Women's experiences of traumatic birth and its impact on early post-partum adjustment.

Rachael Baker MA (hons), MSc

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

School of Health and Wellbeing

College of Medical, Veterinary and Life Sciences

University of Glasgow

March 2025

Table of Contents

List of Tables

List of Figures

Acknowledgements

Firstly, I would like to recognise and thank the friends and patients who have openly shared their experiences of navigating traumatic birth and made me so passionate about understanding and improving experiences of and outcomes after birth. Thank you to all the women who participated in this project, I am so grateful for your openness and for trusting me to tell your story.

To my academic supervisor Professor Andrew Gumley, you have been such a patient, kind and encouraging support, especially over the last couple of months when things were particularly difficult for me. Your insight and expertise have been invaluable, and I am eternally grateful to you for helping me to produce such important work. A huge thank you also to my field and clinical supervisor Dr Marisa Forte, for teaching me everything I know about maternity care and fuelling my passion for it. Thank you for holding space for my 'worry of the week' and for being a supportive and encouraging voice of reason. Thank you also to Paul Cannon for your support navigating my search strategy and to Claire for taking the time to be my second reviewer.

I am so grateful also to Wendy, Kelly and all the health visitors and midwives who showed an interest and agreed to support the project. You do such wonderful and important work. Thanks too to Dr Rachel King, for all your informal support, encouragement and for the laughs. I have learned so much from you over the last year. To Nicola also, for taking time to help me to understand my admin, without you I'm sure I'd still be very confused.

To my parents, for everything you have done for me and for always believing in me even when I didn't believe in myself. You have both shown incredible strength this year and I am so proud of you. I know that I have and will continue to make you both proud of me too.

To the girls, for providing endless nonsense, but also for checking in and being there for me through some of the hardest months despite navigating your own challenges. I don't know what I'd do without you, and I can't wait to see what this next chapter of our lives brings.

Finally, to my fiancé for your endless love and support over 10 years of lost weekends and evenings while we both navigated our degrees. Thank you for knowing how I felt and what I needed before I knew myself. Thank you for being so kind, but also for being such good fun and helping me to laugh through some really tough times. I cannot wait to marry you.

Chapter 1: Systematic Review

Women's experiences of birth trauma: A systematic review

Prepared in accordance with the author requirements for Qualitative Research

Author Guidelines

Abstract

This review aimed to provide an up-to-date critical synthesis of the current literature base exploring women's experiences of traumatic birth. A pre-planned systematic search with no date restrictions was conducted on 13 September 2024. Studies were screened by title and abstract then by full text. Quality appraisal was used to organise studies of which findings were synthesised using thematic synthesis. 14 studies were included in the review. Three themes were generated highlighting that while women experience the physical act of childbirth and associated complications to be distressing, traumatic birth is largely influenced by interactions with the healthcare system. Woman-centred, trauma-informed care may mitigate the impact of a traumatic birth experience. Global healthcare policy should ensure that women have a legal right to a safe, and respectful childbirth free of discrimination and that adequate resource is allocated to maternity services to enable them to uphold women's human rights in childbirth.

Keywords: Birth; birth trauma; thematic synthesis; systematic review; maternity care

Introduction

Research suggests that approximately one third of women perceive their experience of childbirth to have been traumatic (Ayers, 2004). Definitions of birth trauma within the literature base have evolved over the last 20 years. Beck (2004) defined birth trauma as "*an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror*". In recent years, there has been a recognition that factors which may contribute to birth trauma extend further than this definition, for example interpersonal interactions (Olza et al., 2018). In recognition of this Leinweber et al. (2022) collaboratively redefined birth trauma to be inclusive of all experiences and interactions relating to birth that may cause a women distress: "*A traumatic childbirth experience refers to a woman's experience of interactions and/ or events directly related to childbirth that caused overwhelming distressing emotions and reactions; leading to short and/ or long- term negative impacts on a woman's health and wellbeing*" (p.691).

A traumatic birth can have a lasting impact on women and their loved ones. Women who have a traumatic birth experience may experience difficulties with their mental health (Elmir et al., 2010). Research suggests that between 3%-19% of women will go on to develop Post Traumatic Stress Disorder (PTSD) because of their birth (Yildiz et al., 2017). Women may also experience difficulties with mother-infant bonding (Nicholls & Ayers, 2007; Stuijfzand, Garthus-Niegel, & Horsch, 2020) partner relationships (Ayers et al., 2006; Moyzakitis, 2004) and may develop Tokophobia (Dencker et al., 2019), a fear of childbirth that can have implications for future family planning. Several factors have been identified as increasing risk of PTSD. These include complications with labour and delivery, pain, duration of labour (Grekin and O'Hara, 2014), surgical delivery, dissociation (Ayers et al., 2016) and quality of interactions with medical staff (Grekin and O'Hara, 2014; Ayers et al., 2016).

Over the past decade in the UK there has been increased awareness of birth trauma following several investigations into maternity care failings across NHS trusts (All-Party Parliamentary Group on Birth Trauma [APPGBT], 2024). In 2024 a national inquiry was established to investigate the causes of traumatic childbirth experiences in the UK and to support amendments

to policy (APPGBT, 2024). The inquiry concluded that although most individuals who contributed had experienced a medical emergency, this was not necessarily the defining feature of their trauma. In their summary of key themes, lack of pain relief was the only theme directly related to medical factors. Most findings related to interactions with the healthcare system such as not feeling listened to, lack of informed consent and poor communication.

Qualitative research can provide important insights into birth trauma that cannot be captured quantitively. A recent scoping review (Watson et al., 2021) found that interactions with the healthcare system, perceptions of control, and social support contributed to women's experiences of birth trauma. They emphasised the importance of individualised care during birth to support women to feel in control and informed. The most recent systematic review of qualitative research exploring women's experiences of birth trauma (Elmir et al., 2010) found that women are more likely to perceive their birth as being traumatic if their opinions, values and rights were ignored during the birth, they had no control over their birth experience, and they felt they had been treated "inhumanely". While the findings of this review are insightful, it has several limitations. Details of the search strategy were vague, which creates issues for reproducibility and limits transparency. Despite discussion of the quality appraisal process, authors did not explicitly detail the quality appraisal tool or criteria used, making it difficult to reproduce their findings. Studies perceived to be of lower quality were excluded from synthesis, however it is argued that quality appraisal may not assess the meaningfulness of studies and that authors may exclude studies that may provide valuable insights into the research issue (Sattar et al., 2021). All papers included in the review were conducted in western countries meaning that the review was unlikely to capture the diversity of experiences across different cultural and healthcare contexts. Non-western populations may provide unique insights that are absent in western health contexts. These limitations may serve to compromise the credibility of the findings.

To improve outcomes for women in birth, it is crucial to continue to develop an understanding of the factors that contribute to a traumatic birth experience as healthcare evolves. Despite a growing number of studies being published exploring women's experiences of birth trauma, there have been no systematic reviews of the literature base published since 2010. During this time, definitions of birth trauma have evolved, and more recent research may capture a wider breadth of childbirth events and interactions which may provide further insights into how women

experience traumatic birth. This systematic review aims to provide an up-to-date critical synthesis of the current literature base exploring women's experiences of traumatic birth, and where relevant, provide evidence-based recommendations that may serve to improve the provision of maternity care both pre and postnatally.

Methods

Registration

The protocol for this systematic review was registered with the International Prospective Register of Systematic Reviews (PROSPERO) on 13 August 2024 (CRD42024555515) and reported in line with PRISMA guidelines (Page et al., 2021) (Appendix 1.1). The Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) guidelines (Tong et al., 2012) (Appendix 1.2) were also followed to ensure transparency of reporting throughout the review.

Search Strategy

Data sources

A pre-planned systematic search with no date restrictions was conducted on 13 September 2024. The following databases were searched: CINAHL, PsycINFO, Psychology and Behavioural Science Collection, EMBASE, Medline, and Web of Science Core Collection. These databases cover healthcare, psychology, and interdisciplinary and emerging research which allows for the identification of comprehensive research around birth trauma. Databases were searched individually instead of a multiple database search to reduce the chance of papers being missed due to conflicts of index terms within each database. Reference lists from identified articles were hand searched for additional papers, as well as reference lists from systematic reviews and meta-analyses conducted on similar topics.

Search terms

Search terms were formulated using the SPIDER framework. Boolean logic was used to increase the sensitivity and specificity of the search. Support developing the strategy was sought from a specialist librarian from the University of Glasgow. A preliminary search found that searching for the terms relating to the sample excluded papers that did not refer to "women".

The following key concepts were searched:

- Childbirth
- Psychological Trauma
- Qualitative Research

A detailed account of search terms and the full electronic search strategy can be found in Appendices 1.3 and 1.4.

Inclusion criteria

- Qualitative research studies exploring women's experiences of traumatic birth.
- Participants are women who have given birth and self-identify their childbirth experience to have been traumatic.
- Experiences of birth trauma are captured using narrative data collection approaches such as interview, focus groups, written reflections and surveys.
- Conducted in any setting.
- Published after October 2010
- Published in English or with English translations available.
- Published in peer reviewed journals

Exclusion criteria

- Studies that do not focus specifically on women's experiences of traumatic birth.
- Studies that do not use women as participants. E.g. research focusing on childbirth experiences of healthcare providers, partners, or family members.
- Studies that do not use women's accounts of their birth i.e. the accounts of healthcare providers, partners, or family members.

- Studies that focus on interventions related to traumatic birth.
- Studies that use primarily quantitative methods or do not provide qualitative data.
- Published before October 2010
- Not published in English without available translation.
- Not published in peer reviewed journals.

Review process

Study Screening

Database searches were completed by the lead researcher and citations were stored on EndNote. Duplicates were identified and removed electronically and manually. The search results were screened by title and abstract, in line with the inclusion criteria and exclusion criteria. Where it was unclear if an article should be included, the full article was identified for retrieval.

Where abstracts met the inclusion criteria, the full text was retrieved. References and full text articles were uploaded on to Rayyan and read in detail to ensure their relevance, and any irrelevant papers were excluded. All full text exclusions were reported in sufficient detail to report to PRISMA standards. 100% of the retrieved articles were checked by an independent reviewer via the Rayyan software to ensure that they met the inclusion and exclusion criteria.

Data extraction

Information was extracted from the included papers by hand and recorded electronically using a standardised data extraction form.

Data extracted included:

- Study characteristics: study title, authors, year of publication, research design, data collection method, data analysis methods.
- Study sample: sample size, sampling method, population, age range, setting, ethnicity.
- Study findings: all text was extracted from the "results" or "findings" section of the included studies to a word document.

The accuracy of the extracted data was verified by a second reviewer for four of the included studies.

Quality appraisal

Each study was appraised for methodological quality and risk of bias using the Critical Appraisal Skills Programme (CASP) Qualitative Studies Checklist (Critical Appraisal Skills Programme, 2023) (Appendix 1.5) as recommended by the ENTREQ guidelines (Tong et al., 2012). A second reviewer independently appraised four studies to ensure reliability. To ensure consistency across appraisers, the independent reviewer took a sample of studies of varying quality ratings.

Exclusion of studies based on methodological quality may lead to the exclusion of meaningful data (Sattar et al., 2021). Therefore, quality appraisal results were used to group studies based on quality and subsequently organise thematic synthesis (Long et al., 2020). The CASP tool does not provide cut offs for determining quality, therefore the author established cut offs for the CASP to plan the order of synthesis.

Data synthesis

The review aims to synthesise the current literature base to develop a further understanding of experiences of traumatic birth by summarising and presenting the existing qualitative findings without interpreting or generating new theories. Therefore a 'thematic synthesis'(TS) approach was used to answer the research question, following the methodology proposed by Thomas and Harden (2008). As the research in this area is currently limited, TS allowed for an overview of the current research landscape. The results of the quality appraisal were used to guide TS (Long et al., 2020). All text in the "results" or "findings" sections of each was extracted into a word document. Studies deemed to be of higher methodological quality were hand coded line by line using language that stayed close to the original data. To ensure coding remained close to the research question, any data relating to post-partum adjustment were not coded. Codes capturing similar meanings were transformed into one code and were used to code studies of medium quality. Where relevant to the review aims, new codes were developed and added to the code list. The process of deriving themes was inductive, similar codes were grouped together to form broader descriptive themes and subthemes. An initial thematic map (Appendix 1.7) was generated to explore relationships within themes prior to the establishment of the final themes. Descriptive themes were deemed adequate to answer the research question and therefore analytical themes were not generated (Thomas and Harden, 2008). Throughout the data synthesis

process, a second researcher AG was consulted through supervision to support reflexivity and the generation of themes.

Researcher reflexivity

The researcher is a white female Trainee Clinical Psychologist. The researcher's motivation to conduct this review was both personal and professional and their experiences of working as a trainee within a Maternity and Neonatal Psychological Interventions Service (MNPI) has heightened their awareness of the psychological impact of childbirth.

The researcher was aware that their personal and professional experiences may influence their approach to this review, particularly in the selection of studies and interpretation of findings. From their experiences, they were aware that they hold negative views of childbirth and have an existing knowledge from clinical practice of the ways in which birth trauma may be experienced by women. It is possible that this could have led to a prioritisation of studies which fitted with their own views and clinical observations. To address this, explicit and transparent inclusion criteria were developed, an independent reviewer was utilised to ensure that the studies selected met the inclusion criteria, and they engaged in regular reflective discussions in supervision to challenge assumptions. Throughout the review process a reflexive journal was maintained to document thoughts and decisions to ensure an awareness of their influence on the review. Regular supervision was used to ensure that interpretations were grounded in the data rather than being shaped solely by experiences and perceptions.

Results

Data screening

The search process initially identified 8919 articles. After deduplication, 4064 articles were screened by title and abstract. 4034 articles were excluded. 30 reports were retrieved for full text screening and assessed for eligibility. An independent reviewer (CM) screened all the retrieved articles with an interrater agreement of 93%. Any discrepancies were discussed and resolved. 16 were excluded as they did not meet the inclusion criteria. Hand searching of 726 citations identified four articles which were retrieved and assessed for eligibility. All four articles were

assessed as not being eligible for inclusion and were excluded. 14 studies were included in the quality appraisal and data synthesis. A PRISMA (2020) diagram outlining this process can be found in Figure 1.1.

Study characteristics

Table 1.1 summarises the study characteristics. Accuracy of extraction from four papers was checked by CM with interrater agreement of 100%. Studies were published between 2014 and 2024. Studies were conducted in the UK (n=3), USA (n=2), Norway (n=2), Turkey (n=2), Iran (n=2), Spain (n=1) and Sweden (n=1). One study (Reed et al., 2017) conducted in Australia, also recruited participants from the USA, South America, Asia, South Africa and the Middle East.

The total number of participants across studies was 1,057. All participants were female aged between 18 -77 years. Time from birth varied from 20 hours post-partum to 32 years. Ethnicity was not reported for 98% of participants. Reported participant ethnicities were Iranian (n=43), White (n=17), Mixed Race (n=1) 'Other' (n=1), Black (n=2) and African American (n=6).

Studies were qualitative (n=10), mixed methods (n=3) and one was a qualitative paper which existed as part of a larger mixed methods study. Data was collected through semi-structured interviews (n=10), questionnaires or online surveys (n=3), and podcast interviews (n=1). Methods of analysis were thematic analysis (n=7), content analysis (n=4), interpretative phenomenological analysis (n=1), contrapuntal analysis (n=1), and narrative analysis (n=1).

Figure 1: PRISMA Diagram

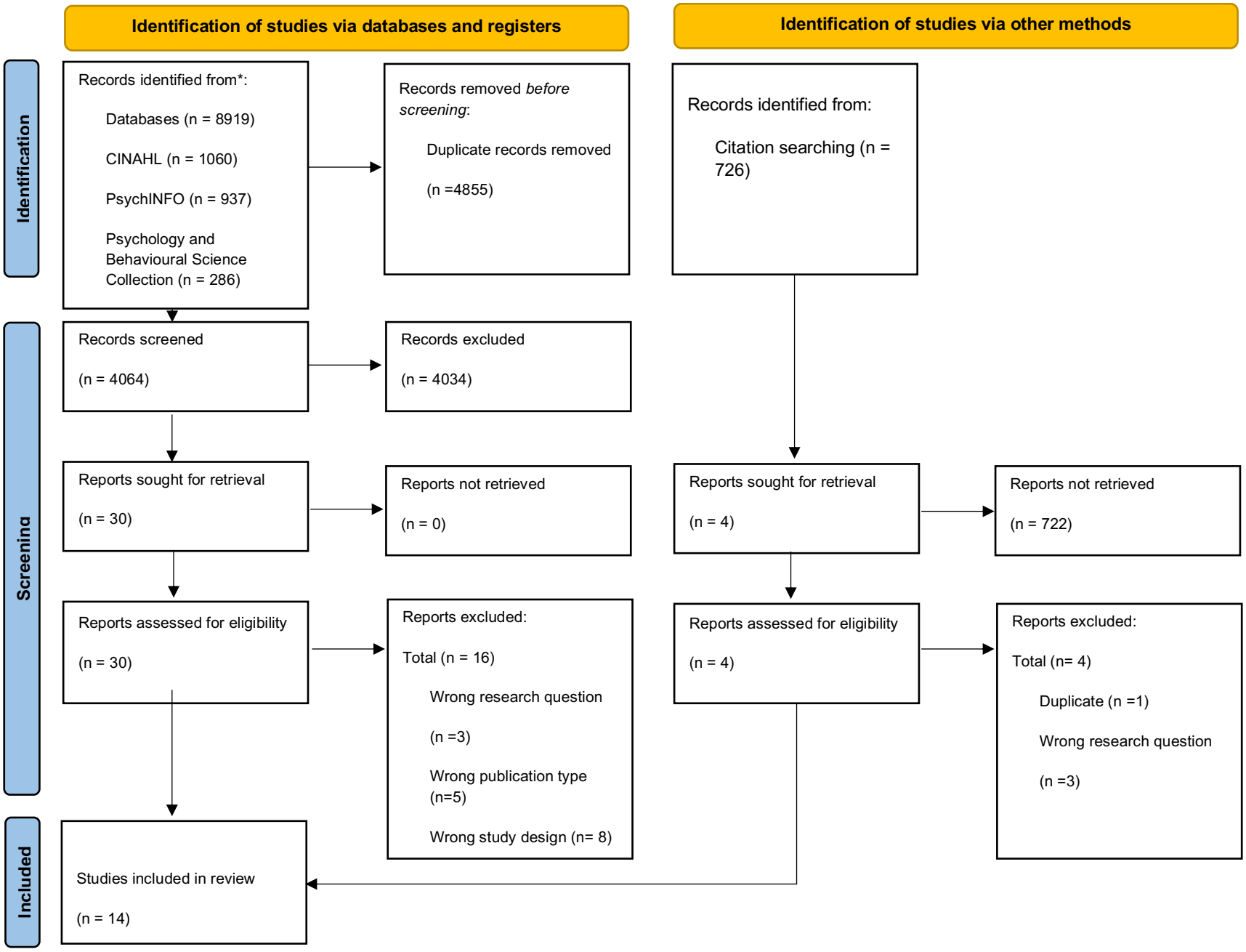


Table 1: Study characteristics

Author/s, Year, Title & Place	**Sample Characteristics**	**Design & Methodology**	**Qualitative Findings Themes & subthemes**
1. Aksu and Sercekus (2023) Turkey	16 women within 6 months post-partum Purposive sampling Mean age= 25.25 (Range 18-32) Ethnicity = not reported (N/R)	Qualitative Demographic form Semi-structured interview (Setting= telephone) Content analysis	Reasons for traumatic childbirth • Fear of childbirth • Negative childbirth environment • Severe pain • Obstetric interventions. The Effects of Traumatic Childbirth • Postpartum Discomforts • Fear of Childbirth Developing Connected to Traumatic Childbirth Coping • Social Support • Coping Behaviours • Religion

2.
Aktas and Aydin (2019)
 	
Turkey
	11 women
	20-24 hours post-partum
	
	Purposive sampling
	
	Mean age= 27.45 (Range= 21-35)
	
	Ethnicity= N/R
		Qualitative
		
		Demographic form
		Semi-structured interview
		(Setting= maternity unit)
		
		Thematic Analysis
			• Challenges/difficulties encountered
			  ○ Inability to cope with birth pains
			  ○ Inability to push
			  ○ Interventions applied during labour
			  ○ Hunger
			• Embarrassment/privacy
			  ○ Vaginal examination
			  ○ Gynaecological examination by a male doctor
			• Inadequate communication
			• Inadequate hospital facilities

3. Baptie, Andrade, Bacon, and Norman (2020) UK	14 women 3-5 months post-partum Criterion sampling Mean age= N/R (Range= 24-41) Ethnicity= White (86%), Mixed race (7%), Other (7%)	Qualitative Semi-structured interview (Setting= telephone) Thematic analysis	Empowered • Trust o Personalised care o Listened to and respected o Partner support • Control o Vocalised needs/wishes o Working with the body o Active role in decisions made • Informed o Knowledge is power o End justifies the means Powerless • Distrust o Impersonalised care o Ignored o Let down • Lacked control o No choice o Disconnected o Undignified o Fearful • In the dark o Poor communication o Limited antenatal or postnatal information
4. Baxter (2020) UK	16 women 8 months – 3 years post-partum Mixed sampling approach	Qualitative Semi-structured interview (Setting= 16/15 at home)	• Giving birth as traumatic/horrific o Medical interventions o The pain of labour o The effect of poor staff communication • Lasting emotions linked to the birth process

	Mean age= N/R (Range= 20-39) Ethnicity= N/R	Thematic analysis	○ Anger ○ Fear of giving birth again ○ Living in an emotional bubble • The impact of the health professional on women's experiences of giving birth ○ Trust in staff ○ The need for more sensitive communication ○ Relationships with staff ○ Supported by staff ○ The need for information
5. Byrne, Egan, Mac Neela, and Sarma (2017) Norway	7 women Within 12 months post-partum Convenience sampling Mean age= 31 (Range= 27-35) Ethnicity=N/R	Mixed methods Quantitative: PCL-5 Edinburgh Postnatal Depression Scale Qualitative: Semi-structured interview Interpretative Phenomenological Analysis	Superordinate theme: What about me? The loss of self through the experience of traumatic childbirth. • The 'I' in childbirth ○ Active and informed ○ Undermined and excluded • Dismissed, dehumanised and passive • Detached self ○ Distant mother 'Elvis has left the building' ○ Coping through detachment • Us against them ○ Self as altered ○ Self as stuck
6. Cronin-Fisher and Timmerman (2023) USA	41 post-partum women Secondary data sampling Mean age=N/R	Qualitative Data taken from birth podcast interviews with birth trauma as central theme	Dominant Discourse: Traumatic Birth as Incongruent with Intensive Motherhood ○ Bad birth is something that happens to you ○ Bad birth disconnects mind and body ○ Bad birth is isolating and unnatural Marginalized Discourse: Individualism

	(Range= N/R) Ethnicity= N/R (95%), Black (5%)	Contrapuntal analysis	
7. Evans (2024) USA	6 women One-year post-partum Purposive sampling Mean age= N/A (Range= 26-41) Ethnicity= African American (100%)	Qualitative Semi-structured interview (Setting= N/R) Thematic analysis	• Feeling alone • Feeling misunderstood • Doubting oneself/feeling incapable • Loss of hope • Feeling angry • Prompt to action

8.
Henriksen, Grimsrud, Schei, and Lukasse (2017)
 	
Norway
	Quantative:1352 women
	Qualitative:103 women
	
	Convenience sampling
	
	Mean age=N/R (Range= N/R)
	
	Ethnicity=N/R
		Mixed methods
		
		Quantitative:
		Demographic questionnaire
		Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ)
		Edinburgh Depression Scale (EDS-5)
		
		Cross-tabulation
		Pearson' chi-squared
			• Complications for mother, child or both
			  ○ Complications
			  ○ Wrong treatment and follow up
			  ○ Satisfied despite everything
			• Not being seen or heard
			  ○ Being left alone
			  ○ Lack of participation
			  ○ Meeting the midwife
			• An experience of pain and lack of control
			  ○ The expectation of birth
			  ○ Pain, pain, pain

		Multivariate logistic regression model Qualitative: Birth experience questionnaire (Setting= questionnaires sent by mail) Thematic analysis	
9. Murphy and Strong (2018) UK	5 women (1 withdrew consent to share data) 3-8 years post birth Purposive sampling Mean age= 36.25 (Range= 30-42) Ethnicity= White British (100%)	Qualitative Semi-structured interview (Setting= consulting room (2), mutually agreed public place (2), participant's home (1)) Narrative analysis	• Experiencing birth trauma • Being invisible • Just get on with it • Making things better
10. Reed et al. (2017) Australia	748 women Convenience sampling Mean age =33.13 (Range = 18-77)	Qualitative as part of larger mixed methods study Online survey Thematic analysis	• Prioritising the care provider's agenda • Disregarding embodied knowledge • Lies and threats • Violation

	Ethnicity= N/R (Global sample)		

11.
Rodriguez-Almagro et al. (2019)
 	
Spain
	32 women
	
	Consecutive sampling
	
	Mean age= 35.5
	(Range=18-43)
	
	Ethnicity= N/R
		Qualitative
		
		Semi structured interview
		(Setting=N/R)
		
		Thematic analysis
			• Birth plan compliance
			  ○ Healthcare staff not empathetic
			  ○ Feelings of being misinformed
			• Obstetric problems
			  ○ Childbirth
			  ○ Postpartum
			• Mother-infant bond
			  ○ Skin-to-skin
			  ○ Breastfeeding
			• Emotional wounds
			  ○ Fear of things not going well
			  ○ Loneliness
			  ○ Stress and frustration
			  ○ Depression
			• Perinatal experiences
			  ○ Traumatic
			  ○ Obstetric violation
			  ○ Wonderful

12. Taghizadeh, Irajpour, Nedjat, Arbabi, and Lopez (2014) Iran	23 women 72 hours - 32 years after delivery Purposive sampling Mean age = N/R	Qualitative Semi-structured interview (Setting=N/R) Content analysis	• Childbirth suffering • Childbirth sequelae

	(Range= 18-50) Ethnicity= Iranian (100%)		

13.
Taghizadeh, Arbabi, Kazemnejad, Irajpour, and Lopez (2015)
 	
Iran
	23 women
	24 hrs -30 years after delivery
	
	Purposive sampling
	
	Mean age= N/R
	(Range= 18-50)
	
	Ethnicity= Iranian (100%)
		Qualitative
		
		Semi-structured interview
		(Setting= N/R)
		
		Content analysis
			• Human environment
			  ○ Communication with mother
			  ○ Awareness of mother's needs
			  ○ Support for mother
			  ○ Medical clinical competence
			  ○ Professional responsibility
			• Non-human environment
			  ○ Hospital's physical structure
			  ○ Hospital's equipment
			  ○ Routine care in hospital
			• Rules governing the hospital's environment

14.
Viirman et al. (2023)
 	
Sweden
	112 women
	8 weeks post-partum
	
	Purposive sampling
	
	Mean age = 31.06
	(Range =N/A)
	
	Ethnicity = N/R
		Mixed methods
		
		Quantitative:
		Review of medical records
		EQ-VAS
		Edinburgh Post-natal Depression Scale
		Traumatic Events Scale
		
		Qualitative:
		Online questionnaire
		Content analysis
			• Within the body
			  ○ Experiencing fear-based emotions
			  ○ Experiencing physical distress
			• From the outside
			  ○ Being affected by care providers' and partner's behaviour
			  ○ Being affected by bad facilities and poor organisation

Quality appraisal

All included studies were rated as being of either high or medium quality (Table 1.2). Interrater agreement following co-rating was initially 88% (35/40). Disagreements centred on adequate detail regarding clarity of aims, recruitment strategy and rigour of data analysis. After discussion between raters there was 100% agreement.

