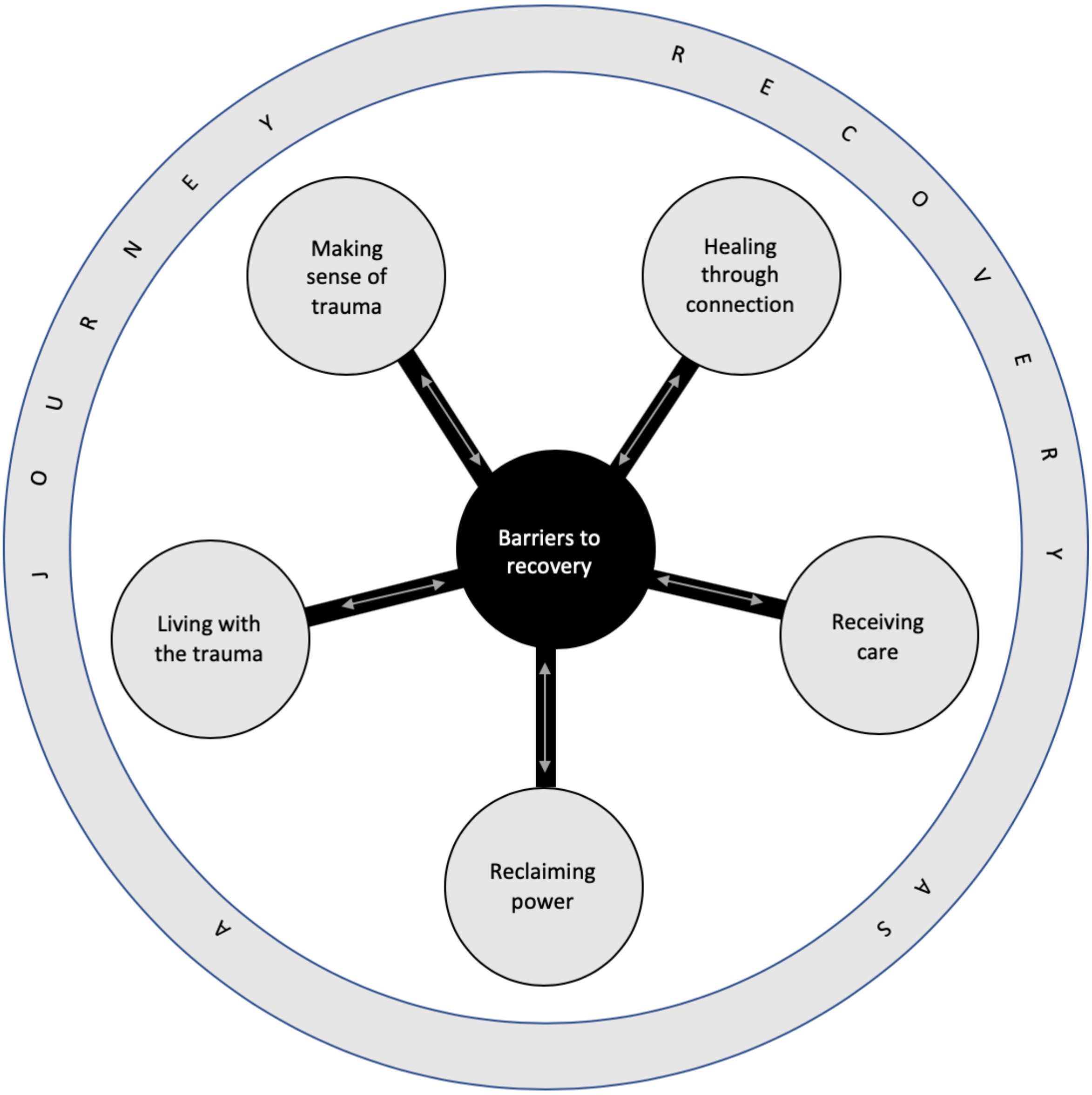

Figure 2. Grounded theory model of the process of recovery from birth trauma

The process of recovery from birth trauma was multifaceted, dynamic, interconnected, and iterative. The category ‘recovery as a journey’ encompassed all other categories, which all impacted on each other. Barriers to recovery could impede the process. The model is shown in Figure 2. Below are some examples of how the categories interacted with each other.

‘Making sense of trauma’ and ‘healing through connection’

As women began to understand that they were traumatised, this could facilitate them connecting with others, for example by seeking support. Externalising responsibility could also reduce guilt and promote bonding with their baby. Similarly connecting with others could help women to make sense of, and externalise responsibility for the trauma. A barrier, such as sleep deprivation could reduce emotional capacity for making sense of trauma and connection.

‘Reclaiming power’ and ‘receiving care’

Women empowered themselves by seeking out care. Accepting they were traumatised was the first step towards doing this. The care they received could also be empowering, for example, being supported to birth a subsequent child as they wished, or gaining autonomy over trauma symptoms via strategies learnt in therapy. A barrier such as invalidation could disempower and silence women from getting the care they needed.

‘Living with the trauma’ and ‘making sense of trauma’

Living with the trauma tended to be a later stage of recovery, but the iterative nature of recovery meant that sense-making continued as women learned more about themselves and their trauma. For example, during a conversation about sleep and recovery, one woman drew new links between breastfeeding, sleep, and recovery. She showed clear signs of post-traumatic growth but was experiencing ongoing anxiety which she managed well with medication, and her trust in others to keep her and her family safe remained shattered. A newly found drive to help others who were suffering was what attracted her to participate in the study and enabled this conversation. She hadn’t previously had the opportunity to talk in-depth with family and friends about her experiences due to their own trauma, lack of ability to understand, or social norms.

Discussion

This study used a feminist social constructionist grounded theory approach with the aim of exploring women's experiences of the process of recovery from birth trauma. Based on 17 interviews with mothers whose traumatic births occurred between 17 months and 8 years previously, the findings pointed to clear processes and experiences that appeared to facilitate and hinder women's processing of the trauma and sense of recovery. As no previous studies had focused specifically on how women experience recovery from birth trauma, or sought to shed light on psychological processes involved in recovery, these findings provide novel information in this area.

The main theoretical categories were:

1. Making sense of trauma
2. Healing through connection
3. Receiving care
4. Reclaiming power
5. Living with the trauma in the past
6. Barriers to recovery
7. Recovery as a journey

These categories will be discussed in relation to existing literature and theories of trauma and recovery. The methodology will be critiqued, with discussion of its strengths and limitations. The implications of the findings will also be discussed with regard to practice and society. Finally, the role of the researcher on the research process will be reflected upon, and conclusions will be drawn.

Summary of findings

This grounded theory model of recovery from birth trauma extends from the model of postnatal PTSD proposed by Iles and Pote (2015). Like their sample, the women who participated in this project presented differently. Although there was no attempt to measure using validated tools, conversations with the women revealed that they struggled with a variety of different signs of trauma, which appeared to differ in severity and duration.

1. Making sense of trauma

Making sense of the trauma was one of the most fundamental processes in influencing the course of distress and recovery. This applied to making sense of the events surrounding the birth, with regard to what happened, how it happened, and why, as well as making sense of subsequent trauma and how to improve the wellbeing of the whole family unit. This echoes Judith Herman's theory of recovery from trauma (Herman, 1992).

Constructing their experiences as trauma was the first step towards recovery. This came at different points for each woman. Although all knew that the birth had been very difficult, understanding the impact that that had on them often came later, as some described being in denial, and most spoke about the difficulty they had in distinguishing trauma from what they assumed was 'normal' for a new, sleep-deprived mother. Interestingly, although Iles and Pote (2015) identify that women's narratives of trauma were intertwined with their wider postnatal experiences, the birth trauma literature does not identify that women had problems in realising that they were traumatised, whereas it was a common theme in this study. It is, however, commonly mentioned in the wider PND literature (Button et al., 2017). The postnatal period as the context to trauma gives birth trauma a unique phenomenology. For first-time mothers in particular, they face the huge existential shift from non-mother to mother, during which their body undergoes significant changes, in addition to the physical and mental assaults of pain and sleep deprivation. These experiences were in addition to other emotional challenges women faced, such as her own illness, baby's illness, or illness or death of a loved one, issues at work, complex family dynamics, and moving house. Trauma distorts one's ability to locate the self in chronological space (Ratcliffe et al., 2014), and sense of time is further confused by motherhood itself (Baraitser, 2009). Normal maternal hypervigilance becomes difficult to distinguish from hypervigilance stemming from trauma's shattering of implicit trust in the world, further impairing women's sense of what is 'normal'. The multitude of psychological and physical challenges women undergo during birth trauma therefore has a great impact on their ability to make sense of their experiences.

Creating a coherent narrative of their whole trauma journey appeared important in being able to integrate birth trauma into their wider life story. Birth Afterthoughts sessions were felt to be helpful in facilitating the creation of a coherent narrative of the birth. Being able to make sense of the events of birth was crucial to women in being able to make sense of their subsequent trauma. This finding was consistent with the meta-synthesis (Allen, 1998; Bailey & Price, 2008; Iles & Pote, 2015; Peeler et al., 2018), as well as current understandings of the cognitive changes that occur during trauma processing (Ehlers & Clark, 2000). Understanding the rationale for interventions may also have facilitated some restoration of trust in health professionals and helped to reconstruct core schema about the safety of the world. Additionally, one woman's beliefs about the danger to her baby's life were updated with reassurance that this was not the case, which appeared to retrospectively reconstruct the meaning of her memory, removing the threat. This process emulates a technique used in trauma-focused CBT.

The process of moving from internalising to externalising responsibility for the birth and subsequent trauma response was a powerful part of women's recovery. Dominant societal narratives about how birth and early motherhood 'should' be seemed to have a powerful impact on how women made sense of, and appraised their experiences. This echoes McGrath et al. (2013), who noted how women's understanding of their experiences of postpartum psychosis (PP) evolved over time, and that their initial understanding, whereby they felt guilty and ashamed of not matching societal expectations of new mothers, silenced them from speaking about their experiences. The sociocultural context was felt to have a significant impact on their understanding of their experiences, silencing, and seeking support. An important difference between McGrath et al.'s study and this one are the social and psychiatric constructions of PP and PTSD. Whereas dominant narratives around PP emphasise biological causes (Royal College of Psychiatrists, 2019), PTSD has a much more integrated framework of understanding, incorporating the importance of experiences, as well as social and neuropsychological processes, which may facilitate externalising.

In the current study, several women spoke out about the impact of narratives around women having power over their own births and their pain, naming hypnobirthing approaches specifically as contributing to them internalising responsibility for the birth. The role of previous expectations in birth trauma has been mentioned before in the literature (Allen, 1998; Byrne et al., 2017; Iles & Pote, 2015; Moyzakitis, 2004; Nicholls & Ayers, 2007); it has also been reported as an important factor in distress in women experiencing PP (Heron et al., 2012; McGrath et al., 2013; Robertson & Lyons, 2003), and PND (Beck, 2002). This suggests hypnobirthing practitioners have a role to play in easing birth trauma, which will be discussed later.

It may be that externalising allowed women to reflect on the birth without the great threat to the self presented by guilt, feelings of failure, and self-criticism. This echoes a finding by Beck (2004a) that women who externalised their anger and trauma were more likely to describe a more active narrative of survival. Similarly, internalising responsibility has been hypothesised to mediate women's feeling of being frozen in the trauma (Byrne et al., 2017). Externalising was widely reported to reduce distress and may have prevented one woman who felt traumatised by her birth from experiencing most of the recognised symptoms of trauma. However, for some, externalising was not a neat, packaged state, as they spoke about still harbouring some guilt either some or all of the time. Society's expectations and judgements about mothers, as well as the ‘double-bind’ nature of some of these ensures that women are constantly being made to feel guilty for failing in one way or another. This constant triggering of guilt for other areas of parenting may impede the resolution of guilt related to the birth as it ensures that such feelings are constantly being triggered and reinforced by judgements about wider parenting issues. The frequency with which women raised the impact of dominant narratives and societal judgements on their ability to make sense of what was happening, feel safe in seeking support, and on their subsequent distress was marked. Although the impact of such narratives and judgements has been named before, the focus of the perinatal literature appears to be on other factors, such as loss of the non-mother identity, support, and previous mental health problems or trauma. Although these were all named, dominant narratives appeared to have significance greater than the literature to date suggests. They did not act solely on the woman either, but very much influenced the support a woman received from others.

Approximately half of the women interviewed named the role of the patriarchy in their experiences of birth and motherhood. They understood that it influenced their experiences during birth and postnatally on multiple levels, from hostility to flexible working, to disempowerment in birth, to the lack of care for their physical rehabilitation. Some explicitly reported that they developed new understandings through conversations with other mothers after birth, whereas others reported that their ability to apply their knowledge of patriarchal oppression of mothers to themselves was limited when they were ‘in’ the trauma. This way of understanding helped them to reconstruct their experiences, alleviating guilt. For some, connecting with other mothers, particularly those experiencing similar distress was the key to finding a new way to understand, and externalise their experiences. However, being aware of patriarchal oppression and feeling powerless to enact changes was also named as contributing towards feeling trapped, underlining the importance of opportunities for action and empowerment in addition to awareness. The literature describes the role of societal expectations in how women make sense of their experiences, but outside of the feminist literature (e.g., Kitzinger, 1992; Moyzakitis, 2004) there is little discussion of the specific role of patriarchy in birth trauma. Moyzakitis (2004) is the only study included in the meta-synthesis that explores patriarchy within maternity hospital systems. None link it with how it shapes narratives around birth and motherhood, and the impact this then has on appraisals and the course of trauma. This indicates that the literature itself may be inadvertently perpetuating epistemic injustice and impeding real change in helping health professionals to understand how they can help to prevent and ease the distress of birth trauma. It points to a need for a wider discussion of systemic issues in research into birth trauma and perinatal distress.

Validation was an important part of making sense of trauma, as it helped to confirm to women that they had been through a traumatic experience, and acknowledged their severe distress. This need for validation is consistent with the literature (Allen, 1998; Beck, 2004b; Beck, 2006; Beck, 2016). Most women felt that receiving a diagnosis was, or would have been helpful in validating their distress. The diagnosis of PTSD was not experienced as stigmatising. The role of diagnosis in validating women's distress has not previously been mentioned in the birth trauma literature. Research exploring women's experience of receiving a diagnosis of PND and PP has also reported some mixed views around diagnosis, with some reporting concerns about stigma (Button et al., 2017; McGrath et al., 2013). It could be hypothesised that PTSD is somewhat less stigmatising as it places distress in a relatively straightforward framework of being a justified response to a traumatic experience, helping women to externalise responsibility for their distress. The language of psychiatric disorder has been challenged by some as pathologising understandable responses to experiences and locating the problem in the person (Kinderman et al., 2017). The general consensus, however, was that this was not how women experienced diagnosis in this study.

2. Healing through connection

The conceptual category ‘healing through connection’ supports previous research and theory about the role of feeling connected in recovery from trauma and mental health problems (Herman, 1992; Leamy et al., 2011). ‘Grounding’, or connecting the self to one’s body, environment, and the ‘here and now’ is a key component of trauma therapy (Fisher, 1999). Connection may be hypothesised to engender feeling grounded and safe - the opposite of the trauma experience. At a neuropsychological level, feeling safe is hypothesised to be necessary for the brain to be able to process experiences in a way that integrates cognition, emotion, and sensory stimuli. In this way, it enables reflection and the updating of beliefs about the safety of the world believed to be necessary in trauma recovery (Foa, 1997).

‘Connectedness’ is a key component of Leamy et al’s (2011) conceptual framework of personal recovery in mental health. However, connectedness in their framework only refers to the role of connecting with others, and not the self, world, or time, as in this study. Their category of ‘Identity’ could in part be conceived as overlapping with the focused code of connecting with the self. However, the importance of connecting with the self appears particularly pertinent for women who have experienced such a physical trauma, for which many blamed their own bodies. The task of reconnecting with the body as part of recovery is supported by the literature as reported in the meta-synthesis, in which women have described the trauma of birth as leaving them feeling their sense of self was broken, incomplete, or stripped from them. Women reconnected with their sense of self in part through exercise, particularly yoga, and named the mindfulness aspect of yoga as facilitating this. A few women also spoke about how connecting with themselves and their needs nurtured self-compassion, which helped to alleviate guilt. Connecting with the self mindfully has been suggested to facilitate the development of self-compassion in body-focused trauma therapy (Fisher, 2014).

Connection with others through a sense of shared understanding and/or experience may allow women to feel emotionally ‘held’ by others, again helping to rebuild their beliefs about the trustworthiness and safety of others. Connecting with other mothers who were felt to share similar non-idealised experiences of parenting, and in particular, other mothers who had also experienced difficult or traumatic births, was valued. A sense of solidarity with other mothers was felt to be helpful, and connecting with non-traumatised mothers could help by identification with 'normal' maternal experiences, supporting previous findings about the importance of perceiving similarities with other mothers (Iles & Pote, 2015). Building relationships with other mothers with birth trauma helped women to understand their experiences as a normal response to a traumatic birth, challenging their sense of personal failure and shame. This supports findings from previous research regarding the role of peer support in recovery from a range of perinatal mental health difficulties (Cust, 2016; Doucet et al., 2012; Heron et al., 2012; Jones et al., 2014; McGrath et al., 2013; Moore & Ayers, 2017; Robertson & Lyons, 2003). Peer support for women experiencing birth trauma may be particularly powerful, as discovering salient shared details about their births, such as feeling poorly treated by staff, and having felt they 'failed' at hypnobirthing may occur fairly quickly. The process of externalisation of responsibility of their trauma may then take place as they socially construct new understandings of their experiences.

Only one woman spoke explicitly about the role of connection with women who were much further along in their recovery in providing a sense of hope. Whereas most women discovered they shared experiences of birth trauma with other mothers via their National Childbirth Trust (NCT) group or mother and baby groups, this woman connected with others via a Twitter community. This enabled anonymity, and the opportunity to connect with other women at different stages of recovery. It also provided a forum whereby she was able to share her experiences to help others. Research has found that connecting with peers online can be helpful to women experiencing birth trauma and depression (Moore & Ayers, 2017).

Many of the women who participated in the study reported some difficulties bonding with their baby. Connecting with their baby was felt to be healing. Successful breastfeeding helped to promote bonding for some, consistent with previous literature (Beck & Watson, 2008). The healing power of the bond with baby has also been named in women experiencing PND (Stone & Kokanovic, 2016). For a few women, blaming the baby, and feelings of guilt contributed towards depression. This supports previous research by (Williams et al., 2016) that found the association between PTSD and bonding was mediated by depression.

Connection with the world was also found to facilitate recovery. It appeared to reconnect women with life, and their sense of self. It was reported to be particularly beneficial when women were able to take part in meaningful activities they enjoyed prior to the trauma, away from their children. This was constructed both as an aspect of self-care, as well as of connecting with the outside world. Exposure to the outside world may again support women to reconstruct their shattered core beliefs about the safety of the world. This would support Foa's (1997) hypothesis that recovery from trauma involves changes in core schema. The sample in the study were well-educated, professional women, so it is likely that they were able to afford to live in relatively safe communities. Similarly connection with the outside world via a return to work was only experienced as helpful when women felt ready to undertake their work, and they were supported. It is possible therefore that connection with the world is helpful conditional on it being safe and supportive.

Connection with time supported women not only to chronologically structure their recollection of traumatic labour and birth on anniversaries, but also helped women to connect with the present, and experience the trauma as in the past. The finding that women tend to anchor their recollection of the trauma on anniversaries according to the clock echoes previous research into women's experiences of anniversaries (Beck, 2006; Beck, 2017). Brain scans have shown that the part of the brain believed to be involved in our sense of time is inactive when traumatised people are asked to recall their trauma (Van der Kolk, 2014). Being supported to connect with time may assist women in constructing a narrative of their experiences.

Connecting survivors with a sense of time may be one way in which mindfulness may help in recovery from trauma.

Phenomenologically, trauma has also been hypothesised to distort person's sense of time after the event, and is believed to contribute to the 'foreshortened sense of future' that is often reported (Ratcliffe et al., 2014). Additionally, it has been suggested that mothers experience time differently to non-mothers, and that the cyclical nature of caregiving and their intersubjectivity with their child connects them simultaneously to the past, present and the future (Baraitser, 2008). Robertson (2015) suggests that a mother's embodied sense of time may be further distorted by caring for a disabled child, as they are constantly faced with ableist constructions of normative chronology and development. Two women spoke about part of their birth trauma relating to their children's birth-related injuries, and how this transported them forward in time, imagining the impact of disability on their child's life, which further compounded their guilt and sense of threat in the future. These women also felt tentatively positive about their children's ability to thrive within a largely ableist society, which may have minimised the differences in sense of time between them and the other participants. It may be helpful for future research to explore such experiences further to aid understanding of how birth injuries in children contribute more widely to the course of women's birth trauma.

