

# Shattered Expectations

The experience of care provider interaction from the perspectives of women with Post Traumatic Stress Disorder Post Childbirth, and midwives.

An Interpretative Phenomenological Analysis.

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<b>Index of Tables and Figures .....</b>	<b>23</b>
<b>Glossary.....</b>	<b>25</b>
<b>Abstract.....</b>	<b>26</b>
<b>Chapter One The background of this thesis.....</b>	<b>27</b>
<b>1.1. Introduction to Chapter 1.....</b>	<b>28</b>
<b>Part 1: What is PTSD and how can it be associated with childbirth? .....</b>	<b>28</b>
1.1.1. The traumatic response in humans .....	28
1.1.1.1. Humans respond individually to trauma.....	29
1.1.1.2. The process of the human response to trauma .....	29
1.1.1.3. The traumatic response in women.....	32
1.1.2. The development of a definition of PTSD .....	33
1.1.2.1. A brief history of the recognition of the condition now known as PTSD	33
1.1.2.2. The systems used to classify psychiatric illness.....	33
1.1.2.3. The DSM definition of PTSD .....	35
1.1.3. Attempts to model the risk factors and causes of PTSD.....	39
1.1.3.1. The model by Green et al. (1985).....	39
1.1.3.2. The model by Ehlers and Clark (2000).....	41
1.1.3.3. The model by Charuvastra and Cloitre (2008) .....	43
1.1.4. Aspects from these models of most relevance to PTSD associated with childbirth .....	44
1.1.4.1. The context of childbirth .....	46
1.1.4.2. The interpersonal aspect of childbirth .....	46
1.1.4.3. Fear and Negative cognitions related to childbirth .....	47
1.1.4.4. Memory and childbirth.....	48
1.1.4.5. Pain as part of childbirth.....	49
1.1.4.6. So, what makes childbirth traumatic? .....	49
1.1.5. Summary of Part 1 .....	49
<b>Part 2 Initial scoping of current literature regarding PTSD post Childbirth (PTSD-PC)</b> <b>.....</b>	<b>50</b>
1.2.1. The purpose of the initial scoping exercise .....	50
1.2.2. The process of the initial scoping exercise .....	51
1.2.2.1. The scoping search .....	51

1.2.2.2. <i>Narrowing down the focus of the scoping search</i> .....	51
1.2.2.3. <i>Selection of literature to inform the scoping exercise</i> .....	52
1.2.3. The findings of the initial scoping exercise .....	52
1.2.3.1. <i>The growth in awareness of PTSD associated with childbirth</i> .....	52
1.2.3.2. <i>The summary of findings from the 48 articles and reviews</i> .....	54
1.2.3.2.1. The prevalence of PTSD-PC.....	54
1.2.3.2.2. The risk factors and causes of PTSD-PC .....	55
1.2.4. Summary of Part 2 .....	57
1.3.1. Why is PTSD-PC important to examine? .....	57
1.3.1.1. <i>Prioritising maternal mental health</i> .....	57
1.3.1.2. <i>PND and PTSD</i> .....	58
1.3.2. Implications for maternal, child, and family wellbeing and healthcare services.....	59
1.3.2.1. <i>Impact on daily life</i> .....	59
1.3.2.2. <i>Impact on breastfeeding and future births</i> .....	59
1.3.2.3. <i>Impact on family relationships</i> .....	60
1.3.2.4. <i>Implications for child health</i> .....	61
1.3.2.5. <i>Implications for health services</i> .....	62
1.3.3. Summary of Part 3: rationale for undertaking the literature review .....	63
<b>Chapter Two A review of existing literature</b> .....	<b>65</b>
<b>2. A systematic literature review of studies examining PTSD-PC</b> .....	<b>66</b>
<b>2.1. Introduction to the literature review</b> .....	<b>66</b>
2.1.1. Selecting the method for the review .....	67
2.1.1.1. <i>A literature review in two stages</i> .....	68
2.1.2. Stage one of the literature review .....	69
<i>The search process and overview of findings from stage one are now presented</i> .....	69
2.1.2.1. <i>Identifying the search terms and inclusion/exclusion criteria</i> .....	69
2.1.2.2. <i>Performing the literature search</i> .....	71
2.1.2.3. <i>The methodologies of the 96 studies included in stage one of the review</i> .....	75

2.1.2.4. <i>The overview of findings of the 96 studies included in stage one of the review</i> .....	75
2.1.2.4.1. Terminology used in the overview of findings from the 96 studies included in stage one of the review.....	76
2.1.2.4.2. Category 1: Subjective childbirth experience .....	77
2.1.2.4.3. Category 2: Objective birth Interventions .....	78
2.1.2.4.4. Category 3: Prior trauma .....	79
2.1.2.4.5. Category 4: Demographic Factors.....	79
2.1.2.4.6. Category 5: Pre-existing factors.....	79
2.1.2.5. <i>Summary of stage one of the literature review</i> .....	86
2.1.2.6. <i>Rationale and focus for stage two of the literature review</i> .....	86
2.1.3. Stage two of the literature review.....	87
2.1.3.1. <i>The aims and questions for stage two of the literature review</i> .....	87
2.1.3.2. <i>Inclusion/exclusion criteria for stage two of the literature review</i> .....	88
2.1.3.3. <i>Method of quality assessment of studies in stage two of the literature review</i> .....	89
2.1.3.4. <i>Method of narrative synthesis of findings from studies in stage two of the literature review</i> .....	89
2.1.3.5. <i>The findings of stage two of the literature review</i> .....	90
2.1.3.5.1. The 14 studies that met stage two inclusion criteria .....	90
2.1.3.5.2. Summary of characteristics of the 14 studies.....	90
2.1.3.5.3. The foci of the 14 studies.....	105
2.1.3.5.4. The quality of the 14 studies with regard to their chosen methodology .....	105
2.1.3.5.5. The CASP quality assessment of the 14 studies.....	105
2.1.3.5.6. The Narrative synthesis of findings of the 14 studies.....	106
2.1.3.5.6.1. Key findings .....	106
2.1.3.5.6.2. Attitude of the midwife .....	107
2.1.3.5.6.3. Communication, information and decision making .....	108

2.1.3.5.6.4. Support.....	108
2.1.3.5.6.5. Control and confidence in midwives .....	109
2.1.3.5.6.6. Women’s expectations .....	110
2.1.3.5.6.7. Considerations for midwives .....	111
2.1.3.6. <i>Discussion of literature review findings</i> .....	111
2.1.3.7. <i>Implications from the literature review with regard to future research</i> .....	112
2.1.3.8. <i>Limitations of the literature review</i> .....	113
2.1.3.9. <i>Conclusion of the literature review</i> .....	113
2.1.3.10. <i>New research published since the review</i> .....	114
2.1.4. The rationale for the proposed research study and selected methodology .....	115
<b>Chapter Three Study methodology, strategy, and method .....</b>	<b>117</b>
<b>3.1. Introduction to the research process .....</b>	<b>118</b>
3.1.1. Identifying the research gap .....	118
3.1.2. Addressing the research gap.....	118
3.1.3. Defining the research study .....	119
<b>3.2. Choosing the research methodology .....</b>	<b>119</b>
<b>3.3. Choosing the research strategy .....</b>	<b>120</b>
3.3.1. Grounded theory.....	121
3.3.2. Phenomenology .....	121
3.3.3. What is phenomenology? .....	122
3.3.4. Phenomenological traditions .....	123
3.3.4.1. <i>Transcendental phenomenology</i> .....	123
3.3.4.2. <i>Existential phenomenology</i> .....	124
3.3.4.3. <i>Hermeneutic phenomenology</i> .....	124
3.3.5. Choosing the way of ‘doing’ phenomenology .....	125
3.3.5.1. <i>Hermeneutic phenomenology</i> .....	126
3.3.6. Summary regarding the selected research strategy .....	128
<b>3.4. Choosing a hermeneutic phenomenological research method.....</b>	<b>128</b>
3.4.1. Thematic Analysis.....	129

3.4.2. Framework analysis.....	129
3.4.3. Reflective Lifeworld.....	129
3.4.4. Interpretative Phenomenological Analysis (IPA) .....	130
<b>3.5. IPA as the research method .....</b>	<b>131</b>
3.5.1. Theoretical underpinnings of IPA.....	131
3.5.1.1. <i>Phenomenology</i> .....	132
3.5.1.2. <i>Hermeneutics</i> .....	132
3.5.1.3. <i>Idiography</i> .....	133
3.5.2. Use of IPA in recent years .....	134
3.5.3. Scientific robustness of IPA as a method .....	134
3.5.4. Learning how to 'do' IPA .....	135
3.5.5. Ensuring the quality of my IPA research .....	136
3.5.6. Being reflexive.....	138
3.5.6.1. <i>An initial word about terminology</i> .....	138
3.5.6.2. <i>Why be reflexive</i> .....	138
3.5.6.3. <i>Being reflexive</i> .....	138
3.5.6.4. <i>Use of a reflective journal</i> .....	139
3.5.7. Summary of why IPA as the research method.....	139
<b>3.6. Articulating the final research question.....</b>	<b>140</b>
3.6.1. Introduction .....	140
3.6.2. Moving from what to how .....	140
3.6.3. Being open to hear how .....	141
3.6.4. The research purpose, questions, aims, and objectives .....	142
<b>3.7. The research design and implementation .....</b>	<b>145</b>
3.7.1. Setting and context for the study .....	145
3.7.2. Sample size .....	145
3.7.3. Recruitment .....	146
3.7.3.1. <i>Inclusion/exclusion criteria for informants</i> .....	146
3.7.3.2. <i>Recruitment of childbearing women</i> .....	147
3.7.3.3. <i>Recruitment of midwives</i> .....	149
3.7.3.4. <i>The midwives were not those who had cared for the women</i> .....	150
3.7.4. Ethical considerations .....	151

3.7.4.1. <i>Informed Consent</i> .....	151
3.7.4.2. <i>Confidentiality and anonymity</i> .....	152
3.7.4.3. <i>Trust</i> .....	152
3.7.4.4. <i>Protection of informants and debriefing</i> .....	152
3.7.4.5. <i>Ethical approval</i> .....	153
3.7.5. Data collection .....	154
3.7.5.1. <i>Quantitative and qualitative data to inform recruitment and background</i> .....	154
3.7.5.2. <i>Qualitative data collection to address the research questions</i> .....	155
3.7.6. Data processing and analysis .....	156
3.7.6.1. <i>Processing of the study data</i> .....	156
3.7.6.2. <i>Analysis of the quantitative and background data</i> .....	157
3.7.6.3. <i>Analysis of interview data</i> .....	157
3.7.6.3.1. Step 1: Reading and re-reading.....	159
3.7.6.3.2. Steps 2 and 3: Initial noting and identifying emergent themes ...	159
3.7.6.3.3. Step 4: Searching for connections across emergent themes .....	159
3.7.6.3.4. Step 5: Moving to the next case .....	160
3.7.6.3.5. Step 6: Looking for patterns across cases.....	160
3.7.6.3.6. Step 7: Writing up the analysis .....	161
3.7.6.4. <i>Summary of data processing and analysis</i> .....	163
<b>Chapter Four The analysis of the study data .....</b>	<b>164</b>
<b>4. Study findings</b> .....	<b>165</b>
<b>4.1. Recruitment of women and midwives</b> .....	<b>165</b>
4.1.1. Recruitment of women experiencing PTSD-PC.....	165
4.1.2. Identification of women experiencing PTSD-PC .....	165
4.1.3. Recruitment of midwives .....	169
<b>4.2. Background data</b> .....	<b>170</b>
4.2.1. Women informants' sociodemographic data .....	170
4.2.2. Women informants' Birth Satisfaction Scale .....	171
4.2.3. Midwife informants online survey .....	174
4.2.4. Summary of background data.....	178

<b>4.3. Introduction to the IPA analysis findings .....</b>	<b>179</b>
4.3.1. Terminology .....	179
4.3.2. QPI viewed through idiographic lenses .....	179
4.3.3. Remembering the positive, highlighting the negative.....	180
4.3.4. Identification of the master and sub themes. ....	181
4.3.4.1. <i>How the findings emerged through the analysis process</i> .....	181
4.3.4.2. <i>Writing up the analysis findings</i> .....	182
4.3.5. Presentation of results .....	182
<b>4.4. The Midwives' experiences of interacting with women during labour, birth, and the early postnatal period. ....</b>	<b>183</b>
4.4.1. Introduction .....	183
4.4.2. Master theme 1: Being with women, what it is all about .....	186
4.4.2.1 <i>Introduction</i> .....	186
4.4.2.2. <i>Sub theme 1: Building relationships</i> .....	186
4.4.2.2.1. Building relationships is essential .....	186
4.4.2.2.2. Building relationships requires time .....	187
4.4.2.2.3. Continuity helps to build relationships .....	188
4.4.2.2.4. Relationship goes beyond birth – maintaining continuity.....	188
4.4.2.2.5. Actively building relationships .....	189
4.4.2.2.6. Recognising individuality when building relationships.....	190
4.4.2.2.7. Summary of sub theme 1: Building relationships .....	191
4.4.2.3. <i>Sub theme 2: Seeing women as individuals</i> .....	191
4.4.2.3.1. Individuality of women .....	191
4.4.2.3.2. Being open and non-judgemental .....	192
4.4.2.3.3. Tailoring care to the individual .....	193
4.4.2.3.4. Using empathy to understand women's needs.....	194
4.4.2.3.5. Women are individual in their perception.....	195
4.4.2.3.6. Summary of sub theme 2: Seeing women as individuals .....	195
4.4.2.4. <i>Sub theme 3: Let's talk</i> .....	196



4.4.2.4.1. Women need information and to be empowered to make choices .....	196
4.4.2.4.2. Finding out what women want to know .....	197
4.4.2.4.3. The Midwives need information about women too .....	198
4.4.2.4.4. The way of communicating .....	198
4.4.2.4.5. Listening .....	199
4.4.2.4.6. Birth Plans .....	200
4.4.2.4.7. Summary of sub theme 3: Let's talk .....	201
<i>4.4.2.5. Sub theme 4: Being responsible .....</i>	<i>202</i>
4.4.2.5.1. Getting it right for the individual, so she has a positive experience .....	202
4.4.2.5.2. The future impact of the woman's experience .....	203
4.4.2.5.3. Ensuring her pathway through birth has been optimal and safe ..	204
4.4.2.5.4. The potential impact on the pathway of childbirth.....	205
4.4.2.5.5. Failing to meet this responsibility reflects a sense of onus on The Midwives .....	206
4.4.2.5.6. Summary of sub theme 4: Being responsible .....	206
<i>4.4.2.6. Summary of master theme 1: Being with women, what it is all about</i>	<i>207</i>
4.4.3. Master theme 2: What we have to work within.....	207
<i>4.4.3.1. Sub theme 1: Torn in two .....</i>	<i>208</i>
4.4.3.1.1. One size doesn't fit all.....	208
4.4.3.1.2. Building bridges and locking horns .....	209
4.4.3.1.3. Reconciling safety and women's wishes.....	210
4.4.3.1.4. Abandoning women, loss and grief .....	212
4.4.3.1.5. Summary of sub theme 1: Torn in two .....	213
<i>4.4.3.2. Sub theme 2: We cannot control.....</i>	<i>213</i>
4.4.3.2.1. Women want control, but we can't give it, we can't control childbirth .....	213

4.4.3.2.2. When things do not go to plan .....	214
4.4.3.2.3. Time and timing .....	215
4.4.3.2.4. Being unable to change the workplace culture .....	216
4.4.3.2.5. At the mercy of the medical staff .....	217
4.4.3.2.6. Moving on, claiming control .....	217
4.4.3.2.7. Summary of sub theme 2: We cannot control.....	218
<i>4.4.3.3. Sub theme 3: The pressures we face .....</i>	<i>218</i>
4.4.3.3.1. Numbers of women and staffing .....	218
4.4.3.3.2. Practicalities of the workload, looking after more than one woman .....	219
4.4.3.3.3. Practicalities of the workload, ticking the boxes .....	220
4.4.3.3.4. Practicalities of the workload, pressure to move onto the next woman.....	221
4.4.3.3.5. Unrealistic demands from women .....	222
4.4.3.3.6. Being open to women .....	223
4.4.3.3.7. What do women want from me?.....	223
4.4.3.3.8. I am not a robot .....	224
4.4.3.3.9. Protecting myself and my registration .....	225
4.4.3.3.10. Summary of sub theme 3: The pressures we face.....	226
<i>4.4.3.4. Summary of master theme 2: What we have to work within .....</i>	<i>227</i>
4.4.4. Master theme 3: Enable me as a midwife .....	227
<i>4.4.4.1. Sub theme 1: Others need to do their bit.....</i>	<i>227</i>
4.4.4.1.1. Colleagues need to carry their fair share of the workload .....	227
4.4.4.1.2. Distress at the behaviour of colleagues.....	228
4.4.4.1.3. Impact on how women interact with the midwife .....	230
4.4.4.1.4. When colleagues do it well .....	230
4.4.4.1.5. We need to stop accepting things the way they are, it's not the way it should be.....	231

4.4.4.1.6. Preparation and expectations of women .....	232
4.4.4.1.7. I need communication and feedback from women .....	232
4.4.4.1.8. Summary of sub theme 1: Others need to do their bit .....	234
<b>4.4.4.2. Sub theme 2: Support me .....</b>	<b>234</b>
4.4.4.2.1. Support to have time with women .....	234
4.4.4.2.2. Support from colleagues, being dismissed, undermined, and bullied .....	235
4.4.4.2.3. Support from colleagues to advocate for women .....	237
4.4.4.2.4. We need resources and training.....	238
4.4.4.2.5. Summary of sub theme 2: Support me .....	239
<b>4.4.4.3. Sub theme 3: Trust and respect me.....</b>	<b>239</b>
4.4.4.3.1. Trust is essential.....	239
4.4.4.3.2. I am doing my best.....	240
4.4.4.3.3. I am skilled at identifying women’s needs and advocating for them .....	240
4.4.4.3.4. See my skills in comparison to others.....	241
4.4.4.3.5. I need women to trust and respect my clinical knowledge .....	241
4.4.4.3.6. I need colleagues to trust and respect my clinical knowledge .....	242
4.4.4.3.7. Summary of sub theme 3: Trust and respect me .....	243
4.4.4.4. Summary of master theme 3: Enable me as a midwife .....	243
<b>4.5. The Women’s experiences of interacting with their care providers during labour, birth, and the early postnatal period.....</b>	<b>244</b>
4.5.1. Introduction .....	244
4.5.2. Master theme 1: Shattered expectations .....	247
4.5.2.1 Introduction.....	247
4.5.2.2. Sub theme 1: Haunted by disbelief .....	247
4.5.2.2.1. Expectations being met.....	248
4.5.2.2.2. The need for obstetric interventions .....	248

4.5.2.2.3. I can't believe you did this to me .....	249
4.5.2.2.4. The contrast and inconsistency in the behaviour of midwives ....	251
4.5.2.2.5. The pressure on midwives .....	252
4.5.2.2.6. Summary of sub theme 1: Haunted by disbelief .....	252
<i>4.5.2.3. Sub theme 2: Trusting you .....</i>	<i>253</i>
4.5.2.3.1. Placing oneself in the hands of midwives .....	253
4.5.2.3.2. Competent midwives caring for me.....	254
4.5.2.3.3. Lack of competent care.....	255
4.5.2.3.4. The integrity and honesty of care providers.....	256
4.5.2.3.5. Summary of sub theme 2: Trusting you.....	256
<i>4.5.2.4. Sub theme 3: Keeping me safe.....</i>	<i>257</i>
4.5.2.4.1. Expecting to be safe .....	257
4.5.2.4.2. Women feeling safe .....	257
4.5.2.4.3. The loss of safety.....	258
4.5.2.4.4. Keeping themselves safe from midwives.....	258
4.5.2.4.5. Impact on future choices .....	260
4.5.2.4.6. Summary of sub theme 3: Keeping me safe. ....	262
<i>4.5.2.5. Sub theme 4: Threatening me.....</i>	<i>262</i>
4.5.2.5.1 Putting baby at risk .....	262
4.5.2.5.2. Threat of interventions .....	263
4.5.2.5.3. Threatened by the staff .....	264
4.5.2.5.4. Horror .....	265
4.5.2.5.5. Summary of sub theme 4: Threatening me. ....	266
<i>4.5.2.6. Summary of master theme 1: Shattered expectations .....</i>	<i>266</i>
<i>4.5.3. Master theme 2: Being with me. ....</i>	<i>267</i>
<i>4.5.3.1. Sub theme 1: Building relationship with me. ....</i>	<i>267</i>
4.5.3.1.1. Desire for relationship .....	267
4.5.3.1.2. Positive relationships .....	268

4.5.3.1.3. Lack of relationship .....	268
4.5.3.1.4. Language <i>The Women</i> used .....	269
4.5.3.1.5. The role of continuity .....	270
4.5.3.1.6. The impact on labour progress .....	271
4.5.3.1.7. The Women acknowledging midwives .....	272
4.5.3.1.8. Summary of sub theme 1: Building relationship with me .....	272
<i>4.5.3.2. Sub theme 2: See me – I need you.....</i>	<i>273</i>
4.5.3.2.1. Being seen as an individual and having one’s needs recognised .	273
4.5.3.2.2. Misunderstanding needs .....	273
4.5.3.2.3. My emotional needs were not seen .....	273
4.5.3.2.4. My physical needs were not seen.....	274
4.5.3.2.5. Ticking boxes .....	276
4.5.3.2.6. Summary of sub theme 2: Seeing me .....	277
<i>4.5.3.3. Sub theme 3: Talking and listening to me.....</i>	<i>277</i>
4.5.3.3.1. Good communication .....	277
4.5.3.3.2. Contrast in communication.....	278
4.5.3.3.3. Lack of communication .....	278
4.5.3.3.4. Timing of communication .....	279
4.5.3.3.5. Birth plans .....	279
4.5.3.3.6. Nature of communication.....	279
4.5.3.3.7. Impact of communication .....	280
4.5.3.3.8. Summary of sub theme 3: Talking and Listening to me .....	281
<i>4.5.3.4. Sub theme 4: Supporting me.....</i>	<i>282</i>
4.5.3.4.1. Feeling supported .....	282
4.5.3.4.2. Shifting sense of support .....	283
4.5.3.4.3. Poor support .....	283
4.5.3.4.4. Lack of support during labour and birth .....	283

4.5.3.4.5. Lack of support during the early postnatal period .....	284
4.5.3.4.6. The role of partners and doulas.....	286
4.5.3.4.7. Being abandoned and isolated .....	287
4.5.3.4.8. Summary of sub theme 4: Supporting me .....	288
4.5.3.5. <i>Summary of master theme 2: Being with me .....</i>	288
4.5.4. Master theme 3: Whose power? .....	289
4.5.4.1. <i>Introduction: the vulnerable context of childbirth .....</i>	289
4.5.4.1.1. Physical vulnerability .....	289
4.5.4.1.2. Emotional vulnerability .....	290
4.5.4.2. <i>Sub theme 1: How not what.....</i>	290
4.5.4.2.1. Being nice with me .....	291
4.5.4.2.2. Tutting and sighing.....	291
4.5.4.2.3. Being a bother .....	291
4.5.4.2.4. Annoying the midwives.....	292
4.5.4.2.5. Feeling patronised or chastised .....	293
4.5.4.2.6. Focus on midwives needs .....	295
4.5.4.2.7. Summary of sub theme 1: How not what.....	296
4.5.4.3. <i>Sub theme 2: Struggling for power .....</i>	296
4.5.4.3.1. Psychological power struggle.....	296
4.5.4.3.2. Physical power struggle .....	298
4.5.4.3.3. Violation .....	300
4.5.4.3.4. Summary of sub theme 2: Struggling for power.....	301
4.5.4.4. <i>Sub theme 3: Finding and losing power .....</i>	301
4.5.4.4.1. Being powerful .....	301
4.5.4.4.2. Moving from powerful to powerless .....	302
4.5.4.4.3. Powerless within the process of labour and birth .....	302
4.5.4.4.4. Powerless to comply with demands or give consent .....	305
4.5.4.4.5. Powerless to be with or care for their baby .....	305

4.5.4.4.6. Worn down to total powerlessness .....	306
4.5.4.4.7. The Women claiming their own power .....	306
4.5.4.4.8. Summary of sub theme 3: Finding and losing power .....	307
4.5.4.5. <i>Summary of master theme 3: Whose power?</i> .....	308
<b>4.6. Bringing together both sides of the story .....</b>	<b>308</b>
4.6.1. Introduction .....	308
4.6.2. Human need as a converging theme with diverging pathways.....	309
4.6.2.1. <i>Keeping safe</i> .....	309
4.6.2.2. <i>Being respected</i> .....	310
4.6.2.3. <i>Having power</i> .....	310
4.6.2.4. <i>Receiving support</i> .....	311
4.6.3. Relationship as a converging theme .....	313
4.6.3.1. <i>Ticking boxes</i> .....	315
4.6.3.2. <i>Communication</i> .....	315
4.6.4. Summary of both sides of the story.....	315
<b>Chapter Five Discussion of the study findings .....</b>	<b>317</b>
<b>5.1. Introduction to the discussion .....</b>	<b>318</b>
5.1.1. How the discussion is presented .....	318
5.1.2. The language used within the discussion .....	318
5.1.3. Why the discussion is primarily focussed on midwives .....	318
5.1.4. Moving from findings to theory: the context within which the discussion rests.....	319
5.1.5. Balancing the negative weight in the discussion .....	319
5.1.6. Summary of the Introduction to the discussion .....	319
<b><i>Part 1: How a gap in the PTSD-PC research literature was identified and addressed</i></b> .....	<b>320</b>
<b><i>5.2. How the literature review identified a gap in the PTSD-PC research literature</i></b> .....	<b>320</b>
<b><i>5.3. How the study addressed the identified gap in the PTSD-PC research literature</i></b> .....	<b>320</b>
5.3.1. A reminder of the research questions, aims, and objectives .....	321
5.3.2. Study limitations .....	323

5.3.2.1. <i>The impact of previous life experiences</i> .....	323
5.3.2.2. <i>Inability to determine the cause of the PTSD-PC in The Women</i> .....	323
5.3.2.3. <i>Not interviewing the woman/midwife dyads</i> .....	323
5.3.2.4. <i>The retrospective nature of the research</i> .....	323
5.3.2.5. <i>Self-selection of informants</i> .....	324
5.3.2.6. <i>Limited socio-demographic of the samples</i> .....	325
5.3.2.7. <i>Potential influence of the interview schedules</i> .....	325
5.3.3. Study strengths .....	325
5.3.3.1. <i>The comprehensive nature of the literature review</i> .....	325
5.3.3.2. <i>The in-depth qualitative analysis</i> .....	325
5.3.3.3. <i>The use of reflexivity</i> .....	326
5.3.4. Ethical considerations during the study.....	326
<b>5.4. Summary of the study findings.....</b>	<b>326</b>
5.4.1. <i>The Midwives lived experiences and the meaning these had for them when interacting with women?</i> .....	327
5.4.2. <i>The Women’s lived experiences and the meaning these had for them when interacting with women?</i> .....	328
5.4.3. Findings that converge.....	329
5.4.4. Findings that diverge.....	329
5.4.5. Validation of the study findings .....	330
<b>5.5. The novel contribution to the PTSD-PC research literature:.....</b>	<b>330</b>
5.5.1. The novel contribution from the literature review .....	331
5.5.2. The novel contribution regarding how the research gap was addressed ..	331
5.5.3. The novel contribution from the study .....	331
5.5.4. The novel contribution through creative dissemination of study findings	332
5.5.5. Moving towards the discussion .....	332
<b>Part 2: Discussion of the key study findings.....</b>	<b>333</b>
<b>5.6. Foundational theories that inform an understanding of the key study findings</b> .....	<b>333</b>
5.6.1. Introduction .....	333
5.6.1.1. <i>Embarking on interaction: factors influencing behaviour and expectations</i> .....	334



5.6.1.2. <i>During interaction: factors influencing behaviour and expectations ..</i>	334
5.6.2. Four theories that inform the cycle of experience, expectation, and behaviour .....	335
5.6.2.1. <i>Cognitive dissonance: when reality does not match the ideal.....</i>	335
5.6.2.2. <i>Emotional labour: which informs the management of relationship....</i>	337
5.6.2.3. <i>The Reasonable Person Model (RPM): which informs attitude .....</i>	338
5.6.2.4. <i>Transactional Analysis (TA): which informs communication .....</i>	339
5.6.3. Summary of foundational theories that inform understanding of the key study findings .....	340
<b>5.7. Discussion of the key study findings in relation to foundational theories and wider midwifery research.....</b>	<b>340</b>
5.7.1. Being human .....	341
5.7.1.1. <i>Shared human background.....</i>	341
5.7.1.2. <i>Women’s human needs.....</i>	342
5.7.1.3. <i>Midwives’ human needs.....</i>	342
5.7.1.4. <i>The power inequalities at the outset .....</i>	343
5.7.2. The shared human experience of reality not meeting the ideal .....	344
5.7.2.1. <i>The desired ideal .....</i>	344
5.7.2.2. <i>The ideal/reality gap .....</i>	345
5.7.2.3. <i>The organisational context of ideal/reality gap.....</i>	345
5.7.2.4. <i>Women’s experiences of the ideal/reality gap .....</i>	346
5.7.2.5. <i>Midwives’ experiences of the ideal/reality gap .....</i>	347
5.7.2.6. <i>Midwives’ responses to the ideal/reality gap .....</i>	347
5.7.2.7. <i>Consequences for midwives due to the ideal/reality gap.....</i>	348
5.7.3. Developing relationship .....	349
5.7.3.1. <i>Women and midwives shared desire for relationship.....</i>	349
5.7.3.2. <i>Women’s and midwives’ perspectives on relationship .....</i>	350
5.7.3.3. <i>The impact on relationship from midwives’ emotional labour.....</i>	351
5.7.3.4. <i>Managing risk within relationship .....</i>	352
5.7.3.5. <i>The rewards of relationship .....</i>	352
5.7.4. Women’s and midwives’ shared desire for communication .....	352
5.7.4.1. <i>The Women’s desires for communication.....</i>	353

5.7.4.2. <i>The Midwives' desires for communication</i> .....	353
5.7.4.3. <i>The role of TA in communication</i> .....	354
5.7.5. Where does the reasonable person model fit in? .....	354
5.7.6. Summary of discussion of the key findings.....	355
<b>Chapter Six Recommendations from the study findings .....</b>	<b>356</b>
<b>6.1. Introduction to the recommendations .....</b>	<b>357</b>
<b>Part 1: Developing the recommendations .....</b>	<b>357</b>
<b>6.2. Considerations to be addressed by the maternity services .....</b>	<b>357</b>
6.2.1. Consideration 1: The prevention of psychological harm must be prioritised within maternity services.....	358
6.2.1.1. <i>Iatrogenic psychological harm must be avoided.</i> .....	358
6.2.1.2. <i>Equal status must be accorded to both psychological and physical wellbeing</i> .....	359
6.2.1.3. <i>All women must be assumed to be at risk of psychological harm.</i> .....	359
6.2.1.4. <i>The woman/midwife relationship must be protected</i> .....	360
6.2.1.5. <i>Summary of consideration 1</i> .....	361
6.2.2. Consideration 2: Interpersonal skills are not nice extras but are fundamental.....	361
6.2.2.1. <i>Good interpersonal skills are not nice extras</i> .....	361
6.2.2.2. <i>Good interpersonal skills include compassion, empathy, and ultimately love.</i> .....	363
6.2.2.2.1. <i>Compassion</i> .....	363
6.2.2.2.2. <i>Empathy</i> .....	365
6.2.2.2.3. <i>Kindness and respect</i> .....	366
6.2.2.2.4. <i>A word about love</i> .....	366
6.2.2.3. <i>Emotional Intelligence is a foundation from which interpersonal skills can be developed and maintained.</i> .....	367
6.2.2.4. <i>Summary of consideration 2</i> .....	368
6.2.3. Consideration 3: A woman-centred service requires a midwife-centred organisation. ....	369
6.2.3.1. <i>Midwives needs must be met before they attend to women</i> .....	369

6.2.3.1.1. Introduction with a personal reflection .....	369
6.2.3.1.2. Why the focus is not on improving midwives.....	369
6.2.3.1.3. Putting midwives first .....	370
6.2.3.1.4. Why the focus is not on improving women .....	370
6.2.3.2. <i>Midwives' prior history and humanity must be acknowledged.</i> .....	371
6.2.3.2.1. Human rights for midwives .....	372
6.2.3.3. <i>Summary of consideration 3</i> .....	372
6.2.4. Consideration 4: A toxic culture undermines maternity services and QPI. It should not be tolerated. ....	372
6.2.4.1. <i>The presence of a toxic culture</i> .....	372
6.2.4.1.1. Acknowledging the primarily positive culture of midwifery.....	372
6.2.4.1.2. The dark side of midwifery services organisation .....	373
6.2.4.1.3. The impact of a toxic culture of midwifery .....	373
6.2.4.2. <i>The organisational responsibility for tackling this toxic culture</i> .....	374
6.2.4.2.1. Organisational responsibilities.....	374
6.2.4.2.2. Is it up to midwives to become resilient? .....	375
6.2.4.3. <i>A policy of zero tolerance towards individuals who persist in perpetuating the toxic culture is required.</i> .....	376
6.2.4.4. <i>Summary of consideration 4</i> .....	377
<b>Part 2: Recommendations</b> .....	<b>377</b>
<b>6.3. Introduction</b> .....	<b>377</b>
6.3.1. Recommendations for midwifery education .....	378
6.3.2. Recommendations for midwifery practice .....	379
6.3.3. Recommendations for midwifery policy development .....	381
6.3.4. Recommendations for midwifery research .....	383
6.3.5. Considerations regarding the recommendations .....	384
6.3.6. Summary of the recommendations .....	384
<b>Chapter Seven Conclusion of the thesis</b> .....	<b>385</b>
<b>7.1. Introduction</b> .....	<b>386</b>
<b>7.2. Background</b> .....	<b>386</b>

<b>7.3. Contribution to knowledge .....</b>	<b>386</b>
7.3.1. The role of QPI .....	386
7.3.2. The gap in knowledge .....	386
7.3.3. Addressing this gap in knowledge.....	387
7.3.4. The key findings from the study .....	387
<b>7.4. Acknowledging limitations .....</b>	<b>387</b>
<b>7.5. Implications for midwifery education, practice, and policy.....</b>	<b>387</b>
<b>8. References.....</b>	<b>388</b>
<b>Appendix 1.1. Comparison of the ICD-10 PTSD Diagnosis with the DSM-IV-TR</b>	
<b>Criteria.....</b>	<b>424</b>
<b>Appendix 1.2. The DSM-IV diagnostic criteria B to F for PTSD .....</b>	<b>425</b>
<b>Appendix 1.3. The DSM-V diagnostic criteria for PTSD.....</b>	<b>426</b>
<b>Appendix 1.3. The DSM-V diagnostic criteria for PTSD (continued) .....</b>	<b>427</b>
<b>Appendix 1.4. List of studies used in the scoping findings .....</b>	<b>428</b>
<b>Appendix 2.1. Keywords, subject headings and terms used for the systematic</b>	
<b>literature search.....</b>	<b>429</b>
<b>Appendix 2.2. List of the 96 studies included in stage one of the review.....</b>	<b>430</b>
<b>Appendix 2.2. List of the 96 studies included in stage one of the review (continued)</b>	
.....	431
<b>Appendix 2.3. CASP checklists.....</b>	<b>432</b>
<b>Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies</b>	
.....	435
<b>Appendix 3.1. Dissemination of research findings .....</b>	<b>448</b>
<b>Appendix 3.2. Original creative contributions to research and dissemination....</b>	<b>450</b>
<b>Appendix 3.3. Postnatal groups who advertised the study .....</b>	<b>451</b>
<b>Appendix 3.4. Women’s advertising poster .....</b>	<b>452</b>
<b>Appendix 3.5. Women’s information leaflet for initial screening, page 1 .....</b>	<b>453</b>
<b>Appendix 3.6. Women’s eligibility form .....</b>	<b>455</b>
<b>Appendix 3.7. Women’s consent form for initial screening .....</b>	<b>456</b>
<b>Appendix 3.8. Women’s interview information .....</b>	<b>457</b>
<b>Appendix 3.9. Women’s interview consent form .....</b>	<b>459</b>
<b>Appendix 3.10. Women’s debrief information sheet (initial screening) .....</b>	<b>460</b>

<b>Appendix 3.11. Midwives’ advertising poster .....</b>	<b>462</b>
<b>Appendix 3.12. Midwives’ online survey .....</b>	<b>463</b>
<b>Appendix 3.12. Midwives’ online survey (continued) .....</b>	<b>464</b>
<b>Appendix 3.12. Midwives’ online survey (continued) .....</b>	<b>465</b>
<b>Appendix 3.13. Midwives’ interview information leaflet .....</b>	<b>466</b>
<b>Appendix 3.14. Midwives’ interview consent form .....</b>	<b>468</b>
<b>Appendix 3.15. Midwives’ debrief information sheet.....</b>	<b>469</b>
<b>Appendix 3.16. City BiTS PTSD-PC screening scale .....</b>	<b>471</b>
Appendix 3.16.1. City BiTS form.....	471
Appendix 3.16.2. City BiTS scoring sheet .....	473
Appendix 3.16.3. City BiTS Diagnostic Criteria.....	476
Appendix 3.16.4. City BiTS Rating scale information .....	477
<b>Appendix 3.17. Birth Satisfaction Scale – Revised.....</b>	<b>478</b>
<b>Appendix 3.18. Women’s sociodemographic form.....</b>	<b>480</b>
<b>Appendix 3.19. Interview schedules .....</b>	<b>481</b>
Appendix 3.19.1. Women’s interview schedule .....	481
Appendix 3.19.2. Midwives’ interview schedule .....	482
<b>Appendix 3.20. An example IPA coding page.....</b>	<b>483</b>
<b>Appendix 3.21. An example of initial lists of emergent themes .....</b>	<b>484</b>
<b>Appendix 3.22. An example colour coding of emergent themes.....</b>	<b>485</b>
<b>Appendix 3.23. An example of grouping colour coded themes.....</b>	<b>486</b>
<b>Appendix 3.24. An example cut and paste page showing master themes groupings and interpretative processes .....</b>	<b>487</b>
<b>Appendix 3.25. An example showing stages of groupings .....</b>	<b>488</b>
<b>Appendix 3.26. Example table of frequencies used to clarify final master themes .....</b>	<b>489</b>
<b>Appendix 3.27. Example of re-grouping of themes through use of the frequency table .....</b>	<b>490</b>
Appendix 3.27.1. Example of groupings prior to use of frequency table .....	490
Appendix 3.27.2. Example of revised groupings after use of frequency table.....	491
<b>Appendix 3.28. Example of the tracking and coding done to cross reference women’s extracts used .....</b>	<b>492</b>

<i>Appendix 3.29. Example of document for one informant showing extracts relevant to individual sub themes .....</i>	<b>493</b>
<i>Appendix 3.30. Example page of colour coded transcript templates (midwives). .....</i>	<b>494</b>
<i>Appendix 3.31. Example from document with all the extracts relating to the sub theme conflict .....</i>	<b>495</b>
<i>Appendix 3.32. Example of one-line summaries for extracts relating to the sub theme incompetence .....</i>	<b>496</b>
<i>Appendix 4.1. Range of potential interpersonal skills to include in midwifery education.....</i>	<b>497</b>

## **Index of Tables and Figures**

Table 2.1	Concept and synonyms for the literature search	70
Table 2.2.	Stage one inclusion and exclusion criteria	71
Table 2.3.	Number of studies identified from main literature search	72
Table 2.4.	Timing and methods of PTSD-PC research from the 96 studies	75
Table 2.5.	Overview of findings regarding factors contributing to the development of PTSD-PC from the 96 studies included in stage one of the literature review	81
Table 2.6.	Studies included in Stage two of the review	90
Table 2.7.	Summary characteristics and findings of the reviewed studies	91
Table 2.8.	CASP rating awarded to the 14 studies	106
Table 3.1.	Terminology used in this study	119
Table 3.2.	Research strategies excluded from further consideration	121
Table 3.3.	Examples of phenomenology use encountered during the literature review	125
Table 3.4.	Synthesis of quality assurance requirements for assessing trustworthiness and rigour	137
Table 3.5.	Inclusion/exclusion criteria for recruitment of informants	146
Table 3.6.	Quantitative data collected for recruitment and background information	154
Table 3.7.	Data processing techniques	157
Table 3.8.	Identifying, collating, selecting and managing data extracts within the writing up process	162
Table 4.1.	The summary of the City BiTS scoring for each of the 24 women (those meeting full PTSD diagnostic criteria are highlighted)	166
Table 4.2a.	Sociodemographic features for all the 24 screened women.	170
Table 4.2b.	Sociodemographic features for the 6 interviewed women.	171
Table 4.3a.	Number of women scoring each category of BSS-R (24 screened women)	173
Table 4.3b.	Number of women scoring each category of BSS-R (6 interviewed women)	174
Table 4.3c.	Average scores for each subscale and total scores	174
Table 4.4a.	Background data for the 57 midwives who responded to the survey (number of midwives)	175
Table 4.4b.	Background data for the 6 midwives who were interviewed (number of midwives)	175
Table 4.5.	Midwives' beliefs about what contributes to PTSD-PC for women and the number who held this belief	177
Table 4.6.	Examples of emerging findings produced by the analysis process	181
Table 5.1.	The ego state model	340
Table 5.2.	Reciprocity in woman/midwife relationship	351
Table 6.1.	The 6C's	365
Table 6.2.	Salovey and Mayer model of EI	367

Table 6.3. Recommendations for midwifery education	379
Table 6.4. Recommendations for midwifery practice	380
Table 6.5. Recommendations for midwifery policy development	383
Table 6.6. Recommendations for midwifery research	384
Figure 1.1. The HPA axis	30
Figure 1.2. The fear/immobility cycle	32
Figure 1.3. Green's PTSD psychosocial model	40
Figure 1.4. Ehlers and Clark's Cognitive model	41
Figure 2.1. Study selection process for stages one and two of the review	74
Figure 2.2. Summary of themes within the findings of the 14 studies	110
Figure 3.1. The 7 steps of IPA analysis process	158
Figure 4.1. Flowchart of recruitment of women	168
Figure 4.2. Flow chart of recruitment of midwives and selection for interview	169
Figure 4.3. The actions the 57 midwives considered to be most important to reduce the risk of PTSD-PC	178
Figure 4.4. Master and sub themes from <i>The Midwives'</i> data	184
Figure 4.5. Connections between <i>The Midwives'</i> sub themes in different master themes	185
Figure 4.6. <i>The Women's master and</i> sub themes	245
Figure 4.7. Connections between <i>The Women's</i> sub themes in different master themes	246
Figure 4.8. The convergent human needs of <i>The Women</i> and <i>The Midwives</i> , the associated sub themes, and the expressed human emotions and concerns.	312
Figure 4.9. How relationship was experienced by each group	314
Figure 5.1. Human factors influencing the interaction between women and midwives	334
Figure 5.2. The pathway of cognitive dissonance	336
Figure 5.3. Maslow's hierarchy of needs	340
Figure 5.4. Model of Cognitive Dissonance	348



## **Glossary**

AN: Antenatal  
APA: American Psychological Association  
AQR: Association for Qualitative Research  
CASP: Critical Appraisal Skills Programme  
CD: Cognitive Dissonance  
CDCP: Centers for Disease Control and Prevention  
CQC: Care Quality Commission  
CRD: Centre for Reviews and Dissemination  
CS: Caesarean Section  
DoH: Department of Health  
DSM: Diagnostic and Statistical Manual of Mental Disorders  
EI: Emotional Intelligence  
FNP: Family Nurse Partnership  
ICD: International Classification of Diseases  
ICM: International Confederations of Midwives  
IPA: Interpretative Phenomenological Analysis  
JCPMH: Joint Commissioning Panel for Mental Health  
MBBRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries-UK  
MCQIC: Maternity and Children Quality Improvement Collaborative  
NCT: National Childbirth Trust  
NFER: National Foundation for Educational Research  
NHS: National Health Service  
NICE: National Institute for Clinical Excellence  
NMC: Nursing and Midwifery Council  
PIPUK: Parent Infant Partnership UK  
PN: Postnatal  
PTSD: Post Traumatic Stress Disorder  
PTSD-PC: Post Traumatic Stress Disorder Post Childbirth  
PTS: Post Traumatic Stress  
PTSS: Post Traumatic Stress Symptoms  
QPI: Quality of Provider Interaction  
RCGP: Royal College of General Practitioners  
RCM: Royal College of Midwives  
RCOG: Royal College of Obstetricians and Gynaecologists  
SIGN: Scottish Intercollegiate Guideline Network  
SoM: Supervisor of Midwives  
SVB: Spontaneous Vaginal Birth  
TA: Transactional Analysis  
UNICEF: United Nations International Emergency Children's Fund  
VE: Vaginal Examination  
WHO: World Health Organisation

## **Abstract**

### **Shattered Expectations**

**The experience of provider interaction from the perspectives of women with Post Traumatic Stress Disorder post childbirth, and midwives. An Interpretative Phenomenological Analysis.**

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**Background:** Post Traumatic Stress Disorder-Post Childbirth (PTSD-PC) has important implications for mothers, children, families, and healthcare services. Interpersonal factors are the strongest predictor for the development of PTSD-PC, with the woman's subjective experience of Quality of Provider Interaction (QPI) being a significantly associated factor. Within PTSD-PC research, no studies were identified that explored midwives' experiences of interacting with women during the provision of care, nor any qualitative studies that specifically investigated women's experiences of QPI.

#### **Aims:**

To explore the lived experience of QPI during childbirth in women who have developed PTSD following this childbirth event.

To explore midwives' lived experiences of interacting with women during maternity care provision.

To inform appropriate recommendations for the education and development of midwives.

**Methods:** Six women who had developed PTSD-PC were recruited from across three regions in Scotland. Six intrapartum midwives were recruited from one NHS region in Scotland. In-depth, semi-structured interviews were carried out for all 12 informants. These interviews were audio recorded and transcribed verbatim. The interview data was analysed using Interpretative Phenomenological Analysis (IPA).

#### **Results:**

For the women informants, master themes emerged from their lived experiences of QPI: *Being with me; Shattered expectations; and Whose power?*

For the midwife informants, master themes emerged from their lived experience of interacting with women during care provision: *Being with women, what it is all about; What we have to work within; and Enable me as a midwife.*

**Conclusion:** This study enables deeper understanding of *both sides of the story* relating to QPI. While experiences are subjective, understanding the way women who develop PTSD-PC perceived QPI, alongside the challenges that midwives experience in terms of optimising QPI, serves to highlight the issues that may require further attention within maternity services. This knowledge and understanding will therefore inform future research, midwifery education and practice, as well as policy development.

## Chapter One

### The background of this thesis

## **1.1. Introduction to Chapter 1**

This chapter will be in three parts, covering the following:

**Part 1: What is PTSD and how can it be associated with childbirth?**

**Part 2: Initial scoping of existing literature regarding PTSD post Childbirth (PTSD-PC)**

**Part 3: Rationale for undertaking a review of the existing PTSD-PC literature**

### **Part 1: What is PTSD and how can it be associated with childbirth?**

*“A trauma is by definition an event that is threatening, unexpected, and uncontrollable and from a cognitive perspective directly challenges the beliefs that the world is safe, predictable, and controllable, contributing to the cardinal emotion of PTSD, namely fear.” (Charuvastra and Cloitre, 2008)*

*“The human response to psychological trauma is one of the most important public health problems in the world.” (van der Kolk, 2000)*

This part presents an overview of the traumatic response in humans and the potential for subsequent development of the condition known as Post Traumatic Stress Disorder (PTSD), from the earliest recognition to the latest definition. Throughout, reference is made to the hormonal and psychological physiology of childbirth, with particular attention to the unique aspects of the childbearing experience that may predispose women to develop PTSD.