All studies included a clear statement of aims, appropriate methodology and a clear statement of findings. Most studies demonstrated appropriate research design, recruitment strategies, data collection, rigorous data analysis and adequately considered ethical issues. However, some were rated 'can't tell' due to lack of information as detailed below.

Taghizadeh et al. (2014) failed to report adequate detail regarding recruitment methods. Studies by Evans (2024), Rodriguez-Almagro et al. (2019) and Taghizadeh et al. (2014) did not account for why they chose their method of analysis. Byrne et al. (2017) did not provide information about their topic guide and data saturation. Evans (2024) did not provide information about setting or form of data and Taghizadeh et al. (2014) lacked information about setting and topic guide. Three studies (Reed et al., 2017; Aksu and Sercekus, 2023; Evans, 2024) lacked clarity regarding the derivation of themes from data.

Within five studies (Aksu and Sercekus, 2023; Aktas and Aydin, 2019; Evans, 2024; Henriksen et al., 2017; Viirman et al., 2023), authors considerations of ethical implications were unclear. Despite detailing the process of informed consent, Evans (2024) did not report ethical approvals. Cronin-Fisher and Timmerman (2023) did not include any information about ethical considerations despite using podcasts as their data source which gives rise to issues with consent and privacy (British Psychological Society, 2021).

Across all studies there were issues with reflexivity. In all but one study (Viirman et al., 2023) authors failed to acknowledge or examine their role and any potential bias within their research. Viirman et al. (2023) discussed the professional backgrounds of their authors and acknowledged the value of the mixture of professional backgrounds within their research team, however, did not detail how this influenced their study design or data analysis.

Table 2: CASP Ratings

CASP Q #	Aksu & Sercekus (2023)*	Aktas & Aydin (2018)*	Baptie et al. (2021)	Baxter (2020)	Byrne et al. (2017)	Cronin-Fisher & Timmerman (2023)	Evans (2024)	Henkriksen et al. (2017)	Murphy & Strong (2018)	Reed et al. (2017)*	Rodriguez- Almagro et al. (2019	Taghizadeh et al. (2014) *	Taghizadeh et al. (2015)	Viirman et al. (2023)
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														

Green= 'Yes', Red= 'No', Amber= 'Can't tell'

White cells indicate 'high quality' group, grey cells indicate 'medium quality' group.

*= Study has been co-rated

Thematic synthesis

The author produced three descriptive themes and seven subthemes: *Birth as a distressing physical and emotional experience, Positive vs negative maternity care, 'What about me': birth as disempowering.* A thematic diagram of the findings is presented in Figure 1.2. Appendix 1.6 illustrates the frequency of codes used in theme construction as they appear across studies and can be used to cross check synthesis. Primary data is presented within quotation marks and secondary data in italics.

Birth as a distressing physical and emotional experience

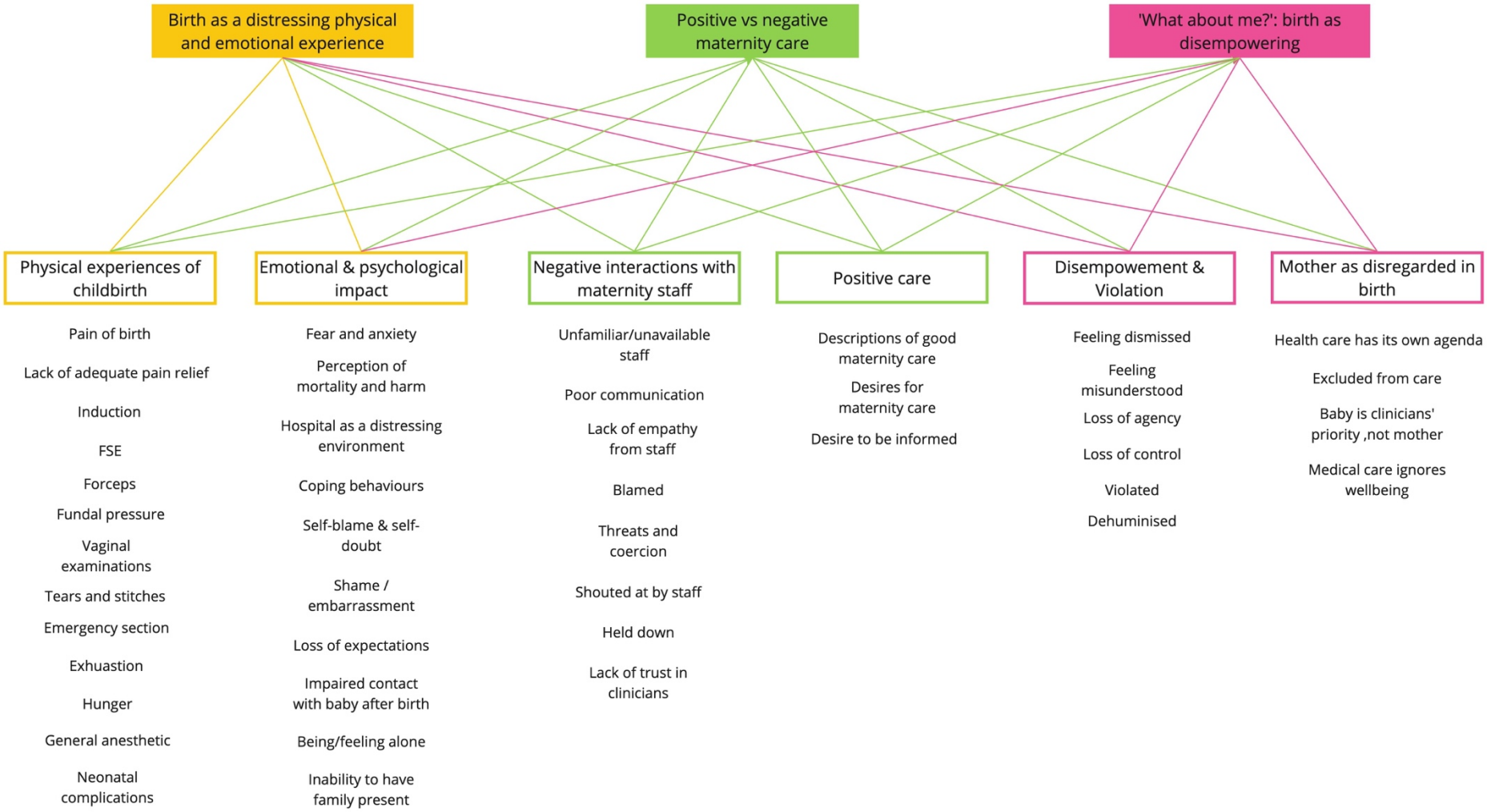
Traumatic birth is described as a distressing physical experience due to pain, obstetric interventions and complications. The physicality of birth is closely intertwined with experiences of emotional and psychological distress.

Physical experiences of childbirth

Women experienced *intense pain* (Viirman et al., 2023: , p.151) equated to burning "in hell" ('M1' Aktas and Aydin, 2019: ,p.6) and being "split in two" ('Georgia' Murphy and Strong, 2018: p.627). Some referred to the pain of instrumental birth methods, techniques such as induction, episiotomies and fundal pressure, vaginal examinations and the application of foetal scalp electrodes. Others described a lack adequate pain relief: ""I had a C-section and they began cutting before the anaesthesia had taken effect […] so I felt the pain of them cutting me and I could feel their hands opening my belly."('W14', Rodriguez-Almagro et al., 2019: p.6).

Beyond pain, birth was cited as exhausting making it harder for women to cope. In Aktas and Aydin (2019), hunger worsened this. Mothers experienced birth complications including neonatal complications and emergency interventions. Emergency c-sections were cited as a source of trauma, some were administered under general anaesthetic leading women to wake up confused, frightened and uncertain of the outcome of their birth: "I don't know that I've ever been more scared in my life as waking up in recovery by myself" ('I24' Cronin-Fisher and Timmerman, 2023: p.11). Some babies required resuscitation and stays in NICU contributing to significant anxiety and fear, while some women experienced loss.

Figure 2: Thematic Diagram



Emotional and psychological impact

Across 12 studies, women described feeling anxiety and fear during birth: “Childbirth was a difficult process for me. It was really frightening. I was afraid, very afraid.” ('8' Aksu and Sercekus, 2023: p.2). In Reed et al. (2017) the experience of birth triggered past trauma of sexual assault. Due to pain or complications, women feared they were dying or that harm would come to their baby. Some women did not know if their babies had survived. The hospital environment elicited distress due to the presence of medical instruments and it’s clinical design , as well as being an *unknown* (Aksu and Sercekus, 2023: p.4), busy and noisy environment: “[…] the woman in the room next door, who gave birth after me, also didn’t get help with the pain[…] I’m still having nightmares about hers and my screams combined.” (Viirman et al., 2023: p.149). Women described praying, gritting their teeth, closing their eyes and detaching from their experience to cope.

Some women conveyed doubt over their ability to get through labour, others described a sense of responsibility for the difficulties they had experienced in birth and blamed themselves. In both Turkish studies (Aktas and Aydin, 2019; Aksu and Sercekus, 2023), where there are cultural restrictions around women’s bodies, women reported feelings of shame and embarrassment during labour and birth, particularly in the presence of male clinicians.

Experiences of labour and birth conflicted with participants hopes and expectations: “it was exactly the opposite of everything that I had hoped and planned for my first birth experience.” ('I124' Cronin-Fisher and Timmerman, 2023: p.9). They reported being separated from or having impaired contact with their baby, or delivering under general anaesthetic, feeling that they had “miss[ed] the experience of becoming a mother” (Henriksen et al., 2017: p.36). Participants felt lonely and unsupported during labour and birth, worsened for some by an inability to have family present.

Positive vs negative maternity care

Across all studies, healthcare professionals played a significant role in experiences of birth trauma, with authors differentiating between positive and negative examples of care. Where experiences of care were positive women felt supported in birth, and both participants and authors perceived this to lessen the impact of the birth experience.

Conversely, most interactions described were negative and perceived to contribute directly to the trauma of birth.

Negative interactions with maternity staff

Women experienced healthcare professionals to be unavailable and unfamiliar contributing to feelings of anxiety and loneliness in labour and birth: "[…] there were a lot of strangers in the operating room, and my partner wasn't there. I didn't know who was who, the gynaecologist, the front desk personnel, the anaesthetist […]" ("W5"Rodriguez-Almagro et al., 2019: p.5). Nine studies identified poor communication as a source of distress. Women reported that staff did not introduce themselves to them prior to undertaking medical intervention or examinations and failed to provide a medical rationale or explanation for procedures. In Murphy and Strong (2018), poor communication meant that women were uncertain of their baby's health status: "They didn't explain anything to me, they were just taking her to neonatal to get her checked out[…] I kept waking up in the night thinking where is she? And I wasn't being told anything." ('Sarah'p.629). Other participants described being faced with *inconsistent information* (Baptie et al., 2020: p.679) and *care providers not being informed about the women's health history, or birth plans* (Viirman et al., 2023: p.151).

Staff were perceived to lack "empathy of any kind" ('W15' Rodriguez-Almagro et al., 2019: p.5) and that *they are disinterested to the point of uncaring* (Murphy and Strong, 2018: p.628): "She said 'Why are you yelling? Don't you know how it feels? This is your fourth birth […]" ('M6' Aktas and Aydin, 2019: p.9). Women described being blamed for difficulties that they experienced in labour: "The midwife told me that I didn't know how to push, and it was my fault that the baby wasn't coming out." ("W23", Rodriguez-Almagro et al., 2019: p.4). In four studies, participants reported being threatened, pressured and coerced into complying and consenting to interventions: "I was told off for screaming […] I think the midwife was trying to make a joke but one of the few things she said to me was, "If you don't stop making such a fuss, I'll have to get a doctor" ('P10' Baxter, 2020: p.28). In one study, women were threatened with the removal of their baby if they did not comply: "if you do not consent to syntocin OR a c-section then we can get our friend the psych registrar down here to section you - then we can do whatever we want to you but you may not be able to keep your baby" ('186' Reed et al., 2017: p.5). In some studies compliance was sought

through shouting at women and holding them down. These factors contributed to a lack of trust in clinicians as reported in eight studies: “I had no more hope in them helping me” (Evans, 2024: p.734)

Positive care

Within half of the studies, narratives included reflections on positive interactions. These illustrated person-centred care, with clinicians described as attentive, empathetic, respectful, reassuring and thorough: “the midwife who dealt with me when I was having her was just fantastic. I felt like she read my birth plan and she reassured me and listened to me and took our concerns seriously” ('participant 14' Baxter, 2020: p.30) .Women felt that their needs were respected and were clearly informed about what to expect from procedures, why they were being done and were offered choice in labour and birth. Both participants and authors perceived positive care to have a mitigating effect on the impact of trauma: “I think everything that happened to me with the good things that the midwives did actually made it less traumatic, the fact that I was informed all the way through, the fact that they talked to me all the way through” ('Elaine', Byrne et al., 2017: p.6).

Authors and participants expressed desires for improved maternity care based on positive and negative experiences. Reassuring, compassionate care is highlighted as being essential from initial contact with hospital staff: “Firstly, when you walk into the hospital, they've got to acknowledge you and say, ‘This is your room, this is what's going to happen. We're going to leave you but we're going to monitor you. You're not on your own’” (‘Mel’ Murphy & Strong,2018: p.631). Women expressed *the need for staff to listen to them and involve them in decisions* (Baxter, 2020: p.30). Studies recognise that women need to be well informed across labour and birth, requiring *regular, clear information from staff* (Baxter, 2020: p.30) about *what happened and what was currently happening* and *who is treating them at all times* (Rodriguez-Almagro et al.,2019: p.4). It’s suggested that providing details about what to expect from labour and birth as well as any possible complications could *create more realistic expectations of childbirth, rather than an idealised view* (Rodriguez-Almagro et al.,2019: p.9).

‘What about me?’: birth as disempowering

This theme captures the meaning that authors and women make of interactions with the health care system. Women are perceived to have no role within the birth experience and that the delivery of the baby is the care provider’s sole concern. Byrne et al., (2017) summarise childbirth as *a ‘production line’ which women are pressured to follow, like parts in a factory, in order for the system to function* (p.5).

Disempowerment and violation

Women reported feeling dismissed by staff when they voiced concerns: “I felt like I was being told I was silly for thinking I was in labour and that this awful pain was nothing to be worried about.” (‘463’, Reed et al., 2017: p.4). Some women were sent home in pain when they attended hospital in labour. In Evans (2024) study focussing on African American women’s experiences, participants felt that implicit racial bias contributed to their dismissal by staff: “I think they thought I was exaggerating because I was a black woman […] I doubt they even knew why” (p.734). In line with this, women also perceived staff to be unable to understand and subsequently meet their needs.

Narratives suggest a lack of agency in birth: “I think I had to push to discuss it with anyone and even when someone discusses the choices with you it's not really a discussion; it's more like this is how it happens” (‘Jane’, Byrne et al., 2017: p.6). Women reported a loss of control over their bodies, having examinations and interventions administered without being asked for consent, and sometimes after refusing to consent: “The doctor would not get her fingers out of my vagina even when directly told […] I wanted the tearing to be healed on its own - no stitches, but she and another doctor stitched anyway, despite my screaming at them to stop.” (‘445’, Reed et al., 2017). They equated the behaviour of staff to abuse, using language such “raped and mutilated”('376', Reed et al., 2017: p.6) and felt “violated” by their actions: “I feel kind of violated, that was wrong, that happened to me, it wasn’t something that I was doing, it was something that happened to me, like I didn’t get to take part in it, it was enforced on me or inflicted on me […]” (‘Rebecca’, Byrne et al., 2017). These interactions led women to feel less than human, using language to describe themselves such as “a thing” (‘12’ Aksu & Sercekus, 2023: p.4), “an incubator” (‘Rebecca’, Byrne

et al., 2017: p.5), “cattle” (‘W15’ Rodriguez-Almagro et al., 2019: p.5), and “a piece of meat” (‘979’, Reed et al., 2017: p.6).

Mother as disregarded in birth

The healthcare system was perceived to have its own agenda, with staff “just content in doing their routine jobs” (Taghizadeh et al., 2015) which often conflicted with the needs of the women. Women described being observed and practiced on by students without consent and that despite having a birth plan, this was not respected. Women felt that they were expected to comply with demands. In Byrne et al. (2017) women reported feeling like a “problem” to staff by entering the birth experience informed: “I was just being a problem to them questioning everything and that just did not sit with them at all. I just wasn’t playing ball for them and it wasn’t how they wanted it to go.” (Jane). Staff were also perceived to care more about the end of their shift: “I found the comment “let’s get this over and done with, I have a golf game to get to” traumatic...”('045', Reed et al., 2017: p.3) .

Authors perceive women to be *redundant* and *disregarded* within the birth. This is further reflected in experiences of feeling excluded from conversations about their care: “One of my main negative feelings about that was I didn't feel anybody was actually talking to me directly. It was like I wasn't in the room”('Georgia', Murphy and Strong, 2018: p.628). Participant narratives highlight beliefs that ultimately the health system is only interested in the delivery of the baby: “The only thing that they are thinking is to remove the baby from there.” (‘15’ Aksu & Sercekus, 2023: p.4). Women felt that staff failed to acknowledge their mental health needs during birth and were offered no follow up care: “they keep going ‘Sure well he's fine, that's the main thing’, but you’re like well I’m the fully functioning adult who is having a mental breakdown and I need to look after him so telling me he's fine isn’t really helping me” ('Fiona', Byrne et al., 2017: p.5).

Discussion

Overview of findings

This review aimed to provide an up-to-date critical synthesis of qualitative research exploring women's experiences of traumatic birth. Three descriptive themes were generated capturing the physical and emotional distress of childbirth, experiences of positive and negative interactions with the healthcare system and women's feelings of disempowerment within a system perceived to disregard their needs. The findings highlight that while women experience the physical act of childbirth and associated complications to be distressing, the experience of birth trauma is largely influenced by interactions with the healthcare system.

Relevance to existing literature

The findings of this review highlight that pain, instrumental procedures and invasive examinations during labour and birth contribute to perceptions of birth trauma. Although Elmir et al. (2010) did not report these findings in their meta-analysis, they align with broader research exploring risk factors for PTSD after birth (Grekin and O'Hara, 2014; Ayers et al., 2016) and those of the UK Birth Trauma Enquiry which included lack of pain relief as a key theme (APPGBT, 2024). Unlike existing reviews, we did not identify issues with social support, partner or mother-infant relationships (Elmir et al., 2010; Watson et al., 2021). Our synthesis focussed on the immediate birth experience rather than the broader post-partum period which may account for differences in findings.

The most significant finding was the role of the healthcare system, causing feelings of powerlessness, violation, and exclusion. The quality of interactions with healthcare staff has been found to be a risk factor in the development of PTSD following childbirth (Ayers et al., 2016) and mistreatment of women during childbirth has been reported across research worldwide (Bohren et al., 2015). Similar themes of inhumane treatment and 'feeling invisible and out of control' were found in Elmir et al. (2010). Our review only included studies published since 2010 indicating that, despite the passage of time, the experiences of women within the maternity care system have not improved. Our findings also align with those of Watson et al. (2021) who in their literature review, summarised that negative interactions with the healthcare system

were damaging to women's expectations of birth leaving them feeling "dismissed and disregarded".

Iatrogenic harm in the context of clinician behaviour has been observed across different areas of healthcare (Wong et al., 2015; Currie et al., 2015), receiving particular research attention within mental health services where patients may be at increased risk of harm due to a history of interpersonal trauma (Hallett et al., 2025). Within maternity services, patients are also at high risk of re-traumatisation as healthcare practices may mimic previous experience of interpersonal and sexual trauma (Gordon et al., 2025), this experience of re-traumatisation was found in the present review.

Maternity professionals may also be negatively impacted by traumatic birth. As a professional group, midwives have been found to experience high levels of emotional distress (Hunter et al., 2019; Cramer and Hunter, 2019). In a systematic review of the impact of witnessing birth trauma on health professionals, (Uddin et al., 2022) maternity staff were found to experience symptoms of PTSD, helplessness, guilt, sadness, self-blame and compassion fatigue. Midwives have been found to experience high levels of burnout (Hunter et al., 2019) which have been attributed to difficulties providing safe, high-quality care within the context of high levels of staff shortages (Hunter et al., 2019; Cull et al., 2020) and high workload (Cramer and Hunter, 2019). Midwives report a conflict between their values, the philosophy of midwifery practice and the medical model leading to feelings of powerlessness, findings which are suggestive of moral injury (Dean et al., 2019). In Cull et al. (2020) midwives expressed an awareness of their inability to provide the quality of care that they wanted to due to the demands on them and acknowledged that they had to be "task centred rather than woman centred" (p.552) due to lack of time. Fontein-Kuipers et al. (2016) found that midwives experienced several barriers to providing woman-centred care, including time and perceived resources. It is possible that these factors may account for the negative interactions experienced by women across the present review.

Strength and limitations

This review presents an up-to-date synthesis of research exploring experiences of traumatic birth and in presenting similar findings, suggests a lack of improvement in women's experiences over the past 15 years. In contrast with the most recent systematic

review of this area which included only western samples (Elmir et al., 2010), this review included studies published outside of the western context. The consistency of themes across all studies, despite their country of publication, suggests that factors contributing to the experience of trauma in childbirth may be consistent across the world despite differences in healthcare systems and practices.

Despite attempts to include global studies, non-English papers were excluded which may have excluded valuable insights from other countries, cultures and health systems. Due to available resources the review did not include grey literature and studies that were not published in peer-reviewed journals which may have further limited findings.

Despite some papers highlighting issues pertaining to culture and ethnicity (Evans, 2024; Aksu and Sercekus, 2023; Aktas and Aydin, 2019), it is unclear the extent to which minority ethnic groups are represented due to inconsistent reporting. Black and minority ethnic women are more likely to experience adverse outcomes in pregnancy and birth therefore understanding their experiences may help to address racial disparity in maternity care. LGBTQIA+ women and birthing people also experience increased adversity during pregnancy and birth (Klittmark et al., 2023), however this review failed to extract data on sexuality from the included studies.