3. Receiving care

Caring for the self was named by many women as promoting their recovery, consistent with previous literature (Allen, 1998; Beck, 2006). It facilitated connection with the self and others, and protected them from further distress. Self-compassion promoted self-care. The value of self-care in recovery is also reported in the PND and PP literature (Engqvist & Nilsson, 2014; McGrath et al., 2013; Williams, 2013). Self-care may be particularly important in the postnatal period due to the nature of caring for a small baby, which leaves little space for the self.

Health professionals played an important role in supporting women. Feeling genuinely cared for by knowledgeable staff who took the necessary action to get them the right help was pivotal for women's recovery. Previous research has also emphasised the role of good care in supporting women through Birth Afterthoughts sessions and having subsequent children (Bailey & Price, 2008; Beck, 2004b; Thomson & Downe, 2010). It is likely that these experiences supported them to rebuild trust in health professionals, and reconstruct core schema (Foa, 1997).

Women reported that practical and emotional support from friends and family was invaluable, a finding echoed in previous research (Iles & Pote, 2015; Peeler et al., 2018). Despite some difficulties, the majority of women reported that their partners had been very supportive, emotionally, practically or both, and many named them as key facilitators of their recovery. This has previously been reported (Ayers, Eagle, et al., 2006; Iles & Pote, 2015; Nicholls & Ayers, 2007; Peeler et al., 2018; Reid, 2011), although many studies describe a more negative picture (Allen, 1998; Ayers, Eagle, et al., 2006; Peeler et al., 2018; Taghizadeh et al., 2015). This could be hypothesised as being due in part to the nature of the sample, who all felt they had made significant progress in their recovery or were recovered. This suggests that such partner support may be integral to recovery, or that part of the process of recovery is working through difficulties placed on the relationship by having a baby and birth trauma.

Several women reported that they felt their partners were also traumatised by the birth, and this could be a barrier to them using their partner for support. Not wanting to burden them was named, as was a sense that their husbands had suppressed their own trauma to survive, and asking them to talk about it was dangerous for the stability of the family. Birth trauma in partners has not yet received much focus in the qualitative literature, with just one published study (Nicholls & Ayers, 2007) and one unpublished doctoral thesis (Bristow, 2016) exploring fathers' experiences of birth trauma. Also, research exploring couples' responses in the context of their parenting roles and relationships would be useful in understanding how they co-construct meaning around birth trauma and talk together about their joint experience.

4. Reclaiming power

Women reclaimed power by building strength in their bodies and minds, including gaining autonomy over their trauma symptoms. They felt empowered through helping others, and asserting themselves, including achieving an acknowledgement or apology from the hospital, caring for their child as they saw best, and birthing their subsequent child as they wished. This echoes previous birth trauma research (Allen, 1998; Bailey & Price, 2008; Beck, 2004b; Beck, 2006; Beck & Watson, 2008, 2016; Byrne et al., 2017; Peeler et al., 2018; Thomson & Downe, 2010). Reclaiming power appeared to be a key part of the recovery process. This category is similar to Iles & Pote's sub-code 'Regaining control' in their analysis of experiences of postnatal PTSD. However, the women in the study were all from well-educated, professional backgrounds, with the support and privilege to be able to do this; their experiences did not happen against a backdrop of poverty and marginalisation. Where they did experience powerlessness in relation to the systems in their life, this often triggered a worsening of their mental health. That some women cited that paying privately for the therapy they felt they needed was helpful to them indicates that current NHS practice regarding the provision of therapy does not always serve women's needs, in spite of policy assurances (NICE, 2014, 2018).

One strategy that women reported employing to help them to manage different aspects of their recovery was the cognitive compartmentalising of experience, e.g., separating the baby from the trauma. This is consistent with previous research (Beck, 2006; Iles & Pote, 2015), and illustrates the challenge named by one participant as having to simultaneously hold contrasting feelings about the same thing at the same time. An example of this was women's complex relationship with gratitude. Their need to feel grateful for their child appeared to help by giving them a positive focus, whilst simultaneously invalidating their trauma. Women who did not associate the anniversary with the birth did not experience this time as emotionally challenging. Reports that anniversaries were not triggers for some women differs from the literature (Beck, 2006; Beck, 2017), but this may be due to selection bias in these studies, as those wishing to discuss their anniversary experiences may be more likely to have found them difficult. Separating the baby from other experiences that intrude on the relationship as ‘ghosts’, is a key part of parent-infant psychotherapy (Lieberman et al., 2000). One participant named that she perceived her baby as a fellow victim of trauma and ally, and she and others spoke about a shared sense of resilience and survival. Supporting women to see the child as sharing their trauma, and their recovery, may be one way in which the mother-baby bond may be strengthened.

Acceptance was a key process by which women reclaimed power at different points in their recovery. Accepting they had been traumatised enabled them to seek and receive the care they needed to improve their wellbeing. Where closure was not achieved, accepting the reality of their experiences facilitated them in moving forward. Acceptance is a key component of some psychotherapies, e.g., Acceptance and Commitment Therapy (ACT) (Hayes, 2004); Dialectical Behaviour Therapy (DBT) (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). Accepting loss has been proposed as a key process in recovery from PP (McGrath et al., 2013). In this model, it is conceptualised as a parallel process to using experience positively. In both McGrath et al’s model, and this one, these processes by which women reclaim power could be conceptualised as managing the dialectic between acceptance and change, a mechanism of recovery underpinning the theory of DBT.

5. Living with the trauma in the past

Almost all women reported a sense of ongoing vulnerability and living with the trauma, rather than being ‘recovered’. For many, this coexisted alongside signs of post-traumatic growth, (Calhoun & Tedeschi, 2014; Tedeschi & Calhoun, 1995, 1996, 2004; Tedeschi et al., 1998) as previously indicated in the literature (Wright, 1989). They reported a strong sense of shared humanity, greater empathy and compassion, and a drive to help others, feeling stronger and more resilient, in addition to changing priorities, with a greater focus on their important relationships. Some also described a sense of being a part of something much greater than themselves, a connection to all life on earth. However, it is unclear to what extent these experiences would have happened without the trauma, triggered by becoming a mother, as this event in itself appears to be linked with signs of post-traumatic growth (Sawyer & Ayers, 2009). One way to elucidate matters may be to research the experiences of multiparous women who experienced birth trauma with a subsequent birth, but not their first; longitudinal and qualitative designs would both be valuable.

The emphasis women placed on the importance of exercise in giving them a sense of mental and physical strength suggests a sense of embodied PTG, as previously noted in literature relating to survivors of life-threatening illness (Hefferon et al., 2010). This aspect of PTG has not previously been reported in the perinatal literature, suggesting it may be unique to women experiencing birth trauma. This may be due to the nature of their trauma, as it was physical as well as psychological. Further research would be helpful in exploring exercise as a facilitator of recovery. It also appeared to show the potential to nurture a sense of growth following trauma.

One woman described signs that the staff attending her birth had also been traumatised. Similarly, the midwife who participated described defensiveness and an apparent denial or need to separate from the reality of her trauma on the part of her colleagues. Awareness that staff are sometimes traumatised by the births they attend is growing, and is supported by research (Sheen et al., 2016). This awareness did not appear helpful to the participant, as it added extra stress when they sought acknowledgement for the harm they had suffered, indicating the need to protect women from this knowledge whilst supporting staff. Defensiveness of some staff in

Birth Afterthoughts sessions may also indicate trauma amongst staff, and the desire of managers to protect themselves and their team from further harm by admitting substandard care. The research by Sheen et al (2016) also found that 35% of respondents seriously considered leaving midwifery following a traumatic event, indicating that birth trauma may be contributing to a vicious cycle whereby reduced numbers of midwives are increasingly stressed, decreasing their capacity to work effectively and increasing the likelihood of birth trauma and errors.

6. Barriers to recovery

Silencing was named as process that impeded making sense of trauma, as has previously been highlighted (Beck, 2004b). Interestingly, reference to silencing or being silenced is not explicitly named in Ehlers & Clark's cognitive model of PTSD (Ehlers & Clark, 2000). In this model, silencing can be considered a 'strategy intended to control threat/symptoms'. A number of different processes were felt to silence women, including dominant narratives around how they 'should' be feeling, which were both internalised and communicated to them either explicitly or implicitly by others. A focus on the baby, and a lack of questions for the mother about her own wellbeing was one way in which women felt silenced by health professionals, family and friends. Focus on the baby to the detriment of the mother has also been named previously in the perinatal literature (Button et al., 2017; Megnin-Viggars, Symington, Howard, & Pilling, 2015). Silencing and invalidation appeared to be linked processes that acted together as a barrier towards making sense and processing the trauma.

Women reported being explicitly invalidated by others, often through their adoption of dominant narratives such as 'all that matters is a healthy baby', or ignorance about trauma. This chimes with previous studies (Beck, 2004a, 2004b; Iles & Pote, 2015; Kitzinger, 1992). They also described how social comparisons, which tended to be influenced by dominant narratives, led to self-invalidation. Invalidation as a process which contributes to silencing isn't explicitly named in Ehlers and Clark's model either, although it does describe more generally the outcome of invalidation, i.e., 'negative appraisal of trauma and/or its sequelae' (Ehlers & Clark, 2000). The model names the impact of beliefs on silencing, but does not discuss how the sociocultural context is involved in shaping these, and subsequently, the course of trauma. Similarly, the diathesis-stress model of birth trauma suggested by Ayers (2004), focuses on intra and interpersonal experiences, rather than encompassing the impact of the sociocultural context and its dominant narratives, which was so clearly articulated by women as an important influence on the course of birth trauma.

Only two women explicitly articulated that the impact of feeling betrayed by health professionals was a shattering of their core beliefs about the trustworthiness of others. Others spoke about how this contributed to them feeling overprotective and having difficulty separating from their child. Feeling betrayed by staff was articulated in just one of the previous qualitative papers on birth trauma (Moyzakitis, 2004). The women in the current study were asked to focus on their postnatal experiences, which may help to explain why so few spoke about this. They spoke about what had been helpful in their recovery, such as being shown kindness, continuity of care and feeling genuinely cared for postnatally (all things that should serve to build trust) without explicitly naming this sense of repair to their beliefs about others or the world. Similarly, there was no direct exploration of the impact of birth trauma on their core beliefs about others and the world, and how or whether these beliefs changed during recovery. The health professions are amongst a relatively small number of professions that are perceived as being comprised of some of the safest, kindest, most caring people. However, in naming this betrayal, health professionals risk feelings of shame, and may find their own beliefs about themselves challenged. Being able to admit mistakes necessitates being supported to do so by a system that perceives failures as opportunities to learn and improve, rather than scapegoat and exclude. Unfortunately, it appears that in some settings at least, there is need for systemic change.

The retraumatising nature of being dismissed and invalidated by health professionals has been reported in the literature with regard to complaints procedures (Beck, 2004b), but not specifically Birth Afterthoughts sessions. Invalidation tended to trigger anger rather than silencing women, although it did appear to impede sense-making. Qualitative reports of experiences of Birth Afterthoughts sessions in the literature have been universally positive (Bailey & Price, 2008; Thompson & Downe, 2010), but this may be a selection bias. Studies exploring their effectiveness in reducing trauma symptoms has found positive results, but only when targeted at women who perceived the birth as traumatic (rather than when done prophylactically with women who had *potentially* traumatic births, e.g., emergency caesareans) (Sheen & Slade, 2015). The impact of staff in influencing outcomes on trauma appears to be a factor that has not been significantly considered. Timing and structure of sessions, and targeted vs untargeted intervention have been the variables which appear to have dominated discussion (Bailey & Price, 2008; Sheen & Slade, 2015).

The mixed experiences of Birth Afterthoughts sessions reported by women in this study indicate that how staff manage these sessions has a significant impact on the course of trauma. Although NHS staff have a duty of candour to patients (Care Quality Commission, 2015), women named that they felt defensiveness was a barrier to staff acknowledging mistakes. This may be due to a number of reasons; systemic issues within the team or wider hospital or Trust, personal defensiveness on the part of the facilitator, or a lack of training, which may have left staff feeling vulnerable. All carry implications for policy and practice, which shall be discussed later.

Women additionally named that not being asked about their psychological or physical wellbeing by health professionals was a barrier to making sense of trauma, and help-seeking. This has been reported before (Byrne et al., 2017). Health professionals framing their experiences as PND was also named as a failure of care. This has also been previously reported (Iles & Pote, 2015). Implications of these findings will be discussed later.

Sleep deprivation served to impede reflection and greatly reduced women's sense of self-efficacy and ability to manage stress. Sleep was impaired both by the infant's routine, as well as trauma symptoms, which many women were unable to distinguish between. The baby's routine, as well as sleep deprivation being dismissed as 'normal' impaired women's ability to make sense of trauma. Physical ill-health also contributed to the sense of embodied bombardment of feelings, and both the experience of ill-health, and narratives about postpartum pain similarly impaired women's ability to reflect and make sense of trauma. These two aspects of experience contributed towards the unique embodied experience of birth trauma. Both have been mentioned before as comprising part of the birth trauma experience (Ayers, Eagle, et al., 2006; Beck, 2004a; Beck & Watson, 2008; Iles & Pote, 2015), but aside from such experiences being constructed as a 'lens' through which the birth experience is perceived (Iles & Pote, 2015), their specific contributions to the course of trauma have not previously been discussed. Dismissal of pain was often felt by those who spoke about it to be a largely systemic issue, attributed to patriarchal devaluing of women's distress and wilful dismissal of their embodied knowledge.

7. Recovery as a journey

Many women described recovery as a journey, and spoke about the multifaceted nature of trauma and recovery. This analogy is commonly used in descriptions of mental health recovery (e.g., Anthony, 1993; Leamy et al., 2011). Women reported a sense of recovery ebbing and flowing, consistent with the PP literature (McGrath et al., 2013). Noticing, or recognising recovery was also identified by McGrath et al. (2013) in their exploration of recovery from PP as providing motivation for further efforts to return to a sense of 'normal' life. Recovery as a socially constructed concept was underlined by two women who noted that they hadn't previously understood their experiences as a 'recovery'.

Recovery was marked by having to work through multiple challenges, many of which were felt to be double-edged swords, simultaneously supporting and impeding recovery at the same time. This reflected the sense of fragmentation in trauma, and the challenge of holding onto the truth in contrasting feelings about the same thing. This ability to hold contradictory feelings about the same thing simultaneously relates to the idea of the depressive position in psychodynamic object relations theory. Increased ability to tolerate the depressive position is considered a sign of a more integrated ego (Segal, 2018), and a positive marker for recovery.

Birth trauma, epistemic injustice, and the patriarchy

Women who experience birth trauma report incidences of epistemic injustice throughout their experience of trauma. Societal narratives about birth and motherhood leave them in a position whereby they are unable to make sense of their experiences. Many women become bound by a collective silence where they dare not share what they do know, as this reality threatens what is held to be true. Health professionals collude in the silence by not asking questions about wellbeing. Those who break the silence open avenues to women knowing that other truths about birth and motherhood may exist and may be shared by others. However, there is evidence to suggest that systemic factors beyond matters like staff training and competence intervene to ensure that women remain silenced. In overstretched systems, the act of asking about wellbeing may in itself endanger the capacity of the health professional to manage their workload and thereby threaten their sense of self-efficacy. Mothers, midwives, and obstetricians could all be said to be somewhat dependent on men and patriarchal systems for their survival. This may also contribute to internalisation of responsibility, collusion, and silencing for fear of being ostracised, as posited by social mentality theory (Gilbert, 2009, 2015). In this way, dominant narratives and systemic factors help to ensure epistemic injustice.

One way of reflecting upon such epistemic injustice may be to question its function. Why is it advantageous to a society to hold idealised conceptions about birth and motherhood?

What are the feared consequences if this were not the case? It could be argued that such silencing exists to ensure that women are not deterred from procreating and taking on the majority of parenting and home duties. If women's working lives were not interrupted by childrearing, they would have fewer structural impediments to holding equal power to men within existing patriarchal work structures. Disempowering women by denying their embodied knowledge during birth may be considered a form of testimonial injustice (Kidd & Carel, 2017), a product of the subjugation of women in patriarchal society. Silencing through idealised narratives, and the structural devaluing of women's health serves to ensure that women suffer hermeneutical injustice, denied access to the information they need to enable them to make sense of their experiences. The consequence is that women then internalise difficulties as 'their fault', or believe their long-term pain is 'normal'. Either way, they suffer. That patriarchal society functions in this way in rich countries makes women's suffering a political choice, and a seemingly acceptable price to pay to ensure that power remains within patriarchal hands. Cross-cultural research considering the role of patriarchy in birth trauma would be helpful to better understand this hypothesis.

Critique of methodology

As with most perinatal mental health research, the demographic diversity of the sample was fairly limited. All but two of the women identified as white British or white Irish/Northern Irish, which limited the opportunity to explore the intersectionality of gender, culture and race in women's experiences. During the interviews, there were conversations about the influence of race in the denial of a caesarean to a woman of mixed racial heritage, whose birth ultimately resulted in a near-fatal haemorrhage. An explicitly racist experience within healthcare services during the first pregnancy was also raised by a participant of Mediterranean descent. Although there was no indication that race played a significant part in their recovery, it is likely that having a more racially diverse sample may have indicated differently. Similarly, all the women who took part were well-educated, professional women with partners, and therefore likely had more social capital, financial power and access to knowledge than less privileged women. Six of them were actively working in mental health fields. Given the importance of empowerment in recovery, it is important that future research in this area specifically recruits less-privileged women to ensure that they are not further marginalised by interventions designed to cater for middle-class women. As the sample was largely homogenous, the findings are not transferable outside of this population (Guba & Lincoln, 1985). However, they do offer tentative ‘grounded understandings’ as to the significance of the phenomena reported, and may help to make meaning of, or explain phenomena in related populations (Misco, 2007).

The recruitment strategy may have contributed to the homogeneity of the sample. The study was advertised on social media and on the Birth Trauma Association (BTA) website. The use of social media to recruit may have led to it being shared within an ‘echo chamber’ of women with similar backgrounds and perceptions of the world. Data were not collected regarding how women found out about the study, but referral statistics for the study website suggest that the greatest number of people visited the site from Facebook (259), followed by Twitter (154), with 14 directed from the Birth Trauma Association website. These figures cannot be extrapolated to make inferences about where those who participated learnt about the study. It may be that recruiting exclusively from the Birth Trauma Association may have increased heterogeneity of the sample as women may be more likely to find this via an internet search rather than the ‘echo chamber’ of their social media. Similarly recruiting via NHS services may have led to a more diverse sample, and may also enabled greater purposive sampling. However, this would likely have led to only those with a PTSD diagnosis participating.

Due to competing demands during data collection, analysis was not undertaken simultaneously in the traditional grounded theory sense to allow theoretical sampling. However, following initial analysis, which generated further theoretical questions, eight follow-up interviews were completed (one of which was in the form of written responses to questions), which informed the ongoing analysis. Findings hinted that recruiting younger women, those with fewer financial resources, lower levels of education, and women from black or minority ethnic backgrounds may have added more depth to the theory. However, having a sample larger than the one recruited would have exceeded the capacity of the researcher to complete the study on time.

The concept of theoretical saturation is a key part of grounded theory (Charmaz, 2008), and is linked to the process of theoretical sampling. Participants were diverse in some ways e.g., in terms of birth events, previous mental health difficulties, and mental health knowledge, but not others, e.g., ethnicity, socioeconomic status or age. This allowed the categories to be well developed, but there was a sense that further development may have been possible with a more diverse sample. As theoretical sampling was not ultimately achieved, only limited claims about theoretical saturation are possible. This limits the transferability of the findings. However, with regard to the theoretical categories, there was a broad consensus in the data regarding processes involved in recovery from birth trauma. It is likely that there will always be novel codes arising in a heterogenous sample, and it is hoped that further research using purposive sampling as informed by this study will further help to illuminate different influences and processes.

Although evidence suggests that women's recall of their experiences of distress in the perinatal period is good (Doucet et al., 2012), this study included women whose traumatic births had occurred up to ten years previously. This was increased from five years shortly after recruitment opened as it became apparent that this would exclude many women whose story encompassed a first traumatic birth followed by a delayed subsequent birth, which previous studies have indicated has a significant influence on recovery (Beck & Watson, 2010; Thomson & Downe, 2010). There was some evidence that recall was a little impaired with regard to the chronology of events, but this did not appear to impact on memories of the meaning of those events. Where women were unable to remember, they were open about this. Opening up the time period also enabled one woman to identify societal changes around perinatal mental health that she felt had occurred recently, illustrating how changes in societal narratives around distress in motherhood influenced recovery.