#### **1.1.1. The traumatic response in humans**

The earliest humans needed to respond to and survive life threats from natural events and predators. This continues in some areas of the world today. Such trauma is an essential component of human experience and enables the development of life skills and survival responses that maintain and protect wellbeing (Fischer, 2017). Being exposed to trauma is part of life, with up to 50-60% of people in the US experiencing extreme stress at some point in their life (Hughes, 2012, Oken et al., 2015), which can be a devastating intrusion into normal life (McCraty and Zayas, 2014). Yet, the human heart is designed to manage periods of chaos as well as coherence (McCraty and Zayas, 2014), and while the traumatic response may be inherently similar to animals

(Levine, 2010), humans differ in that they ascribe meaning to the traumatic event (Charuvastra and Cloitre, 2008).

#### **1.1.1.1. Humans respond individually to trauma**

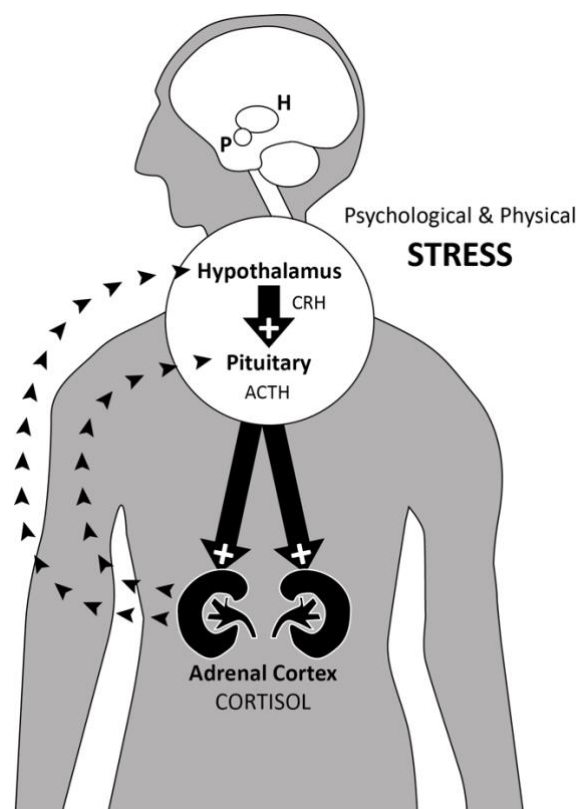
The individual experience is subjective and unique, and not everyone exposed to the same traumatic event will develop PTSD (Sherin and Nemeroff, 2011, Hughes, 2012, Oken et al., 2015) even when the trauma is severe (Crocq and Crocq, 2000). An individual's response to trauma depends on both their genetic predisposition and their early life history (each of which may determine the other) (de Kloet et al., 2005). The term *resilience* refers to how effectively and quickly a person can recover from stress or trauma (Oken et al., 2015). Originally PTSD was thought to represent an extreme end of the normative response to trauma, being related only to the severity of the traumatic event (Sherin and Nemeroff, 2011). However, the correlation between length, severity, and complexity of the traumatic event, and the complexity of subsequent PTSD is often partial, not absolute (Blank, 1993), and depends on the individual's characteristics (Yehuda and LeDoux, 2007). The development of PTSD may depend on factors such as: *exposure to earlier stress* that may pre-dispose to trauma (Sherin and Nemeroff, 2011) or increase ability to withstand trauma (Hughes, 2012); the *level of activity in key areas of the brain*, particularly communication between the neocortex (reasoning brain) and the limbic (emotional brain); and *epigenetic factors* (Hughes, 2012). Over time, post trauma symptoms may diminish naturally, or worsen, determined by a range of further factors that include social support, coping mechanisms, subsequent stress, family circumstances, personality, other disorders (Rothbaum and Foa, 1993), and having an optimistic disposition (Hughes, 2012). These biological, genetic, and social factors contribute to the person's resilience, with research continuing to identify these and their role in the development of PTSD (Hughes, 2012).

#### **1.1.1.2. The process of the human response to trauma**

When threat is perceived the first response may be to freeze, which enables increased attention on the threat before moving to fight or flight. This *fight or flight* response to a traumatic event is designed to enable the individual to seek a solution or safety. It

effects an almost instantaneous range of hormonal and physiological responses that incorporate cognitive, physiological, and behavioural aspects (Harvard, 2018). The cognitive response involves appraisal of the threat, which is fundamental and unique to the individual, and interpretation of the event. If threat is perceived, the hippocampus and amygdala in the limbic system (or emotional brain that processes emotions and memory), along with the anterior cingulate cortex (ACC) within the neocortex (or thinking brain that processes reasoning and decision making), regulate the physiological and behavioural stress processes (McEwen and Gianaros, 2010, Hughes, 2012). This physiological process, known as the hypothalamic-pituitary-adrenal (HPA) axis, issues signals from the pituitary gland in the brain (Everly et al., 2013) that stimulate the adrenal glands (by the kidneys) to release the stress hormones adrenaline and cortisol. See Figure 1.1.

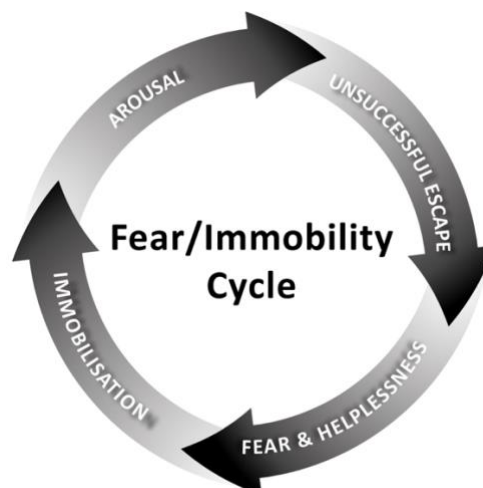
Figure 1.1. The HPA axis (adapted from Alschuler (2016))



CRH = Corticotropin Releasing Hormone  
ACTH = Adrenocorticotropic Hormone

Consequently, the individual's heart rate, blood pressure, and breathing rate increase and they may begin to sweat. Importantly, their senses become sharper and strong memories are formed (to remember what to avoid in future), while extra energy is released to facilitate action (Harvard, 2018, Hughes, 2012). The multiple roles of adrenaline in regulating arousal and autonomic stress response, as well as encoding of memories, have received particular research focus (Sherin and Nemeroff, 2011). This physiological and behavioural stress response is regulated by the HPA axis, through which increasing cortisol levels generate a negative feedback loop that inhibits continuation of this process and returns the system to equilibrium (Alschuler, 2016). However, these stress response systems, while adaptive in the short term, can be maladaptive in the long term (McEwen and Gianaros, 2010). Thus, PTSD can result from an alteration in the HPA axis caused by a significant stressful event, resulting in the inability to return to equilibrium (Valente, 2010). Within *fight or flight* there exists the further important aspect of *tonic immobility*, which results in the full stress response sequence being 'Hypervigilance, escape, struggle, tonic immobility', often referred to as 'Freeze, fight, flight, fright' (Bracha et al., 2004), or otherwise referred to as 'Arousal, unsuccessful escape, experience of fear and helplessness, immobility' (Levine, 2010) (Figure 1.2.). This sequence prevents the return to equilibrium and maintains the presence of PTSD symptoms (Levine, 2010). Furthermore, resilience to PTSD may be linked with more activity in, and a stronger connection between, the hippocampus, the amygdala, and the ACC, with observations of under-activity in these primary areas of the brain in people experiencing PTSD (Hughes, 2012).

Figure 1.2. The fear/immobility cycle (adapted from Levine (2010))



### **1.1.1.3. The traumatic response in women**

Several differences have been documented in the neurobiological trauma response in women compared to men (Sherin and Nemeroff, 2011). Over a lifetime, PTSD is more prevalent in women than men (U.S. Department of Veteran's Affairs, 2016), with twice as many women suffering from PTSD than men (Sherin and Nemeroff, 2011). Women are generally subject to different types of trauma than men and are more likely to experience trauma within the context of interpersonal relationships (van der Kolk et al., 2005). Complex traumas, such as sexual or physical abuse, involve interpersonal relationships and may include numerous traumatic interactions over a prolonged period (Karatzias et al., 2017). These types of events are more likely to result in a wider range of emotional difficulties compared to single non-interpersonal traumas, such as a car accident or natural disaster (van der Kolk et al., 2005). Women are at particular risk of developing PTSD during pregnancy (Mattocks et al., 2010, Sherin and Nemeroff, 2011). While little research exists into the prevalence of PTSD in men following childbirth, one study found that women were more likely than men to develop PTSD post childbirth (PTSD-PC) (Skari et al., 2002). but another found equal levels of PTSD-PC in men and women (Ayers et al., 2007). In most parts of the world, pregnancy and childbirth take place in the company of others, including the baby's father and sometimes family or friends. Furthermore, for most women, especially in the UK, pregnancy and childbirth also involve regular interaction with healthcare providers, as noted by Briddon et al. (2011). Consequently, during childbirth, when women are in a heightened state of sensitivity and vulnerability (Robinson, 2007), they need to engage in unique, and often intimate, interpersonal relationships with their care providers.

In summary, women are more susceptible to developing PTSD than men, particularly within the context of interpersonal relationships. Childbirth not only creates unique vulnerability for women but, for the majority of women, it occurs within the context of an interpersonal engagement with their midwife. The midwife-mother relationship has long been viewed as core to women's experiences and maternity outcomes (Kirkham, 2010), and therefore it should be considered that this interpersonal relationship has the potential to influence the perception of trauma, as discussed in section 1.1.4.2.



### **1.1.2. The development of a definition of PTSD**

This section presents an overview of how PTSD came to be defined, incorporating a description of the systems used to diagnose PTSD.

#### **1.1.2.1. A brief history of the recognition of the condition now known as PTSD**

While reference to human symptoms of trauma date back to biblical times (Crocq and Crocq, 2000), some of the earliest historical accounts come from 1666, during the great fire of London (Daly, 1983). Since 1687, over 80 names for the phenomenon of trauma symptoms have been used including *Irritable Heart* (Da Costa's term in the American civil war) (Crocq and Crocq, 2000) and *Shell Shock* from the first world war (Tick, 2005). Over the last 300 years, various hypotheses regarding trauma and its related symptoms emerged, with controversy around whether symptoms were physical or psychological, or connected to individual personality or previous experiences (Crocq and Crocq, 2000). Before being labelled, PTSD was recognised in soldiers for over 100 years (Foa and Rothbaum, 1992). The symptoms observed over several decades in World War Two veterans, and the prevalence of delayed and chronic PTSD in Vietnam War veterans (Crompton, 1996), ultimately led to a definition of PTSD in 1980 (Crocq and Crocq, 2000).

#### **1.1.2.2. The systems used to classify psychiatric illness**

Determining a reliable and valid system for diagnosing and classifying mental illness enables accurate identification of psychiatric disorders, which is of value in terms of health care provision and cost, legal implications of criminal cases, and increased confidence in the discipline of psychiatry (Dalal and Nolan, 2009). Currently there are two systems available for classification of psychiatric illness, the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), and Chapter V of the International Classification of Disease: Classification of Mental and Behavioural Disorders (ICD). The ICD has been a core function of the World Health Organisation (WHO) since 1948 (APA, 2009), while the DSM is produced by the American Psychiatric Association (APA), which is a professional body of psychiatrists. Of interest in this research project is the classification criteria for PTSD. It is worth taking a moment to clarify the ICD notation. The WHO manuals are named ICD-9 and ICD-10 and based on

these are the 'clinical modification' publications, the ICD-9-CM and ICD-10-CM. These provide the official system of assigning codes to diagnoses and procedures, used to produce statistics for the purpose of healthcare costs billing (CDCP, 2015). The ICD-10 was released in 1993, with the ICD-10-CM due to be implemented in October 2014, but was delayed until October 2015 (Regier et al., 2013). The newly released ICD-11 WHO (2018c) is due to come into effect in 2022.

PTSD was first classified in the DSM-III (APA, 1980), which revolutionised psychiatric nosology (APA, 2009). At this point the DSM-III and the ICD-8 were quite different. Nevertheless, the DSM's descriptive nosological system based on co-occurring clusters of symptoms became the dominant system (APA, 2009). Following the publication of the DSM-III, there was worldwide call for the ICD to adopt more explicit diagnostic criteria that adhere to the DSM-III model. After 10 years of consultation between the WHO and the APA, the ICD-9 was updated to the ICD-10 in 1993, and the DSM-IV was released in 1994 (Regier et al., 2013), and updated to the DSM-IV-TR in 2000. These systems now provide similar, but separate diagnostic criteria, and the apparently slight differences have produced variations in published prevalence rates of PTSD (Andrews et al., 1999, Regier et al., 2013). A comparison between the ICD-10 and the DSM-IV-TR is given in Appendix 1.1. The newly released ICD-11 proposes new criteria for PTSD that differ more substantially than before from the DSM criteria (Friedman, 2014), for reasons given by the National Center for PTSD (Box 1.1). The inclusion of Complex PTSD (CPTSD) as a related diagnosis to PTSD, can identify individuals with complex symptoms particularly subsequent to multiple or prolonged interpersonal trauma (Karatzias et al., 2017).

**Box 1.1. Reasons for differences between the new ICD-11 and the DSM-V criteria for PTSD (Friedman, 2014)**

- The ICD-11 has endorsed a narrow approach, focussing on PTSD as a stress-induced fear-based anxiety disorder.
- The ICD-11 has taken a much less conservative approach and did not seek the weight of scientific proof that the DSM-V required to change any of the DSM-IV criterion. Hence, the ICD-11 revision looks much more drastic than the DSM-V.
- The ICD-11 will include Complex PTSD as a separate diagnosis, whereas the DSM-V will not.

It is argued that the definitions presented within each version of the DSM do not attempt to suggest an underlying mechanism or theory for the brain and body physiology of trauma (Levine, 2010). Nor do they deal with the complexity of PTSD found in clinical settings, possibly due to differences between subtypes of PTSD (Chu, 2010). The potential for the ICD-11 criteria to distinguish CPTSD from PTSD (Karatzias et al., 2017) further suggests limitations in the DSM definition. Nevertheless, the DSM system continues to dominate both in terms of the provision of a standard language for clinicians, researchers, and public health officials, along with its use as a guide for making clinical diagnosis (Regier et al., 2013).

### **1.1.2.3. The DSM definition of PTSD**

The DSM-III first definition of PTSD was based on existing literature, which was sparse and had examined the experiences of men (van der Kolk et al., 2005), particularly in relation to war, natural disaster, and abuse (Blank, 1993). The DSM-III introduced the understanding that a disorder could result from an external stressor. PTSD was classed as an anxiety disorder for which the external stressor was a catastrophic traumatic event outside the range of usual human experience (APA, 1980, Friedman, 2015). Childbirth is a very usual human experience, so this definition excluded the possibility of officially diagnosing PTSD in association with childbirth. The revised version (DSM-III-R) more clearly grouped the symptoms into three dimensions: re-experiencing, avoidance and numbing, and physiological arousal, as well as specifying the onset and duration of the disorder (Brett et al., 1988, Foa and Rothbaum, 1992, Brewin, 2003).

The 1994 update, DSM-IV, made a clear distinction between acute trauma symptoms and PTSD, although symptoms may appear for the first time several months post the trauma (Blank, 1993), which was a distinction often lacking in earlier works and research (Crocq and Crocq, 2000). The role of interpersonal trauma, especially for women, was considered in the updated definition of PTSD in the DSM-IV (van der Kolk et al., 2005), which expanded the definition of a traumatic event (criterion A) to include subjective perception (Box 1.2.). This is of note, as PTSD is considered to be a fear-circuitry disorder characterized by difficulty coping with a fear response (Bryant et

al., 2011). Criterion A now consisted of 2 parts: A1 and A2, where A2 relates to the fear response (Boorman et al., 2014).

**Box 1.2. DSM-IV diagnostic Criterion A for PTSD (APA, 1994)**

The person has been exposed to a traumatic event in which both of the following were present:

**A1:** The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

**A2:** The person's response involved intense fear, helplessness or horror.

Full diagnostic criteria (B to F) are listed in Appendix 2. PTSD can only be diagnosed when symptoms last for over 1 month and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 1994).

A direct actual threat to life was no longer necessary, but the individual's subjective experience of horror or helplessness in response to a perceived external threat was necessary, with this experience affecting psychological and interpersonal functioning (Brewin, 2003, d'Ardenne and Heke, 2014, Karam et al., 2010). The experience of the event was now seen as the fundamental aspect, and not whether it was judged to be outside normal human existence. This change enabled childbirth to qualify as an external stressor, as it has potential for both conditions A1 and A2 to be present in an individual. While some authors claim childbirth may qualify as a traumatic event (Beck, 2004a), others highlight the need to use appropriate measures to appraise childbirth as traumatic and assess the traumatic stress response (Ayers, 2003). For a full description of the other DSM-IV criteria see Appendix 1.2.

In 2000 a text revision was published for the DSM-IV with no changes to the diagnostic criteria for PTSD (APA, 2000). 2008 saw the beginning of a five-year, in-depth revision process, involving the 15 members of the DSM-V Anxiety and Dissociative Disorders Work Group. They debated narrowing the criteria and directing clinicians to core elements, for the purpose of simplifying diagnosis, through proposing that this would enable a distinction to be made between PTSD and other anxiety disorders or depression. However, the wider range of criteria was deemed to be of more use clinically and subsequently shown to be reliable and manageable for clinicians

(Friedman, 2013). Debate existed around criterion A regarding its appropriateness as PTSD does not always follow trauma and symptoms can exist without trauma (Nielsen and Large, 2011), and whether it was necessary to include criterion A2 (Karam et al., 2010). Boorman et al. (2014) found that of the postnatal women who met criterion A1 (threat of death or injury) only half responded with fear. Whilst they acknowledge that their version of criterion A2 only referred to fear, and not horror or helplessness, they take account of other research and propose that small nuances in the wording of criterion A may influence classification of a childbirth event as traumatic. Further detail regarding the background to revisions for DSM-V is given in Box 1.3a. and the notable revisions are outlined in Box 1.3b. The full DSM-V diagnostic criteria are listed in Appendix 1.3. (also highlighting the changes from the DSM-IV).

Within DSM-V (APA, 2013), childbirth can still fit the criteria for trauma if women directly experience, or partners/midwives witness, actual or threatened death or injury. However, of particular note is the exclusion of the death of a family member by natural causes, as this may exclude stillbirth or neonatal death depending on what is classed as natural causes (Ayers, 2013). Also, Ayers (2013) suggest the removal of criterion A2 could increase the prevalence of PTSD-PC, while the requirement for four categories of symptoms may reduce prevalence of PTSD-PC.

**Box 1.3a. Background to revisions in the DSM-V** (Friedman, 2013, APA, 2013)

- The very large Anxiety Disorders chapter of the DSM-IV (APA, 1994) was divided up, resulting in new chapters, one of which is trauma and stressor related disorders. In this category every disorder has been preceded by exposure to a traumatic or otherwise adverse environmental event. PTSD is now classed within this chapter.
- There was debate about retaining criterion A, or whether diagnosis should just focus on the symptoms. It was decided that exposure to a traumatic event was crucial, as for the individual the traumatic event is a watershed in their lives, creating discontinuity between before and after, with things never the same again.
- The single sentence of the DSM-IV criterion A1 was further detailed into 4 sentences within the DSM-V criterion A.
- There was debate about the required nature of exposure, either direct or indirect. It was decided to retain both these features, given evidence that PTSD occurs in a significant proportion of individuals who were never in danger themselves.
- It was decided to remove the DSM-IV criterion A2, as many people exposed to a traumatic event deny experiencing these emotional reactions. It was recognised that this criterion had neither predicted people at risk or reduced the number who met the DSM-IV criterion A1 and developed PTSD. Furthermore, there were people experiencing PTSD who were not diagnosed under the DSM-IV because they did not meet the DSM-IV criterion A2. These people would now be diagnosed by the DSM-V.
- inclusion of anhedonic/dysphoric presentations, marked by negative cognitions and mood states (e.g., fear, horror, anger, guilt, or shame), as well as disruptive (e.g., angry, impulsive, reckless, and self-destructive) behavioural symptoms, recognises the complexity of post trauma symptoms, particularly from interpersonal trauma (Beck et al., 2015).

**Box 1.3b. Notable revisions in the DSM-V (Ayers, 2013, APA, 2018)**

- PTSD was re-categorised from an *anxiety disorder* to a *trauma and stressor-related disorder*.
- The person has to directly experience or witness “actual or threatened death, serious injury or sexual violation”.
- Criterion A2 that related to the individual’s response to the event with intense fear, helplessness or horror, was removed since it proved not to predict the onset of PTSD.
- The unexpected death of a family member by natural causes is excluded from qualifying as a traumatic event.
- A subtype of PTSD with dissociative symptoms has been added.
- The symptom clusters of PTSD have been restructured into four groups rather than three:
  1. Intrusions
  2. Avoidance
  3. Arousal (now include more aggressive or self-destructive behaviours)
  4. Negative cognitions and mood (including some symptoms of numbing that were previously in the avoidance cluster. Also new symptoms such as persistent blame of self or others).

**1.1.3. Attempts to model the risk factors and causes of PTSD**

While defining and describing PTSD is important, it is imperative to understand the risk factors and causes of PTSD. To this end, there have been many attempts to create conceptual models of PTSD. This section overviews three models widely cited in the literature and discusses the aspects of PTSD that carry most potential relevance when exploring PTSD in association with childbirth.

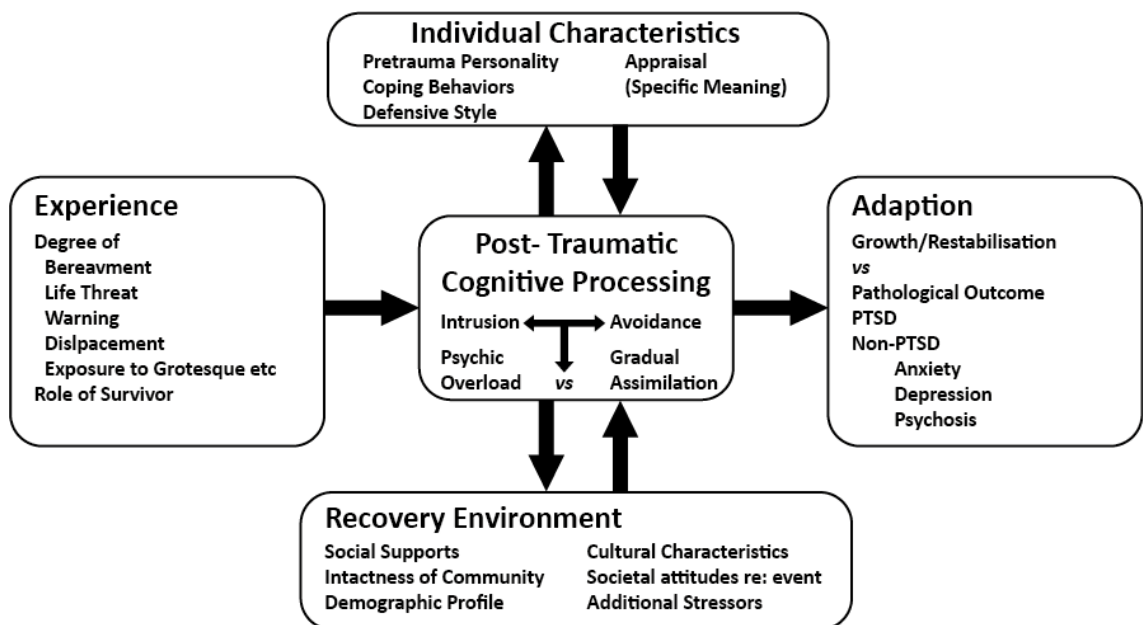
The three models discussed are those by Bonnie Green, John Wilson, and Jacob Lindy in 1985 (Green et al., 1985), Anke Ehlers and David Clark in 2000 (Ehlers and Clark, 2000), and Anthony Charuvastra and Marylene Cloitre in 2008 (Charuvastra and Cloitre, 2008).

**1.1.3.1. The model by Green et al. (1985)**

One of the first psychosocial models of PTSD was proposed in 1985, following the recognition that stress disorders constituted a pervasive mental health problem (Green et al., 1985). Their model details the factors connected with onset, manifestation, and course of the disorder, noting that an initial response to trauma is natural within the first month, and not considered pathological unless it causes

significant disruption to normal functioning or lasts beyond 1 month. [Green et al. \(1985\)](#) proposed that an explanation for this continuance of symptoms is the completion tendency ([Horowitz et al., 1979](#)), where the elements of the event remain distressingly active in the mind, until the event can be assimilated into existing life. A central feature is the uncontrollable, distressing, cognitive re-experiencing of elements of the trauma, co-existing, or alternating with, a sense of numbness and loss of emotional responsiveness. Secondary symptoms are increased arousal, alongside avoidance of anything connected with the trauma (Figure 1.3.).

Figure 1.3. Green's PTSD psychosocial model (adapted from [Green et al. \(1985\)](#))



The model by [Green et al. \(1985\)](#) relates aspects of the individual's experience to the later development of PTSD (Box 1.4.). While many of the aspects were still being researched at that time (1985), [Green et al. \(1985\)](#) argued that there exists a complex interaction between the individuals' characteristics and their social/cultural environment.



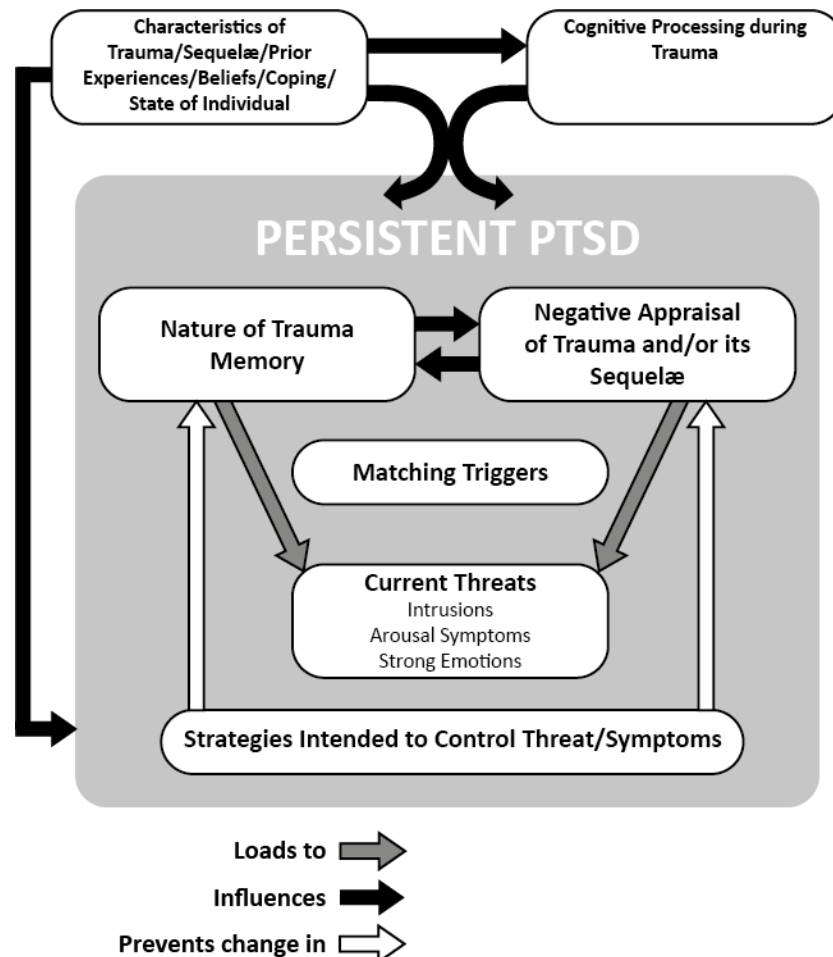
**Box 1.4. Aspects of individual experience that relate to development of PTSD (Green et al., 1985)**

- The nature of the event; the person's role within the event; the level of suddenness of, or preparedness for, the event; whether the person is passive or an active participant in the event.
- Individual characteristics may interact, such as the person's prior experience or pre-existing psychopathology.
- Recovery environment. The social environment within which the individual existed, including: cultural characteristics of the society; the support network of friends and family; and demographic factors.

**1.1.3.2. The model by Ehlers and Clark (2000)**

In 2000, an important cognitive model of PTSD was developed by Ehlers and Clark (2000), which remains widely cited (Figure 1.4.).

**Figure 1.4. Ehlers and Clark's Cognitive model (adapted from James (2015))**



At the time of their publication [Ehlers and Clark \(2000\)](#) highlighted an important puzzle. They noted that PTSD was classed as an anxiety disorder, yet contemporary cognitive models related anxiety to current impending threat, whereas PTSD relates to past events.

[Ehlers and Clark \(2000\)](#) resolved this issue by considering PTSD to arise when individuals continue to have a sense of serious current threat. However, since 2013, within the DSM-V, PTSD is now classed as a trauma related disorder and so this puzzle has been resolved. Nevertheless, their model proposed two key processes leading to sense of current threat (Box 1.5.) and a range of factors that influence these processes (Box 1.6.).

**Box 1.5. Key processes leading to current sense of threat** ([Ehlers and Clark, 2000](#))

- **Individual appraisals of the trauma.** They propose that those experiencing PTSD were unable to see the event as time-limited, without negative implications for their future, and have idiosyncratic negative appraisal of the event.
- **Individual nature of memory and link to previous experience.** The nature of the relationship between trauma memory and future unwanted recollections is another puzzle of PTSD. Some individuals report difficulty intentionally retrieving a complete memory of the event, whilst simultaneously having involuntary intrusive memories. The re-experiencing is triggered by a wide range of stimuli and is mainly sensory impressions, usually visual, rather than thoughts. They feel as if they are happening in the present. The model proposes that in PTSD the memory of the trauma is not well integrated into the appropriate context, of time and place, in relation to other life memories.

**Box 1.6. Factors that influence the processes leading to current sense of threat** ([Ehlers and Clark, 2000](#))

- **The relationship between both processes.** Recalling the event, can be selective, biased by the individual's appraisal of the event and can impact on the continued appraisal of the event and current life situation. For example, remembering that no one cared and re-experiencing a feeling of loneliness, may lead to believing still that one is lonely or uncared for.
- **Maladaptive behavioural strategies** such as suppressing thoughts, or keeping the mind occupied with non-traumatic thoughts, and safety behaviours.
- **The type of cognitive processing during the trauma**, such as mental defeat (influences trauma appraisal), confusion and overwhelm (may limit the processing of the memory, leading to unorganized memory), dissociation during the trauma (fragmentation of memories).
- **Background factors** including, but not limited to, characteristics of the trauma (duration, predictability, or level of control), previous experiences (previous abuse), beliefs (prior understanding of the nature of the world), and current state (alcohol consumption, exertion, or arousal).

Further aspects of PTSD explained by the [Ehlers and Clark \(2000\)](#) model include, delayed onset (months or years after the traumatic event), anniversary reactions, being frozen in time (locked into the past), and sense of impending doom (worse to come). Several years later [Charuvastra and Cloitre \(2008\)](#) amended and added to this theory.

#### **1.1.3.3. The model by Charuvastra and Cloitre (2008)**

[Charuvastra and Cloitre \(2008\)](#) developed a conceptual framework, the *social ecology of PTSD*, for understanding the role of social phenomena within the risk of developing PTSD and the subsequent path to recovery. They presented a theoretical model for interpersonal trauma that acknowledges concerns when researching interpersonal trauma regarding self-reporting and the quality or bias of memory. Yet they state, that both retrospective and prospective studies have consistent findings, suggesting that vulnerability is determined by social cognition, attachment organisation, and social support before and after the trauma. They propose that the most relevant aspect of social support is the subjective experience and not the quantitative measure of a social network.

The model by [Charuvastra and Cloitre \(2008\)](#), recognises that social information is processed subconsciously, often based on non-verbal communication, such as body language, touch, and social assumptions, with these factors modulating the fear system. Furthermore, neurochemistry has a role to play, with the hormone oxytocin potentially reducing fear, but only in connection with social interaction. To feel safe, one needs an absence of fear, and awareness of support and social connection, suggesting an interaction between the limbic and neocortex regions of the brain, as is involved within the feeling of trust ([Adolphs, 2002](#)).

Furthermore, they asserted that the nature of the trauma may in itself elicit a positive support response (visible and clearly distressing trauma) or negative response (less visible trauma, often associated with shame). Having no support, or experiencing negative social interactions, such as negative reactions or attitudes, consistently worsens or maintains PTSD and may heighten and maintain fear responses. The impact

of positive interaction varies, depending on the support provider and whether this meets the person's needs. Importantly, women most often report negative social interactions.

The risk of developing PTSD is higher in individuals exposed to traumatic events generated by other people, reflected by the statement in the DSM-IV-R that PTSD may be more severe when the stressor is of human design (APA, 2000). Interpersonal trauma changes how safe the person feels in the world and their sense of connection in their community, often leaving the person feeling let down by those they expected to stand by them and feeling others are now ashamed of them (Charuvastra and Cloitre, 2008).

#### **1.1.4. Aspects from these models of most relevance to PTSD associated with childbirth**

The context within which the traumatic event occurs, and the importance of social and interpersonal aspects of the traumatic event, is highlighted in all of the models discussed in section 1.1.3. Consider that military personnel expect to enter life threatening situations, they receive preparatory training and yet 8-15% still develop PTSD (Gradus, 2016). Pregnant women may be aware of embarking on a challenging event that requires some preparation, and some trepidation is likely, but on the whole, they anticipate a joyful outcome. In the UK, most childbearing women expect to be taken care of and kept safe. If they encounter an event more shocking, life threatening, or unsupported than anticipated, it is unsurprising that this may lead to trauma, with PTSD a potential further consequence.

Fear is the predominant emotion, important in the formation and maintenance of PTSD alongside helplessness and horror (APA, 1994). The role of non-fear based emotional states and negative dysfunctional thoughts or cognitions in the aetiology and maintenance of PTSD is highlighted (Beck et al., 2015, Ehlers and Clark, 2000). Shame is now included in the DSM-V as a potential negative cognition (APA, 2013). Following interpersonal trauma, pervasive thoughts about self-blame and incompetence, as well as the world being dangerous, may mediate PTSD (Foa et al.,

1993, Foa and Rothbaum, 1998, Beck et al., 2015). Anger, shame, guilt, and sadness are frequently associated with an interpersonal traumatic event (Lewis, 1971, Lee et al., 2001, Holmes et al., 2005), and can be particularly disabling, impeding the emotional processing of the event (Brewin et al., 1996). These emotions can maintain a persistent sense of threat, perpetuating the symptoms of PTSD (Beck et al., 2015) and contributing to treatment failure (Holmes et al., 2005).

Each model suggests that memory plays an important role, whereby elements of the event remain distressingly in the mind (Green et al., 1985). Some memories cannot be recalled, while others surface involuntarily (Ehlers and Clark, 2000), and traumatic memories are not well integrated into the appropriate context (Charuvastra and Cloitre, 2008). Within PTSD, memory phenomena may be inconsistent and unusual (Brewin, 2003). Research in the area suggests that traumatic memories are not fixed or indelible, and that with increasing PTSD symptoms the memory of traumatic events is amplified (Southwick et al., 1997), whilst others suggest that traumatic memories, in contrast to ordinary memories, are fixed and static (Levine, 2010). Of particular importance, may be memory organisation, considered by some to be generally disorganised in PTSD (Ehlers et al., 2004), while others disagree (Jelinek et al., 2010). Furthermore, evidence has not supported the theory that people experiencing PTSD have more incoherent memories of their traumas than those without PTSD (Rubin, 2011). Some evidence suggests that the worst moments of the traumatic event, referred to as *hotspots*, show different characteristics from other trauma memories (Jelinek et al., 2010). Some argue that intrusions are sensations that occur just before the hotspot, much like a warning (Ehlers et al., 2002) or reflecting inadequately processed trauma memories (Brewin et al., 1996, Brewin, 2001), whilst others found that 78% of intrusions match a hotspot (Holmes et al., 2005), consistent with the claim by Ehlers and Clark (2000) that hotspots are the moments that are re-experienced as intrusions. Furthermore, in response to a need to establish if PTSD-PC is akin to general PTSD (Ayers et al., 2008), it has been shown that symptoms of PTSD-PC are comparable to symptoms of general PTSD (James, 2015). Let us now look more closely at context, interpersonal aspects, negative cognitions, and memory in connection with childbirth.

#### **1.1.4.1. The context of childbirth**

A woman's individual characteristics, including genetic predisposition, early life experience, education, coping mechanisms, family circumstances, experience of social support, as well as personality and mental health, will inform her expectations, hopes, and fears for childbirth (Gilbert, 2015). In my experience as a midwife, what women consider to be their ideal birth can vary widely. Some women desire to completely hand over to care providers and follow their guidance. Many women create birth plans of varying complexity and detail, and desire care providers to adhere to these and follow their wishes. Some, although few, will choose to freebirth, not engaging the services of care providers at all. In addition, the objective aspects of childbirth range from physiological with no medical intervention to containing a complex range of medical interventions. Furthermore, childbirth takes place in a variety of settings, with access to varying level of resources, including consultant led hospitals, birth centres, and women's homes, to unexpected births in taxis or ambulances. Even within seemingly structured settings such as hospitals, there can be a range of cultures and practices to which the woman is exposed. Furthermore, women may be receiving care from a situation of need and midwives may be providing care from a perspective of duty. This leads to the consideration that interpersonal relationships are the most common context within which women experience trauma and that the midwife-mother relationship may create a potential context for trauma.

#### **1.1.4.2. The interpersonal aspect of childbirth**

Negative interpersonal experience in childbirth may shatter the three key world assumptions described by Janoff-Bulman (1992) that the world is benevolent and meaningful, and the self is worthy. Women place themselves in the hands of others at this vulnerable time, while holding these assumptions, and so like sexual abuse, this may mean that those being trusted potentially cause trauma. During positive human social interaction, such as hand holding or supportive touch, endorphins and the hormone oxytocin are released, with each having important roles in boosting trust and reducing anxiety (Hughes, 2012), and are central to the physiology of childbirth (Buckley, 2009). The hormonal state during childbirth and the early postnatal period creates hyperawareness, which means that regardless of previous history or mental

stability women can feel vulnerable to whatever level of kindness or gentleness is expressed within social interaction (Robinson, 2007). It is suggested that the growing use of technology, even during normal physiological childbirth, such as ultrasound, cardiotocograph (CTG), epidural analgesia, and forceps, may alter the interpersonal interactions with healthcare providers (Driscoll, 2013), and particular concern exists with regard to the language currently used during childbirth communication (Mobbs et al., 2018). In keeping with this, Hughes (2012) highlight that chronic neglect and abuse increases the risk of developing PTSD, while receiving kindness and compassion directly after trauma may reduce this risk. The need for compassion has been strongly highlighted by several health professionals (Byrom and Downe, 2015). Compassion is defined as *a sensitivity to the suffering of self and others, with a deep commitment to try to relieve and prevent it* (Gilbert, 2015). Within the interpersonal relationship between women and midwives, each person is unique in their ability to give or accept compassion, depending on their level of comfort with the other and how each have been shaped by their life context and experience (Gilbert, 2015). How others view the childbirth event may influence their level of compassion and potentially their interaction with and support of childbearing women. In childbirth, consistent with the model by Charuvastra and Cloitre (2008), outcomes can appear objectively traumatic, such as stillbirth or severe physical trauma from obstetric interventions or contain less visible subjective trauma within objectively normal births with healthy outcomes.

#### **1.1.4.3. Fear and Negative cognitions related to childbirth**

Fear is potentially the strongest emotion attached to a woman's most distressing memories of a traumatic childbirth experience (Harris and Ayers, 2012). Although not all women who perceive threat during childbirth experience fear (Alcorn et al., 2010, Boorman et al., 2014), more than 1 in 10 women experience childbirth as an ordeal of threat and fear, and so fear is considered an important diagnostic criterion for assessing traumatic childbirth (Boorman et al., 2014). Within childbirth, self-blame can be exacerbated by the many social and cultural expectations around giving birth, and so in the case of less visible trauma, it may be difficult for a woman to express her feelings and she may feel shame in not meeting the expectations, which is consistent with the nature of *hotspots* reported by (Holmes et al., 2005). In addition, Briddon et

al. (2011) highlight that childbirth is emotionally complex and that women describe childbirth both as positive and negative, with little acceptance of a negative response to the positively constructed, societal, and cultural expectations.

#### **1.1.4.4. Memory and childbirth**

The quality or accuracy of childbirth memories impact on the value of any retrospective research into PTSD-PC. Anecdotally, many women describe *never forgetting* the births of their children. Research examining the accuracy or consistency of memory within the context of childbirth, shows that women's memories remain generally accurate and strikingly vivid up to 20 years after the childbirth event (Bennett, 1985, Simkin, 1992, Waldenström, 2003, Takehara et al., 2014). Simkin (1992) highlights that birthing women are predisposed to clear memory due to being vulnerable, physically exposed, often among strangers in strange environment, and unable to maintain their desired image through their appearance or way of being, with their bodies functioning outside their control. The significance some women attach to negative events may intensify over time (Simkin, 1992, Waldenström, 2003). A recent study in Japan found women to have more precise recollections of positive events at 5 years and suggests that women's memories tend to become more positive over time (Takehara et al., 2014). This finding is in keeping with the findings of Stadlmayr et al. (2006), but contrasts those of a larger Swedish study that suggests women's childbirth memories become more negative over the first year (Waldenström, 2003). Rijnders et al. (2008) also suggests that the negative or positive recall of the childbirth experience is related to perinatal factors. Women experiencing PTSD-PC were more coherent and could recall memories more clearly than those without PTSD-PC (Ayers et al., 2015b), consistent with the findings of Rubin (2011). Differences in recall have been described as more a matter of degree than substance (Simkin, 1992). However, Briddon et al. (2011) found that women experiencing PTSD-PC are more likely to have memory disorganisation at six weeks post childbirth, in contrast to women without PTSD-PC, with no difference between women's memory organisation at 72 hours post childbirth. Briddon et al. (2011) suggest this may be because women with more negative experiences are less willing to rehearse their memories, thereby reducing the organisation of them.



#### **1.1.4.5. Pain as part of childbirth**

Pain is often core to traumatic experiences, with endogenous opiates playing an important role in the processing of pain through reducing the intensity and panic type responses (Kapfhammer, 2014). Yet, uncontrollable pain during and following trauma must be considered an independent condition that increases the risk of developing PTSD (Kapfhammer, 2014). Pain is a predominant feature of childbirth. Yet, women's subjective experiences of pain vary widely, possibly because pain can be defined as an unpleasant experience that results from actual or potential tissue damage, whilst suffering is related to the person's negative emotional reactions, and it is important to note that one does not imply the other (Simkin and Hull, 2011). The healthcare provider's subjective approach to pain may include discomfort at witnessing it or belief that pain equals suffering, which creates an overriding focus on the desire to provide pain relief (Simkin and Hull, 2011).

#### **1.1.4.6. So, what makes childbirth traumatic?**

When considering PTSD-PC, it is necessary to begin with the potential for childbirth to be a traumatic event. As discussed in section 1.1., the perception of trauma is unique to the individual, and is driven by a complex interaction of biological, genetic, and social factors. In keeping with the DSM-IV definition of a traumatic event, Cheryl Tatano Beck defines childbirth 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, during which the birthing woman experiences intense fear, helplessness, loss of control, and horror (Beck, 2004a). It has been discussed above that the childbirth context, interpersonal aspects, negative cognitions, memory, and pain may all contribute to the perception of trauma and the development of PTSD-PC.

#### **1.1.5. Summary of Part 1**

Part 1 provided an overview of PTSD, in terms of the human trauma response, the development of the current definition, and important physiological considerations. Through discussion of relevant aspects of childbirth, it has shown that childbirth has the potential to be a traumatic event that can initiate development of PTSD.

## **Part 2 Initial scoping of current literature regarding PTSD post Childbirth (PTSD-PC)**

Part 1 showed that childbirth has the potential to be a traumatic event that can initiate development of PTSD. This section presents an initial scoping exercise, incorporating background reading of childbirth trauma literature, and a preliminary database search, to gain an overview of what is known about the prevalence of PTSD-PC and the factors that contribute to its development.

### **1.2.1. The purpose of the initial scoping exercise**

The research topic assigned to this thesis was *PTSD associated with childbirth*. While Part 1 shows that childbirth is a potentially traumatic event that can lead to the development of PTSD. The next step was to overview existing research and findings regarding the prevalence of and contributing factors towards developing PTSD-PC and from these findings identify the aims and questions for the main literature review. To enable a broad understanding of existing research into PTSD-PC, the scoping exercise extended back to 1980, which was the time of the initial DSM definition of PTSD, although at that time (as described in Part 1), childbirth was not yet considered a potential trigger event. This scoping exercise also informed the selection of search terms for the main literature search.

Considering the dominance of the DSM system and the potential difference between the DSM and the ICD systems in identifying prevalence of PTSD, only studies that measured PTSD as per the DSM definition were included (Box 1.7.). Indeed, all identified articles used the DSM classification, and none the ICD.

#### **Box 1.7. The aims of the initial scoping exercise**

- Identify the range of relevant research literature relating to PTSD-PC, performed since 1980, and which used the DSM criteria to assess of PTSD.
- Identify research literature relating to the prevalence of PTSD-PC.
- Identify research literature examining risk factors and causes of PTSD-PC.
- Briefly summarise findings from this initial exploration of the literature.
- From this scoping exercise, identify the primary aims and questions for the main literature review.

## **1.2.2. The process of the initial scoping exercise**

### **1.2.2.1. The scoping search**

The scoping search was performed in October and November 2015 and consisted of two strands. The first was a general immersion in the literature around childbirth trauma and PTSD. During this process, the textbook *Traumatic Childbirth* (Beck et al., 2013) and a two-day online seminar in November 2015 run by the collective known as *Prevention and Treatment of Traumatic Childbirth* (PaTTCh), entitled *Healing Birth Trauma* (PaTTCh, 2015), provided an initial glimpse into the world of traumatic childbirth and PTSD. These springboards highlighted the primary authors in the field, particularly Cheryl Tatano Beck, Susan Ayers, Jeanne Watson Driscoll, Sue Watson, Penny Simkin, Jean Robinson, and Ulla Waldenström, and enabled a grasp of the wider context of relevant research. Also, a scoping search of existing literature was performed via Google Scholar and the literature databases CINAHL and PsycINFO. The keywords PTSD, childbirth, midwifery, labour, and counselling were used alongside a range of associated terms.

### **1.2.2.2. Narrowing down the focus of the scoping search**

An initial look at some of the identified studies showed that many were focussed on other mental health conditions, such as depression or anxiety. Also, the keyword *labour* had identified many studies associated with *workforce* or *manual work* rather than childbirth. The scoping search was re-run excluding the keyword *labour* and the terms *depression* and *anxiety*, limiting to only studies relating to childbearing and psychosocial factors. Together this process yielded 4,640 articles.

Since the aim of the scoping exercise was to identify research into prevalence and risk factors of PTSD-PC, studies that explored assessment or diagnosis techniques were out with the aims of this exercise, as were studies exploring the effects or experience of living with PTSD, or pregnancy PTSD. As discussed in Part 1, the main criteria for an event to have the potential to trigger PTSD, is *actual or threatened, death or serious injury*, and indeed evidence confirms that PTSD-PC is associated with serious maternal morbidity or events such stillbirth or pre-term birth (Ford, 2013). As a midwife, I was aware that trauma can arise following childbirth experiences from which both the

mother and baby emerge well, and so studies exploring PTSD following stillbirth, pre-term birth or severe maternal morbidity were excluded to enable specific focus on other potential causes of PTSD-PC. Unexpected objective outcomes such as emergency caesarean, instrumental delivery, post-partum haemorrhage, or difficulties during childbirth, such as shoulder dystocia or the baby requiring initial resuscitation, are included. The rationale being that unforeseen negative events during childbirth that do not result in the baby's admission to the neonatal intensive care unit, or continued serious morbidity for the mother, are not uncommon in childbirth and form a major feature of the context of childbirth and women's experiences.

### **1.2.2.3. Selection of literature to inform the scoping exercise**

Alongside the textbook by [Beck et al. \(2013\)](#), and references from the PaTTCh seminar, 48 studies were selected to inform this scoping exercise (Appendix 1.4). Further to this, wider reading was conducted in relation to birth trauma and PTSD-PC.

### **1.2.3. The findings of the initial scoping exercise**

#### **1.2.3.1. The growth in awareness of PTSD associated with childbirth**

Notably, the awareness of the existence of a traumatic response to childbirth was present in the 1970's, prior to the DSM definition of PTSD. This awareness initially emerged within professional childbirth organisations, and subsequently within the academic research community.