Implications for practice, policy and future research

The review has implications for practice within maternity care. To reduce iatrogenic harm and re-traumatisation, women should be provided with regular, clear information about risks and processes throughout their labour and birth. They should be offered choice and autonomy within the birth experience and be provided with compassionate, responsive care that recognises their individual differences. Maternity professionals should be made aware of the role of interpersonal interactions as an influencing factor within birth trauma and the risk of re-traumatisation. Mandatory staff training should focus on the implementation of trauma informed practice across maternity services worldwide. As trauma informed practice is rolled out across maternity care in Scotland, further research could focus on the impact of this training programme on women's experiences of birth. Staff should also receive mandatory training on cultural awareness and discrimination to begin to address longstanding issues with disparities in the provision of care.

There is a need to understand trauma in childbirth from a systems perspective. Healthcare providers should reflect on this data within the context of their own system and consider why these experiences are happening. This may allow patients, clinicians, health care commissioners and policy makers to collaborate to find meaningful solutions to this issue. An example may be to provide training to address the impact of trauma on maternity professionals.

Global health care policy should ensure that all women are entitled to a childbirth experience that protects their human rights (United Nations General Assembly, 1948) and that failure to provide safe, respectful maternity care has legal implications for healthcare providers.

Conclusions

Women experience traumatic birth as a physically and emotionally distressing event that is negatively influenced by interactions with care providers and the health care system. Woman-centred, trauma-informed care may mediate the impact of a traumatic birth experience. This review recognises the need for increased training provision and support for maternity professionals to enable them to provide high quality care. Global healthcare policy should ensure that women have a legal right to a safe, and respectful childbirth free of discrimination and that adequate resource is allocated to maternity services to enable them to uphold women's human rights in childbirth.

References

Aksu DF and Sercekus P (2023) Traumatic childbirth experiences, effects and coping: A qualitative study. *Sexual and Reproductive Healthcare* 37(no pagination).

Aktas S and Aydin R (2019) The analysis of negative birth experiences of mothers: a qualitative study. *Journal of Reproductive and Infant Psychology* 37(2): 176-192.

All-Party Parliamentary Group on Birth Trauma [APPGBT] (2024) Listen to mums: Ending the postcode lottery on perinatal care.

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

Ayers S, Bond R, Bertullies S, et al. (2016) The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework. *Psychol Med* 46(6): 1121-1134.

Ayers S, Eagle A and Waring H (2006) The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health & Medicine* 11(4): 389-398.

Baptie G, Andrade J, Bacon AM, et al. (2020) Birth trauma: the mediating effects of perceived support. *British Journal of Midwifery* 28(10): 724-730.

Baxter J (2020) An exploration of reasons why some women may leave the birth experience with emotional distress. *British Journal of Midwifery* 28(1): 24-33.

Beck CT (2004) Birth trauma: in the eye of the beholder. *Nurs Res* 53(1): 28-35.

Bohren MA, Vogel JP, Hunter EC, et al. (2015) The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLoS Medicine* 12(6): e1001847-e1001847.

British Psychological Society (2021) Ethics guidelines for internet-mediated research. DOI: 10.53841/bpsrep.2021.rep155.5. 8-21.

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

Cramer E and Hunter B (2019) Relationships between working conditions and emotional wellbeing in midwives. *Women and Birth* 32(6): 521-532.

Critical Appraisal Skills Programme (2023) CASP (Qualitative Studies Checklist). [online]. https://casp-uk.net/casp-tools-checklists/qualitative-studies-checklist/.

Cronin-Fisher V and Timmerman L (2023) Redefining 'healthy mom, healthy baby': Making sense of traumatic birth stories through relational dialectics theory. *Western Journal of Communication* 87(1): 1-21.

Cull J, Hunter B, Henley J, et al. (2020) “Overwhelmed and out of my depth”: Responses from early career midwives in the United Kingdom to the Work, Health and Emotional Lives of Midwives study. *Women and Birth* 33(6): e549-e557.

Currie K, Strachan PH, Spaling M, et al. (2015) The importance of interactions between patients and healthcare professionals for heart failure self-care: a systematic review of qualitative research into patient perspectives. *European Journal of Cardiovascular Nursing* 14(6): 525-535.

Dean W, Talbot S and Dean A (2019) Reframing clinician distress: moral injury not burnout. *Federal Practitioner* 36(9): 400.

Dencker A, Nilsson C, Begley C, et al. (2019) Causes and outcomes in studies of fear of childbirth: A systematic review. *Women and Birth* 32(2): 99-111.

Elmir R, Schmied V, Wilkes L, et al. (2010) Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *J Adv Nurs* 66(10): 2142-2153.

Evans C (2024) African american womens' experience of birth traum. *Journal of Reproductive and Infant Psychology* 42(4): 731-740.

Fontein-Kuipers Y, Boele A and Stuij C (2016) Midwives’ perceptions of influences on their behaviour of woman-centered care: a qualitative study. *Frontiers in Women’s Health* 1(2).

Gordon J, Hunter A, Callanan F, et al. (2025) An Integrative Review Exploring Womens' Experiences of Retraumatization Within Perinatal Services. *Journal of midwifery & women's health* 70(1): 32-49.

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

Hallett N, Dickinson R, Eneje E, et al. (2025) Adverse mental health inpatient experiences: Qualitative systematic review of international literature. *International Journal of Nursing Studies* 161: 104923.

Henriksen L, Grimsrud E, Schei B, et al. (2017) Factors related to a negative birth experience - A mixed methods study. *Midwifery* 51: 33-39.

Hunter B, Fenwick J, Sidebotham M, et al. (2019) Midwives in the United Kingdom: Levels of burnout, depression, anxiety and stress and associated predictors. *Midwifery* 79: 102526.

Klittmark S, Malmquist A, Karlsson G, et al. (2023) When complications arise during birth: LBTQ people's experiences of care. *Midwifery* 121: 103649.

Leinweber J, Fontein-Kuipers Y, Thomson G, et al. (2022) Developing a woman-centered, inclusive definition of traumatic childbirth experiences: A discussion paper. *Birth* 49(4): 687-696.

Long HA, French DP and Brooks JM (2020) Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences* 1(1): 31-42.

Moyzakitis W (2004) Exploring women's descriptions of distress and/or trauma in childbirth from a feminist perspective. *Evidence-Based Midwifery* 2: 8+.

Murphy H and Strong J (2018) Just another ordinary bad birth? A narrative analysis of first time mothers' traumatic birth experiences. *Health care for women international* 39(6): 619-643.

Olza I, Leahy-Warren P, Benyamini Y, et al. (2018) Women's psychological experiences of physiological childbirth: a meta-synthesis. *BMJ Open* 8(10): e020347.

Page MJ, McKenzie JE, Bossuyt PM, et al. (2021) The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 372: n71.

Reed R, Sharman R and Inglis C (2017) Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth* 17(1): 21.

Rodriguez-Almagro J, Hernandez-Martinez A, Rodriguez-Almagro D, et al. (2019) Women's perceptions of living a traumatic childbirth experience and factors related to a birth experience. *International Journal of Environmental Research and Public Health* 16(9): 1654.

Sattar R, Lawton R, Panagioti M, et al. (2021) Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. *BMC health services research* 21(1): 50.

Taghizadeh Z, Arbabi M, Kazemnejad A, et al. (2015) Iranian mothers' perceptions of the impact of the environment on psychological birth trauma: A qualitative study. *International journal of nursing practice* 21(Supplement 2): 58-66.

Taghizadeh Z, Irajpour A, Nedjat S, et al. (2014) Iranian mothers' perception of the psychological birth trauma: A qualitative study. *Iranian Journal of Psychiatry* 9(1): 31-36.

Thomas J and Harden A (2008) Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology* 8(1): 45.

Tong A, Flemming K, McInnes E, et al. (2012) Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology* 12(1): 181.

Uddin N, Ayers S, Khine R, et al. (2022) The perceived impact of birth trauma witnessed by maternity health professionals: A systematic review. *Midwifery* 114: 103460.

United Nations General Assembly (1948) Universal Declaration of Human Rights.

Viirman F, Hess Engstrom A, Sjomark J, et al. (2023) Negative childbirth experience in relation to mode of birth and events during labour: A mixed methods study. *European Journal of Obstetrics and Gynecology and Reproductive Biology* 282: 146-154.

Watson K, White C, Hall H, et al. (2021) Women's experiences of birth trauma: A scoping review. *Women and Birth* 34(5): 417-424.

Wong P, Liamputtong P, Koch S, et al. (2015) Families' experiences of their interactions with staff in an Australian intensive care unit (ICU): A qualitative study. *Intensive and Critical Care Nursing* 31(1): 51-63.

Yildiz PD, Ayers S and Phillips L (2017) The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *Journal of Affective Disorders* 208: 634-645.

Chapter 2: Major Research Project

Women and birthing people's experiences of early post-partum adjustment following a traumatic birth.

Prepared in accordance with the author requirements for Qualitative Research

Author Guidelines

An explanation of terminology

The gender additive terminology ‘women and birthing people’ (WABP) has been used within the research question and throughout the research documentation, as advised by Green and Riddington (2020a), to ensure that the research felt inclusive and accessible to individuals of all gender identities. The current literature base uses the terminology ‘woman/women’, therefore for continuity, this language is reflected in the text. All participants recorded their gender as ‘female’ and are referred to as ‘women’ throughout.

Plain Language Summary

Title: Women and birthing people's experiences of early post-partum adjustment following a traumatic birth.

Background: Research suggests that approximately one third of women perceive their experience of childbirth to have been traumatic (Ayers, 2004). Research investigating women's experiences of birth trauma has focussed predominantly on the factors contributing to the development of post-traumatic stress disorder (PTSD) and the experience of PTSD during the post-partum period. There is limited understanding of how individuals who have experienced a subjectively traumatic birth navigate adjustment to life during the early post-partum period.

Aims: This study aimed to explore experiences and needs of women during the early-postpartum period following a traumatic birth.

Research Questions: (1) What are WABP's experiences of early post-partum adjustment following a traumatic birth? (2) What support or information would be helpful for WABP in the early post-partum period following a traumatic birth?

Methods: Participants were women who had given birth within NHS Ayrshire and Arran and perceived their birth to have been traumatic. Six women took part in interviews about their experiences of adjusting to life with their new baby after a traumatic birth. Interviews were recorded, transcribed and analysed using Reflexive Thematic Analysis.

Findings: Three main themes were generated from the interview data. These captured women's experiences of learning to cope and move forward after their birth trauma at the same time as they adapted to becoming a new mum. Their experiences of interacting with the healthcare system impacted how well they were able to do this.

Conclusions: To be able to cope well during the early post-partum period, women identified that they need adequate information to prepare them for birth and to receive trauma informed care from health professionals. This requires improvements to maternity policy and practice.

Abstract

This study aimed to explore experiences of early post-partum adjustment following a traumatic birth and to determine what information and resources may be required to facilitate adjustment. A qualitative approach with a critical realist stance was adopted to explore women's experiences. Six participants, who self-identified as having had a traumatic birth, engaged in semi-structured interviews. Data was transcribed and analysed using reflexive thematic analysis. Three main themes were generated from the interview data. Women described a journey of adaptation from the immediate physical impact of their birth to a place of coping and acceptance. Whilst navigating the impact of their birth, they were also adjusting to the challenges of becoming a new mum. Their interactions with healthcare directly influenced their experiences. Improvements are needed to policy and practice within maternity care, ensuring trauma-informed and responsive care that promotes physical recovery, post traumatic growth, and supports the development of maternal identity.

Keywords: *Birth; traumatic birth; post-partum adjustment*

Introduction

Childbirth can be a positive and enriching experience for many, but for some may be a traumatic experience. Childbirth is a particularly vulnerable time for women due to several psychological (Howard et al., 2014), physiological (World Health Organisation, 2018) and social factors (Global Burden of Disease 2015 Maternal Mortality Collaborators, 2016; Small et al., 2014; Bedaso et al., 2021). Childbirth involves significant physical changes, risk of physical trauma and other complications (WHO, 2018). It can involve interventions which may not be sensitive to the woman's needs, values and personal preferences (Renfrew et al., 2014) and invasive procedures during which a woman relinquishes control of her own body to clinical staff. Cultural beliefs, access to health care, lower socioeconomic status (Small et al., 2014; GBD 2015 MMC, 2016), and lack of support can further impact vulnerability (Bedaso et al., 2021). These, alongside hormonal changes can increase risk of developing mental health difficulties (Howard et al., 2014).

Research suggests approximately one third of women perceive childbirth to have been traumatic (Ayers, 2004) and that between 3%-19% of women will go on to develop Post Traumatic Stress Disorder (PTSD) (Yildiz et al., 2017). Ayers et al. (2016) found that depression in pregnancy, fear of childbirth, complications in pregnancy and a history of trauma or psychological problems increased vulnerability to the development of childbirth related PTSD. While risk factors during birth included having an operative birth, lack of support from staff, dissociation, and subjective birth experiences that include negative emotions during birth and lack of control or agency. Findings suggest that women who appraised their birth as traumatic and those who met diagnostic criteria for PTSD reported that their opinions, values and rights were ignored during childbirth, that they had no control over their birth experience, and that they felt they had been treated "inhumanely" (Elmir et al., 2010)

Qualitative research highlights the psychological consequences of traumatic childbirth experiences. Consistent with PTSD symptoms, women report intrusive memories, flashbacks and nightmares about the birth experience, and avoidance of situations that serve as reminders of the birth (Moyzakitis, 2004). Elmir et al. (2010) identified that women experienced heightened mental health difficulties, suicidal ideation, doubted

their ability to cope with the day to day demands of their life and reported poor self-image. Fear of further childbirth has also been identified (Dencker et al., 2019).

The psychological impact of childbirth related PTSD (CB-PTSD) may extend to difficulties with mother-infant bonding. Stuijfzand et al. (2020) used structural equation modelling to examine the relationship between CB-PTSD mother-infant bonding. Based on a robust sample they found that higher levels of CB-PTSD symptoms at one month postpartum were associated with poorer mother-infant bonding at three months. Qualitative research has also identified issues with bonding. Women describe feeling emotionally disconnected from their baby (Nicholls and Ayers, 2007) or feeling hypervigilant or overprotective (Nicholls and Ayers, 2007). This disruption in bonding may have implications for attachment (Dekel et al., 2019).

In addition to mother-infant relationship, experiences of CB-PTSD have been identified as having an impact on partner relationships. Findings suggest women felt practically supported but that emotional support (Moyzakitis, 2004) and validation of their experiences was lacking (Ayers et al., 2006). Furthermore, women reported sexual intimacy to be a reminder of the birth and that they felt disconnected from their partner (Nicholls and Ayers, 2007) which for some led to feelings of inadequacy (Ayers et al., 2006).

As detailed above, most research that explores experiences of post-partum adjustment after birth trauma focusses on women who meet the DSM-V diagnostic criteria for PTSD. To meet these criteria, during birth the woman must have been 'exposed to: death, threatened death, actual or threatened serious injury […]' (American Psychiatric Association, 2022). Defining birth trauma this way is widely debated as a range of birth experiences outside of this definition can contribute to ongoing distress in the postpartum period (Elmir et al., 2010). An added complexity is that childbirth differs from other traumatic stressors in that it is often voluntary, and women may perceive their baby to be a positive outcome which made the experience 'worth it' (Ayers, 2004). It is argued that categorising birth trauma using diagnostic criteria risks pathologizing a normal response to a birth experience that is distressing and fear inducing (Tseris, 2013).

The DSM-V definition may fail to recognise the experiences of women who have not experienced actual or threatened death or injury but have had a subjectively traumatic birth experience.

Given that only a small percentage of women who experience a birth trauma meet diagnostic criteria for PTSD (Yildiz et al., 2017), the existing research may fail to include experiences of women whose birth and its sequelae do not. It is likely that these women still face challenges post-partum as a result of the impact of their experience (Soet et al., 2003), however may be less likely to be seen by services meaning that their distress and their difficulties go unrecognised. To address this, Leinweber et al. (2022) formulated a women-centred, inclusive definition of traumatic birth which expands the narrow lens of PTSD:

> "A traumatic childbirth experience refers to a woman's experience of interactions and/ or events directly related to childbirth that caused overwhelming distressing emotions and reactions; leading to short and/ or long-term negative impacts on a woman's health and wellbeing" (p.691).

By adopting this definition of birth trauma, this study aims to include the voices of women who may not have had their experiences recognised in previous research. Exploring early post-natal adjustment using this definition of traumatic birth may offer a broader framework for understanding the impact of child-birth related trauma and allow for the identification of women who may have increased vulnerability and require further support post-partum. Understanding the support needs of women following a birth trauma may serve to improve care and prevent adverse mental health and attachment outcomes.

Aims

The study aimed to explore WABP's experiences of early post-partum adjustment following a traumatic birth experience. It also aimed to determine what information and resources may be required to best support individuals during the post-partum period following a traumatic birth.

Primary Question

- What are WABP's experiences of early post-partum adjustment following a traumatic birth?

Secondary Question

- What support or information would be helpful for WABP in the early post-partum period following a traumatic birth?

Methods

Ethics

This study was granted ethical approval (North of Scotland Research Ethics Committee, REC Reference: 24/NS/0038; Appendix 2.3). An amendment (AM01) was approved to reflect a change in video conferencing software requested by NHS Ayrshire and Arran (NHS AA) Information Governance and a second amendment (AM02) was approved to correct an error in time from birth to interview across documentation. Management approval was granted by NHS AA Research and Development (Reference: 2024AA01; Appendix 2.3)

Design

As little is known about early post-partum adjustment following a traumatic birth experience, this study adopts a qualitative approach using Reflective Thematic Analysis (RTA) (Braun and Clarke, 2006) of semi-structured interviews. RTA allows for the identification of patterns of meaning across individual experiences whilst being theoretically flexible. RTA allows for an inductive approach to analysis and is compatible with the author's critical realist stance as outlined below. The study was cross-sectional, capturing WABP's experiences of adjustment within the first six months post-partum.

Recruitment

A purposive sampling approach was used. Community midwives and health visitors within NHS Ayrshire and Arran (NHS AA) were chosen to identify potential participants, as all individuals in NHS AA have contact with these professionals following their birth. Individuals who met the inclusion criteria (Table 1.) were provided with verbal information about the study, as well as a participant information leaflet (Appendix 2.4).

If a potential participant provided consent to be contacted, contact details were shared with the Principal Investigator (PI) via NHS email. Individuals could also contact the PI directly via a study email address. Those who consented to be contacted were telephoned by the PI to discuss the study further. A participant information sheet (PIS), privacy notice, and consent form (Appendix 2.4) were sent for review, and individuals were given a minimum of 24 hours to decide if they would like to participate. The PI conducted a follow-up call to confirm interest, review study documentation and address questions. Informed consent was obtained electronically via Qualtrics before interviews.

Nine participants expressed interest and provided consent to be contacted by the PI. One withdrew interest, one did not respond to follow up contact, and one did not attend the interview. Six individuals participated.

Table 3: Inclusion and Exclusion Criteria

Inclusion	Exclusion
WABP who had a traumatic childbirth experience during their most recent birth as defined by Leinweber et al. (2022)	Partners or family members of the birthing person
WABP who are engaging with community midwifery and/or health visitors	The individual's trauma experience is a baby loss
Participants who have capacity to consent	WABP who have been discharged by community midwifery and/or health visitors
Able to read and speak English	Inability to provide informed consent
Aged 18 and over	Under 18 years old

Procedure

Consenting participants completed a demographic form (Appendix 2.5) and semi-structured interview facilitated by the PI. Participants attended alone or with their baby. Prior to interview they were reminded of confidentiality limits and their right to refuse questions, take breaks and withdraw. After, participants were redirected to the PIS for support resources. Interviews were conducted by the PI at Ayrshire Maternity Hospital, or online via Near Me. Interviews lasted between 45-70 minutes and consideration was given to factoring in breaks for infant care. Four participants attended online and two attended in person. No repeat interviews were carried out. Interviews were audio recorded using a secure NHS Ayrshire and Arran digital recording device, transcribed verbatim, checked for accuracy and anonymised. The researcher made reflective notes post-interview and during transcription. Due to time constraints transcripts were not returned to participants for comment.

Topic guide

A topic guide (Appendix 2.6) was designed in collaboration with the Consultant Clinical Psychologist from the NHS AA Maternity and Neonatal Psychological Interventions Team and a Community Midwife from NHS AA to ensure that questions were relevant and sensitive. Due to resources this was not pilot tested. The topic guide was used flexibly to inform semi-structured interviews focussing on the impact of birth trauma on well-being, relationships, infant bonding and information and resources that would be helpful to support post-partum adjustment.

Participants

All six participants were white, heterosexual, cisgender females who had experienced a traumatic birth within NHS AA within the last 6 – 23 weeks (Mean= 17.5 weeks). For four participants this had been their first pregnancy, one participant reported two pregnancies, and one reported three pregnancies. Four participants were married and two were in a relationship. All women were employed full time, and all had completed higher education.

Data Analysis

To ensure theoretical and methodological validity, data analysis followed the Braun and Clarke (2006) six phase process. Transcripts were read and re-read, and initial ideas were noted. Interesting features of the data were coded systematically by hand across the entire data set by the PI and data relevant to each code was collated. An inductive approach to coding was used with no attempt to fit data within an existing theoretical framework. Codes were arranged into themes and reviewed by checking if they work in relation to the data set. An initial thematic map was developed (Appendix 2.10) to visualise the relationships between provisional themes. Analysis continued to evolve through write up, and specifics of each theme were refined to gain clear definitions and names. Supervision was used to review transcripts, the coding process, study data and generation of themes. The Chief Investigator confirmed consistency of themes.

Justification of sample size

Resources available for the study allowed for the recruitment of between six to 12 participants, in line with recommendations for thematic analysis (Braun and Clarke, 2006). After six interviews it was clear that there was a consistent pattern of experiences brought by the participants. It was also apparent that these experiences were portrayed in detail. We therefore judged that the data had sufficient depth and richness to convey adequate informational power to answer the original questions.

Epistemological Perspective

A critical realist stance was adopted, recognising both the objective and subjective dimensions of participant experiences (Olsen, 2007). This stance acknowledges real, sometimes hidden, structures (for example societal expectations and healthcare interventions) that impact post-partum adjustment after birth trauma, whilst also considering participants' unique individual and social contexts. By exploring how structural and contextual factors may influence trauma and adjustment, critical realism enables a nuanced interpretation of individual narratives and provides framework for understanding their experiences and how post-partum care may be improved.

Researcher Reflexivity

I am a white, female trainee clinical psychologist currently working within a Maternity and Neonatal Psychological Interventions Team (MNPI) in NHS AA. As a woman, I am passionate about and have personal experience of disparities in women's health care. Having watched loved ones and patients navigate birth trauma, I have developed a heightened awareness of challenges and complexities of post-partum adjustment. However, as I have not given birth, I also sit as an outsider to participant experiences. I had no existing relationship with participants and I was aware that it may be intimidating to share their experiences with a maternity professional. My knowledge of birth trauma may have shaped how I interpreted participant narratives, particularly regarding psychological theory which may have unconsciously influenced data analysis. Given my familiarity with the subject, it was important that I remained open to perspectives that differed from my clinical experience. I was also aware that it may have been hard for me to separate my role as a clinician from my role as a researcher, especially having an emotional connection to the subject matter. Throughout the research process I kept a reflective journal (Appendix 2.11) to increase my awareness of how my existing assumptions thoughts and feelings influenced the data collection and analysis process as well as engaging in regular supervision. During data analysis I ensured that coding and theme development stayed close to participants words rather than imposing my own interpretations.

Results

Through a process of reflective thematic analysis, the author identified three main themes with 10 sub-themes: *'Personal adaptation', 'A system under pressure', 'Becoming a mother'.* These illustrate two intrapersonal processes which evolve with proximity to the birth, and an interpersonal process which occurs in parallel. A thematic diagram including codes is presented in Figure 3.

Personal adaptation

This theme captures participants experiences of adaptation after their birth experience, from the immediate physical impact of birth to a place of acceptance and coping.

Physical and cognitive impact

Women described the significant impact that their birth experience had on their bodies and cognition. They described the physical impact of obstetric interventions such as emergency caesarean sections, repairs following perineal tears and episiotomy procedures, and post-partum health complications such as pre-eclampsia, high-blood pressure and sepsis. As well as being in pain, women described difficulties with mobility which impacted functioning.

> *"[…] I just remember being really sore, not having a lot of movement to sleep and lie and things".* – Natalie

Participants described a physical recovery prolonged by the demands of having a newborn, preventing them from rest and recovery. Ellie felt that she had to keep going in the early weeks despite recovering from a caesarean section because she had to be there for her baby and that the physical impact of her birth caught up with her when her mum came to stay, allowing her a prolonged period of rest:

> "*Like mid-June when my mum stayed for a big chunk when most women are probably starting to feel like their normal selves again, you know six weeks after their caesarean, whereas I was almost bed bound again. It was like it all caught up with me, I couldn't put him down, and I was massively swollen. Em so it was like a delay I suppose."*

Ongoing health issues meant participants remained engaged with the health system for months after birth. Some became severely unwell and were re-admitted to hospital. Holly described her hospital re-admission as *"an added trauma that I had to work through".* Repeated attendance at the GP for monitoring, and appointments at the maternity unit added to the demands participants were already facing.