The use of a self-identified sample could be considered a strength or a limitation, but its merits as a strength was behind the rationale for it. The variety of different presentations sheds light on different psychological processes and how these relate to theories of how trauma operates at the neuro-physiological, cognitive, spiritual and social levels. However, there is a danger that the word 'trauma' comes to encompass such a wide range of experiences as to dilute its meaning and perceived impact. The findings point to the impact of multiple processes in trauma, all of which stem from an experience in which the woman experienced extreme powerlessness and feared for the integrity of her embodied self, or her baby during birth. One word, 'trauma', appears somewhat inadequate to encompass the different manifestations of trauma described by the women in this study. It could be argued that by narrowing the eligibility criteria to only those who had received a PTSD diagnosis, the study would have been able to 'know' that the findings related to recovery from 'actual trauma'. However, given that PTSD as 'real trauma' is a socially constructed concept itself, and one that was only created relatively recently, on balance the chosen design allowed comparisons to be made between women with different reported presentations, which contributed to a greater theoretical understanding of recovery from birth trauma.

The decision to include women whose babies were in admitted to NICU for more than 24 hours differs from some other birth trauma studies (e.g., Iles & Pote, 2015), which exclude these women on the basis that their trauma may be more about having a severely unwell baby rather than the birth itself. Again, this could be considered a strength or a limitation, or both, depending on the lens through which it is viewed. The decision was made as it too was considered a strength, on balance. The intention was to increase heterogeneity of the sample and ensure that these women had a voice in the study. It was felt that to exclude these women would be to exclude an important proportion of the women who experience birth trauma and try to create artificial barriers between experiences in a futile effort to narrow down ‘pure’ birth trauma. It also raises the question as to whether women with other stressful experiences, such as moving house, illness or death of loved ones, or other important life experiences should be excluded. The diversity of experiences illuminated that potential long-term disability did affect women’s trauma, but these children weren’t necessarily admitted to NICU. Other women whose children were admitted to NICU for more than 24 hours spoke about forced separation due to their own illness that appeared to influence their distress in the longer-term rather than feelings triggered by the child’s sickness. The inclusion of these women was felt to fit with grounded theory methodology as it allowed comparisons to be made between women with different experiences.

Participants were given the opportunity to examine their transcript and the initial analysis, and to engage in further discussion about the meaning of their words. From an epistemological perspective, meanings regarding women’s experiences were viewed as socially constructed, therefore rather than verifying the existence of a discoverable position. This process was aimed at confirming mutually constructed meanings and to provide an opportunity for further discussion. Not all women responded, and not all that did respond had had an opportunity to examine their transcript. The process was also felt to be important for ethical reasons, to ensure that participants had the opportunity to play a more active role in the study.

Implications

The study has wide implications for practice, as well as at a societal level. These will be discussed in turn.

With regard to practice, the role of building a relationship with a health professional whom they felt genuinely cared for, and understood them was paramount. Continuity of care was a key facilitator of relationship-building. Women named that it contributed to them feeling psychologically held by services, whereas lack of continuity of care was felt to enable their avoidance. This was important for women after the traumatic birth, as well as during subsequent pregnancy. Continuity of care has been found to support disclosure of distress in the perinatal period (Button et al., 2017). In theory, health visitors are one of the based placed professions to provide these relationships postnatally, but in practice, health visiting has been split away from the NHS and managed either by local authorities or private companies, who have either had their budgets slashed, or gained contracts on the basis of price. As case-loading models of care are more expensive than teamworking models, in privatised and austerity-driven services, they are rarely used. A focus on adequately funding health visiting and midwifery to enable a caseload model of practice would go some way to improving the likelihood of detecting birth trauma and facilitating access to the right support.

In addition to health visitors, GPs are also ideally placed to pick up on birth trauma and refer to appropriate support due to their position in primary care, and the universal six-week check. The findings suggested that ensuring all women are asked regularly about own mental and physical wellbeing, and that their responses are listened to, is one of the single most important changes to practice that can be made to improve care. Educating all health professionals regarding birth trauma, and how it may be obscured by narratives around birth, issues with the baby’s health, sleep-deprivation, and pain, would also facilitate women getting the right care quickly. Given that those women who developed postnatal depression attributed this to a lack of appropriate support for their trauma, it could also prevent many women from becoming more deeply distressed. Additionally, awareness that women presenting with low mood, anxiety or apparent OCD-like symptoms (e.g., constantly needing to check baby is breathing) may be experiencing birth trauma should also be a key part of training for primary care services working with women perinatally. One way to educate more GPs may be to add information about how mental health difficulties may be obscured in the perinatal period, and about how birth trauma may present, via the Royal College of General Practitioners' Perinatal Mental Health Toolkit (Royal College of General Practitioners, 2019).

For some women, bonding problems were attributed in part to the baby's physical distress. When this was alleviated, this created space for them to connect. Raising awareness amongst health professionals that physical health issues may be a factor in babies being 'difficult', and listening to mothers' concerns may be one way in which staff can support bonding.

The use by women of strategies to separate the baby from the mother's trauma suggests that additional support from a parent-infant therapy to achieve this could have a significant impact on the wellbeing of both. The sense of shared trauma and survival that some women commented had been helpful in their recovery suggests that perhaps in addition to separating the baby from mother's trauma, it may be helpful to support women to construct their experiences in this way too.

Women's reports of their experiences of staff defensiveness and invalidation in Birth Afterthoughts sessions suggests that this is an area demanding considerable improvement in the way these are facilitated. Defensiveness may indicate a need to protect the organisation from litigation, which may translate into a lack of support from managers to name poor care and make positive changes. It may also indicate staff vulnerability, potentially due to trauma. These findings, as well as evidence of staff being traumatised draw attention to the need for systemic changes in practice to enable staff to name trauma, highlight systemic issues contributing to poor care, and receive appropriate support without fear of scapegoating or recrimination. Spaces for health professionals to reflect on their own practice, including reflecting on systemic influences on practice may be one way to facilitate the creation of a less blaming, more solution-focused culture, and allow the voices of both women and staff to be heard. Additionally, at present, there does not appear to be any research exploring birth trauma amongst obstetricians. Differences in power and responsibility between doctors and midwives suggests that this would be a unique and useful area of future research.

Wider issues regarding staff shortages also need to be addressed, as there is evidence that current midwife shortages are having a detrimental impact on patient outcomes (Gerova, Griffiths, Jones, & Bick, 2010). Although this study used medical events such as interventions, readmissions, and breastfeeding rates as outcomes, many of these could be considered proxy indicators for birth trauma (Allen, 1998; Beck, 2004a; Beck & Watson, 2008; Byrne et al., 2017; Iles & Pote, 2015; Moyzakitis, 2004; Nicholls & Ayers, 2007; Reid, 2011; Taghizadeh et al., 2015; Thomson & Downe, 2008).

Only one woman reported that a health professional, a health visitor, asked after her husband's wellbeing. Given that many women spoke about their partners also being traumatised, and the crucial role they played in providing support, this is an area of practice that would also benefit from additional training and funding. As part of the NHS Long Term Plan (NHS England, 2018), fathers are to be offered screening and support for mental health problems by Community Perinatal Mental Health Teams. However, despite shared parental leave being available to fathers, the reality is that men remain subject to patriarchal expectations about their role in the family, and as such, this restricts their access to care, as well as peer support. Facilitating father-friendly spaces outside working hours, for example, at family centres at weekends, may provide a helpful way of delivering such opportunities.

Where couples attended Birth Afterthoughts sessions together, this could be helpful for fathers too, suggesting that partners should be informed how it may benefit them too, if they are struggling to make sense of the birth. Awareness of birth trauma in fathers and other paternal perinatal mental health problems is low, and may have been somewhat silenced by the dominance of PND and narratives around hormonal causes of postnatal distress. The value that some women placed on their partner's stoicism despite their own trauma indicates that the timing and nature of support for the couple and its impact on the family system should be carefully considered.

It should also be noted that at present, research and services for birth trauma are constructed around heterosexual families. There is as yet no research exploring experiences of birth trauma in same-sex couples, or in transgender people who give birth but do not identify as women or mothers. This is an important area requiring urgent research, in order to ensure that health professionals have access to the knowledge they need to equip them to best work with same-sex couples and transgender people affected by birth trauma.

With regard to psychological interventions for birth trauma, Iles and Pote (2015) suggest that CBT for birth trauma focuses on integrating hopes and expectations about birth with the reality of what happened, separating the baby from the trauma, and supporting women to reconnect with a sense of time, with the trauma in the past. These findings suggest that discussing how those hopes and expectations were constructed may also be helpful in shifting post-trauma cognitions about self-blame and personal failure.

The findings relating to experiences of therapy also suggest that a more flexible and collaborative approach to providing therapy would be helpful with this group, considering the barriers to accessibility that mothers experience. Reports of how helpful women found being able to pay for the therapy they felt they needed raise important questions about the role of privilege in the course birth trauma, and to what extent it facilitates recovery. The lack of diversity of socioeconomic status in this sample is common in birth trauma research, and these findings add weight to the impetus for research to be carried out with less economically and socially privileged groups. This will help to facilitate understanding of what interventions may universally assist recovery, even in the context of poverty and marginalisation.

The study indicated a strong rationale for the role of peer support in recovery from birth trauma. Peer supporters form a part of some community perinatal mental health services in the UK (e.g., Nottinghamshire Healthcare NHS Foundation Trust), but signposting to online peer support communities could provide not only support and facilitate sense-making, but the opportunity for women to empower themselves and others. Online communities can also provide more responsive and regular support and a sense of solidarity when needed, rather than as a structured part of formal care. They may be a particular lifeline to more isolated or unwell women who are struggling to connect with other mothers in person.

The number of women who named yoga as having been beneficial to their recovery supports the findings of previous studies exploring its use in trauma recovery (Van der Kolk, 2006; Van der Kolk et al., 2014). Women noted that its contribution to their recovery was multifaceted. Yoga as an intervention for trauma is not something that has received much research interest. The findings from this study suggest a rationale for funding further investigation into its use for birth trauma. However, similar to yoga for sexual abuse survivors, it is likely important that yoga is taught with consideration of the intensity of some positions which may trigger embodied memories of the birth. Previous research suggests that this is key to the acceptability of yoga interventions (Van der Kolk et al., 2014). Any future research into yoga as an intervention for birth trauma should therefore consider this. Classes aimed at postnatal women could also potentially facilitate peer support for women, away from their babies, which may further encourage them to reflect on themselves.

The role of hypnobirthing practices and narratives in women's birth trauma was named repeatedly. This poses some difficult questions. Hypnobirthing is sometimes advocated as an empowering approach to support women in subsequent birth following birth trauma, but this finding suggests that it needs a careful approach to ensure that it does not compound women's distress. Achieving a balance between promoting autonomy as well as naming that sometimes interventions are needed, and this is not due to women 'failing' at birth, appears crucial.

Findings regarding the role of narratives in the course of trauma carry significant implications for society as a whole. At present, it appears to be mothers themselves who are breaking the silence, questioning dominant narratives, and displaying confidence in their own parenting, via books and social media (e.g., 'The Unmumsy Mum' (Turner, 2017)). However, this carries a risk for mothers that clearly most are unwilling to take. Women spoke about selectively sharing information with those who they felt safe would not judge them if they disclosed their distress or what they perceived to be taboo, e.g., not enjoying life with their baby. The onus therefore needs to be on everyone to bear some responsibility for how these narratives are constructed and used. Challenging the taboo of birth trauma, naming birth-shaming, other forms of mother-shaming, and encouraging the sharing of subjugated narratives are all ways in which each person can contribute towards positive change. Listening without judgement, being interested in the mother's (and her partner's) wellbeing, and providing emotional and practical support is another way in which those within close circles can support mothers.

Similar to maternal mental health, there has been a shift in narratives around mental health more generally, and targeted campaigns to break the taboo (e.g., Time to Change, 2007-present). However, understandings amongst the general public, and even mental health professionals remain restricted and constrained by the psychiatric model of distress. There is a danger that when one way of understanding distress dominates society that it may whitewash or suffocate alternative, personalised narratives. Making sense of experiences in a way that related to women's individual circumstances and externalised the 'problem' was key to recovery from trauma. With birth trauma, although there was a concrete trigger for women's distress, many spoke about how other stresses or pre-existing anxiety contributed towards their distress. Once they realised something was wrong, this allowed them a focal point for them to begin to understand what they were experiencing, and why. They were able to construct rich, personalised narratives that guided them in their recovery. Where psychiatric constructions of distress are focused on more biological 'vulnerabilities' (e.g., postpartum psychosis), and less on understanding how experiences contribute towards mental health problems, this may disempower women from fully understanding their distress. It is important therefore that multiple different ways of understanding distress are given to women to support them to make sense of their experiences in a way that is meaningful to them.

Researcher's reflections

Reflections on the research process were recorded throughout the two-and-a-half years since the study's conception. This is an important part of the social constructionist grounded theory approach, and supported me to understand my own influence on the research process. Here I will discuss my own reflections on the research, and the impact of my own position on the analysis and conclusions drawn.

I chose this topic after having worked in perinatal mental health research previously, where I was extremely moved by women's written experiences of difficult or traumatic experiences, and the process of writing about them. I felt a deep sense of empathy with their pain, and the complexity of the challenges they faced as mothers. As a feminist, I constructed their experiences in part as a product of living in a patriarchal society in which they found their embodied knowledge denied, and facing impossible, double-bind standards of society. I was mindful of the potential impact of my own feminist lens on the study, particularly as I was open on the study website about my motivation for the study coming partly from my feminism. This informed my decision to use social constructionist grounded theory methodology for the study, as I felt it was a useful framework for understanding how we understand and communicate about the world with each other. I was mindful during interviews of my own internal excitement when women offered similar perspectives about the impact of the patriarchy on their experiences of birth and motherhood and offer this analysis as a socially constructed representation of women's experiences of the process of recovery, seen through a feminist lens. Others may likely construct birth trauma differently.

I was particularly mindful throughout the interviews that I was not a mother myself. I was open with women about this if they asked, but was anxious in some way that this may have triggered suspicion of me as an ‘outsider’ to the ‘club’ or influenced how safe they felt talking to me about their experiences. When they named having had no idea what birth or motherhood would really be like until it happened, and the sense that there were unspoken secrets about having a baby that all mothers apparently knew, this amplified my feelings of being a fraud, of knowing but not knowing.

I have reflected on my dual identity of the clinician and researcher identities that I occupy as a Trainee Clinical Psychologist. With my research background, I have always embraced the researcher identity, and found the process of being able to design and conduct my own research project empowering. I have observed how my experiences of working in a Community Perinatal Team have influenced my understanding of the meaning of women’s experiences, and how my developing understanding of birth trauma that has evolved throughout the research process has impacted on my practice.

I have noticed how my own understanding of the world has developed as I learned more about ontology, epistemology, and psychological theories of human interconnectedness and distress. There have been many ‘penny-drop’ moments as I have learned deeper, more complex ways to understand the world. In some ways, this has entrenched my political views, which I felt were already well-informed and integral to my identity prior to starting training. Training to become a Clinical Psychologist has humbled these views. I identify with the expression ‘the personal is political’, and these new understandings of the world have served to ensure that my passion for the project has not waned.

Although I had previously felt great empathy for women who wrote about the challenges they experienced in motherhood, including birth trauma, I was unprepared for the deep anger, sense of injustice, and admiration I felt for the women who participated, and the emotional toll that this took as I experienced it repeatedly, during the interview, and particularly in the transcription and analysis stages of the research. As a Trainee Clinical Psychologist, I hear first-hand accounts of abuse and structural oppression regularly, but feel some sense of self-efficacy in working to support people to make sense of their experiences and reduce distress. However, during the research process I experienced a sense of powerlessness and anger that I was not used to. For me, this was perhaps an indicator that I was not working as I would in therapy to support people to construct new meanings that I felt would be helpful to them. I wondered whether these feelings also arose from a sense that most of the distressing experiences women reported were in the past and unable to be changed in the present. Women's acceptance alleviated these feelings to an extent. I was mindful not to slip into a therapist role, but I was also aware at the time that it seemed like a very fine line. This was illustrated further when some women named their experience of the interview as being quite cathartic, or likened it to a therapy session.

I reflected on what women's own experiences of interviews might be like, and of receiving their transcripts with their experiences dissected and analysed for the purpose of research and battled with the ethics of using such deeply personal experiences for my own research. I felt uncomfortable with their gratitude towards me for researching this topic and their hope that it would have a positive impact on women's experiences of traumatic birth in future. Despite not being particularly comfortable with this pressure, it has helped me to stay motivated during the process, which I hope will continue through the dissemination period.

Conclusion

Birth trauma is a common yet devastating experience for many mothers. This study has illuminated a snapshot of women's experiences of recovery from birth trauma, and shown it to be a multifaceted, iterative, and ongoing process. For many, trauma presented an ongoing challenge of simultaneously holding apparently contradictory feelings about the same experience, a constant psychological juggling of double-edged swords. Patriarchal power, dominant societal narratives about birth and motherhood, and healthcare systems that have evolved within the context of patriarchal society were hypothesised to underpin many of the drivers of women’s suffering. There was much evidence to suggest that changes at societal, systemic, and interpersonal levels could accelerate the healing process for women. This research has detailed several implications for practice, and indicated where further research is needed to support recovery from birth trauma.

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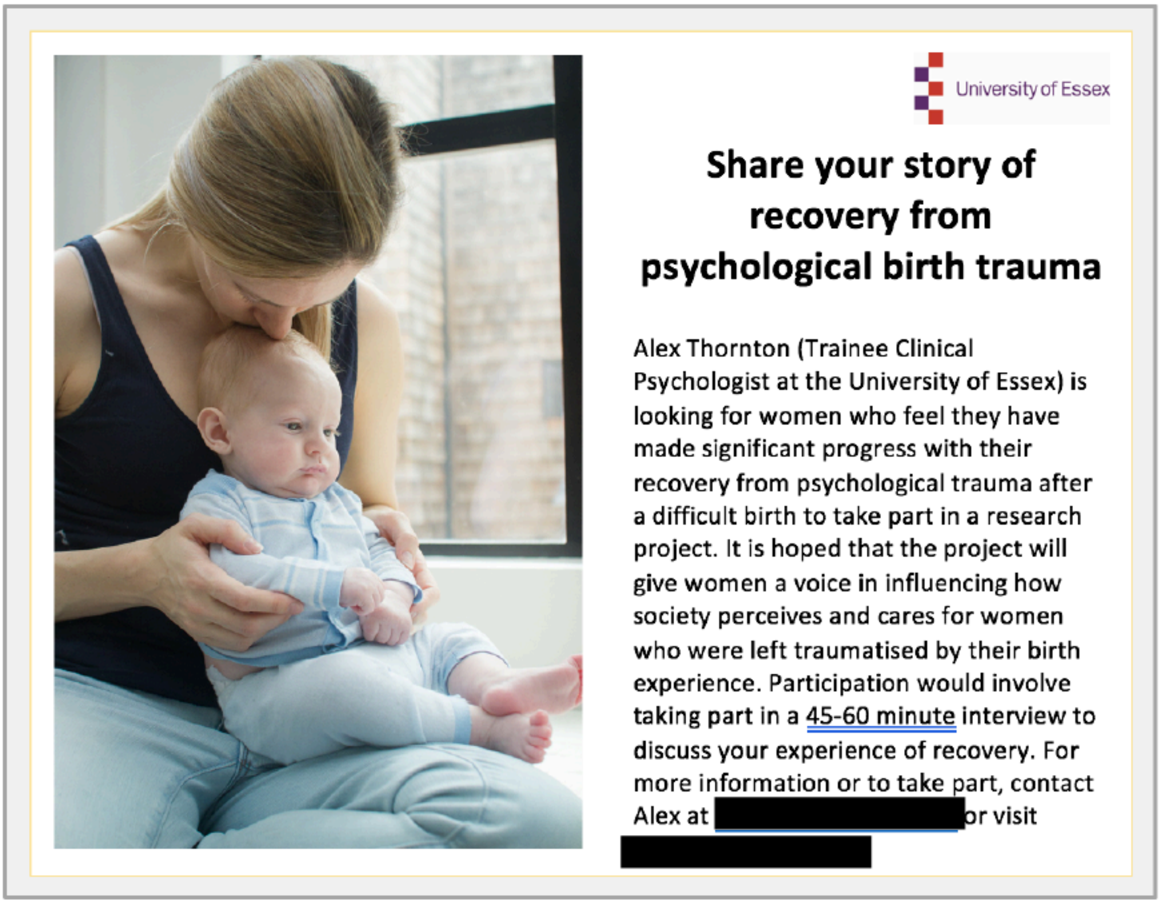
Appendices