In 1972, Jean Robinson was chair of the *Patient's Association*, which was a forerunner of the current organisation *Association for Improvement in Maternity Services (AIMS)*. Jean received hundreds of letters about induced labour and quickly realised that what women were describing was akin to *shell shock* ([Robinson, 2007](#)). In the late 1970's, French obstetricians first documented symptoms in women that were *like PTSD* ([Arizmendi and Affonso, 1987](#)). The official definition of PTSD prompted questions to be raised about the correct diagnosis of the mental wellbeing of postnatal women. In the early 1980's, Jeanne Watson Driscoll, who was a clinical nurse specialist in adult psychiatric-mental health, first *formally* diagnosed a woman experiencing PTSD secondary to childbirth experience. Driscoll observed that the presenting symptoms

could only fit into that diagnostic criteria (Driscoll, 2013). There was also a growing body of research documenting PTSD symptoms after events that were not viewed as out with the range of usual human experience (Bailham and Joseph, 2003).

In 1985, Beverly Beech and Jean Robinson, who were both members of AIMS, attempted to draw attention to the number of women describing *nightmares* following traumatic childbirth, and their concern that these women were undiagnosed and untreated (Beech and Robinson, 1985). Shortly after this, research exploring the stressful nature of childbirth and the magnitude of stress and the potential impact on the mental wellbeing of the mother, suggested that the stressors associated with childbirth were multiple, complex, and variable in their impact (Arizmendi and Affonso, 1987). In the early 1990's, Penny Simkin noted that childbirth was unique as a life event, in that over the course of a day it may involve pain, emotional stress, vulnerability, possible injury or death, and results in a permanent role change and full responsibility for a dependent human being (Simkin, 1992). Meanwhile a seminal and large quantitative study explored the traumatic aspects of obstetric and gynaecological events (Menage, 1993) and the first reports about *postpartum onset of panic disorder* appeared (Beck et al., 2013).

The DSM-IV revised definition of PTSD (APA, 1994), opened the way for childbirth to meet Criteria A, and enabled official recognition and diagnosis of PTSD-PC. In response to this altered definition, more and more research began to appear that linked childbirth with PTSD. One of the first studies was a qualitative case study report that presented four women's experiences of traumatic childbirth (Ballard et al., 1995). In 1996, AIMS and the British Journal of Midwifery (BJM) both produced special supplements derived from presentations in London at the *Breaking the chains: Positive Care in Childbirth* event, which was devoted to childbirth trauma and PTSD. The included articles highlighted the connection between traumatic childbirth events (subjective and objective) and subsequent development of PTSD (Warshal, 1996, Crompton et al., 1996). Other articles at this time highlighted that PTSD was an under recognised complication of difficult childbirth (Goldbeck-Wood, 1996). In 1999, Susan Ayers completed her PhD thesis on Post Traumatic Stress Disorder (PTSD) following

childbirth (Ayers, 1999) and began many years of research into this field. In 2000, Jo Czarnocka and Pauline Slade concluded that PTSD was now a recognisable condition relating to childbirth, occurring even after normal births (Czarnocka and Slade, 2000).

Since 2001, there has been a growing body of literature examining PTSD-PC. It is now acknowledged that childbirth is potentially traumatic with around 45% of women meeting criterion A (Alcorn et al., 2010). Out of this 45% of women, some will go on to develop PTSD as a direct result of perceived negative experience during the antenatal, intranatal, or postnatal periods of childbirth (McKenzie-McHarg et al., 2015, Simpson and Catling, 2015).

### ***1.2.3.2. The summary of findings from the 48 articles and reviews***

The purpose of this initial scoping exercise was to gain an overview of existing research regarding PTSD-PC, and a first sense of the prevalence of and risk factors related to the development of PTSD-PC. The summary of the findings from the 48 studies, presented next, informed the aims and questions for the main literature review.

#### **1.2.3.2.1. The prevalence of PTSD-PC**

While studies confirm the existence of PTSD-PC, the findings regarding the prevalence rate of diagnostic PTSD vary between many quantitative studies, with a range of 1.5-32.1%, which may relate to variations in the timing of assessment, the assessment tool used, or the characteristics of the women in the samples (Paul, 2008, Olde et al., 2006). The timing of assessment is important given that rates can be higher in the first 1-3 months (Denis et al., 2011, Fairbrother and Woody, 2007, Grekin and O'Hara, 2014, Olde et al., 2006) and reduce further beyond 6 months, although not always (Grekin and O'Hara, 2014). In contrast to most other studies, Zaers et al. (2008) highlighted an increase in rates over time with 6% at 6 weeks and 14.9% at 6 months.

The most oft quoted range of prevalence of PTSD-PC is 1.5% to 5.6% (Beck, 2004a, Czarnocka and Slade, 2000, Ayers et al., 2015a, Grekin and O'Hara, 2014) with other studies finding lower or higher rates. The highest rates were observed in women with

high risk pregnancy, such as 15% in those following stillbirth or pre-term birth (Ayers et al., 2015a).

Notably, a rate of 20% was identified across a mixed risk level sample of Iranian women (Modarres et al., 2012). The prevalence of partial PTSD symptoms was generally much higher, and presented with observed rates of 24% (Czarnocka and Slade, 2000), 28% (Zaers et al., 2008), and 30% (Soet et al., 2003). A wide range of assessment tools are used to diagnosis PTSD, with this highlighted as an important consideration when interpreting the range of prevalence rates (Boorman et al., 2014). It is noted that small variations in the wording of Criterion A may influence the classification of the childbirth experience as traumatic or not (Alcorn et al., 2010, Boorman et al., 2014, Wosu et al., 2015)..

Overall, the meta-analysis by Grekin and O'Hara (2014) identified the prevalence of full PTSD-PC in community populations and high-risk populations to be 3.17% and 15.7% respectively. Note that since this scoping exercise was performed, the meta-analysis by Yildiz et al. (2017) confirmed the prevalence of PTSD-PC to be 4% in community populations and 18.5% in high-risk populations.

#### 1.2.3.2.2. The risk factors and causes of PTSD-PC

Across the 48 studies, some factors emerged that were consistently related to the development of PTSD-PC. In contrast, the association with other factors was less clear. Some factors were widely researched, while others featured much less so.

Factors consistently associated with the development of PTSD-PC include pre-existing conditions, such as anxiety or high trait anxiety (14 studies); depression (10 studies); previous traumatic experiences, being a victim of childhood sexual abuse (CSA) or violence (19 studies); social support (7 studies); expectations of the childbirth experience (including a lack of knowledge or preparation) (9 studies); loss of control (9 studies); subjective perception of childbirth experience (15 studies); fear (7 studies); and perceived negative staff attitude (communication, information, support, consent) (9 studies). It was anticipated that obstetric interventions would trigger PTSD-PC,

especially emergency caesarean section (EMCS) and instrumental births, and this was confirmed in 21 studies, but not all, with one study finding PTSD occurred more often with normal childbirth (Czarnocka and Slade, 2000); while two others found no increase in PTSD-PC after obstetric procedures (Fairbrother and Woody, 2007, Stramrood et al., 2011). Similarly, pain was expected to be an initiating factor for developing PTSD, seven studies found it was, but two did not (Ballard et al., 1995, Soet et al., 2003). A factor that appears to mitigate the influence of pain and interventions is the level of perceived support, both during and following childbirth (Garthus-Niegel et al., 2013). The quality of previous childbirth experiences was shown to be potentially relevant in eight studies, especially if it is a first birth (Denis et al., 2011), but not always (Fairbrother and Woody, 2007, Gamble and Creedy, 2005). Some studies explored at least one of a range of demographic factors (e.g., age, BMI, ethnicity, socioeconomic status), but findings did not consistently show association with PTSD-PC (11 studies) and two studies looked at PTSD-PC amongst teenagers but did not account for other life factors such as current physical health (e.g., BMI) or previous trauma (Anderson and McGuinness, 2008, Anderson, 2010). Finally, some factors were less explored in the research: pre-existing PTSD (3 studies); having a wanted pregnancy (1 study); pregnancy spacing (2 studies); and place of birth (1 study). Furthermore, some factors may confound the effect of others. For example, it could be argued that pre-existing anxiety or depression may pre-dispose to a more negative perception of the childbirth experience and level of social support provided. Similarly, a previous traumatic experience may predispose to fear.

From this summary of findings, it appears that the risk factors for the development of PTSD-PC fall into five main categories (Box 1.8.).

**Box 1.8. Five possible categories for factors contributing to PTSD-PC**

- Individual characteristics, such as personal vulnerability from previous life experience.
- Pre-existing conditions, such as anxiety, depression, and fear.
- Current life situation in terms of socioeconomic and social support.
- Perceived experience of childbirth, including expectations, support, pain, and control.
- Objective childbirth outcomes, including interventions and complications.



#### **1.2.4. Summary of Part 2**

Part 2 presented the initial scoping exercise to gain an overview of what is known about the prevalence of PTSD-PC and the factors that contribute to its development. This exercise found that some factors have been looked at by a variety of studies in varying combinations. Many studies miss out several potential factors, reflecting how difficult it is to cover all possibilities and eliminate all confounding factors. The range of factors contributing to the development of PTSD-PC is wide and interactions between factors are inherently complex.

#### **Part 3: Rationale for undertaking a review of the existing PTSD-PC literature**

Parts 1 and 2 presented an overview of PTSD as a condition together with the growth in awareness and subsequent recognition that PTSD can be associated with the experience of childbirth (PTSD-PC). Also presented was the current evidence regarding the prevalence of PTSD-PC and an initial exploration of the possible contributing factors. Part 3 now presents an overview of why it is important to focus closely on PTSD-PC and undertake a full review of the existing literature that has examined PTSD-PC.

#### **1.3.1. Why is PTSD-PC important to examine?**

##### ***1.3.1.1. Prioritising maternal mental health***

Maternal mental health impacts on the wellbeing and lives of mothers and babies ([Galloway and Hogg, 2015](#), [Knight et al., 2016](#)). The World Health Organization (WHO) considers maternal mental health to be a major public health challenge ([WHO, 2018b](#)). While maternal mental health remains less of a priority in healthcare services ([Ayers et al., 2015a](#)) recent reviews aim to improve this ([RCOG, 2017](#)). Perinatal mental illness (PMI) contributes to a quarter of maternal deaths 6 weeks to 1 years postpartum ([Draper et al., 2018](#)) with suicide subsequent to PMI the leading cause of maternal death in the UK between 2006 and 2009 ([Hogg, 2013](#)) resulting in calls for improved identification of severe PMI ([Iacobucci, 2016](#), [RCOG, 2017](#)). Within PMI, Post Natal Depression (PND) and Postpartum Psychosis (PP), with prevalence rates of 10-15% ([MIND, 2016a](#), [Noyman-Veksler et al., 2015](#)), and 0.1% ([MIND, 2016b](#)) respectively, are most commonly acknowledged. Yet, with around 136 million live births worldwide

(United Nations, 2015), and 700,000 in the UK (Index Mundi, 2017), the most recent prevalence figure for PTSD-PC of 4% in the community population (Yildiz et al., 2017) means each year around 28000 UK women birthing a live baby may develop PTSD-PC. The National Institute for Health and Care Excellence (NICE) include PTSD-PC in their most recent PMI guideline (NICE, 2014), yet the Scottish Intercollegiate Guidelines Network (SIGN) latest guidelines overlook PTSD-PC (SIGN, 2012), and a recent position paper on perinatal mental health does not include PTSD-PC (Brockington et al., 2017). Perinatal depression and anxiety disorders are primary research foci (Howard et al., 2014, O'Hara and Wisner, 2014, Bauer et al., 2014) and along with PP, are primary foci of policy and guidance documents (NHS Education for Scotland, 2006, Galloway and Hogg, 2015). Calls exist for increased attention on PTSD-PC (Bauer et al., 2014, McKenzie-McHarg et al., 2015, Simpson and Catling, 2015).

#### **1.3.1.2. PND and PTSD**

PND and PTSD-PC are highly comorbid (Ayers et al., 2016, Dikmen-Yildiz et al., 2017a, Agius et al., 2016), both conditions being positively correlated and sharing underlying vulnerabilities (Söderquist et al., 2009, Agius et al., 2016). While both conditions exhibit some degree of overlap in symptoms (Bailham and Joseph, 2003, Bromley et al., 2017) they are separate disorders (Lyons, 1998, Czarnocka and Slade, 2000, van Son et al., 2005), thus a diagnosis of both PND and PTSD-PC constitutes a dual diagnosis (Bromley et al., 2017).

PMI is often assessed using the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987) even though its validity is questioned (SIGN, 2012, Hewitt et al., 2009), the Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983), or the Patient Health Questionnaire (PHQ-9) (Spitzer et al., 1999, Spitzer et al., 2000). These three scales are considered inappropriate for assessing PMI (McGlone et al., 2016). In particular, using PND scales may misdiagnose PTSD-PC as PND, or miss up to 25% of women experiencing PTSD-PC because they do not present with PND, thus leading to incorrect management and treatment (Czarnocka and Slade, 2000, White et al., 2006, Skinner and Dietz, 2015). Furthermore, Skinner and Dietz (2015) suggest PTSD-PC is more complicated than PND as women may feel obliged to show gratitude to the

maternity healthcare professionals (MHP) present during their traumatic childbirth. PTSD-PC, like general PTSD, has substantial implications for public health and health services (Furuta et al., 2012, McKenzie-McHarg et al., 2015), with further implications for the short and long-term wellbeing of babies and children (Rees, 2015). These implications are considered next.

### **1.3.2. Implications for maternal, child, and family wellbeing and healthcare services**

This section presents an overview of findings from some studies and reviews that explore the impact PTSD-PC on the lives of women, families, and healthcare services.

#### **1.3.2.1. Impact on daily life**

PTSD-PC may have a long-term impact on women. Nightmares may affect sleep quality. Women may struggle to endure each day and their ways of coping may not be positive for them or their families. Women may feel like *shadows of their former selves*, needing to talk excessively about their experience, then becoming withdrawn or angry when they feel family or health professionals are tired of listening (Beck, 2004b). Beck (2006a) found that the child's birthday can be a challenging reminder of trauma and difficult to celebrate. Furthermore, some women may develop coping strategies such as: being over protective of their child; returning to work to avoid connection with their child; putting on 'a fake face' and 'doing what was expected'; taking things out on meaningful others; being angry at the world; being disproportionately preoccupied with physical symptoms; and considering suicide (Fenech and Thomson, 2015).

#### **1.3.2.2. Impact on breastfeeding and future births**

Mothers experiencing PTSD-PC may be less likely to initiate breastfeeding than those without PTSD-PC (Halperin et al., 2015, Cook et al., 2018, Garthus-Niegel et al., 2018), and those who choose to breastfeed may continue for a shorter duration than originally planned, often less than 1 month (Beck et al., 2011, Beck et al., 2015, Halperin et al., 2015). For women experiencing PTSD-PC, breastfeeding may become a focus for overcoming the traumatic birth or else may be hindered through fear of further violation of their bodies (Beck and Watson, 2008).

PTSD-PC may influence women's decisions about future pregnancies and may result in them having less children or a longer interval between children (Gottvall and Waldenström, 2002, Jack, 2005, Nicholls and Ayers, 2007). Severe fear of future childbirth, called tokophobia, can arise (Otley, 2011, Hofberg and Brockington, 2000) and may result in increased demand for elective caesarean section (Otley, 2011, Beck, 2004b). Unresolved PTSD-PC may impact on a future pregnancy by exposing the unborn child to stress hormones altering development of their stress response system (Hogg, 2013), which can result in increased cortisol levels in new born babies (Yehuda et al., 2005), increased risk of premature birth, and reduced infant birthweight (Seng et al., 2011). The review by Fenech and Thomson (2014) suggests traumatic childbirth may impact on women's future reproductive choices.

#### **1.3.2.3. Impact on family relationships**

PTSD-PC may negatively affect relationships with partners including sexual avoidance (Ayers et al., 2006, Bailham and Joseph, 2003, Nicholls and Ayers, 2007). The review by Fenech and Thomson (2014) regarding traumatic childbirth presents women's descriptions of a negative impact on their relationships with their partners and infants. The later review by Delicate et al. (2018) shows that PTSD-PC can have a perceived impact on the couple's relationship. This can be negative, including loss of intimacy and strain on the relationship, but may also positively strengthen the relationship.

Some studies suggest PTSD-PC may negatively affect the woman's relationship with her infant in terms of perception, bonding (Parfitt and Ayers, 2009), and attachment (Ayers et al., 2006, Davies et al., 2008). Dekel et al. (2018) found that attachment was lower with PTSD-PC than general PTSD even when pre-birth psychiatric conditions, acute distress in birth, and lack of breastfeeding, are accounted for. McDonald et al. (2011) found that PTSD-PC at 3 months contributes to relationship difficulties with the child in the longer term, and if co-morbid with PND may account for some continued difficulties at around 2 years old. Hairston et al. (2018) found that in women with avoidant attachment styles PTSD-PC may mediate greater rejection and anger towards the child. However, the review by Cook et al. (2018) concluded that evidence was

contradictory. They cite studies that found no association between maternal PTSD-PC and mother/infant interaction or infant interactional behaviour (Bosquet et al., 2011, Parfitt et al., 2013), but acknowledge methodological limitations in these studies and call for further research. Cook et al. (2018) also note mixed evidence regarding mother/infant bonding but conclude that the evidence is stronger in support of a poorer bond being associated with PTSD-PC.

#### **1.3.2.4. Implications for child health**

Nutrition is essential for child development. Breast milk is considered the optimal food for babies up to 6 months old, providing both short- and long-term health benefits (WHO, 2015b, WHO, 2015a, Unicef, 2016). Thus, any negative impact on breastfeeding (described in section 1.3.2.2.) may affect child health. The infant's healthy physical and psychological development, and potential human capacities can be realised through sensitive, responsive caregiving (WHO, 2018a, Barlow et al., 2013). For optimum outcomes, the quality of early relationships and environment matters (Olson, 2012), with experiences in the first two years of life being most crucial (PIPUK, 2018). Most literature examining the effect of PMI on child development focusses on PND or postnatal anxiety (Kingston and Tough, 2014). PMI is shown to be associated with negative child outcomes in terms of attachment, cognitive development, physical growth and development, and eating habits, problems that sometimes persist into late adolescence (Hogg, 2013, Stein et al., 2014). Maternal PTSD may undermine child regulatory capacity and increase distress, with poor social-emotional outcomes for the children (Lang and Gartstein, 2018) who develop behavioural strategies similar to those displayed by children of depressed mothers (Ionio and Di Blasio, 2014). McKenzie-McHarg et al. (2015) noted a lack of research regarding the long-term impact of PTSD-PC on child development, and a recent review found existing research to be of variable quality with inconsistent findings (Cook et al., 2018). Subsequent individual studies suggest PTSD-PC may impact on the infant's social-emotional development at around 2 years of age (Garthus-Niegel et al., 2017) and may impair infant neurodevelopment (Koen et al., 2016).

### **1.3.2.5. Implications for health services**

PMI healthcare and societal cost estimates relate primarily to perinatal depression, perinatal anxiety, and PP, thus limiting the opportunity to estimate PTSD-PC costs (Bauer et al., 2014). Recent UK estimates of PMI costs are £8.1 billion per annual cohort of women, and 72% of these costs result from long-term impacts on children, with the average cost of one case of perinatal depression being £74,000, of which £51,000 relates to children (Bauer et al., 2014). Cognisant of potential costs of general PTSD (Kessler, 2000) alongside the co-morbidity of PND and PTSD-PC, it is possible that important costs may be associated with PTSD-PC.

Significant under-provision of PMI healthcare services (Box 1.9.) results in a wide variation of care with only 7% of women with PMI being referred to specialist care (RCOG, 2017). Suggested reasons include a lack of interdisciplinary information sharing, with 50% of healthcare professionals having poor knowledge of women's histories (Russell et al., 2013) and poor awareness of PMI conditions (RCOG, 2017). This situation reflects a possible lack of implementation of guidance regarding regional PMI health strategies for specific staff training in the emotional changes of childbearing women (NHS Education for Scotland, 2006, JCPMH, 2012). Nonetheless, increased awareness of the need to improve practice following reviews by Bauer et al. (2014) and NHS Improving Quality (NHS Improving Quality, 2015), has triggered improvement initiatives with calls to make PMI a clinical priority (Royal College of General Practitioners, 2016, RCOG, 2017) in keeping with calls to ensure that women experiencing all levels of traumatic stress responses to pregnancy or birth have access to psychological interventions (NICE, 2011).

#### **Box 1.9. UK provision of PMI healthcare services (Bauer et al., 2014)**

- Full recommended service: less than 15% of UK localities
- No service: 40% of Scotland and England, 70% of Wales and Northern Ireland.
- 3% of Clinical Commissioning Groups (CCG) in England have any PMI health strategy in place, 60% have no plan to develop such a service (NCT, 2014).
- Of those diagnosed, only 60% receive treatment, which is adequate for less than half (Gavin et al., 2015).
- 90% of women receiving PMI treatment do so within primary care (Shakespeare, 2014).

Providing an effective service may be further hampered when women do not fully disclose PMI problems, due to a range of complex reasons, including: lack of knowledge or hope; stigma; feeling rushed and unheard; lack of continuity of carer; and perceiving that the MHP's focus is on physical maternal health or the child's health (Khan, 2015). Investing resources in improved identification of PMI, complemented by individualised, focussed care can reduce women's morbidity at 12 months post childbirth, as well as their ongoing use of health services, which may result in similar financial costs, but less human cost (MacArthur et al., 2003, McKenzie-McHarg et al., 2015). Several recent reviews and studies call for more research and resources to raise awareness of PTSD-PC alongside relevant training and skill development, which can prevent against trauma and to enable MHPs to identify and sensitively respond to women's psychosocial concerns (Fenech and Thomson, 2014, McKenzie-McHarg et al., 2015, Simpson and Catling, 2015).

### **1.3.3. Summary of Part 3: rationale for undertaking the literature review**

The cultural and scientific move towards prioritising childbearing women's emotional and psychological wellbeing, alongside their physical wellbeing is well founded. Current evidence confirms the existence of PTSD-PC as a distinct condition and highlights potential associated risks and impact, alongside those of more recognised PMI conditions including PND and PP. This has resulted in some national bodies incorporating guidelines regarding PTSD-PC within PMI. Therefore, it is necessary to understand the causes of PTSD-PC and effectively assess and treat those affected. The preliminary examination from a selection of existing research presented in part 2, provides an initial insight into the potential risk factors for developing PTSD-PC. However, the comparatively recent recognition of PTSD-PC indicates that many MHPs may have inadequate awareness or knowledge regarding the nature of PTSD-PC. Given the potential societal and healthcare costs of PTSD-PC, it is imperative that MHP's have access to the most up to date evidence and knowledge regarding PTSD-PC. Also, any gaps in evidence must be identified and new research brought forward that increases the knowledge about PTSD-PC, which enables the education of MHPs to appropriately identify the risk of, diagnose, and treat PTSD-PC. This is of paramount importance to initiate appropriate practices to help reduce the incidence of PTSD-PC. It is anticipated

that preventing incidence will reduce the overall impact on financial and human cost that have been highlighted above.

To fully capture current evidence regarding factors that contribute to the development of PTSD-PC in childbearing women and identify gaps in current knowledge, the next stage in this research project was to perform a systematic review of all existing PTSD-PC literature that has explored these factors. From this literature review an important gap in current knowledge will be identified and will inform the thesis research question.

This systematic literature review is presented in Chapter 2.



## Chapter Two

### A review of existing literature

## **2. A systematic literature review of studies examining PTSD-PC**

Chapter 1 discussed the now recognised potential for the development of PTSD-PC, the currently acknowledged prevalence rates of PTSD-PC, and a first look at some of the factors that contribute to the development of PTSD-PC. Also outlined was the rationale for undertaking the literature review that is now presented.

### **2.1. Introduction to the literature review**

As a midwife, I am particularly interested in the development of PTSD in childbearing women subsequent to their childbirth experience. Therefore, this literature review:

- will **not** examine research that explores pregnancy PTSD.
- will **only** focus on the development of PTSD in childbearing women, although it is acknowledged that women's partners and also midwives may develop PTSD subsequent to being present during childbirth ([White et al., 2006](#), [Ayers, 2007](#), [White, 2007](#), [Pezaro et al., 2016](#), [Leinweber and Rowe, 2010](#)).

Furthermore, the literature review was undertaken cognisant of the considerations established in Chapter 1. Box 2.1. presents a summary of these.

#### **Box 2.1. Considerations from Chapter 1**

- PTSD-PC exists in childbearing women with a prevalence of 4% in community populations and 18.5% in high-risk populations. See section 1.2.3.2.1.
- Five possible categories of contributing factors exist. See Box 1.8.
- To explore contributing factors free from the confounding impact of infant morbidity such as stillbirth, pre-term birth and severe maternal morbidity. See section 1.2.2.2.

The resultant aims and questions for the literature review are presented in Box 2.2.

## Box 2.2. The aims and questions of the literature review

### The aims of the literature review

1. To provide a closer examination of the published peer-reviewed research exploring PTSD-PC in childbearing women.
2. To examine the existing research findings regarding prevalence of and risk factors that contribute to the development of PTSD-PC in childbearing women.
3. Identify a critical gap in current knowledge from which to base the research question for the author's PhD thesis.

### The literature review questions

1. What peer-reviewed research exists that explores the prevalence of PTSD-PC in childbearing women?
2. What peer-reviewed research exists that examines the factors that contribute to the development of PTSD-PC in childbearing women?
3. What does the identified research tell us about the prevalence of PTSD-PC in childbearing women and the risk factors for PTSD-PC?
4. What gaps exist in the current knowledge regarding the development of PTSD-PC in childbearing women?

### 2.1.1. Selecting the method for the review

An important step towards identifying the review process involved unravelling various associated terminology. While a *Full Systematic Review* is recognised as the gold standard (Moher et al., 2009), it may require at least 8-12 months and a small team to perform well, whereas a *Literature Review* or *Narrative review*, terms often used interchangeably, and can take up to 2 months (Civil Service, 2014). Another definition of a *Full Systematic Literature Review* focusses less on the length of time or number of researchers, rather on a documented, highly comprehensive search with transparent, robust, and systematic methodology (NFER, 2017). Green et al. (2006) defines a *Systematic Literature Review* as a process that employs detailed, rigorous, and explicit methods, with the hallmark being a detailed search of literature around a focussed question. The language of *Full Systematic Reviews* is most frequently associated with quantitative research and meta-analyses (Ebling Library, 2017, Moher et al., 2009).

While *Literature (or Narrative) Reviews* are considered to be less rigorous and subject to bias (Bettany-Saltikov, 2010), they can be appropriate to review a combination of both qualitative and quantitative methods (Dixon-Woods et al., 2005), enabling a presentation of a broad range of findings, with a view to identifying any gaps or inconsistencies in what is known (Bauermeister and Leary, 1997). It was anticipated that PTSD-PC research might include both quantitative and qualitative studies,

exploring both incidence and contributing factors that may be objective or subjective. The Cochrane Handbook acknowledges the value of qualitative research and debates the need for comprehensive, exhaustive searches alongside a more purposive sampling search (Noyes et al., 2016). Mindful of the time limitation of three years for the full research project performed by a single researcher, alongside the potential inclusion of both quantitative and qualitative research, it was decided to perform a *Literature Review* in a *Systematic* manner. The review findings were drawn together using a narrative synthesis, as this is deemed appropriate for both qualitative and quantitative research (CRD, 2009).

#### **2.1.1.1. A literature review in two stages**

The scoping exercise in chapter 1 identified five potential categories of factors that contribute to the development of PTSD-PC (Box 1.8). To narrow the focus of the literature review appropriately, there were two stages to the review (Box 2.3.). Stage one incorporated a wide sweep of all relevant PTSD-PC literature. From close examination of the stage one studies a key focus was identified. In stage two, the subset of stage one studies that specifically addressed this key focus were identified and critically reviewed. A new literature search was not required as the overall inclusion/exclusion criteria remained the same with the additional exclusion of studies that did not specifically address the key focus. From this critical review of studies addressing the key focus, the research gap was identified.

#### **Box 2.3. The stages of the literature review**

##### **Stage one**

1. A systematic literature search for studies that explore the prevalence of PTSD-PC and/or risk factors that contribute to the development of PTSD-PC.
2. An overview of current knowledge regarding factors that contribute to the development of PTSD-PC in childbearing women.
3. Identification of a key focus for stage two of the literature review.

##### **Stage two**

1. A critical review and narrative synthesis of findings of the subset of studies from stage one that address the key focus for review.
2. Identification of a critical gap in current knowledge which will inform the basis of the research question for this thesis.

## 2.1.2. Stage one of the literature review

*The search process and overview of findings from stage one are now presented*

### 2.1.2.1. Identifying the search terms and inclusion/exclusion criteria

To establish the components of the literature search and enable selection of relevant studies through appropriate inclusion and exclusion criteria, the PICOS/PICOT models have been recommended (Richardson et al., 1995, Sackett, 2006). These models include the components: Population; Intervention; Comparison; Outcomes (Richardson et al., 1995); and Time (Sackett, 2006). However, a review of factors contributing to the development of PTSD-PC is incompatible with the elements *Intervention* and *Comparison*. Unlike the application of a treatment or an intervention, the experience of childbirth is the applicable *event*, within which there may be few or several *Interventions*. Similarly, no direct comparison is undertaken. Within an alternate model known as *Concept Mapping* (University of Toronto, 2017) the literature review questions are first presented as sentences, then broken down into concepts and different ways of describing each concept (synonyms) and presented as a *Concept Table*, from which search terms and inclusion and exclusion criteria are established. Combining the considerations in box 2.1. and the aims and questions in box 2.3, the overall search questions were:

- What research exists that explores the prevalence of PTSD-PC in childbearing women?
- Considering the five possible categories of risk factors for the development of PTSD-PC in childbearing women, what research exists that explores risk factors other than severe maternal morbidity or prematurity / severe morbidity / mortality of the baby?

A table was drawn up of *concepts* and *synonyms* (Table 2.1.).

**Table 2.1. Concept and synonyms for the literature search**

PTSD-PC	Pre-existing factors	Objective factors	Subjective factors	Type of research
PTSD post childbirth in women	Childhood Sexual Abuse (CSA)	Type of birth	Emotional experience	Peer-reviewed
Not pregnancy PTSD	Intimate Partner Violence (IPV)	Use of analgesia	Perceived threat to wellbeing or life	Primary
Not PTSD in partners	Previous traumatic birth experience	Medical interventions	Perception of quality of care	Secondary (literature reviews, meta-analysis)
Not PTSD in midwives	Parity (number of previous births)	Actual threat to wellbeing or life	Perception of attitudes of staff	Qualitative
Not depression or anxiety	Demographics such as age, ethnicity	Not as a result of stillbirth, pre-term birth, and/or sick infant		Quantitative
	Social support	Not as a result of severe pregnancy complications such as pre-eclampsia or HELLP		Mixed methods
	History of psychological ill health, or other psychological factors			

From these concept mapping terms, the keywords *PTSD*, *Childbirth/labour*, and *Midwifery* were considered. However, the earlier scoping exercise found that the keyword *labour* also retrieved studies related to *working* or *workforce*. Therefore, specific childbirth/obstetric terms were included when searching the keyword *labour* (See appendix 2.1.). To identify studies looking at midwifery staff attitudes, midwifery terms regarding type of care were included, such as *midwife-led* and *woman centred*. The final keywords were *PTSD*, *Childbirth/labour* (that incorporated obstetric factors) and *Midwifery approach* (that incorporated midwifery factors). The full list of subject headings and terms used are listed in Appendix 2.1. The inclusion and exclusion criteria and rationale for each are presented in Table 2.2.

**Table 2.2. Stage one inclusion and exclusion criteria**

Feature	Inclusion criteria	Exclusion criteria	Rationale
Year of publication	Studies after 1980	Studies prior to 1980	DSM criteria for PTSD was first established in 1980
Language of publication	English	Any other languages	Author not fluent in any languages other than English
Country study performed in	Any country	None	
Type and quality of research	Peer-reviewed primary or secondary research	Non-peer-reviewed such as: Grey literature, commentary or opinion, PhD theses.	To ensure only quality studies are assessed. Secondary research includes literature reviews, meta-analyses.
Study assessment of PTSD-PC in childbearing women	Refers to PTSD as per DSM (III, IV or V) criteria	No measure of PTSD Does not refer to DSM criteria Refers only to ICD criteria	To avoid inconsistency in approach between DSM and ICD (in fact no studies were identified that referred to ICD criteria)
Methodology	Any: qualitative, quantitative or mixed	No restriction	To identify a wide range of primary or secondary research
Focus of study	Focus on assessing prevalence of PTSD-PC in childbearing women.  Identifying or exploring factors contributing to PTSD-PC in childbearing women.	Focus on antenatal PTSD. Serious maternal morbidity (such as HELLP*, DIC** or Pre-eclampsia). Stillbirth, neonatal loss, pre-term birth, serious neonatal morbidity (including admission to a neonatal unit for more than observation). Depression, anxiety, treatment or assessment of PTSD-PC. Experience of living with PTSD-PC. PTSD in fathers/partners or in midwives/healthcare staff.  <i>*HELLP severe medical complication of pregnancy comprising of Haemolysis, Elevated Liver enzymes and Low Platelet count.</i> <i>**DIC Disseminated Intravascular Coagulation</i>	To focus on factors that contribute to PTSD-PC in childbearing women, when both mother and baby emerge physically well.

### **2.1.2.2. Performing the literature search**

A computerised literature search was performed between the 6<sup>th</sup> January 2016 and the 12<sup>th</sup> January 2016, using the bibliographic databases: CINAHL; Medline; PsycINFO; and Psychology and Behavioural Sciences Collection. Subject headings and terms (Appendix 2.1.) were used to both expand and focus the searches for each of the

keywords using the Boolean operator 'OR'. Paired combinations of the searches were made using the Boolean operator 'AND', giving 'PTSD' AND 'Childbirth/labour' and 'PTSD' AND 'Midwifery approach'. Searches were run through each database separately with subject headings adjusted as necessary to fit the database terms. Further studies came from reading study references, those from the scoping exercise that did not emerge in the main search, and ongoing regular monitoring for new research via the International Network for Perinatal PTSD Research (INPPR) (INPPR, 2017). Table 2.3. presents the numbers of studies identified.

**Table 2.3. Number of studies identified from main literature search**

Database	<i>PTSD and Childbirth/labour</i>	<i>PTSD and Midwifery approach</i>	Unique studies
CINAHL	272	19 (4 already in the 272)	287
Medline	171	7 (3 already in the 171)	175
Psychology and behavioural sciences	83	1	84
PsycINFO	94	1 (already in the 94)	94
<b>Total</b>			<b>640</b>

Through initial examination of these 640 potentially relevant studies, 197 were excluded (Box 2.4.), as per exclusion criteria (Table 2.2.). For any studies where the record was not available, further searching was carried out through the National Library of Scotland, the British Library, and university inter-library access. 13 remained unavailable.

**Box 2.4. Reasons for exclusion of studies from the initial 640 identified**

Theses	16
Books	2
Non-human related	2
Non-birth related	13
Not women	8
No abstract	100
Stillbirth study	1
Pre-1980, not English	42
Record not available	13
<b>Total excluded</b>	<b>197</b>

From the remaining 443 studies, the removal of duplicates, addition of those identified through the process described above, and application of stage one inclusion/exclusion

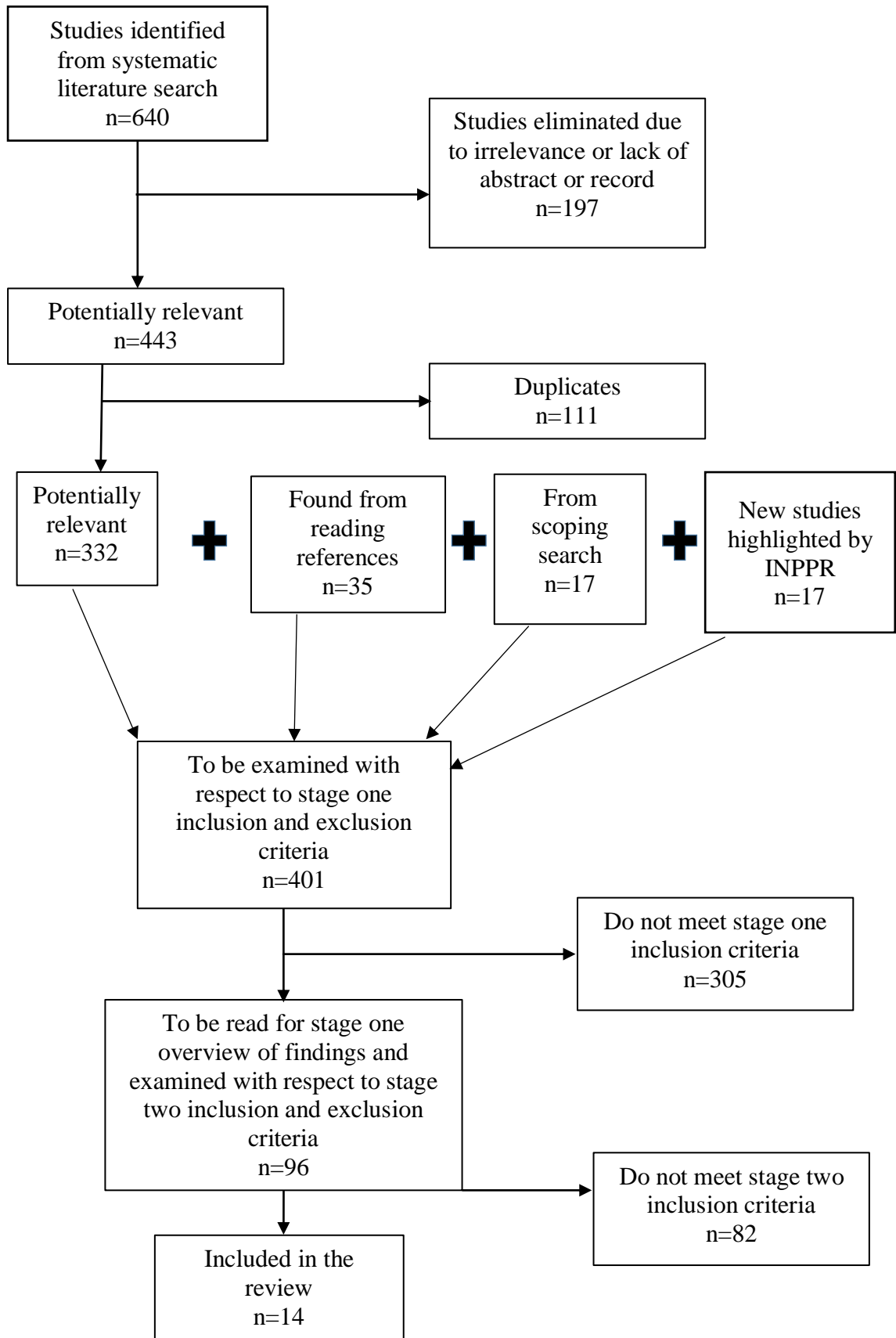


criteria (Table 2.2.), 96 studies were included for close examination (Box 2.5., Figure 2.1. and Appendix 2.2.). The overview of findings from these 96 studies, presented next, informed the rationale for stage two of the literature review.

**Box 2.5. Further exclusion from the 401 studies as per stage one inclusion/exclusion criteria**

Not exploring PTSD-PC in childbearing women	189
Not original research (e.g. grey lit, commentary/opinion, discussion)	28
Stillbirth, neonatal loss, pre-term birth	24
Treatment or assessment of PTSD-PC	41
Living with PTSD-PC	23
<b>Total excluded</b>	<b>305</b>

Figure 2.1. Study selection process for stages one and two of the review



### **2.1.2.3. The methodologies of the 96 studies included in stage one of the review**

While the inclusion criteria allowed for including studies since 1980, it was not until 1993 that a study first explored the potential consequence of PTSD following obstetric procedures (Menage, 1993), followed closely in 1995 with the case studies from (Ballard et al., 1995), both concurrent with the 1994 revised DSM-IV definition of PTSD that first allowed for childbirth to be categorised as a potential traumatising event (APA, 1994) (see Chapter I). Subsequently, PTSD-PC research primarily focussed on identifying prevalence and causative factors using a mixture of research methods (Table 2.4.).

**Table 2.4. Timing and methods of PTSD-PC research from the 96 studies**

Date	Type of article	Methodology	Number of studies
1993-2000	Primary	Quantitative	6
		Qualitative	4
2001-2017	Primary	Quantitative	57
		Qualitative	9
		Mixed methods	2
	Non-primary	Quantitative meta-analysis	3
		Qualitative meta-synthesis	3
		Mixed meta-synthesis	1
	Reviews		11

### **2.1.2.4. The overview of findings of the 96 studies included in stage one of the review**

This body of research clearly confirmed the existence of PTSD-PC (Ayers and Pickering, 2001, Bailham and Joseph, 2003, Ayers et al., 2015a, James, 2015, Sawyer et al., 2010) and identified the potential prevalence and range of contributing factors (Ayers, 2004, Alcorn et al., 2010, Grekin and O'Hara, 2014, Yildiz et al., 2017, King et al., 2017).

Furthermore, the co-morbidity of PTSD-PC and PND as distinct, yet correlated disorders was established (White et al., 2006, van Son et al., 2005, Olde et al., 2005, Söderquist et al., 2009). In keeping with the scoping exercise findings, the identified factors that contribute to the development of PTSD-PC can be grouped into five categories (Box 2.6.). Many of the studies explored a combination of these.

### Box 2.6. Categories of factors that contribute to the development of PTSD-PC

• <b>Subjective birth experience</b>	Place of birth, model of care, perception of experience.
• <b>Objective birth interventions</b>	Obstetric interventions, such as caesarean section or forceps.
• <b>Prior trauma</b>	Childhood sexual abuse, previous birth trauma, victim of violence.
• <b>Demographic factors</b>	Age, ethnicity, socioeconomic factors, parity.
• <b>Pre-existing psychopathology</b>	Depression, anxiety, PTSD, other mental health conditions.

The childbirth experience (subjective and objective) and pre-existing psychopathology were most frequently explored, consistent with PTSD being a trauma-related disorder associated with a traumatic event (APA, 2013), while pre-existing psychopathology aligns with PTSD as a mental health disorder. Fewer studies addressed prior trauma or demographic factors, often noted as a limitation. These limitations are reasonable, small qualitative studies may not enable comparison across some demographics, such as ethnicity or parity, while information about prior trauma, such as childhood sexual abuse can be challenging to obtain. However, those studies that explored the demographic characteristics of participants do contribute to our understanding of PTSD-PC, such as the prevalence amongst teenagers (Anderson and McGuinness, 2008) and specific ethnic populations (Halperin et al., 2015, Lev-Wiesel et al., 2009, Lev-Wiesel and Daphna-Tekoah, 2010). The purpose of this first stage was to overview the breadth of findings and inform the rationale for the critical review in stage two. Thus, the methodological quality or limitations of the 96 studies is not addressed. While some findings may be unsubstantiated following rigorous examination, they nonetheless highlight the range of potential issues, and provide a background from which to identify the focus of stage two of the literature review. A narrative overview of findings related to each category of factors contributing towards the development of PTSD-PC is now presented in conjunction with Table 2.5.

#### 2.1.2.4.1. Terminology used in the overview of findings from the 96 studies included in stage one of the review

Across the studies reviewed the method of assessment of post traumatic stress symptoms varied, with reference to 'full PTSD', 'partial PTSD', 'PTSD symptoms', 'PTS symptoms', and 'partial PTS'. For simplicity this overview uses the term PTSD-PC throughout, acknowledging that while some findings did not relate to full diagnostic

PTSD, all related to at least moderate symptoms of PTSD as per DSM III, IV, or V criteria.

#### 2.1.2.4.2. Category 1: Subjective childbirth experience

With regard to the development of PTSD-PC, a woman's subjective experience of childbirth was identified as a contributing factor in many review studies, and [Garthus-Niegel et al. \(2013\)](#) identified this the most important significant factor.

Within the subjective experience, the contribution of pain is uncertain ([Andersen et al., 2012](#)). Negative emotions may increase the influence of pain ([Goutaudier et al., 2012](#)) consistent with suggestions that the impact of pain is mediated by the overall childbirth experience ([Garthus-Niegel et al., 2014a](#)) or staff support ([van Son et al., 2005](#)).

Lack of, or poor support during labour were consistent factors. Healthcare provider support was most important ([Andersen et al., 2012](#)) and a major negative factor ([Harris and Ayers, 2012](#)). Interestingly, being well supported, informed, and reassured by staff, may reduce the fear response in women who perceive threat ([Boorman et al., 2014](#)).

Not coping or having a low sense of coherence were contributing factors, particularly if there was a lack of coherence between the anticipated and the actual experience, further impacted by poor information. Feeling powerless or a lack of control were consistently significant, especially when receiving poor information ([Soet et al., 2003](#)) or perceiving staff to be incompetent ([De Schepper et al., 2015](#)).

Within the subjective experience, the perception of care quality was frequently highlighted and was identified as the most important factor ([Czarnocka and Slade, 2000](#)). A major feature of care quality was staff attitude and interaction termed 'Quality of Provider Interaction' (QPI) ([Sorenson, 2003](#)). The perception of *How* care was provided ([Beck, 2006b, Beck, 2011](#)), or the perceived quality of care ([Creedy et al., 2000](#)) was core to the subjective experience. In particular, trauma hotspots related to

interpersonal difficulties (being ignored, lack of support, poor communication, being abandoned, being put under pressure) were the strongest predictor of PTSD-PC, being four times more likely to lead to PTSD-PC compared to trauma hotspots related to neonatal complications (Harris and Ayers, 2012). Within some of the 96 studies, QPI has been described using several expressions and words, a range of which is given in Box 2.7.

**Box 2.7. Expressions and words regarding QPI that are discussed in literature**

Dehumanising	(Elmir et al., 2010, Nicholls and Ayers, 2007)
Disrespectful	(Elmir et al., 2010, Ford et al., 2010)
Uncaring	(Elmir et al., 2010, Soet et al., 2003)
Ignored or abandoned	(Harris and Ayers, 2012, Nicholls and Ayers, 2007)
Dismissive or disinterested	(Iles and Pote, 2015)
Hostile	(Soet et al., 2003, Ford et al., 2010)
staff having a negative attitude	(Denis et al., 2011)
staff betraying trust	(Beck, 2004a)

**2.1.2.4.3. Category 2: Objective birth Interventions**

It is reasonable to consider that undergoing significant medical procedures is likely to be traumatic and many studies showed that obstetrical variables, especially if performed as an emergency, contribute to the development of PTSD-PC, as does experiencing pressure to accept an intervention (Beck et al., 2011). Mode of birth was found to have an inconsistent effect (Ayers et al., 2009) and being in hospital was not a contributing factor (Polachek et al., 2015), unless unplanned (Stramrood et al., 2011). One study only found an associated increase in PTSD-PC after operative birth in women with an avoidant attachment style (Ayers et al., 2014), and another only found an association with forceps delivery (Ford et al., 2010). While vaginal or perineal tissue trauma is considered a potential factor (Skinner and Dietz, 2015), some found it not to be related to PTSD-PC (Andersen et al., 2012, Fairbrother and Woody, 2007), unless from a medically induced cut to the perineum, known as an episiotomy (Paul, 2008, König et al., 2016). While trauma hotspots related to obstetric events were three times more likely to lead to PTSD-PC compared to trauma hotspots related to neonatal complications, interpersonal difficulties were the strongest predictor of PTSD-PC (Harris and Ayers, 2012), and the impact of objective events was partially mediated by the subjective experience (Garthus-Niegel et al., 2013).

#### 2.1.2.4.4. Category 3: Prior trauma

Prior experience of trauma was a significant contributing factor towards the development of PTSD-PC and potentially the main issue (O'Donovan et al., 2014). However, Ford et al. (2010) and Leeds and Hargreaves (2008) found no association with prior trauma and others suggest good support may mediate its impact (Ford and Ayers, 2011). Childhood Sexual Abuse (CSA) was a major research focus and identified to be a significant factor, although not in all studies. Vossbeck-Elsebusch et al. (2014) found that once age and wellbeing in pregnancy are accounted for, CSA was no longer significant. Previous birth trauma was not a universal factor (Andersen et al., 2012). However, the quality of existing research that explores the role of prior trauma was questioned with calls for improved design of future studies exploring CSA and PTSD-PC (Wosu et al., 2015).