> *"So that was a challenge because I just felt as if I was constantly just faced with things all the time like doctors, and hospitals, and here, and there and it just felt like it was never ending".* – Natalie

Women described a *"rollercoaster of hormones"* (Hannah) leading to a heightened emotional experience making it harder to navigate challenges. They spoke of *"brain fog"* (Ellie) which made simple tasks complicated and overwhelming. Sarah became distressed when she was unable to understand how to work her bottle sterilizer:

> *"[…] when you are in that period of that massive drop in hormones that women experience. It's the silly things like that that can send you over the edge".*

All women reported sleep deprivation and exhaustion in the days and weeks after birth, intensified by physical pain and illness as highlighted above, further contributing to cognitive challenges and heightened emotions.

Meaning Making

Women described the time after their birth as a *"blur"* (Hannah and Ellie) in which time appeared to be distorted. Feelings of relief and elation after the baby was born, were accompanied by confusion and detachment. The competing demands of parenting created additional barriers to processing their experience, as participants had to *"shut off what just happened"* (Ellie) to prioritise caregiving. Participants described difficulty remembering their early experiences and that it took them until they had re-emerged from the 'blur' to realise that their birth had been traumatic. Megan shared that she experienced nightmares and flashbacks:

> *"Because my birth went so fast that at the time I didn't really think 'oh that was traumatic'. It wasn't until a few weeks later with all of these flashbacks I was having I was like that wasn't nice actually."*

Sarah also experienced trauma symptoms and shared that the smell of blood and her baby served as triggers for flashbacks to being in hospital.

As time passed women tried to piece together the events surrounding their birth to make sense of what happened to them. The most prominent reflection was that the outcomes of their birth could have been different and that either their baby or themselves could have died.

> *"[…] it could have gone so much the other way. You know, something bad could have happened to me and I wouldn't have been there for any of it."*-Natalie

The urgency of their delivery and the contrast with their expectations, meant women found it difficult to make sense of the chain of events leading to their birth. They described ruminating over their experience and having unanswered questions. Ellie expressed frustration that she may never have answers as to why her placenta was abnormal:

> *"I was like ok what does that mean? […] I need an answer […] maybe I will never find out but that will be something that I'll be angry about for years to come I think."*

Participants adopted various strategies to support meaning making such as talking through the birth with their partners and friends, writing and reviewing their maternity notes.

> *"I felt as if I was able to manage it a wee bit bitter when I was able to piece things together so I wrote everything to try and read through and figure out what was happening and I was able to work through the emotions of each stage of my birth."*-Holly

Coping, acceptance and growth

Participants acknowledged the challenges of losing pre-existing coping strategies upon the arrival of their baby, in particular the ability to go out for a walk and to exercise. They struggled with feelings of isolation, anxiety, low mood and a loss of sense of self but over time they developed new ways of coping. During interview, participants laughed when talking about serious subjects or used language which minimised their experiences. They shared that they did not have any option apart from having to be resilient and take on challenges as they arose. Self-care was perceived to be particularly important, allowing participants more resources to look after their baby, but that it took time for them to be able to separate from their baby to do this.

"Since I've been able to get out and to the gym […] it's got miles better." -Megan

As women started to physically recover, make sense of their experiences and develop ways of coping they reflected on and grieved for what they had lost before moving towards acceptance and gratitude. Women lost their expectations for pregnancy, birth, and early post-partum motherhood because of their birth experience.

> *"And it felt like everything I had dreamed and wanted and thought about for eight and a half months had gone […] you know, so grief I think it's that..*" – Ellie

All women recognised that the emotional distress that they experienced reduced over time and that *"time does heal"* (Ellie). They used language that indicated they had started to come to terms with and accept their experience. For example, *"it is what it is"* (Natalie and Hannah) and *"it's all worked out and it's fine"* (Ellie). Holly shared:

> *"[…] although I was sad that I didn't get the birth I wanted- I now, maybe don't care isn't the right word but it seems like it matters a lot less."*

With the passage of time the nature of their birth seemed to diminish in importance and was replaced by an overwhelming gratitude that their babies were happy and healthy and that they too had their own health.

A system under pressure

This theme relates to women's experiences of interacting with the health care system across the postpartum period. These interactions occurred in parallel with and directly influenced the other two themes.

Just get on with it

Participants highlighted the crucial role that staff played in supporting them to navigate the early post-partum period. Some described compassionate, responsive care that they felt gratitude for. Others described a health care system that lacked compassion. Women recognised the demand facing the health care system and how this impacted their care.

> *"I think it's because they're really busy. I got chucked out because they were trying to get space in the ward."*-Hannah

Megan felt like a *"burden"* pressing her buzzer to seek help in hospital due to her awareness of the ward being *"busy".* The impact of this system pressure on staff attitudes was also felt. Ellie's baby was in the neonatal intensive care unit (NICU) after birth which due to her injuries, she only was able to access via a lift accompanied by staff. She described the experience of asking to be accompanied two days after her caesarean section:

> *"She really huffed and puffed and then when I got down there she was like 'you really should start to think about taking the stairs, I know you've just had a C-section but we're really busy'."*

Holly felt that staff perceived her to be a *"bother",* whilst Natalie also used the phrase *"huff and puff"* to described staff attitudes to her help seeking. There was a perception that staff did not understand that childbirth was a *"life changing event"* (Ellie) and an expectation that the women should know how to look after their baby. As a result of this women described feeling abandoned and unsupported after birth.

> *"In my experience I think that within hospital there can maybe be a slightly more trauma informed approach. […] I don't feel like I experienced that […] I felt as if it was kind of like right well, just get on with it. You've got your baby now you need to- it's not really that big of a deal."*-Holly

These experiences contributed to a lack of trust in the health professionals providing their care and anxiety about hospital readmission. Megan shared a negative interaction with her GP which almost prevented her from returning to seek crucial support for her mental health:

> *"She asked me some questions and I burst out in to tears and she didn't really help me. She was quite dismissive […] it was almost like she was thinking of time […] she was like […] ' if you want to come and talk to me about it you can come back'. But I was kind of like well I'm here now and I'm upset? Like why are you sending me away?"*

Participants described the need to *"get on with it"* (Natalie), something which was perceived to be expected of them, but also essential to get their needs met in the in the context of unresponsive care.

> *"Like I was septic and I wasn't well but I just got on with it because nobody really came."* -Natalie

Continuity of care

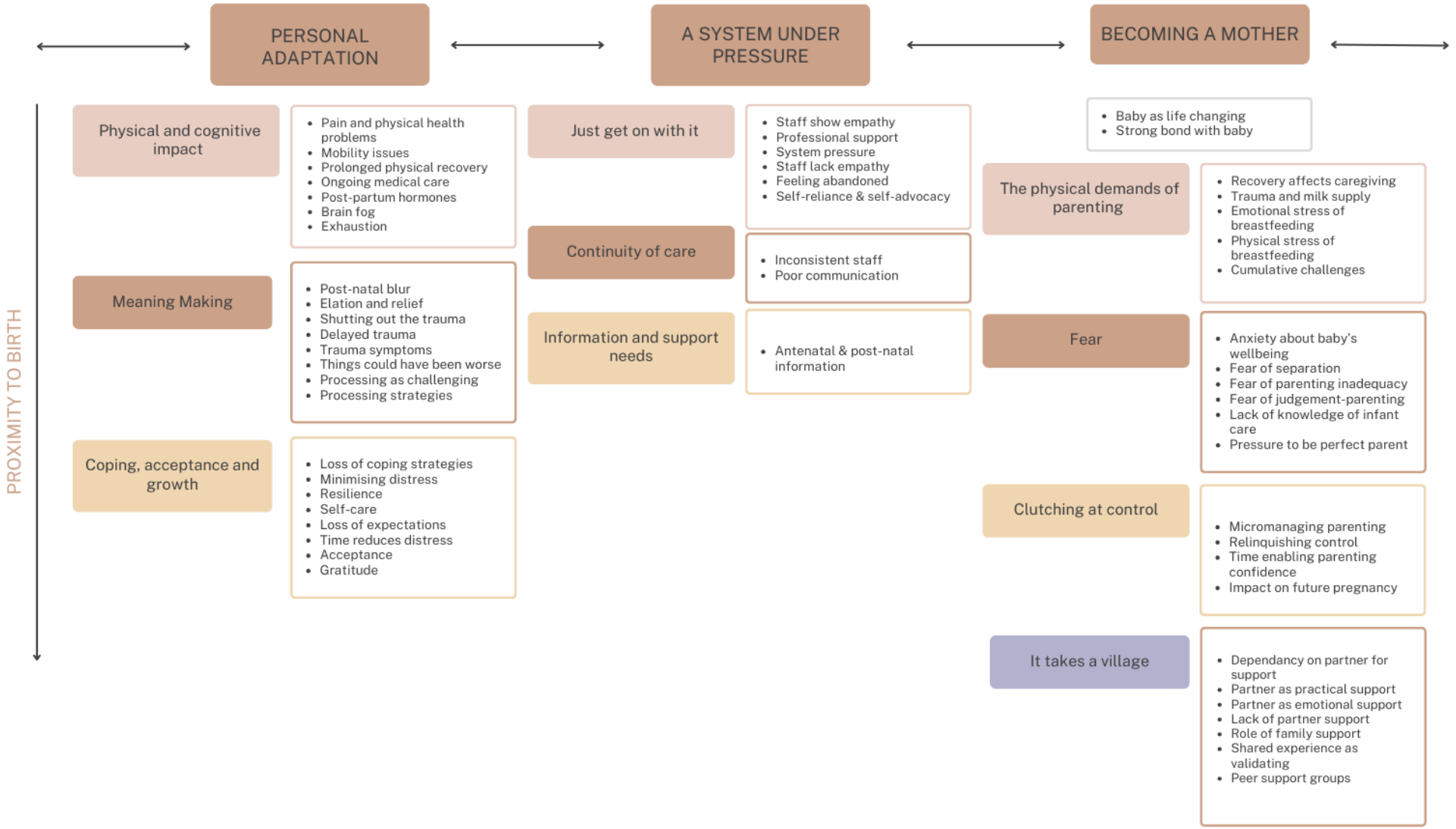
Participants felt that their needs were not understood by clinicians, and they were unable to build trusting relationships due to a lack of continuity of care. High staff turnover was recognised as a barrier. For some women, this existed in the context of community post-natal care with a lack of a consistent midwife. For Ellie, an uninformed, changing ward staff team meant that she had to repeatedly tell her story, causing her distress.

Issues with communication were identified across participants, contributing to ongoing stress and frustration. Megan and Ellie shared referrals had *"got lost"* (Megan) which delayed their access to support. Poor communication between health professionals led to difficulties accessing feeding equipment and medication. Women also felt that they were not adequately communicated with about various elements of their care, which contributed to feelings of uncertainty and anxiety. Hannah shared:

> *"They'd given me a pump and things before I left the hospital because they knew that my milk wouldn't come in- but never had told me it wouldn't, no one really told me about it. Didn't have enough information about it. So I wasn't prepared for that"*

Participants acknowledged that in the days following their birth their midwife visited at inconsistent times without informing them in advance.

Figure 3: Thematic Diagram



Information and support needs

A lack of knowledge and information about birth and the post-natal period resulted in participants feeling unprepared for complications and life at home with their baby. Women were unable to access ante-natal classes and identified a lack of information about bottle feeding which they attributed to the public health messaging around breastfeeding. This gap in knowledge made feeding a distressing experience for them, further contributing to feelings of abandonment. Participants lacked knowledge about potential pregnancy and post-partum health complications, recognising the unpredictability of birth and noting that unexpected complications exacerbated the trauma of their birth.

> *"What does it mean I could get an infection? Whereas if someone had sat down and explained. Now I know he just needed a little cannula in, he was totally fine. But if someone had explained that to me I don't think I would have initially been as panicked. It's the fear of the unknown […]"*-Sarah

Participants expressed a desire to be informed about potential risks as it allowed them to feel prepared. Holly experienced post-partum pre-eclampsia and stated:

> *"I like to know what's going on and I like to know what could potentially happen so that I can prepare myself for that[…]so even just a few leaflets that tell you these things that can happen post-partum and what to be on the watch for I think would be of huge benefit".*

Similarly, Hannah experienced an emergency section and explained that she found theatre to be distressing as it was unexpected. She stated:

> *"If I'd seen the theatre before I think I would have been less scared".*

Becoming a mother

This theme captures the process of adjustment to becoming a mother after a traumatic birth. Although some women were multiparous, the title of this theme reflects the idea that maternal identity is tied to a unique mother-infant relationship with each baby. Women described having a baby as *"life changing"* (Ellie) and that despite challenges, all participants felt overwhelming love for their baby.

The physical demands of parenting

Participants spoke of the impact of the physicality of motherhood immediately after birth which is closely tied to the subtheme "Physical and cognitive impact". Due to pain and stitches, participants struggled to lift their infants and bend over to change them. They felt as though they were missing out on early parenting experiences and were anxious that they were unable to adequately care for their babies without support.

> *" […] I wasn't able unless I was able to stand at a changing table, I couldn't change his nappy. So if we were out and about and he had to be laid on the floor for changing his nappy or even on the couch leaning forward to change him. I couldn't do that."*-Holly

Natalie's experience of sepsis impacted her cognitive abilities meaning that she struggled to take in the instructions for her son's bottles:

> *"This was then when I started to get quite anxious because I thought […] Can I not look after my child? Because I cannot understand this information."*

Some women experienced difficulties establishing their milk supply which they attributed to the trauma of their birth. Issues pumping and providing enough milk to sustain their babies contributed to emotional and physical stress with Hannah stating that this experience *"gave me more trauma".* The experience of physical recovery, feeding and adjusting to being a mother created an accumulation of difficulties that women found challenging to navigate.

> *"So whilst I was trying to figure out having him home and I was trying to stop pumping but I couldn't because I had mastitis and blocked ducts. I was in a process of like putting cold packs in my bra continuously and then like warm packs and then still trying to express to release some pain, backwards and forwards to the doctors, taking antibiotics, whilst also dealing with recovering from a seven-layer surgery and trying to understand what being a new mum is."*-Ellie

Fear

All participants in the study described experiencing anxiety and fear relating to parenting during the early post-partum period. Anxiety commonly revolved around the wellbeing, safety and development of their infant.

> *"I feel as if I find it really difficult not to overreact like something really terrible is going to happen to him […] I find that I overreact when something small goes wrong*". -Holly

Participants reflected that their birth created a perception of increased risk of harm to themselves and their babies. This led to difficulties separating from them, creating barriers to self-care and physical recovery. Natalie stated:

> *"I now don't like him being away from me. So I feel like he's always got to be with me […] I feel like I want him with me all the time [crying]. Which sometimes isn't the best thing because he doesn't settle well with people now […]"*

Anxiety also presented as a fear of parenting inadequacy. Hannah and Holly expressed concerns that others perceived them to be inadequate parents and were *"judging"* them.

> *"The first time I had to feed him in public was in Buchannan Galleries with a bottle and I could just feel people walking past going 'look at her with her bottle-fed baby'".*
> - Hannah

For some primiparous participants, a lack of knowledge of newborn care made parenting feel *"overwhelming"* (Megan). Participants worried about accidentally causing harm to their baby during infant care. Sarah explained:

> *"I was worried about what if- how often do we change his nappy? What if we don't do the bottle right? These things, crazy things. Could there be a clump of powder? Could he choke?"*

As evidenced from Sarah, participants also experienced concerns about *"doing it the right way"* (Natalie) and felt pressure to be *"perfect"* (Holly). Ellie reflected that her baby's start in life meant that she felt as though she had to provide him with the best care and constant stimulation to compensate, equating herself to a children's television character:

> *"I'm conscious that everything he sees is like a whole experience. I feel like I am Miss Rachel."*

Clutching at control

Participants shared that they needed to have control over all elements of parenting as they experienced a distrust in others to provide the same quality of care.

> *"Everything's got to be done in such a way. Like you know, this time, that time, this is what's happening […] and it works for him. Em but like it's like oh I'll just do it because then I know it's done right".* -Natalie

Ellie wondered if this response to parenting stemmed from her birth experience:

> *"I also don't know if that's something from having like a clutching at control kind of thing, because I hadn't had any control over like his start in life. Maybe trying to micromanage a bit too much".*

The experience of post-partum anxiety reduced over time, as women began to recover physically, developed confidence in their parenting abilities and understood their baby's needs. With this, they recognised that they started to relinquish control over parenting as explained by Holly:

> *"I was really particular about how things were done which has kind of gone away now. There's still things that I'm particular about but not to the point of he can't be with anyone else […]."*

For some women, their birth led them to seek control over future pregnancies. Planned caesareans were perceived to equate to less uncertainty, more control, and less risk of complications. Sarah's birth played a part in her decision to have no more children:

> *"[…] I know what could happen. As such I wouldn't be wanting to put myself through it again. I couldn't blame anyone but myself […] He'll be an only child."*

It takes a village

During the early weeks, support from others was crucial. As women started to establish autonomy, they balanced a fear of relinquishing control with a need for support. Partners were cited as the most important sources of support, with participants recognising that they would have found it difficult to cope without them.

> *"[…] if I'd gone home to a house with just me and the baby which I know some women do, or a partner who let's be serious wasn't that supportive, I don't know how I would have coped."*-Sarah

They were able to contain the women's anxiety and provide reassurance and were described as holding *"role of mum and dad"* (Sarah), to allow participants to rest. Where access to partner support was limited, participants found it more challenging to find time for self-care and to manage their anxiety.

Family also played a role, helping with infant care, practical tasks, and providing social support.

> *"And then my mum got here […] she went into full mode of 'please sit down, don't you dare bend over, don't do this' and I really needed that."* -Ellie

Sharing their experiences with other mothers, especially those who've experienced a birth trauma, helped them to adapt by validating their emotions and experiences. They suggested that peer support groups for new mothers would be a valuable resource.

> *"I think if there was some kind of group where new mums could be put in together […] Just somewhere to vent I think."*–Megan

Discussion

This study aimed to explore WABP's experiences of adjustment in the early post-partum period following a traumatic birth experience and to identify necessary information and resources. Using an inclusive definition of a traumatic birth experience (Leinweber et al., 2022), this study aimed to include the voices of women who may not have had their experiences recognised in previous research. Three themes emerged which illustrated parallel processes of adaptation following birth trauma and adjustment to motherhood, while women's interactions with the health care system influenced how they coped with and navigated these processes.

Literature exploring the immediate post-partum period is limited and predominantly focusses on women who meet DSM-V criteria for CB-PTSD. While some participants reported trauma symptoms such as flashbacks, nightmares (Moyzakitis, 2004; Ayers, 2007; Beck, 2016) and

dissociation (Byrne et al., 2017) , our findings consider the consequences of birth trauma by expanding the narrow lens of PTSD, providing broader insights into sequelae of birth trauma.

The physical burden of recovery emerged across themes. Existing research suggests that women experience prolonged physical recovery which negatively impacts quality of life (Aksu and Sercekus, 2023; Baghirzada et al., 2018). We elaborate on this by suggesting that physical recovery has implications for adjustment to motherhood, with cognitive symptoms such as 'brain fog' posing additional challenges.

Post-natal healthcare demanded significant time, creating a barrier to rest and recovery as well as spending time with family and adjusting to motherhood. Participants depended on support from the healthcare system during the postnatal period, however for many the care that they received had negative implications for post-natal adjustment. This aligns with women's experience of traumatic birth (Elmir et al., 2010; Watson et al., 2021). Our findings build upon the existing literature base, illustrating that negative interactions with the healthcare system persist into the post-natal period, serving as an extension of the trauma of birth. Our findings are consistent with treatment burden (Eton et al., 2012)– typically associated with chronic health conditions. To our knowledge this is the first study to recognise treatment burden within routine post-natal health care, existing studies focus on pregnant women with chronic conditions (Jakubowski et al., 2022).

Our findings deepen understanding of women's relationships with their infants and loved ones. Previous research has proposed associations between birth trauma and attachment issues (Nicholls and Ayers, 2007; Ayers et al., 2006). All women in our study reported a strong bond with their baby, however many felt overprotective and anxious (Nicholls and Ayers, 2007; Ayers et al., 2006). The study expands on existing research, highlighting how anxiety can evolve over time. The present study builds on the impact of trauma on partner relationships (Ayers et al., 2006; Nicholls and Ayers, 2007), highlighting the crucial support of loved ones in adjustment. Where partners were less accessible, family and girlfriends took on a supporting, potentially easing strain on partner relationships. Validation and support from other mothers was particularly valuable.

The results of the study can be understood through relevant theoretical frameworks, providing valuable insights which can inform practice. Cognitive theories of trauma processing may explain the experience of dissociation reported by participants (Ehlers and

Clark, 2000). This, coupled with the demands of parenting may serve to delay memory processing meaning that memories are a blur, and women fail to recognise their birth as traumatic until weeks after birth. For some women ,disruptions to memory processing led to flashbacks and nightmares (Ehlers and Clark, 2000). An ongoing sense of threat led to the development of 'safety behaviours' (Ehlers and Clark, 2000), like exerting control over parenting and avoiding separating from their baby. Interactions with the healthcare system served as a continuation of their trauma , this may be due to power imbalance and dismissiveness leading to continued feelings of vulnerability and appraisals of threat (Ehlers and Clark, 2000).

All maternity professionals should receive training in trauma informed practice and be aware of iatrogenic harm. The study supports the role out of the National Trauma Transformation Programme across maternity care in Scotland (NHS Education for Scotland (NES), 2021) which should include the use of testimony to bridge the gap between theory and practice. Women reported that midwives lacked understanding of their distress. Beck (2004) suggests that health professionals may not recognise psychological trauma due to a perception of birth trauma as physical injury. Despite the medical information available to them, midwives should treat all women with trauma informed principles.

When perception of threat decreased, participants described a process of adaptation, learning and emotional growth which aligns with the stages of post-traumatic growth (PTG) - *"the experience of positive change"* following a traumatic event (Tedeschi and Calhoun, 2004). Opportunities for trauma processing and social connectedness can promote PTG (Tedeschi and Calhoun, 2004). The study supports national guidelines (Healthcare Improvement Scotland, 2023) for the provision of birth reflections at 6 weeks to promote processing and facilitate PTG. As social connectedness is important for PTG, services should assess the availability of social support and respond accordingly. Peer support groups for new mothers may play a valuable role in trauma adaptation as well as building parenting confidence.

The process of PTG coincided with adjustment to motherhood. Mercer's Theory of Becoming a Mother (BAM) (Mercer, 2004) is a four stage model describing the process of maternal identity development and the influence of personal, social and environmental factors. Participants moved through each stage, although they were disrupted by physical, emotional and interpersonal challenges. In stage two, women depend on healthcare staff to build parenting confidence. However, participants felt unsupported by clinicians leading to a

delayed confidence in their parenting abilities. Restoration was also delayed due to the intensive physical demands of parenting whilst physically recovering.

Healthcare staff should look wider than symptoms of trauma and be aware of any barriers to progressing through these stages. Women need increased support with infant care in hospital to facilitate rest and early recovery. This could be facilitated by allowing partners or family members to stay overnight. Limited antenatal classes contributed to women feeling unprepared, these should be offered routinely to all women.

These considerations inform the secondary research question which asked about preferences for information and resources. Participants expressed a desire to be better informed, recognising a need for more information about risks, complications, feeding and infant care. Resources should also provide psychoeducation to support normalisation of trauma responses in the early weeks post-partum (Ehlers and Clark, 2000), offer advice for processing the experience and facilitating PTG, and sources of peer and professional support. Women may be better equipped to engage with information during pregnancy, and providing information in advance may facilitate agency and prevent feelings of helplessness, a core feature of traumatic birth (Elmir et al., 2010).

Strengths and Limitations

In-depth interviews provided detailed narratives which clearly illustrate how women experience adjustment during the early post-partum period after a self-reported traumatic birth. The data presents novel findings within this population relating to post-natal treatment burden and the complex interplay between interactions with the health care system, the psychological impact of birth trauma and adjustment to becoming a mother.

The study sample lacks diversity, as all participants were heterosexual, white, cis-gendered women with higher education and employment. Individuals from minority groups are known to experience poorer outcomes throughout pregnancy and birth (Klittmark et al., 2023; Evans, 2024; Silverio et al., 2023). Inclusion of a more diverse range of voices would have provided a broader understanding of post-natal experiences. All women were in relationships and had consistent and reliable sources of support, a factor known to influence coping and adjustment after birth trauma (Beck & Watson, , 2016). Without the perspectives of individuals who may experience isolation or strained relationships the findings of the study may overlook a wider experience of adjustment difficulties.

Participants were recruited from the community through midwives and health visitors rather than the MNPI or Perinatal Mental Health Services. Although this allowed us to recruit women who may not require specialist mental health services, it is possible that our study failed to capture those who were experiencing acute distress and difficulties with adjustment following their birth.