Appendix A

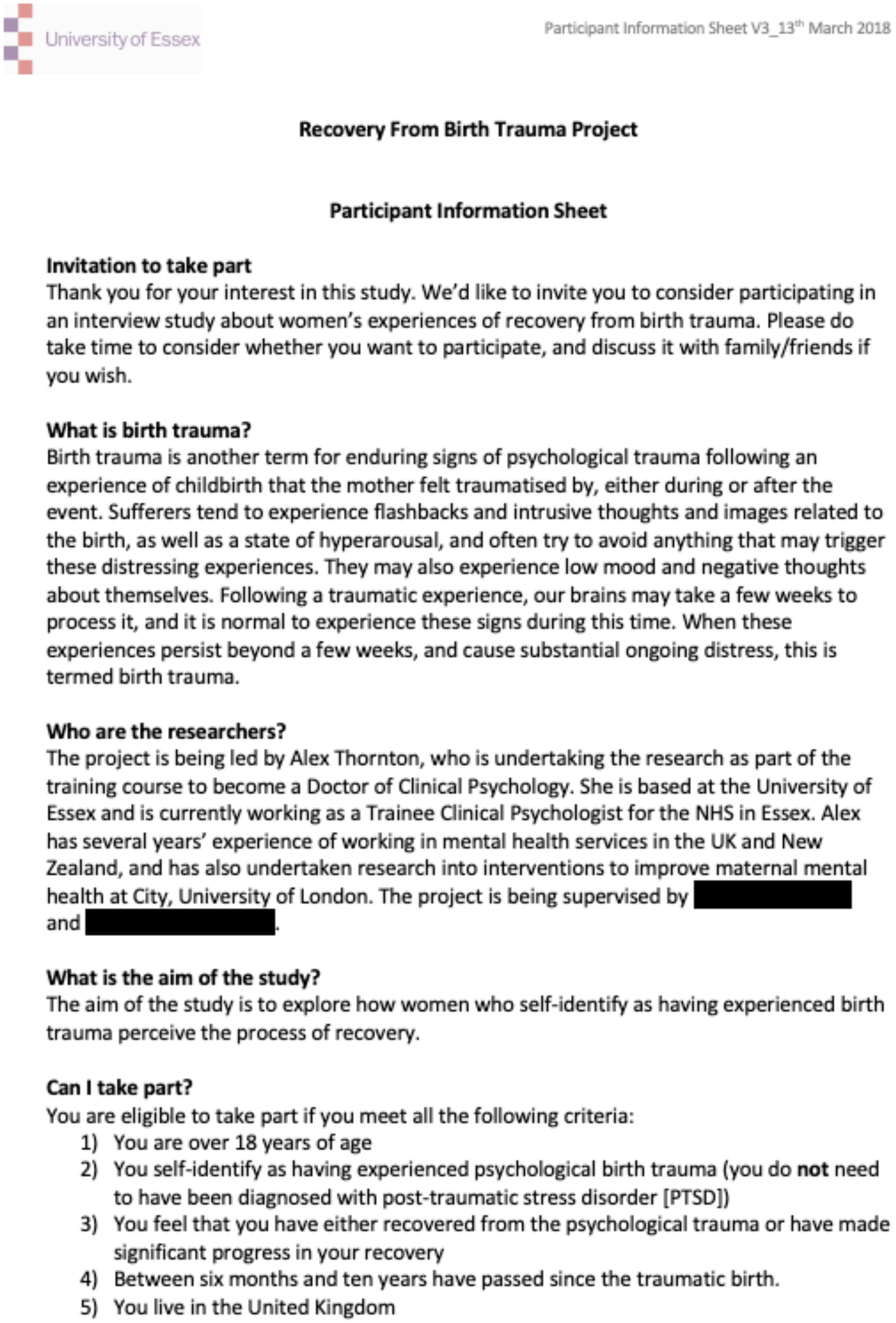


University of Essex

Share your story of recovery from psychological birth trauma

Alex Thornton (Trainee Clinical Psychologist at the University of Essex) is looking for women who feel they have made significant progress with their recovery from psychological trauma after a difficult birth to take part in a research project. It is hoped that the project will give women a voice in influencing how society perceives and cares for women who were left traumatised by their birth experience. Participation would involve taking part in a 45-60 minute interview to discuss your experience of recovery. For more information or to take part, contact Alex at [redacted] or visit [redacted]

Appendix B



Participant Information Sheet V3_13th March 2018

Recovery From Birth Trauma Project

Participant Information Sheet

Invitation to take part

Thank you for your interest in this study. We'd like to invite you to consider participating in an interview study about women's experiences of recovery from birth trauma. Please do take time to consider whether you want to participate, and discuss it with family/friends if you wish.

What is birth trauma?

Birth trauma is another term for enduring signs of psychological trauma following an experience of childbirth that the mother felt traumatised by, either during or after the event. Sufferers tend to experience flashbacks and intrusive thoughts and images related to the birth, as well as a state of hyperarousal, and often try to avoid anything that may trigger these distressing experiences. They may also experience low mood and negative thoughts about themselves. Following a traumatic experience, our brains may take a few weeks to process it, and it is normal to experience these signs during this time. When these experiences persist beyond a few weeks, and cause substantial ongoing distress, this is termed birth trauma.

Who are the researchers?

The project is being led by Alex Thornton, who is undertaking the research as part of the training course to become a Doctor of Clinical Psychology. She is based at the University of Essex and is currently working as a Trainee Clinical Psychologist for the NHS in Essex. Alex has several years' experience of working in mental health services in the UK and New Zealand, and has also undertaken research into interventions to improve maternal mental health at City, University of London. The project is being supervised by [redacted] and [redacted].

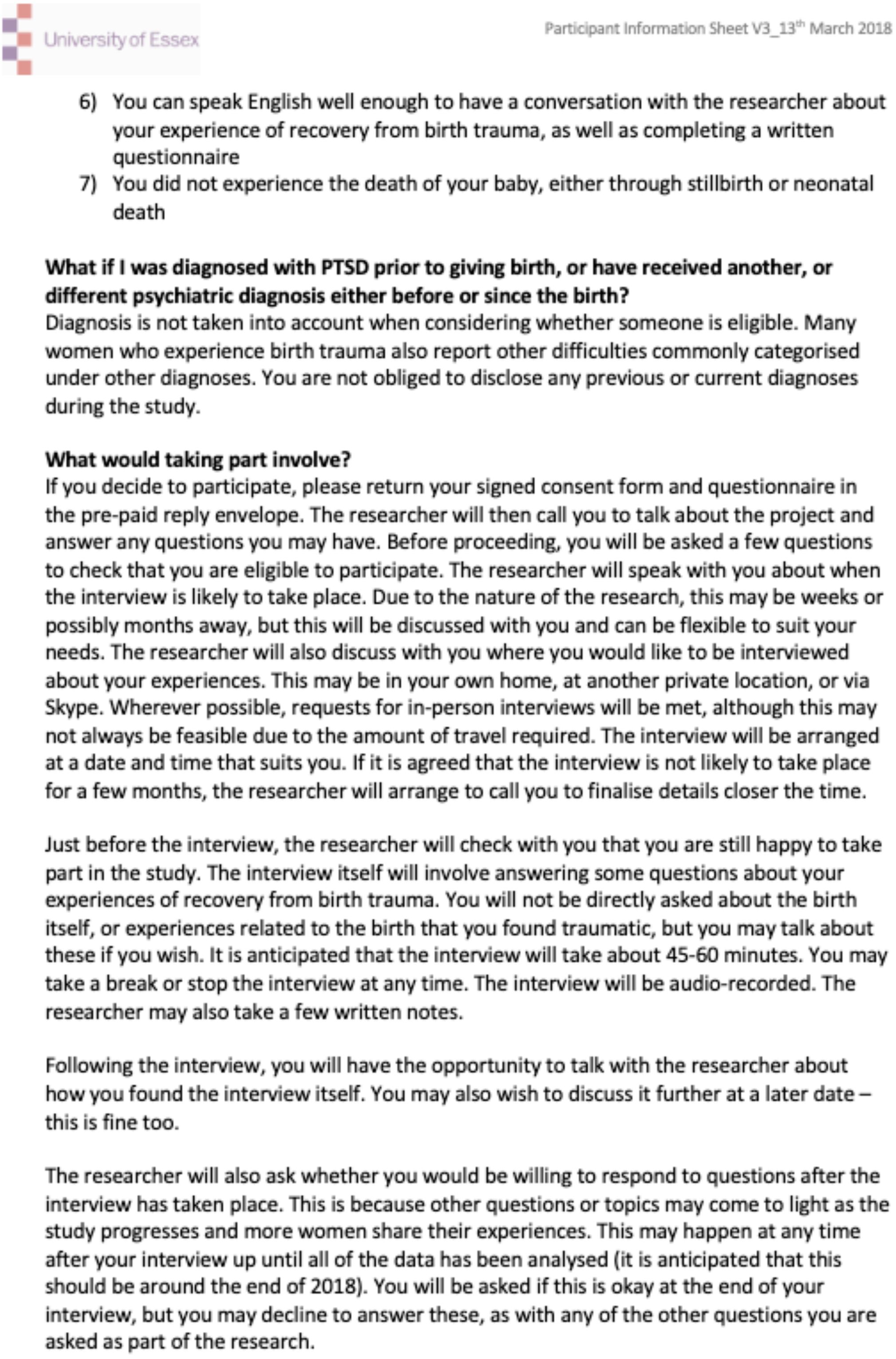
What is the aim of the study?

The aim of the study is to explore how women who self-identify as having experienced birth trauma perceive the process of recovery.

Can I take part?

You are eligible to take part if you meet all the following criteria:

1) You are over 18 years of age
2) You self-identify as having experienced psychological birth trauma (you do **not** need to have been diagnosed with post-traumatic stress disorder [PTSD])
3) You feel that you have either recovered from the psychological trauma or have made significant progress in your recovery
4) Between six months and ten years have passed since the traumatic birth.
5) You live in the United Kingdom



6) You can speak English well enough to have a conversation with the researcher about your experience of recovery from birth trauma, as well as completing a written questionnaire
7) You did not experience the death of your baby, either through stillbirth or neonatal death

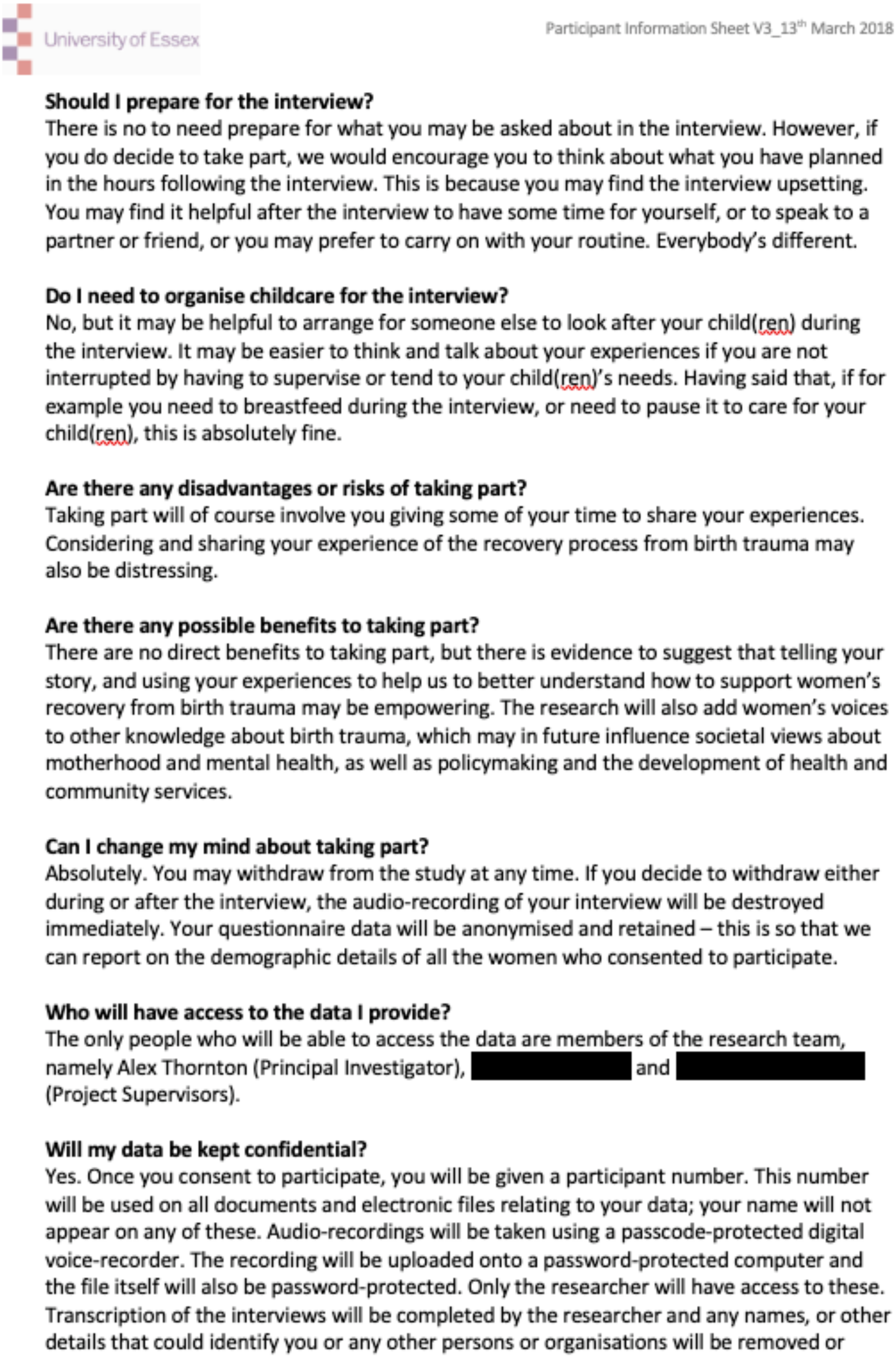
What if I was diagnosed with PTSD prior to giving birth, or have received another, or different psychiatric diagnosis either before or since the birth?
Diagnosis is not taken into account when considering whether someone is eligible. Many women who experience birth trauma also report other difficulties commonly categorised under other diagnoses. You are not obliged to disclose any previous or current diagnoses during the study.

What would taking part involve?
If you decide to participate, please return your signed consent form and questionnaire in the pre-paid reply envelope. The researcher will then call you to talk about the project and answer any questions you may have. Before proceeding, you will be asked a few questions to check that you are eligible to participate. The researcher will speak with you about when the interview is likely to take place. Due to the nature of the research, this may be weeks or possibly months away, but this will be discussed with you and can be flexible to suit your needs. The researcher will also discuss with you where you would like to be interviewed about your experiences. This may be in your own home, at another private location, or via Skype. Wherever possible, requests for in-person interviews will be met, although this may not always be feasible due to the amount of travel required. The interview will be arranged at a date and time that suits you. If it is agreed that the interview is not likely to take place for a few months, the researcher will arrange to call you to finalise details closer the time.

Just before the interview, the researcher will check with you that you are still happy to take part in the study. The interview itself will involve answering some questions about your experiences of recovery from birth trauma. You will not be directly asked about the birth itself, or experiences related to the birth that you found traumatic, but you may talk about these if you wish. It is anticipated that the interview will take about 45-60 minutes. You may take a break or stop the interview at any time. The interview will be audio-recorded. The researcher may also take a few written notes.

Following the interview, you will have the opportunity to talk with the researcher about how you found the interview itself. You may also wish to discuss it further at a later date – this is fine too.

The researcher will also ask whether you would be willing to respond to questions after the interview has taken place. This is because other questions or topics may come to light as the study progresses and more women share their experiences. This may happen at any time after your interview up until all of the data has been analysed (it is anticipated that this should be around the end of 2018). You will be asked if this is okay at the end of your interview, but you may decline to answer these, as with any of the other questions you are asked as part of the research.



University of Essex

Participant Information Sheet V3_13th March 2018

Should I prepare for the interview?
There is no to need prepare for what you may be asked about in the interview. However, if you do decide to take part, we would encourage you to think about what you have planned in the hours following the interview. This is because you may find the interview upsetting. You may find it helpful after the interview to have some time for yourself, or to speak to a partner or friend, or you may prefer to carry on with your routine. Everybody's different.

Do I need to organise childcare for the interview?
No, but it may be helpful to arrange for someone else to look after your child(ren) during the interview. It may be easier to think and talk about your experiences if you are not interrupted by having to supervise or tend to your child(ren)'s needs. Having said that, if for example you need to breastfeed during the interview, or need to pause it to care for your child(ren), this is absolutely fine.

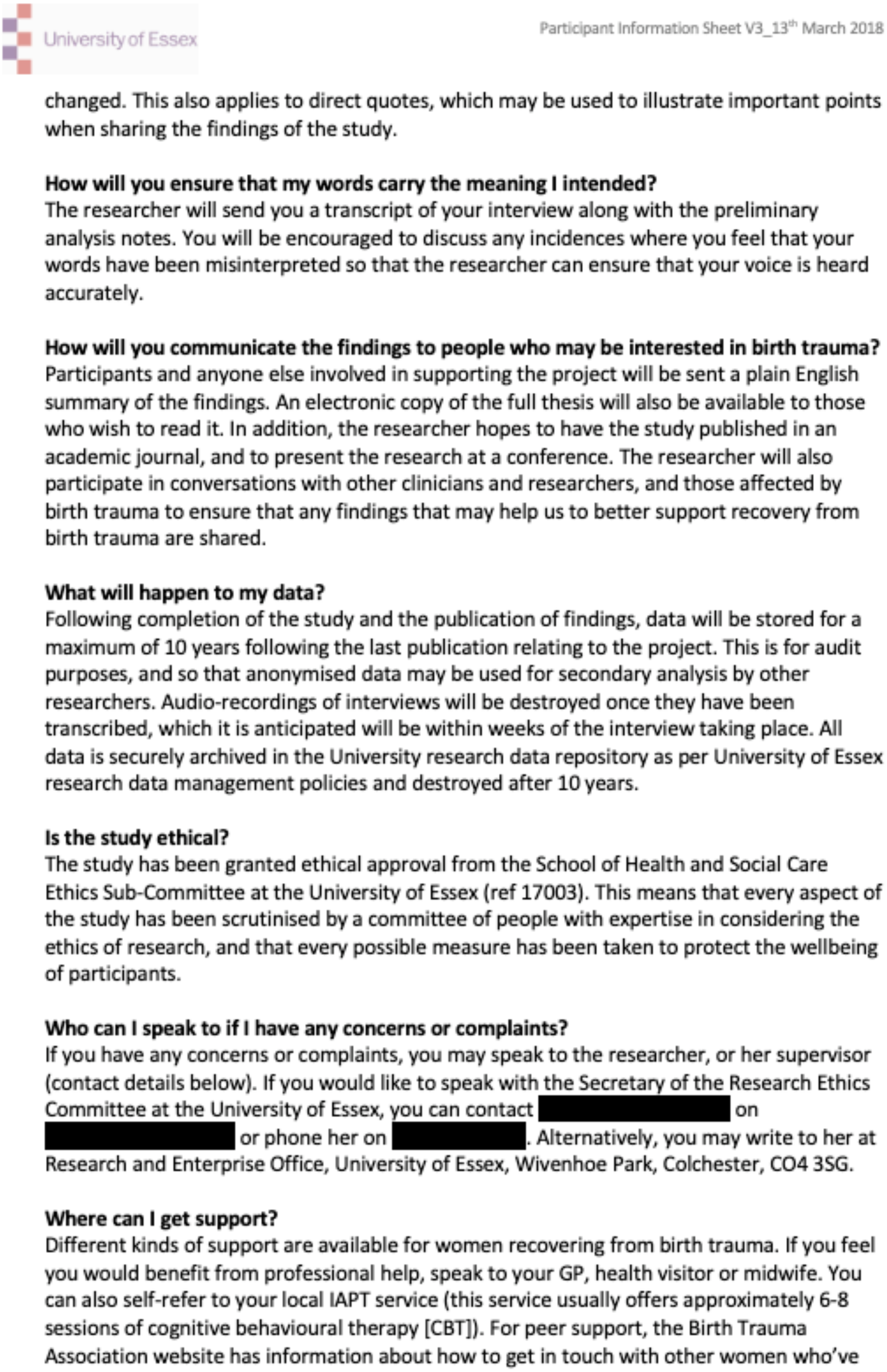
Are there any disadvantages or risks of taking part?
Taking part will of course involve you giving some of your time to share your experiences. Considering and sharing your experience of the recovery process from birth trauma may also be distressing.

Are there any possible benefits to taking part?
There are no direct benefits to taking part, but there is evidence to suggest that telling your story, and using your experiences to help us to better understand how to support women's recovery from birth trauma may be empowering. The research will also add women's voices to other knowledge about birth trauma, which may in future influence societal views about motherhood and mental health, as well as policymaking and the development of health and community services.

Can I change my mind about taking part?
Absolutely. You may withdraw from the study at any time. If you decide to withdraw either during or after the interview, the audio-recording of your interview will be destroyed immediately. Your questionnaire data will be anonymised and retained – this is so that we can report on the demographic details of all the women who consented to participate.