#### 2.1.2.4.5. Category 4: Demographic Factors

A lack of specific research regarding demographic factors, particularly socioeconomic and parity (whether or not this pregnancy was a first or subsequent pregnancy) was noted (Iles and Pote, 2015). Consequently, findings are somewhat mixed and unclear (Moghadam et al., 2015) with findings regarding age, socioeconomic group, education level and ethnicity being inconsistent (Andersen et al., 2012). However, Adewuya et al. (2006) found a greater incidence of PTSD-PC in Nigerian women compared to western women, and Furuta et al. (2016) found that black women, or women with higher BMI pre-pregnancy were more likely to develop PTSD-PC. Lack of social support contributed but not over and above other factors (Vossbeck-Elsebusch et al., 2014). Whether increased social support reduced symptoms, or lack of support increased symptoms was unclear (Ford et al., 2010).

#### 2.1.2.4.6. Category 5: Pre-existing factors

General psychological morbidity before or during pregnancy was not found to be a significant by Stramrood et al. (2011). However, depression prior to the pregnancy, depression or anxiety during the current pregnancy or alongside anxiety trait, were consistently important (Soet et al., 2003, Zaers et al., 2008, Olde et al., 2006), sometimes associated with prior birth trauma (Polachek et al., 2012). Pre-traumatic

stress was identified as a pre-existing factor (Grekin and O'Hara, 2014, Söderquist et al., 2009). Fear of childbirth, known in its extreme form as Tokophobia was an inconsistent factor, found to be mediated by the overall subjective experience (Garthus-Niegel et al., 2013, Polachek et al., 2012). Furthermore, such fear and its contribution to PTSD-PC may be exacerbated by inadequate antenatal education (Modarres et al., 2012). One study suggests that an avoidant attachment style is important regarding women's responses to childbirth and a possible risk factor for PTSD-PC, particularly following operative birth (Ayers et al., 2014).



**Table 2.5. Overview of findings regarding factors contributing to the development of PTSD-PC from the 96 studies included in stage one of the literature review**

Factor being explored	Shown to be significant in the development of PTSD?	Studies from the 96 that produce this finding
Overall subjective experience	Yes, this is a key factor	(Alcorn et al., 2010, Andersen et al., 2012, Ayers et al., 2016, Dale-Hewitt et al., 2012, Elmir et al., 2010, Ford et al., 2010, Furuta et al., 2014, Lyons, 1998, Zaers et al., 2008, Sorenson and Tschetter, 2010, James, 2015)
Subjective experience of Pain	Yes	(Denis et al., 2011, Ballard et al., 1995, Garthus-Niegel et al., 2014a, Goutaudier et al., 2012)
	No	(Lyons, 1998, Moghadam et al., 2015, Söderquist et al., 2002, Milosavljevic et al., 2016)
	Only with failed epidural	(Paul, 2008)
Subjective experience of support	Yes	(Ayers et al., 2016, Cigoli et al., 2006, Czarnocka and Slade, 2000, Elmir et al., 2010, Modarres et al., 2012, Sorenson and Tschetter, 2010)
	Need is increased in women with high anxiety	(Cigoli et al., 2006, Maggioni et al., 2006)
	Only if prior trauma or receipt of obstetric intervention	(Ford and Ayers, 2011).
Perception of lack of coping and/or low sense of coherence	Yes	(Andersen et al., 2012, Stramrood et al., 2011, Soet et al., 2003, Ayers, 2007, Tham et al., 2007)
	Yes, particularly if lack of coherence between anticipated and actual experience	(Garthus-Niegel et al., 2014b, Denis et al., 2011, O'Donovan et al., 2014, Ayers et al., 2008, Zaers et al., 2008, Leeds and Hargreaves, 2008)
	Augmented by a poor understanding of what is happening	(Ayers, 2007, Elmir et al., 2010, Nicholls and Ayers, 2007)

**Table 2.5. continued Overview of findings regarding factors contributing to the development of PTSD-PC from the 96 studies included in stage one of the literature review**

<b>Factor being explored</b>	<b>Shown to be significant in the development of PTSD?</b>	<b>Studies from the 96 that produce this finding</b>
Perception of loss of control and powerlessness	Yes	(Allen, 1998, Andersen et al., 2012, Beck, 2004a, Ballard et al., 1995, Ford et al., 2010, Denis et al., 2011, Furuta et al., 2014, Leeds and Hargreaves, 2008, Lyons, 1998, Menage, 1993, Soet et al., 2003, Furuta et al., 2016, Ísbir et al., 2016)
	Improved if women are involved in decision making	(Tham et al., 2010, Furuta et al., 2014)
Perception of care received	Yes	(Allen, 1998, Ayers et al., 2016, Zaers et al., 2008, Andersen et al., 2012, Beck, 2004a, Boorman et al., 2014, Ford and Ayers, 2011, Wijma et al., 1997, Dale-Hewitt et al., 2012, Ryding et al., 1998, Denis et al., 2011, De Schepper et al., 2015, Lev-Wiesel et al., 2009, Ayers, 2007, Creedy et al., 2000)
	Found to be a major factor	(Wijma et al., 1997, Modarres et al., 2012, Paul, 2008, Tham et al., 2010, Grekin and O'Hara, 2014, Simpson and Catling, 2015, Slade, 2006, Olde et al., 2006, Czarnocka and Slade, 2000, Soet et al., 2003, Ford et al., 2010, Cigoli et al., 2006, Denis et al., 2011, Harris and Ayers, 2012, Iles and Pote, 2015, Sorenson and Tschetter, 2010, Beck, 2006b)
	Yes, in relation to staff attitude	(Elmir et al., 2010, Menage, 1993, Nicholls and Ayers, 2007)
Negative emotions about childbirth or negative memory of childbirth	Yes	(Olde et al., 2005, Goutaudier et al., 2012, Hauer et al., 2009, Ryding et al., 2000, Edworthy et al., 2008, Halperin et al., 2015)
Perceived poor information or lack communication	Yes	(Ayers, 2007, Harris and Ayers, 2012, Beck, 2004a, Nicholls and Ayers, 2007, De Schepper et al., 2015)

**Table 2.5. continued Overview of findings regarding factors contributing to the development of PTSD-PC from the 96 studies included in stage one of the literature review**

Factor being explored	Shown to be significant in the development of PTSD?	Studies from the 96 that produce this finding
Objective birth interventions	<p>No</p> <p>Yes</p> <p>Yes, particularly if the intervention is carried out in an emergency or is unexpected</p> <p>Yes, if related to pregnancy and birth complications</p> <p>Yes, if ongoing physical problems post childbirth</p>	<p>(Maggioni et al., 2006, O'Donovan et al., 2014, Cohen, 2004, Polachek et al., 2015)</p> <p>(Fairbrother and Woody, 2007, Furuta, 2014, Soet et al., 2003, Ayers et al., 2016, Ayers et al., 2009, Ayers, 2014, Gamble and Creedy, 2005, Skinner and Dietz, 2015, Furuta et al., 2012, Alcorn et al., 2010, König et al., 2016, Creedy et al., 2000)</p> <p>(Andersen et al., 2012, Leeds and Hargreaves, 2008, Gamble and Creedy, 2005, Denis et al., 2011, Srkalović Imširagić et al., 2017, Furuta et al., 2016, Olde et al., 2006, Söderquist et al., 2002, Milosavljevic et al., 2016)</p> <p>(Modarres et al., 2010)</p> <p>(Beck et al., 2011)</p>
Mode of birth	<p>Yes, caesarean particularly significant</p> <p>Yes, spontaneous vaginal delivery reduced the risk</p> <p>Yes, spontaneous vaginal delivery increased the risk</p> <p>Yes, augmented by a poor understanding of what is happening</p> <p>No</p>	<p>(Ryding et al., 1997, Paul, 2008, Boorman et al., 2014, Söderquist et al., 2009)</p> <p>(De Schepper et al., 2015, Halperin et al., 2015)</p> <p>(Polachek et al., 2012, Söderquist et al., 2002)</p> <p>(Ayers, 2007, Elmir et al., 2010, Nicholls and Ayers, 2007)}</p> <p>(Lyons, 1998, Leeds and Hargreaves, 2008, Sorenson and Tschetter, 2010)</p>

**Table 2.5. continued Overview of findings regarding factors contributing to the development of PTSD-PC from the 96 studies included in stage one of the literature review**

Factor being explored	Shown to be significant in the development of PTSD?	Studies from the 96 that produce this finding
Experiencing prior trauma in general	Yes	(Polachek et al., 2012, Modarres et al., 2010, Moghadam et al., 2015, Andersen et al., 2012, Boorman et al., 2014, Alcorn et al., 2010, Cohen et al., 2004, Lev-Wiesel et al., 2009, Vossbeck-Elsebusch et al., 2014, Zaers et al., 2008)
Childhood sexual abuse	Yes	(Wosu et al., 2015, Andersen et al., 2012, Ayers et al., 2009, Ayers, 2014, Lev-Wiesel and Daphna-Tekoah, 2010, Soet et al., 2003, Theroux, 2009, Verreault et al., 2012, Vossbeck-Elsebusch et al., 2014, Oliveira et al., 2016)
	No	(Cohen et al., 2004, Polachek et al., 2015)
Prior birth trauma	Yes	(Söderquist et al., 2006, Moghadam et al., 2015)
	No	(Lyons, 1998, Leeds and Hargreaves, 2008)
Demographic factors in general	No	(Gamble and Creedy, 2005, Stramrood et al., 2011, Sorenson and Tschetter, 2010)
Having a first baby	Yes	(Boorman et al., 2014, Cigoli et al., 2006, Wijma et al., 1997, Ayers et al., 2009)
	No	(Moghadam et al., 2015, Polachek et al., 2015, Gamble and Creedy, 2005, Sorenson and Tschetter, 2010)
Age	Yes, if younger	(Theroux, 2009, Anderson and McGuinness, 2008, Vossbeck-Elsebusch et al., 2014)
	No	(Sorenson and Tschetter, 2010)
Religious beliefs	Yes	(De Schepper et al., 2015, Lev-Wiesel et al., 2009)
Socioeconomic group	Yes, if low socioeconomic group	(De Schepper et al., 2015, Lyons, 1998, Modarres et al., 2010)
	Yes, if higher income	(Cohen et al., 2004)
Ethnicity	Yes	(Cohen et al., 2004)
	No	(Halperin et al., 2015)
Social support	Yes, if lack of social support	(Noyman-Veksler et al., 2015, Lyons, 1998, Söderquist et al., 2006, Modarres et al., 2010)

**Table 2.5. continued Overview of findings regarding factors contributing to the development of PTSD-PC from the 96 studies included in stage one of the literature review**

Factor being explored	Shown to be significant in the development of PTSD?	Studies from the 96 that produce this finding
Anxiety in current pregnancy	Yes	(O'Donovan et al., 2014, Alcorn et al., 2010, Andersen et al., 2012, Czarnocka and Slade, 2000, Fairbrother and Woody, 2007, Garthus-Niegel et al., 2014b, Maggioni et al., 2006, Verreault et al., 2012, Zaers et al., 2008)
Depression prior to or during current pregnancy	Yes	(Alcorn et al., 2010, Andersen et al., 2012, Ayers et al., 2016, Cigoli et al., 2006, Cohen et al., 2004, Czarnocka and Slade, 2000, Garthus-Niegel et al., 2014b, Haagen et al., 2015, Leeds and Hargreaves, 2008, Lev-Wiesel et al., 2009, Maggioni et al., 2006, Polachek et al., 2015, Söderquist et al., 2006, Söderquist et al., 2009, König et al., 2016)
Fear / Fear of childbirth	Yes	(Polachek et al., 2012, Ayers, 2007, Söderquist et al., 2006, Ayers et al., 2016, Söderquist et al., 2009, Garthus-Niegel et al., 2014b)
	No	(Lyons, 1998, Fairbrother and Woody, 2007)
General psychological morbidity	Yes	(Zaers et al., 2008, Wijma et al., 1997, Theroux, 2009, Boorman et al., 2014, Garthus-Niegel et al., 2013, Leeds and Hargreaves, 2008, Söderquist et al., 2006, Srkalović Imširagić et al., 2017, Edworthy et al., 2008)
Pre-existing PTSD	Yes	(Garthus-Niegel et al., 2013, Lev-Wiesel et al., 2009, Polachek et al., 2015, Wosu et al., 2015, Alcorn et al., 2010, Ayers et al., 2016)

#### **2.1.2.5. Summary of stage one of the literature review**

Stage one of the literature review comprised a systematic search of existing research literature pertaining to PTSD-PC. The 96 included studies were closely examined to produce an overview of existing knowledge regarding factors that contribute towards the development of PTSD-PC. This first stage highlighted five categories of contributing factors:

1. Subjective childbirth experience.
2. Objective birth interventions.
3. Prior trauma.
4. Demographic factors.
5. Pre-existing factors.

Some of the findings related to categories 2 to 5 were contradictory, and it appears that the perception of the overall childbirth experience mediates the influence of individual factors. While some studies conclude demographic features are insignificant factors, findings are inconsistent alongside a noted paucity of research specifically exploring the impact of a range of demographic factors.

However, category 1: a woman's subjective childbirth experience, was identified as the most important significant factor contributing towards the development of PTSD-PC, especially if the experience was more negative than expected. Within the woman's subjective experience of childbirth, the perceived care quality was frequently highlighted. Interpersonal difficulties were the strongest predictors of PTSD-PC and the quality of care provider interaction (QPI) was significantly correlated with the development of PTSD-PC. The findings that care provider support may mediate the impact of obstetric events further suggest an important role of QPI in the development of PTSD-PC.

#### **2.1.2.6. Rationale and focus for stage two of the literature review**

Attempts have been made to adapt the Ehlers and Clark (2000) PTSD model to suit PTSD-PC (Iles and Pote, 2015, Vossbeck-Elsebusch et al., 2014, Ford et al., 2010) while King et al. (2017) found it was applicable to PTSD-PC. Given the complexity of human individuals, mapping a model of prediction for PTSD-PC is challenging. Nevertheless, the existing models alongside the overview of findings from stage one of this literature

review, show that the development of PTSD-PC depends on a complex interaction between the individual's characteristics and life experience, as well as their experience of the childbirth event, as noted by [Slade \(2006\)](#). Therefore, cognisant of this complexity, my experience as a midwife, as noted above, meant I was keen to explore and address any factor contributing to the development of PTSD that held potential to be modified.

With regard to categories 3 to 5 in section 2.1.2.5., midwives are unable to alter women's social and medical histories, they acknowledge these factors during the provision of care, in particular with respect to women's presenting health conditions and the social care and protection of both mother and child. Midwives do, however, hold a direct role within categories 1 and 2: the subjective and objective childbirth experiences. This echoes the consideration by [Ayers et al. \(2015a\)](#) that the events of pregnancy and/or childbirth hold potential to be altered through appropriate maternity care and support, thereby reducing PTSD-PC incidence.

Considering the key significance of: the woman's subjective experience and interpersonal factors, and association of QPI, in the development of PTSD-PC; the fact that these are potentially modifiable factors; alongside existing calls for further research into QPI ([Simpson and Catling, 2015](#), [Slade, 2006](#), [McKenzie-McHarg et al., 2015](#)); the narrowed focus of stage two of the review was directed towards a critical examination of primary PTSD-PC studies that explored women's subjective experience, in particular QPI.

### **2.1.3. Stage two of the literature review<sup>1</sup>**

#### **2.1.3.1. The aims and questions for stage two of the literature review**

Considering the overview of findings from stage one, and the rationale presented in section 2.1.2.6., the second stage of the literature review critically examined PTSD-PC

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<sup>1</sup> Stage two of the literature review forms the main aspect of this literature review and has been peer-reviewed and published online [PATTERSON, J., HOLLINS MARTIN, C. & KARATZIAS, T. 2018. PTSD post-childbirth: a systematic review of women's and midwives' subjective experiences of care provider interaction. \*Journal Of Reproductive And Infant Psychology\*, 1-28..](#)

studies that had a primary focus on women's subjective childbirth experience, particularly QPI. Given that an interaction is two-sided, this second stage also examined PTSD-PC research that explored QPI from the perspective of midwives. The individual aims and questions for stage two are presented in Box 2.8.

**Box 2.8. The aims and questions of stage two of the literature review**

**The aims of stage two of the literature review**

- To identify primary PTSD-PC studies where the key focus was to examine the woman's subjective childbirth experience, particularly QPI.
- To identify primary PTSD-PC studies where the key focus was to examine the midwife's experience of QPI.
- To assess the quality of the included studies.
- To summarise the findings of the included studies, particularly in terms of QPI.
- Identify an important gap in current knowledge regarding QPI, from which to base the research question for the author's PhD thesis.

**The review questions for stage two of the literature review**

1. Which primary PTSD-PC studies have a key focus on the woman's subjective childbirth experience, particularly QPI?
2. Which primary PTSD-PC studies focus on midwives' experiences of QPI?
3. What is the quality of the included studies?
4. What are the findings of the included studies in terms of women's and midwives' perceptions of QPI during pregnancy and childbirth?
5. Which area of exploration regarding the woman's perception of QPI during pregnancy and childbirth in connection experiencing PTSD-PC requires further research?

N.B. As per the considerations presented in section 2.1., PTSD-PC relates only to PTSD that develops post childbirth in childbearing women, not midwives nor partners.

**2.1.3.2. Inclusion/exclusion criteria for stage two of the literature review**

A further literature search was not required as the overall inclusion/exclusion criteria for stage one of the review remained valid. However, due to a specific focus on primary research exploring women's subjective childbirth experience, particularly QPI, the inclusion/exclusion criteria were narrowed with respect to the features of 'Type of research' and 'Focus of study' as shown in Box 2.9. For completeness, as described in section 2.1.2.2., monitoring for new research that met the full inclusion/exclusion criteria was made via the International Network for Perinatal PTSD Research (INPPR) (INPPR, 2017).



**Box 2.9. Narrowing of inclusion/exclusion criteria for stage two of the literature review**

Feature	Inclusion criteria	Exclusion criteria	Rationale
Type of research	Primary research	Non-primary research	To only examine primary research in this field
Focus of study	Specific focus on either: the subjective childbirth experience, including QPI, of women experiencing PTSD-PC <b>or</b> specific focus on the experience of QPI from the perspective of maternity care providers (in the context of PTSD-PC).	General focus on assessing the prevalence of PTSD-PC or identifying potential factors contributing to PTSD-PC.	To focus on relevant research based on stage two review aims and questions.

**2.1.3.3. Method of quality assessment of studies in stage two of the literature review**

Study quality was assessed using the Critical Appraisal Skills Program (CASP) suitable for appraising both quantitative (cohort study checklist) and qualitative (qualitative study checklist) methodologies (CASP, 2017). The CASP checklists can be viewed in Appendix 2.3. All studies meeting the review inclusion criteria also met the CASP screening criteria (yes on checklist questions 1 and 2) for inclusion. Study quality was based on the answers to checklist questions 3 onwards (Box 2.10.).

**Box 2.10. Quality grading according to answer to CASP checklist questions 3 onwards**

High Quality	Meeting YES on all
Moderate quality	Meeting YES on all, but only partially on some
Moderate quality	Meeting YES on more than half
Low quality	Meeting YES on less than half

**2.1.3.4. Method of narrative synthesis of findings from studies in stage two of the literature review**

The narrative synthesis followed the three steps of the Economic and Social Research Council (ESRC) guidance (Popay et al., 2006). Step one: a preliminary synthesis through tabulation of methods and findings (Table 2.7.). Step two: key findings related to aspects of QPI were identified across all studies. These formed sub themes that were then grouped to form main themes (Figure 2.2). Step three: the robustness of the synthesis is considered through reference to, and discussion of, study quality.

### **2.1.3.5. The findings of stage two of the literature review**

#### **2.1.3.5.1. The 14 studies that met stage two inclusion criteria**

14 studies met stage two inclusion criteria (Figure 2.1. and Box 2.9 above), see Table 2.6.

**Table 2.6. Studies included in Stage two of the review**

Author	Date of publication	Focus of the paper
<a href="#">Allen (1998)</a>	1998	Experience of childbirth
<a href="#">Anderson and McGuinness (2008)</a>	2008	Pilot study, teenage, experience of childbirth
<a href="#">Ayers (2007)</a>	2007	Experience of childbirth
<a href="#">Ballard et al. (1995)</a>	1995	Description of childbirth experience
<a href="#">Beck (2004a)</a>	2004	Experience of childbirth
<a href="#">Cigoli et al. (2006)</a>	2006	Experience of relational factors during childbirth
<a href="#">De Schepper et al. (2015)</a>	2015	Experience of maternity team care factors
<a href="#">Ford and Ayers (2011)</a>	2011	Experience of support during childbirth
<a href="#">Harris and Ayers (2012)</a>	2012	Intrapartum hotspots
<a href="#">Menage (1993)</a>	1993	Experience of obstetric procedures
<a href="#">Nicholls and Ayers (2007)</a>	2007	Experience of both mothers and fathers
<a href="#">Nyberg et al. (2010)</a>	2010	Midwives experience of being with women
<a href="#">Sorenson and Tschetter (2010)</a>	2010	Experience of QPI
<a href="#">Tham et al. (2010)</a>	2010	Experience of support after caesarean section

#### **2.1.3.5.2. Summary of characteristics of the 14 studies**

Table 2.7. presents summary characteristics, findings, and quality assessment of the 14 review studies. Note that the cell headings are consistent with the relevant CASP checklists. Also, the following abbreviations have been used: AN = antenatal; AND = antenatal depression; CS = caesarean section; PC = post childbirth; PTS = post traumatic stress; and SVB = spontaneous vaginal birth. While many studies had a range of findings relating to the subjective experience, only those findings that relate to QPI are presented.

**Table 2.7. Summary characteristics and findings of the reviewed studies**

Author, title, date, location.	Characteristic of participants	Aims and focus of the study	Assessment of PTSD-PC	Methodology and analysis technique	Findings connected with care provider interaction	CASP rating Study value and implications
<p><b>Allen 1998</b> A qualitative analysis of the process, mediating variables and impact of traumatic childbirth.</p>	<p><b>Sample size</b> 20 <b>Selection process</b> Recruitment via health visitor routine check-up 8 months PC. Stage 1: assess level of perceived distress in labour. Stage 2: interview women who found labour extremely distressing. <b>Rationale</b> Recruit larger number of women, including those not only attending due to problems. <b>Drop-outs</b> 223 check-ups, 145 took part in 1<sup>st</sup> stage, 26 met incl. criteria for stage 2, 23 consented, 2 moved away and 1 changed her mind. <b>Ethical Approval</b> Local health district. Info provided and consent obtained.</p>	<p><b>Goal</b> Explore distressing aspects of labour - the subjective experience. <b>Why important</b> Minimal previous work on subjective experience relevant to postnatal psychological state. <b>Relevance</b> Developing knowledge about PTSD-PC.</p>	<p><b>Measure of PTSD</b> States IES-R, but references IES (Horowitz et al., 1979) 8 months PC. 8 with PTSD-PC 6 women score &gt; cut-off 42 and 2 women score borderline =41. Note higher cut-off values than the suggested 33 for IES-R, resulting doubt onto the actual tool used, and the appropriateness of the cut-off values</p>	<p><b>Method</b> Qualitative. <b>Design</b> Grounded Theory. <b>Data collection</b> Semi-structured interviews. Questions developed from pilot study. <b>Collection technique</b> Audio-taped and transcribed. <b>Rationale</b> Qualitative data provide richer more elaborate study of exploring experience. Grounded theory more structured. <b>Analysis</b> Exploratory framework based on Strauss and Corbin paradigm model. Used axial and selective coding. <b>Reflexivity and reflection</b> Not discussed. <b>Saturation</b> Not discussed, fixed sample size.</p>	<p><b>Clear statement of findings</b> Lack of control due to: staff errors, staff panicking or too busy, dismissive, lack of communication, poor pain relief, being ignored, unmet expectations and lack of support. Lack of support also led to feeling isolated and abandoned. Receiving support reduced distress. <b>Consistent with other findings</b> PTSD related to threat of harm. Subjective interpretation influences perception of trauma. Inaccurate expectations may lead to shock. <b>Discussion of findings</b> Findings can be explained in the framework of the psycho-social model of PTSD (Green et al., 1985) <b>Limitations noted</b> Small sample, no comparison between trauma and non-trauma</p>	<p><b>CASP rating</b> High <b>Value of study</b> Adds to growing awareness of PTSD-PC and related complex causes. <b>implications</b> Optimise support, sense of control. Increase provider awareness of PTSD-PC. Take account of PTSD-PC during AN education and need for treatment.</p>
<p><b>UK</b></p>						

**Table 2.7. Summary characteristics and findings of the reviewed studies**

Author, title, date, location.	Characteristic of participants	Aims and focus of the study	Assessment of PTSD-PC	Methodology and analysis technique	Findings connected with care provider interaction	CASP rating Study value and implications
<p><b>Anderson and McGuinness 2008</b> Do Teenage Mothers Experience Childbirth as Traumatic?  USA</p>	<p><b>Sample size</b> 28. Aged 15-19. <b>Selection process</b> Random sample of women previously attending a nursing educational program, spoke English, had a telephone. <b>Rationale</b> Not stated. <b>Drop-outs</b> n/a <b>Ethical approval</b> University board. Info provided and consent obtained – not described.</p>	<p><b>Focus</b> Assess symptoms of PTS and PND. Also measured subjective experience. Small focus on QPI.  <b>Population</b> Teenage, childbearing women.</p>	<p><b>Measure of PTSD</b> IES (Horowitz et al., 1979). Timing not stated but assumed to be at same time as interview - 9 months PC, to coincide with peak time of PTSD. Cut-offs used: 19-25 mild PTS, 26-34 moderate PTS. No one had over 34. EPDS was also used at the same time as the IES.</p>	<p><b>Method</b> Quantitative, Pilot Study. <b>Subjective measure</b> Likert scales. <b>Objective measures</b> Mode of birth (22 SVB, 6 non-specified, non-SVB) <b>Blinding used</b> n/a <b>Data collection</b> Telephone Interview. <b>Confounding factors</b> Does not record history of PTS. <b>Analysis</b> Descriptive summary statistics.</p>	<p><b>Results</b> Fear (28), anxiety (27), midwives kind (23) supportive (26), experience ‘awful’ (worst rating) (4). <b>Application to local population</b> Teenage mothers in this area of USA. <b>Fit with other findings</b> High % of positive perception of midwives, inconsistent with other findings, may be due to particular care of teenage mothers. <b>Discussion of findings</b> Some teenage mothers are vulnerable to PTSD. <b>Limitations noted</b> Lack of knowledge re previous PTS.</p>	<p><b>CASP rating</b> Low <b>Implications for practice</b> For teenage women, assessing previous trauma and providing positive midwife support, and involvement in decision making may reduce psychological sequelae of childbirth.</p>

**Table 2.7. Summary characteristics and findings of the reviewed studies**

Author, title, date, location.	Characteristic of participants	Aims and focus of the study	Assessment of PTSD-PC	Methodology and analysis technique	Findings connected with care provider interaction	CASP rating Study value and implications
<p><b>Ayers 2007</b> Thoughts and Emotions During Traumatic Birth: A Qualitative Study</p> <p><b>UK</b> <b>Ayers 2007 continued</b></p>	<p><b>Sample size</b> 25 with PTSD-PC, 25 without PTSD-PC, matched by obstetric factors.</p> <p><b>Selection process</b> Subsample from longitudinal study</p> <p><b>Rationale</b> PTSD group scored above cut-off of 19 on either scale at 1 and 6 weeks PC.</p> <p><b>Drop-outs</b> PTSD group: 38 met incl., 28 consented, 3 had data recording errors. Non-consenters had more avoidance. Non-PTSD group: no drop outs</p> <p><b>Ethical approval</b> Obtained in original study. No mention of info provided, or consent obtained.</p>	<p><b>Goal</b> Explore non-medical aspects of childbirth experience, thoughts, emotions, memories.</p> <p><b>Why important</b> Lack of previous research.</p> <p><b>Relevance</b> Developing knowledge about PTSD-PC.</p>	<p><b>Measure of PTSD</b> IES (Horowitz et al., 1979) and PSSS (Foa et al., 1993) adapted to reflect childbirth as the traumatic event. Cut-off used was 19 for either scale Assessed at 1 and 6 weeks PC. Did not assess Criterion A of DSM-IV, so referred to women having PTS symptoms rather than PTSD.</p>	<p><b>Method</b> Qualitative.</p> <p><b>Design</b> Not explicit.</p> <p><b>Data collection</b> Face-to-face interview at 3 months PC</p> <p><b>Collection technique</b> Audio recorded and transcribed.</p> <p><b>Rationale</b> Qualitative is most appropriate to understand range of thoughts and emotions.</p> <p><b>Analysis</b> Thematic analysis, coding.</p> <p><b>Reflexivity and reflection</b> Not described specifically, although transcripts were checked by a second researcher.</p>	<p><b>Clear statement of findings</b></p> <p><b>Women with PTS:</b> poor understanding of what was going on, unmet expectations, anger.</p> <p><b>Women with and without PTS:</b> lack choice, panicky, wanting all to stop (more when PTS).</p> <p><b>Women without PTS:</b> unaware of seriousness, upset at staff behaviour or treatment, sense of control, sense of acceptance.</p> <p><b>Consistent with other findings</b> Anger associated with general PTSD.</p> <p><b>Discussion of findings</b> midwives must attend to women’s emotional state during birth to minimise negative emotions and perception of life threat.</p> <p><b>Limitations noted</b> Did not measure criterion A of DSM-IV.</p>	<p><b>CASP rating</b> Moderate</p> <p><b>Value of the research</b> A detailed glimpse into thoughts and emotions of women during childbirth, highlighting some that occur more in women with PTSD.</p> <p><b>Implications</b> midwives being more aware of PTSD and potential signs and provide care to minimise risk.</p>

**Table 2.7. Summary characteristics and findings of the reviewed studies**

Author, title, date, location.	Characteristic of participants	Aims and focus of the study	Assessment of PTSD-PC	Methodology and analysis technique	Findings connected with care provider interaction	CASP rating Study value and implications
<p><b>Ballard et al. 1995</b> Post-Traumatic Stress Disorder (PTSD) after Childbirth</p>	<p><b>Sample size</b> 4 <b>Selection process</b> Convenience sample of case reports for subjects with stress reactions after delivery. <b>Rationale</b> Describe the clinical picture and course of disorder of stress reactions PC. <b>Drop-outs</b> n/a <b>Ethical Approval</b> Not stated.</p>	<p><b>Goal</b> To further explore the link between PTSD and childbirth. <b>Why important</b> Earlier studies suggest a link, which may be a concern. <b>Relevance:</b> An early seminal piece of work, widely referenced in the PTSD-PC literature</p>	<p><b>Measure of PTSD</b> The paper relates the symptom profiles to that of PTSD. No formal assessment tool described.</p>	<p><b>Method</b> Qualitative. <b>Design</b> Case Study. <b>Data Collection</b> Cases arising requiring psychological care. <b>Collection technique</b> Written accounts of individual case histories. <b>Rationale</b> Not given. <b>Analysis</b> Descriptive. <b>Reflexivity and reflection</b> None described.</p>	<p><b>Clear statement of findings</b> All had elements of PTSD. 3 describe being left alone, unsupported, lack of pain relief. 1, with objectively good outcome, describes being ignored, dismissed, overruled by punitive midwives, whilst lacking confidence in midwives' knowledge. 2 expressed anger and rage towards midwives. <b>Consistent with other findings</b> Ground breaking early study, consistent with other early observations and studies. <b>Discussion of findings</b> Confirms lack of control a consistently important feature. <b>Limitations noted</b> Small sample</p>	<p><b>CASP rating</b> Low <b>Value of the research</b> Confirms further a link between PTSD and childbirth, prompting need for further research. <b>Implications</b> Suggests prompt apology after adverse events might avert some incidence.</p>

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<p><b>Beck 2004</b> Birth Trauma In the Eye of the Beholder</p> <p><b>New Zealand</b> (n=23), <b>USA</b> (n=8), <b>Australia</b> (n=6), <b>UK</b> (n=3).</p>	<p><b>Sample size</b> 40. <b>Selection process</b> Purposive sample of women who perceived they had experienced birth trauma. Length of time since traumatic birth 5 weeks to 14 years. <b>Rationale</b> Gain perspective from those who had experienced the phenomena being studied. <b>Drop-outs</b> n/a <b>Ethical Approval</b> University review board. Participant Info provided and consent received</p>	<p><b>Goal</b> Explore essential structure of women's experience of birth trauma. <b>Why important</b> Growing knowledge of PTSD-PC, need to understand features of totality of subjective experience of childbirth. <b>Relevance</b> Developing knowledge re PTSD-PC.</p>	<p><b>Measure of PTSD</b> Not specified. Women self-stated birth was traumatic. Study states 32/40 had diagnosis of PTSD and 8 had PTS symptoms but had not yet sought mental healthcare. No details re means of diagnosis.</p>	<p><b>Method</b> Qualitative. <b>Design</b> Descriptive Phenomenology. <b>Data collection</b> Women submitted, written birth stories. <b>Collection technique</b> Via internet or post. <b>Rationale</b> Exploring experience. <b>Analysis</b> Colaizzi's thematic analysis (1978) (Colaizzi, 1978). <b>Reflexivity and reflection</b> Husserl's bracketing referenced, but not made explicit re use in the study</p>	<p><b>Clear statement of findings</b> Feeling abandoned and alone, stripped of dignity, lack of consent, felt like a battlefield. Midwife uninterested, being ignored, dismissed. Lack of support - especially when fearful. Lack of midwife communication with women and other midwives. Perception of unsafe care led to fear, powerlessness and shattered expectations of safe care. Being uninformed led to lack of trust in midwife. Words used about care: mechanical, arrogant, cold, technical, raped. <b>Consistent with other findings</b> Consistent with other findings re types of birth trauma. <b>Discussion of findings</b> n/a.</p>	<p><b>CASP rating</b> Moderate <b>Value of the research</b> Increases understanding of subjective experience. <b>Implications</b> need good history taking re birth trauma, enhance sense of control, address unmet expectations, be alert to early signs of trauma. Treat all women as though a survivor of trauma.</p>

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<p><b>Cigoli et al. 2006</b> Relational factors in psycho-pathological responses to childbirth</p>	<p><b>Sample size</b> 160 recruited sequentially. <b>Sample represents defined population</b> Yes, pregnant women in late pregnancy or new mothers. <b>Drop-outs</b> Sequential process, meant no drop-outs, 160 returned the questionnaires with at least 75% completed. <b>Ethical Approval</b> States process of providing information re the study and gaining consent. But source of ethical approval not specified.</p>	<p><b>Focus</b> To examine how support relates to stress symptoms of PTSD. <b>Population</b> Age over 18, at least 39 weeks pregnant, or have had healthy baby, and have no psychiatric diagnosis.</p>	<p><b>Measure of PTSD</b> PTSD-Q (Czarnocka and Slade, 2000) adapted to reflect childbirth as the traumatic event, at 48 hours and 3-6 months PC, used to categorise into two groups. Also BDI, EFS, STAI, Perceived Desire and Support Scale (PDSS).</p>	<p><b>Method</b> Observational study, selected cohort, mixed methods comparing 2 groups. Non-risk (no PTSD) n=112, risk group (partial, n=46 or full PTSD, n=2). <b>Subjective measures</b> Subjective assessment scales. Article states there is an interview, but interview data not presented in this paper or referenced. <b>Objective measures</b> Demographics using Anamnestic Schedule. <b>Blinding used</b> n/a. <b>Data collection</b> Survey and semi-structured interview <b>Confounding factors</b> Not discussed. <b>Analysis</b> Correlation statistics, Mann-Whitney and Rho of spearman. Comparisons using t-test. No details re analysis of interviews</p>	<p><b>Results</b> Only quantitative results presented, discussed. Factors which contribute significantly to PTSD-PC: Unmet desired support from midwife. However, perceived support from midwife is not significant. NB only 2 participants had clinically significant PTSD, 46 had varying levels of PTS symptoms, 112 had no symptoms. <b>Application to local population</b> Yes, local childbearing women. <b>Fit with other findings</b> Yes, in terms of support being important. <b>Discussion of findings</b> PTSD is a complex situation, but higher scores are associated with stronger desire for support, often then perceived as not being met. <b>Limitations observed</b> Finding re support and PTSD, are only small part of the study.</p>	<p><b>CASP rating</b> Moderate <b>Implications for practice</b> Effective social interventions, need targeted consultation at end of pregnancy and early parenthood with both mother and her potential support network.</p>



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<p><b>De Schepper et al. 2015</b> Post-Traumatic Stress Disorder after childbirth and the influence of maternity team care during labour and birth: A cohort study  <b>Belgium</b></p>	<p><b>Sample size</b> 340 women in first week 229 women at 6 weeks. <b>Sample represents defined population</b> Yes, random sample from across 13 maternity postnatal wards. <b>Drop-outs</b> 420 invited, 340 agreed to first phase and of these 229 agreed to the second phase. The cohort of 340 and the cohort of 229 were similar demographically and in terms of PTSD. <b>Ethical Approval</b> Antwerp University Hospital. Info provided and consent obtained.</p>	<p><b>Focus</b> Main focus is role of midwifery team care factors, also examines Prevalence of PTSD and personal and obstetric factors. AIM to inform midwives about PTSD as a possible postpartum complication. <b>Population</b> Age &gt; 18, Dutch Speaking. Excluded stillbirth, pre-term &lt;24 weeks and intrapartum psychosis.</p>	<p><b>Measure of PTSD</b> At 1 week (day1-4) and 6 weeks IES-R (Weiss and Marmar, 1997) (cut-off = 24) and the TES (Wijma et al., 1997) Designed for general PTSD (cut-off is not specified). PTSD assessment questionnaires completed a few days after birth and at 6 weeks, via telephone call or email</p>	<p><b>Method</b> Quantitative Prospective Cohort study. <b>Subjective measures</b> Likert scales MW team care for perception of fear, experience of birth, care received, admission process, level of info, freedom to ask questions, trust &amp; respect for midwife, support, reassurance, respect, locus of control, perception of team being in control, involved in birth process. <b>Objective measures</b> Demographics, mode of birth, complications, medical and obstetric history. <b>Blinding used</b> n/a <b>Data collection</b> Few days after birth: Questionnaire- Demographics, medical/obstetric history and midwifery team care. <b>Confounding factors</b> Accounted for in focus. <b>Analysis</b> Descriptive, t-tests, one-way ANOVAs, X<sup>2</sup> tests, Mann Whitney U, Spearman rank, multiple linear regression, and logistic regression</p>	<p><b>Results</b> 6 weeks, factors which contribute significantly to lower PTSD-PC: perception of midwife being in control, free to ask questions. <b>Application to local population</b> Good sample size representing a balanced snapshot of Belgian childbearing women. <b>Fit with other findings</b> Aligns with other findings; importance of internal locus of control by being able to ask questions. <b>Discussion of findings</b> Rate of PTS symptoms reduced between 1 and 6 weeks. PTSD at 6 weeks 0% (IES-R) and 4% (TES). Being able to ask questions is protective of PTSD as 6 weeks. <b>Limitations</b> Data collected at 6 weeks, PTSD symptoms may decline by 3 months. Different scores on IES-R and TES, possibly TES takes account of more DSM-IV criteria. Telephone/email data collection may bias results. Excluding women with language barrier, may underestimate PTSD.</p>	<p><b>CASP rating</b> High <b>Implications for practice</b> First assessment of MW team care factors. Can be influenced by MW. Calls for research into QPI. Highlight PTSD-PC to MW and medical students. MWs need to be aware of the impact of care provision on woman's wellbeing. Take caution with interventions to let the women be in control as much as possible.</p>

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<p><b>Ford and Ayers 2011</b> Support during birth interacts with prior trauma and birth intervention to predict postnatal post-traumatic stress symptoms</p> <p><b>UK</b></p>	<p><b>Sample size</b> 138  <b>Sample represents defined population</b> Recruited from UK NHS Maternity units.  <b>Drop-outs</b> 215 recruited, 138 completed at least one questionnaire: at 33-37 weeks pregnant (136); at 3 weeks PC (125); at 3 months PC (109). Only demographic difference between responders and non-responders was responders had fewer children.  <b>Ethical approval</b> University research governance committee and NHS local research ethics committee. No mention of info given or consent obtained</p>	<p><b>Focus</b> Role of midwife support and personal control during birth as predictors of PTSD-PC whilst controlling for prior trauma, antenatal depression (AND), self-efficacy, external locus of control and interventions.  <b>Rationale</b> Lack of research into midwife role in PTSD-PC.  <b>Population</b> Age&gt;18, 33-37wks pregnant, able to understand questionnaires.</p>	<p><b>Measure of PTSD</b> PTSD diagnostic scale (PDS) (Foa et al., 1997) adapted for postnatal women, at 3 weeks and 3 months PC.  <b>Other scales used</b> EPDS, MHLC scale, SES, IIS, SCIB.</p>	<p><b>Method</b> Quantitative Cohort  Prospective longitudinal study  <b>Subjective measures</b> Various scales as listed in previous column  <b>Objective measures</b> Demographics, prior trauma and birth interventions.  <b>Blinding used</b> n/a.  <b>Confounding factors</b> Accounted for in focus.  <b>Analysis</b> Correlations (statistic not identified). Hierarchical multiple regressions.</p>	<p><b>Results</b> Factors which contribute significantly to PTSD-PC: Low midwife support in women with prior trauma, or average, or above average level of birth interventions. Significant correlations: midwife support &amp; internal locus of control; midwife support &amp; external locus of control; midwife support &amp; PTSD.  <b>Application to local population</b> findings not generalisable to local population.  <b>Fit with other findings</b> other findings: control related to interpersonal e.g. midwife support (Green and Baston, 2003).  <b>Discussion of findings</b> Prioritise support rather than control  <b>Limitations observed</b> High attrition rate. Low power, although sample size appropriate to find a difference. Unknown if correlation between midwife support and external control is due to bias or nature of challenging conditions</p>	<p><b>CASP rating</b> High  <b>Implications for practice</b> Calls for one-to-one supportive care being necessary to maximise positive psychological outcomes for women.</p>

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<p><b>Harris and Ayers 2012</b> What makes labour and birth traumatic? A survey of intrapartum 'hotspots'  <b>UK</b></p>	<p><b>Sample size</b> Purposive recruitment via internet support groups n=675. <b>Sample represents defined population</b> Childbearing women in UK. <b>Drop-outs</b> 699 recruited 24 excluded due to substantial missing data. <b>Ethical Approval</b> University research ethics committee. No mention of info given or consent obtained.</p>	<p><b>Focus</b> Identifying frequency of hotspots, content of hotspots, cognitions and emotions during hotspots, and PTSD symptoms in women with traumatic birth experiences. <b>Population</b> Age &gt; 18, had given birth, can read/write English fluently.</p>	<p><b>Measure of PTSD</b> PTSD diagnostic scale (PDS) (Foa et al., 1997) adapted for postnatal women. Assessed at least 1 month PC. <b>Other measures</b> Cognitions and emotions during hotspots were measured using the 'Initial reactions' sub-scale of the 'Potential Stressful Events Interview' (adapted) (Resnick et al 1996).</p>	<p><b>Method</b> Quantitative cross-sectional internet survey. <b>Subjective measure</b> Hotspots, questionnaire based on previous studies. Identifying hotspots of emotional distress in the trauma. Description of worst hotspot. <b>Objective measures</b> Mode of birth, parity, previous traumatic events, and time since birth. <b>Blinding used</b> n/a <b>Data collection</b> Online questionnaires. <b>Confounding factors</b> A range built into the regression models. <b>Analysis</b> Coding the description of the worst hotspots according to most prominent theme, based on coding schedule developed by the authors in a pilot study. Principal components analysis. Non-parametric tests (Kruskal-Wallis, Chi Square). Backward stepwise logistic regression.</p>	<p><b>Results</b> 3 categories of worst hotspot: interpersonal difficulties (INT), obstetric compl (OBS), and neonatal compl (NEO). INT most freq content of worst hotspot: being ignored, lack of support, poor communication, (abandoned, under pressure), sig higher no. cases PTSD, sig distress, sig impairment, total symptoms, anger and conflict. INT gave 4x risk PTSD vs NEO. OBS gave 3x risk of PTSD vs NEO. <b>Application to local population</b> Mainly white women, not easy to generalise. <b>Fit with other findings</b> Only hotspot study. Findings; INT and lack support, consistent with previous findings in PTSD-PC &amp; general PTSD. <b>Discussion of findings</b> suggests hotspots involve emotions / cognitions beyond DSM diagnostic criteria: Anger, failure, and negative effect (sadness and guilt). <b>Limitations</b> Retrospective design may make recall less accurate. Internet sampling, allows larger sample, but may limit range of postnatal women taking part.</p>	<p><b>CASP rating</b> High <b>Implications for practice</b> Significance of interpersonal factors suggests reassurance, support, identifying and dealing with interpersonal difficulties, may prevent birth being experienced as traumatic. Future research needed around dissociation.</p>

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<p><b>Menage 1993</b> Post-traumatic stress disorder in women who have undergone obstetric and/or gynaecological procedures: A consecutive series of 30 cases of PTSD  <b>UK</b></p>	<p><b>Sample size</b> 30 <b>Sample represents defined population</b> Advertising for women volunteers. Research was described as investigating psychological stress caused by smear tests and vaginal examinations. Volunteers were age 18-60. <b>Drop-outs</b> 500 volunteered, 102 had a history which fulfilled criterion A of DSM-III-R, 30 fulfilled full PTSD criteria. <b>Ethical approval</b> Not specified</p>	<p><b>Focus</b> Investigate whether the psychological stress caused by obstetric or gynaecological examinations could lead to PTSD.  <b>Population</b> Women volunteers predominately from across UK.</p>	<p><b>Measure of PTSD</b> PTSD Interview PTSD-I (Watson et al., 1991) designed for general PTSD</p>	<p><b>Method</b> Mixed <b>Subjective measures</b> Perception of obstetrical or gynaecological experience using response scales. Women were also asked to relate their experience. <b>Objective measures</b> Demographic measures. For the 30 women with PTSD, history of previous trauma. <b>Blinding used</b> n/a <b>Confounding factors</b> Previous trauma was included, but no measure of previous PTSD. <b>Analysis</b> Descriptive statistics, 2-way mixed ANOVA.</p>	<p><b>Results:</b> Factors significantly contributing to PTSD-PC: hostile doctor attitude, powerlessness, being ignored, adequacy of info given, lack of consent. <b>Words used by women:</b> Dehumanizing, degrading, distressing, dismissed, ignored, invaded, violated, brutal, excruciating, mutilated, held down, shouted at, humiliated, abused, terrifying, rape. <b>Application to local population</b> Limited to readership of advertising publications, a self-selected group, likely recognised stress in themselves. <b>Fit with other findings</b> Confirms other findings, especially re subjective experience. <b>Discussion of findings</b> Particularly important for women with previous sexual abuse, which may be undisclosed or repressed. <b>Limitations</b> Does not address other psychological issues.</p>	<p><b>CASP rating</b> Moderate <b>Implications for practice</b> Medical profession to be aware that women need to be listened to more carefully, to determine their needs and perceptions, and to be mindful that there could be a history of sexual abuse. Medico-legal implications following trauma.</p>