Caesarean and other assisted methods of birth are known to be risk factors for CB-PTSD (Ayers et al., 2016) and may lead to longer physical recovery time. However, methods of delivery were not gathered with demographic data. Knowing the method of delivery may have provided an insight into any differences in adaptation or adjustment and therefore any unique support needs within this population.

Policy Implications

The present study shares findings with the UK Birth Trauma Inquiry who described "a maternity system where poor care is all-too-frequently tolerated as normal […]" (All-Party Parliamentary Group on Birth Trauma [APPGBT], 2024). Policy makers should listen to the testimony of women to inform maternity policy, strengthening legal rights to ensure the provision of trauma informed practice and the prioritisation of physical and psychological wellbeing following a birth trauma. Clinical guidelines and policy should recognise the physical, cognitive and emotional impact of birth complications and the treatment burden experienced by women as a result. They should aim to improve continuity of care and establish pathways for birth trauma to reduce treatment burden. Furthermore, current policy uses powerful public health messaging to promote breastfeeding in Scotland (Scottish Government, 2019) however, the physical stress and pressure felt by women who wanted to breastfeed following birth trauma was re-traumatising. Policy should consider the impact of birth trauma on ability to breastfeed and assess whether an alternative strategy would be more appropriate.

Future Research

Future research should aim to explore experiences of post-natal adjustment after a birth trauma in individuals that this study failed to reach. For example, those from minority groups. It is important to understand the experiences of individuals who do not have the same level of informal post-natal support as the participants in the present study. It is possible that method of birth may also influence women's experiences of post-partum adjustment, further research

could compare experiences of women who had a caesarean or assisted birth, and those who had a spontaneous vaginal delivery to determine if there are differences in support needs.

Conclusions

This study illustrates the complex interplay of personal adaptation and adjustment to motherhood that occurs following a birth trauma and is directly influenced by interactions with the healthcare system. While the study facilitated an understanding of information and resources required for women in the post-natal period, it went further than that, recognising the need for improvement in maternity and post-natal healthcare practice and policy more widely. The testimonies of those who have experienced birth trauma should inform maternity policy, ensuring that women have the legal right to trauma informed, responsive healthcare that promotes emotional and physical recovery and supports the development of maternal identity.

References

Aksu DF and Sercekus P (2023) Traumatic childbirth experiences, effects and coping: A qualitative study. *Sexual and Reproductive Healthcare* 37(no pagination).

All-Party Parliamentary Group on Birth Trauma [APPGBT] (2024) Listen to mums: Ending the postcode lottery on perinatal care.

American Psychiatric Association (2022) *Diagnostic and statistical manual of mental disorders*

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

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

Ayers S, Bond R, Bertullies S, et al. (2016) The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework. *Psychol Med* 46(6): 1121-1134.

Ayers S, Eagle A and Waring H (2006) The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health & Medicine* 11(4): 389-398.

Baghirzada L, Ibrahimov F and Macarthur AJ (2018) Recovery after childbirth: A qualitative study of postpartum women. *Clinical Case Studies and Reports* 1.

Beck CT (2004) Birth trauma: in the eye of the beholder. *Nurs Res* 53(1): 28-35.

Beck CT (2016) Posttraumatic Stress Disorder After Birth: A Metaphor Analysis. *MCN. The American journal of maternal child nursing* 41(2): 76-76.

Beck CT and Watson S (2016) Posttraumatic Growth After Birth Trauma: “I Was Broken, Now I Am Unbreakable”. *MCN: The American Journal of Maternal/Child Nursing* 41(5).

Bedaso A, Adams J, Peng W, et al. (2021) The relationship between social support and mental health problems during pregnancy: a systematic review and meta-analysis. *Reprod Health* 18(1): 162.

Braun V and Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2): 77-101.

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

Dekel S, Thiel F, Dishy G, et al. (2019) Is childbirth-induced PTSD associated with low maternal attachment? *Archives of Women's Mental Health* 22(1): 119-122.

Dencker A, Nilsson C, Begley C, et al. (2019) Causes and outcomes in studies of fear of childbirth: A systematic review. *Women and Birth* 32(2): 99-111.

Ehlers A and Clark DM (2000) A cognitive model of posttraumatic stress disorder. *Behav Res Ther* 38(4): 319-345.

Elmir R, Schmied V, Wilkes L, et al. (2010) Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *J Adv Nurs* 66(10): 2142-2153.

Eton DT, Ramalho de Oliveira D, Egginton JS, et al. (2012) Building a measurement framework of burden of treatment in complex patients with chronic conditions: a qualitative study. *Patient Related Outcome Measures* 3(null): 39-49.

Evans C (2024) African american womens' experience of birth traum. *Journal of Reproductive and Infant Psychology* 42(4): 731-740.

Global Burden of Disease 2015 Maternal Mortality Collaborators (2016) Global, regional, and national levels of maternal mortality, 1990-2015: a systematic analysis for the Global Burden of Disease Study 2015. *Lancet* 388(10053): 1775-1812.

Green H, and Riddington A (2020a). Gender Inclusive Language in Perinatal Services: Mission Statement and Rationale. Retrieved from https://www.bsuh.nhs.uk/maternity/wp-content/uploads/sites/7/2021/01/Gender-inclusive- language-in-perinatal-services.pdf

Healthcare Improvement Scotland (2023) SIGN 169 Perinatal mental health conditions: A national clinical guideline. Healthcare Improvement Scotland.

Howard LM, Molyneaux E, Dennis C-L, et al. (2014) Non-psychotic mental disorders in the perinatal period. *The Lancet* 384(9956): 1775-1788.

Jakubowski BE, Hinton L, Khaira J, et al. (2022) Is self-management a burden? What are the experiences of women self-managing chronic conditions during pregnancy? A systematic review. *BMJ Open* 12(3): e051962.

Klittmark S, Malmquist A, Karlsson G, et al. (2023) When complications arise during birth: LBTQ people's experiences of care. *Midwifery* 121: 103649.

Leinweber J, Fontein-Kuipers Y, Thomson G, et al. (2022) Developing a woman-centered, inclusive definition of traumatic childbirth experiences: A discussion paper. *Birth* 49(4): 687-696.

Mercer RT (2004) Becoming a Mother Versus Maternal Role Attainment. *Journal of Nursing Scholarship* 36(3): 226-232.

Moyzakitis W (2004) Exploring women's descriptions of distress and/or trauma in childbirth from a feminist perspective. *Evidence-Based Midwifery* 2: 8+.

NHS Education for Scotland (NES) (2021) 2021 Maternity Services Report Transforming Psychological Trauma. NHS Education for Scotland (NES).

Nicholls K and Ayers S (2007) Childbirth-related post-traumatic stress disorder in couples: a qualitative study. *Br J Health Psychol* 12(Pt 4): 491-509.

Olsen W (2007) Critical Realist Explorations in Methodology. *Methodological Innovations Online* 2(2): 1-5.

Renfrew MJ, McFadden A, Bastos MH, et al. (2014) Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *Lancet* 384(9948): 1129-1145.

Scottish Government (2019) Becoming Breastfeeding Friendly Scotland: report. Scottish Government.

Silverio SA, Varman N, Barry Z, et al. (2023) Inside the ‘imperfect mosaic’: Minority ethnic women’s qualitative experiences of race and ethnicity during pregnancy, childbirth, and maternity care in the United Kingdom. *BMC public health* 23(1): 2555.

Small R, Roth C, Raval M, et al. (2014) Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries. *BMC Pregnancy Childbirth* 14: 152.

Soet JE, Brack GA and DiIorio C (2003) Prevalence and Predictors of Women's Experience of Psychological Trauma During Childbirth. *Birth* 30(1): 36-46.

Stuijfzand S, Garthus-Niegel S and Horsch A (2020) Parental Birth-Related PTSD Symptoms and Bonding in the Early Postpartum Period: A Prospective Population-Based Cohort Study. *Front Psychiatry* 11: 570727.

Tedeschi RG and Calhoun LG (2004) " Posttraumatic growth: conceptual foundations and empirical evidence". *Psychological inquiry* 15(1): 1-18.

Tseris E (2013) Trauma Theory Without Feminism? Evaluating Contemporary Understandings of Traumatized Women. *Affilia* 28: 153-164.

Watson K, White C, Hall H, et al. (2021) Women's experiences of birth trauma: A scoping review. *Women and Birth* 34(5): 417-424.

World Health Organisation (2018) WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organisation

Yildiz PD, Ayers S and Phillips L (2017) The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *J Affect Disord* 208: 634-645.

Appendices

Appendix 1.1: Prisma Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	p.7
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	p.8
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	p.9-11
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p.11
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p.12, p.14
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p.11 Appendices 1.3,1.4
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Appendix 1.4
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	p.13, p.15
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p.13, p.16
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	p.13
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	p.13
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	p.14
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	n/a
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	p.13-14
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	n/a
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	p.14,27

Section and Topic	Item #	Checklist item	Location where item is reported
			Figure 2 Appendices 1.6,1.7
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	p.14-15
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	n/a
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	n/a
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	n/a
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	n/a
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	p.15-16 Figure 1
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	p.15-16 Figure 1
Study characteristics	17	Cite each included study and present its characteristics.	p.16 Table 1
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	p.25 Table 2
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Table 1
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	27-33
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	n/a
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	n/a
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	n/a
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	n/a
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	n/a
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.34
	23b	Discuss any limitations of the evidence included in the review.	p.36

Section and Topic	Item #	Checklist item	Location where item is reported
	23c	Discuss any limitations of the review processes used.	p.36
	23d	Discuss implications of the results for practice, policy, and future research.	p.36-38
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p.11
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p.11
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	p.11
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	n/a
Competing interests	26	Declare any competing interests of review authors.	n/a
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	n/a

Appendix 1.2: ENTREQ Checklist

Item No.	Guide and Description	Report Location
1. Aim	State the research question the synthesis addresses	p.11
2. Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis)	p.14
3. Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved)	p.11
4. Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type)	p.12-13
5. Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources	p.11
6. Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits)	p.12 Appendices 1.3,1.4
7. Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies)	p.13
8. Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions)	Table 1 p.16
9. Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development)	Figure 1 p.15-16

10. Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings)	p.14
11. Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting)	p.14
12. Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required	p.14
13. Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale	p.25 Table 2
14. Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software)	*p.13*
15. Software	State the computer software used, if any	p.13
16. Number of reviewers	Identify who was involved in coding and analysis	p.14-15
17. Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts)	p.14
18. Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary)	p.14
19. Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive	p.14
20. Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation	p.27-33
21. Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct)	p.27-37

Appendix 1.3: Search Terms

Key Concept: Birth

Thesaurus Terms

Embase (OVID)	Medline (OVID)	PsychINFO (EBSCOhost)	CINAHL (EBSCOhost)	Psychology and Behavioural Sciences Collection (EBSCOhost)	Web of Science
exp birth	exp parturition	DE Birth	MH "Childbirth+"	DE "CHILDBIRTH"	
exp natural childbirth		DE "Natural Childbirth"			
exp childbirth		DE "Birth Trauma"			

Free Text Terms

Embase (OVID)	Medline (OVID)	PsychINFO (EBSCOhost)	CINAHL (EBSCOhost)	Psychology and Behavioural Sciences Collection (EBSCOhost)	Web of Science
Parturition	Parturition.tw	Parturition.tw	Parturition.tw	Parturition.tw	Parturition
Childbirth	Childbirth.tw	Childbirth.tw	Childbirth.tw	Childbirth.tw	Childbirth
Child adj1 birth	Child adj1 birth.tw	"Child n1 birth".tw	"Child n1 birth".tw	"Child n1 birth".tw	"Child near/1 birth"
Birth	Birth.tw	Birth.tw	Birth.tw	Birth.tw	Birth

Key Concept: Psychological Trauma

Thesaurus terms

Embase (OVID)	Medline (OVID)	PsychINFO (EBSCOhost)	CINAHL (EBSCOhost)	Psychology and Behavioural Sciences Collection (EBSCOhost)	Web of Science
exp psychotrauma	Exp psychological trauma	DE "Emotional Trauma"	MH "Psychological Trauma"	DE "EMOTIONAL trauma"	
exp posttraumatic stress disorder	exp stress disorders, post-traumatic	DE "Posttraumatic Stress"	MH "Stress Disorders, Post-Traumatic"	DE "POST-traumatic stress disorder"	
		DE "Trauma"			
		DE "Birth Trauma"			

Free Text Terms

Embase (OVID)	Medline (OVID)	PsychINFO (EBSCOhost)	CINAHL (EBSCOhost)	Psychology and Behavioural Sciences Collection (EBSCOhost)	Web of Science
((psychological adj (trauma* or distress*)) or Post traumatic stress disorder or PTSD).tw	((psychological adj (trauma* or distress*)) or Post traumatic stress disorder or PTSD).tw	((psychological n (trauma* or distress*)) or Post traumatic stress disorder or PTSD).tw	((psychological n (trauma* or distress*)) or Post traumatic stress disorder or PTSD).tw	((psychological n (trauma* or distress*)) or Post traumatic stress disorder or PTSD).tw	((psychological near/ (trauma* or distress*)) or Post traumatic stress disorder or PTSD).
(*birth trauma or traumatic *birth).tw	(*birth trauma or traumatic *birth).tw	(Birth trauma or traumatic birth).tw	(Birth trauma or traumatic birth).tw	(Birth trauma or traumatic birth).tw	(Birth trauma or traumatic birth)

Key Concept: Qualitative Design & Methodology

Thesaurus Terms

Embase	**Medline**	**PsychINFO**	**CINAHL**	**Psychology and Behavioural Sciences Collection**	**Web of Science**[1]
qualitative stud$.mp.	Qualitative Research/	DE "Qualitative Methods"	Qualitative Studies/	DE "QUALITATIVE research"	(birth stories or birth narratives
nursing methodology research.mp.	Nursing Methodology Research/		Research Nursing/		qualitative research
questionnaire/	Questionnaires/	DE "Questionnaires"	exp Questionnaires/	Exp DE “QUESTIONNAIRES”	qualitative stud*
attitude/	exp Attitude/		exp Attitude/	DE "ATTITUDE (Psychology) -- Social aspects"	nursing research methodology
focus group$.mp.	Focus Groups/	DE "Focus Group"	Focus Groups/		questionnaire
discourse analysis.mp.	discourse analysis.mp.	DE "Discourse Analysis"	Discourse Analysis/	DE "DISCOURSE analysis"	attitude
content analysis.mp.	content analysis.mp.	DE "Content Analysis"	Content Analysis/	DE "CONTENT analysis"	focus groups
ethnographic research.mp.	ethnographic research.mp.	DE "Ethnography"	Ethnographic Research/	DE "ETHNOGRAPHIC analysis"	discourse analysis
ethnological research.mp.	ethnological research.mp.		Ethnological Research/		content analysis
ethnonursing research.mp.	ethnonursing research.mp.		Ethnonursing Research/		ethnographic research
constant comparative method.mp.	constant comparative method.mp.		Constant Comparative Method/		constant comparative method
qualitative validity.mp.	qualitative validity.mp.		exp Qualitative Validity/		qualitative validity

[1] There is a limit placed on search terms in Web of Science therefore qualitative search terms were split into five sections (denoted by brackets). Five searches were completed including all the birth and trauma terms and sequential sections of the qualitative terms.

purposive sample.mp.	purposive sample.mp.		Purposive Sample/		purposive sampl*
observational method$.mp.	observational method$.mp.	DE "Participant Observation"	exp Observational Methods/	DE "OBSERVATION (Psychology)"	observational research
field stud$.mp.	field stud$.mp.		Field Studies/		field stud*
theoretical sampl$.mp.	theoretical sampl$.mp.		Theoretical Sample/		theoretical sampl*
phenomenology/	phenomenology/	DE "Phenomenology"	Phenomenology/		phenomenology
phenomenological research.mp.	phenomenological research.mp.	DE "Interpretative Phenomenological Analysis"	Phenomenological Research/		phenomenological research
life experience$.mp.	life experience$.mp.	DE "Life Experiences"	exp Life Experiences/	DE "LIFE change events"	life experiences
cluster sampl$.mp.	cluster sampl$.mp.		exp Cluster Sample/		cluster sample*)
		DE "Narrative Analysis"		DE "NARRATIVE discourse analysis"	
		DE "Thematic Analysis"			

Free Text Terms

Embase (OVID)	**Medline (OVID)**	**PsychINFO (EBSCOhost)**	**CINAHL (EBSCOhost)**	**Psychology and Behavioural Sciences Collection (EBSCOhost)**	**Web of Science**
(birth narratives or birth stories).tw	(birth narratives or birth stories).tw	(birth narratives or birth stories).tw	(birth narratives or birth stories).tw	(birth narratives or birth stories).tw	(ethnonursing
qualitative research.tw	qualitative research.tw	qualitative research.tw	qualitative research.tw	qualitative research.tw	ethnograph
ethnonursing.af.	ethnonursing.af.	ethnonursing.af.	ethnonursing.af.	ethnonursing.af.	Phenomenol*
ethnograph$.mp.	ethnograph$.mp.	ethnograph$.mp.	ethnograph$.mp.	ethnograph$.mp.	grounded theory*

phenomenol$.af.	phenomenol$.af.	phenomenol$.af.	phenomenol$.af.	phenomenol$.af.	grounded stud*
grounded theory.mp.	grounded theory.mp.	grounded theory.mp.	grounded theory.mp.	grounded theory.mp.	grounded research
(grounded adj (theor$ or study or studies or research or analys?s)).af.	(grounded adj (theor$ or study or studies or research or analys?s)).af.	(grounded adj (theor$ or study or studies or research or analys?s)).af.	(grounded adj (theor$ or study or studies or research or analys?s)).af.	(grounded adj (theor$ or study or studies or research or analys?s)).af.	grounded analys?s
((life stor$) or (women's stor$))	((life stor$) or (women's stor$))	((life stor$) or (women's stor$))	((life stor$) or (women's stor$))	((life stor$) or (women's stor$))	life stor*
(emic or etic or hermeneutic$ or heuristic$ or semiotic$).af. or (data adj1 saturat$).tw. or (participant observ$).tw.	(emic or etic or hermeneutic$ or heuristic$ or semiotic$).af. or (data adj1 saturat$).tw. or (participant observ$).tw.	(emic or etic or hermeneutic$ or heuristic$ or semiotic$).af. or (data adj1 saturat$).tw. or (participant observ$).tw.	(emic or etic or hermeneutic$ or heuristic$ or semiotic$).af. or (data adj1 saturat$).tw. or (participant observ$).tw.	(emic or etic or hermeneutic$ or heuristic$ or semiotic$).af. or (data adj1 saturat$).tw. or (participant observ$).tw.	women's stor*
((social construct$ or (postmodern$ or post-structural$) or (post structural$ or poststructural$) or (post modern$) or post-modern$ or feminis$ or interpret$).mp.	((social construct$ or (postmodern$ or post-structural$) or (post structural$ or poststructural$) or (post modern$) or post-modern$ or feminis$ or interpret$).mp.	((social construct$ or (postmodern$ or post-structural$) or (post structural$ or poststructural$) or (post modern$) or post-modern$ or feminis$ orinterpret$).mp.	((social construct$ or (postmodern$ or post-structural$) or (post structural$ or poststructural$) or (post modern$) or post-modern$ or feminis$ orinterpret$).mp.	((social construct$ or (postmodern$ or post-structural$) or (post structural$ or poststructural$) or (post modern$) or post-modern$ or feminis$ orinterpret$).mp.	emic
(action research or cooperative inquir$ or (co operative inquir$) or (co-operative inquir$)).mp.	(action research or cooperative inquir$ or (co operative inquir$) or (co-operative inquir$)).mp.	(action research or cooperative inquir$ or (co operative inquir$) or (co-operative inquir$)).mp.	(action research or cooperative inquir$ or (co operative inquir$) or (co-operative inquir$)).mp.	(action research or cooperative inquir$ or (co operative inquir$) or (co-operative inquir$)).mp.	etic
(humanistic or existential or experiential or paradigm$).mp.	(humanistic or existential or experiential or paradigm$).mp.	(humanistic or existential or experiential or paradigm$).mp.	(humanistic or existential or experiential or paradigm$).mp.	(humanistic or existential or experiential or paradigm$).mp.	Hermeneutic*

(field adj (study or studies or research).tw.	(field adj (study or studies or research).tw.	(field adj (study or studies or research).tw.	(field adj (study or studies or research).tw.	(field adj (study or studies or research).tw.	heuristic*
(human science).tw.	(human science).tw.	(human science).tw.	(human science).tw.	(human science).tw.	semiotic*
(biographical method).tw.	(biographical method).tw.	(biographical method).tw.	(biographical method).tw.	(biographical method).tw.	data saturat*
(qualitative validity).af.	(qualitative validity).af.	(qualitative validity).af.	(qualitative validity).af.	(qualitative validity).af.	participant observ*)
(purposive sampl$).af.	(purposive sampl$).af.	(purposive sampl$).af.	(purposive sampl$).af.	(purposive sampl$).af.	(social construct*
(theoretical sampl$).af.	(theoretical sampl$).af.	(theoretical sampl$).af.	(theoretical sampl$).af.	(theoretical sampl$).af.	postmodern*
((purpos$ adj4 sampl$) or (focus adj group$)).af.	((purpos$ adj4 sampl$) or (focus adj group$)).af.	((purpos$ adj4 sampl$) or (focus adj group$)).af.	((purpos$ adj4 sampl$) or (focus adj group$)).af.	((purpos$ adj4 sampl$) or (focus adj group$)).af.	post structural*
(account or accounts or unstructured or open-ended or (open ended) or text$ or narrative$.mp.	(account or accounts or unstructured or open-ended or (open ended) or text$ or narrative$.mp.	(account or accounts or unstructured or open-ended or (open ended) or text$ or narrative$.mp.	(account or accounts or unstructured or open-ended or (open ended) or text$ or narrative$.mp.	(account or accounts or unstructured or open-ended or (open ended) or text$ or narrative$.mp.	feminis*
((life world) or life-world or conversation analys?s or personal experience$ or theoretical saturation).mp.	((life world) or life-world or conversation analys?s or personal experience$ or theoretical saturation).mp.	((life world) or life-world or conversation analys?s or personal experience$ or theoretical saturation).mp.	((life world) or life-world or conversation analys?s or personal experience$ or theoretical saturation).mp.	((life world) or life-world or conversation analys?s or personal experience$ or theoretical saturation).mp.	interpret*
(lived experience$).tw.	(lived experience$).tw.	(lived experience$).tw.	(lived experience$).tw.	(lived experience$).tw.	action research
(life experience$.mp.	(life experience$.mp.	(life experience$.mp.	(life experience$.mp.	(life experience$.mp.	co-operative inquir*
(cluster sampl$).mp.	(cluster sampl$).mp.	(cluster sampl$).mp.	(cluster sampl$).mp.	(cluster sampl$).mp.	humanistic
(theme$ or thematic).mp.	(theme$ or thematic).mp.	(theme$ or thematic).mp.	(theme$ or thematic).mp.	(theme$ or thematic).mp.	existential
categor$.mp.	categor$.mp.	categor$.mp.	categor$.mp.	categor$.mp.	experiential
observational method$.af.	observational method$.af.	observational method$.af.	observational method$.af.	observational method$.af.	paradigm*

field stud$.mp.	field stud$.mp.	field stud$.mp.	field stud$.mp.	field stud$.mp.	field stud*
focus group$.af.	focus group$.af.	focus group$.af.	focus group$.af.	focus group$.af.	field research
questionnaire$.mp.	questionnaire$.mp.	questionnaire$.mp.	questionnaire$.mp.	questionnaire$.mp.	human science)
(content analysis).af.	(content analysis).af.	(content analysis).af.	(content analysis).af.	(content analysis).af.	(biographical method*
(thematic analysis).af.	(thematic analysis).af.	(thematic analysis).af.	(thematic analysis).af.	(thematic analysis).af.	qualitative validity
(constant comparative).af.	(constant comparative).af.	(constant comparative).af.	(constant comparative).af.	(constant comparative).af.	purposive sampl*
(discourse analys?s).af.	(discourse analys?s).af.	(discourse analys?s).af.	(discourse analys?s).af.	(discourse analys?s).af.	theoretical sampl*
((discourse$ or discurs$) adj3 analys?s).tw.	((discourse$ or discurs$) adj3 analys?s).tw.	((discourse$ or discurs$) adj3 analys?s).tw.	((discourse$ or discurs$) adj3 analys?s).tw.	((discourse$ or discurs$) adj3 analys?s).tw.	open-ended account*
(constant adj (comparative or comparison)).af.	(constant adj (comparative or comparison)).af.	(constant adj (comparative or comparison)).af.	(constant adj (comparative or comparison)).af.	(constant adj (comparative or comparison)).af.	unstructured account*
(narrative analys?s).af.	(narrative analys?s).af.	(narrative analys?s).af.	(narrative analys?s).af.	(narrative analys?s).af.	narrative*
heidegger$.tw.	heidegger$.tw.	heidegger$.tw.	heidegger$.tw.	heidegger$.tw.	life world
colaizzi$.tw.	colaizzi$.tw.	colaizzi$.tw.	colaizzi$.tw.	colaizzi$.tw.	conversation analys?s
speigelberg$.tw.	speigelberg$.tw.	speigelberg$.tw.	speigelberg$.tw.	speigelberg$.tw.	theoretical saturation
(van adj manen$).tw.	(van adj manen$).tw.	(van adj manen$).tw.	(van adj manen$).tw.	(van adj manen$).tw.	lived experience*
(van adj kaam$).tw.	(van adj kaam$).tw.	(van adj kaam$).tw.	(van adj kaam$).tw.	(van adj kaam$).tw.	cluster sampl*
(merleau adj ponty$).tw.	(merleau adj ponty$).tw.	(merleau adj ponty$).tw.	(merleau adj ponty$).tw.	(merleau adj ponty$).tw.	theme*
(merleau adj ponty$).tw.	husserl$.tw.	husserl$.tw.	husserl$.tw.	husserl$.tw.	Thematic analysis)
giorgi$.tw.	giorgi$.tw.	giorgi$.tw.	giorgi$.tw.	giorgi$.tw.	(discurs*
foucault$.tw.	foucault$.tw.	foucault$.tw.	foucault$.tw.	foucault$.tw.	narrative analys?s
(corbin$ adj2 strauss$).tw.	(corbin$ adj2 strauss$).tw.	(corbin$ adj2 strauss$).tw.	(corbin$ adj2 strauss$).tw.	(corbin$ adj2 strauss$).tw.	heidegger*