Who will have access to the data I provide?
The only people who will be able to access the data are members of the research team, namely Alex Thornton (Principal Investigator), [redacted] and [redacted] (Project Supervisors).

Will my data be kept confidential?
Yes. Once you consent to participate, you will be given a participant number. This number will be used on all documents and electronic files relating to your data; your name will not appear on any of these. Audio-recordings will be taken using a passcode-protected digital voice-recorder. The recording will be uploaded onto a password-protected computer and the file itself will also be password-protected. Only the researcher will have access to these. Transcription of the interviews will be completed by the researcher and any names, or other details that could identify you or any other persons or organisations will be removed or



changed. This also applies to direct quotes, which may be used to illustrate important points when sharing the findings of the study.

How will you ensure that my words carry the meaning I intended?
The researcher will send you a transcript of your interview along with the preliminary analysis notes. You will be encouraged to discuss any incidences where you feel that your words have been misinterpreted so that the researcher can ensure that your voice is heard accurately.

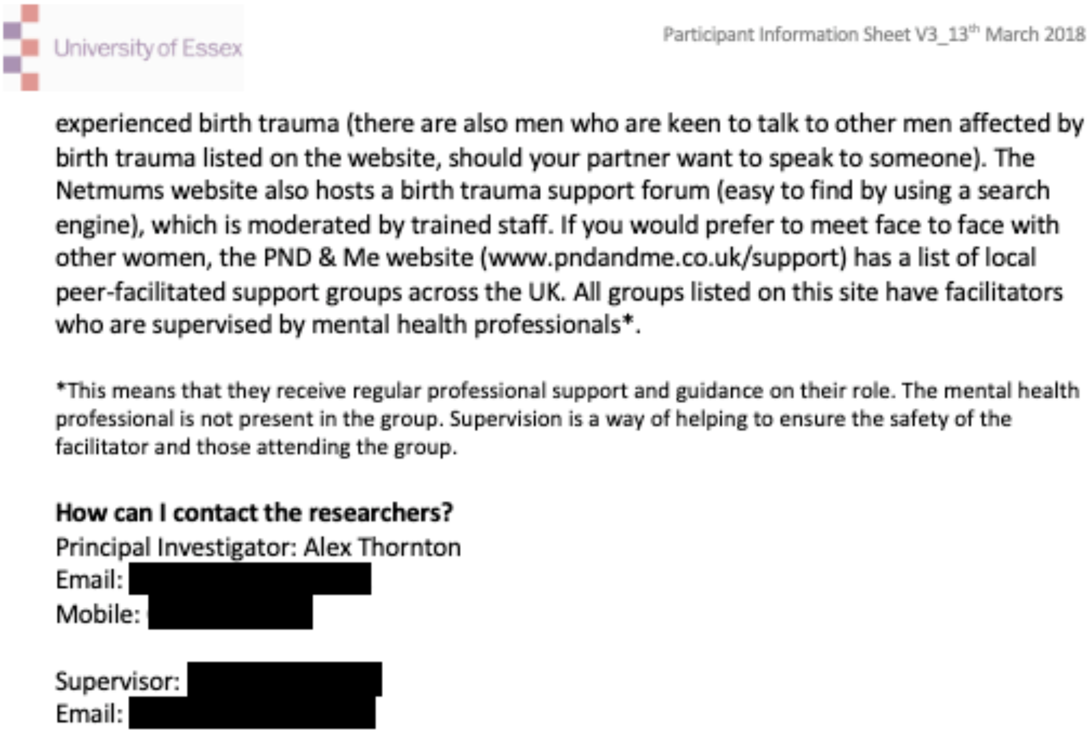
How will you communicate the findings to people who may be interested in birth trauma?
Participants and anyone else involved in supporting the project will be sent a plain English summary of the findings. An electronic copy of the full thesis will also be available to those who wish to read it. In addition, the researcher hopes to have the study published in an academic journal, and to present the research at a conference. The researcher will also participate in conversations with other clinicians and researchers, and those affected by birth trauma to ensure that any findings that may help us to better support recovery from birth trauma are shared.

What will happen to my data?
Following completion of the study and the publication of findings, data will be stored for a maximum of 10 years following the last publication relating to the project. This is for audit purposes, and so that anonymised data may be used for secondary analysis by other researchers. Audio-recordings of interviews will be destroyed once they have been transcribed, which it is anticipated will be within weeks of the interview taking place. All data is securely archived in the University research data repository as per University of Essex research data management policies and destroyed after 10 years.

Is the study ethical?
The study has been granted ethical approval from the School of Health and Social Care Ethics Sub-Committee at the University of Essex (ref 17003). This means that every aspect of the study has been scrutinised by a committee of people with expertise in considering the ethics of research, and that every possible measure has been taken to protect the wellbeing of participants.

Who can I speak to if I have any concerns or complaints?
If you have any concerns or complaints, you may speak to the researcher, or her supervisor (contact details below). If you would like to speak with the Secretary of the Research Ethics Committee at the University of Essex, you can contact [redacted] on [redacted] or phone her on [redacted]. Alternatively, you may write to her at Research and Enterprise Office, University of Essex, Wivenhoe Park, Colchester, CO4 3SG.

Where can I get support?
Different kinds of support are available for women recovering from birth trauma. If you feel you would benefit from professional help, speak to your GP, health visitor or midwife. You can also self-refer to your local IAPT service (this service usually offers approximately 6-8 sessions of cognitive behavioural therapy [CBT]). For peer support, the Birth Trauma Association website has information about how to get in touch with other women who've



experienced birth trauma (there are also men who are keen to talk to other men affected by birth trauma listed on the website, should your partner want to speak to someone). The Netmums website also hosts a birth trauma support forum (easy to find by using a search engine), which is moderated by trained staff. If you would prefer to meet face to face with other women, the PND & Me website (www.pndandme.co.uk/support) has a list of local peer-facilitated support groups across the UK. All groups listed on this site have facilitators who are supervised by mental health professionals*.

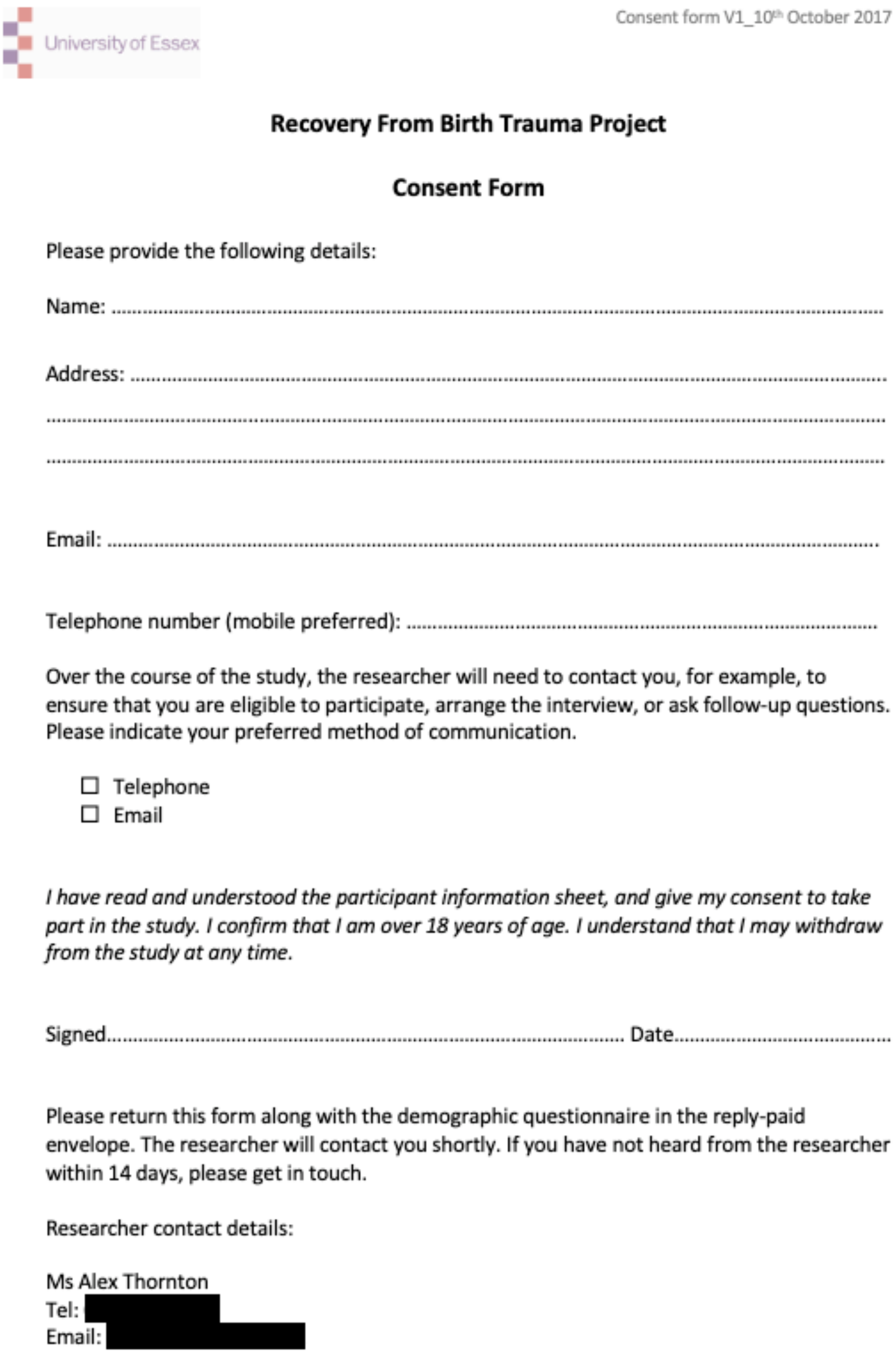
*This means that they receive regular professional support and guidance on their role. The mental health professional is not present in the group. Supervision is a way of helping to ensure the safety of the facilitator and those attending the group.

How can I contact the researchers?

Principal Investigator: Alex Thornton
Email: [redacted]
Mobile: [redacted]

Supervisor: [redacted]
Email: [redacted]

Appendix C



University of Essex

Consent form V1_10th October 2017

Recovery From Birth Trauma Project

Consent Form

Please provide the following details:

Name: ………

Address: ……
……
……

Email: ………

Telephone number (mobile preferred): ………………………………………………………………

Over the course of the study, the researcher will need to contact you, for example, to ensure that you are eligible to participate, arrange the interview, or ask follow-up questions. Please indicate your preferred method of communication.

- ☐ Telephone
- ☐ Email

I have read and understood the participant information sheet, and give my consent to take part in the study. I confirm that I am over 18 years of age. I understand that I may withdraw from the study at any time.

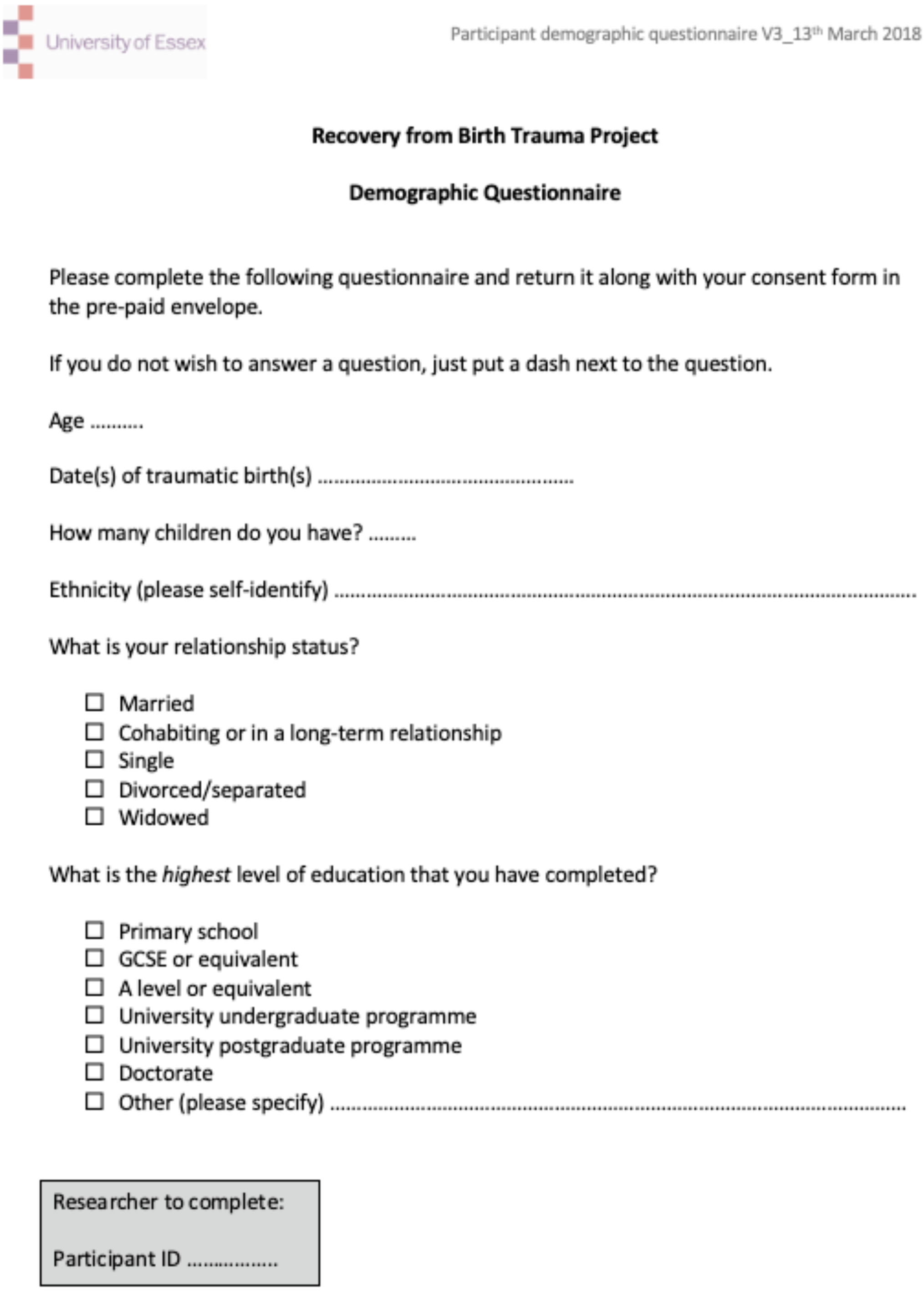
Signed……………………………………………………………………… Date………………………………

Please return this form along with the demographic questionnaire in the reply-paid envelope. The researcher will contact you shortly. If you have not heard from the researcher within 14 days, please get in touch.

Researcher contact details:

Ms Alex Thornton
Tel: [redacted]
Email: [redacted]

Appendix D



University of Essex

Participant demographic questionnaire V3_13th March 2018

Recovery from Birth Trauma Project

Demographic Questionnaire

Please complete the following questionnaire and return it along with your consent form in the pre-paid envelope.

If you do not wish to answer a question, just put a dash next to the question.

Age ....

Date(s) of traumatic birth(s) ....

How many children do you have? ....

Ethnicity (please self-identify) ....

What is your relationship status?

- ☐ Married
- ☐ Cohabiting or in a long-term relationship
- ☐ Single
- ☐ Divorced/separated
- ☐ Widowed

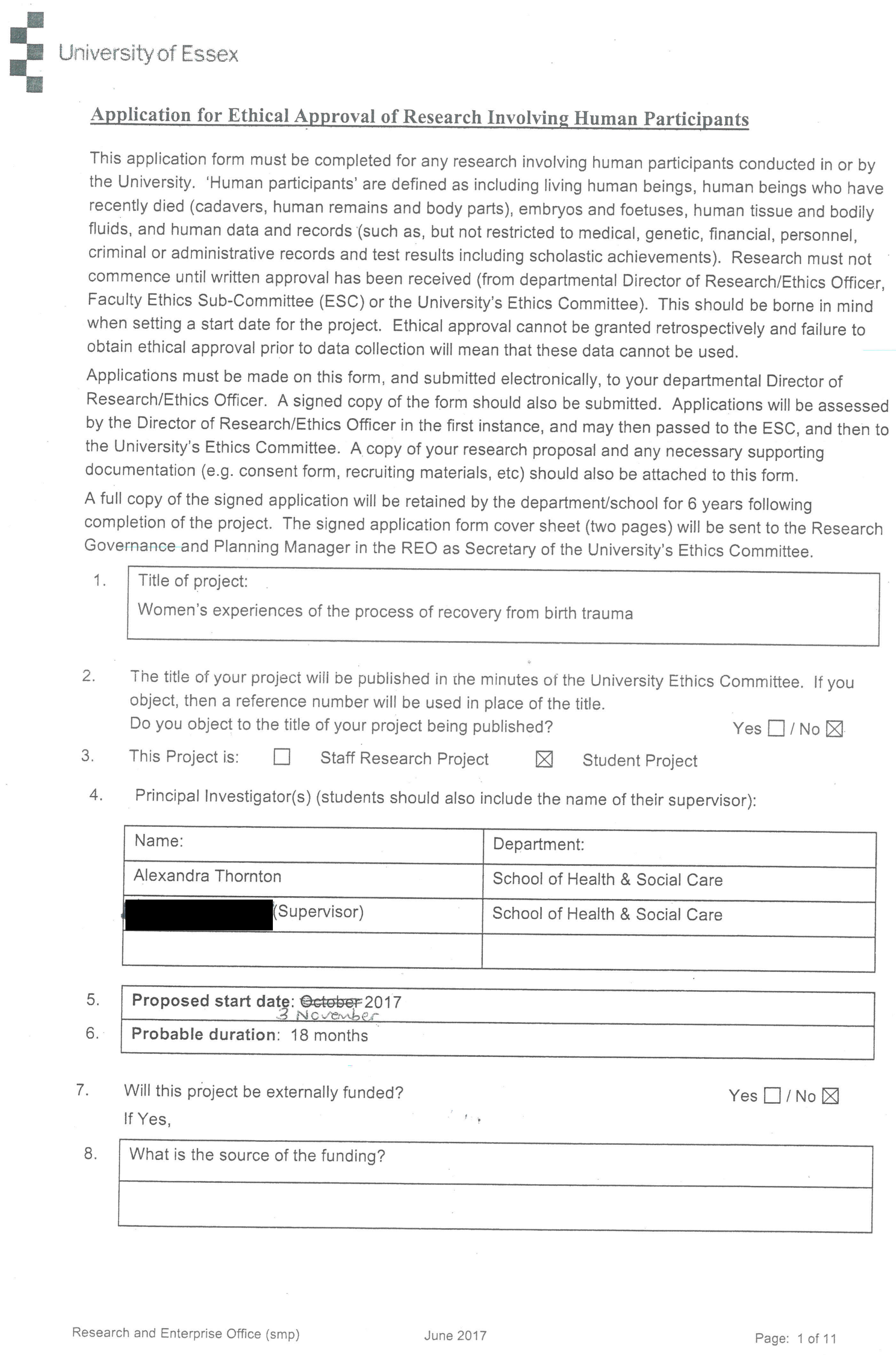
What is the *highest* level of education that you have completed?

- ☐ Primary school
- ☐ GCSE or equivalent
- ☐ A level or equivalent
- ☐ University undergraduate programme
- ☐ University postgraduate programme
- ☐ Doctorate
- ☐ Other (please specify) ....

Researcher to complete:

Participant ID ....

Appendix E



University of Essex

Application for Ethical Approval of Research Involving Human Participants

This application form must be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research must not commence until written approval has been received (from departmental Director of Research/Ethics Officer, Faculty Ethics Sub-Committee (ESC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project. Ethical approval cannot be granted retrospectively and failure to obtain ethical approval prior to data collection will mean that these data cannot be used.

Applications must be made on this form, and submitted electronically, to your departmental Director of Research/Ethics Officer. A signed copy of the form should also be submitted. Applications will be assessed by the Director of Research/Ethics Officer in the first instance, and may then passed to the ESC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1. Title of project:
   Women's experiences of the process of recovery from birth trauma

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.
   Do you object to the title of your project being published? Yes ☐ / No ☒

3. This Project is: ☐ Staff Research Project ☒ Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Alexandra Thornton	School of Health & Social Care
[redacted] (Supervisor)	School of Health & Social Care

5. **Proposed start date**: ~~October~~ 3 November 2017
6. **Probable duration**: 18 months

7. Will this project be externally funded? Yes ☐ / No ☒
   If Yes,

8. What is the source of the funding?

Research and Enterprise Office (smp) June 2017 Page: 1 of 11

9. If external approval for this research has been given, then only this cover sheet needs to be submitted
External ethics approval obtained (attach evidence of approval) Yes ☐/ No ☒

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s): ....

Name(s) in block capitals: .....ALEXANDRA THORNTON..

Date: ...10/10/2017..

Supervisor's recommendation (Student Projects only):

I have read and approved ~~the quality of both~~ the research proposal and this application.