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<p><b>Nicholls and Ayers 2007</b> Childbirth-related post-traumatic stress disorder in couples: A qualitative study</p>	<p><b>Sample size</b> 6 couples: 5 women and 3 men with PTSD-PC, 1 woman and 3 men without PTSD-PC. Time since birth event, 9 months to 2 years. <b>Selection process</b> Age &gt;18, read/speak English fluently, one member of couple had to have experienced traumatic birth &gt; 3 months ago, and one had to fulfil DSM-IV criteria for PTSD. Both had to be willing to be interviewed. <b>Rationale</b> Explore experience of both partners re-experience of PTSD-PC and traumatic birth. <b>Drop-outs</b> 9 couples met incl. criteria, 6 consented. 3 partners did not consent. <b>Ethical Approval</b> Sussex university. Info provided, consent obtained.</p>	<p><b>Goal</b> Exploring subjective experience of PTSD-PC in couples, but also explored experience of women and their partners during birth. <b>Why important</b> Need to extend knowledge re aetiology of PTSD-PC, the effect on women, men and parent-infant attachment <b>Relevance</b> Developing knowledge re couples' perspectives on traumatic birth/PTSD-PC.</p>	<p><b>Measure of PTSD</b> PTSD diagnostic scale (PDS) (Foa et al., 1997) adapted for postnatal women.</p>	<p><b>Method</b> Qualitative <b>Design</b> Phenomenological <b>Data collection</b> Semi-structured interviews using 14 open questions. <b>Collection technique</b> Not explicit about whether hand or audio recorded. Transcribed. <b>Rationale</b> Exploring experience. <b>Analysis</b> Thematic analysis per individual. <b>Reflexivity and reflection</b> Not explicit, although independent coding by a 3<sup>rd</sup> researcher.</p>	<p><b>Clear statement of findings</b> 'Quality of care' (especially midwife attitude, information, environment) emerged as a major theme. Others were birth factors (pain, lack of choice, control, decision making, being restrained), perceived effect on relationship with partner/child. <b>Consistent with other findings</b> Lack of: control, communication, information, decision making. <b>Discussion of findings</b> Men reported more shock and helplessness. Women reported more fear, confusion, violation, dehumanisation, and anger. Authors highlight the emergence of 'quality of care' as a factor, which had not been asked about in the interview. Men and women differed in where they placed importance. <b>Limitations</b> No measure of pre-existing psychopathology and retrospective approach. Small sample, self-selected. Those who dropped out may have had more interpersonal difficulties.</p>	<p><b>CASP rating</b> Moderate <b>Value of the research</b> Quality of care as major theme was particularly important as not specifically asked about yet was important for all participants. <b>Implications</b> Need to increase midwife awareness of PTSD and contributing practices. Acknowledge and include partners, recognise risk of dissociation. Include partners in screening for PTSD, and consider families.</p>

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<p><b>Nyberg et al. 2010</b> Midwives' experience of encountering women with posttraumatic stress symptoms after childbirth</p> <p><b>Sweden</b></p>	<p><b>Sample size</b> 8</p> <p><b>Selection process</b> Midwives working in specialised clinics for women with PTS symptoms post childbirth.</p> <p><b>Rationale</b> purposive sampling in one council area</p> <p><b>Drop-outs</b> 15 invited, 8 consented and completed the interviews.</p> <p><b>Ethical approval</b> Permission from the heads of the county's councils responsible for the clinics. Ethics group at the dept. of health sciences, Luleå University of Technology. Info provided, consent sought.</p>	<p><b>Goal</b> Exploring midwives' experiences of encountering women with post traumatic stress symptoms after birth.</p> <p><b>Why important</b> The only study to explore midwives experience of relating to women with PTSD-PC.</p> <p><b>Relevance</b> Provides the midwives perspective, albeit in the postnatal period.</p>	<p><b>Measure of PTSD</b> No measure of PTSD. Women attending clinics had been diagnosed with PTSD-PC.</p>	<p><b>Method</b> Qualitative</p> <p><b>Design</b> Phenomenological</p> <p><b>Data collection</b> Semi-structured interviews.</p> <p><b>Collection technique</b> Audio recorded and transcribed verbatim.</p> <p><b>Rationale</b> Describe experience.</p> <p><b>Analysis</b> Thematic content analysis.</p> <p><b>Reflexivity and reflection</b> Not explicit, although all texts were read and coded a second time to check for appropriateness.</p>	<p><b>Clear statement of findings</b> Midwives highlight major themes: meeting women with severe or frightening experiences, childbirth affected women's lives, need to listen to and respond to women, be gentle with words, storytelling creates confirmation, enable women to express feelings, support women to give birth, lost confidence in giving birth, caesarean section does not solve problems. Some women had PTSD-PC after objectively normal childbirth. Women described: lack of control and respect, not being involved in decision making, and unmet expectations.</p> <p><b>Discussion of findings</b> Midwives highlight need to reflect on their own attitude and use gentleness. Midwives desire access to mentoring and referral options for women.</p> <p><b>Limitations</b> Small sample, but rich data. May need to explore from the women's perspective.</p>	<p><b>CASP rating</b> Moderate</p> <p><b>Value of the research</b> Women's needs to be respected and listened to seems to be one of the most important healthcare issues.</p> <p><b>Implications</b> Need to raise quality of care for women with childbirth fear, support women to feel safe, well informed/involved. Midwives should know women's wishes. Need to develop further midwifery interventions to meet the needs of women with PTSD-PC.</p>

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<p><b>Sorenson and Tschetter 2010</b> Prevalence of Negative Birth Perception, Disaffirmation, Perinatal Trauma Symptoms, and Depression Among Postpartum Women</p> <p><b>USA</b></p>	<p><b>Sample size</b> 71 <b>Sample represents defined population</b> Women identified from archive of birth announcements in local paper, and who had current entry in local phone directory. <b>Drop-outs</b> 134 invited, 95 consented, 71 returned questionnaires <b>Ethical approval</b> Not specified</p>	<p><b>Focus</b> Explore relationship between PTS symptoms, negative birth perception and QPI <b>Population</b> Women 6 months postpartum, who had recently given birthed locally.</p>	<p><b>Measure of PTSD</b> Post traumatic childbirth stress inventory (PTCS) (Sorenson, 2003) (DSM-IV) <b>Other measures</b> Birth Perception Rating scale (BPRS), Quality of provider interaction inventory (QPI-I) Beck depression inventory II (BDI-II)</p>	<p><b>Method</b> Quantitative. <b>Subjective measures</b> Perception of birth experience, quality of provider interaction <b>Objective measures</b> Demographic data. <b>Blinding used</b> n/a <b>Confounding factors Analysis.</b> Prior trauma or psychiatric wellbeing not assessed.</p>	<p><b>Results:</b> Significant Correlations: QPI &amp; PTS. QPI &amp; birth perception. Birth perception &amp; PTS. Provider affirmation more frequent than disaffirmation 15/21 affirm, 6/21 disaffirm <b>Application to local population</b> Sample mostly white and in stable relationships. <b>Fit with other findings</b> Theory of relationship between QPI and psychological status (Peplau, 1953). <b>Discussion of findings</b> QPI significantly correlated with PTS. QPI modifiable by midwife, whereas unmodifiable factors such as age, parity, mode of birth are not associated with PTS (statistics not provided). <b>Limitations</b> Sampling method may not allow accurate prevalence estimates. Correlations do not imply causal relationships.</p>	<p><b>CASP rating</b> Moderate <b>Implications for practice</b> Raised questions: level of monitoring &amp; enforcement of MIDWIFE ethic conduct. Poor QPI more readily tolerated than poor technical skills. Reinforce need for psychiatric liaison advanced practice nurses to support midwives to assess and interact with women appropriately. Reassuring that provider affirmation was more common than disaffirmation.</p>

**Table 2.7. Summary characteristics and findings of the reviewed studies**

Author, title, date, location.	Characteristic of participants	Aims and focus of the study	Assessment of PTSD-PC	Methodology and analysis technique	Findings connected with care provider interaction	CASP rating Study value and implications
<p><b>Tham et al. 2010</b> Experience of support among mothers with and without post-traumatic stress symptoms following emergency caesarean section</p> <p><b>Sweden</b></p>	<p><b>Sample size</b> 42 women with PTSS, 42 women without PTSS, 6 months PC (note the authors refer to Post traumatic stress symptoms not full PTSD). <b>Selection process</b> Healthy women, Swedish or English speaking, delivered between 37-42 weeks, planned SVB. <b>Rationale</b> not specified <b>Drop-outs</b> 148 who met criteria were invited, 19 declined, 4 dropped out, 3 moved abroad.122 enrolled. <b>Ethical issues addressed</b> Local research ethics committee at Karolinska Institute, Stockholm. Info provided and consent obtained.</p>	<p><b>Goal</b> Experience of support amongst mothers with and without PTSD following Emergency Caesarean section (EMCS). <b>Why important</b> Understanding difference in experience between women with and without PTSD-PC following EMCS. <b>Relevance</b> Explores birth experience in relations to PTSD-PC.</p>	<p><b>Measure of PTSD</b> IES (Horowitz et al., 1979) to measure PTSD. 2 groups, no symptoms of PTSD and at least moderate symptoms of PTSD, using cut-off 19/20 points. <b>Other measure made</b> SoC scales completed at 2-3 days PC, reported in parent longitudinal study.</p>	<p><b>Method</b> Qualitative. <b>Design</b> Secondary analysis of 84 women from a longitudinal study. <b>Data collection</b> PTSD assessed at 3 months PC. <b>Collection technique</b> Telephone Semi-structured interview at 6-7 months PC. Interviews based on a questionnaire plus supplementary questions to understand experience. Hand recorded then transcribed. <b>Rationale</b> To explore lived experience. <b>Analysis</b> Content analysis. <b>Reflexivity and reflection</b> Interviewer did not know women's PTSS status at time of interview. Authors analysed texts separately until consensus was reached.</p>	<p><b>Clear statement of findings</b> No figures shown. States majority women found midwife kind/supportive, contradicts findings: <b>Women with PTS:</b> several found midwife nervous; &gt; ½ found midwife disinterested, lack support, communication; many felt lack of info, lack involvement in decisions, lack postpartum follow up (About ½ saw MW at 3 months); ⅓ experienced fear. <b>Women without PTS:</b> few found midwife uninterested or unsupportive. Almost all saw midwife at 3 months. <b>New mums:</b> majority: lack info. ⅓ each group: lack continuity. All desire counselling, only those with obj trauma, received this. <b>Discussion of findings</b> Midwives actions important, query worse care or women with PTS more sensitive, due to anxiety or history. <b>Limitations</b> Phone Interviews lack visual contact. Hand recording possible inaccuracy. No record of prior trauma or history of PTSD.</p>	<p><b>CASP rating</b> Moderate <b>Value of research</b> Highlights importance of midwife's actions/inactions. <b>Implications</b> Treat all women as if vulnerable to trauma. Midwives have important support roles during EMCS. Suggest follow up women at risk of PTSD-PC. Midwives must recognise women who may be angry/feel staff are to blame/feel shame, offering them an open discussion.</p>



#### 2.1.3.5.3. The foci of the 14 studies

Within the wider PTSD-PC literature, few studies focussed on QPI. Two review studies had a primary focus close to QPI, for others QPI emerged as a feature of women's subjective childbirth experiences. All review studies refer predominately to midwives as the maternity care providers, and so the findings refer to midwives throughout. [Nyberg et al. \(2010\)](#) was the only study identified that looked at midwives' experiences of interacting with women within the context of PTSD-PC, and this occurred during a postnatal clinic. The midwives do not directly describe their experience of interacting during childbirth, however they provide their reflections on women's perception of QPI during childbirth. This study was included to enable review of all sources of research examining the perception of QPI in the context of PTSD-PC.

#### 2.1.3.5.4. The quality of the 14 studies with regard to their chosen methodology

Study methodologies were appropriate for each study design, with the following considerations. The use of grounded theory by one study was potentially appropriate due to limited existing research into factors contributing to PTSD-PC ([Allen, 1998](#)), but the fixed sample did not reflect theoretical sampling to determine data saturation ([Charmaz, 2006](#)). Reflexivity ([Berger, 2015](#), [Finlay, 2008](#)) was acknowledged by two studies, addressed by one ([Tham et al., 2010](#)), but not the other ([Ballard et al., 1995](#)). Three papers acknowledged and addressed the need for reliability ([Ayers, 2007](#), [Nicholls and Ayers, 2007](#), [Nyberg et al., 2010](#)). Four quantitative studies built appropriate confounding variables into their statistical models ([De Schepper et al., 2015](#), [Ford and Ayers, 2011](#), [Menage, 1993](#)), but four did not discuss pre-existing confounding variables ([Anderson and McGuinness, 2008](#), [Cigoli et al., 2006](#), [Harris and Ayers, 2012](#), [Sorenson and Tschetter, 2010](#)), although two acknowledged lack of inclusion of a history of PTS ([Anderson and McGuinness, 2008](#), [Menage, 1993](#)).

#### 2.1.3.5.5. The CASP quality assessment of the 14 studies

The quality assessment of each study based on the CASP checklists (Appendix 2.3) and using the characteristics described in Table 2.7. is detailed in Appendix 2.4. and summarised in Table 2.8.

**Table 2.8. CASP rating awarded to the 14 studies**

High quality	(Allen, 1998, De Schepper et al., 2015, Ford and Ayers, 2011, Harris and Ayers, 2012)
Moderate quality	(Ayers, 2007, Beck, 2004a, Cigoli et al., 2006, Menage, 1993, Nicholls and Ayers, 2007, Nyberg et al., 2010, Sorenson and Tschetter, 2010, Tham et al., 2010)
Low quality	(Anderson and McGuinness, 2008, Ballard et al., 1995)

The review studies claimed inclusion of women experiencing PTSD-PC, so it was important to reflect on PTSD-PC assessment. Two studies did not specify the PTSD-PC assessment method. Of these the frequently cited, seminal study by [Ballard et al. \(1995\)](#), was potentially biased because it contained only 4 case studies, while the internet-based story collecting design weakened the quality of the valuable study by [Beck \(2004a\)](#). The remaining studies based PTSD-PC assessment on DSM-III or DSM-IV criteria but utilised a variety of tools and measurement cut-off levels. Five studies used the Impact of Event Scale, which is not supported as a diagnostic tool for PTSD ([Motlagh, 2010](#)). Only one study ([Cigoli et al., 2006](#)) referenced reliability of their scale in a birth trauma context, rather than general PTSD. [Ayers \(2007\)](#) used two validated scales, but failed to measure criterion A, so their PTSD-PC diagnosis did not fulfil DSM criteria. [Allen \(1998\)](#) provided a thorough qualitative exploration of women's experiences, but their unusually high cut-off value for significant PTSD-PC symptoms created uncertainty regarding the PTSD-PC level. [Tham et al. \(2010\)](#) hand recorded interviews, provided imprecise and contradictory presentation of results, and failed to provide actual frequencies on which statements were based. [Anderson and McGuinness \(2008\)](#) provided limited details about PTSD-PC levels. Within three studies, retrospective recall may have been an issue as for some participants it was up to 10 ([Nicholls and Ayers, 2007](#)), 14 ([Beck, 2004a](#)) and 47 ([Harris and Ayers, 2012](#)) years since the childbirth event.

#### 2.1.3.5.6. The Narrative synthesis of findings of the 14 studies

##### *2.1.3.5.6.1. Key findings*

In keeping with the findings from [Garthus-Niegel et al. \(2013\)](#) that a woman's subjective experience of childbirth, is the most important factor to predispose PTSD-

PC, other high-quality studies identified women's subjective experiences of care to be significant (De Schepper et al., 2015, Ford and Ayers, 2011). A moderate quality study identified QPI to be significantly correlated with PTSD-PC (Sorenson and Tschetter, 2010) and high-quality studies found the following features of QPI within women's subjective experiences were the strongest predictors for developing PTSD-PC: (1) *interpersonal difficulties*, such as being ignored. Interpersonal difficulties and obstetric complications were respectively four and three times more likely to predict PTSD-PC, than neonatal complications (Harris and Ayers, 2012); (2) *midwifery care factors*, such as control and communication (De Schepper et al., 2015); and (3) *lack of support* (Ford and Ayers, 2011). In keeping with the planned method of synthesis, the sub themes within these key features were collated into four main theme groups, although some sub themes overlap: 1) attitude of the midwife, 2) communication, information and decision making, 3) support, and 4) control and confidence in midwives (Figure 2.2).

#### 2.1.3.5.6.2. Attitude of the midwife

Experiencing the midwife's interaction as disaffirming significantly correlated with PTSD-PC (Sorenson and Tschetter, 2010). The attitude of the midwife was important (Nicholls and Ayers, 2007, Nyberg et al., 2010) with lack of respect (Nyberg et al., 2010), being *humiliated* (Menage, 1993, Nicholls and Ayers, 2007), being *dismissed* (Allen, 1998, Ballard et al., 1995, Beck, 2004a, Menage, 1993), and the midwife being *disinterested* (Tham et al., 2010) reported. The midwife's attitude and degree to which women's views were respected were significant (Menage, 1993). Women described QPI using words such as: *dehumanising* (Nicholls and Ayers, 2007), *degrading* (Menage, 1993), or *betraying trust* (Beck, 2004a). Some women expressed feeling *violated or raped* (Beck, 2004a, Menage, 1993), alongside being physically restrained or having movement restricted (Nicholls and Ayers, 2007).

*"I was trying to cover my bottom by holding the gown, and a nurse took my hands from the gown. So, I felt raped and my dignity was taken from me"*

(Beck, 2004a)

Being ignored was frequently identified (Allen, 1998, Ballard et al., 1995, Beck, 2004a, Nicholls and Ayers, 2007) and significant (Menage, 1993), and was the most frequent subcategory in the hotspot of *interpersonal difficulties* (Harris and Ayers, 2012)

accounting for 30% of the thematic content. Three studies found that only women experiencing PTSD-PC expressed anger or aggressiveness at their treatment by midwives (Ayers, 2007, Ballard et al., 1995, Beck, 2004a) with anger being significantly more likely as a result of interpersonal factors than other factors (Harris and Ayers, 2012). Two studies reported that the majority of women found midwives to be *kind and supportive* (Anderson and McGuinness, 2008) or *nice and friendly* (Tham et al., 2010). However, Tham et al. (2010) contradict themselves by reporting that more than half the women described midwives as uninterested, providing insufficient support, and limited in their communication. Within interpersonal difficulties, midwifery care factors, particularly communication and support, were highlighted features (Harris and Ayers, 2012).

#### 2.1.3.5.6.3. *Communication, information and decision making*

Not coping or having a low sense of coherence was highlighted as important, augmented by a poor understanding of what is happening and receiving poor information (Ayers, 2007, Nicholls and Ayers, 2007, Nyberg et al., 2010), with poor information being a significant factor (Menage, 1993). For women experiencing PTSD-PC, *having a poor understanding of what is going on* related to how things were done or communicated (Ayers, 2007).

*“I didn’t really understand what they were doing”* (Ayers, 2007)

Some women felt midwives had poor communication skills (Harris and Ayers, 2012, Nicholls and Ayers, 2007) or neglected to communicate with them (Beck, 2004a, Tham et al., 2010). Many women felt they were not involved in decision making or lacked choice (Nicholls and Ayers, 2007, Nyberg et al., 2010). This lack of communication extended to whether consent was obtained (Beck, 2004a), which was a significant factor (Menage, 1993). Being able to ask questions lessened PTSD-PC symptoms, even when demographics, prior trauma, and obstetric history were accounted for (De Schepper et al., 2015).

#### 2.1.3.5.6.4. *Support*

Lack of support significantly correlated with PTSD-PC, being particularly predictive of PTSD-PC in women with prior trauma or who received birth interventions, even when

mental health issues were accounted for (Ford and Ayers, 2011). Lack of support led to feeling *alone* (Ballard et al., 1995), *isolated* (Allen, 1998), *abandoned* (Allen, 1998, Beck, 2004a, Harris and Ayers, 2012, Nicholls and Ayers, 2007, Nyberg et al., 2010), or out of control (Allen, 1998), but may only be a factor for women with high anxiety (Cigoli et al., 2006).

*“I just felt really abandoned and alone...I felt really unsafe with those midwives because I knew if I had a haemorrhage in that bed and I pressed the emergency buzzer and they would ignore me”* (Nicholls and Ayers, 2007)

An unmet desire for support from midwives significantly contributed towards developing PTSD-PC (Cigoli et al., 2006). Harris and Ayers (2012) noted that in general, women with obstetric or neonatal complications are acknowledged to require more support, also identified by Tham et al. (2010) who described that only women who experienced objectively traumatic events automatically received a follow-up postnatal discussion, while, others, even though they desired one, were not offered this.

#### 2.1.3.5.6.5. Control and confidence in midwives

Regarding the development of PTSD-PC, lack of control or powerlessness during labour and birth were identified as important (Allen, 1998, Ballard et al., 1995, Beck, 2004a, Tham et al., 2010), and significant (De Schepper et al., 2015, Harris and Ayers, 2012, Menage, 1993). Some women described having no control (Allen, 1998), or feeling that midwives were over controlling (Nicholls and Ayers, 2007), which differs from feeling midwives are in control of the situation, which was a significant protective factor (De Schepper et al., 2015). One study found lack of control was significantly correlated with perception of midwife support (Ford and Ayers, 2011). Women’s sense of control was improved when involved in decision making (Tham et al., 2010). Perceiving midwives to be incompetent or unprofessional was highlighted as an issue (Allen, 1998, Ballard et al., 1995, Beck, 2004a, Tham et al., 2010), which maintained distress when reassurance was lacking or women felt midwives were panicking or not in control (Allen, 1998, De Schepper et al., 2015, Nicholls and Ayers, 2007).

*“I remember believing that the labor and delivery team would know what was right and would be there should things go wrong. That was my first mistake. They didn’t and they weren’t”* (Beck, 2004a)

**Figure 2.2. Summary of themes within the findings of the 14 studies**

**Women’s expectations**

Midwives to have positive attitude.  
 To be seen as more than a means to an end.  
 To be communicated with.  
 To have safe care.  
 To trust midwives.

**Women’s experiences**

**Attitude of the midwife**  
 Lack of respect.  
 Being ignored.  
 Being dismissed, dehumanised, degraded, violated.  
 Midwives are hostile, disaffirming, disinterested.

**Communication, information and decision-making**  
 Lack of information.  
 Unable to question.  
 Not involved in decision-making.  
 Poor communication skills of midwives.  
 Lack of communication.  
 Being overruled.

**Support**  
 Feeling abandoned, isolated, unsafe.  
 lack of support, Left alone.

**Control and confidence in midwives**  
 Lack choice, consent.  
 Unable to rely on or trust.  
 Midwives incompetent, unprofessional, nervous.

**2.1.3.5.6.6. Women’s expectations**

How women perceive the midwife’s attitude; communication, information and decision making; support; and control and confidence in midwives, may relate to their expectations. In the studies, many women felt their expectations were unmet (Allen, 1998, Ayers, 2007, Ballard et al., 1995, Beck, 2004a, Nicholls and Ayers, 2007). Women expect midwives to be competent and hold positive attitudes (Nicholls and Ayers, 2007), and feel it is not too much to expect supportive and safe care (Beck, 2004a, Nicholls and Ayers, 2007). When this is not their perceived experience women feel fearful and unsafe (Nicholls and Ayers, 2007), betrayed and powerless (Beck, 2004a).

Some women desired that midwives understand the effect poor QPI can have on them (Nicholls and Ayers, 2007). See Figure 2.2.

#### *2.1.3.5.6.7. Considerations for midwives*

Several review studies highlighted the importance of respecting women's needs regarding information, control, and support, alongside a call to treat all women as potential survivors of trauma, given the impossibility of knowing who is potentially vulnerable (Beck, 2004a, Menage, 1993, Tham et al., 2010). The suggestion by Sorenson and Tschetter (2010) that QPI is not an innate skill, but needs to be taught and assessed, further reflected in the calls to educate midwives about PTSD-PC and clinical practices that contribute to its development (Allen, 1998, Ayers, 2007, De Schepper et al., 2015, Nicholls and Ayers, 2007), as well as the urgent need for guidelines (Allen, 1998, Ayers, 2007, Beck, 2004a, De Schepper et al., 2015), should be noted.

#### **2.1.3.6. Discussion of literature review findings**

While the quality of studies varied, this review offers an important overview of current knowledge regarding the aspects of QPI that correlate with the development of PTSD-PC.

The relationship between a woman and her midwife, core to QPI, is considered distinct from other healthcare professional/client relationships (Kirkham, 2000), with a shift from the theoretical model of *vigil of care*, or surveillance perspective, to that of *care as gift*, characterised by trust and generosity (Fox, 1999, Walsh, 2011), and is only focussed on "*engaging and responding to the other*" (Walsh, 2007). Therefore, the finding that interpersonal difficulties, especially being ignored, were the strongest predictors for developing PTSD-PC is especially important. The four main theme groups of the narrative synthesis suggest that even though a midwife may appropriately perform her clinical duties, a negative perception by the woman regarding the midwife's 'way of being' with her, can significantly contribute to the development of PTSD-PC. This highlights the importance of 'how' rather than 'what' care is provided. In other words, woman's constructions of midwives' attitudes and behaviour towards

them, reflect their views of how they perceived they were treated as opposed to physically what happened to them. The further finding that women lacked confidence in their midwives, being related to either the midwife's competency or level of control in the situation, reflect that women need to rely on and trust their midwives at a time of vulnerability (Briscoe et al., 2016). These assertions are strengthened by the finding that an unmet desire for support was a significant factor predisposing the development of PTSD-PC.

While QPI has been further highlighted as a key issue in a recent large international birth trauma study (Reed et al., 2017), it is important to note that the population of women who develop full PTSD-PC (4%) is a minority. On the whole women more often perceive midwives to be affirming rather than disaffirming (Sorenson and Tschetter, 2010), in keeping with findings of Garthus-Niegel et al. (2013) p.5 that *"On average, the women who were not very frightened during birth, rated their birth as a good overall experience, and felt well taken care of."*

The importance of *how* along with *what* is reflected in the Care Quality Commission values of excellence (high-performance), caring (treating everyone with dignity and respect), and integrity (doing the right thing) (CQC, 2017). Furthermore, midwives have a duty to provide safe care and use appropriate interpersonal skills in terms of both physical and psychological wellbeing (Knight et al., 2016, NMC, 2009, WHO, 2018b). Given the potential impact of PTSD-PC on the wellbeing of women and children, the review findings suggest that optimisation of women's perceptions of QPI with a view to reducing associated development of PTSD-PC, may be of clinical importance.

#### **2.1.3.7. Implications from the literature review with regard to future research**

This review suggests that to optimise QPI some midwives may need to change their practice. Review studies offer suggested changes and call for guidelines and education to be developed. NICE (2017) highlight the need to identify and understand potential barriers to change, noting vital first steps to be awareness and knowledge. Midwives need awareness of their role in women's perception of QPI, and knowledge regarding required changes in behaviour. This review highlights the midwife's role in women's



perception of QPI, however the two high quality studies that focussed on QPI were quantitative, with limited insight into women's lived experiences. While other review studies offered valuable insight into women's perception of QPI, their focus on QPI was limited by being only a part of the bigger picture of the subjective experience. Deeper understanding of required behaviour changes could be gained through high quality qualitative research, focussed specifically on the perception of QPI from the perspective of women experiencing PTSD-PC. Furthermore, to enable midwives to change it is essential to understand how midwives experience their interactions with women. Midwives' 'ways of being' may be influenced by their access to resources, support, training, rest, nutrition, and hydration (Edwards et al., 2016, RCM, 2016c). In addition, personal concerns and systemic pressures are often significant (Edwards et al., 2016, Pezaro et al., 2016). This review shows that current research regarding the correlation of QPI with the development of PTSD-PC primarily focusses on women's experiences. Qualitative exploration of midwives' experiences of their interactions with women would give insight into midwives understanding and knowledge regarding QPI, and their needs in terms of education, guidance, and support to optimise QPI.

#### ***2.1.3.8. Limitations of the literature review***

The systematic approach to this review is a strength. However, the limitation of a single reviewer had potential to bias the collation and presentation of findings. The only study of teenage women (Anderson and McGuinness, 2008) was of low quality, and its findings regarding positive QPI have not been replicated so it is not possible to say if this is unique to teenage women. Nevertheless, this review has enabled synthesis of existing research and highlights a significant association between women's perceptions of QPI, and subsequent development of PTSD-PC.

#### ***2.1.3.9. Conclusion of the literature review***

This review identified the significant correlation of women's negative perceptions of QPI with the development of PTSD-PC and identified four overall themes relating to negative aspects of QPI: (1) attitude of the midwife, (2) communication, information and decision making, (3) support, and 4) control and confidence in midwives. Optimising women's perceptions of QPI may require changes in the behaviour of

midwives with regard to each of these themes, and midwives should be supported through education and guidance relating to their role in women's perceptions of QPI. This education and guidance needs informed by high quality qualitative research aimed to more deeply understand women's experiences of QPI, midwives' understanding and knowledge regarding QPI, and midwives' experiences of interacting with women.

#### ***2.1.3.10. New research published since the review***

In August 2018, a further check for new data via the International Network for Perinatal PTSD Research (INPPR) identified 12 new studies published since the literature review was performed (Box 2.11), which met the inclusion criteria for stage one of the review (Table 2.2.) but not stage two (Box 2.9.), Their findings were consistent with the overview of findings from stage one (Section 2.1.2.4.). Notably, the review by [Dekel et al. \(2017\)](#) also concluded, from research other than that of [Garthus-Niegel et al. \(2013\)](#), that subjective childbirth experience is the most significant factor in the development of PTSD-PC.

### Box 2.11. New studies published since the literature review was performed

<a href="#">van Heumen et al. (2018)</a>	Factors: low social support, poor coping
<a href="#">Brandão et al. (2018)</a>	Factors: pre-existing mental disorder
<a href="#">Santoro et al. (2018)</a>	Factors. Comparing women with low and high PTSS – subjective experience quantitative coding of 15 minutes writing about subjective experience - no particular focus on QPI
<a href="#">Tomsis et al. (2018)</a>	Factors: Influence of personal coping strategies on PTSD-PC
<a href="#">Simpson et al. (2018)</a>	Review of factors. Confirms review findings but main focus on objective events, with less focus on subjective. Mainly looking at the experience of living with PTSD but summarises risk factors.
<a href="#">Lopez et al. (2017)</a>	Factors: anaesthesia complication during CS is independent risk factor for PTSD-PC.
<a href="#">Sentilhes et al. (2017)</a>	Factors: Previous abortion. Previous hemorrhage.
<a href="#">Dikmen-Yildiz et al. (2017b)</a>	Factors: objective factors at 4-6wks, but not at 6 months, satisfaction with health professionals.
<a href="#">Geller and Stasko (2017)</a>	Factors: pre-existing mental health and trauma
<a href="#">Mahmoodi et al. (2016)</a>	Factors: PTSD-PC more common after CS than SVD but not statistically significant. Social support was significant
<a href="#">Dekel et al. (2017)</a>	Also show <b>subjective experience to be the most important**</b>
<a href="#">Takegata et al. (2017)</a>	Factors: fear of birth, prior mental illness, prior birth experiences

#### 2.1.4. The rationale for the proposed research study and selected methodology

Women's perceptions of QPI may not accurately reflect objective QPI, in that their perceptions may be influenced by pre-existing mental illness or unrealistic expectations, or indeed retrospectively through the subsequent development of PTSD-PC. However, to dismiss the importance of QPI on the basis that it is *only the woman's perception and not objective reality* would be naïve and fail to acknowledge the potential importance of QPI in the development of PTSD-PC. Importantly, some evidence suggests that the risk of developing PTSD-PC may be reduced by improving QPI, particularly for women at high risk of PMI ([McKenzie-McHarg et al., 2014](#)), and many studies have recently called for further research into QPI ([Simpson and Catling, 2015](#), [Slade, 2006](#), [McKenzie-McHarg et al., 2015](#)).

Only two studies were identified that specifically explored QPI from the woman's perspective, and both used a quantitative approach. Only one study was identified that asked the midwives for their experience in the context of PTSD-PC, but it was limited

and not directly focussed on QPI. While cognisant of many background considerations for women, less focus has previously been placed on what impacts on midwives. While midwives are beholden to professional rules and guidance, they are nevertheless human individuals, with their own sets of fears, hopes, anxieties, and life context.

Also, while the findings of the literature review related to both midwives and doctors. Midwives are considered the experts in normal birth (NMC, 2015b) and within the UK are the primary providers of maternity care. Therefore, to develop relevant midwifery guidance or education that has realistic potential to improve QPI, there is a need to fully hear the midwives' sides of the story with regard to QPI. Neglecting to do this, and creating education or guidance based only on women's experiences of QPI, risks placing pressure on midwives, which may negatively affect their ability to interact optimally with women.

The proposed research study will therefore use a qualitative approach to explore the perception of QPI and the lived experience of QPI from both women experiencing PTSD-PC and midwives. The next Chapter will describe the methodology of the research project.

## Chapter Three

### Study methodology, strategy, and method

### **3.1. Introduction to the research process**

*'It is perfectly true, as philosophers say, that life must be understood backwards. But they forget the other proposition, that it must be lived forwards. And if one thinks over that proposition it becomes more and more evident that life can never be understood in time because at no particular moment can I find the necessary resting-place from which to understand it.'*  
(Bakewell, 2016)

This chapter presents the process through which a gap in the PTSD-PC research literature was identified, the study aims were defined, an appropriate study methodology was selected, and the final research question was articulated. There follows a description of the study design, setting, sample size determination, informant selection and recruitment, ethical considerations and approval, and data collection, data processing, and data analysis techniques.

#### **3.1.1. Identifying the research gap**

The literature review showed that a negative perception of *Quality of Provider Interaction* (QPI) during maternity care provision is significantly correlated with the development of Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) for some women (Sorenson and Tschetter, 2010, Ford and Ayers, 2011, Harris and Ayers, 2012, De Schepper et al., 2015). Of the existing PTSD-PC literature only two studies were identified that specifically focus on QPI from the perspective of women, both were quantitative. No studies were identified that explore midwives' experiences of QPI during childbirth care. Therefore, a research gap exists regarding the experience of QPI from the perspectives of midwives, with only limited and quantitative research from the perspectives of women.

#### **3.1.2. Addressing the research gap**

The study purpose is to address the identified research gap. This requires exploration of the lived experience of interacting from the perspectives of childbearing women who subsequently developed PTSD-PC and midwives. Deeper understanding of this experience from both sides, should illuminate considerations regarding training and

support for midwives, thereby improving women’s experiences of QPI and potentially reducing their risk of developing PTSD-PC from this source.

### 3.1.3. Defining the research study

Within social research texts there exists a confusion of research terminology, with various applications of *method* and *methodology*, the same term being applied differently by various authors (Richards, 2007). The terminology used throughout this chapter (Table 3.1.) was defined following attendance at a qualitative methods study day (Clausen, 2016a), alongside further reading.

**Table 3.1. Terminology used in this study**

<b>Methodology</b>	Refers to the overall approach that can be either qualitative, quantitative, or a mix of both (Bryman, 2016).
<b>Strategy</b> – type of enquiry (design) that is the structure for collection and analysis of data	These include, ethnography, case studies, phenomenology, grounded theory, participatory action, biographical or life history (Janesick, 2001, Miles and Huberman, 1994, Creswell, 2003)
<b>Method</b> – technique used	E.g. Thematic analysis (Braun and Clarke, 2006) and Framework analysis (Srivastava and Thomson, 2009).

Awareness that all research is theory dependent even if this is not recognised or acknowledged (Clausen, 2016a), necessitated the development of knowledge and understanding regarding relevant theory that would underpin this study.

*Methodological* congruence relates to ensuring an appropriate fit between the research question and the methodology, strategy, and method employed (Richards, 2007), and improves research trustworthiness (Willgens et al., 2016).

### 3.2. Choosing the research methodology

Identifying the most appropriate methodology necessitated understanding the ontological and epistemological foundations of different methodologies. In particular, the beliefs, knowledge, and approaches to gaining knowledge that underpin each methodology. Within the overarching philosophies of positivism and interpretivism, positivism encompasses objective, measurable, deductive research, free of influence from the researcher, within which quantitative methodology is usually associated

(Clausen, 2016b). Quantitative research is appropriate when testing hypothesis or prior theory and involves measuring or assessing (Richards, 2007). However, since the 1980's recognition of limitations in empirical quantitative research in addressing many significant human questions has grown (Lavery, 2003). In contrast, interpretivism is associated with the study of human relationships, or an individual's interaction with their world, and is most often performed using qualitative methodology, which the researcher may influence (Clausen, 2016a). Within healthcare research, qualitative methodologies, unlike quantitative methodologies, enable the researcher to encounter the heart and individuality of the patient's experience (Biggerstaff and Thompson, 2008). Thus, qualitative research is now acknowledged as valuable by scientific and medical journals (Box 3.1.) (Mays and Pope, 2000, Biggerstaff and Thompson, 2008).

**Box 3.1. The features of qualitative methodology** (Clausen, 2016a, Richards, 2007)

- Subjective, looking through the eyes of informants to learn the way they experience.
- Looking at the meanings and interpretations informants give to their experience and not just description.
- Understanding phenomena in detail, which in this case is the lived experience of the informants.
- Enables discovery and deep analysis of core concerns.
- Inductive, as we don't know what will emerge, with this enabling new ways of seeing existing data.

This study aims to describe and understand, rather than assess or measure, human relationships and interactions, and thus fits within interpretivist philosophy and qualitative methodology. This enables new understanding since existing PTSD-PC research that specifically examines QPI has thus far used the positivist approach and quantitative methodology (Sorenson and Tschetter, 2010, De Schepper et al., 2015).

### **3.3. Choosing the research strategy**

While some strategies were excluded early on (Table 3.2.), phenomenology and grounded theory held potential for effectively answering the research question. Close exploration of both, via relevant texts, online tutorials, and studies from the literature review, enabled understanding of their different approaches and use in research.



**Table 3.2. Research strategies excluded from further consideration**

Strategy	Comments
Case studies, biographical or life histories or narrative synthesis.	Rather than describing individual cases, this study aims to go deeper and explore how this was experienced by the individuals in these cases.
Ethnography	Originating in anthropology and adopted in market research, refers to a practice in which researchers spend long periods of time, “hours, days or weeks - observing and/or interacting with informants in areas of their everyday lives” (AQR, 2017) It is about what is happening (Richards, 2007). It is not my intention to 'be in' the experience, to journey with the informants in any way, to immerse myself in the experience.
Ethnomethodology	Developed from phenomenology by Alfred Schutz and then Harold Garfinkel is more focussed on the social understanding people developed through everyday life. (Cohen and Crabtree, 2006)
Participatory action	Participatory action is a form of public health research that aims to improve health by involving people. The research creates the opportunity of participants to actively engage in ways to improve their health. It involves learning and active partnership that leads to action for change. (Baum et al., 2006). My research is more about hearing and understanding lived experience, and not assessing or measuring the impact or ways forward and action.

### 3.3.1. Grounded theory

Grounded theory is appropriate when developing new theory and generating new knowledge (McCreaddie and Payne, 2010), or further substantiating theory (Barbour, 2007). The goal of this study is not new theory since the literature review identified a correlation QPI with the development of PTSD-PC, but rather to gain rich understanding of the lived experience of QPI.

### 3.3.2. Phenomenology

Phenomenology is considered appropriate for expanding the understanding of human experience by describing and interpreting our lived world (Dahlberg et al., 2008), and was the specified approach in some of the literature review studies that explored lived experience (Beck, 2004a, Nyberg et al., 2010, Ryding et al., 2000). Essentially, phenomenology aims to describe and understand rather than measure (Clausen, 2016a). Thus, grounded theory identifies *what*, while phenomenology understands *how*. Phenomenology is considered particularly appropriate for nursing and midwifery research (Standing, 2009, Miles et al., 2013a, Miles et al., 2013b), as the inter-

subjective understanding between people occurs through human relationships (Standing, 2009), and distinctive relationship is core to the woman/midwife interaction (Kirkham, 2010). The purpose of this study is to deepen understanding of lived experience rather than identify causality. This is in keeping with the role of phenomenology (Denscombe, 2014, Henriksson and Friesen, 2012). Therefore, phenomenology appeared to be the research strategy most suited to this study, and this was confirmed through discussion with Dr. Maira Giatsi Clausen (Clausen, 2016a).

### 3.3.3. What is phenomenology?

The term phenomenology first appeared in philosophy texts during the 18th century, notably by Franz Brentano (Moran, 2000). However, Edmund Husserl is considered the *father of phenomenology*, drawing inspiration from Brentano and formally introducing phenomenology in his major work *logical Investigations* in 1900-1901 (Moran, 2000, Laverty, 2003), which was considered a radical new way of approaching philosophy (Kafle, 2011). Martin Heidegger saw phenomenology as the essence of philosophy, with no single associated method (Moran, 2000). Berrios (1989) considers phenomenology to be a set of philosophical doctrines that include ontological assumptions about *what the world is like*, and epistemological assumptions about *how the world can be known*, alongside strategies for describing individual experiences of the world, with these doctrines upheld as foundations of human science research (Dahlberg et al., 2008).

Phenomenology is considered an umbrella term for a range of approaches (Kafle, 2011). The French philosopher Maurice Merleau-Ponty, saw phenomenology as describing, not explaining, and in keeping with Husserl understood that it could support and clarify deductive approaches to science (Moran, 2000). Merleau-Ponty saw lived experience as existing within the space we inhabit, our body, time, and human interaction (van Manen, 2016), with language and understanding as inseparable aspects of *being-in-the-world* (MacManus Holroyd, 2007). Phenomenology penetrates deep into human experience to understand both the hidden meanings and essences, and to focus on the way things appear through experience or in our consciousness, the purpose being to provide rich textured description of lived

experience (Kafle, 2011). Phenomenology attempts to provide a rigorous defence of the role of subjectivity in the nature of knowledge (Moran, 2000) and functions as a link between realism and idealism as the foundations of scientific truth (Dahlberg et al., 2008).

However, phenomenology is considered to have a subversive tendency. The Husserlian, Jan Patočka suggested that a bond unites those whose sense of the everyday is jolted through some significant experience, which he called “*solidarity of the shaken*”, and claimed it could lead to rebellion (Bakewell, 2016). Exploring how childbearing women who develop PTSD-PC and midwives’ experience interacting, may illuminate features of QPI that challenge the *everydayness* or accepted culture of maternity services. Indeed, over twenty years ago this was considered a *danger* of researching QPI (Warshal, 1996). In fact, angry comments following online tabloid coverage of a conference presentation of the results of this study, suggest this *danger* is real (RCM, 2017, Taylor, 2017). Even though DoH (1993) directed focus towards women-centred care in 1993, the literature review findings, alongside recognition of childbearing women’s needs and rights (Schiller, 2016), and the needs and resilience of midwives (RCM, 2018, Hunter and Warren, 2014), suggest that researching QPI from both perspectives is necessary. Therefore, for this study to uncover a rich description of the woman/midwife interaction from both perspectives, while accepting that everyday cultures within midwifery services may be challenged, phenomenology was the optimal strategy.

### **3.3.4. Phenomenological traditions**

Within the western tradition of phenomenology there exist three main schools of phenomenological thought: transcendental; existential; and hermeneutic (Kafle, 2011).

#### **3.3.4.1. Transcendental phenomenology**

Conceptualised by Husserl, transcendental phenomenology posits that it is possible to *transcend* an experience to identify an essential description of a phenomenon. This is realised through *reduction* or *setting aside* preconceptions to access the core essence that makes the experience what it is, the things that matter, like the positivist premise

of reality or truth (van Manen, 2016, Kafle, 2011). Husserl believed that to reach the reality or truth of experience the researcher is required to detach from all pre-existing opinion, common sense, and consensus (Moran, 2000, Dahlberg et al., 2008). That is, to put aside psychological, cultural, religious, and scientific assumptions in a procedure that Husserl called *bracketing* (Moran, 2000, Kafle, 2011, Lavery, 2003). While Husserl himself acknowledged bracketing as unnatural (Moran, 2000), others, notably Heidegger and Merleau-Ponty, considered it impossible to completely bracket, because we remain dependent on the world and can only reflect from our own *being-in-the-world* (Moran, 2000). From now on the term *preconceptions* is used to refer to all possible pre-existing knowledge, beliefs, and assumptions.

#### **3.3.4.2. Existential phenomenology**

Existentialism was the adopted heading under which Heidegger, Merleau-Ponty, Jean Paul Sartre, and other twentieth century philosophers were grouped, based on their shared rejection of Husserl's belief in reduction and their emphasis on individual perception and description of experience (Kafle, 2011, MacManus Holroyd, 2007). Existentialist phenomenology is attributed to Søren Kierkegaard who, like Blaise Pascal, rejected the definition that human beings are solely rational, and recognised an inherent contradiction between the human mind and body (Kafle, 2011). For Heidegger, phenomenology was a way of thinking about human nature that considered the concrete practical aspect of human experience, which he called *being-in-the-world* or *Dasein* and he claimed that phenomenology must attend to the experience of being in a particular time and being in the world (Moran, 2000). Merleau-Ponty focussed on experience as being perceived through the human body (Moran, 2000), with individuals not *having* bodies, but *being* their bodies (Dahlberg et al., 2008).

#### **3.3.4.3. Hermeneutic phenomenology**

Hermeneutic phenomenology, proposed by Heidegger and enriched by Merleau-Ponty, Hans-Georg Gadamer, Jean Paul Gustave Ricouer, and Max Van Manen, is distinct among phenomenological strategies, as it involves the study of experience together with its meanings (Kafle, 2011, Henriksson and Friesen, 2012). Hermeneutic

phenomenology focusses on that which is taken for granted, to create meaning and develop understanding (Lavery, 2003). During what became known as *the turn*, Heidegger moved from the focus on consciousness and essence to the existential and interpretative, or hermeneutic focus (Dahlberg et al., 2008, Kafle, 2011), using interpretation of the description to get beneath subjective experience and find the objective nature of things, believing that description itself is interpretative (Kafle, 2011). Hermeneutic phenomenology rejects the notion that preconceptions can be fully suspended to reach fixed transcendental conclusions, and places emphasis on interpretation and re-interpretation of meaning (Kafle, 2011, Henriksson and Friesen, 2012). Merleau-Ponty understood meaning to be the core essence of experience, being always more than what is given from a single perspective (Kafle, 2011).

### 3.3.5. Choosing the way of 'doing' phenomenology

Phenomenology is simultaneously considered an overarching term, a philosophical approach, and a range of methods (Dowling, 2007, Clausen, 2016a), while Moran (2000) p.4 defines phenomenology as "*a radical way of doing philosophy, a practice rather than a system*". Phenomenology is generally viewed as a strategy of qualitative interpretivist research (Dowling, 2007, Gray, 2014). Yet, some argue that Husserl's tradition of descriptive phenomenology is more suited to a positivist paradigm that assumes an objective reality (Kafle, 2011, Dowling, 2007). The literature review revealed various terms and specified forms of phenomenology (Table 3.3.).

**Table 3.3. Examples of phenomenology use encountered during the literature review**

Description of approach/design	Method of analysis	Study
Descriptive phenomenology.	Phenomenological analysis (Colaizzi, 1978)	(Beck, 2004a)
Colaizzi's phenomenological research method.	Colaizzi's protocol analysis. (Colaizzi, 1978)	(Beck and Watson, 2008)
Interpretative phenomenological approach.	Thematic analysis. (Braun and Clarke, 2006)	(Thomson and Downe, 2010)
Descriptive phenomenology.	In accordance with (Dahlberg et al., 2008)	(Nilsson et al., 2010)
Hermeneutic.	Lifeworld perspective.	(Nilsson, 2014)

Kafle (2011) proposes the need for distinction between philosophical concerns and the issues faced when actually *doing* the research. In this study, epistemology, understood

as the process of developing knowledge through research, involves engaging with informants' accounts, and is influenced by the researcher's prior understandings, referred to as axiology (Kafle, 2011), which is a major concern in qualitative research (Bryman, 2016). My personal experience of QPI as a mother and midwife, makes it challenging to set aside all preconceptions. Heidegger understood the term phenomenology to be derived from the Greek understanding of phenomenon or *phainomenon*, meaning *that which shows itself* and *logos* meaning the *word or concept*, which he saw as the discourse through which the *phenomenon* can be seen or manifest (Moran, 2000). Thus, hermeneutic phenomenology enables understanding of the informant's experience, through engagement in a practical and attentive way with their expressed story, which is inherently interpretative and requires acknowledgment of that which influences the interpretation (Moran, 2000). Therefore, hermeneutic phenomenology held most potential for this study and was explored further.