(strauss$ adj2 corbin$).tw.	(strauss$ adj2 corbin$).tw.	(strauss$ adj2 corbin$).tw.	(strauss$ adj2 corbin$).tw.	(strauss$ adj2 corbin$).tw.	colaizzi*
(glaser$ adj2 strauss$).tw.	(glaser$ adj2 strauss$).tw.	(glaser$ adj2 strauss$).tw.	(glaser$ adj2 strauss$).tw.	(glaser$ adj2 strauss$).tw.	speigelberg*
glaser$.tw.	glaser$.tw.	glaser$.tw.	glaser$.tw.	glaser$.tw.	Van kaam*
or/1- 48	or/1- 48	or/1- 48	or/1- 48	or/1- 48	van manen*
					merleau ponty*
					husserl*
					giorgi*
					foucault*
					corbin*
					strauss *
					glaser*)

Broad based terms

Embase (OVID)	**Medline (OVID)**	**PsychINFO (EBSCOhost)**	**CINAHL (EBSCOhost)**	**Psychology and Behavioural Sciences Collection (EBSCOhost)**	**Web of Science**
findings.af.	findings.af.	findings.af.	findings.af.	findings.af.	findings
interview$.af. or Interviews/	interview$.af. or Interviews/	interview$.af. or exp Interviews/	interview$.af. or exp Interviews/	interview$.af. or exp Interviews/	Interview*
qualitative.af.	qualitative.af.	qualitative.af.	qualitative.af.	qualitative.af.	qualitative
or/1-3	or/1-3	or/1-3	or/1-3	or/1-3	

Appendix 1.4: Search History (Conducted 13th September 2024)

Embase (OVID)

1	exp birth/	38271
2	exp natural childbirth/	2863
3	exp childbirth/	78944
4	(Parturition or childbirth or (child adj1 birth) or birth).tw.	551993
5	1 or 2 or 3 or 4	611716
6	exp psychotrauma/	13060
7	exp posttraumatic stress disorder/	87678
8	((psychological adj (trauma* or distress*)) or Post traumatic stress disorder or PTSD).tw.	92363
9	(Birth trauma or traumatic birth).tw.	2754
10	6 or 7 or 8 or 9	141180
11	qualitative stud$.mp.	92037
12	nursing methodology research.mp.	14888
13	questionnaire/	983610
14	attitude/	81316
15	focus group$.mp.	87555
16	discourse analysis.mp.	3877
17	content analysis.mp.	60001
18	ethnographic research.mp.	2189
19	ethnological research.mp.	12
20	ethnonursing research.mp.	57
21	constant comparative method.mp.	2763
22	qualitative validity.mp.	253

23 purposive sample.mp. 7491

24 observational method$.mp. 2936

25 field stud$.mp. 27862

26 theoretical sampl$.mp. 1321

27 phenomenology/ 14734

28 phenomenological research.mp. 877

29 life experience$.mp. 12373

30 cluster sampl$.mp. 12619

31 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 1303685

32 (birth narratives or birth stories).tw. 121

33 qualitative research.tw. 24855

34 ethnonursing.af. 141

35 ethnograph$.mp. 17679

36 phenomenol$.af. 46342

37 grounded theory.mp. 20739

38 (grounded adj (theor$ or study or studies or research or analys?s)).af. 21022

39 (life stor$ or women's stor$).mp. 2319

40 (emic or etic or hermeneutic$ or heuristic$ or semiotic$).af. or (data adj1 saturat$).tw. or participant observ$.tw. 39326

41 (social construct$ or (postmodern$ or post-structural$) or (post structural$ or poststructural$) or post modern$ or post-modern$ or feminis$ or interpret$).mp. 707179

42 (action research or cooperative inquir$ or co operative inquir$ or co-operative inquir$).mp. 7816

43 (humanistic or existential or experiential or paradigm$).mp. 265060

44 (field adj (study or studies or research)).tw. 24005

45 human science.tw. 336

46 biographical method.tw. 34

47 qualitative validity.af. 253

48 purposive sampl$.af. 20631

49 theoretical sampl$.af. 1322

50 ((purpos$ adj4 sampl$) or (focus adj group$)).af. 121443

51 (account or accounts or unstructured or open-ended or open ended or text$ or narrative$).mp. 1127504

52 (life world or life-world or conversation analys?s or personal experience$ or theoretical saturation).mp. 94966

53 lived experience$.tw. 16624

54 life experience$.mp. 12373

55 cluster sampl$.mp. 12619

56 (theme$ or thematic).mp. 245964

57 categor$.mp. 802022

58 observational method$.af. 2939

59 field stud$.mp. 27862

60 focus group$.af.88383

61 questionnaire$.mp. 1397579

62 content analysis.af. 60174

63 thematic analysis.af. 66858

64 constant comparative.af.5262

65 discourse analys?s.af. 3930

66 ((discourse$ or discurs$) adj3 analys?s).tw. 3694

67 (constant adj (comparative or comparison)).af. 8145

68 narrative analys?s.af. 2463

69 heidegger$.tw. 973

70 colaizzi$.tw. 1531

71 speigelberg$.tw. 1

72 (van adj manen$).tw. 679

73 (van adj kaam$).tw. 50

74 (merleau adj ponty$).tw. 315

75 husserl$.tw. 425

76 giorgi$.tw. 1330

77 foucault$.tw. 1049

78 (corbin$ adj2 strauss$).tw. 535

79 (strauss$ adj2 corbin$).tw. 535

80 (glaser$ adj2 strauss$).tw. 157

81 glaser$.tw. 1200

82 findings.af. 3693147

83 interview$.af. or Interviews/ 694766

84 qualitative.af. 510144

85 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83 or 84 7862474

86 5 and 10 and 85 2549

MEDLINE(R) (OVID)

1	exp parturition/	23346
2	(Parturition or Childbirth or (Child adj1 birth) or Birth).tw.	398026
3	1 or 2	405963
4	exp psychological trauma/	2156
5	exp stress disorders, post-traumatic/	43833
6	((psychological adj (trauma* or distress*)) or Post traumatic stress disorder or PTSD).tw.	71930
7	(Birth trauma or traumatic birth).tw.	1642
8	4 or 5 or 6 or 7	90396
9	Qualitative Research/	92472
10	Nursing Methodology Research/	16438
11	Questionnaires/	593672
12	exp Attitude/	654842
13	Focus Groups/	38454
14	discourse analysis.mp.	2838
15	content analysis.mp.	49430
16	ethnographic research.mp.	1329
17	ethnological research.mp.	8
18	ethnonursing research.mp.	44
19	constant comparative method.mp.	2064
20	qualitative validity.mp.	24
21	purposive sample.mp.	5103
22	observational method$.mp.	1059
23	field stud$.mp.	19390
24	theoretical sampl$.mp.	1019

25 phenomenology/ 0

26 life experience$.mp. 8479

27 cluster sampl$.mp. 10293

28 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 1248505

29 (birth narratives or birth stories).tw. 119

30 qualitative research.tw. 20505

31 ethnonursing.af. 136

32 ethnograph$.mp. 15079

33 phenomenol$.af. 37586

34 grounded theory.mp. 16639

35 (grounded adj (theor$ or study or studies or research or analys?s)).af. 16897

36 (life stor$ or women's stor$).mp. 1849

37 (emic or etic or hermeneutic$ or heuristic$ or semiotic$).af. or (data adj1 saturat$).tw. or participant observ$.tw. 33401

38 (social construct$ or (postmodern$ or post-structural$) or (post structural$ or poststructural$) or post modern$ or post-modern$ or feminis$ or interpret$).mp. 665664

39 (action research or cooperative inquir$ or co operative inquir$ or co-operative inquir$).mp. 6270

40 (humanistic or existential or experiential or paradigm$).mp. 211025

41 (field adj (study or studies or research)).tw. 20810

42 human science.tw. 270

43 biographical method.tw. 25

44 qualitative validity.af. 24

45 purposive sampl$.af. 14733

46 theoretical sampl$.af. 1019

47 ((purpos$ adj4 sampl$) or (focus adj group$)).af. 101328

48 (account or accounts or unstructured or open-ended or open ended or text$ or narrative$).mp. 892774

49 (life world or life-world or conversation analys?s or personal experience$ or theoretical saturation).mp. 18949

50 lived experience$.tw. 14156

51 life experience$.mp. 8479

52 cluster sampl$.mp. 10293

53 (theme$ or thematic).mp. 196185

54 categor$.mp. 536445

55 observational method$.af. 1060

56 field stud$.mp. 19390

57 focus group$.af.77241

58 questionnaire$.mp. 1026234

59 content analysis.af. 49452

60 thematic analysis.af. 49395

61 constant comparative.af.4232

62 discourse analys?s.af. 2892

63 ((discourse$ or discurs$) adj3 analys?s).tw. 3346

64 (constant adj (comparative or comparison)).af. 6468

65 narrative analys?s.af. 2182

66 heidegger$.tw. 814

67 colaizzi$.tw. 1439

68 speigelberg$.tw. 2

69 (van adj manen$).tw. 595

70 (van adj kaam$).tw. 45

71 (merleau adj ponty$).tw. 276

72 husserl$.tw. 342

73 giorgi$.tw. 932

74 foucault$.tw. 997

75 (corbin$ adj2 strauss$).tw. 493

76 (strauss$ adj2 corbin$).tw. 493

77 (glaser$ adj2 strauss$).tw. 123

78 glaser$.tw. 1136

79 findings.af. 2865870

80 interview$.af. or Interviews/ 528731

81 qualitative.af. 386780

82 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79 or 80 or 81 6010304

83 28 or 82 6333885

84 3 and 8 and 83 1660

Psychology and Behavioural Sciences Collection (EBSCOhost)

1	DE "CHILDBIRTH"	1,291
2	TI parturition OR AB parturition	135
3	TI childbirth OR AB Childbirth	1,420
4	TI Child n1 birth	85
5	AB Child n1 birth	636
6	TI birth	4,411
7	AB birth	16,918
8	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7	19,141
9	DE "EMOTIONAL trauma"	2,164
10	DE "POST-traumatic stress disorder"	9,340
11	TI (((psychological n (trauma* or distress*)) or Post traumatic stress disorder or PTSD))	3,392
12	AB (((psychological n (trauma* or distress*)) or Post traumatic stress disorder or PTSD))	9,671
13	TI ((Birth trauma or traumatic birth)) OR AB ((Birth trauma or traumatic birth))	193
14	S9 OR S10 OR S11 OR S12 OR S13	14,133
15	DE "QUALITATIVE research"	14,261
16	Exp DE “QUESTIONNAIRES”	0
17	Exp DE “QUESTIONNAIRES”	57
18	DE "ATTITUDE (Psychology) -- Social aspects"	12
19	DE "DISCOURSE analysis"	1,050
20	DE "CONTENT analysis"	4,126
21	DE "ETHNOGRAPHIC analysis"	155
22	DE "OBSERVATION (Psychology)"	196
23	DE "LIFE change events"	2,197
24	DE "NARRATIVE discourse analysis"	43

25 TI ((birth narratives or birth stories)) OR AB ((birth narratives or birth stories))61

26 TI qualitative research OR AB qualitative research 4,260

27 TX ethnonursing 43

28 Ethnograph* 3,729

29 TX phenomenol* 36,775

30 grounded theory 3,809

31 TX ((grounded adj (theor* or study or studies or research or analys?s))) 2

32 ((life stor*) or (women's stor*)) 2,034

33 TX ((emic or etic or hermeneutic* or heuristic* or semiotic*)) Expanders - Apply equivalent subjects 36,605

34 TI (data n1 saturat*) OR AB (data n1 saturat*) 93

35 TI (participant observ*) OR AB (participant observ*) 2,747

36 ((social construct* or (postmodern* or post-structural*) or (post structural* or poststructural*) or (post modern*) or post-modern* or feminis* or interpret*) 4,620

37 (action research or cooperative inquir* or (co operative inquir*) or (co-operative inquir*)) 2,822

38 (humanistic or existential or experiential or paradigm*) 24,824

39 TI ((field n1 (study or studies or research)) OR AB ((field n1 (study or studies or research).) 3,151

40 TI (human science) OR AB (human science) 1,293

41 TI (biographical method) OR AB (biographical method) 37

42 TX (qualitative validity)2,163

43 TX (theoretical sampl*) 3,083

44 TX (((purpos* n4 sampl*) or (focus n1 group*))) 41,631

45 (account or accounts or unstructured or open-ended or (open ended) or text* or narrative*. 63,955

46 ((life world) or life-world or conversation analys?s or personal experience* or theoretical saturation) 11,316

47 TI (lived experience*) OR AB (lived experience*) 2,893

48 (life experience*) 5,354

49 (cluster sampl*) 791

50 (theme* or thematic) 30,669

51 Categor* 31,247

52 TX observational method* 6,200

53 field stud* 5,059

54 TX focus group* 42,036

55 Questionnaire* 73,795

56 TX (content analysis) 29,545

57 TX (thematic analysis) 21,770

58 TX (constant comparative) 2,810

59 TX (discourse analys?s) 7,961

60 TI (((discourse* or discurs*) n3 analys?s)) OR AB (((discourse* or discurs*) n3 analys?s)) 1,220

61 TX ((constant adj (comparative or comparison))) 1

62 TX (narrative analys?s) 8,150

63 TI Heidegger* OR AB Heidegger* 375

64 TI Colaizzi* OR AB Colaizzi* 64

65 TI Speigelberg* OR AB Speigelberg* 0

66 TI (van n1 manen*) OR AB (van n1 manen*) 69

67 TI (van n1 kaam*) OR AB (van n1 kaam*) 7

68 TI (merleau n1 ponty*) OR AB (merleau n1 ponty*) 136

69 TI Husserl* OR AB Husserl* 162

70 TI Giorgi* OR AB Giorgi* 260

71 TI Foucault* OR AB Foucault* 455

72 TI (corbin* n2 strauss*) OR AB (corbin* n2 strauss*) 64

73 TI (strauss* n2 corbin*) OR AB (strauss* n2 corbin*) 64

74	TI (glaser* n2 strauss*) OR AB (glaser* n2 strauss*)	33
75	TI Glaser* OR AB Glaser*	159
76	TX findings OR TX interview* AND TX qualitative	562,412
77	S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR 26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR 38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR 50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR 62 OR S63 OR S64 OR S65 OR S66 OR S67 OR S68 OR S69 OR S70 OR S71 OR S72 OR S73 OR 74 OR S75 OR S76	677,428
78	S8 AND S14 AND S77	268

CINAHL (EBSCOhost)

1	MH "Childbirth+"	36,580
2	TI parturition OR AB parturition	908
3	TI childbirth OR AB Childbirth Expanders	14,592
4	AB Child n1 birth OR TI Child n1 birth	2,863
5	AB Birth OR TI Birth	118,792
6	S1 OR S2 OR S3 OR S4 OR S5	142,251
7	MH "Psychological Trauma"	3,186
8	MH "Stress Disorders, Post-Traumatic"	27,955
9	AB (((psychological n (trauma* or distress*)) or Post traumatic stress disorder or PTSD)) OR TI (((psychological n (trauma* or distress*)) or Post traumatic stress disorder or PTSD))	17,505
10	TI ((Birth trauma or traumatic birth)) OR AB ((Birth trauma or traumatic birth))	1,160
11	S7 OR S8 OR S9 OR S10	35,366
12	(MH "Qualitative Studies")	156,131
13	(MH "Research Nursing")	70
14	(MH "Questionnaires+")	508,817
15	(MH "Attitude+")	563,892
16	(MH "Focus Groups")	52,450
17	(MH "Discourse Analysis")	5,695
18	(MH "Content Analysis")	46,900
19	(MH "Ethnographic Research")	9,433
20	(MH "Ethnological Research")	6,852
21	(MH "Ethnonursing Research")	224
22	(MH "Constant Comparative Method")	7,473
23	(MH "Qualitative Validity+")	1,904

24	(MH "Purposive Sample")	42,784
25	(MH "Observational Methods+")	21,890
26	(MH "Field Studies")	3,690
27	(MH "Theoretical Sample")	1,990
28	(MH "Phenomenology")	4,449
29	(MH "Phenomenological Research")	20,567
30	(MH "Life Experiences+")	67,015
31	(MH "Cluster Sample+")	6,704
32	S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31	1,105,493
33	TI ((birth narratives or birth stories)) OR AB ((birth narratives or birth stories))	479
34	TI qualitative research OR AB qualitative research	25,745
35	TX ethnonursing	319
36	Ethnograph*	15,375
37	TX phenomenol*	30,926
38	grounded theory	22,636
39	TX (grounded adj (theor* or study or studies or research or analys?s))	0
40	TX (grounded adj (theor* or study or studies or research or analys?s))	27
41	((life stor*) or (women's stor*))	3,888
42	TX ((emic or etic or hermeneutic* or heuristic* or semiotic*)) or TI (participant observ*) OR AB (participant observ*) OR TI (data n1 saturat*) OR AB (data n1 saturat*)	24,714
43	((social construct* or (postmodern* or post-structural*) or (post structural* or poststructural*) or (post modern*) or post-modern* or feminis* or interpret*)	134,829
44	(action research or cooperative inquir* or (co operative inquir*) or (co-operative inquir*))	12,819
45	(humanistic or existential or experiential or paradigm*)	52,641
46	TI ((field n1 (study or studies or research)) OR AB ((field n1 (study or studies or research).)	7,782
47	TI (human science) OR AB (human science)	1,588

48	TI (biographical method) OR AB (biographical method)	90
49	TX (qualitative validity)	995
50	TX (purposive sampl*)	46,393
51	TX (theoretical sampl*)	2,929
52	TX (((purpos* n4 sampl*) or (focus n1 group*)))	108,075
53	account or accounts or unstructured or open-ended or (open ended) or text* or narrative*	224,022
54	((life world) or life-world or conversation analys?s or personal experience* or theoretical saturation)	39,885
55	TI (lived experience*) OR AB (lived experience*)	13,335
56	(life experience*)	56,605
57	(cluster sampl*)	9,289
58	(theme* or thematic)	163,028
59	Categor*	160,550
60	TX observational method*	31,968
61	field stud*	15,933
62	TX focus group*	68,213
63	Questionnaire*	631,273
64	TX (content analysis)	61,648
65	TX (thematic analysis)	108,382
66	TX (constant comparative)	9,432
67	TX (discourse analys?s)	6,926
68	TI (((discourse* or discurs*) n3 analys?s)) OR AB (((discourse* or discurs*) n3 analys?s))	3,343
69	TX ((constant adj (comparative or comparison))	0
70	TX ((constant adj (comparative or comparison))	194
71	TX (narrative analys?s)	4,901

72 TI Heidegger* OR AB Heidegger* 1,006

73 TI Colaizzi* OR AB Colaizzi* 1,542

74 TI Speigelberg* OR AB Speigelberg* 1

75 TI (van n1 manen*) OR AB (van n1 manen*) 869

76 TI (van n1 kaam*) OR AB (van n1 kaam*) 76

77 TI (merleau n1 ponty*) OR AB (merleau n1 ponty*) 206

78 TI Husserl* OR AB Husserl* 299

79 TI Giorgi* OR AB Giorgi* 716

80 TI Foucault* OR AB Foucault* 866

81 TI (corbin* n2 strauss*) OR AB (corbin* n2 strauss*) 496

82 TI (strauss* n2 corbin*) OR AB (strauss* n2 corbin*) 496

83 TI (glaser* n2 strauss*) OR AB (glaser* n2 strauss*) 219

84 TI Glaser* OR AB Glaser* 551

85 TX findings 706,074

86 TX interview* 417,932

87 TX qualitative 242,895

88 S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62 OR S63 OR S64 OR S65 OR S66 OR S67 OR S68 OR S69 OR S70 OR S71 OR S72 OR S73 OR S74 OR S75 OR S76 OR S77 OR S78 OR S79 OR S80 OR S81 OR S82 OR S83 OR S84 OR S85 OR S86 OR S87 1,936,481

89 S32 OR S88 2,188,675

90 S6 AND S11 AND S89 1,060

PSYCH INFO (EBSCOhost)

1	DE Birth	8,465
2	DE “Natural Childbirth”	254
3	DE “Birth Trauma”	382
4	TI parturition OR AB parturition	1,388
5	TI childbirth OR AB Childbirth Expanders	6,352
6	AB Child n1 birth OR TI Child n1 birth Expanders	3,222
7	AB Birth OR TI Birth	67,325
8	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7	73,531
9	DE "EMOTIONAL trauma"	16,555
10	DE "POST-traumatic stress disorder"	70,972
11	DE "POST-traumatic stress disorder"	70,972
12	AB (((psychological n (trauma* or distress*)) or Post traumatic stress disorder or PTSD)) OR TI (((psychological n (trauma* or distress*)) or Post traumatic stress disorder or PTSD))	46,288
13	TI ((Birth trauma or traumatic birth)) OR AB ((Birth trauma or traumatic birth))	911
14	S9 OR S10 OR S11 OR S12 OR S13	60,147
15	DE "Qualitative Methods"	11,684
16	DE "Questionnaires"	27,546
17	DE "Focus Group"	867
18	DE "Discourse Analysis"	10,560
19	DE "Content Analysis"	5,989
20	DE "Ethnography"	11,792
21	DE "Participant Observation"	597
22	DE "Phenomenology"	19,269
23	DE "Interpretative Phenomenological Analysis"	1,386

24	DE "Life Experiences"	30,605
25	DE "Narrative Analysis"	1,338
26	DE "Thematic Analysis"	2,196
27	S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26	118,731
28	TI ((birth narratives or birth stories)) OR AB ((birth narratives or birth stories))	301
29	TI qualitative research OR AB qualitative research	40,016
30	TX ethnonursing	75
31	Ethnograph*	36,774
32	TX phenomenol*	60,646
33	grounded theory	25,645
34	TX (grounded adj (theor* or study or studies or research or analys?s))	22
35	TX (grounded adj (theor* or study or studies or research or analys?s))	22
36	((life stor*) or (women's stor*))	9,873
37	TX ((emic or etic or hermeneutic* or heuristic* or semiotic*)) or TI (participant observ*) OR AB (participant observ*) OR TI (data n1 saturat*) OR AB (data n1 saturat*)	56,247
38	((social construct* or (postmodern* or post-structural*) or (post structural* or poststructural*) or (post modern*) or post-modern* or feminis* or interpret*)	305,298
39	(action research or cooperative inquir* or (co operative inquir*) or (co-operative inquir*))	19,774
40	(humanistic or existential or experiential or paradigm*)	172,173
41	TI ((field n1 (study or studies or research)) OR AB ((field n1 (study or studies or research).)	25,365
42	TI (human science) OR AB (human science)	5,547
43	TI (biographical method) OR AB (biographical method)	258
44	TX (qualitative validity)	557
45	TX (purposive sampl*)	9,478
46	TX (theoretical sampl*)	1,866
47	TX (((purpos* n4 sampl*) or (focus n1 group*)))	80,846

48 (account or accounts or unstructured or open-ended or (open ended) or text* or narrative* 441,338

49 ((life world) or life-world or conversation analys?s or personal experience* or theoretical saturation) 58,636

50 TI (lived experience*) OR AB (lived experience*) 26,844

51 (life experience*) 62,623

52 (cluster sampl*) 4,124

53 (theme* or thematic) 192,041

54 Categor* 207,236

55 TX observational method* 7,117

56 field stud* 41,624

57 TX focus group* 71,467

58 Questionnaire* 586,323

59 TX (content analysis) 46,114

60 TX (thematic analysis) 38,244

61 TX (constant comparative) 4,180

62 TX (discourse analys?s) 18,010

63 TI (((discourse* or discurs*) n3 analys?s)) OR AB (((discourse* or discurs*) n3 analys?s)) 10,650

64 TX ((constant adj (comparative or comparison))) 57

65 TX ((constant adj (comparative or comparison))) 57

66 TI Heidegger* OR AB Heidegger* 2,062

67 TI Colaizzi* OR AB Colaizzi* 836

68 TI Speigelberg* OR AB Speigelberg* 0

69 TI (van n1 manen*) OR AB (van n1 manen*) 684

70 TI (van n1 kaam*) OR AB (van n1 kaam*) 569

71 TI (merleau n1 ponty*) OR AB (merleau n1 ponty*) 766

72 TI Husserl* OR AB Husserl* 1,452

73	TI Giorgi* OR AB Giorgi*	1,053
74	TI Foucault* OR AB Foucault*	3,213
75	TI (corbin* n2 strauss*) OR AB (corbin* n2 strauss*)	834
76	TI (strauss* n2 corbin*) OR AB (strauss* n2 corbin*)	834
77	TI (glaser* n2 strauss*) OR AB (glaser* n2 strauss*)	476
78	TI Glaser* OR AB Glaser*	1,237
79	TX findings	1,055,914
80	TX interview*	671,316
81	TX qualitative	441,268
82	S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62 OR S63 OR S64 OR S65 OR S66 OR S67 OR S68 OR S69 OR S70 OR S71 OR S72 OR S73 OR S74 OR S75 OR S76 OR S77 OR S78 OR S79 OR S80 OR S81	2,719,730
83	S27 OR S82	2,719,748
84	S8 AND S14 AND S83	937

Web of Science Core Collection (Science Citation Index, Social Sciences Citation Index, Conference Proceedings Citation Index – Science, Conference Proceedings Citation Index - Social Science & Humanities, Emerging Sources Citation Index).