Supervisor's signature: ...[redacted]..

Outcome:

The departmental Director of Research (DoR) / Ethics Officer (EO) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR / EO considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the ESC ☑

This application is referred to the ESC because it does not fall under Annex B ☐

This application is referred [redacted] independent scrutiny ☐

Signature(s): ....

Name(s) in block capitals: ....

Department: ......S.H.S.C..

Date: ....3/11/17..

The application has been approved by the ESC ☐

The application has not been approved by the ESC ☐

The application is referred to the University Ethics Committee ☐

Signature(s): ....

Name(s) in block capitals: ....

Faculty: ....

Date: ....

Details of the Project

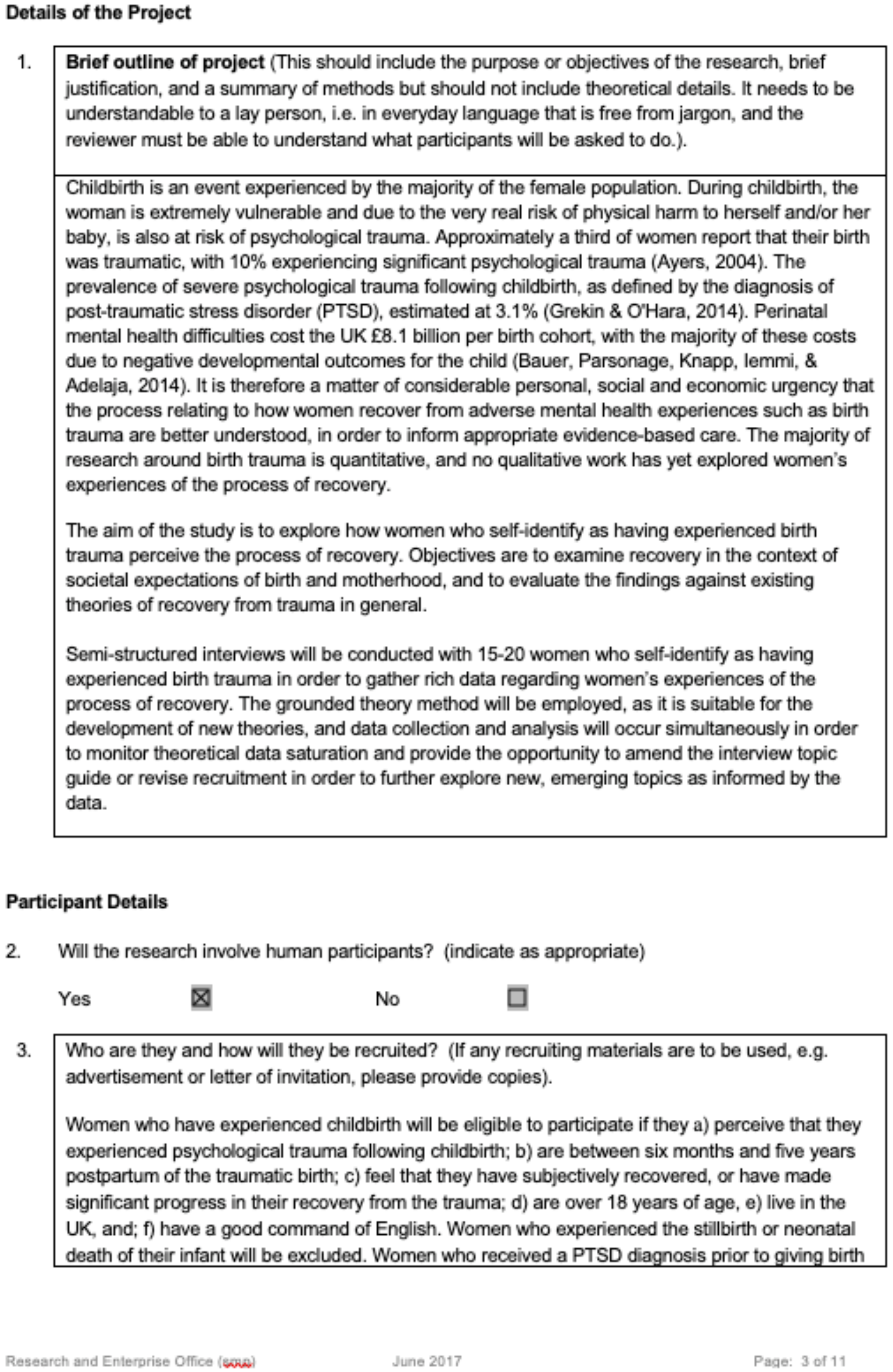
1.	**Brief outline of project** (This should include the purpose or objectives of the research, brief justification, and a summary of methods but should not include theoretical details. It needs to be understandable to a lay person, i.e. in everyday language that is free from jargon, and the reviewer must be able to understand what participants will be asked to do.).
	Childbirth is an event experienced by the majority of the female population. During childbirth, the woman is extremely vulnerable and due to the very real risk of physical harm to herself and/or her baby, is also at risk of psychological trauma. Approximately a third of women report that their birth was traumatic, with 10% experiencing significant psychological trauma (Ayers, 2004). The prevalence of severe psychological trauma following childbirth, as defined by the diagnosis of post-traumatic stress disorder (PTSD), estimated at 3.1% (Grekin & O'Hara, 2014). Perinatal mental health difficulties cost the UK £8.1 billion per birth cohort, with the majority of these costs due to negative developmental outcomes for the child (Bauer, Parsonage, Knapp, Iemmi, & Adelaja, 2014). It is therefore a matter of considerable personal, social and economic urgency that the process relating to how women recover from adverse mental health experiences such as birth trauma are better understood, in order to inform appropriate evidence-based care. The majority of research around birth trauma is quantitative, and no qualitative work has yet explored women's experiences of the process of recovery. The aim of the study is to explore how women who self-identify as having experienced birth trauma perceive the process of recovery. Objectives are to examine recovery in the context of societal expectations of birth and motherhood, and to evaluate the findings against existing theories of recovery from trauma in general. Semi-structured interviews will be conducted with 15-20 women who self-identify as having experienced birth trauma in order to gather rich data regarding women's experiences of the process of recovery. The grounded theory method will be employed, as it is suitable for the development of new theories, and data collection and analysis will occur simultaneously in order to monitor theoretical data saturation and provide the opportunity to amend the interview topic guide or revise recruitment in order to further explore new, emerging topics as informed by the data.

Participant Details

2. Will the research involve human participants? (indicate as appropriate)

Yes ☒ No ☐

3.	Who are they and how will they be recruited? (If any recruiting materials are to be used, e.g. advertisement or letter of invitation, please provide copies). Women who have experienced childbirth will be eligible to participate if they a) perceive that they experienced psychological trauma following childbirth; b) are between six months and five years postpartum of the traumatic birth; c) feel that they have subjectively recovered, or have made significant progress in their recovery from the trauma; d) are over 18 years of age, e) live in the UK, and; f) have a good command of English. Women who experienced the stillbirth or neonatal death of their infant will be excluded. Women who received a PTSD diagnosis prior to giving birth



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Childbirth is an event experienced by the majority of the female population. During childbirth, the woman is extremely vulnerable and due to the very real risk of physical harm to herself and/or her baby, is also at risk of psychological trauma. Approximately a third of women report that their birth was traumatic, with 10% experiencing significant psychological trauma (Ayers, 2004). The prevalence of severe psychological trauma following childbirth, as defined by the diagnosis of post-traumatic stress disorder (PTSD), estimated at 3.1% (Grekin & O'Hara, 2014). Perinatal mental health difficulties cost the UK £8.1 billion per birth cohort, with the majority of these costs due to negative developmental outcomes for the child (Bauer, Parsonage, Knapp, Iemmi, & Adelaja, 2014). It is therefore a matter of considerable personal, social and economic urgency that the process relating to how women recover from adverse mental health experiences such as birth trauma are better understood, in order to inform appropriate evidence-based care. The majority of research around birth trauma is quantitative, and no qualitative work has yet explored women's experiences of the process of recovery.

The aim of the study is to explore how women who self-identify as having experienced birth trauma perceive the process of recovery. Objectives are to examine recovery in the context of societal expectations of birth and motherhood, and to evaluate the findings against existing theories of recovery from trauma in general.

Semi-structured interviews will be conducted with 15-20 women who self-identify as having experienced birth trauma in order to gather rich data regarding women's experiences of the process of recovery. The grounded theory method will be employed, as it is suitable for the development of new theories, and data collection and analysis will occur simultaneously in order to monitor theoretical data saturation and provide the opportunity to amend the interview topic guide or revise recruitment in order to further explore new, emerging topics as informed by the data.

Participant Details

2. Will the research involve human participants? (indicate as appropriate)

Yes ☒ No ☐

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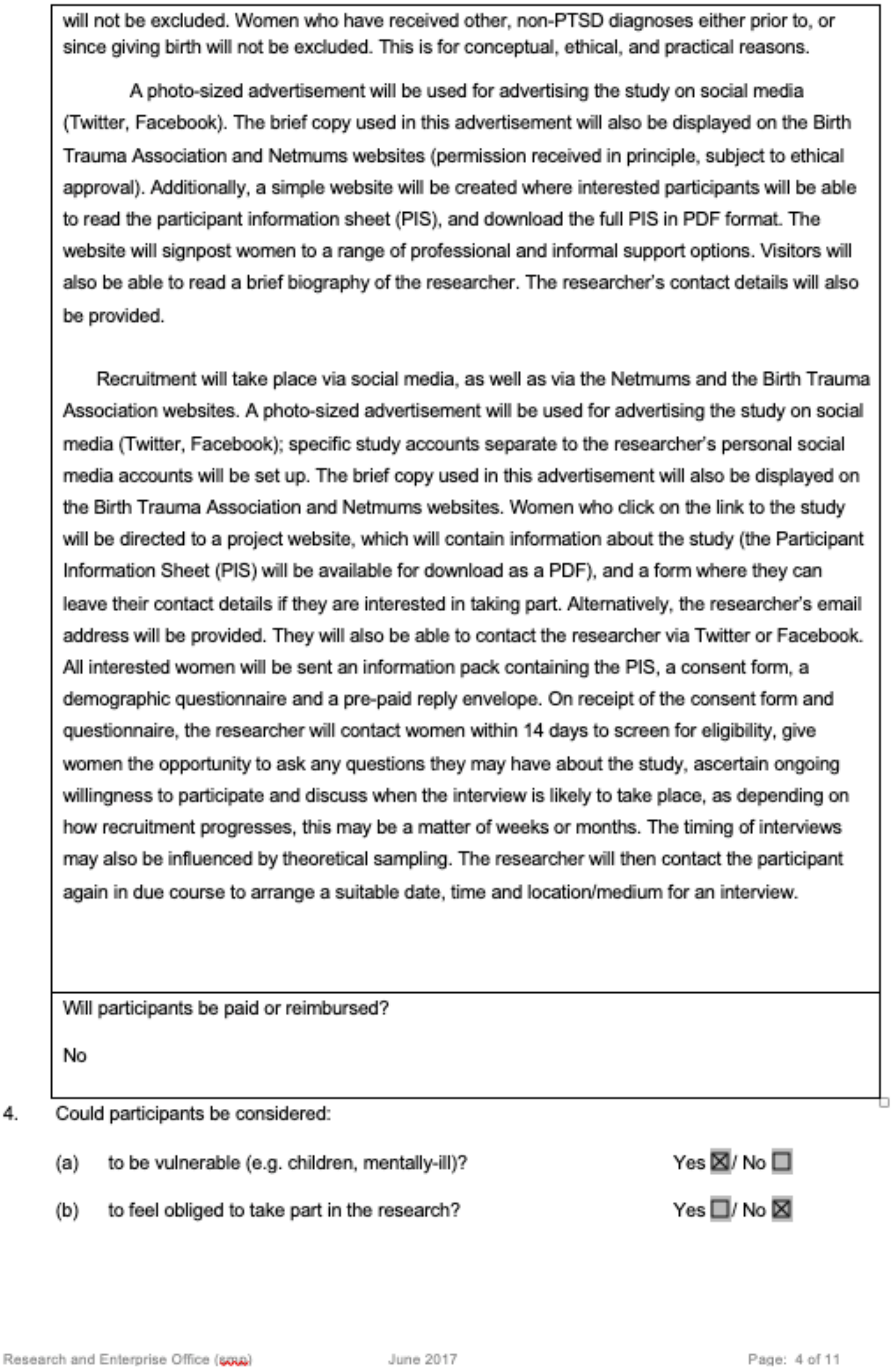


will not be excluded. Women who have received other, non-PTSD diagnoses either prior to, or since giving birth will not be excluded. This is for conceptual, ethical, and practical reasons.

A photo-sized advertisement will be used for advertising the study on social media (Twitter, Facebook). The brief copy used in this advertisement will also be displayed on the Birth Trauma Association and Netmums websites (permission received in principle, subject to ethical approval). Additionally, a simple website will be created where interested participants will be able to read the participant information sheet (PIS), and download the full PIS in PDF format. The website will signpost women to a range of professional and informal support options. Visitors will also be able to read a brief biography of the researcher. The researcher's contact details will also be provided.

Recruitment will take place via social media, as well as via the Netmums and the Birth Trauma Association websites. A photo-sized advertisement will be used for advertising the study on social media (Twitter, Facebook); specific study accounts separate to the researcher's personal social media accounts will be set up. The brief copy used in this advertisement will also be displayed on the Birth Trauma Association and Netmums websites. Women who click on the link to the study will be directed to a project website, which will contain information about the study (the Participant Information Sheet (PIS) will be available for download as a PDF), and a form where they can leave their contact details if they are interested in taking part. Alternatively, the researcher's email address will be provided. They will also be able to contact the researcher via Twitter or Facebook. All interested women will be sent an information pack containing the PIS, a consent form, a demographic questionnaire and a pre-paid reply envelope. On receipt of the consent form and questionnaire, the researcher will contact women within 14 days to screen for eligibility, give women the opportunity to ask any questions they may have about the study, ascertain ongoing willingness to participate and discuss when the interview is likely to take place, as depending on how recruitment progresses, this may be a matter of weeks or months. The timing of interviews may also be influenced by theoretical sampling. The researcher will then contact the participant again in due course to arrange a suitable date, time and location/medium for an interview.

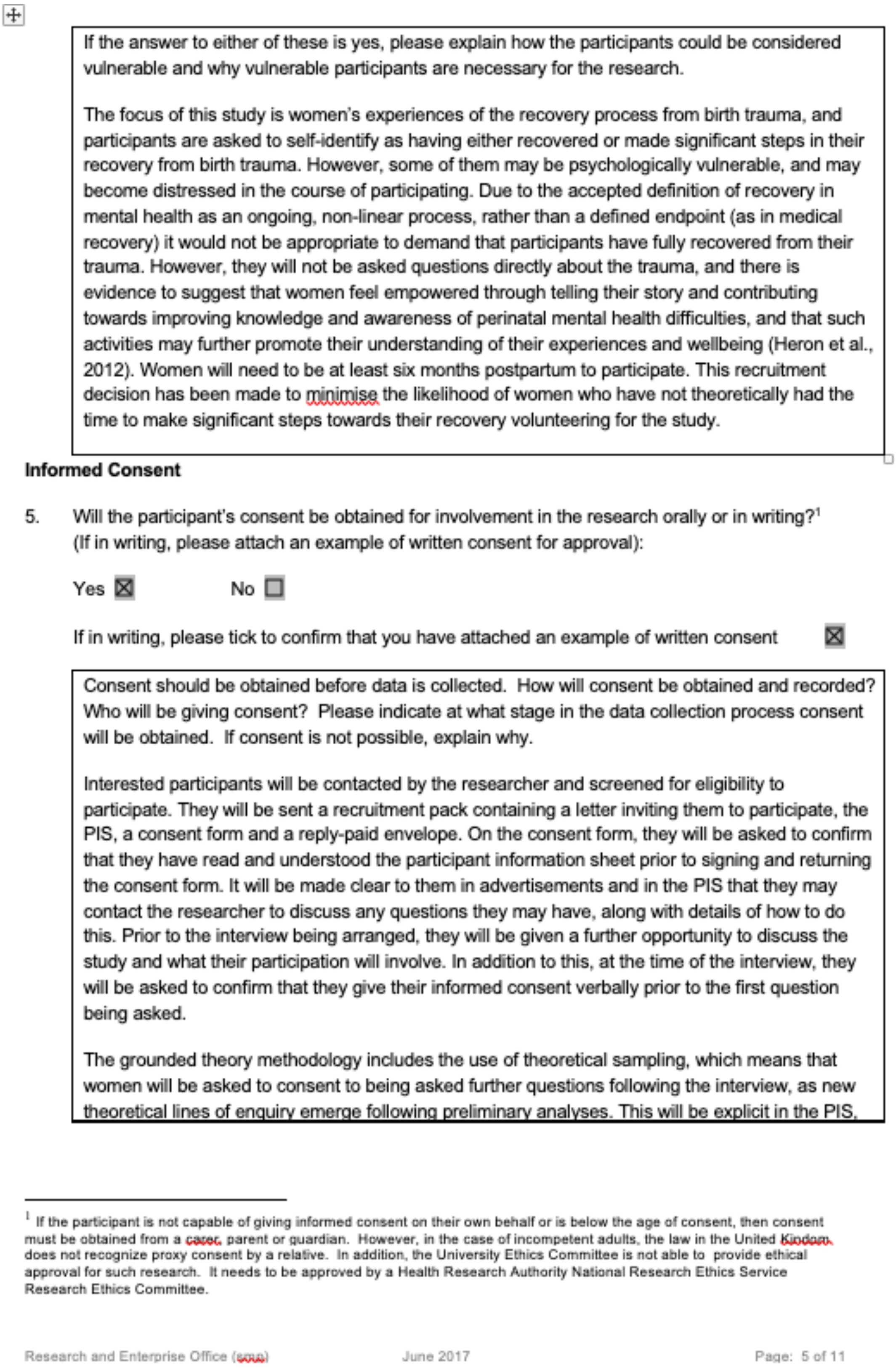
Will participants be paid or reimbursed?

No

4. Could participants be considered:

(a) to be vulnerable (e.g. children, mentally-ill)? Yes ☒/ No ☐

(b) to feel obliged to take part in the research? Yes ☐/ No ☒



If the answer to either of these is yes, please explain how the participants could be considered vulnerable and why vulnerable participants are necessary for the research.

The focus of this study is women's experiences of the recovery process from birth trauma, and participants are asked to self-identify as having either recovered or made significant steps in their recovery from birth trauma. However, some of them may be psychologically vulnerable, and may become distressed in the course of participating. Due to the accepted definition of recovery in mental health as an ongoing, non-linear process, rather than a defined endpoint (as in medical recovery) it would not be appropriate to demand that participants have fully recovered from their trauma. However, they will not be asked questions directly about the trauma, and there is evidence to suggest that women feel empowered through telling their story and contributing towards improving knowledge and awareness of perinatal mental health difficulties, and that such activities may further promote their understanding of their experiences and wellbeing (Heron et al., 2012). Women will need to be at least six months postpartum to participate. This recruitment decision has been made to minimise the likelihood of women who have not theoretically had the time to make significant steps towards their recovery volunteering for the study.

Informed Consent

5. Will the participant's consent be obtained for involvement in the research orally or in writing?[1] (If in writing, please attach an example of written consent for approval):

Yes ☒ No ☐

If in writing, please tick to confirm that you have attached an example of written consent ☒

Consent should be obtained before data is collected. How will consent be obtained and recorded? Who will be giving consent? Please indicate at what stage in the data collection process consent will be obtained. If consent is not possible, explain why.

Interested participants will be contacted by the researcher and screened for eligibility to participate. They will be sent a recruitment pack containing a letter inviting them to participate, the PIS, a consent form and a reply-paid envelope. On the consent form, they will be asked to confirm that they have read and understood the participant information sheet prior to signing and returning the consent form. It will be made clear to them in advertisements and in the PIS that they may contact the researcher to discuss any questions they may have, along with details of how to do this. Prior to the interview being arranged, they will be given a further opportunity to discuss the study and what their participation will involve. In addition to this, at the time of the interview, they will be asked to confirm that they give their informed consent verbally prior to the first question being asked.