#### **3.3.5.1. Hermeneutic phenomenology**

Hermeneutic phenomenology is founded upon the *ontological or being-in-the-world* view (Palmer, 1969, Henriksson and Friesen, 2012) that lived experience is an interpretative process (Dowling, 2007). Ricoeur claimed it is impossible to study experience without simultaneously looking at its meaning (Henriksson and Friesen, 2012). Hermeneutic phenomenology is considered the art of understanding the phenomenon (Moran, 2000), in that phenomenology *uncovers* meaning, while hermeneutics *interprets* meaning (van der Zalm and Bergum, 2000, Pringle et al., 2011). Hermeneutic phenomenology sees experience as being best understood by interpreting the stories we tell (Langdridge, 2007), and enables intersubjective understanding (Standing, 2009).

Heidegger encountered hermeneutics through Wilhelm Dilthey and Friedrich Schleiermacher. Heidegger understood the whole manner of human existence to be interpretative, with our assertions and judgements arising in the context of prior judgments (Moran, 2000). Yet, this can also limit understanding (MacManus Holroyd, 2007), thus hermeneutic phenomenology demands that the researcher adopts an open attitude and is willing to let go of prior understanding (Finlay, 2012). However,

complete suspension of one's preconceptions is not considered possible, or totally desirable, being more realistic to acknowledge them and make them explicit (Kafle, 2011), and account for how interpretations are managed (Finlay, 2012).

Gadamer, following on and along with Husserl, Heidegger, Dilthey, and Schleiermacher, saw an essential connection between hermeneutics and phenomenology (Moran, 2000). Gadamer viewed that understanding is central to human experience, the *being-in-the-world*, and understanding is realised through language, within which speech is core (Moran, 2000). Furthermore, Gadamer saw hermeneutics as present throughout human life and a universal aspect of phenomenology and he described the *horizons* that limit our understanding, and while these can overlap with other people's horizons, mutual understanding is possible through interpenetration or fusion of these horizons (Moran, 2000). Gadamer practiced hermeneutics of trust rather than suspicion, seeking to get to the core or matter beneath what is said, while acknowledging that *being-in-the-world* mainly involves making sense by using what is already understood (Moran, 2000).

Thus, in hermeneutic phenomenology, the researcher takes self-reflection as the standpoint from which they cycle through reading, reflective writing, and interpretation (Lavery, 2003). This links to the hermeneutic circle, first discussed by Schleiermacher and subsequently revived by Heidegger and Gadamer (Moran, 2000). We cannot ask questions unless we first have prior understandings (even if these are not obvious) from which these questions arise, subsequent *answers* inform subsequent questions, and so on, and each step deepens understanding (Moran, 2000, MacManus Holroyd, 2007).

For this study, the focus on QPI and the aim to explore beneath description to discover meaning and develop understanding, aligns with hermeneutic phenomenology. Furthermore, in relation to midwifery practice, hermeneutical phenomenology provides multiple ways of knowing, and enables deeper understanding than might be uncovered by more superficial description (Miles et al., 2013b).

### 3.3.6. Summary regarding the selected research strategy

Overall, phenomenology is an approach to studying lived experience that involves reflection and reflexivity by the researcher, either full *reduction* or *bracketing* as proposed by Husserl, or acknowledgement and incorporation of the prior understandings, as emphasised by Heidegger and Merleau-Ponty. Schleiermacher, along with Heidegger and Gadamer incorporated the hermeneutic aspect, where they recognised that understanding develops through interpretation, a process informed by the prior understanding and experience of the researcher. Their notion of the hermeneutic circle encompasses a view of the interpretation process whereby each new understanding leads to further questions and therefore deeper understanding.

### 3.4. Choosing a hermeneutic phenomenological research method

None of the original phenomenological philosophers developed specific research methods (Dowling, 2007) and hermeneutic phenomenology has no set method of analysis (Goble, 2014, Kafle, 2011), although Finlay (2014) describes four key processes (Box 3.2.).

#### Box 3.2. Key processes of hermeneutic phenomenology (Finlay, 2014)

- **Seeing afresh:** being open and sensitive to the data, genuinely curious, but ensuring reflexivity (critical self-reflection) regarding the researcher's own position.
- **Dwelling:** ways of engaging with the minutiae of the data, respectfully embracing the language of the informants.
- **Explicating:** further processing the data and pulling together individual analyses, aiming to remain true to the phenomenon rather than mere conceptual theorising.
- **Languaging:** transforming the analysis into engaging language capable of describing and evoking the phenomenon in all its subtlety and rich layers.

To identify an appropriate research method for this study, four existing research methods were explored. *Thematic Analysis* (Braun and Clarke, 2006) and *Framework analysis* (Ritchie and Spencer, 1994), both of which feature often in research literature, and in addition, *Reflective Lifeworld* approach (Dahlberg et al., 2008), and *Interpretative Phenomenological Analysis* (Smith et al., 2009).



### 3.4.1. Thematic Analysis

Braun and Clarke (2006) see thematic analysis as a foundational method for qualitative analysis, which provides a flexible and useful research tool, potentially providing rich detailed, yet complex accounts of data. Bryman (2016) does not consider thematic analysis to be an identifiable approach yet suggests guiding principles (Box 3.3.). However, it appeared to lack the depth of interpretation that this study required, from the perspective of the informants or the researcher. Furthermore, the term *thematic analysis* seems to be a generic term for any qualitative research study that identifies themes, which is somewhat weak and imprecise, and resonates with the observation by Pringle et al. (2011) that the lack of theoretical roots in thematic analysis can result in a lack of depth and purpose.

#### Box 3.3. Guiding principles for thematic analysis (Bryman, 2016)

- Read through at least a sample of the materials to be analysed.
- Begin coding the materials.
- Elaborate many of the codes into themes.
- Evaluate the higher order codes or themes.
- Examine possible links and connections between concepts.
- Write up insights from the previous stages to provide a compelling narrative about the data.

### 3.4.2. Framework analysis

Framework Analysis is particularly suited to applied policy research, because it addresses a set of a priori issues (Srivastava and Thomson, 2009) that identify *what* exists and the associated reasons or causes, through appraising policy effectiveness, and identifying new theories, policies, or plans (Ritchie and Spencer, 1994). This was too rigid and formulaic, as it lacked flexibility to explore individual lived experience deeply. The study aims to delve beyond simple description of QPI and unearth meanings that previous research had alluded to (Beck, 2004a), and understand how women's and midwives' experiences made them feel.

### 3.4.3. Reflective Lifeworld

This reflective lifeworld approach (Dahlberg et al., 2008) was appealing as it is strongly rooted in hermeneutic phenomenological philosophy and appropriately focusses on the individual unique lived experience, with a view to approaching this with curiosity

and a willingness to be surprised. This openness to identifying experience alongside a strong focus on the researchers need to be reflective is consistent with the hermeneutic approach and resonates with this study, yet the approach feels quite theoretical and does not clearly define specific qualities or processes with which to perform the method.

#### **3.4.4. Interpretative Phenomenological Analysis (IPA)**

*'Often in wonderfully creative and authentic discussions with others, insights come through'* (Dahlberg et al., 2008)

Initial reading around Interpretative Phenomenological Analysis (IPA), was promising. IPA offers a rigorous, somewhat structured yet open and flexible way to perform research into specific lived experience. The strongly theoretical foundation of IPA locates the research directly in informant's experiences (Pringle et al., 2011), while meeting the criteria described by Finlay (2014) (Box 3.2.). Smith et al. (2009) clearly outline the theory and processes of IPA, which when new to qualitative analysis and phenomenology, is helpful. Firmly rooted in hermeneutic phenomenology, IPA has a strong foundation and focus upon the importance of the researcher's prior knowledge and experience of the research area, with clear inbuilt reflective mechanisms to consider this (Smith et al., 2009). Growing support exists for the use and recognition of IPA as a rigorous qualitative method, which yields value in health research (Smith et al., 2009, Pringle et al., 2011). IPA goes beyond a standard thematic analysis (Brocki and Wearden, 2006) and although Braun and Clarke (2006) argue that IPA is constrained by theoretical roots, it is precisely these theoretical roots that add the depth and purpose lacking in thematic analysis (Pringle et al., 2011). Also, IPA allows more room for creativity and freedom than other approaches (Willig, 2001). Within midwifery, the in-depth individualised findings from IPA can narrow the gap between accepted broad knowledge and understanding, within a local context (Charlick et al., 2016). IPA seemed the most promising method for this study. Following closer examination IPA was selected as the research method. The rationale is given next.

### **3.5. IPA as the research method**

The theoretical underpinnings of the selected research method of IPA are now explored (Smith et al., 2009), specifically the key components of phenomenology, hermeneutics, and idiography, alongside the validity of IPA as a research method in the context of this study.

#### **3.5.1. Theoretical underpinnings of IPA**

IPA, first articulated by Johnathon Smith (Smith, 1996, Smith, 2010) is “*a qualitative research approach committed to the examination of how people make sense of their major life experiences*” (Smith et al., 2009). IPA makes phenomenology accessible and usable in healthcare research (Smith et al., 2009, Pringle et al., 2011, Charlick et al., 2016), and is especially useful when the researcher is interested in the lived experience of events that have significance within the life of the person (Smith et al., 2009). When an experience takes on significance in our lives, we tend to reflect on the meaning this has for us, to *make sense* of the experience, and IPA researchers endeavour to make sense of the informant’s sense making of the experience (Smith et al., 2009). This study focusses on QPI during childbirth, and while a common human experience, childbirth is of particular importance to those living through it, being viewed as a life changing rite of passage (Reed et al., 2016).

IPA takes an epistemological stance, using a careful explicit interpretive method that acknowledges the researcher’s engagement with the informant, and is suited to studies that aim to relate findings to bio-psycho-social theories that dominate current thinking within healthcare professions (Biggerstaff and Thompson, 2008). IPA, although essentially simple, is rigorous, given that it is concerned with lived experience (phenomenological), and sees this as only accessible through interpretation on the part of the informant and the researcher (hermeneutic), and being focused on detailed analysis of each case (idiographic) (Smith, 2010, Biggerstaff and Thompson, 2008, Charlick et al., 2016). These phenomenological, hermeneutic, and idiographic underpinnings of IPA are thus described.

### **3.5.1.1. Phenomenology**

IPA is rooted in phenomenology, the chosen research strategy for this study. [Smith et al. \(2009\)](#) see phenomenology as a philosophical approach to the study of experience which provides a rich source of ideas about ways to examine and understand lived experience. The work of Husserl, Heidegger, Merleau-Ponty, and Sartre inform the phenomenological underpinnings of IPA ([Smith et al., 2009](#)). IPA acknowledges Husserl's focus on perception, awareness, and consciousness, alongside viewing as core Heidegger's *Dasein*, the uniquely situated quality of human *being*, while also drawing on the phenomenological concept of intersubjectivity ([Smith et al., 2009](#)). This intersubjectivity encompasses the shared relational nature of how we are in the world, founded on Heidegger's view of *person-in-context*, Sartre's view that human experience is contingent on the presence or absence of others, and centrally, Merleau-Ponty's emphasis of the embodied nature of our existence in the world through which we experience and know the world, in a way that can never be the same as that of another, who can only know the world through their body ([Smith et al., 2009](#)). Furthermore, our perception of the *other* develops from our own embodied perspective ([Charlick et al., 2016](#)). These theoretical underpinnings fit closely to this study where the focus lies on the interaction between women and midwives, which is a shared relational experience that involves perception of another, contingent on the presence, or not, of each person, and is deeply embedded in the context of labour and birth, inherently situated within the body.

### **3.5.1.2. Hermeneutics**

[Smith et al. \(2009\)](#) acknowledge the importance of bracketing or setting aside our taken-for-grantedness, which Husserl promoted as the route to the heart or truth of experience. Yet, they value Heidegger's questioning of the practicality of existence itself, through which we make sense of the world, understanding that knowledge is only possible through interpretation from our individual perspective, which is uniquely grounded in the lived world of people, things, relationships, and language. The move from Husserl's *detached* understanding of experience to the view that all experience is in some way *interpreted*, forms the basis of the hermeneutic aspect of IPA that draws on the work of Schleiermacher, Heidegger, and Gadamer. IPA is particularly rooted in

Schleiermacher's view that how an individual interprets or makes meaning of an experience is shaped not only by the conventions of their society, but also by their individual prior understandings, seeing Heidegger's call to be constantly mindful of these preconceptions as an essential task of the IPA researcher (Smith et al., 2009). Furthermore, the cyclical process of revision and re-interpretation outlined in IPA (Smith et al., 2009), reflects Gadamer's view that preconceptions need constantly revisited and revised throughout the analysis process, consistent with the hermeneutic circle discussed in section 3.3.5.1. Also, IPA acknowledges the active role of the researcher, which is key to uncovering meaning (Pringle et al., 2011) through a two-step sense making process, whereby the informant makes meaning of their experience and the researcher makes meaning of the informant's experience, referred to as the *double hermeneutic* aspect of IPA (Smith et al., 2009).

These cyclical and double hermeneutic aspects of IPA are important to this study, given my personal experiences as both a mother and midwife, necessitating engagement in a research method that enables full acknowledgement of this.

### **3.5.1.3. Idiography**

An important philosophical debate in psychology considers nomothetic versus idiographic. Nomothetic is concerned with making generalisations, often associated with natural sciences and laws of nature, while idiographic is concerned with the private or unique, and is associated with social science and individual meaning (McLeod, 2007). The idiographic nature of IPA refers to a commitment to the *particular* both in terms of the sense of detail and subsequent depth of analysis, and the understanding of individual experience from the perspective of people in a specific context (Smith et al., 2009). This is more than *individual* perspective, but considers the embodied, *in-relation-to* nature of this perspective, which arises from being immersed in relationships and the world of *things* (Smith et al., 2009). Regarding this research study, this is an important distinction, as the purpose is not to make generalised statements about the nature of QPI, but to deeply explore individual lived experience of those who are uniquely situated in the context of this interaction (Morse, 1999). Another level of consideration is that within a shared context, women and midwives

form distinct groups. The women share the context of being in labour and all that this may entail, while midwives are conducting a professional role for which they share a common training. However, between groups there are stark differences. During childbirth, women are inherently vulnerable and at the mercy of their body and those around them. Midwives are in a comparable position of strength yet carry the weight of professional responsibility. Furthermore, with relevance to this study, it is suggested that IPA offers a methodological approach to midwifery research that considers the individual in a local context, thereby aligning with a woman-centred philosophy and producing relevant findings focussed within a social and cultural context (Charlick et al., 2016).

### **3.5.2. Use of IPA in recent years**

As a research process, IPA originated in health psychology (Smith et al., 2009) and over the last 15-20 years has been increasingly used in healthcare, particularly in British psychology (Biggerstaff and Thompson, 2008) and applied psychology (Hefferon and Gil-Rodriguez, 2011), with continued growth in use considered to be very likely (Pringle et al., 2011). Indeed, IPA is increasingly used across the human, social, and health sciences (Charlick et al., 2016), recently recognised as valuable by the National Institute for Health and Care Excellence (NICE) (Flowers, 2017).

### **3.5.3. Scientific robustness of IPA as a method**

While some uphold IPA as a rigorous qualitative method (Biggerstaff and Thompson, 2008), others challenge the scientific quality of IPA (Giorgi, 2010). The concerns relate to how IPA can be called phenomenological and the level of freedom researchers appear to have with regard to the way in which IPA is performed, since it is described as being non-prescriptive, which makes it difficult to check the findings (Giorgi, 2010). From the phenomenological perspective, IPA is more aligned to the philosophy of Heidegger than Husserl, with a strong focus on interpretation (Finlay, 2009). Furthermore, Johnathan Smith strongly defends IPA arguing that while qualitative methodologies are prescribed distinctly from quantitative methodologies, the strength of IPA lies in the intellectual and intuitive work performed at each stage (Smith, 2010). IPA is based on guidelines for good practice rather than strict adherence to specific

procedures, thus high-quality IPA research relies on the researcher's professional and personal abilities and their proficiency in complex skills for each stage of the process (Smith, 2010, Hefferon and Gil-Rodriguez, 2011), for which training is recommended (Smith et al., 2009). Assessing the quality or validity of IPA research is essential (Hefferon and Gil-Rodriguez, 2011), with the caveat that qualitative research requires alternative criteria to that of quantitative research (Yardley, 2000, Elliott et al., 1999). While the criterion of replicability is neither necessary nor appropriate for qualitative research (Smith, 2010), checking how IPA results emerged should be possible for a reader and the facilitation of checking has been detailed by Smith et al. (2009) and Hefferon and Gil-Rodriguez (2011). IPA is inherently idiographic and does not seek to find one single truth (Pringle et al., 2011). Yet, it recognises the possibility of drawing single cases together for further analysis and moves towards more general claims on the basis that by exploring the *particular* more closely, we can approach the *universal* (Smith et al., 2009, Charlick et al., 2016), and thus gaining insight into the individual can provide insight into the whole (Pringle et al., 2011). Rather than empirical generalisability, it is more appropriate to think of IPA in terms of theoretical transferability (Smith et al., 2009), or just a different way of establishing generalisability (Charlick et al., 2016). This is consistent with the closer focus on transferability within the qualitative paradigm (Hefferon and Gil-Rodriguez, 2011).

An important drawback with IPA is the potential time needed to perform the required depth of analysis. With this and the above considerations in mind it was clear that it was necessary to develop my knowledge regarding how IPA is carried out.

#### **3.5.4. Learning how to 'do' IPA**

Although IPA is now widely used, it has been observed that IPA research is often poorly constructed due to lack of understanding of the method, particularly the interpretative dimension (Hefferon and Gil-Rodriguez, 2011). Thus, the importance of health professionals needing to learn how to *do* IPA is highlighted (Biggerstaff and Thompson, 2008). Therefore, essential training was gained through attendance at several IPA study days, workshops, and seminars, via the Scottish Graduate School for Social Science (SGSSS), the Scottish IPA group based at Glasgow Caledonian University (GCU),

and Edinburgh Napier University (ENU). This training was led by those who articulated IPA, Johnathan Smith, Paul Flowers, and Michael Larkin, as well as other skilled IPA researchers, Kirsty Darwent (SGSSS), Adele Dickson (GCU), and Zoe Chouliara (ENU). This training was enhanced by attendance at both the first and second international IPA conferences ([IPA conference, 2017](#), [IPA conference, 2018](#)). Such in-depth and nuanced training enabled a strong grasp of the *doing* of IPA as a first-time IPA researcher, and culminated in oral presentations at both IPA conferences.

### **3.5.5. Ensuring the quality of my IPA research**

The concerns regarding poorly constructed IPA research ([Hefferon and Gil-Rodriguez, 2011](#)) initiated a drive to ensure a high-quality process in this study. This prompted reflection on recognised quality assurance requirements for qualitative research, in particular suggestions by [Mays and Pope \(2000\)](#), [Yardley \(2000\)](#) and [Elliott et al. \(1999\)](#), the latter two being referenced within the field of IPA and hermeneutic phenomenology ([Standing, 2009](#), [Hefferon and Gil-Rodriguez, 2011](#), [Mapplebeck et al., 2015](#)). All three of these guides specify valuable features for quality assurance. In an attempt to draw this learning together and create a basis from which the quality of this study could be built I synthesised these recognised quality assurance requirements. My synthesis is presented via an adapted version of the critical framework to assess trustworthiness and rigour proposed by [Standing \(2009\)](#) (Table 3.4.).



**Table 3.4. Synthesis of quality assurance requirements for assessing trustworthiness and rigour**

	<b>Impact and value</b>	<b>Commitment and rigour</b>	<b>Fittingness to context</b>	<b>Transparency and auditability</b>
<b>Suitability of research approach</b>	Theoretical underpinning is valid.	Researcher skill and competence in method.	Appropriate sample and respect for informants and regard for ethical issues.	Clearly defined method and appropriate fit to theoretical underpinning.
<b>Clarity of Analysis</b>	Explicit scientific context and purpose.	Thorough data collection, depth and breadth of analysis. Checking convergence and divergence of emergent themes.	Relevant literature review and sociocultural setting.	Clear process of coding and reflexivity. Credibility checks.
<b>Clarity of findings</b>	Data comparison of emergent themes.	Grounded in examples, particularly informant quotes. Identifying convergence from a range of findings. Clarity regarding contradictory findings. Reflexivity.	Presentation of findings as relevant to context.	Clear data presentation and interpretation including reflexivity.
<b>Usefulness of findings</b>	Practical value in healthcare policy. Contribution to knowledge.	Public engagement and public dissemination to check resonance of findings.	Linking with wider research and research question.	Coherence and clear arguments.

In keeping with the requirements laid out by [Yardley \(2000\)](#) IPA provides a credible account, which can be validated through clear auditable transparent and reflective processes, presented through explicit detail ([Smith et al., 2009](#)). Also, the implications from IPA research are rooted in what informants actually said, through the use of direct quotes to substantiate findings ([Pringle et al., 2011](#)).

[Biggerstaff and Thompson \(2008\)](#) states the need to receive supervision and checking throughout the research process, and this was incorporated through review of samples of analysis by my research supervisor, who is a midwife and researcher, as well as expert IPA researcher Adele Dickson and IPA developer Paul Flowers ([Dickson and Flowers, 2017](#)). To further ensure validation and trustworthiness of the data I sought

engagement with a wider network of childbearing women, midwives, and researchers through dissemination of the initial research process and findings at several conferences (Appendix 3.1.), and through two interactive public engagement workshops (Appendix 3.2.). Positive feedback from these events showed that the findings resonated strongly with these wider audiences, suggesting validity and appropriateness of the research. The reflexive process described next.

### **3.5.6. Being reflexive**

#### **3.5.6.1. An initial word about terminology**

While reflection is a process of engaging in observing or examining one's preconceptions, reflexivity encompasses the further dimension of recursion. That is, the process of questioning the basis of interpretation and development of one's preconceptions and learning from this, which in turn alters one's reflection or future conceptions (Hibbert et al., 2014). This aligns closely with the hermeneutic circle.

#### **3.5.6.2. Why be reflexive**

The need for reflexivity on the part of the researcher is integral both to hermeneutic phenomenology as a strategy and IPA as a method (see sections 3.3.4 to 3.3.6.) and is an important procedure for study quality (Table 3.4.). Reflexivity is affected by whether the researcher shares the participants experience (Berger, 2015), which requires consideration, since as a mother and midwife, I would possibly associate or not, with the informant's lived experiences. However, reflexivity is a professional requirement of midwives, and so the centrality of *seeing afresh* (Box 3.2.) and being reflexive is something I value.

#### **3.5.6.3. Being reflexive**

The reflexive process involves the researcher's preconceptions being recognised, acknowledged, and then suspended while engaging with the interview transcripts (Biggerstaff and Thompson, 2008). This requires becoming self-conscious about how preconceptions were shaped (Denscombe, 2014), through engaging in self-critique and self-appraisal, and articulating the influence of these preconceptions on perceptions during the research process (Dowling, 2007). Whether preconceptions are suspended

or *bracketed*, or whether they are acknowledged but not allowed to dominate, otherwise termed *bridling*, depends on whether the phenomenological approach is descriptive or interpretative, respectively (Dowling, 2007). Accounting for preconceptions is best done through the development and use of a reflective journal (Biggerstaff and Thompson, 2008), recognised as an appropriate technique within hermeneutic phenomenology (Wall et al., 2004). The IPA process follows the hermeneutic circle of reading, reflection using the reflective journal, and writing and re-writing (Richards, 2007, Kafle, 2011). Critical engagement with the interview transcripts, alongside acknowledgement of preconceptions via a reflective journal, is integral to the research process (Biggerstaff and Thompson, 2008) and results in the double hermeneutic process (Smith et al., 2009). Within this study, an interpretative approach was used, thus identifying the reflexive process as *bridling*.

#### **3.5.6.4. Use of a reflective journal**

The reflective journal facilitated disengagement from the research process to examine emerging feelings, issues, or preconceptions. Consideration of these features enabled the data to be approached through a new lens. Reviewing the journal, revealed a repetitive process in that preconceptions previously noted were often returned to. Contrary to reflecting poor learning, this re-iterative process deepened the focus on key preconceptions that influenced data interpretation. While merit exists in discussing one's journal and reflections with an appropriate colleague, this carried the risk of confusion through adding their interpretation of my interpretation. Thus, potentially adding a third hermeneutic level. Therefore, the focus was on deep honest reflection. Nonetheless, sometimes performing interviews or transcribing the audio recordings elicited challenging emotional responses in myself, usually through empathy or sympathy. It was beneficial to discuss this with a researcher friend or my supervisor, both of whom are midwives.

#### **3.5.7. Summary of why IPA as the research method**

There is no *right* answer in IPA in that as appropriate for qualitative research (Yardley, 2000), interpretation is very much via the researcher's unique lens, informed by knowledge and experience, alongside reflexivity. Nevertheless, through motivation to

ensure the informant's experiences were appropriately represented, I synthesised three key recognised quality assurance guides to develop my own framework for assessing the trustworthiness and rigour of the research process. Research used to inform education or policy, as valued by Elliott et al. (1999), needs to be robust and accurate. I therefore delved deeply and repeatedly reworked my interpretations, using reflexivity, accompanied by discussion with other midwives, my thesis supervisors, IPA researchers, and wider research and public engagement feedback.

### **3.6. Articulating the final research question**

#### **3.6.1. Introduction**

This chapter has so far discussed the congruence between the study purpose and the methodology, strategy, and method employed. Articulating the study purpose as a research question, must consider all these aspects. As discussed in section 3.1.2., the study purpose was: *to explore how childbearing women who develop PTSD-PC and midwives, experience interacting during maternity care provision.*

#### **3.6.2. Moving from what to how**

While defining the research question the expression: *What aspects of the interaction?* was initially considered. However, the first attended IPA seminar highlighted the importance of framing the question appropriately and posited that asking *what* is not in keeping with IPA (Darwent, 2016). IPA does not aim to test hypotheses, but instead deeply explores an area of concern (Smith and Osborn, 2008). In IPA the focus is on *how* something was experienced and the meaning this had for the informant (Dickson, 2016, Flowers, 2016b), which is subtly, yet clearly distinct from *what* happened. Since this study aims to delve beneath *what* happened within the experience of QPI during childbirth and identify associated feelings and meaning, this difference was critical to acknowledge. Moreover, this difference underpins the concept of Non-Violent Communication (NVC), which is a process for mediating between individuals who experience conflict within a relationship or interaction (Rosenberg, 2015). NVC rests on the premise that laying out the *what* of an experience by one party, can be perceived as an accusation of wrong doing by the other (Rosenberg, 2015), whilst expressing feelings and meaning facilitates growth in understanding. Identifying the difference

between *what* and *how* created a liberating and important shift with regards to a novel research contribution. The literature review suggests that the creation of a further list of traumatic *aspects* of QPI (*what*) may add little to current academic or clinical knowledge, whereas deeper understanding of the associated meanings (*how*) is shown to be necessary. Also, in the context of PTSD-PC, no prior research has explored *how* midwives experience interacting with women and the meaning this had for them, except related to their role in debriefing or treating women.

### **3.6.3. Being open to hear how**

To address the identified gap in knowledge (Section 3.1.1.) this research needed to gain deeper understanding about the subjective experience of interacting, from women who had developed PTSD-PC and from midwives. For women, interacting with midwives might encompass antenatal education, information provision, seeking of consent, respect, and compassion. For the midwives, this might include their knowledge regarding PTSD-PC; awareness of their role in the woman's journey; and their experience of fulfilling this role. My reflective journal revealed personal struggles with my perception of negative attitudes of colleagues and the maternity system. Thus, my preconceptions (Box 3.4.) were formed through being hurt, scared, challenged, and surrounded by many negative conversations regarding QPI. Open honest engagement with the informants and their narratives, required *bridling* these preconceptions, acknowledging that the range of childbirth experiences are much wider than that to which I have thus far been exposed.

#### **Box 3.4. Initial preconceptions regarding QPI**

- Perceiving childbirth as traumatic arose because of the way maternity care professionals treated women.
- Maternity care professionals were mostly trying their best but were hampered by negative and unsupportive systems.
- Some maternity care professionals did not behave well towards women.
- Maternity services were not conducive to healthy birth, either psychologically or physically.

The literature review confirmed that negatively perceived QPI is significantly associated with trauma and PTSD-PC, which reinforced my first preconception. While setting aside the remaining three preconceptions, the belief that QPI was an important

research topic persisted. The paucity of PTSD-PC research that specifically explores QPI, may be related to the suggestion that exploring QPI would potentially place blame at the door of midwives and thus be politically dangerous to do (Warshal, 1996). Nonetheless, I refused to be dissuaded or bridle the belief that QPI was a topic in serious need of exploration.

#### **3.6.4. The research purpose, questions, aims, and objectives**

In response to the identified gap in knowledge (Box 3.5.), the primary research purpose was articulated (Box 3.6.) and the research questions, aims and objectives were developed (Box 3.7., 3.8., 3.9., 3.10.).

##### **Box 3.5. The identified gap in knowledge from section 3.1.1.**

To hear both sides of the story with regard to the lived experience of the woman/midwife interaction, from the perspectives of women who have subsequently developed PTSD-PC and from midwives.

##### **Box 3.6. The research purpose from section 3.1.2.**

To explore how childbearing women who develop PTSD-PC and midwives, experience interacting with each other during labour, birth, and early postnatal care provision.

To fulfil the research purpose the research questions were formulated (Box 3.7.)

### **Box 3.7. The research questions**

#### **Overarching question**

How do childbearing women who develop PTSD-PC and midwives experience their interactions during labour, birth, and early postnatal care provision?

#### **Specific questions**

1. How did childbearing women experiencing PTSD-PC experience interacting with their midwives during labour, birth, and early postnatal care provision?
2. What meaning do childbearing women experiencing PTSD-PC, who perceived their childbirth experience as distressing or traumatic, ascribe to their experiences of interacting with their midwives during labour, birth, and early postnatal care provision?
3. How do midwives experience interacting with women whilst providing their labour, birth, or early postnatal care, in the context of knowing that women may find childbirth distressing or traumatic?
4. What meaning do midwives ascribe to their experiences of interacting with women whilst providing their labour, birth, and early postnatal care, in the context of knowing that women may find childbirth distressing or traumatic?

### **Box 3.8. The research aims.**

1. To understand from women with Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) how they experienced their interaction with their midwives during labour, birth, and early postnatal care provision.
2. To understand from midwives what they know about PTSD-PC, and how they experience their interaction with women during labour, birth, and early postnatal care provision.
3. To use the findings from this research to develop recommendations for maternity services in terms of minimising the risk of trauma that potentially results from women's subjective experience of labour, birth, and early postnatal care provision.

### **Box 3.9. The research objectives regarding the experiences of childbearing women**

1. To invite childbearing women who perceived their childbirth experience as distressing or traumatic to take part in the study.
2. To assess the level of birth satisfaction using the Revised Birth Satisfaction Scale (BSS-R)\* for the childbearing women who accepted the invitation to the study, met the eligibility criteria, and consented to complete the BSS-R.
3. To screen for PTSD-PC using the City Birth Trauma Scale (City BiTS)\*\*, the childbearing women who accepted the invitation to the study, met the eligibility criteria, and consented to be screened for PTSD-PC.
4. From a sample of the women screened for PTSD-PC and who met the diagnostic criteria for PTSD-PC using the City BiTS, to obtain descriptions of their lived experience of interacting with the midwives providing their labour, birth, and early postnatal care.
5. To analyse, using Interpretative Phenomenological Analysis (IPA), the obtained descriptions of the women's lived experiences of interacting with the midwives providing their labour, birth, and early postnatal care.

\* (Hollins Martin and Martin, 2014)

\*\* (Ayers et al., 2018) See section 3.7.5.1.

### **Box 3.10. The research objectives regarding the experiences of midwives**

1. To generate an overview of what is known or understood by midwives about Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) by using a short quantitative survey and to use this data to provide pointers for the semi-structured interviews with midwives.
2. To obtain descriptions from a sample of midwives about their experience of interacting with women whilst providing their labour, birth or early postnatal care in the context of knowing that women may find childbirth distressing or traumatic.
3. To analyse using Interpretative Phenomenological Analysis (IPA), the descriptions from this sample of midwives about their experience of interacting with women whilst providing their labour, birth, and early postnatal care in the context of knowing that women may find childbirth distressing or traumatic.
4. To use the findings from these analyses to provide recommendations for maternity services to support midwives in optimising their interaction with women during labour, birth, and early postnatal care provision, which meets the needs of women and may reduce the potential for them to perceive childbirth as traumatic.



### **3.7. The research design and implementation**

This section presents the study setting, sample size, informant inclusion/exclusion criteria, recruitment, ethical considerations, data collection and processing, and the IPA process.

#### **3.7.1. Setting and context for the study**

The study was conducted in Scotland, with data collected from a study population of two separate groups. Namely, childbearing women and practising midwives.

#### **3.7.2. Sample size**

There is no specific rule to determine sample size within qualitative research (Bryman, 2016). The attempt by Galvin (2015) to devise a statistical technique relied on the qualitative research aim being able to produce percentages of themes, subsequently critiqued by Ramsden (2016) as being of no value in qualitative research. The recommended approach in hermeneutic phenomenology is to choose a sample size in keeping with previous qualitative research in the field (Cohen, 2000). This approach suggests sample sizes from from 11 (Iles and Pote, 2015) to 25 per group (Ayers, 2007), consistent with a recommended average sample size of 30, or less when exploring rich data and detail (Bryman, 2016). This concept of *less when more* underpins the approach offered by Malterud et al. (2016), which is based on *information power*. Taking this approach, this study has high information power due to the narrow focus on QPI within a specific population, which is supported by established QPI theory alongside my related experience in the field, and therefore only required a small sample. Furthermore, IPA becomes problematic with too large a sample as successful IPA analysis requires time, reflection, and dialogue, which larger datasets can limit (Smith et al., 2009, Hefferon and Gil-Rodriguez, 2011). Within IPA, Smith et al. (2009) recommend a sample comprising of three to six reasonably homogenous informants. Discussion with IPA experts confirmed that a sample of six women and six midwives was appropriate (Flowers, 2016a, Dickson, 2016), and would enable detailed examination of divergence and convergence between and across both groups (Smith et al., 2009, Larkin, 2018, Larkin, 2017). IPA is time consuming, with 12 informants, requiring around six months for interview transcription, analysis, and initial writing up

(Smith et al., 2009). This required consideration when timing recruitment and data collection, alongside the suggestion by Smith et al. (2009) that in IPA, as with any qualitative research, one must be willing to engage with a level of unpredictability and chaos. This study required purposive sampling, which is typically used in qualitative research to select informants based on their relevance to the research questions (Bryman, 2016), which in this case was experience of QPI.

### 3.7.3. Recruitment

This section outlines the inclusion/exclusion criteria and rationale for selecting each group of informants, and the recruitment methods. Considerations regarding the recruitment process and my identity as a midwife are also discussed.

#### 3.7.3.1. Inclusion/exclusion criteria for informants

The study inclusion/exclusion criteria are presented in Table 3.5. Both primiparous and parous women, who are women having their first or subsequent babies respectively, were eligible as in keeping with recommendations of (Iles and Pote, 2015).

**Table 3.5. Inclusion/exclusion criteria for recruitment of informants.**

<b>Informant group</b>	<b>Inclusion</b>	<b>Exclusion</b>	<b>Rationale</b>
<b>Women</b>	Women who gave birth at least one month ago.		In keeping with the DSM-IV Criterion E and DSM-V Criterion F regarding duration of PTS symptoms of at least one month.
<b>Women</b>	Women who gave birth to a healthy baby who is still well.	Admission of the baby to neonatal unit for more than routine checks.	To exclude women whose subjective childbirth experience was influenced by the death or serious morbidity of their baby.
<b>Women</b>	Women who had reached at least 37 weeks of gestation in pregnancy.	Women giving birth to a premature baby, i.e. prior to 37 weeks of pregnancy gestation.	To exclude women whose subjective childbirth experience was influenced by having a premature baby.
<b>Women</b>	Women who described their childbirth experience as distressing or traumatic.		To recruit women who may have met Criterion A of the DSM-IV or DSM-V for PTSD.

Continued -

**Table 3.5. Inclusion/exclusion criteria for recruitment of informants (continued).**

<b>Informant group</b>	<b>Inclusion</b>	<b>Exclusion</b>	<b>Rationale</b>
<b>Women</b>		Women who at the time of recruitment were receiving medication for mental health conditions that existed prior to this childbirth experience.	To reduce the confounding effect of pre-existing mental ill health.
<b>Women</b>		Women who have been diagnosed with Postpartum Psychosis following this childbirth experience.	To reduce the confounding effect of co-existing serious mental ill health. Given the high co-existence of PND with PTSD, PND was not an exclusion criteria.
<b>Women</b>	Aged 18 or over.		Women younger than 18 are a specific maternity group and require a specific research focus.
<b>Women</b>	Able to read and speak English fluently.		To facilitate ease of understanding regarding the research questions and the interview responses.
<b>Midwives</b>	Midwives who at the time of recruitment were currently registered and had been actively practising for at least 6 of the previous 12 months.		To gain information from currently practising midwives who were able to reflect on a current maternity care environment and experience.
<b>Midwives</b>	Midwives who provided intrapartum and early postnatal care for women.		Since the women informants primarily recounted their traumatic experience to occur during labour, birth or early postnatal period, it was important to hear from midwives who could provide their <i>side of the story</i> during this time period.

### **3.7.3.2. Recruitment of childbearing women**

Most births in Scotland occur within the NHS so this was potentially the environment associated with birth trauma. Therefore, to make it easier for women to consider participating, they were recruited via several non-NHS postnatal groups based in Lothian Region in Scotland. As detailed in Appendix 3.3., these third sector groups provided a range of postnatal support for women, including psychological help. Having received written information about the study, each postnatal group signed an

agreement to advertise the study in their venues or through their Facebook groups, using provided posters and leaflets (Appendix 3.4.).

The term *distressing* was included in the women's advertisements, as research suggests this word is associated with PTSD-PC (Stevens et al., 2012, Soet et al., 2003). An email address was provided for potential informants to contact me directly, therefore the postnatal groups only held responsibility to advertise or promote the study. Women only became aware of the study through these groups, I did not approach women. Of the women who expressed an interest in the study, only one was known to me from a previous encounter and in fact she was not eligible for any part of the study as her child was unwell at birth and admitted to the Neonatal Unit.

My identity as a midwife was potentially inhibiting for women, in terms of recruitment and engagement, especially if their prior experiences with midwives had been negative. Reflection and discussion with midwife PhD student colleagues (Keely and Waddell, 2016) confirmed this concern. I therefore chose not to state this social identity unless specifically asked.

The decision to conceal my clinical identity became redundant as one recruiting group highlighted my midwifery role when posting the advertisement on social media. As this advertisement yielded the most informants it appears that my midwifery role did not deter women. In fact, informants were delighted to find a midwife interested in their traumatic childbirth experiences, as has been noted by other researchers (Beck, 2005). Within four days of posting the advertisements, 19 women responded, 9 on the first day (Box 3.11.).

**Box 3.11. Timing of responses to study advertisements for women informants**

<b>Number of responses</b>	<b>Date</b>
9	14/9
2	15/9
5	16/9
2	18/9
1	21/9
3	23/9
2	October
4	November
1 in each of	December, January, February, and March
3	Between November and February through word of mouth from other women

Post reading the participant's information leaflet (Appendix 3.5.), women who met the eligibility criteria (Appendix 3.6.), and who wanted to participate in the initial screening, were invited to sign a consent form (Appendix 3.7.) and be assessed for the presence of PTSD symptoms by completing the City Birth Trauma Scale (City BiTS) (Ayers et al., 2018) see section 3.7.5.1. and Appendix 3.16. Each woman who met the diagnostic criteria for PTSD-PC, received further written information (Appendix 3.8.) and was invited to participate in an interview. Screening and invitations continued until the required sample of six women was achieved. Those women willing to be interviewed were asked to complete an interview consent form (Appendix 3.9.). A summary of the recruitment process outcome is presented in Chapter 4, section 4.1.

**3.7.3.3. Recruitment of midwives**

Midwives were recruited via an anonymous online survey (Appendix 3.12), that collected background data regarding awareness of PTSD-PC and/or experience of caring for women experiencing PTSD-PC. The survey was developed by discussing potential questions with midwifery colleagues and my PhD supervisor who is also a midwife. A pilot version was run past a small sample of 6 midwives and checked with NHS clinical governance for appropriateness. Within the survey, midwives could declare a willingness to be interviewed. Study information and advertisements were disseminated via personal contact details and non-NHS social media, which included an online poster (Appendix 3.11.). Through purposive snowball sampling, an initial invited group of midwives proposed others (Bryman, 2016). As an independent

midwife some NHS midwives have mistrusted me, through misconceptions regarding my role and training, and this potentially influenced some midwives' decisions to participate. However, snowball sampling encouraged midwives to pass the study information on within their own networks, thereby casting the net beyond midwives I knew or who knew me.

The goal was to have at least 40 midwives complete the survey. Email and Facebook advertisements were sent to midwives on 14<sup>th</sup> November 2016. Over the next week snowball sharing took place. The survey remained open until 16<sup>th</sup> January 2017, by which time new responses had slowed down and 57 midwives had already responded, which exceeded the aim for 40. The identity of 19 of the 57 midwives remained unknown, the other 38 had provided contact details declaring their willingness to be interviewed. Of these 38, 21 were previously known to me in some capacity, but only 4 were known well to me. Of these 4, only 1 was interviewed.

From those willing to be interviewed, a sub-sample of six midwives was purposively selected. Although the initial plan was to interview midwives from both community and hospital settings, the women's interviews showed that the primary period of trauma occurred during intrapartum and early postnatal care within the hospital setting. Therefore, to hear the relevant other side of the story, hospital-based midwives were purposively invited for interview. Also, ethical approval from the NHS clinical governance team was only sought and received from NHS Lothian, and so only midwives from this area could be interviewed. After reading the interview information leaflet (Appendix 3.13), midwives who agreed to participate completed and signed a consent form (Appendix 3.14).

#### ***3.7.3.4. The midwives were not those who had cared for the women***

An important consideration was whether to interview the woman/midwife dyads. That is, the actual midwives who provided the maternity care for the women informants. While desirable in terms of the unique interaction event, this was neither practical nor appropriate. The retrospective nature of this study, with at least one month having passed since the women's childbirth events meant their midwives were unlikely to

clearly recall the reality of that particular interaction. Furthermore, if a midwife discovered that a woman she cared for had subsequently developed PTSD-PC, she might have found this distressing or become defensive. This concern was validated through discussion with colleagues and so the midwives who provided the women informant's care were not sought.

#### **3.7.4. Ethical considerations**

All researchers are governed by the Helsinki Declaration ([World Medical Association, 2013](#)). The cardinal principles within research ethics are respect for the informant's autonomy, ensuring beneficial effect, minimising harm, and behaving with justice and fairness ([Ledward, 2011](#)). The practical application of these principles exists within the consideration of informed consent, confidentiality, anonymity, trust, protection of informants, and debriefing ([Ryan et al., 2011](#)). Furthermore, these principles form the foundation of the midwifery Code of Practice ([NMC, 2015b](#)). Cognisant of the risk of upset or distress, all women and midwives who took part in screening or interviews were provided with a list of follow-up debrief and support resources (section 3.7.4.4.).

##### **3.7.4.1. Informed Consent**

Informed consent is a process and not just a one-off event ([Parahoo, 2014](#)). It lies at the heart of ethical research ([DoH, 2005, Ledward, 2011](#)), and relates to the ethical principle of respect that underpins midwifery practice ([NMC, 2015a](#)). Freely given consent is central to the research process and is only possible if the informant receives relevant and easily understood information about the research and what participation entails. This information must clearly detail that individuals can decline to participate or cease participation at any stage in the process ([Gelling et al., 2011](#)). For this study, all potential informants received information sheets (Appendices 3.5., 3.8, and 3.12.) and were asked to complete an Edinburgh Napier University approved consent form (Appendices 3.7., 3.9., and 3.13.). At all stages, informants had the opportunity to ask further questions and to decline continued participation.

#### **3.7.4.2. Confidentiality and anonymity**

Confidentiality is grounded within respect, with anonymity the means through which confidentiality can be preserved (Giordano et al., 2007). Assurance of confidentiality is essential (Ledward, 2011), with some regarding this as a further ethical principle (Parahoo, 2014). The security of confidentiality through anonymity is likely to enable the informants to feel safe and willing to be more open in sharing their experiences (Giordano et al., 2007). To preserve confidentiality and anonymity, informant numbers and pseudonyms were applied. Interview recordings did not include informants' names and only myself and my supervisors had access to the audio recording and transcripts. Furthermore, all audio and electronic transcript data were stored in password protected electronic files, labelled with simple coded file names. Paper versions were stored in a locked cabinet only accessible to me. The use of the Edinburgh Napier University survey tool NOVI was set up through an education registration and all data was extracted and held in password protected excel files. When presenting results, especially interview quotes, any identifying data was masked through alteration of names or locations.

#### **3.7.4.3. Trust**

Although the study was primarily qualitative, quantitative data was collected to screen for PTSD-PC, gather women's socio-demographic data and satisfaction with their childbirth experience, and midwives background knowledge regarding PTSD-PC. Quantitative data were used to provide background descriptive statistics and inform the interview schedules. There is an ethical imperative to value and utilise data provided by informants (World Medical Association, 2013), which for me extended to ensuring that all informants felt their contribution was valued. Therefore, for informants who did not progress to interview stage, gathering birth satisfaction data from women and survey data from midwives, ensured that each informant contributed to the study.

#### **3.7.4.4. Protection of informants and debriefing**

It is imperative that no one suffers as a result of their involvement in research (Denscombe, 2014). The study did not expose informants to procedures or



medications but required them to explore feelings and perceptions regarding emotionally charged events, and therefore carried potential for causing distress. [Rogers \(2008\)](#), highlight this potential within the growing acceptance of qualitative research in midwifery as a valid means to inform practice, alongside the need to be explicit about the purpose of the research activity. A topic as sensitive as traumatic childbirth requires careful consideration. Yet, some women express relief at having someone show genuine interest in their experience ([Beck, 2005](#)) and find interviews cathartic and therapeutic ([East et al., 2010, Elmir et al., 2011](#)). The aim was to ensure a safe interview experience that enabled women to fully tell their stories. This was achieved by minimising any potential power imbalance, developing a rapport, creating a safe, comfortable, and private environment in a place of the woman's choosing, with the interview held at a time convenient to her ([Elmir et al., 2011](#)). The ongoing option to freely decline to answer questions or to withdraw at any point was made clear to informants, and their choice to continue was regularly checked. Nevertheless, some informants may have experienced distress or trauma due to being interviewed, so a range of back up services were signposted via an information sheet (Appendices 3.10. and 3.15), including local counselling services and birth trauma support networks.

#### **3.7.4.5. Ethical approval**

Ethical approval for this study was sought and received from the Edinburgh Napier University ethics committee. NHS research and development ethical approval was not required, because NHS premises or systems were not used to access informants or collect data. NHS clinical governance approval was required to interview midwives, as the interview content by definition included reference to the midwives' NHS roles. This approval was received following the completion of a short form, provision of all recruitment and data collection materials for midwives, and a face-to-face interview with the Lothian clinical governance team. Clinical governance approval only applied to Lothian and so midwives from outside Lothian could not be interviewed.

### 3.7.5. Data collection

This section outlines the process of collecting the quantitative and qualitative data that formed the recruitment and background information, and the qualitative data that informed the main IPA research.

#### 3.7.5.1. Quantitative and qualitative data to inform recruitment and background

The range of quantitative data collected for recruitment and background information is given in table 3.6.

**Table 3.6. Quantitative data collected for recruitment and background information**

<b>Informant group</b>	<b>Data collected</b>	<b>Tool</b>	<b>Rationale</b>
<b>Women</b>	Assessment of the presence of PTSD symptoms.	City Birth Trauma Scale (City BiTS) (Ayers et al., 2018) (Appendix 3.16.)	To identify women who met the diagnostic criteria for PTSD-PC.
<b>Women</b>	Birth Satisfaction.	Birth Satisfaction scale-revised (BSS-R) (Hollins Martin and Martin, 2014) (Appendix 3.17.)	To assess how all informants reflected on their childbirth experience that they may have found distressing or traumatic.
<b>Women</b>	Socio-demographic data.	Socio-demographic data form (Appendix 3.18.)	To gather background demographic data for women informants.
<b>Midwives</b>	Background data regarding midwives' knowledge or experience regarding PTSD-PC in women.	Online survey created using Edinburgh Napier University in-house NOVI survey tool.	Given the lack of current knowledge in this area. To enable a basic understanding of existing knowledge, attitude, and perceptions of midwives in relation to PTSD-PC and their role as midwives in this context. Midwives had the option within the survey to express an interest in being interviewed. From the survey, interview questions were developed.
<b>Midwives</b>	Identify midwives willing to participate in an interview.	Online survey created using Edinburgh Napier University in-house NOVI survey tool.	Midwives had the option within the survey to express an interest in being interviewed. From the survey, interview questions were developed.