Search 1

1 (((((((TI=(Parturition)) OR AB=(Parturition)) OR AB=(Childbirth)) OR TI=(childbirth)) OR TI=(child near/1 birth)) OR AB=(child near/1 birth)) OR AB=(birth)) OR TI=(birth) 482,665

2 (TI=(((psychological near/2 (trauma* or distress*)) or Post traumatic stress disorder or PTSD).)) OR AB=(((psychological near/2 (trauma* or distress*)) or Post traumatic stress disorder or PTSD).) 89,461

3 ((((((((((((((((((((ALL=(birth stories or birth narratives)) OR ALL=(qualitative research)) OR ALL=(qualitative stud*)) OR ALL=(nursing research methodology)) OR ALL=(questionnaire)) OR ALL=(attitude)) OR ALL=(focus groups)) OR ALL=(discourse analysis)) OR ALL=(content analysis)) OR ALL=(ethnographic research)) OR ALL=(ethnological research)) OR ALL=(ethnonursing research)) OR ALL=(constant comparative method)) OR ALL=(qualitative validity)) OR ALL=(purposive sampl*)) OR ALL=(observational research)) OR ALL=(field stud*)) OR ALL=(theoretical sampl*)) OR ALL=(phenomenology)) OR ALL=(phenomenological research)) OR ALL=(life experiences)) OR ALL=(cluster sample*). 6,534,356

4 #3 AND #2 AND #1. 865

Search 2

1 (((((((TI=(Parturition)) OR AB=(Parturition)) OR AB=(Childbirth)) OR TI=(childbirth)) OR TI=(child near/1 birth)) OR AB=(child near/1 birth)) OR AB=(birth)) OR TI=(birth). 482,665

2 (TI=(((psychological near/2 (trauma* or distress*)) or Post traumatic stress disorder or PTSD).)) OR AB=(((psychological near/2 (trauma* or distress*)) or Post traumatic stress disorder or PTSD).). 89,461

3 ((((((((((((((ALL=(ethnonursing)) OR ALL=(ethnograph*)) OR ALL=(phenomenol*)) OR ALL=(grounded theor*)) OR ALL=(grounded stud*)) OR ALL=(grounded research)) OR ALL=(grounded analys?s)) OR ALL=(life stor*)) OR ALL=(women's stor*)) OR ALL=(emic)) OR ALL=(etic)) OR ALL=(hermeneutic*)) OR ALL=(heuristic*)) OR ALL=(semiotic*)) OR ALL=(data saturat*)) OR ALL=(participant observ*). 1,843,896

4 #3 AND #2 AND #1. 106

Search 3

1 (((((((TI=(Parturition)) OR AB=(Parturition)) OR AB=(Childbirth)) OR TI=(childbirth)) OR TI=(child near/1 birth)) OR AB=(child near/1 birth)) OR AB=(birth)) OR TI=(birth). 482,665

2 (TI=(((psychological near/2 (trauma* or distress*)) or Post traumatic stress disorder or PTSD).)) OR AB=(((psychological near/2 (trauma* or distress*)) or Post traumatic stress disorder or PTSD).). 89,461

3 ((((((((((((ALL=(social construct*)) OR ALL=(postmodern*)) OR ALL=(post structural*)) OR ALL=(feminis*)) OR ALL=(interpret*)) OR ALL=(action research)) OR ALL=(co-operative inquir*)) OR ALL=(humanistic)) OR ALL=(existential)) OR ALL=(experiential)) OR ALL=(paradigm*)) OR ALL=(field stud*)) OR ALL=(field research)) OR ALL=(human science) 9,949,557

4 #3 AND #2 AND #1 389

Search 4

1 (((((((TI=(Parturition)) OR AB=(Parturition)) OR AB=(Childbirth)) OR TI=(childbirth)) OR TI=(child near/1 birth)) OR AB=(child near/1 birth)) OR AB=(birth)) OR TI=(birth). 482,665

2 (TI=(((psychological near/2 (trauma* or distress*)) or Post traumatic stress disorder or PTSD).)) OR AB=(((psychological near/2 (trauma* or distress*)) or Post traumatic stress disorder or PTSD).). 89,461

3 ((((((((((((ALL=(biographical method*)) OR ALL=(qualitative validity)) OR ALL=(purposive sampl*)) OR ALL=(theoretical sampl*)) OR ALL=(open-ended account*)) OR ALL=(unstructured account*)) OR ALL=(narrative*)) OR ALL=(life world)) OR ALL=(conversation analys?s)) OR ALL=(theoretical saturation)) OR ALL=(lived experience*)) OR ALL=(life experience*)) OR ALL=(theme*)) OR ALL=(thematic analysis) 1,479,206

4 #3 AND #2 AND #1 365

Search 5

1	(((((((TI=(Parturition)) OR AB=(Parturition)) OR AB=(Childbirth)) OR TI=(childbirth)) OR TI=(child near/1 birth)) OR AB=(child near/1 birth)) OR AB=(birth)) OR TI=(birth).	482,665
2	(TI=(((psychological near/2 (trauma* or distress*)) or Post traumatic stress disorder or PTSD).)) OR AB=(((psychological near/2 (trauma* or distress*)) or Post traumatic stress disorder or PTSD).).	89,461
3	(discurs*)) OR ALL=(narrative analys?s)) OR ALL=(heidegger*)) OR ALL=(colaizzi)) OR ALL=(speigelberg*)) OR ALL=(van manen*)) OR ALL=(van kaam*)) OR ALL=(merleau ponty*)) OR ALL=(husserl*)) OR ALL=(giorgi*)) OR ALL=(foucault*)) OR ALL=(corbin*)) OR ALL=(strauss *)) OR ALL=(glaser*)) OR ALL=(findings)) OR ALL=(interview*)) OR ALL=(qualitative)	6,307,038
4	#3 AND #2 AND #1	7

Appendix 1.5: CASP Checklist

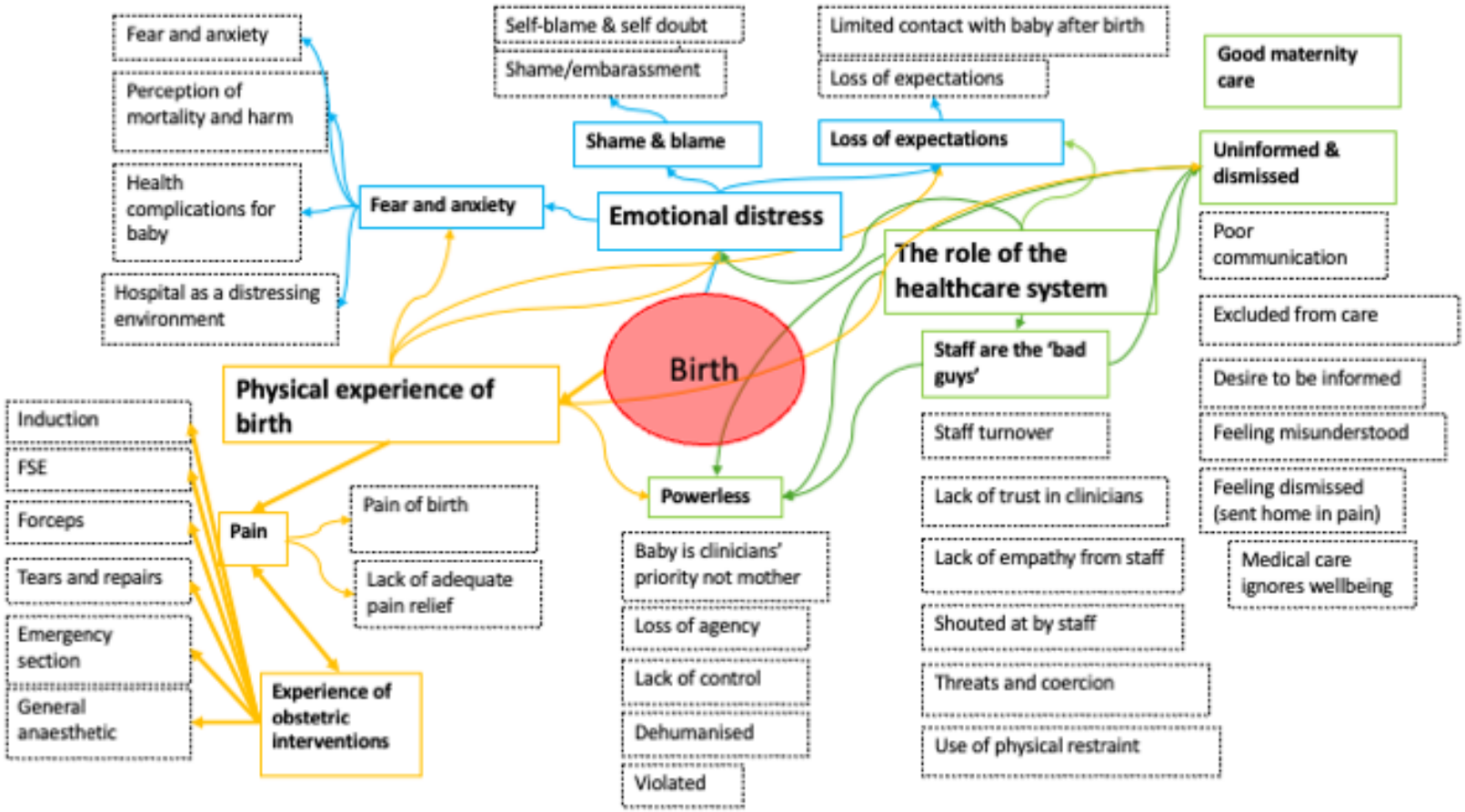
https://casp-uk.net/casp-checklists/CASP-checklist-qualitative-2024.pdf

Appendix 1.6: Code frequencies

No	Study author/ date	Codes																											
		Fear and anxiety	Perception of mortality and harm	Shame /embarrassment	Self-blame & self-doubt	Loss of expectations	Hunger	Limited contact with baby at birth	Health complications for baby	Hospital as a distressing physical environment	Inability to have family present	Alone	Tears and stitches	Forceps delivery	FSE	Induction	Inadequate pain relief	Vaginal examinations	Emergency section	General anaesthetic	Fundal pressure	Pain of birth	Exhaustion	Unfamiliar/unavailable staff	Poor communication	Excluded from care	Dehumanised	Violated
1	Aksu & Sercekus (2023)	✓		✓					✓	✓			✓			✓	✓	✓			✓	✓		✓	✓		✓	
2	Aktas & Aydin (2018)	✓	✓	✓			✓			✓	✓	✓				✓		✓			✓	✓		✓	✓			
3	Baptie et al. (2021)	✓				✓						✓												✓	✓	✓	✓	
4	Baxter (2020)		✓							✓			✓		✓	✓		✓				✓		✓	✓	✓		
5	Byrne et al. (2017)	✓			✓					✓			✓									✓				✓	✓	✓
6	Cronin-Fisher & Timmerman (2023)	✓	✓			✓		✓	✓			✓	✓		✓				✓	✓		✓				✓		
7	Evans (2024)				✓	✓						✓					✓											
8	Henkriksen et al. (2017)					✓			✓			✓				✓	✓		✓	✓		✓	✓			✓		
9	Murphy & Strong (2018)	✓	✓														✓	✓				✓			✓	✓		
10	Reed et al. (2017)	✓				✓				✓							✓								✓		✓	✓
11	Rodriguez-Almagro et al. (2019	✓				✓		✓	✓		✓	✓	✓	✓			✓		✓	✓	✓	✓		✓	✓		✓	✓
12	Taghizadeh et al. (2014)	✓								✓									✓									
13	Taghizadeh et al. (2015)	✓								✓	✓	✓	✓				✓					✓			✓	✓	✓	✓
14	Viirman et al. (2023)	✓	✓		✓			✓	✓	✓	✓	✓	✓									✓	✓	✓	✓	✓		✓

No.	Study author/ date	Codes																	
		Medical care has its own agenda	Shouted at by staff	Held down	Threats and coercion	Blamed	Baby is clinicians' priority not mother	Lack of trust in clinicians	Lack of empathy from staff	Feeling dismissed	Sent home in pain	Feeling misunderstood	Medical care ignores wellbeing	Lack of control	Loss of agency	Desire to be informed	Coping	Descriptions of good maternity care	Desires for maternity care
1	Aksu & Sercekus (2023)						✓										✓	✓	
2	Aktas & Aydin (2018)							✓	✓								✓		
3	Baptie et al. (2021)						✓	✓						✓	✓	✓	✓	✓	
4	Baxter (2020)				✓			✓	✓	✓	✓					✓		✓	✓
5	Byrne et al. (2017)	✓					✓		✓	✓			✓	✓	✓	✓	✓	✓	
6	Cronin-Fisher & Timmerman (2023)					✓	✓			✓				✓	✓	✓	✓		✓
7	Evans (2024)							✓	✓	✓		✓			✓				
8	Henkriksen et al. (2017)	✓		✓				✓	✓	✓	✓			✓				✓	✓
9	Murphy & Strong (2018)	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
10	Reed et al. (2017)	✓	✓	✓	✓				✓	✓				✓	✓				
11	Rodriguez- Almagro et al. (2019)		✓	✓	✓	✓	✓	✓		✓			✓	✓	✓			✓	✓
12	Taghizadeh et al. (2014)												✓	✓					
13	Taghizadeh et al. (2015)					✓	✓		✓	✓		✓	✓		✓				✓
14	Viirman et al. (2023)				✓		✓	✓	✓			✓		✓	✓				

Appendix 1.7: Initial thematic map



Appendix 2.1: CORE-Q

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	52
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	54
Occupation	3	What was their occupation at the time of the study?	54
Gender	4	Was the researcher male or female?	54
Experience and training	5	What experience or training did the researcher have?	54
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	51,54
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	51
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	54
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	53
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	51
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	51
Sample size	12	How many participants were in the study?	52
Non-participation	13	How many people refused to participate or dropped out? Reasons?	51
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	52
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	52
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	52
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	52
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	52
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	52
Field notes	20	Were field notes made during and/or after the inter view or focus group?	52
Duration	21	What was the duration of the inter views or focus group?	52
Data saturation	22	Was data saturation discussed?	53
Transcripts returned	23	Were transcripts returned to participants for comment and/or	52

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	53
Description of the coding tree	25	Did authors provide a description of the coding tree?	Figure 3
Derivation of themes	26	Were themes identified in advance or derived from the data?	53
Software	27	What software, if applicable, was used to manage the data?	n/a
Participant checking	28	Did participants provide feedback on the findings?	n/a
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	54-66
Data and findings consistent	30	Was there consistency between the data presented and the findings?	54-66
Clarity of major themes	31	Were major themes clearly presented in the findings?	54-66
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	54-66

Appendix 2.2: Final approved MRP proposal

https://osf.io/va759

Appendix 2.3: Ethical approval letter

North of Scotland Research Ethics Service
Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Telephone: 01224 558458
Email: gram.nosres@nhs.scot

23 April 2024

Professor Andrew Gumley
School of Health and Wellbeing
University of Glasgow
Clarice Pears Building
GLASGOW
G12 8TB

Dear Professor Gumley

Study title:	**Women and birthing people's experiences of early post-partum adjustment following a traumatic birth**
REC reference:	**24/NS/0038**
IRAS project ID:	**337120**

Thank you for responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a public registry before the first participant is recruited and no later than six weeks after. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

A 'public registry' means any registry on the WHO list of primary registries or the ICMJE list of registries provided the registry facilitates public access to information about the UK trial.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

Where a deferral is agreed we expect the sponsor to publish a minimal record on a publicly accessible registry. When the deferral period ends, the sponsor should publish the full record on the same registry, to fulfil the condition of the REC favourable opinion.

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Where the study is registered on ClinicalTrials.gov, please inform deferrals@hra.nhs.uk and the Research Ethics Committee (REC) which issued the final ethical opinion so that our records can be updated.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter. Where a deferral is agreed, a minimum research summary will still be published in the research summaries database. At the end of the deferral period, we will publish the full research summary.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: Research summaries - Health Research Authority (hra.nhs.uk)

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at Managing your approval - Health Research Authority (hra.nhs.uk)

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research: Participant Information Leaflet	V2.0	21 March 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only): Sponsor Insurance Letter		14 July 2023
GP/consultant information sheets or letters: Staff Information Sheet	V2.0	21 March 2024
GP/consultant information sheets or letters: Letter to GP	V2.1	25 March 2024
Interview schedules or topic guides for participants: Topic Guide	3.0	15 April 2024
IRAS Application Form: IRAS Form 21/03/2024	337120/166 4397/37/725	21 March 2024
IRAS Checklist XML: Checklist 16042024		16 April 2024
Non-validated questionnaire: Participant Demographic Information Form	V2.0	21 March 2024
Ethical Review Response		16 April 2024*
Privacy Notice	V2.0	21 March 2024
Participant Consent Form	3.0	16 April 2024
Participant Information Sheet (PIS)	3.0	16 April 2024
Referee's report or other scientific critique report: University of Glasgow Proposal Review Feedback Sheet		22 September 2023
Research protocol or project proposal	3.0	15 April 2024
Summary CV for Chief Investigator (CI): Chief investigator & Academic Supervisor: Andrew Gumley		12 June 2023
Summary CV for Student: Rachael Baker		15 December 2023

* date received

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: Quality assurance - Health Research Authority (hra.nhs.uk)

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities – see details at: Learning - Health Research Authority (hra.nhs.uk)

IRAS project ID: 337120	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

Dr Ruth Stephenson
Chair

Enclosures: "After ethical review – guidance for researchers" SL-AR2

Copy to: Mrs Shirley Mitchell
gram.nrspcc@nhs.scot

Appendix 2.4: Management Approval Letter

Research & Development
56a Lister Street
University Hospital Crosshouse
Kilmarnock
KA2 0BB

Professor Andrew Gumley
School of Health and Wellbeing
University of Glasgow
Clarice Pears Building
G12 8TB

Date	07 June 2024
Your Ref	
Our Ref	CM/KLB/CI R&D No 2024AA013
Enquiries to	Karen Bell
Extension	25850
Direct line	01563 825850
Fax	01563 825806
Email	Karen.Bell2@aapct.scot.nhs.uk

Dear Professor Gumley

Women and birthing people's experiences of early post-partum adjustment following a traumatic birth

I confirm that NHS Ayrshire and Arran have reviewed the undernoted documents and grant R&D Management approval for the above study.

Documents received:

Document	Version	Date
Organisation Information Document	1.1	28/04/24
IRAS Form	6.3.6	21/03/24
Protocol	4.0	13/05/24
Participant Information Sheet	4.0	13/05/24
Staff Information Sheet	3.0	13/05/24
Topic Guide	4.0	13/05/24
Consent Form	3.0	16/04/24
Privacy Notice	2.0	21/03/24
GP Letter	2.1	25/03/24
Participant Demographic Information Form	2.0	21/03/24

The terms of approval state that the investigator authorised to undertake this study within NHS Ayrshire & Arran is: -

- Rachael Baker, Trainee Clinical Psychologist, NHS Ayrshire & Arran

With additional investigators:-

- Dr Marisa Forte, Consultant Clinical Psychologist , NHS Ayrshire & Arran

The sponsors for this study are University of Glasgow.

This approval letter is valid until 30 October 2025.

Regular reports of the study require to be submitted. Your first report should be submitted to Dr K Bell, Research & Development Manager in 12 months time and subsequently at yearly intervals until the work is completed.

Please note that as a requirement of this type of study your name, designation, work address, work telephone number, work e-mail address, work related qualifications and whole time equivalent will be held on the Scottish National Research Database so that NHS R&D staff in Scotland can access this information for purposes related to project management and report monitoring.

In addition approval is granted subject to the following conditions: -

- All research activity must comply with the standards detailed in the UK Policy Framework for Health and Social Care Research http://beta.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research and appropriate statutory legislation. It is your responsibility to ensure that you are familiar with these, however please do not hesitate to seek further advice if you are unsure.

- Recruitment figures must be submitted to R&D on a monthly basis. If recruitment figures are not received timeously you will be contacted by a member of the R&D team to provide this data.

- You are required to comply with Good Clinical Practice (ICH-GCP guidelines may be found at www.ich.org/LOB/media/MEDIA482.pdf), Ethics Guidelines, Health & Safety Act 1999, General Data Protection Regulation (GDPR) and Data Protection Act 2018.

- If any amendments are to be made to the study protocol and or the Research Team the Researcher must seek Ethical and Management Approval for the changes before they can be implemented.

- The Researcher and NHS Ayrshire and Arran must permit and assist with any monitoring, auditing or inspection of the project by the relevant authorities.

- The NHS Ayrshire and Arran Complaints Department should be informed if any complaints arise regarding the project and the R&D Department must be copied into this correspondence.

- The outcome and lessons learnt from complaints must be communicated to funders, sponsors and other partners associated with the project.

- As custodian of the information collated during this research project you are responsible at all times for ensuring the security of all personal information collated in line with NHS Scotland policies on information assurance and security, until the secure destruction of these data. The retention time periods for such data should comply with the requirements of the Scottish Government Records Management: NHS Code Of Practice. Under no circumstances should personal data be stored on any unencrypted removable media e.g. laptop, USB or mobile device (for further information and guidance please contact the Information Governance Team based at University Hospital Crosshouse 01563 825831 or 826813).

If I can be of any further assistance please do not hesitate to contact me. On behalf of the department, I wish you every success with the project.

Yours sincerely

Dr Crawford McGuffie
Medical Director

c.c. Shirley Mitchell, University of Glasgow (sponsor contact)
Hugh Bunyan, Finance, Ailsa Hospital
Information Governance, NHS Ayrshire & Arran
Dr Marisa Forte, Consultant Clinical Psychologist, NHS Ayrshire & Arran

Appendix 2.5: Amendment 01 Confirmation Email

North of Scotland Research Ethics Committee (2)
Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Telephone: 01224 558458
Email: gram.nosres@nhs.scot

24 May 2024

Professor Andrew Gumley
School of Health and Wellbeing
University of Glasgow
Clarice Pears Building
Glasgow
G12 8TB

Dear Professor Gumley

Study title:	**Women and birthing people's experiences of early post-partum adjustment following a traumatic birth**
REC reference:	**24/NS/0038**
Amendment number:	**AM01**
Amendment date:	**20 May 2024**
IRAS project ID:	**337120**

Ethical opinion

The members of the Sub-Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Completed Amendment Tool [Amendment Tool]	AM01	20 May 2024
Interview schedules or topic guides for participants [Topic Guide]	4.0	13 May 2024
Letter from sponsor [Sponsor Decision on Amendment Type]	1.0	20 May 2024
Other [Staff Information Sheet]	3.0	13 May 2024
Participant information sheet (PIS) [Participant Information Sheet]	4.0	13 May 2024
Research protocol or project proposal [Research Protocol]	4.0	13 May 2024

Membership of the Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities – see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS Project ID 337120:	**Please quote this number on all correspondence**

Yours sincerely

Dr Ruth Stephenson
Chair

E-mail: gram.nosres@nhs.scot

Enclosures:	List of names and professions of members who took part in the review
Copy to:	University of Glasgow Research Governance Ms Rachael Baker, Student Researcher

Appendix 2.6: Minor Amendment Confirmation Emails

email removed due to confidentiality issues

Re: Sponsor Decision on Amendment Type-IRAS ID...

email removed due to confidentiality issues

Appendix 2.7: Study Documentation

Participant consent form: https://osf.io/pmcdy

Privacy notice: https://osf.io/k6nsq

Participant information sheet: https://osf.io/mkvhj

Staff information sheet: https://osf.io/kjwz4

GP Letter: https://osf.io/mjfnt

Appendix 2.8: Participant demographic information form

https://osf.io/pcmga

Appendix 2.9: Topic Guide

https://osf.io/x3zq8

Appendix 2.10: Data availability statement

The study data cannot be shared for important ethical and privacy concerns. The data is of a highly personal nature and participants have not given consent for the study data to be shared with third parties. Interested authors should contact the named author for any information pertaining to study data.