The grounded theory methodology includes the use of theoretical sampling, which means that women will be asked to consent to being asked further questions following the interview, as new theoretical lines of enquiry emerge following preliminary analyses. This will be explicit in the PIS,

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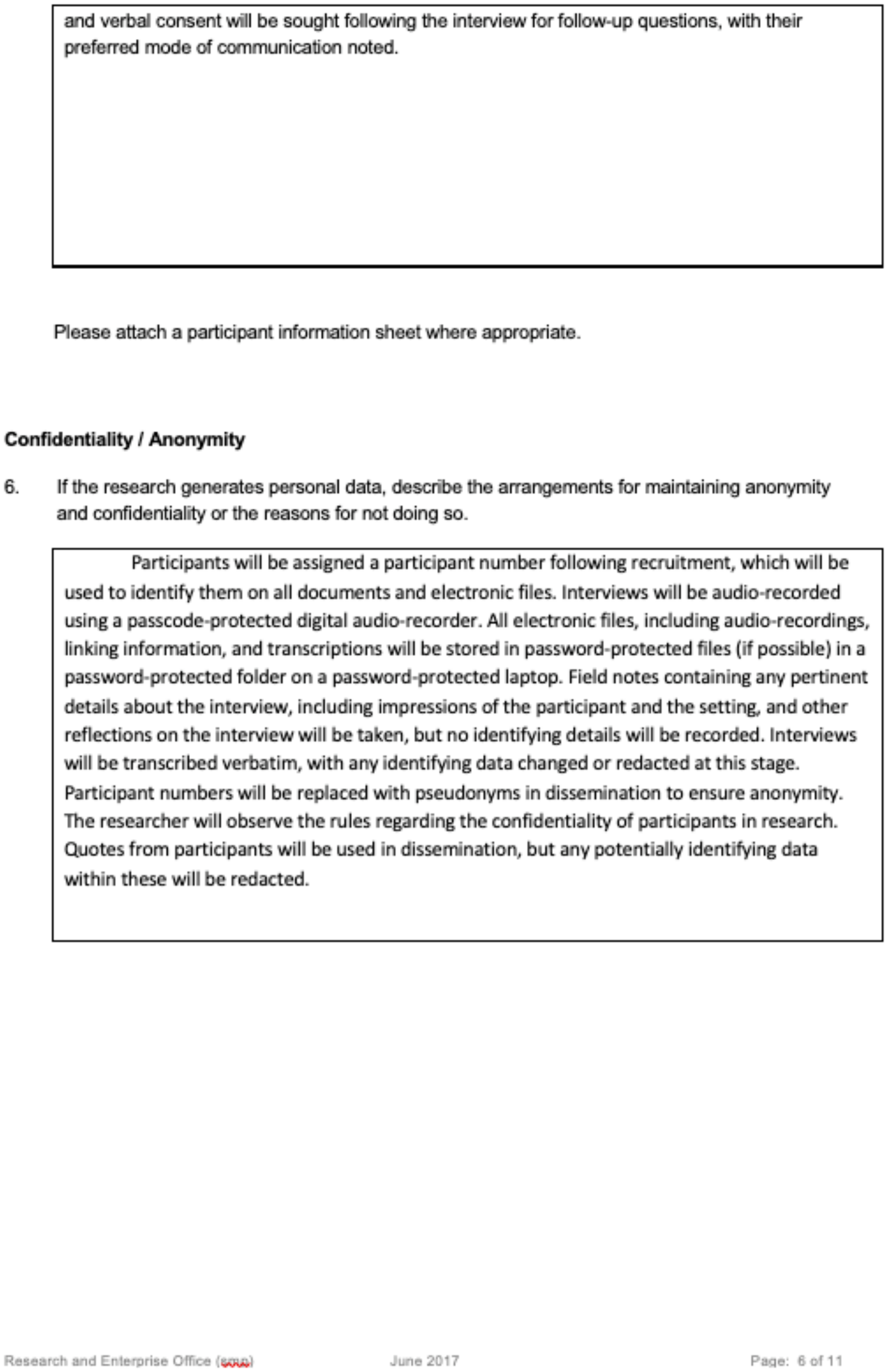
[1] If the participant is not capable of giving informed consent on their own behalf or is below the age of consent, then consent must be obtained from a carer, parent or guardian. However, in the case of incompetent adults, the law in the United Kindom does not recognize proxy consent by a relative. In addition, the University Ethics Committee is not able to provide ethical approval for such research. It needs to be approved by a Health Research Authority National Research Ethics Service Research Ethics Committee.



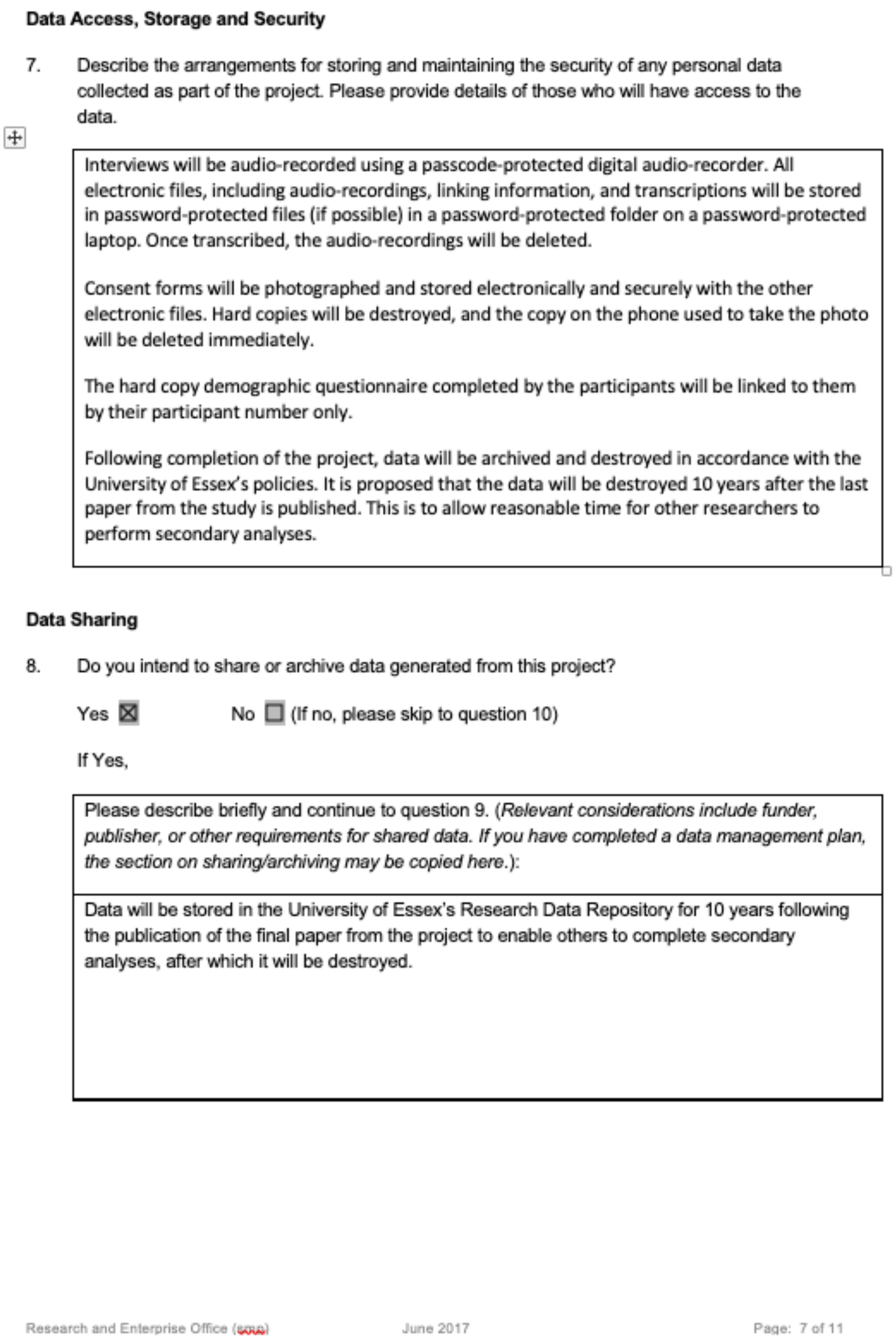
and verbal consent will be sought following the interview for follow-up questions, with their preferred mode of communication noted.

Please attach a participant information sheet where appropriate.

Confidentiality / Anonymity

6. If the research generates personal data, describe the arrangements for maintaining anonymity and confidentiality or the reasons for not doing so.

Participants will be assigned a participant number following recruitment, which will be used to identify them on all documents and electronic files. Interviews will be audio-recorded using a passcode-protected digital audio-recorder. All electronic files, including audio-recordings, linking information, and transcriptions will be stored in password-protected files (if possible) in a password-protected folder on a password-protected laptop. Field notes containing any pertinent details about the interview, including impressions of the participant and the setting, and other reflections on the interview will be taken, but no identifying details will be recorded. Interviews will be transcribed verbatim, with any identifying data changed or redacted at this stage. Participant numbers will be replaced with pseudonyms in dissemination to ensure anonymity. The researcher will observe the rules regarding the confidentiality of participants in research. Quotes from participants will be used in dissemination, but any potentially identifying data within these will be redacted.



Data Access, Storage and Security

7. Describe the arrangements for storing and maintaining the security of any personal data collected as part of the project. Please provide details of those who will have access to the data.

Interviews will be audio-recorded using a passcode-protected digital audio-recorder. All electronic files, including audio-recordings, linking information, and transcriptions will be stored in password-protected files (if possible) in a password-protected folder on a password-protected laptop. Once transcribed, the audio-recordings will be deleted.

Consent forms will be photographed and stored electronically and securely with the other electronic files. Hard copies will be destroyed, and the copy on the phone used to take the photo will be deleted immediately.

The hard copy demographic questionnaire completed by the participants will be linked to them by their participant number only.

Following completion of the project, data will be archived and destroyed in accordance with the University of Essex's policies. It is proposed that the data will be destroyed 10 years after the last paper from the study is published. This is to allow reasonable time for other researchers to perform secondary analyses.

Data Sharing

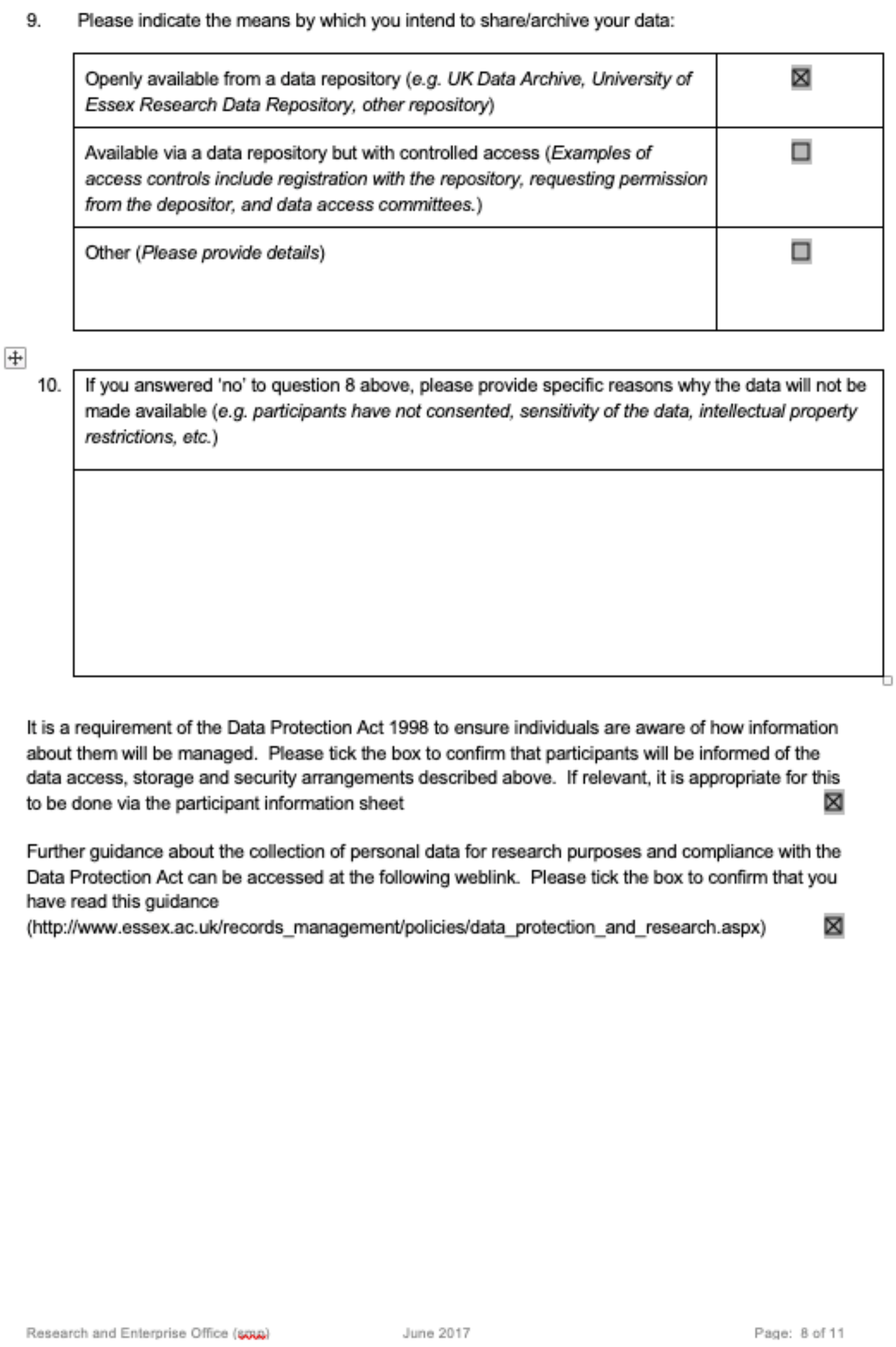
8. Do you intend to share or archive data generated from this project?

Yes ☒ No ☐ (If no, please skip to question 10)

If Yes,

Please describe briefly and continue to question 9. (*Relevant considerations include funder, publisher, or other requirements for shared data. If you have completed a data management plan, the section on sharing/archiving may be copied here.*):

Data will be stored in the University of Essex's Research Data Repository for 10 years following the publication of the final paper from the project to enable others to complete secondary analyses, after which it will be destroyed.



9. Please indicate the means by which you intend to share/archive your data:

Openly available from a data repository (*e.g. UK Data Archive, University of Essex Research Data Repository, other repository*)	☒
Available via a data repository but with controlled access (*Examples of access controls include registration with the repository, requesting permission from the depositor, and data access committees.*)	☐
Other (*Please provide details*)	☐

10. If you answered 'no' to question 8 above, please provide specific reasons why the data will not be made available (*e.g. participants have not consented, sensitivity of the data, intellectual property restrictions, etc.*)

It is a requirement of the Data Protection Act 1998 to ensure individuals are aware of how information about them will be managed. Please tick the box to confirm that participants will be informed of the data access, storage and security arrangements described above. If relevant, it is appropriate for this to be done via the participant information sheet ☒

Further guidance about the collection of personal data for research purposes and compliance with the Data Protection Act can be accessed at the following weblink. Please tick the box to confirm that you have read this guidance (http://www.essex.ac.uk/records_management/policies/data_protection_and_research.aspx) ☒

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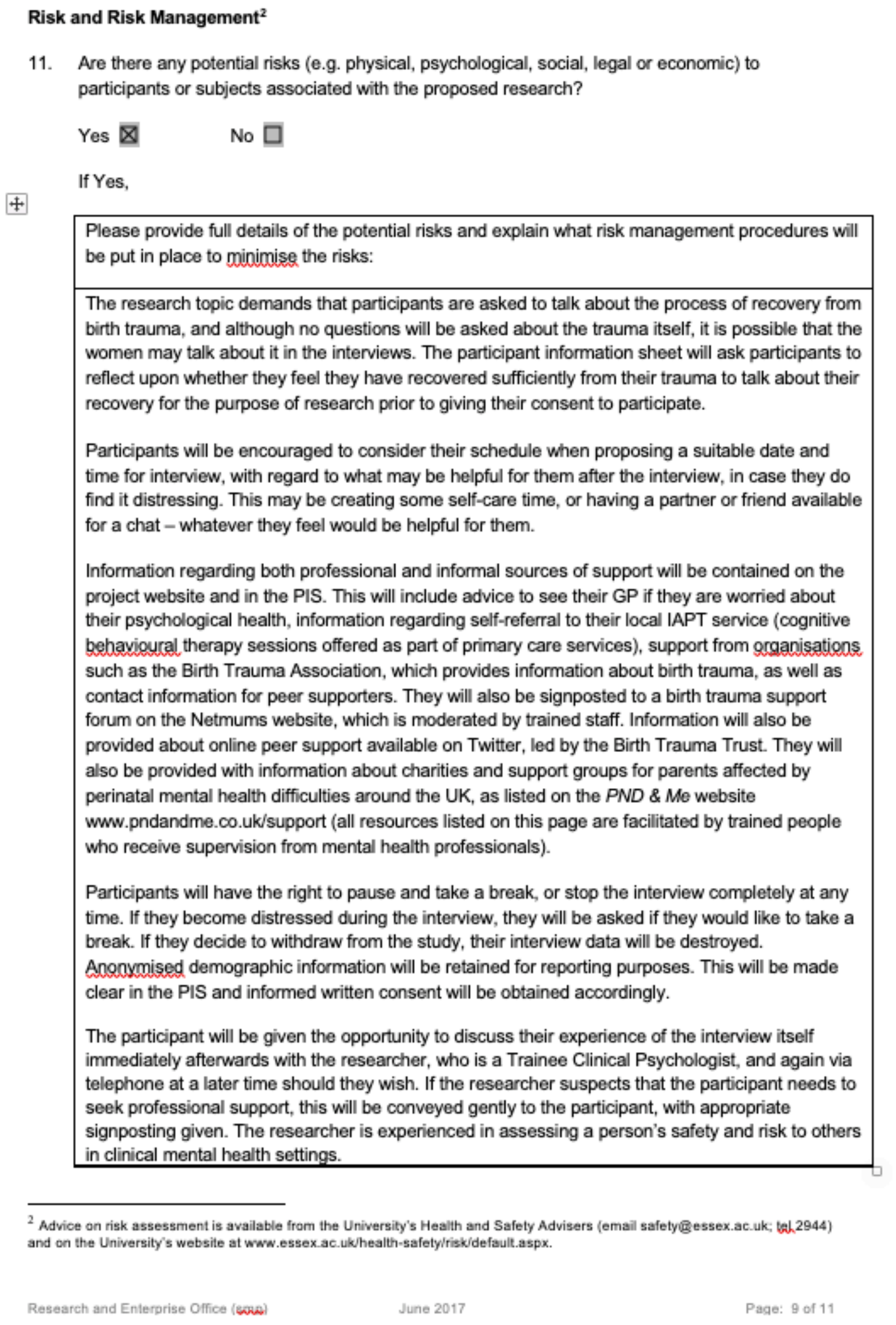

Risk and Risk Management[2]

11. Are there any potential risks (e.g. physical, psychological, social, legal or economic) to participants or subjects associated with the proposed research?

Yes ☒ No ☐

If Yes,

Please provide full details of the potential risks and explain what risk management procedures will be put in place to minimise the risks:

The research topic demands that participants are asked to talk about the process of recovery from birth trauma, and although no questions will be asked about the trauma itself, it is possible that the women may talk about it in the interviews. The participant information sheet will ask participants to reflect upon whether they feel they have recovered sufficiently from their trauma to talk about their recovery for the purpose of research prior to giving their consent to participate.

Participants will be encouraged to consider their schedule when proposing a suitable date and time for interview, with regard to what may be helpful for them after the interview, in case they do find it distressing. This may be creating some self-care time, or having a partner or friend available for a chat – whatever they feel would be helpful for them.

Information regarding both professional and informal sources of support will be contained on the project website and in the PIS. This will include advice to see their GP if they are worried about their psychological health, information regarding self-referral to their local IAPT service (cognitive behavioural therapy sessions offered as part of primary care services), support from organisations such as the Birth Trauma Association, which provides information about birth trauma, as well as contact information for peer supporters. They will also be signposted to a birth trauma support forum on the Netmums website, which is moderated by trained staff. Information will also be provided about online peer support available on Twitter, led by the Birth Trauma Trust. They will also be provided with information about charities and support groups for parents affected by perinatal mental health difficulties around the UK, as listed on the *PND & Me* website www.pndandme.co.uk/support (all resources listed on this page are facilitated by trained people who receive supervision from mental health professionals).

Participants will have the right to pause and take a break, or stop the interview completely at any time. If they become distressed during the interview, they will be asked if they would like to take a break. If they decide to withdraw from the study, their interview data will be destroyed. Anonymised demographic information will be retained for reporting purposes. This will be made clear in the PIS and informed written consent will be obtained accordingly.

The participant will be given the opportunity to discuss their experience of the interview itself immediately afterwards with the researcher, who is a Trainee Clinical Psychologist, and again via telephone at a later time should they wish. If the researcher suspects that the participant needs to seek professional support, this will be conveyed gently to the participant, with appropriate signposting given. The researcher is experienced in assessing a person's safety and risk to others in clinical mental health settings.