While various instruments are used to assess PTSD-PC, the literature review showed that their quality varies, and most were not originally designed for use post childbirth. Therefore, the City Birth Trauma Scale (City BiTS) was selected (Appendix 3.16.), because this was developed by Professor Susan Ayers specifically for use with postnatal women and is grounded in her extensive research in the PTSD-PC field (Box 3.12.).

Box 3.12. The City BITS (Ayers et al., 2018)

- Following thorough checking regarding validity, comprehension and appropriateness for postnatal women, 31 questions were developed, of which 29 map directly onto DSM-5 criteria and 2 onto DSM-IV criteria.
- The scale has been assessed as easily understood by 13 to 15-year olds and around six years of formal education is all that is required to easily read the scale.
- Reliability is good with Cronbach's  $\alpha > 0.83$  on all criteria (Appendix 3.15.4).

### **3.7.5.2. Qualitative data collection to address the research questions**

Individual, in-depth, face-to-face interviews are appropriate within hermeneutic phenomenology (Bryman, 2016). While these are considered the most suitable method of data collection for IPA, focus groups may generate opinion, ideas, or different perspectives, and can be good for sensitive topics (Smith et al., 2009). However, they were potentially inappropriate for the women informants since women may disclose individual, personal, and distressing experiences. For midwives, a focus group may also inhibit full disclosure and individual opinion may be subject to group influence. Furthermore, the depth of understanding of lived experience intrinsic to IPA, is only possible with rich enough data (Smith et al., 2009).

A loosely structured interview, using open-ended questions alongside an interview schedule (Appendix 3.19.), keeps the conversation focussed around the research question (Smith et al., 2009). The open-ended questions for women and midwives were different in content in that women were describing interacting with midwives during a particular traumatic childbirth experience, while the midwives were describing being with a variety of women, cognisant of the potential for trauma for women. Similarly, the woman's interview schedule was designed to probe further into the feelings and meanings women experienced during their specific birth experience. The midwives interview schedule was developed from the answers given in the online survey, with a view to encompassing the context of their interaction with women. All interviews were started by asking the relevant opening question and then leaving the informant to speak freely. This flexibility facilitates the informant to lead a mostly one-sided conversation, freeing them to speak openly and at length. This one-sided approach limited any influence from my personal childbirth or midwifery experiences

and allowed for individuality in how informants told their stories (Biggerstaff and Thompson, 2008). The questions in the interview schedule provided a guide, if needed, to encourage the informant to speak at more depth. The focus being to elicit the informants understanding of their experience and its meaning for them, rather than a description of events (Smith et al., 2009). While it is best not to interrupt informants, sometimes it becomes important to probe or delve to encourage deeper reflection and sharing (Smith et al., 2009). This allows further questions in response to significant replies (Bryman, 2016, David, 2011) to encourage details and clarification (Harris, 2010).

Some IPA researchers suggest note taking during interviews may cause distraction, because it breaks the necessary eye contact to engage the informant and ensure they feel listened to (Flowers, 2016b). Yet, others acknowledge that if the informant is talking at length, notes can assist in remembering points of interest to be returned to (Dickson, 2016). Thus, I explained to each informant that notes would be taken as an aide-memoire.

Midwives were informed about the background of this study and the potential for a negative perception of QPI to contribute to the development of PTSD-PC, and so their interviews were conducted with this in mind. This may have initiated the Hawthorne Effect (Verwellmind, 2018), both in term of participating in research, but also, they may have been keen to present as being knowledgeable regarding PTSD-PC and emphasise their positive attempts to minimise trauma for women. The next section describes the processes used for data analysis.

### **3.7.6. Data processing and analysis**

#### ***3.7.6.1. Processing of the study data***

Data processing techniques are presented in Table 3.7. The interviews were all individual and face-to-face. They were held in the informant's home for 5 midwives and 5 women, and the other two were held in a private office at Edinburgh Napier University. Interviews lasted between 60 and 95 minutes.

**Table 3.7. Data processing techniques**

Data	Handling technique
Women's paper questionnaires and screening tools	All paper forms were annotated with the informant number and summary data were extracted from these.
Midwives online survey	Data were held within the NOVI tool, and the built-in statistical and descriptive tools were used to create summary data sheets in Microsoft Excel from which summary statistics were extracted.
Interview data	Interviews were audio recorded using a double password protected voice recording APP. Interviews were transcribed verbatim by hand by the researcher, by listening to the audio recordings and writing the content into a separate word document for each transcript. Interview transcripts were analysed using IPA processes detailed in section 3.7.6.3.

### **3.7.6.2. Analysis of the quantitative and background data**

Descriptive summaries were produced for the women informants' screening and background data. These provide the background from and context within which the women and midwives were sampled.

### **3.7.6.3. Analysis of interview data**

This section presents the IPA process applied to the interview data. It involves common procedures that are not necessarily followed in a linear manner (Box 3.13.) and utilises specific terminology (Box 3.14.). This section is supported by several appendices depicting stages of the process and method.

Box 3.13. The outline of the process of IPA analysis (Smith et al., 2009)

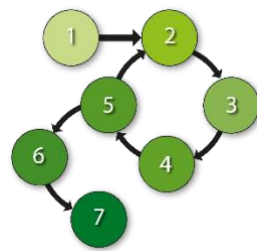
- Close, line-by-line analysis of interview text.
- Identification of emergent themes.
- Developing a dialogue between the researcher, the data and their knowledge of potential meaning for informants in the particular context, which results in an interpretative account.
- The development of an illustration of the relationships between themes.
- Traceable organisation of all analysis material, from initial comments to final themes.
- The use of supervision or audit to help test coherence and plausibility of the interpretation.
- The development of a full narrative, backed up by data extracts, moving through theme-by-theme using a visual representation.
- Researchers own reflection on their ongoing perceptions and processes.

Box 3.14. Terminology used in the analysis process

- **Emergent themes** – individual themes identified during the initial coding process.
- **Sub themes** – headings for groups of related emergent themes.
- **Master themes** – headings for groups of related sub themes.

The use of electronic databases such as NVivo (QSR International, 2018) to support qualitative research is well recognised (Zamawe, 2015) and provides a structure within which to sort large quantities of qualitative data. However, this is considered unusual within IPA (Flowers, 2016a). The rationale being that the reading, re-reading, and utter immersion in the data, is part of the in-depth quality of IPA. Therefore, the analysis was executed by hand, guided by the step-by-step process (Figure 3.1.) outlined by (Smith et al., 2009).

Figure 3.1. The 7 steps of IPA analysis process (adapted from (Smith et al., 2009)).



**Step 1: Reading and re-reading**

Close engagement and immersion in the informant's narrative.

**Step 2: Initial noting**

Identifying and interpreting detailed aspects of the informant's sense making of their experience. This creates an expansive opening up of the data.

**Step 3: Developing emergent themes**

Looking across the lines/phrases in the text together with the associated

initial noting to identify themes.

**Step 4: Searching for connection across emerging themes**

Using processes\* such as abstraction, numeration, polarisation, function, and contextualisation (Smith et al., 2009) to identify common or related themes which can be grouped into sub themes and ultimately master themes.

**Step 5: Moving to the next case**

Repeating steps 1-4 for each informant. Taking care to remain open minded to the ideographic nature of each and bridle previous interpretations or pre-conceptions.

**Step 6: Looking for patterns across cases**

Identifying shared and unique qualities of emergent themes to inform overall sub and master themes.

**Step 7: Writing up the analysis**

Presenting the description and interpretation of the data alongside discussion of wider theory and research through which to view the analysis.

\*Processes suggested by Smith et al. (2009). *Numeration*: the frequency of each emergent theme, *polarisation*: the extremes expressed within this theme, such as within the theme of support this might be *feeling very supported vs a total lack of support*, and *function*: what is the participant trying to say here by expressing this theme.

#### 3.7.6.3.1. Step 1: Reading and re-reading

By personally transcribing the interview audio recordings it was possible to be immersed in the data. Close listening, noting nuance in each informant's voice, particularly pauses, reactions, speech dynamics, including expressions of feeling such as laughing or crying, have been highlighted as valuable (Biggerstaff and Thompson, 2008). Checking transcript accuracy required simultaneously re-reading and listening to interviews, which further satisfied step 1. This enriched the connection to, and understanding of, the informant's feelings and sense making. Noting these observations on the transcript, enabled a rich quality of data extraction.

#### 3.7.6.3.2. Steps 2 and 3: Initial noting and identifying emergent themes

The coding pages contained columns for transcript text, the key components suggested by Smith et al. (2009), and emergent themes (Box 3.15.). Printing these onto A3 paper allowed plenty space for note taking.

##### **Box 3.15. key components of the initial noting**

- **Description and content:** noting what is happening in the narrative, events, objects, experiences.
- **Language:** the informant's use of language in expressing and representing the experience, nuance and tone.
- **Conceptual and interrogative:** interpreting the meaning and sense the person is making, questioning what is said, considering what is not said and the implications.
- **My thoughts:** reflecting on what I am bringing into my interpretation, what sense am I making of this.
- **Emergent Themes:** Reflection on the other columns enables creation of emergent themes.

Throughout steps 2 and 3, my thoughts and reactions, and the lens through which each informant's experience was encountered, were explored using the reflective journal. More detail about this reflexive process is given in section 3.5.5. Each transcript generated 17 to 25 coding pages (see an example in Appendix 3.20.) and several hundred emergent themes.

#### 3.7.6.3.3. Step 4: Searching for connections across emergent themes

Box 3.16. presents the process of gathering emergent themes into sub and master themes.

### Box 3.16. The steps used to gather emergent themes into sub and master themes

1. Typing the *emergent* themes into a word document referenced by informant initial, coding page, and theme number. This facilitated clear cross referencing and identification as *emergent* themes were clustered (Appendix 3.20.).
2. Reading through the *emergent* themes, drawing together those that appeared linked (the process of abstraction), and highlighting them by colour coding (Appendix 3.21.).
3. Sorting the *emergent* themes into colour coded lists, allocating a *sub* theme heading, and printing the lists (Appendix 3.22.).
4. Cutting out each list and identifying initial *master* themes by physically grouping related *sub* themes. Pasting these *sub* theme lists onto A3 paper (Appendix 3.23.).
5. Performing the processes of numeration, polarisation, and function (see Figure 3.1.) for the *emergent* themes across each *master* theme (Appendix 3.23.).
6. During step 5, the activity of looking more closely at the *emergent* themes identified more appropriate *sub* theme and *master* theme groupings and so the groupings were restructured and steps 1-4 repeated (Appendix 3.24.)
7. Stage 6 was repeated until the *sub* theme and *master* theme groupings appropriately reflected the identified *emergent* themes that represented the heart of the informant's experience.

#### 3.7.6.3.4. Step 5: Moving to the next case

To limit carryover of interpretation from one informant to another and approach each case afresh, the analysis was performed alternately between the data from women and the data from midwives.

#### 3.7.6.3.5. Step 6: Looking for patterns across cases

By looking across the initial, idiographic *master* and *sub* themes for each informant, a pattern emerged and informed a preliminary grouping of overall *master* and *sub* themes. Reflecting back on the idiographic enabled more efficient sorting and reinforced some earlier groupings. In particular, a sense of which *sub* themes stood out most for each informant was facilitated by creating a frequency table. This achieved clarity regarding the overall *sub* themes that were key for most informants, and those that were core for perhaps one individual, or did not feature highly for anyone (Appendix 3.26.). Thus, the overall *sub* and *master* themes were restructured to more accurately reflect the data (Appendix 3.27.).



### 3.7.6.3.6. Step 7: Writing up the analysis

The writing up of IPA analysis aims to give the reader an account of the data, a sense of what the data are like, alongside interpretation and suggestion of what the data mean. While patterns of shared meaning are represented, the individual nuance of each informant needs illustrated, thus showing convergence and divergence within the data (Smith et al., 2009). Mindful of these considerations, the analysis is presented using a *case within themes* approach. This enabled quality representation of the collective experience of each group and subsequent convergent and divergent themes across the groups while retaining appropriate idiographic features. The study findings are presented in Chapter 4 in keeping with the overview suggested by Smith et al. (2009) (Box 3.17.).

#### **Box 3.17. Presentation of findings**

- Tabulation of master themes and nested sub themes.
- More detailed outcomes of analysis steps and process presented in appendices.
- Diagrammatic representation of themes showing connection between sub themes across master themes.
- Written summary of findings for each master theme and incorporated sub themes, separately for each group.
- Written summary of convergence and divergence in findings and how they lead to final key findings.
- Tabulation of convergent/divergent findings and final key findings.

Prior to writing up it was necessary to identify illustrative data extracts. The process of identifying and selecting the best extracts for the women's analysis, which was completed first, was extremely unwieldy, time consuming, and vulnerable to confusion and omission of primary extracts. Nevertheless, through application and focus, key extracts were identified. The use of a tracking and coding system (Appendix 3.28.) ensured fair representation of each informant and prevented duplication of extracts. However, a more nuanced and manageable process was developed for the midwives' analysis. Table 3.8. details the processes of identifying, collating, selecting, and managing data extracts, and how these informed the writing up.

**Table 3.8. Identifying, collating, selecting and managing data extracts within the writing up process**

Process	Description	Appendix for example.
<p>Creating lists of extracts that illustrate emergent themes.</p> <p>Colour and notes – instead of lists of extracts.</p>	<p><b>Women’s data:</b> relevant transcript sections were extracted and tagged by informant initial / transcript page / line numbers. These were grouped according to the related sub theme and stored in a word document. This created large documents per informant, with considerable duplication of extracts.</p> <p><b>Midwives’ data:</b> duplicates were made of each transcript template, with an extra column to store the particular notes made during initial noting, such as highlighted areas and strong thoughts. A colour code was allocated to each sub theme, and related transcript extracts were highlighted in the relevant colour.</p>	<p>Appendix 3.29.</p> <p>Appendix 3.30.</p>
<p>Collating lists of extracts.</p>	<p><b>Women’s and midwives’ data:</b> emergent theme extracts were collated into word documents per sub theme.</p>	<p>Appendix 3.31.</p>
<p>Managing duplicates and locating the extracts within the sub theme they best illustrated.</p>	<p><b>Women’s data:</b> further review of the word documents of extracts, especially extracts suited to more than one sub theme, identified the most appropriate location. This process also enabled identification of duplicates.</p> <p><b>Midwives’ data:</b> the colour coding made it possible see at a glance where an extract may align to more than one sub theme, and to then decide where best to place this extract. This reduced duplication and prevented omission and involved a further level of reflection on the data and emergent themes, thereby strengthening the interpretation. Keeping the colour coding throughout the writing up process, made it possible to see where an extract might encompass more than one sub theme and review the writing. By keeping the highlights and strong notes (from the extra column on the duplicate transcript) enabled inclusion of important notes and interpretation.</p>	
<p>Selecting best extracts.</p>	<p><b>Women’s and midwives’ data:</b> the most relevant and illustrative extracts, that provided the bones of the narratives within each sub theme, were extracted out into a new document.</p>	
<p>Summary of content of each quote.</p>	<p><b>Women’s and midwives’ data:</b> one sentence summaries for each illustrative extract were created, and collated to obtain an overview of the content, feelings, and sense making for each</p>	<p>Appendix 3.32.</p>

	informant, and across informants in each group. These summaries informed the writing up of each sub theme and made it possible to see the number of informants expressing similar feelings or sense making, as well as those that differed.	
Ensuring balanced representation across the writing	<b>Women's and midwives' data:</b> to ensure balanced representation across the master and sub themes per informant and to further avoid duplication, the used extracts were tabulated.	Appendix 3.28.
Writing up each sub theme	<b>Women's and midwives' data:</b> During writing up, the initial noting was used to inform interpretation, alongside the summaries and ongoing reflections and considerations, particularly the strong reactions or observations that arose during the initial noting. Drawing on these ensured capturing the full richness of the interpretation. This reflection further provided double checking on interpretation consistency, and discrepancies led to reflection on why/what is different and revised interpretation as needed. The findings present the most illustrative extracts that reflect the collective and individual experiences.	

#### **3.7.6.4. Summary of data processing and analysis**

This section has detailed the analysis process and presentation of all the study data. In particular it has covered the specific processes used while undertaking IPA. Chapter 4 now presents the findings gained from the study through this use of these analysis methods.

Chapter Four  
The analysis of the study data

#### **4. Study findings**

This chapter presents the findings from the research study. First the outcomes of the recruitment process, background data (sociodemographic, Birth satisfaction), and PTSD screening data are presented. Followed by the in-depth IPA analysis of the 12 informant interviews.

#### **4.1. Recruitment of women and midwives**

The method of recruitment has been outlined in Chapter 3 section 3.7.3. A summary of the recruitment process outcome is now presented.

##### **4.1.1. Recruitment of women experiencing PTSD-PC**

Of the 33 women who expressed an interested in the study, three were identified as ineligible during an introductory conversation, due to their baby being born prematurely or requiring admission to the neonatal unit. The remaining 30 were invited to participate in stage one of the research study. 24 women accepted this invitation. All 24 women met the study eligibility criteria (Appendix 3.1.4.) and signed a consent form after receiving and reading the informant information sheets. Each of the 24 women also completed the City BiTS form, the BSS-R form, and the sociodemographic form.

##### **4.1.2. Identification of women experiencing PTSD-PC**

Of the 24 women who were screened using the City BiTS, eight met the full diagnostic criteria for PTSD-PC outlined in Appendix 3.3.1.3., while eight women met partial diagnostic criteria for PTSD-PC (Table 4.1.). A recruitment flow chart is presented, see Figure 4.1.

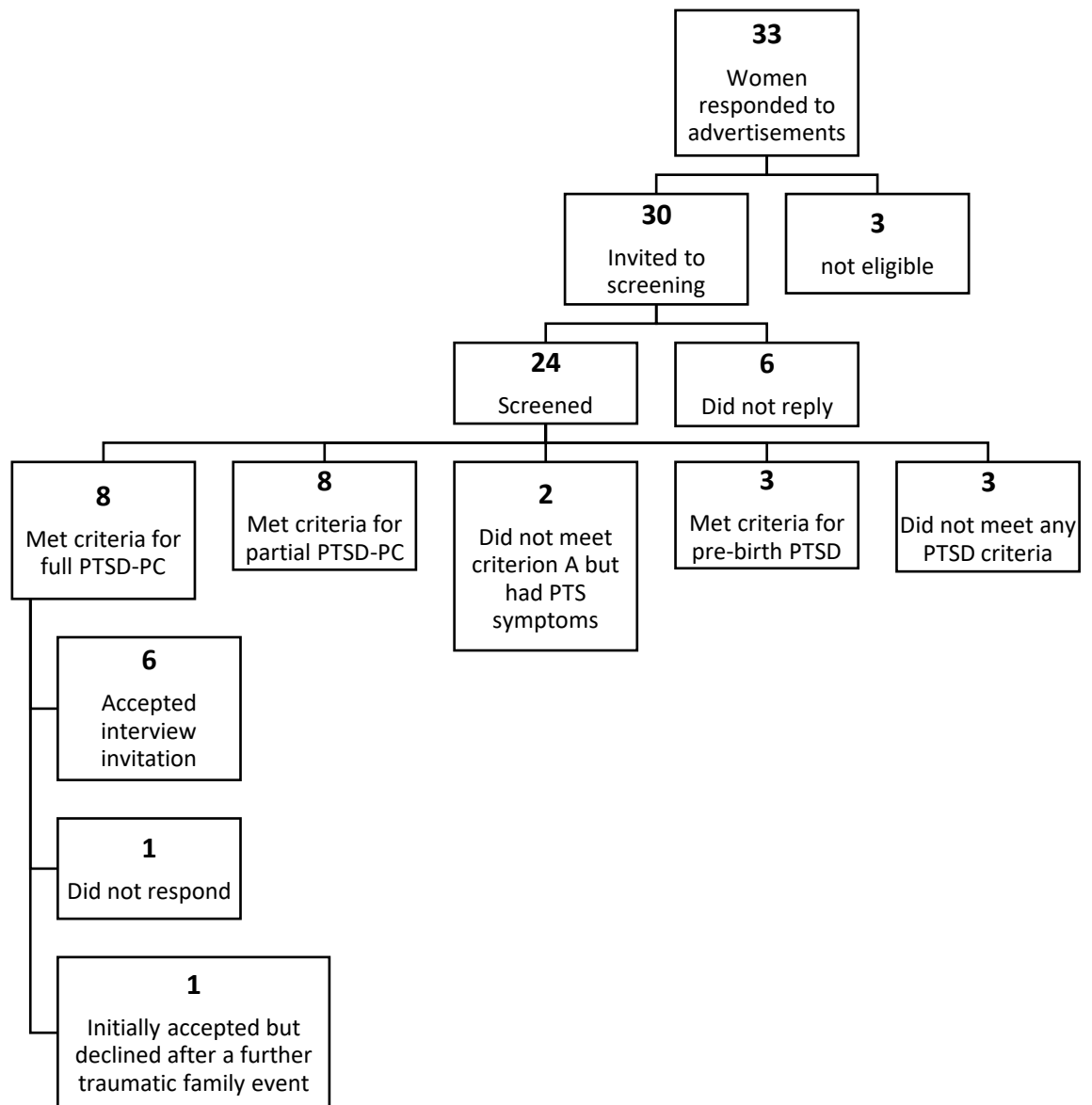
**Table 4.1. The summary of the City BiTS scoring for each of the 24 women (those meeting full PTSD diagnostic criteria are highlighted)**

Informant no.	Criterion A DSM-IV	Criterion A DSM-V	Criterion B	Criterion C	Criterion D	Criterion E	Criterion F	Criterion G	Criterion H	Dissociative symptoms	Time of symptom onset	Met diagnosis of PTSD
001	No	No	No	No	Yes	No	Yes	No	No	No	No	No
002	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Post birth	Yes
003	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Post birth	Yes
004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Pre-birth	no
005	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Post birth	no
006	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Post birth	Yes
007	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	Post birth	No
008	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	Post birth	No
009	No	No	Yes	Yes	No	Yes	Yes	Yes	No	No	Post birth	No
010	Yes	Yes	No	No	No	No	Missing	No	No	No	Post birth	No
011	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Post birth	Yes
012	Yes	Yes	Yes	No	Yes	No	Yes	No	No	No	Pre-birth	No
013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Post birth	Yes
014	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Post birth	No
015	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Post birth	Yes

**Table 4.1. Continued The summary of the City BiTS scoring for each of the 24 women (those meeting full PTSD diagnostic criteria are highlighted)**

Informant no.	Criterion A DSM-IV	Criterion A DSM-V	Criterion B	Criterion C	Criterion D	Criterion E	Criterion F	Criterion G	Criterion H	Dissociative symptoms	Time of symptom onset	Met diagnosis of PTSD
016	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	No	Pre-birth	No
017	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Post birth	Yes
018	No	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes	Pre-birth	No
019	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Pre-birth	No
020	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Post birth	No
021	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	Post birth	No
022	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	No	Post birth	No
023	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No	Pre-birth	No
024	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Post birth	yes

Figure 4.1. Flowchart of recruitment of women

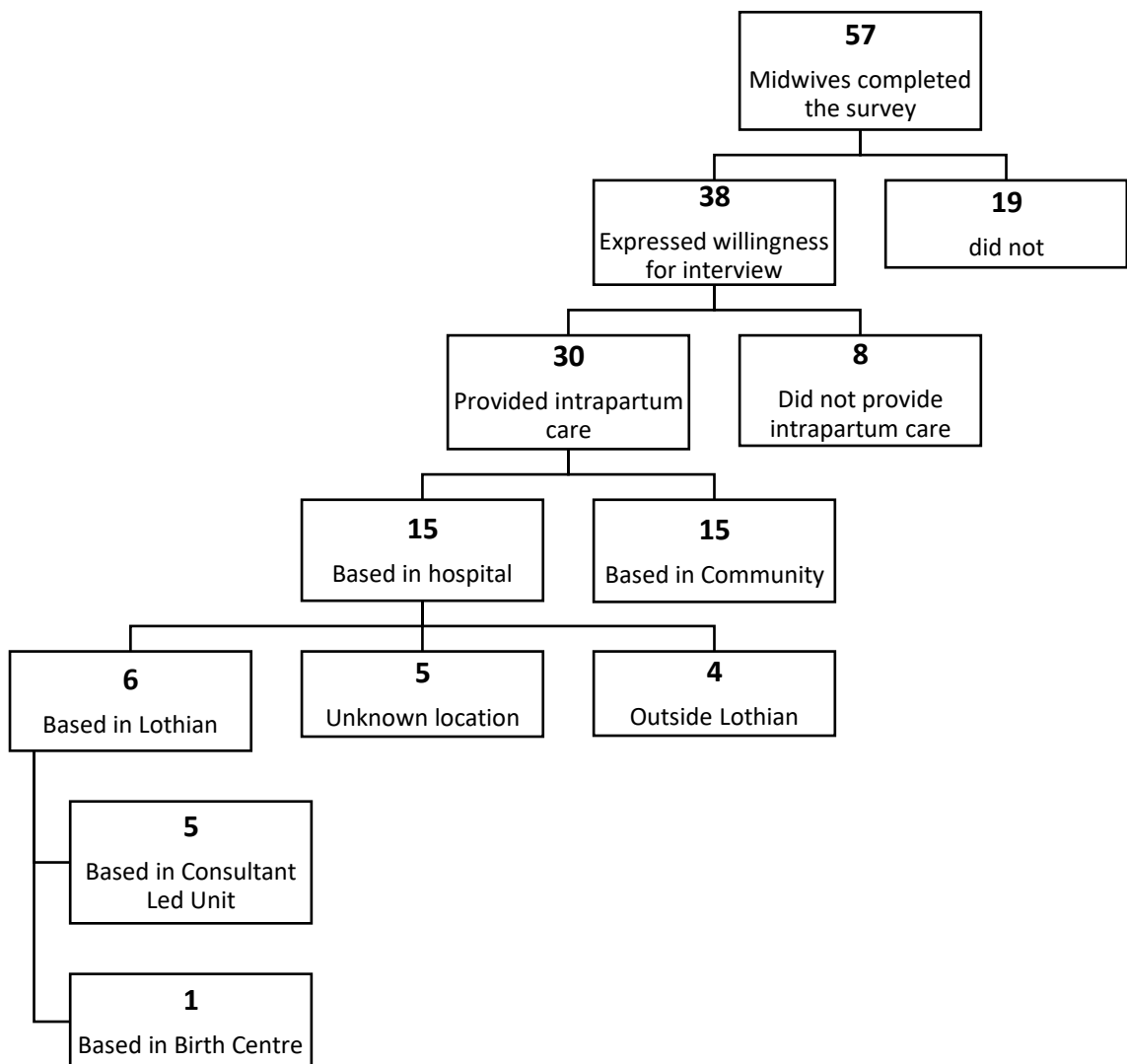




#### 4.1.3. Recruitment of midwives

Of the 57 midwives who completed the survey, 38 declared a willingness to be interviewed. Of these 38, only 6 met the inclusion criteria (providing intrapartum care within a hospital setting in Lothian). All 6 eligible midwives accepted the invitation and so formed the study sample of midwife informants (Figure 4.2.).

Figure 4.2. Flow chart of recruitment of midwives and selection for interview



## **4.2. Background data**

In this section the summaries of the women’s sociodemographic background data and the BSS-R are presented, as well as the summary data from the midwives’ online survey.

### **4.2.1. Women informants’ sociodemographic data**

The sociodemographic data is presented respectively for the 24 screened women and the 6 interviewed women (Tables 4.2a, 4.2b.)

**Table 4.2a. Sociodemographic features for all the 24 screened women.**

Parity	First baby (18) Second baby (6)
Age	Range 29-45 years Average 34.5 years
Ethnicity	White European (6) White British (17) White other (1)
Employment	Out with home (17) Self-employed (2) Not working (at home mum) (5)
Employment role	Professional (6) Management (3) Student (1) Other (9)
Household	Husband and child/children (20) Partner and child/children (3) Parents and child (1)
Issues you were worried about before the birth	None (12) Birth trauma (2) Miscarriage/conception difficulties (3) Bereavement (3) CSA (1) Adult rape (1) Other trauma (2) (Visa issues. Separation from partner)
Issues you have been worried about since the birth	None (16) Ongoing recovery from birth (4) Sick relative / bereavement (3) Other (1) (Visa issues)
Time since traumatic birth	Between 6 months to 4 years post birth (21), 2 months post birth (2), 9 years post birth (1)

**Table 4.2b. Sociodemographic features for the 6 interviewed women.**

Parity	First baby (6)
Age	Range 30-39 years Average 35 years
Ethnicity	White European (1) White British (4) White other (1)
Employment	Out with home (5) Not working (at home mum) (1)
Employment role	Professional (1) Student (1) Other (3)
Household	Husband and child/children (6)
Issues you were worried about before the birth	None (3) Bereavement (2) Adult rape (1)
Issues you have been worried about since the birth	None (3) Ongoing recovery from birth (2) Bereavement (1)
Location of traumatic birth experience	NHS Lothian (4) NHS Greater Glasgow and Clyde (1) NHS Grampian (1)
Time since traumatic birth	6 months (1), 2 years 3 months (1), 2 years 4 months (1), 2 years 8 months (1), 3 years 1 month (1), 4 years 2 months (1)

#### 4.2.2. Women informants' Birth Satisfaction Scale

The BSS-R is a Likert-type scale asking participants to rate their level of agreement with each item (see Appendix 3.16). Details of the sub-scales and scoring system is shown in Box 4.2.1. The summary BSS-R data is presented respectively for the 24 screened women and the 6 interviewed women (Tables 4.3a, 4.3b.). In keeping with [Martin et al. \(2018\)](#) both the subscale scores and total scores are summarised (Table 4.3c). For the QoC subscale, item 10 'The delivery room was clean and hygienic' does not relate to QPI and so the average scores excluding item 10 are also shown. It can be seen that the six interviewed women, those who met the criteria for PTSD-PC, had only slightly lower mean scores compared to the group of 24.

**Box 4.2.1. Scoring system for the BSS-R (Hollins Martin, 2014)**

- **The scores are coded:**
  - Strongly Agree = 5
  - Agree = 4
  - Neither Agree nor Disagree = 3
  - Disagree = 2
  - Strongly Disagree = 1
  
- **Four of the items are reverse-coded**
  - Q2: I thought my labour was excessively long.
  - Q4: I felt very anxious during my labour and birth.
  - Q7: I found giving birth a distressing experience.
  - Q8: I felt out of control during my birth experience.
  
- **There are 10 items in total, formed of three subgroups**
  - Stress experienced during labour (4 items)
  - Women's Attributes (2 items)
  - Quality of Care provision (4 items)
  
- **Overall score** across the 10 items can range from 10 (least satisfaction) to 50 (most)
  - Stress sub-scale: a total score can range from 4 (least) to 20 (most)
  - Women's Attributes sub-scale: a total score can range from 2 (least) to 10 (most)
  - Quality of Care sub-scale: a total score can range from 4 (least) to 20 (most)

**Table 4.3a. Number of women scoring each category of BSS-R (24 screened women)**

<b>For all 24 screened women</b>	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<b>Stress subscale</b>					
I came through childbirth virtually unscathed		1		12	11
I thought my labour was excessively long	8	6	5	4	1
I was not distressed at all during labour		1	2*	9	12
I found giving birth a distressing experience	12	8	3		1*
<b>Women's Attributes (WA) subscale</b>					
I felt very anxious during my labour and birth	8	8	4	3	1
I felt out of control during my birth experience	12	9	1		2
<b>Quality of Care (QoC) subscale</b>					
The delivery room staff encouraged me to make decisions about how I wanted my birth to progress		4	7	7	6
I felt well supported by staff during my labour and birth	1	5	9	7	2
The staff communicated well with me during labour	1	5	8	8	2
The delivery room was clean and hygienic	8	9	7		

\* for two women the distress occurred immediately following birth in the early postnatal period

**Table 4.3b. Number of women scoring each category of BSS-R (6 interviewed women)**

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
For the 6 interviewed women					
<b>Stress subscale</b>					
I came through childbirth virtually unscathed				3	3
I thought my labour was excessively long	3	1	2		
I was not distressed at all during labour				2	4
I found giving birth a distressing experience	3	3			
<b>Women's Attributes (WA) subscale</b>					
I felt very anxious during my labour and birth	2	4			
I felt out of control during my birth experience	4	2			
<b>Quality of Care subscale</b>					
The delivery room staff encouraged me to make decisions about how I wanted my birth to progress		1		2	3
I felt well supported by staff during my labour and birth		1	2	2	1
The staff communicated well with me during labour		1	2	2	1
The delivery room was clean and hygienic		3	2	1	

**Table 4.3c. Average scores for each subscale and total scores**

	Total scores	Stress subscale	WA subscale	QoC subscale	QoC subscale minus item 10*
For the 24 screened women	23.75	7.4	4.0	12.33	8.2
For the 6 interviewed women	19.8	5.7	2.8	11.3	7.5

\*Item 10 'The delivery room was clean and hygienic' does not relate to QPI

#### 4.2.3. Midwife informants online survey

The Background data for the 57 midwives who responded to the survey and the six interviewed midwives is presented in Tables 4.4a and 4.4b. respectively.

**Table 4.4a. Background data for the 57 midwives who responded to the survey (number of midwives)**

Length of practice	Main location of work	% of last year in current location	Aware of PTSD-PC prior to this study	Cared for woman and knew/suspected they had PTSD
Practised for less than 6 of the previous 12 months (4)  Practiced for more than 6 of the previous 12 months (53).  <b>Range:</b> 15 months - 32 years <b>Average:</b> 13.5 years	Consultant Led Unit (28)	> 50% (46)	Yes, for over 5 years (41)	Yes (43)
	Midwife Led Unit (3)	< 50% (11)	Yes for 1-5 years (14)	Not that I was aware (8)
	Birth Centre (3)		No (2) <sup>2</sup>	Did not answer (4)
	Community (18)			
	Other <sup>1</sup> (5)			

1. Other: Independent, fetal medicine, infant feeding, clinics within maternity unit.

2. Both work in CLU, for 5 and 18 years

**Table 4.4b. Background data for the 6 midwives who were interviewed (number of midwives)**

Length of practice	Main location of work	% of last year in current location	Aware of PTSD-PC prior to this study	Cared for woman and knew/suspected they had PTSD
5.5 years (2)	Consultant Led Unit (5)	> 50% (6)	Yes, for over 5 years (5)	Yes (5)
8 years (1)				
13 years (1)	Birth Centre (1)		No (1)	Not that I was aware (1)
21 years (1)				
30.5 years (1)				

Further details relating to the experiences of the 43 midwives who had at some time cared for a woman they knew or suspected was experiencing PTSD-PC (Table 4.4a.), is given in (Box 4.2.2.).

**Box 4.2.2. Details of 43 midwives' previous experiences of caring for women experiencing PTSD-PC**

<b>Area of care provision at time of knowing/suspecting woman had PTSD</b>	
Antenatal	7
Antenatal and intrapartum	1
Antenatal, intrapartum and postnatal	10
Antenatal and postnatal	12
Intrapartum	6
Intrapartum and postnatal	4
Postnatal	3
<b>Time when knew/suspected woman had PTSD-PC</b>	
Antenatal (from previous birth)	21
Intrapartum (from previous birth)	14
Extended postnatal (from current birth)	1
Routine postnatal (from previous birth or acute stress from current birth)	7

In the online survey, midwives were asked to select from a list of potential contributing factors those that they believe or know contribute to the development of PTSD-PC (Table 4.5.). Midwives were asked to suggest, in free text, the four most important actions required by midwives to reduce the risk of PTSD-PC. The text was entered into a word document and a word cloud was created (Figure 4.3.). Midwives also selected from a scale, how supported they felt in their workplace to achieve these important actions (Box 4.2.3.).



**Table 4.5. Midwives' beliefs about what contributes to PTSD-PC for women and the number who held this belief**

	Physical trauma	Emotional Trauma	Significant physical morbidity	Unplanned obstetric interventions	Baby was premature, stillborn or in NNU	Women's expectations not met	Women being unprepared	History of prior trauma	History of pre-existing mental ill health	Other
Midwives who were <b>aware</b> of caring for women experiencing PTSD-PC (43)	37	37	11	30	9	32	12	7	8	5*
Midwives who were <b>unaware</b> of caring for women experiencing PTSD-PC (8)	7	7	5	2	6	6	2	2	1	0
Midwives who were unaware of PTSD-PC prior to the study (2)	2	1	0	1	1	1	2	0	1	0

\* Potentially all of the above or a combination can contribute to PTSD.

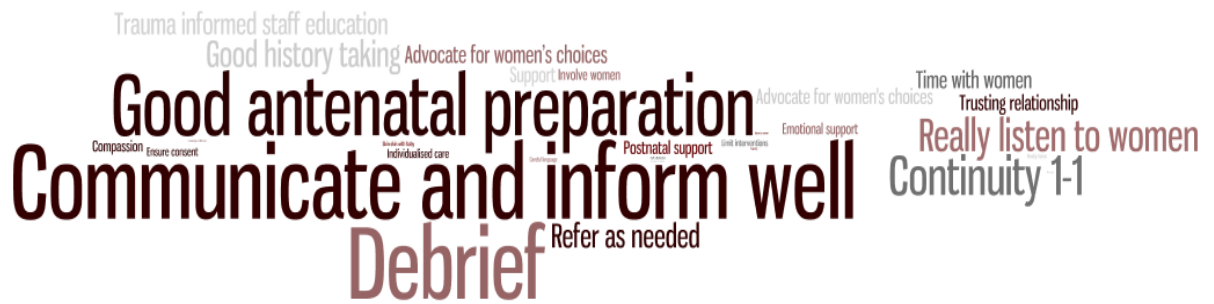
The woman not being properly communicated with or involved in what happens. Something about there being dissonance for her/ lack of integration.

No debrief and full explanation of what and why things happened during birth.

Woman was not believed about her labour experience.

All of above may have contributed, unable to be specific to the women I have looked after.

**Figure 4.3. The actions the 57 midwives considered to be most important to reduce the risk of PTSD-PC**



**Box 4.2.3. How often the 57 midwives feel supported in their workplace to achieve these important actions**

All of the time	3
Most of the time	22
Some of the time	27
Rarely	5

#### **Background data for the 6 interviewed midwives**

While sociodemographic data was not collected for *The Midwives*, background data was available from the survey and from meeting *The Midwives* (Box 4.2.4.).

**Box 4.2.4. Background sociodemographic data for the 6 interviewed midwives**

<b>Ethnicity:</b> all were Caucasian.
<b>Age:</b> estimated to be between 30 and 55.
<b>Motherhood:</b> Five were mothers, for one this was unknown.

#### **4.2.4. Summary of background data**

It is not the focus of this research to do more than describe the background data of the study informants. However, it is noted that all the women informants were white, of average age 34, and 23 out of 24 lived with a partner or husband. Of the six interviewed all had only one child. This sample does not represent any ethnic diversity or minority, nor the experiences of very young or older mothers. Of note, in terms of pre-existing factors that may influence the childbirth experience, five of the interviewed women had not experienced (or did not disclose) any prior interpersonal trauma.

The midwives' data suggest a strong awareness of PTSD-PC and understanding of the complex range of factors which may contribute that reflects current literature. The interviewed midwives' ethnicity and age were closely aligned to those of the interviewed women.

The next section presents the full qualitative IPA analysis of the interview data.

### **4.3. Introduction to the IPA analysis findings**

#### **4.3.1. Terminology**

Hereafter the study informants will be referred to as *The Women* and *The Midwives* when appropriate, to distinguish from the general population of women and midwives. All informants have been allocated a pseudonym to protect their identities. Please note that all data extracts are presented verbatim.

#### **4.3.2. QPI viewed through idiographic lenses**

There exists a key difference between *The Women's* and *The Midwives'* interviews. *The Women* described their lived experience of a particular past event, namely their childbirth. *The Midwives* who, as explained in the methodology chapter, had not interacted directly with *The Women*, describe a much broader lived experience encompassing different time points, events, and aspects within their current role as midwives. Across *The Midwives*, issues that were key for each differed to some extent, but there were core similarities. These formed the master and sub themes.

In keeping with the idiographic aspect of IPA, the analysis focussed on individual perspectives of each of *The Women* and each of *The Midwives*, regarding their lived experiences of QPI. Within *The Women's* experiences it was impossible to know the *facts* of QPI, what midwives actually said or did or failed to say or do. Therein lies a core dilemma of this research topic, that women's subjective experiences of QPI may not always reflect the reality of midwives' actions or inactions, nor the factors that influence midwives. When reading *The Women's* perspectives in section 4.5. there are many instances where one might wish to speak up on behalf of midwives and the realities they face. However, it is essential to allow *The Women's* voices to be heard as

they stand. In balance the full voice of *The Midwives* and their perspective has been presented first in section 4.4. Furthermore, section 4.6. discusses the convergent and divergent themes across both perspectives.

#### **4.3.3. Remembering the positive, highlighting the negative**

By definition, all *The Women* perceived their childbirth experience to be traumatic and all met PTSD-PC screening criteria, with Julie and Geraldine also diagnosed as experiencing PTSD-PC by their GP. When reading the analysis findings, it is important from a midwifery perspective to remember that *The Women* represent the 4% of the population of childbearing women who develop PTSD-PC (Yildiz et al., 2017), and that, as described in the literature review, most childbearing women experience childbirth and QPI positively.

A key aspect of PTSD is the reliving of *hotspots* (Harris and Ayers, 2012), moments within the associated traumatic event that stand out strongly in memory. Consistent with the aims of the research, *The Women* were focussing on their experience of QPI and while this was mostly negative, they also had some strong positive experiences of QPI. Such dichotomy in experiences confirmed that *The Women* were not predisposed to only perceiving interactions as negative. This is crucial from a psychological perspective, as having a predisposition to always perceive a care provider negatively would need considered when interpreting the data.

Trauma and distress relate to negative aspects of an experience. Therefore, to deeply understand the traumatic experience of *The Women*, and identify recommendations for care practice, the focus must weigh more heavily on exploring their negative perceptions, understanding what these meant to *The Women* and how they felt. Nevertheless, where appropriate, positive perceptions are presented and serve to highlight what women seek and need. This balance will enable the development of clear recommendations. Presentation of both positive and negative perceptions of QPI was possible in most sub themes, but some by definition precluded positive experience, for example *Threatening me*, but were balanced by positive findings in other sub themes.

#### 4.3.4. Identification of the master and sub themes.

The process of identifying master and sub themes has been described in Chapter 3.

##### 4.3.4.1. How the findings emerged through the analysis process

Table 4.6. presents an overview of how steps 2 to 6 of the analysis process outlined in chapter 3, enabled the findings to emerge.

**Table 4.6. Examples of emerging findings produced by the analysis process**

Steps	Process	example	comments
<b>2 and 3</b> Initial noting and identifying emerging themes.	Using A3 coding pages to perform initial noting by hand.	Appendix 3.20	For each informant this process created 17 to 25 coding pages and several hundred initial emerging themes.
<b>4 and 5</b> Gathering emerging themes into sub and then master themes per informant.	Initial colour coding of emerging themes to enable creation of sub themes.	Appendix 3.22.	The colour coding enabled like themes to be grouped into initial sub themes.
	Process of identifying the master themes per informant.	Appendix 3.24.	Examples of the enactment of the processes of numeration, polarisation and function can be seen on the pages.
<b>Step 6</b>	Identifying patterns across the cases and finalising the overall master and sub themes	e.g. The master theme <i>being a nuisance/bother</i> was highlighted by two <i>Women</i> . Closer examination of the other <i>Women's</i> transcripts showed that potentially related themes of <i>being shamed/blamed/feeling foolish</i> arose for them.	This process was iterative, initial groupings were revised until overall final master themes were settled upon that best represented the data for each group.

For an example of the iterative lists of themes groupings and processes see Appendix 3.25.

#### 4.3.4.2. Writing up the analysis findings

Once the final master and sub themes were settled upon, the process of identifying illustrative extracts from the data was performed. Considerable overlap existed between sub themes and choosing appropriate extracts often required more than one attempt, utilising deeper analysis, during which important links became more obvious. This iterative process enabled a deeper sense of the emerging themes, with further interpretation and refining of sub and master themes. For example, deciding that *The Women's* sub theme *Threatening me* was more relevant in the master theme *Shattered expectations* than in *Whose power?*

#### 4.3.5. Presentation of results

The literature review showed that women's voices have previously been presented regarding their experience of QPI and yet midwives' voices have not. This has been balanced by presenting *The Midwives'* analysis first. The master and sub themes are presented in graphical form. The iterative process of identifying sub themes reflects the multifaceted interconnection between some sub themes. While sub themes within a particular master theme are by definition somewhat connected, the interconnections between sub themes across master themes are also presented graphically for each group. In keeping with guidance from [Smith et al. \(2009\)](#), this chapter only presents description and interpretation of the data, although where it helps to clarify focus or direction, key references will be included. The discussion of findings in Chapter 5 combines links to wider theory and context.

Regarding presentation of extracts see Box 4.3.1.

##### Box 4.3.1. Notation used in extracts

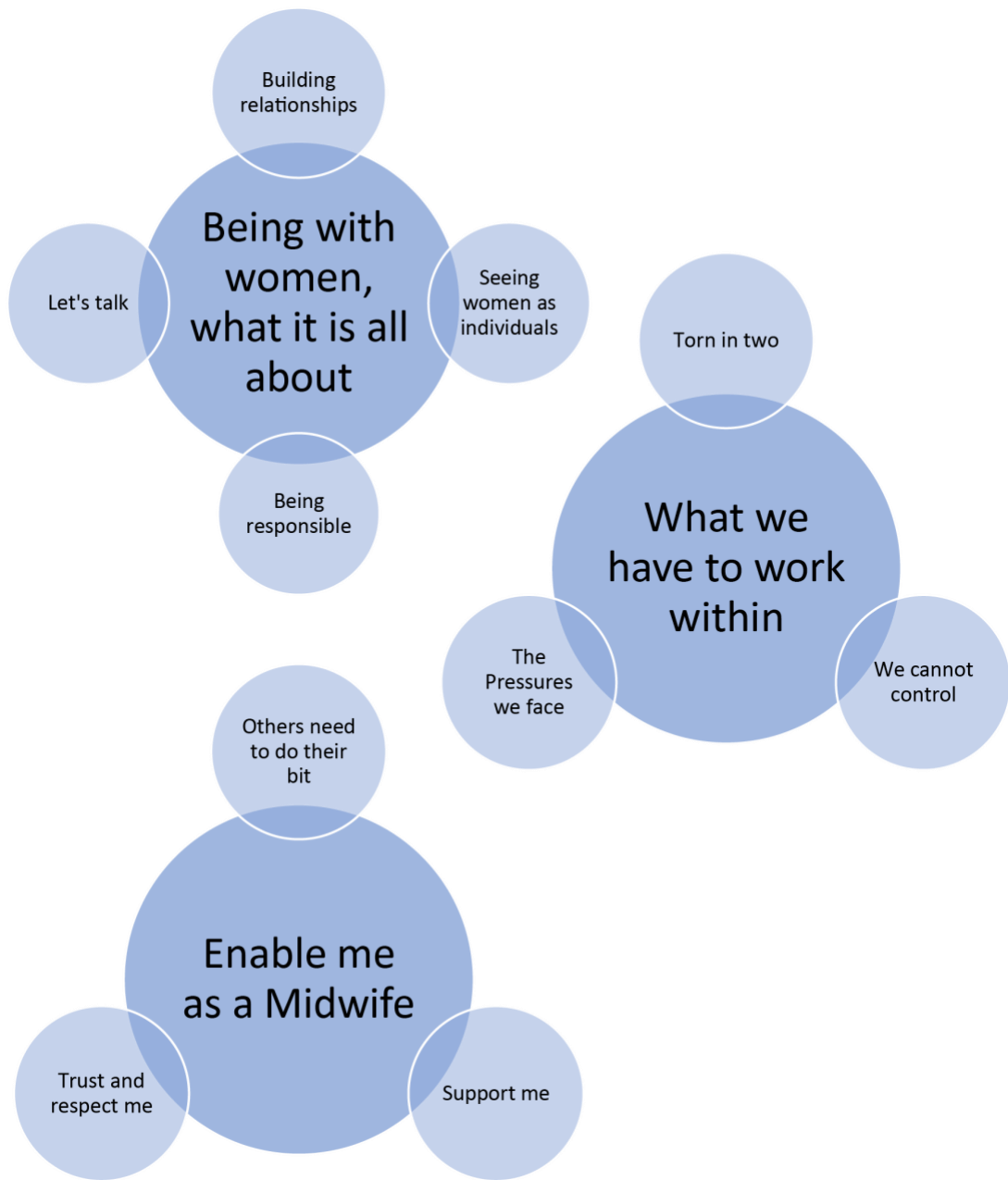
(...)	some text excluded
...	a pause
Text in <b>bold</b>	signifies emphasis or exclamation by the informant
(notes in brackets)	describe other features of what has just been said, such as volume or emotional behaviour

#### **4.4. *The Midwives'* experiences of interacting with women during labour, birth, and the early postnatal period.**

##### **4.4.1. Introduction**

New midwifery students often arrive with vision, passion, and idealistic dreams about what being a midwife will mean for them (Kirkham, 2010, Davies and Coldridge, 2018). Much of their midwifery education will uphold this passion and vision, yet many lament a gap between theory and practice (Armstrong, 2009), and once qualified, midwives often face a reality that does not match their once idealistic vision (Donohoe, 2018). This pathway was clearly expressed by each of *The Midwives* in relation to how they experienced being with women and is reflected by the master and sub themes (Figure 4.4.).