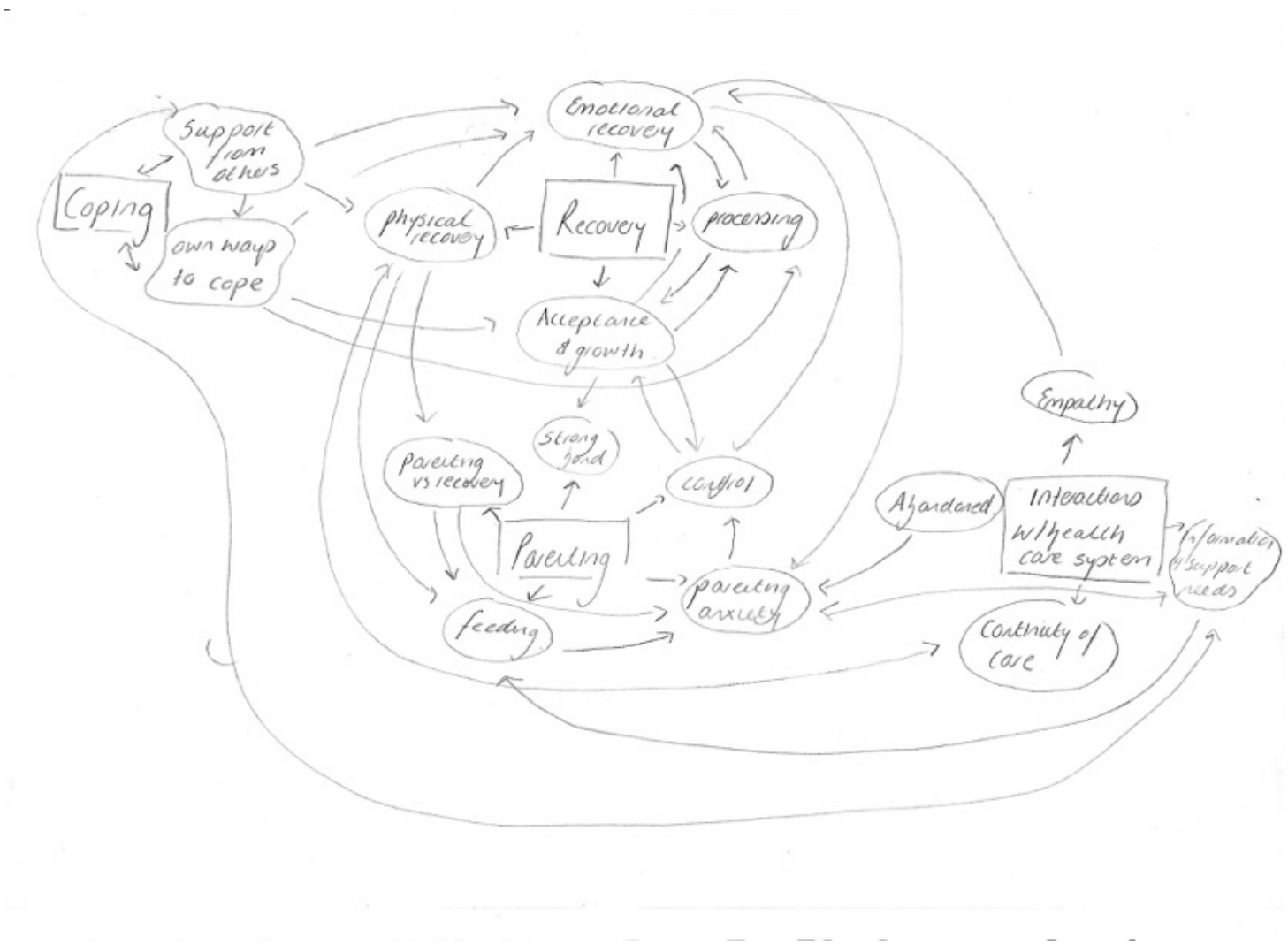
Appendix 2.11: Data analysis plan

https://osf.io/zwk36

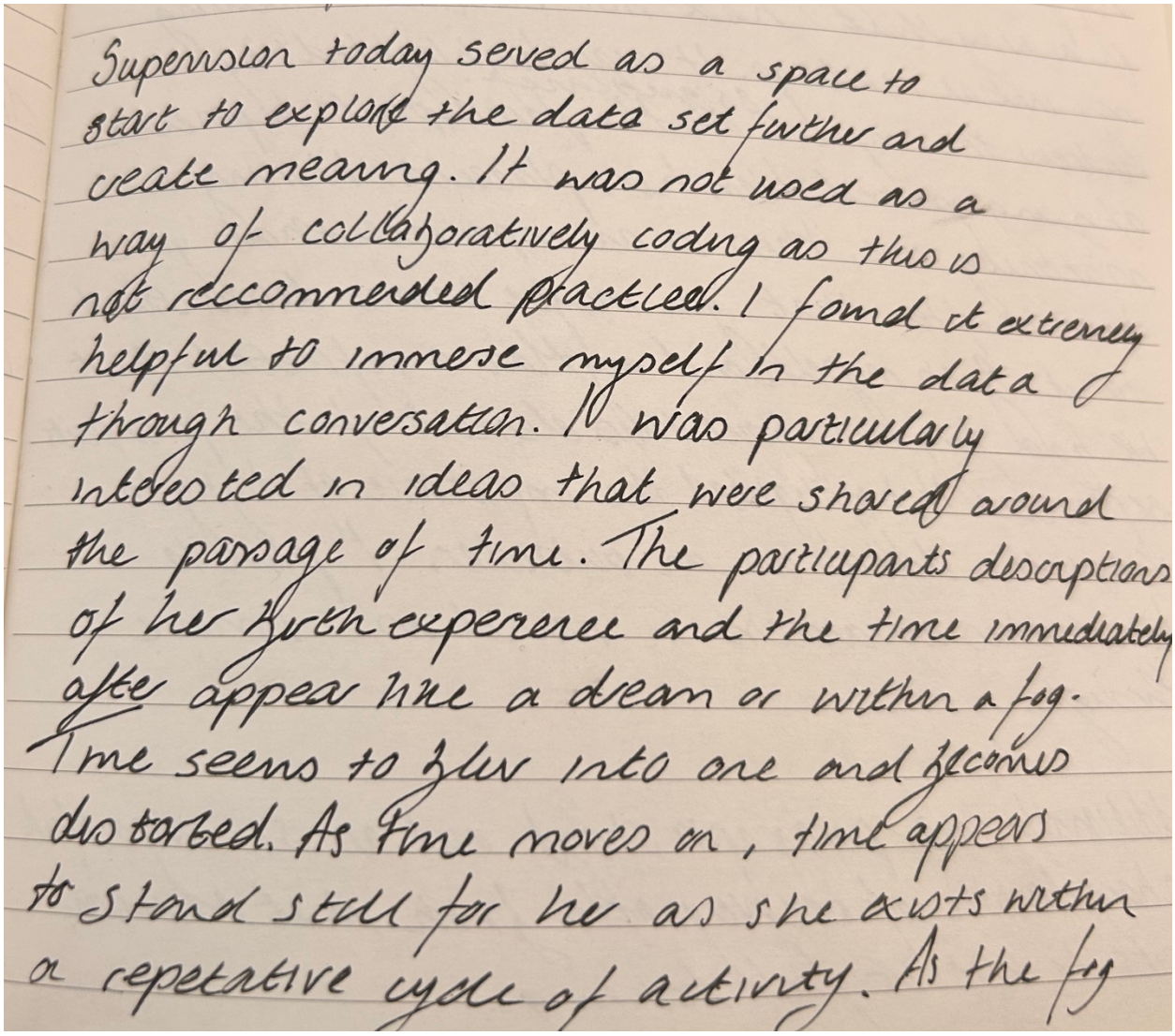
Appendix 2.12: Detailed record of data analysis

https://osf.io/8vj5m

Appendix 2.13: Initial thematic map



Appendix 2.14: Extracts from reflective journal



Supervision today served as a space to start to explore the data set further and create meaning. It was not used as a way of collaboratively coding as this is not recommended practiced. I found it extremely helpful to immerse myself in the data through conversation. I was particularly interested in ideas that were shared around the passage of time. The participants descriptions of her birth experience and the time immediately after appear like a dream or within a fog. Time seems to blur into one and becomes distorted. As time moves on, time appears to stand still for her as she exists within a repetative cycle of activity. As the fog

It's a couple of weeks on, she seems to start to be aware of the challenges she is facing & starts to reflect on her experiences. This brings with it anger, frustration, grief and a desire for answers. In time you see her start to accept her experience and move from ruminating on the experience to prioritising the present moment.

My positionality became clear during this session in a way that I had not considered during my initial readings. It was highlighted by Andrew the impact of the participants experience of being parted from her placenta. Working in maternity care, this is an experience that you hear so often that you maybe become desensitised to it. Both myself and Marisa reflected that we had forgotten about this element of the participants experience. It highlighted the importance of trying to view the data as an outsider. I plan to hold these awareness in mind as I move through.

18/10/24 Transcribing Participant 02.

Noticing that she quickly shuts down the questions about relationship strain & impact of birth experience on relationship with baby. Listening to my response to this makes me feel really uncomfortable as I am very quick to accept this & move on. I remember being uncomfortable in the room. I can't help now but to wonder what that was about. I wonder if she felt unsafe to share? Although I have tried my best to set up safety prior to the interview, it is a lot to expect women to be so open about their experiences having never met me before & knowing that they are being recorded. I am also holding in mind that it could be that there has been no strain or impact & that I am using my previous experiences to make assumptions.

wish i'd asked about her worries about him not getting the best start.' How does this relate to her trauma, if at all? Aware now that worries about caring for a feeding infant are coming up regularly.

I'm hearing a lot of minimising, young & self criticism "I know its daft". Wondering if this is coming up in other interviews.

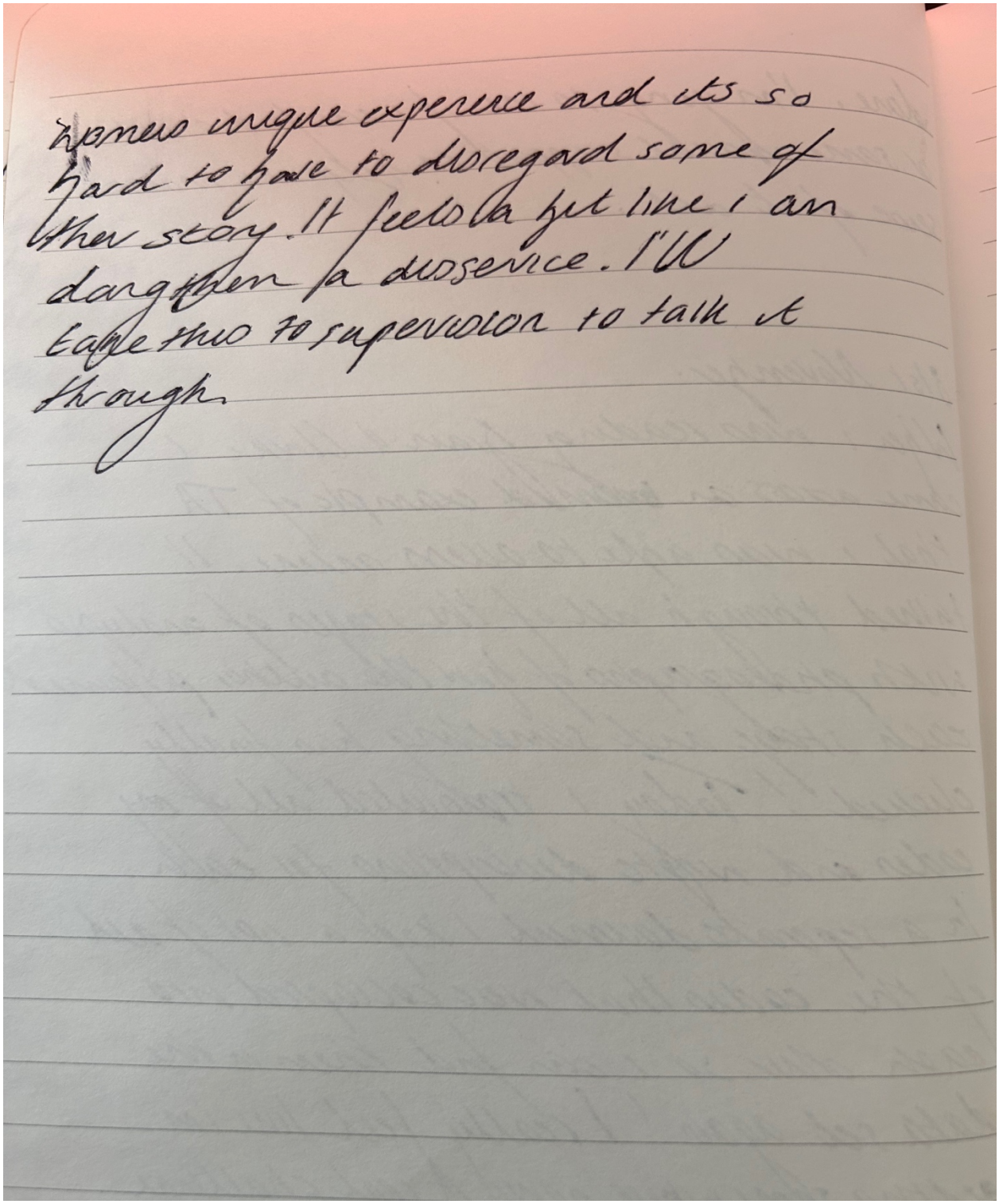
29th November

I've started the coding process but I'm finding myself feeling completely overwhelmed by the data! I have so many codes across studies and I don't know how to start pulling them together. I'd initially started to code by hand but this is too difficult for me. I need to be able to see all the codes in one place. I started to code electronically on word and then colour code the codes for each study & pull them together but I feel a bit out of my depth now. I know that I need to start to pull the codes together and translate them into eachother but I'm not sure the best way to do this. My anxiety about doing this wrong is getting in the way of making a start. I have read the coding chapter of Braun & Clarke multiple times today but it is so wordy and I think I need to see a visual example of this

done. I'm going to see if I can find a video or some sound support to help me make sense of it all.

31st November.

When I was reading Braun & Clarke I came across an extended example of TA that I was able to access online. It talked through all of the stages of analysis with photographs of how the author performed each stage and something has finally clicked! Today I translated all of my codes and wrote descriptions for each. In a seperate document I kept a list of all of the codes that were collapsed into each other so I can find them in the data set again! I really feel like I'm getting somewhere now. A real challenge for me has been getting rid of codes that are not repeated across the data set. I really feel passionately apart each


Yoneus unique experience and its so
hard to hate to disregard some of
other story. It feels a bit like I am
dangerous a disservice. I'll
take this to supervision to talk it
through.

Appendix 2.15: Example of codes and data for subtheme '*just get on with it'* in theme 2, '*A system under pressure.*

Theme	Subtheme	Code	Data
A system under pressure	Just get on with it	Staff show empathy	*"When Ross was born, this was in the labour suite in high dependency I did not get that feeling. I feel as if within the labour suit there was a trauma informed approach. I felt as if the staff really recognized that it had been a huge trauma and it was as much as they could do to support us and like helping me with feeding even with kind of immediately after Ross was born and I had a lot of medication and stuff I couldn't really figure out what I was doing and how to feed. The Midwife who was looking after me held him so that I could breastfeed because she knew how important it was to me and em that was really really helpful too." Holly* *"Oh when I was in the hospital obviously they said to use the lift because it goes straight down rather than going- like they'd buzz me in the lift when I was on the ward. And they are so nice about it they are like "just let us know when you want to go down, you can go down whenever you want as many times as you want." Ellie*
		Professional support	*"I will say though that when I came home , I don't know if it's the general within community midwives or I just had a really good one but she was very she kind of referred me after 6 weeks to like birth reflections and encouraged me to have a debrief with my consultant and em kind of helped me manage the emotions and even after she was discharging myself and Ross she was like if you need advice and you need to be signposted and pointed in a direction and then reach out to*

			me and I'll do my best to do that for you. But I will say that the birth reflections I think`s a really fantastic service." Holly*  *"I know you get your support with your breastfeeding, you get your health visitor and you get your midwife. From that side of it, the professional side I'd actually say it's been pretty good."Megan*  *"So I ended up, I spoke to my health visitor, she`s actually referred me to the mental health team so I've got a meeting with someone next week for that and I've been to the GP and I've got something to help manage my anxiety a bit better. Since then definitely feeling one thousand times better." Megan *"I`ve been to the birth reflections too and they've kind of talked it out and that was good- that was a good service to actually have." Megan*  *"Em my health- as I said my health visitor`s great she`s really good and she`s really informative, and really helpful…" Ellie* *"thank goodness for my health visitor being a diligent as she is in that regard." Ellie* *"Well I wasn't but I was in the hospital so like the nurses in the NICU were doing it and whatever else. But I wonder if– I did think about this at the time- I was like I wonder if I'd feel like I did have more questions if- but I spent nearly a month talking to a nurse pretty much every day*

			about every inch of mine and my baby`s body so that I felt pretty looked after." Ellie*  *"my health visitor has been fantastic, she`s been really really good. Em she came and did some extra visits and stuff like that just because I was totally like wired to the moon at one point I think. Just stressing out about- a lot of it's to do with like is he ok, is there anything I'm missing? You know stuff like that and I know I could still phone her now and she`d just think "oh here she comes again." Like stressing about something that's not that big a deal. No but like she's really good so. I'm not like, it's not like I've been left stewing on my own." Natalie
		System pressure	*"I think it's because they're really busy. I got chucked out because they were trying to get space in the ward." Hannah* *"And I felt as if, I felt a bit of a burden because I know how busy they are in here, buzzing." Sarah* *"So I feel like initially straight away, and I know services are stretched I totally get it I'm a public sector worker I get it, but they need there needs to be more support for women straight away once they have given birth because I think I'd have done a lot better if I'd been able to get a full night's sleep." Sarah* *"I know that people are stressed, services are stretched out and are under staffed." Sarah*

			"And obviously that's harder because of waiting lists and obviously a lot of mums might want help so." Megan *"I know it's hard, people are tired, people are understaffed, people are busy but don't really make a difference to me does it."Ellie* *"I know this is the people`s place of work and it's not always like work isn't always easy and stuff but… it doesn't really matter how you feel at the time you`ve got a job to do."Natalie*
		Staff lack empathy	*"I felt as though sometimes the attitudes of staff was almost like you were a bother" Holly* *"That's kind of the- that might not have been the thoughts of the staff that were working with me but that's how I felt, that's the impression that I got a lot of the time was kind of that it wasn't a big deal and it is. It is a really - It's a really big deal and it felt like a really big deal and it felt really difficult to get that impression that there wasn't - that other people didn't think it was a big deal." Holly* *"I went to the doctors the first time at my 12 week check, is it 12 weeks you get it or 6 weeks? I don't know one of the checks I think it was supposed to be six weeks but I got it at eight or something em and I remember the doctors asking – she checks obviously physically and then they do obviously mentally. She was like asking me some questions and I burst into tears and she didn't really help me. She was quite dismissive she was kind of like – it was almost like she was thinking of time…. I*

			think for like that check they should really be assigning you a good half hour, 45 minute appointment so that if you do want to talk about something- like she was quite dismissive she was like "Oh em you can come back and talk about it. If you want to come and talk to me about it you can come back". But I was kind of like well I'm here now and I'm upset? Like why are you sending me away?" Megan *"I remember I phoned my friend afterwards and she was like "So did you speak to the doctor?" and I was like "Yeah I brought it up" and I was like "But I'm not going to go back" because just like how she acted towards me. It just wasn't – wasn't like the nicest way to act. It wasn't like she was nasty it was just like she was just like – I felt like she was- had an appointment after if that makes sense [laughter]." Megan* *"but that continuity that sensitivity is hugely gone awry. I would also say that em there's pretty much no sensitivity until you tell the story and I think that's pretty sad because I just think- I don't know even if I'd had a perfect, perfect, perfect birth and pregnancy. It's a shame that the next care provider you speak to doesn't really care. And I get it because they see thousands of people and this is their job but also this is a huge life changing event." Ellie* *"Em and I remember asking this one lady and I have no idea who she was and what she did and she really huffed and puffed about taking me down. This is maybe like two days after Harry was born and eh, maybe three days, and she really huffed and puffed and then when I got down*

			there she was like "you should really start to think about taking the stairs, I know you`ve just had a C-section but we`re really busy." Ellie *" I don't know, I don't know. I think from pretty much the get go there was a notable change in the care I received when they realized my situation. You know when they realized "oh your baby`s in NICU". Because that's really sad you're in this room by yourself, everyone else's baby is crying and they realise you don't have your baby with you it's very sad like I guess it's like sympathy. I was just like that's fine I just need care at this point" Ellie* *"I mean I am the kind of person that is like if I can get up and get on with it I will, so I did. But if I had been in a point where I couldn't em you know would it have been more a huff and puff if you know what I mean. I would have asked for help but there would have been an attitude behind it." Natalie* *"attitude towards new mums when they`re in hospital needs to be better." Natalie*  *"This time they were better to start with and then they were quite bad. You know. Em like people who`ve had- it's like a big change you know. Even though I've had another child, it was my second I feel like I still don't- I still need somebody to reassure me. Ok my first- I had no idea what to do with a child like you know. I think just yeah they need to – ki- just be a bit kinder." Natalie*

			“*And a bit of paper and a pen was sat on the thingmy and I was like what am I to do with that? That’s how often you feed them, how much they take, like- you can’t just leave that in front of me after I’ve had a section under general anaesthetic.” Natalie* **“** *It’s not their fault that you feel like that so don`t take your frustration out on – not frustration but just the general attitude like. It actually takes more effort to huff and puff than it does just to pretend to be nice if that’s what you`ve got to do.” Natalie*
		Feeling abandoned	*“I do feel like it’s quite quick you get dropped off the off the radar.” Hannah* *“it’s like here’s a baby get on with it and I was chucked out of hospital really quickly.”Hannah* *“You know that your health visitor is there purely to weigh the baby and she does check in on you but like she`s got other clients and stuff like that. And I don’t feel like she’s just- just reachable to ask for help with.” Hannah*  *“You`re in the midst of the NHS are telling you that breast feeding is the best thing in the world but actually after two weeks tough luck see you later.” Hannah* *“Once I got taken from the recovery up to the ward my partner had to go home and I was just kind of [laughter] kind of left with a baby.” Sarah*

			"So that's what like 48 hours, over 48 hours of being awake and my partner was sent home. And I initially thought that I'm going to a ward I totally understand he`s- I was sent to a single room on my own and I thought ok if my partners been sent home ok I'll be supported all night. And I was but only because I kept buzzing."- Sarah *"Em I think in my experience I think that within hospital there can maybe be a slightly more trauma informed approach. I don't feel that, I don't feel like I experienced that. I don't feel like there was kind of, I don't really know how to explain it. I felt as if it was kind of like right well, just get on with it. You've got your baby now you just need to- it's really not that big of a deal."- Holly* *"I just remember me and Gary standing looking at each other like, they've just left us what do we do?"- Megan* *"But I feel like twelve weeks I was like well nobody cares essentially. In your head your like its fine, it's obviously not been traumatic because no one`s wanting to help if that makes sense."- Megan*  *"I mean it took me everything to actually go back [to the GP] because I didn't want to go back and talk to anyone because I thought well they`re not going to help."- Megan* *"But then it was things like – like they just kind of left you."- Natalie*

		Self-reliance & self-advocacy	*"I did ask several times for sort of like a wee bit of antenatal care and sort of information" – Hannah* *"and I thought ok if my partners been sent home ok I'll be supported all night. And I was but only because I kept buzzing. I kept buzzing to ask for help." – Sarah* *"So having to buzz and then he was choking at one point. Not totally choking but like gagging I think it was mucus I think it's quite normal and I had to buzz like a good few times and they came. Don`t get me wrong they did come but I felt like a burden."- Sarah* *"I was admitted to the inpatient suite and no one really apart from getting obs done every four hours, nothing really happened for three days. Until I asked can someone do something for me here nothings changing, nothings getting better, can somebody please do something because I had-I had sense to ask like what's going on, what's-can somebody do something but I think there might- If I hadn't asked how long would I have sat without anything happening? Without anybody helping me?" – Holly* *"Like I was septic and I wasn't well but I just got on with it because nobody really came if you know what I mean."- Natalie* *"I mean I am the kind of person that is like if I can get up and get on with it I will, so I did."- Natalie*