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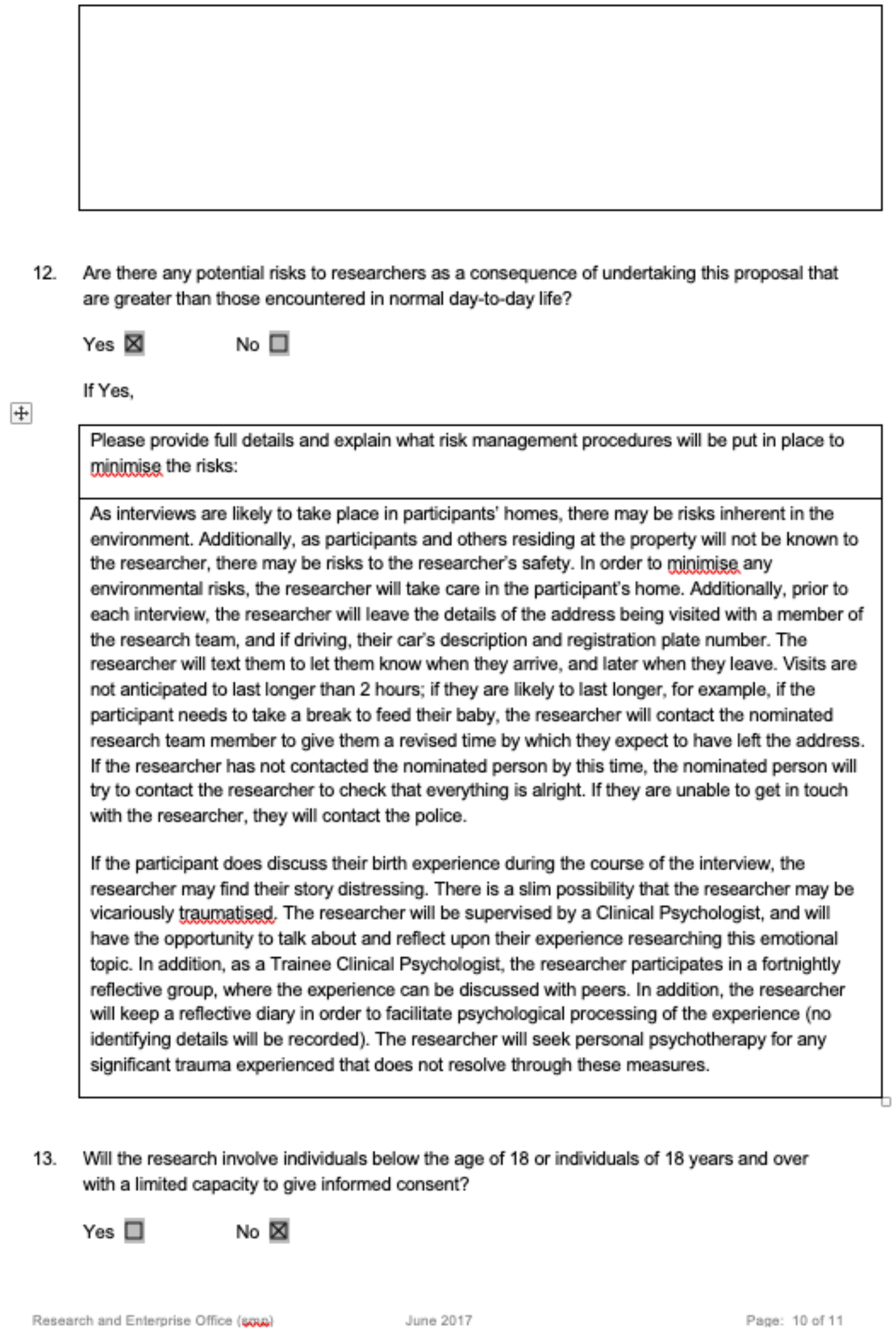
[2] Advice on risk assessment is available from the University's Health and Safety Advisers (email safety@essex.ac.uk; tel 2944) and on the University's website at www.essex.ac.uk/health-safety/risk/default.aspx.



12. Are there any potential risks to researchers as a consequence of undertaking this proposal that are greater than those encountered in normal day-to-day life?

Yes ☒ No ☐

If Yes,

Please provide full details and explain what risk management procedures will be put in place to minimise the risks:
As interviews are likely to take place in participants' homes, there may be risks inherent in the environment. Additionally, as participants and others residing at the property will not be known to the researcher, there may be risks to the researcher's safety. In order to minimise any environmental risks, the researcher will take care in the participant's home. Additionally, prior to each interview, the researcher will leave the details of the address being visited with a member of the research team, and if driving, their car's description and registration plate number. The researcher will text them to let them know when they arrive, and later when they leave. Visits are not anticipated to last longer than 2 hours; if they are likely to last longer, for example, if the participant needs to take a break to feed their baby, the researcher will contact the nominated research team member to give them a revised time by which they expect to have left the address. If the researcher has not contacted the nominated person by this time, the nominated person will try to contact the researcher to check that everything is alright. If they are unable to get in touch with the researcher, they will contact the police. If the participant does discuss their birth experience during the course of the interview, the researcher may find their story distressing. There is a slim possibility that the researcher may be vicariously traumatised. The researcher will be supervised by a Clinical Psychologist, and will have the opportunity to talk about and reflect upon their experience researching this emotional topic. In addition, as a Trainee Clinical Psychologist, the researcher participates in a fortnightly reflective group, where the experience can be discussed with peers. In addition, the researcher will keep a reflective diary in order to facilitate psychological processing of the experience (no identifying details will be recorded). The researcher will seek personal psychotherapy for any significant trauma experienced that does not resolve through these measures.

13. Will the research involve individuals below the age of 18 or individuals of 18 years and over with a limited capacity to give informed consent?

Yes ☐ No ☒

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If Yes, a Disclosure and Barring Service disclosure (DBS check) may be required.[3]

14. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of the Faculty Ethics Sub-Committee and/or University Ethics Committee.

References

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.

Bauer, A., Parsonage, M., Knapp, M., Iemmi, V., & Adelaja, B. (2014). Costs of perinatal mental health problems. Retrieved from http://eprints.lse.ac.uk/59885/1/__lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer,_M_Bauer_Costs_perinatal_mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

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.

Heron, J., Gilbert, N., Dolman, C., Shah, S., Beare, I., Dearden, S., . . . Ives, J. (2012). Information and support needs during recovery from postpartum psychosis. *Arch Womens Ment Health, 15*, 155-165. doi:10.1007/s00737-012-0267-1

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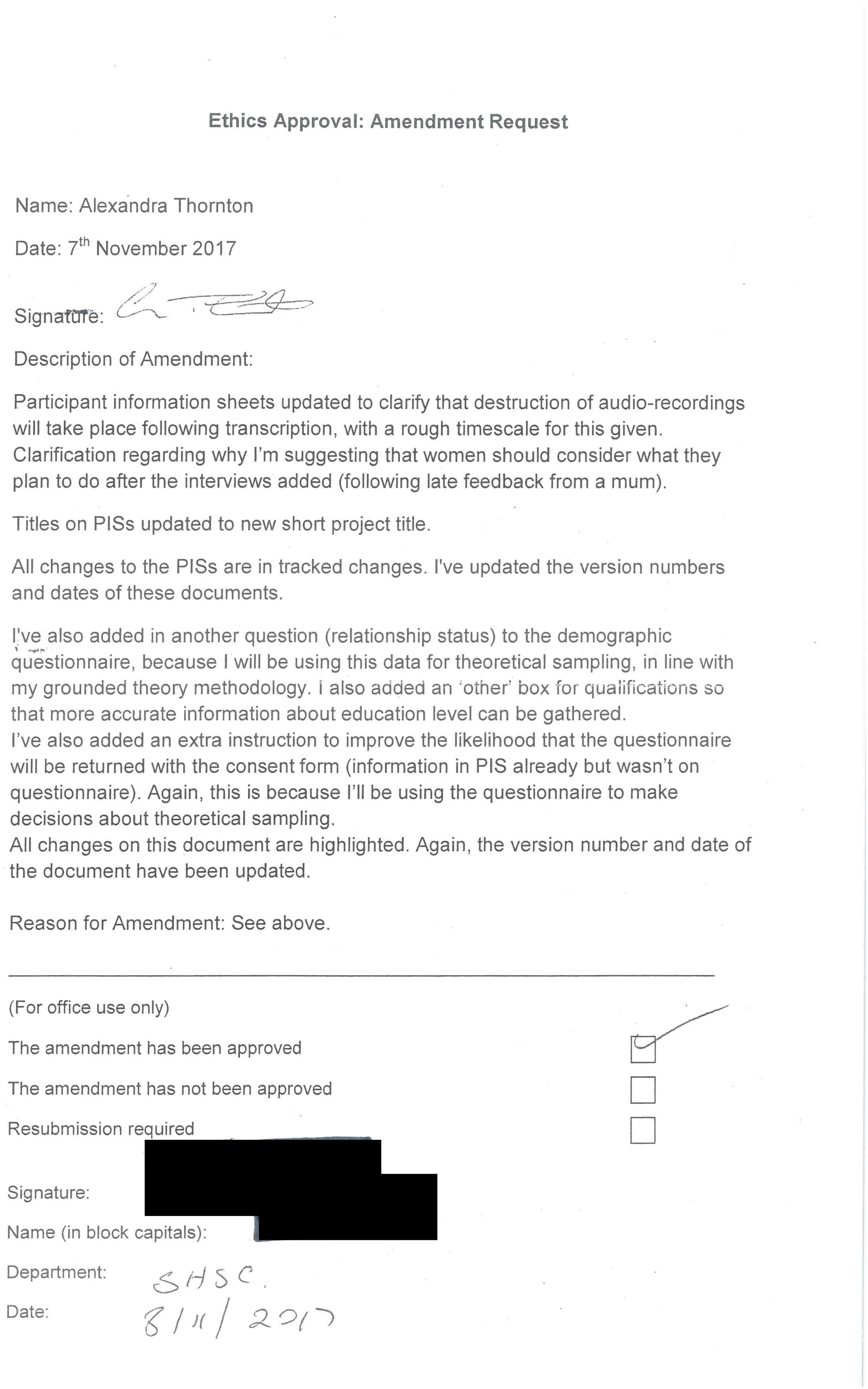
[3] Advice on the Disclosure and Barring Service and requirement for checks is available: (1) for staff from Employment Compliance Manager in Human Resources (email lauren@essex.ac.uk; tel 3508) and on the University's website at http://www.essex.ac.uk/hr/policies/docs/CRBdocumentpolicy.pdf; (2) for students from the University's Academic Section.



Ethics Approval: Amendment Request

Name: Alexandra Thornton

Date: 7th November 2017

Signature:

Description of Amendment:

Participant information sheets updated to clarify that destruction of audio-recordings will take place following transcription, with a rough timescale for this given. Clarification regarding why I'm suggesting that women should consider what they plan to do after the interviews added (following late feedback from a mum).

Titles on PISs updated to new short project title.

All changes to the PISs are in tracked changes. I've updated the version numbers and dates of these documents.

I've also added in another question (relationship status) to the demographic questionnaire, because I will be using this data for theoretical sampling, in line with my grounded theory methodology. I also added an 'other' box for qualifications so that more accurate information about education level can be gathered.
I've also added an extra instruction to improve the likelihood that the questionnaire will be returned with the consent form (information in PIS already but wasn't on questionnaire). Again, this is because I'll be using the questionnaire to make decisions about theoretical sampling.
All changes on this document are highlighted. Again, the version number and date of the document have been updated.

Reason for Amendment: See above.

(For office use only)

The amendment has been approved ☑

The amendment has not been approved ☐

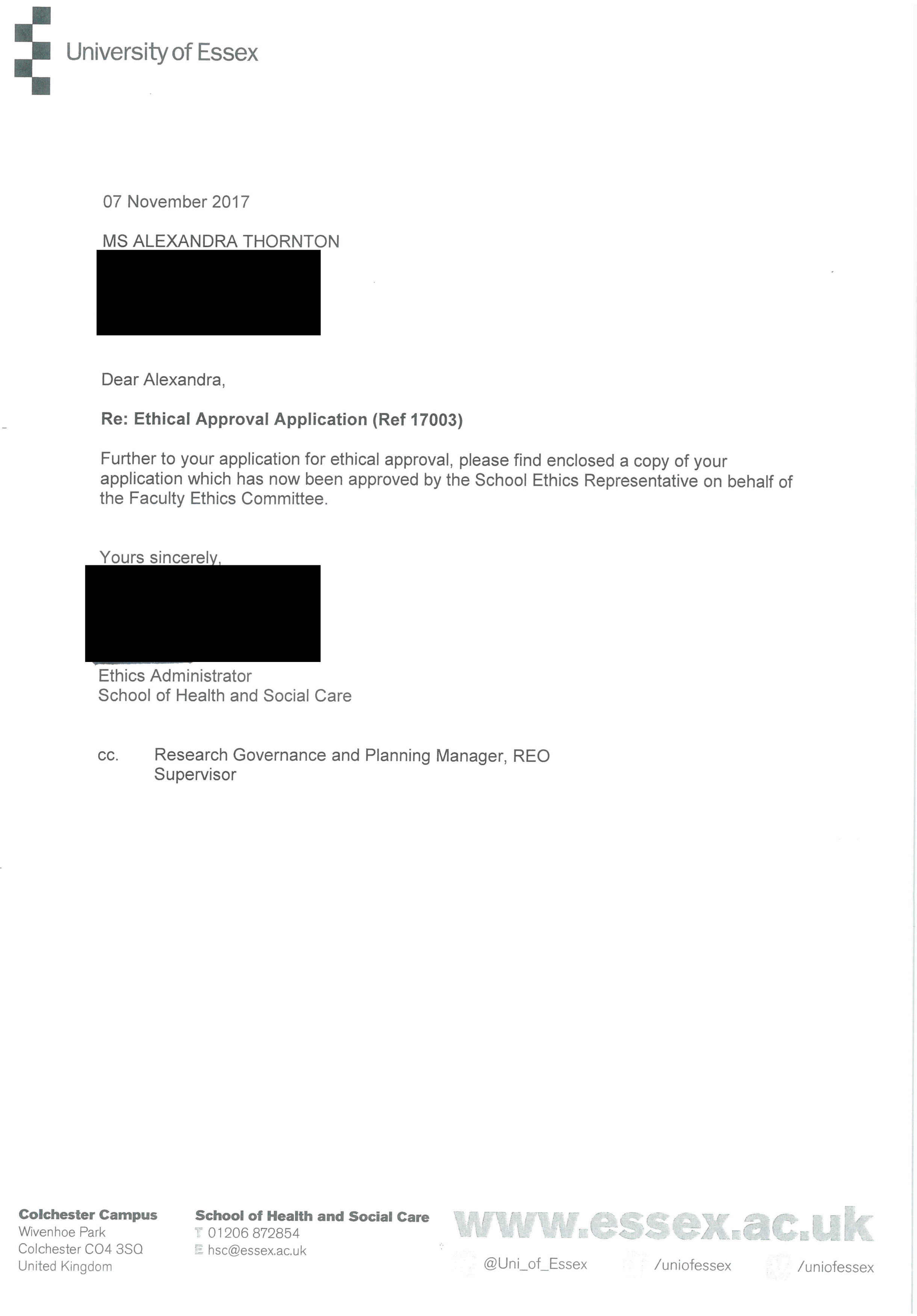
Resubmission required ☐

Signature: [redacted]

Name (in block capitals): [redacted]

Department: SHSC.

Date: 8/11/2017



University of Essex

07 November 2017

MS ALEXANDRA THORNTON
[redacted]

Dear Alexandra,

Re: Ethical Approval Application (Ref 17003)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Representative on behalf of the Faculty Ethics Committee.

Yours sincerely,

[redacted]

Ethics Administrator
School of Health and Social Care

cc. Research Governance and Planning Manager, REO
Supervisor

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom

School of Health and Social Care
T 01206 872854
E hsc@essex.ac.uk

www.essex.ac.uk
@Uni_of_Essex /uniofessex /uniofessex

Ethics Approval: Amendment Request

Name: Alexandra Thornton

Date: 13th March 2018

Signature:

Description of Amendment:

Participant information sheets updated to:

1) Increase the maximum time elapsed since the traumatic birth from five to ten years. This is following further consideration of the need to balance accurate recall about the recovery process with the literature, which reports that recovery may take significantly longer than five years. The impact of subsequent births on recovery, and the fact that many women will delay having further children for many years following birth trauma is also documented in the literature. It is now felt that limiting the eligibility criteria to women whose births were less than five years ago will significantly limit the ability of the research to capture the diversity of women's experiences.

2) Remove information about Birth Trauma Chat on Twitter, as this no longer takes place.

Demographic questionnaire updated to include a question on parity, and to slightly amend phrasing of questions.

All changes to the documents are in tracked changes. The version numbers and dates of the documents have also been updated.

Reason for Amendment: See above.

(For office use only)

The amendment has been approved ☑

The amendment has not been approved ☐

Resubmission required ☐

Signature: [redacted]

Name (in bloc

Department: SH.SE. 21/3/18

Appendix F

Topic guide – Recovery from birth trauma

Discussion of ethical considerations, steps to protect anonymity.

Any questions before we start?

Could you begin by telling me a bit about your experience of recovery from birth trauma, starting from whichever point you feel it began?

Significant events
- ‘Turning points’
- Birth anniversary/Child’s birthdays – separating the two
- Subsequent pregnancy/birth

Relationships:
- Role of relationship with baby in recovery
- Relationships with peers
    - mum and non-mum friends
    - parent and baby groups
    - online communities/peer support
- Relationship with partner
- Relationships with other family members
- Relationships with healthcare professionals

Work/Occupations:
- Return to work
- Occupational identity
- Hobbies

Societal expectations & judgements
- Stigma
- Self-stigma

Self-identity

Diagnosis

Healthcare
- Treatments – therapy, medication - Offered help?
- Gynaecological procedures/check-ups/aftercare
- Validation, apology?

Physical/body
- Role of sleep
- Bodily changes
- Injury to woman or baby

Self-care

Spirituality

Anything I haven't raised?

Reflection on interview

Signposting if indicated

REMEMBER TO ASK VERBAL CONSENT FOR FOLLOW UP QUESTIONS

Appendix G

X demonstrates holding the depressive position, as she talks about how remembering that some of the care she received was amazing, and that some HCPs were really kind to her. Moving from the paranoid schizoid to the depressive position, echoing Klein’s object relations theory. Also so important to connect with the goodness in humanity and in the world - this as reconstructing core beliefs that were once shattered, so that they can hold more nuance and be less rigid. Fits in with Herman’s hypothesis about importance of connecting with others, as well as Foa’s reconstruction of core beliefs hypothesis.

Women talking about the value of just wanting to talk, not have someone problem-solve appears to be about making sense in their own minds. Being heard, validated.

There is a sense of loss, of changing realities and perspectives, that things you thought were important, or a truth or reality in themselves were not perhaps as you thought. The world you had constructed, the participant's sense of trust and truth in relationships with others, is unstable, cracks she can see through that lead her to doubt her old sense of reality. Everything changes, the self changes, and how the self perceives things changes too.

X speaks about her anger at learning that her experience of pain during labour would not be considered during clinical decision making. Woman's wellbeing unimportant, woman as vessel and not much more. Similar to the PND literature where women report that they were made to feel like vessels, with health professionals only interested in the baby’s health.

X describing her interaction with a mental health worker, who appears to name eligibility for concern in terms of safety, cleanliness, being dressed. Would these be said if it was easier to get help from the NHS. Would staff be justifying why they can’t help and pushing away, cloaked in terms of reassurance if more support were available?

Kindness surfacing as a theme a lot. Making me reflect on what I prioritise in my own therapy sessions. I noticed kindness is part of Make Birth Better’s model, so it must be something that others have noted too. Also, X talking about the fragmenting nature of trauma, the challenge of holding both the awfulness and the safety of the present at the same time - this is the depressive position. And that if people find it harder to hold a depressive position before trauma, then trauma places an acute challenge upon the person, and this is why the healing is mostly in the relationship, and why kindness is so important. When people are kind to us we feel special, and important, like mothers are supposed to make us feel. There's a sense of safety, in that somebody is putting in a real effort to put you before them often.

Thinking about the impact of dehumanising, unkind, uncompassionate care subsequent to traumatic event – perhaps changing the appraisal of how at risk the woman and her baby were? Shifting schemas about people who are supposed to be caring, adding to a sense of 'my life could be taken for me in a second, when it was all going so well/normal this morning', with that sense that the people in the world are not what you thought they were too. This chimes with Ratcliffe et al.'s paper on the loss of inherent trust of the world in trauma.

X identifies that the nature of her two traumas was different. One was 'is my baby going to die?', which was soothed to an extent at birth when baby was fine. One was more about faith in humanity being shattered. If you can't trust healthcare staff, people who WANT to look after mums and babies, who can you trust? What is the world? The difference in the nature of trauma is striking – both involved fear of loss of life but it is the second, the more social trauma, that was ultimately more traumatic.