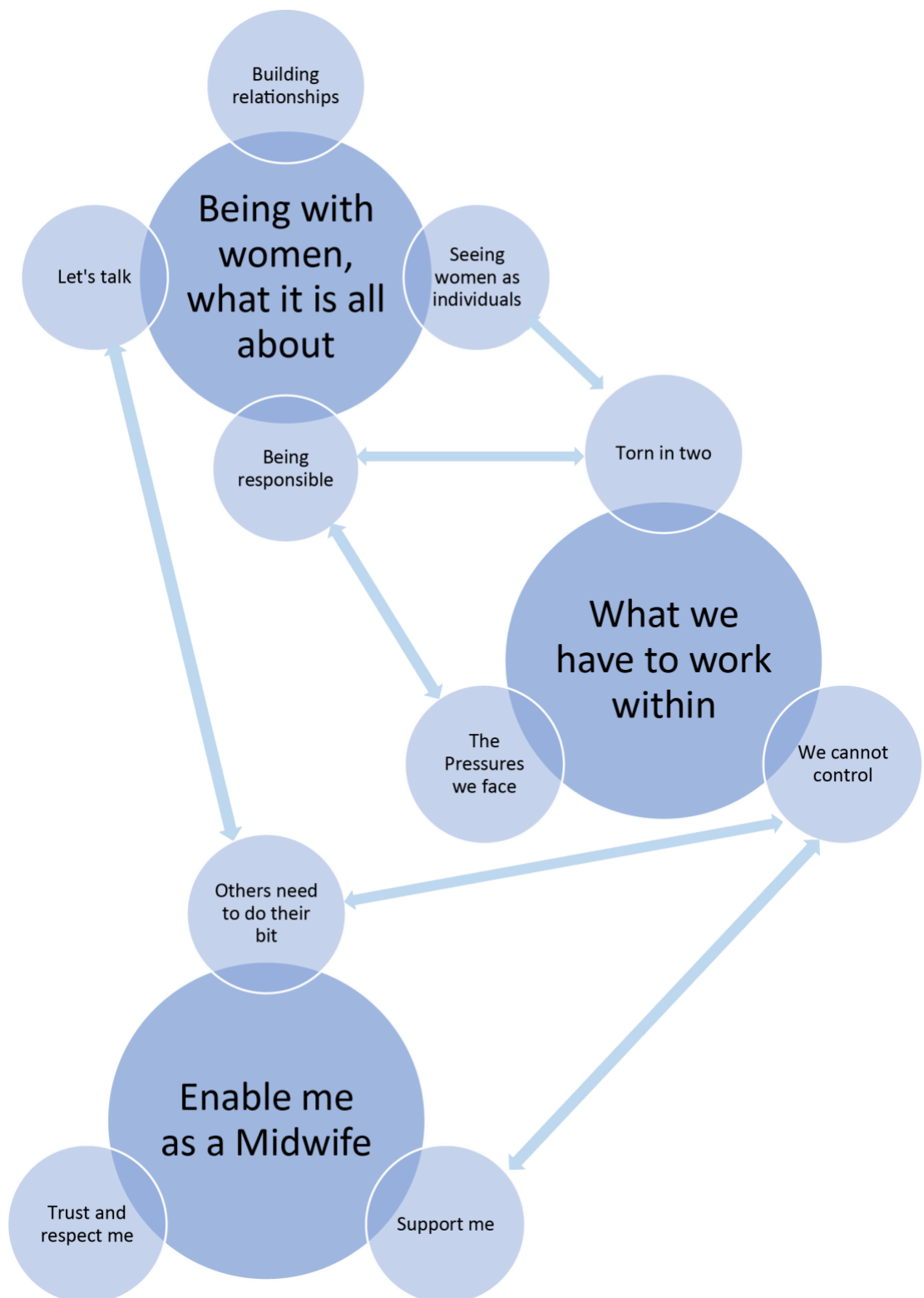
Figure 4.4. Master and sub themes from *The Midwives' data*



As discussed in Chapter 3, distinguishing between sub themes was challenging as overlap often existed. By definition the sub themes within each master theme are somewhat related. Connections also exist across sub themes of different master themes as shown in Figure 4.5.



Figure 4.5. Connections between *The Midwives'* sub themes in different master themes



#### **4.4.2. Master theme 1: Being with women, what it is all about**

##### **4.4.2.1 Introduction**

Throughout their narratives, *The Midwives* express passion and vision in terms of building relationships with women and wanting to enable and empower them as individuals. *The Midwives* emphasise the privilege of being with women during such a key life event. Susan says, '*you're sharing...what's...likely to be one of the biggest experiences of their life*', while Mandy feels she encounters women at a '*specific time, which is super, super important.*' Alongside this privilege, *The Midwives* express a deep sense of responsibility for keeping women and babies safe. This master theme therefore explores four sub themes: (Box 4.4.1)

##### **Box 4.4.1. The sub themes of *Being with women, what it is all about***

1. Building relationships
2. Seeing women as individuals
3. Let's talk
4. Being responsible

##### **4.4.2.2. Sub theme 1: Building relationships**

This sub theme explores *The Midwives'* descriptions of the nature and process of getting to know women.

###### 4.4.2.2.1. Building relationships is essential

For *The Midwives*, building relationships is synonymous with getting to know women, being more than just a pleasant exercise, and fundamental to providing good care. For Kerry, providing the '*best care*' means '*trying to get to know the woman.*' All *The Midwives* strongly value their relationships with women. For Brenda, developing relationships is '*what it's all about*' and '*the one thing that I really wanted to focus on.*' Alice feels it is '*a close relationship that you have with women.*' The quality of relationship influences the time and attention given to women, their ability to identify women's needs, and is instrumental in how they advocate for and work with women. In other words, a good relationship fosters a desire and ability to care, making it easier for Rosie to '*go that extra mile to make sure they've got everything they need*', and Alice to '*help them get what they need.*' Looking at it another way, Susan feels not

knowing the woman makes it more difficult to *'pick up on (...) her behaviour cues'*: (Box 4.4.2.)

**Box 4.4.2. Extract from Susan 4:45-47 5:1-2**

*'I suppose as a midwife if...you...build up a good relationship from the start then...if that level of trust is there, then the woman might hopefully, you know take on board what you're saying'*

Susan does not presume that a good relationship is guaranteed, but feels it is up to her to create this. However, this effort is worthwhile in terms of the ultimate goal of trust, which will mean women are able to respond and work together with the midwife as required.

4.4.2.2. Building relationships requires time

For all *The Midwives*, spending time with women is integral to building relationships. They feel that being with women from early in the childbirth process is important, with continuity though birth and into the early postnatal period. Mandy echoes Brenda who feels that having time with a woman in early labour, is crucial in terms of getting to know her, making *'a huge impact in developing that relationship'* particularly if she is distressed, in which case Mandy will *'definitely try to manage to get that time with her'*. For Kerry, taking over care during advanced labour can mean there is no time to get to know the woman *'you've not had that chance to get to know them.'* Spending time with women is so important to Susan, as she is frustrated by midwives who *'don't spend time with their women'*, often insisting on being able to stay with her women, as does Kerry, *'when you're with the woman...you're trying to be with her and only with her'*. Alice reflects on the positive difference one woman felt when Alice *'spent a bit of time with her'*. However, in contrast, Mandy does not feel that always being in the room is a good thing: (Box 4.4.3.)

**Box 4.4.3. Extract from Mandy 16:4-13**

*'Sometimes I feel that being in the room the entire time...is just weird, because I've not been trained like that I guess. So, staying with a woman and the couple doesn't give them lots of intimacy, so on that...point of view that's a bit weird because sometimes you don't need to speak about...anything...and she doesn't really need you...there at that point for, you know...sometimes quite a bit of time, so you're just there, and they're here, and it's just like very weird, so...that is a bit weird.'*

While Mandy appears to sometimes be very uncomfortable about remaining in the room, which may stem from her training, there is also a sense of discomfort in relating to women. Being in the same space, but not together, suggests a distance between herself and the woman or couple. However, Mandy highlights her awareness of the potential needs of women for privacy and so is potentially tuning into the individual needs of women, which links with the sub theme *Seeing women as individuals*.

**4.4.2.2.3. Continuity helps to build relationships**

While Mandy feels it is sometimes unnecessary to stay in the room with the woman, she highly valued one-to-one care, and giving full attention to *'that specific patient and her baby.'* This is echoed by the other *Midwives* who all desire to have continuity and uninterrupted one-to-one time with women in order to build relationships. Alice says, *'it gives you more opportunity to be that woman's advocate if you know her and you've known her all along.'* Susan echoes this with, *'you're not gonna...you know...get to know her as well, if you're in and out, in and out.'* Mandy feels it is much easier to follow-up with a woman and go over the birth and what happened when she is the midwife who went through it with her, because *'you know exactly what happened'*, which gives her the opportunity to know more than just the documented clinical aspects, rather she has a sense of *'the entire aspect'*.

**4.4.2.2.4. Relationship goes beyond birth – maintaining continuity**

All *The Midwives* see their relationships with women as continuing beyond the birth of the baby into the early postnatal period. They view the early hours with mother and baby, both as a continuation of the forged relationship, and as an important part of midwifery in terms of helping the woman transition to her new role as a mother.

Brenda believes that intrapartum care doesn't stop '*as soon as the baby's delivered*', and desires to have time to continue the relationship: (Box 4.4.4.)

**Box 4.4.4. Extract from Brenda 12:1-2, 8-12**

*'Maybe not so much intrapartum, but in the immediate postnatal period (...) I think women deserve, you know, time to talk about the experience that they've just had em...time to help with breastfeeding...helping having a shower and all the little things that are done after you've had a baby.'*

While Brenda is describing the needs of the woman, there is a sense that she as a midwife values this early time after the baby is born. Brenda's expression, '*All the little things*', suggests intimacy and a level of relationship. She desires time to debrief and to just relish being with this new family, enjoying the special moments following the birth.

The other *Midwives* highlight the importance of this immediate postnatal period when expressing their distress at being separated soon after the birth, with this discussed in the sub theme *Torn in two*.

4.4.2.2.5. Actively building relationships

Building relationships means more than just being present with women. *The Midwives* all recognise that it involves active behaviour on their part. Brenda desires to '*make eye contact with women, smile*'. For Alice '*it's about being **active** like midwives and women **actively** looking at stuff and **actively** seeing what's right for you in the situation*'. Reading body language is a skill Brenda values: '*you can just tell by the way someone's holding themselves and the way they look*'. Likewise, Susan feels that being able to observe and '*notice their body language and how they are*' is necessary when trying to '*build up the rapport*'. For Mandy getting to know someone means being present and open, and physically sitting at their level. All *The Midwives* describe generally chatting with women, which involves talking and getting to know them. Susan enjoyed '*a wee a bit of chat*'. Brenda '*would just talk to women about their lives about their health about how they felt about what their wishes were*'. Kerry notes it is

possible to see what ideas and expectations women have through '*just general chit chat*'. Rosie says, (Box 4.4.5.)

**Box 4.4.5. Extract from Rosie 10:19-29**

*'I would hope to...meet somebody that you can try and get some rapport with, however that may be em...sometimes that doesn't happen instantly, sometimes people need a bit of time to get use to you, to get used to your way. Especially if they've seen so many people over the course...em...but I would hope for somebody that I could have some sort of conversation with, not necessarily about the actual pregnancy and situation that they are in but just some sort of...em chat with, cos I think it makes everybody feel a bit more comfortable.'*

Rosie expresses the active nature of building relationships, spending time, recognising individual needs, but also how it is important for her to be able to use conversation to build connection. Rosie finds chatting is often much more comfortable and enables rapport to be built, which she sees as foundational to the relationship. Like making a new friend, time is needed to chat, soften the edges of unknown, and begin to get to know.

4.4.2.2.6. Recognising individuality when building relationships

When *The Midwives* develop strong, positive relationships with women, this is deeply satisfying and rewarding, especially if they receive clear, positive feedback from women. However, all *The Midwives* recognise that the individuality of each woman is a key factor in building relationships. Mandy, like Rosie, notes that not everyone is easy to get on with, because '*we are all very different, and we cannot get on with, you know, with everybody.*' Rosie finds women '*sometimes quite abrupt, sometimes quite difficult to bond with*' and goes on to say '*rapport can be very difficult to get*'. Brenda recognises that women's backgrounds, especially negative or challenging life experiences, can make them '*hard to reach, very guarded*' and unwilling to '*engage*'. Brenda further describes, (Box 4.4.6.)

**Box 4.4.6. Extract from Brenda 15:28-32 16:4-7, 10-11**

*'I think I've felt that that sort of satisfaction that I've got a really positive relationship with that women and em...there's been a positive outcome from that I think that's probably those are the times that I find more em...get more joy from (...) when you get feedback from a woman saying 'I've not been able to speak to anybody about these things but I can tell you' or 'You're the only person that's listened to me' (...) It makes me feel like I've done a good job in developing that relationship.'*

It is clear that Brenda values the relationships she builds with women as key in her role. She is particularly pleased when she manages this with a woman for whom things are difficult, recognising that the quality of relationship has enabled improved communication and a potentially better outcome.

**4.4.2.2.7. Summary of sub theme 1: Building relationships**

All *The Midwives* recognise building relationships as key. They desire to be able build relationships early in labour, to have time and continuity to get to know women and develop and maintain their relationships, particularly into the first hours after the baby is born. They each recognise the active behaviour that is required of them in building relationships, particularly the use of empathy and communication, acknowledging that the individuality of women influences the nature of the relationship. They express strong feelings when the relationship is lost or broken, further highlighting the importance of this relationship for *The Midwives*.

***4.4.2.3. Sub theme 2: Seeing women as individuals***

*'Always putting the woman and the child at the centre of the care and then everything else around that'* Kerry 3:4-5

This sub theme explores *The Midwives'* perceptions of the individuality of women.

**4.4.2.3.1. Individuality of women**

All *The Midwives* describe trying to work with the individual nature of women who vary in terms of preparation for childbirth, the impact their preparation may have had on them, and how fixed they are with regard to their desires surrounding childbirth,

Kerry notes that *'some women have very set ideas of what they'd like.'* Sometimes women have particular needs not necessarily shared by all women, and Kerry acknowledges that this is especially important for a first-time mum because *'it's a **completely** new experience for them'*. *The Midwives* all refer to the importance of understanding these individual needs and not applying broad brush strokes to all women without reflection. When Rosie feels women's needs and desires have been met: *'it feels like you've done your job properly.'*

#### 4.4.2.3.2. Being open and non-judgemental

In order to see the individual woman and understand her needs, all *The Midwives* feel they must put aside their own expectations and attempt to be open to whatever women have to say. Rosie feels everybody *'wants different things from you'* and doesn't *'really have an expectation of anybody'*. Similarly, Brenda feels it is not helpful to bring *'my expectations I think it's better to hear theirs.'* Kerry feels the best way to look after women is to find out *'the important things they want and their expectations'*, which is echoed by Susan who feels, *'it's not all about me though, it's about them'*. In other words, *The Midwives* feel it is important not to pre-judge women or to make assumptions of how they will be or what they want. Brenda aims to begin with a *'blank canvas'* and not assume *'this is what's going to happen, or this is who these people are'*. Rosie remains open to women who are sometimes labelled as difficult, aware that often it's unknown *'what experiences they've had'*, noting the importance of seeing the *'person at the end of it'* and taking the time to *'actually go into the woman and speak to her'*. Alice feels her role is to not judge, but to *'support the women in whatever they want'* seeing everybody as *'so different'*. Susan finds that being open in her approach is key: (Box 4.4.7.)

#### **Box 4.4.7. Extract from Susan 11:16-24**

*'That often will prompt them to start telling you kinda what their expectations are and what their hopes, and what their em...hope to achieve in the labour. Em...pain relief is always (laughs), it's always a discussion point, but at the same time you don't want her to...feel that either she **should** be having something, or she shouldn't be having something, you know em...I feel, I feel like it should be driven from them.'*



Susan is emphasising her openness to finding out what is important to this individual. There is a sense of treading carefully, and ensuring the woman is free and able to direct what is happening in a way that is suitable for her.

#### 4.4.2.3.3. Tailoring care to the individual

*The Midwives* recognise that how they are able to be with women is influenced by the individual nature of each woman and her unique experience of the childbirth process. Taking a stance of openness and non-judgement is a start, but *The Midwives* also speak about needing to maintain this throughout the process, through continually being open to the unfolding needs of women. Mandy feels it is important to be as *'suitable as possible for this specific patient'*. Alice sees it as holding the space rather than directing events, to *'go with the flow'*. Susan feels it is important to stand back and observe the individual and take account of *'what her feelings are'*. Susan further reflects that women respond differently to the pain they are going through, and their relational needs vary as *'some of them can be quite chatty in between the contractions, others just want to...be...in their own wee world'*. This is echoed by Kerry, who notes the importance of understanding the woman's needs at the point when she takes over, which is most likely impacted by what has already happened, such as if she has an epidural: *'all they want to do is sleep'*. Kerry further notes, (Box 4.4.8.)

#### **Box 4.4.8. Extract from Kerry 11:7-10**

*'Some women don't want you to talk to them in labour, which is fair enough...you know if they just want to be in their own wee zone and just crack on and get on with it and do it that way or they're hypnobirthing.'*

Kerry is aware that different women want to labour in different ways. There is a sense that although Kerry might prefer to talk to women and make connection in some way, she is trying to respect that individuals might feel differently. It is not clear how Kerry knows the woman doesn't want to talk, but this is possibly a skill borne out of many years of being with women.

#### 4.4.2.3.4. Using empathy to understand women's needs

Taking a stance of openness, and being willing to tailor care to needs, are both quite practical and cognitive. However, *The Midwives* express a deeper thread, which encompasses the relational, emotional, and somewhat intuitive nature of midwifery, and that is the use of empathy. While empathy is connected with building relationships and connection, it is clear that all *The Midwives* use empathy primarily as a way of tuning in to women's individual needs.

Three *Midwives* describe putting themselves in women's shoes and trying to connect with what they might be thinking and feeling. Alice and Brenda describe doing this through the shared experience of childbirth. Alice says, *'imagine it was you'*, remembering the positive impact having children had on her life, noting that it's *'a huge deal for women (...) for them to identify as women...and to be proud in it'*. Brenda tries to think back to what she would have wanted: *'to hear or feel from a midwife when I was in labour'*. Rosie is also aware of the needs of women's partners, especially during an emergency when all focus is on the woman and partners are often unattended expressed as, *'I know how it would feel if it was me with someone that I cared about.'* Alice, Mandy, and Rosie express empathy for women, especially if women are difficult to relate to. Alice said, *'I know where it's coming from'* noting that they are likely to be *'vulnerable and sore'* and *'this is a new experience for them'*. Rosie notes, *'It's a vulnerable time for women'* and Mandy mostly accepts how women are and doesn't expect much from them because they're busy *'being sore and being tired and being upset with everything.'* Susan finds it can be more rewarding to help a woman who is *'quite stressed, traumatised'*, or *'bereaved'*, suggesting a positive association between level of need and sense of reward. Brenda tries to make sense of a difficult encounter with a woman: (Box 4.4.9.)

#### **Box 4.4.9. Extract from Brenda 9:10-18, 23-24**

*'The woman was terrified because of those factors (not being heard and forced to comply) and she...she was physically em...aggressive towards me and shouting and afterwards was hugely apologetic and em...was very embarrassed about how she'd felt and I...I didn't want her to feel embarrassed and I didn't want her to feel sorry cos I think the reason why she was like that was...em...she was absolutely terrified and it was...wasn't my own fault (...) I feel em...and I think that's why she was so...so kind of negative and em...antagonistic.'*

Brenda's unease at the woman's embarrassment and apology reflects her desire to convey her understanding of the woman and the acceptability of her behaviour given the circumstances. Brenda interpreted the woman's behaviour as resulting from her fear, and not from any action by Brenda, and this lack of sense of fault, possibly because the situation was out of her control, which is strengthened by Brenda's ability to be generous towards her and to try to see what else might be the cause.

#### 4.4.2.3.5. Women are individual in their perception

Another aspect of recognising individuality is expressed by three *Midwives* who reflect that a woman's perception of her experience is unique and not necessarily the same as the midwife's, or other women with a similar experience. Alice reflects that as a midwife she may not see something as traumatic, but this is not necessarily true for the woman. Rosie often wonders how it is for the woman, particularly if it '*looked pretty awful...like lots of intervention and looked a wee bit dramatic, traumatic*', but finds that sometimes women are indeed fine, and at '*other times really not.*' Mandy reflects that two women with the same experience '*are going to leave that experience in a very, very different way.*'

#### 4.4.2.3.6. Summary of sub theme 2: Seeing women as individuals

*The Midwives* understand that seeing women as individuals and interpreting their needs is integral to their role and although closely bound with developing relationships and getting to know women, this emerged as a strong sub theme in its own right. Being present to the individual requires *The Midwives* to be open and non-judgmental, putting aside their own expectations, and recognising that it is all about women and what they want. They consider it necessary to tailor care to the individual, identifying individual needs as they unfold, and responding to these rather than their own desires. *The Midwives* use empathy to identify needs and remember that while events may unfold as they do for other women, each individual might perceive things differently.

#### 4.4.2.4. Sub theme 3: Let's talk

*'A lot of its communication'* Susan 5:2-3

This sub theme explores what communication means to *The Midwives* in terms of what, how and when communication takes place. Within the *Building relationships* sub theme, *The Midwives* describe getting to know women through general chatting. Here, the focus is on more direct communication about care procedures and women's needs related to the childbirth process.

##### 4.4.2.4.1. Women need information and to be empowered to make choices

All *The Midwives* emphasise the importance of providing information to women. They recognise that women need information to enable them to prepare for childbirth and Alice finds it exciting to *'give her the information...and prepare her'*. Alice and Brenda emphasise the need to ensure women know and understand what is happening, respectively to *'keep her in the loop'* about the facts and options, and *'things that they might want to think about.'* While there is little direct mention of informed consent, it is clear *The Midwives* recognise women's needs to make decisions. Rosie talks about her distress when medical staff carry out procedures without clear information and consent, which is explored in the sub theme *Others need to do their bit*. Alice sees communication as *'empowering'* women by keeping them involved in the process and giving them *'as much choice as possible'*. Rosie refers to, *'giving her some power'*. Alice sees this as enabling women to make their own decisions about what was right for them by *'letting them make their mind up'*, and Susan reflects that women's choices are limited when *'they are not being heard'*. Ultimately Alice feels happy to go with decisions: *'as long as I feel like the woman's been involved'*, echoed by Mandy who is *'happy with that because that's her choice, and we had that discussion'*, while Rosie feels a woman might feel better if she *'made some decisions herself rather than...let us'*. Kerry reflected on her role in communicating to others on behalf of women, noting that sometimes women are unable to *'voice'* things, which then becomes her role: *'you've always got to...say it'* as the advocate for women.

Rosie acknowledges the wonder of childbirth, through expressing that, *'their bodies are doing something really positive for them'*. Whilst Alice laments a lack of celebration of childbirth and feels passionate about enabling women to know how amazing they are: *'I mean for me anyway that's why I'm a midwife.'* Alice expresses, (Box 4.4.10.)

**Box 4.4.10. Extract from Alice 11:12-24**

*'I think it's an amazing thing isn't it to grow a baby and push a baby out in labour and that. It just happens, it's an amazing thing and I would like to make women feel that that how amazing that is for them you know. I think if you understand what's going on even the wee...you know, the wee ins and outs and the chemistry of what is happening and all that. If they kinda understand that they go "God that's amazing" you know. And their instincts of their baby when it's just born and all that. If you kinda explain that to them they're...get them to focus on that, they think it's amazing...I think that's really good for women...and babies and society (laughs)...sorry I'm rambling.'*

It is clear that Alice is in awe of childbirth and what women bring to life and that this passion drives her as a midwife and informs her way of being with women. Alice clearly wants to empower women, both in terms of their knowledge of childbirth and their understanding of their own power. Alice's wider view of the impact of childbirth on society and her apology for rambling further reflects her depth of passion.

**4.4.2.4.2. Finding out what women want to know**

Brenda and Alice acknowledge that women already have their own knowledge and understanding, and respectively see their role as midwives being to *'expand on that knowledge'* and give women information that they *'don't already have'*, tailored to what *'she needs'*. Identifying what women know or need to know is key within communication, with Kerry referring to using some *'set questions'* to begin this discussion. Susan describes needing to respond to the *'questions they may have'*, and Mandy repeatedly speaks about finding out *'If they've got any questions'* and striving to give them answers. Both Brenda and Mandy refer to the need to communicate specifically about pain relief and possible medical interventions, with Mandy finding out if women *'know what's gonna happen, if they know the risk, that kind of stuff.'* The *Midwives* are aware that how much a woman takes in or is open to knowing about aspects related to childbirth depends on her background, and Rosie relates this to

*'things that maybe people have said in the past'*, especially family and friends. For Susan what is important is tuning in to work out just how much communication the woman wants, noting that *'they don't necessarily want to talk'*. Kerry notes *'there's not an awful lot of chitchat when they're tired.'* The important role communication plays, especially when the reality is different from what women expect is raised by two *Midwives*. Kerry thinks it becomes difficult if women are not told *'why things are going to be different from what they expected or why we want to do something.'* While if Susan has a concern re safety, she wants women to understand why she is being offered a *'different type of care'* than she hoped for.

#### 4.4.2.4.3. The Midwives need information about women too

Susan, Kerry, and Brenda emphasise the need to find out as much as possible about women. For Kerry, while she can *'obviously get that from the handover and everything'*, she feels it is important to find things out by speaking directly to women, because, as Brenda also says, *'sometimes there's gonna be things that aren't in the notes'*. When trying to find out about previous childbirth experiences, Brenda reflects that there will always be things women don't tell even if it *'hasn't been particularly scary for them or traumatic.'*

#### 4.4.2.4.4. The way of communicating

All *The Midwives* speak about the importance of how they communicate. As Alice said, *'cos it's absolutely about the way you tell it isn't it?'* Susan and Alice both highlight events when women held onto their every word and remembered this for years to come. When meeting a woman who lost her baby two years ago, Susan is *'gobsmacked'* by the comforting impact of her words at the time: *'she's lost this baby, yet she's still remembers what I said to her'*. Rosie highlights that what might seem very clear to midwives and medical staff could be *'picked up completely differently by whoever's on the receiving end of it (...) often it's not in a good way'*. Susan describes, (Box 4.4.11.)

**Box 4.4.11. Extract from Susan 8:28-32, 22:16-19**

*'Being open and honest em...is always the best policy and I think women, whether you're saying something they want to hear or not, I think being open and honest they...respect you for it and I suppose we respect them as well (...) I think...often if...you...can explain what's happening, and why you're doing a particular thing, they then...sometimes say 'Oh, right, right so that's okay.'*

Susan clearly feels that honesty and openness are key in terms of good communication. She is keen to convey that she is not shy about communicating challenging things. On the contrary, she sees it as important that things are addressed head on, as this actually shows respect for the woman and it becomes easier to engage perhaps because there are no hidden agendas, no sense of mistrust or questioning. This is because everything has been brought out into the light. Susan finds that in turn, women afford her more respect and there is a sense of a much more equal and strong relationship.

**4.4.2.4.5. Listening**

Another key aspect of openness is being willing to really hear what women have to say. All *The Midwives* emphasise the importance of actually listening and ensuring the woman knows you are listening. Susan wants women to *'tell'* her what they need and notes that it is important not to *'put words in their mouth'*, while Mandy tries to *'as much as I could...be here to listen'*, and Brenda wants to *'just listen to them and talk with them so that they've got a chance to work things out.'* The importance Rosie places on listening is clear in her strong desire to ask other health professionals to just *'listen to them'*. While Kerry does not use the word *listen*, threaded throughout her narrative is the implication of needing to hear and understand women when she describes the need to do more than *'tell'* but to *'talk'* and *'discuss'*. Alice speaks at length about the importance of listening, noting that it gives women a sense of *'control'*, and whenever she has positive feedback from women it is usually about *'being listened to...whatever'*, feeling that when women have not been listened to *'it's such a shame because it's **such** an easy thing to do is just listen to someone'*. Alice says, (Box 4.4.12.)

**Box 4.4.12. Extract from Alice 1:19-21, 3:9-12,30-32**

*'Let the woman know that you're listening to her, and...and...actually to listen to them (...) I feel like listening to what the woman's saying is the **very first** thing that you need to do and is...it's not difficult...to do that (...) I think that listening to them is the **least** they can expect from us...is to listen to them.'*

Listening is fundamental in Alice's eyes. She strongly emphasises the primacy of real listening, as well as it being a simple activity that should almost go without saying. There is a sense though that listening is not always done and that Alice is vexed by the way in which it is, perhaps often, overlooked.

4.4.2.4.6. Birth Plans

Birth plans are often used by women to communicate their preferences to midwives. Their value as a form of communication was raised by three *Midwives*. While Alice is happy, describing it as '*absolutely brilliant*' when women present birth plans and seem to have prepared: '*it's fine by me what they want*'. Susan is reluctant to ask about birth plans because she finds that sometimes women became defensive because they think '*oh she wants to know, what does she want to know that for?*', and so she prefers to get to know women and just discuss directly with them and '*never really use the word birth plan*'. Kerry feels that discussing everything is important, because not everyone has a birth plan and '*there might be something they didn't know about*'. For Mandy, birth plans were very important: '*I would be the kind of midwife that would ask them to do a birth plan*'. Mandy sees reading the woman's birth plan as a good way to '*have a reflection prior to the birth of the baby*' and prioritise what needs to be discussed, yet she is anxious that women's expectations might not be met and strongly expresses that while '*this is a good way to bring the discussion*', women need to be realistic about birth plans. For Mandy, an experience where a woman declined (refused) care that Mandy felt was critical to maintain safety, left Mandy uncomfortable about women having very fixed birth plans: (Box 4.4.13.)



**Box 4.4.13. Extract from Mandy 14:1-8, 21:14-22,25-29**

*'This is why I don't like very strict birth plan, and that's why I don't like not being able to speak with the woman about her birth plan. (...) So just to make it clear...just to...maybe like use different words I think, that I would maybe not...I think prior to that, I would...I wouldn't have expressed that that clearly but now I would probably say, you know, I would probably say stuff...as clear as that "Right, this is your birth plan, I respect that. I am very happy", you know, "As long as every, everything is going straightforward, I'm very happy with this birth plan"...but then (...) I'd probably say well em...at some point I might, I might just give you different information or advise you differently.'*

This experience left Mandy somewhat uneasy, and in response she appears defensive and somewhat threatened by strict birth plans. It has caused her to reflect on her own communication, with a sense that she really feels she has to get through to women, even if just to warn them that things might not go to plan. Also, her respect and ease with a plan is conditional on things being well, and should this change, it appears that Mandy expects that women would be open to deviations from their plan.

4.4.2.4.7. Summary of sub theme 3: Let's talk

Lack of communication was clearly highlighted as an issue by *The Women*, and so this is an important sub theme to explore from the perspective of *The Midwives*. Building relationships with women and developing an understanding of their needs is strongly rooted within communication, which all *The Midwives* see as '*a two-way thing*' (Susan). They recognise the importance of providing information to women, to enable them to prepare and make informed choices, and also to empower them, but express that the process of communication is complex and not always straightforward. *The Midwives* recognise that women arrive with their own, albeit variable, knowledge, and see communication as the way to identify what women know and what they need or want to know. The method and approach used in communication is vital and influences how women interpret or take on board what is said. *The Midwives* all emphasise the key importance of listening to women throughout the process. Birth plans are discussed by *The Midwives* as both useful and to be approached with caution.

#### **4.4.2.5. Sub theme 4: Being responsible**

This theme draws together *The Midwives'* feelings about the responsibility inherent in their role.

##### 4.4.2.5.1. Getting it right for the individual, so she has a positive experience

Four *Midwives* express the weight of responsibility they carry as part and parcel of their midwifery role, recognising that they perform this role within the context of the vulnerability of women and the impact they may have on women's experiences. As Brenda and Alice note, this context incorporates the reality that for many women, childbirth is a unique and precious experience. Brenda feels the weight of responsibility as sometimes the '*only person that the women will look to for support*' and tries to communicate well and avoid reaching '*a point later down the line where there was any confusion*'. Brenda also feels she carries the responsibility to make sure the woman has a '*positive memory of the experience rather than, you know something that she just didn't want*'. Similarly, Alice feels that this is her job and the *onus* is on her to get it right. Alice also reflects that the everyday nature of her job means midwives should be aware of becoming blasé about '*very big deals in other people lives*'. This responsibility was echoed by Susan when she describes the impact she had on a woman by going in and out of the room: '*when I was in the room, she was actually a lot **quieter** I thought **wow** (...) she's maybe feeling vulnerable when I go out.*' Rosie recognises the responsibility she holds, expressing that she '*would be absolutely devastated*' if she thought a woman had developed PTSD-PC. Yet, Rosie also sees responsibility extending to the politics of the NHS, in terms of '*how that woman goes away feeling*'. Brenda reflects on how one woman's actual very traumatic experience happened in '*actually quite a short space of time*', from when she arrived in the hospital to when her baby was born. Alice reflects on the nature of childbirth, the responsibility of midwives, and the potential impact on women who are traumatised. Alice recalls contrasting situations where her acknowledgement, or not, of potential trauma impacted on the woman: (Box 4.4.14.)

**Box 4.4.14. Extract from Alice 14:27-31,38-40, 15:1-8**

*'Well, I...I already kinda said it but I feel just feel like it's a massive thing...to be a midwife, and to be with women when their having their babies, because it's massive for women isn't it? it affects their whole life...like (...) and so women who are traumatised and that...I mean that's terrible for them...in more aspects than just their birth experience their **whole Self** eh? I think...like that woman who was...she's completely changed now cos she feels more valued (was kept fully informed) or that other girl who was really traumatised by something that I didn't think was that traumatic (very quick but normal birth)...em...it's, it's, it's massive for everybody, d'y know...so that what I feel being a midwife's about and its horrible to think that women are traumatised, and it's usually by stuff we've done.'*

Alice expresses a great weight of responsibility in the face of such a massive event in someone's life. Added to this, the weight of knowing that even when things seem ok to her as a midwife, women can still be traumatised, with all the impact that carries for them. There is a sense that Alice relishes the status of the role of midwife and the opportunity to create a positive impact at such a precious time in a woman's life, but this is balanced with distress at the thought of being responsible for trauma.

**4.4.2.5.2. The future impact of the woman's experience**

*The Midwives* describe how their responsibility extends beyond the particular childbirth experience they are part of, into the woman's future childbearing choices or childbirth experiences. Kerry reflects that one woman's negative childbirth experience was *'why she had such a gap between her children because she was petrified about coming back to have another one'*. Both Alice and Susan use the word *'huge'* a few times, when reflecting on the impact on women from the way they are treated or communicated with. Susan reflects on discovering that a woman she had cared for, who had a neonatal death, had never forgotten how comforted she had been by Susan's words at the time, (Box 4.4.15.)

**Box 4.4.15. Extract from Susan 9:4-7,23-27**

*'To think...that we...in any...shape or form can influence that (women's childbirth experience)...it's...it's...it's a huge **thing** and...I'm not sure many midwives...quite understand that, the impact of that. (...) It wasn't until...maybe a couple of years ago that I actually realised the...true...tut...influence...and...what we...what we can exp...you know, do to women's experience and thankfully hers was very, hers was a positive one (felt fully supported).'*

While Susan somewhat echoes Alice's feelings (Box 4.4.14.), it feels important to represent both. Susan relates this with quite a lot of pausing and hesitancy, possibly reflecting a level of unease with the weight of this responsibility. It also seems that Susan has only recently in her career become aware of the level of influence she has, and it is possible that she carries a sense of anxiety about care she has provided over the years and is now easing this by highlighting that she is not unusual in this lack of awareness.

#### 4.4.2.5.3. Ensuring her pathway through birth has been optimal and safe

Four *Midwives* speak of their responsibility for safety. Kerry is concerned about getting the best outcome in all ways for the mum and baby, but *'still obviously be as safe as possible'*. She describes carrying in the *'back of your mind'*, a deepened sense of responsibility through awareness of babies dying or being damaged from *'bad scenarios that you've seen.'* Brenda expresses her fear of missing things and sense of responsibility when she says, *'you don't particularly want to be out of the room with her at all because she might be about to have a fit'*. For Susan, it is obvious she carries *'responsibility for ensuring safety as well'*, expressing that *'safety can become paramount'* when weighed against choice. Mandy repeatedly emphasises that keeping women and babies safe is the strongest drive and primary purpose of her role. This is reinforced by Mandy's language because, in contrast to all the other *Midwives*, Mandy refers to women as *'patients'*. Mandy's reference to women as *'patients'* possibly reflects a sense of pathology, viewing women to be requiring clinical care rather than to be supported through a normal human process. This sense is reinforced by Mandy's repeated reference to risk: *'because this is a risk, this is a risk for the baby and a risk for the mum'* and *'there's so many risks around the labour'*. Carrying this acute awareness of risk, almost certainly contributes to a weight of responsibility for getting women through the process safely. The following extract serves to illuminate the strength of focus and responsibility Mandy places around safety: (Box 4.4.16.)

**Box 4.4.16. Extract from Mandy 3:15-16,20-22, 9:26-28, 11:24-29, 12:21-22, 18:15-18**

*'But we're here to make sure they stay safe whatever happens (...) to make sure this woman and this baby stay safe, all the way through the process **whatever** (...) Keeping the mother and the baby as safe as possible. That's my...my mojo (laughs) no, that is the most important for me yeah, keeping them safe (...) I mean, as a midwife you're here to look after this baby and this woman and make sure they stay safe. This is what you're here for, this is what you're trained for, em...what you're trained your entire career for, just to keep up with your skills and everything, just to make sure the baby is safe (...) you're here to make sure...she's gonna stay safe. (...) If anything happened to this baby or this woman, or both, then that would, that would mean you would be responsible for not having done it according to...what the guidelines are.'*

There is little doubt that Mandy puts safety before all else, with her repeated reference to safety suggesting her perception of holding a huge sense of responsibility. There is also a sense that she needs everyone else to see that this is what it's all about, with all her training leading to this. What is concerning is that should something go wrong, Mandy sees this as potentially her failing, and possibly linked to not following a protocol. This ties in with Mandy's concern around women with strict birth plans discussed in the sub theme *Let's talk*.

For Brenda, Susan and Kerry, their sense of responsibility for safety was clear amidst concerns about being able to maintain safety in the workplace. Brenda describes, '*the environment for women and for midwives is unsafe*', while for Susan the negative workplace culture can potentially '*compromise safety*'. This is described further in the sub theme *The pressures we face*.

**4.4.2.5.4. The potential impact on the pathway of childbirth**

Susan also expresses the midwife's potential impact on the objective outcome of childbirth, noting that if women begin to feel '*unsafe and vulnerable*', this could inhibit the optimal progress of labour and possibly contribute to the need for interventions. This is also raised by Alice: (Box 4.4.17.)

**Box 4.4.17. Extract from Alice 7:18-33**

*'I think we push them further down that road by medicalising them and taking the power of it away from them so they've not been able to go into labour on their own, they've not been able to...em...labou...labour on their own without a drip, they've not been able to push the baby out, they've not been able to cope with the pain, they need an epidural, they've not been able to push the baby out they needed forceps or whatever and I think it's I think it's a terrible shame and we all know that one thing leads to another don't we? So, so, that first step for me of saying we'll go for induction which is banded about I feel very blasé about inducing people and it needs to be a much bigger deal than it is...em...I think that's the first step on that road and it makes me really it makes me really sad.'*

Alice expresses shame and grief at how, when they should know better, midwives and the system start women on the road to interventions. She acknowledges her responsibility for not removing and stripping women of power and ability, which makes women weak and vulnerable. There is a sense that she feels we do this when we create need, which takes away power. While this extract does not relate directly to the interaction with women, it highlights the impact the midwife and the system can have on the experience of women. Alice also expresses a lack of control within the bigger system, which is described further in the sub theme *We cannot control*.

4.4.2.5.5. Failing to meet this responsibility reflects a sense of onus on The Midwives

*The Midwives* describe feeling as though they sometimes fail in their role. While often the associated scenarios are related to other sub themes, such as *Building relationships* or *The pressures we face*, there is nevertheless a clear sense that *The Midwives* respect and value the responsibility they carry in their role. Like Mandy, Rosie describes times when she felt that *'you've done your job properly'*, while Susan reflects that when there is too much to do *'you do feel your care's then substandard'*. Susan goes on to express that when this happens, she comes away with *'feelings of 'oh' almost feelings of guilt actually'*. For Brenda, failing to build trust and rapport, means she has failed: *'cos I've not been able to do do my job'*, which leaves her feeling *'really upset'* and *'really emotional'*.

4.4.2.5.6. Summary of sub theme 4: Being responsible

Sometimes *The Midwives* explicitly state responsibility, and at other times it is implied. Four *Midwives* feel responsible for women having positive experiences of an event

that is highly significant in their lives. They feel the onus is on them as midwives, since women often look to them first, and whatever experience they have will influence future childbirth choices and experiences. Four *Midwives* highlight the fundamental responsibility for keeping women and babies safe, which determines *The Midwives* behaviours and actions. *The Midwives* reflections of times when they feel they failed in their role serve to further highlight the weight of responsibility they feel.

#### **4.4.2.6. Summary of master theme 1: Being with women, what it is all about**

For all *The Midwives*, being with women means actively building and maintaining relationships throughout the whole birth process and early postnatal period. *The Midwives* sometimes experience grief when a relationship is broken. Being able to set aside one's own pre-judgements and acknowledging the individuality of women enables midwives to identify needs and tailor care, cognisant of women's individual perceptions. *The Midwives* strongly value talking and listening with women. They see communication as the primary process for building relationships and identifying needs, alongside their own experience in tuning into women. Underpinning their way of being with women is a strong current of responsibility to keep women and their babies safe, which fundamentally directs and feeds all their ways of being with women.

#### **4.4.3. Master theme 2: What we have to work within**

*The Midwives* are acutely aware of the key aspects and responsibilities within their role and are driven to enact these in keeping with their vision of what it is to be a midwife and what they believe is important to women. Yet, the reality of the everyday experience, in terms of the workplace and the people they encounter, for both staff and women impacts on their ability to fulfil their roles as they believe they should. Master theme 2 focusses on *The Midwives'* perceptions of the reality they find themselves in and what it means for them in terms of their way of being with women. This master theme explores three sub themes: (Box 4.4.18.)

##### **Box 4.4.18. The sub themes of *What we have to work within***

1. Torn in two
2. We cannot control
3. The pressures we face

#### 4.4.3.1. Sub theme 1: Torn in two

*'It can make you feel that you're caught between a rock and a hard place'*

Brenda 6:37-44

This sub theme looks at *The Midwives'* experiences of having to simultaneously meet the needs and demands of women, management, and maternity colleagues.

##### 4.4.3.1.1. One size doesn't fit all

While Susan emphasises her awareness that regulations, policies and procedures are important to avoid staff being like *'loose cannons just doing their own thing'*, and so she questions the *'one size fits all'* approach. Rosie also acknowledges the importance of knowing *'your code, and the kind of ethics and the guidelines that you're bound by'*, but like Susan, felt *'it doesn't account for all scenarios'*. Alice feels guidelines are often misinterpreted, moving quickly from *'consider'* to *'must do'*, whilst recognising that sometimes the fear of being criticised means *'you just...go with it and it's not considered properly'*. Susan further describes the tension she feels when trying to respect women's choices when they go against systemic policies: (Box 4.4.19.)

##### **Box 4.4.19. Extract from Susan 5:10-24**

*'It can be very challenging em...particularly as...a...midwife...you know, based in a hospital, because you...legally, you know, you have...your employers, you know...responsibility, you have a responsibility to them, if there is certain...policies and procedures that we...should be following and then you have the ethical dilemma with the woman as well...so you can be...I sometimes feel...that...because of that we are often...we become like the middle person and you become a bit of a mediator...em...but at the same time...if...you're...assisting the woman to follow a particular path that she wants to do...I think legally because we do have an...obligation to our employers, to the NMC, we...we do have to...maintain a level of professionalism as far as that's concerned.'*

Susan clearly feels caught in the middle, pulled in not two, but three directions; between women's wishes, legal obligations, and ethical considerations. There is a sense that Susan really wants to perform in line with her professional role, with this also requiring her to be present for the woman and showing respect for her. Susan



struggles to solve this dilemma but appears to come down on the side of upholding professional regulations.

#### 4.4.3.1.2. Building bridges and locking horns

Four *Midwives* use language such as, '*battling and defend*' (Alice), '*lock horns*' (Rosie and Alice), '*make a bridge*' (Brenda), '*loose cannons*' (Susan), and '*conflict*' (Rosie), which reflect a sense of struggle and combat. Susan's use of the term '*frowned upon*' in this context suggests something not being as it should or could. In their attempts to respect the individuality of each woman, *The Midwives* appear to be, not so much fighting against, but trying to reconcile the needs of women, medical staff, and management. Brenda's description of '*trying to be; you know go between the two kind of parallel universes (laughs) and sort of try and make a bridge*', conjured up the image of having one leg in each of two boats, that are setting off in different directions. This left her feeling torn and trying to hold on. Rather than building bridges, Rosie describes trying to manage '*conflicts between everybody*' and expresses deep frustration at what she calls, '*this constant locking heads*' with the medical profession. Alice also feels that when it comes to listening to women, '*I lock horns a lot with the medical profession*'. Alice goes on to say that she usually manages to '*find a path through it*', by trying to '*protect the women and get them what they need...and not kinda lock horns too much*'. While becoming more senior has made Susan more confident in supporting women, she still feels that to deviate from a medical plan is '*often frowned upon*' and a '*very awkward position to be in*'. Susan describes the tension between using her autonomy as a midwife to respect a woman's declination to have a Cardiotocograph (CTG) monitor on, and having to defend her actions to the medical staff: '*I'd say "Well it's not on because that's not what she wants" and they're like "Well why?" you have to tell her she needs to have it on*'. Alice similarly describes trying to support women's wishes when they go against guidelines or medical opinion, (Box 4.4.20.)

**Box 4.4.20. Extract from Alice 8:16-20, 13:29-30,34-35, 14:2-5**

*'That kinda you feel like you're battling all the time against the system (laughs). This is a system that's supposed to...em...protect women and...it's a service...do you know it's a maternity service (...) I would defend I would defend that against anybody (...) because we all know it's what we should be doing and it's the right thing to (...) it's usually like a medical thing when there's something going on and I feel like a woman's being bullied or I feel it would be fine to wait, and they don't.'*

There is a sense of Alice struggling, caught up in a conflict between her sense of duty to care for and protect women in an environment that seems to be actively contradicting this aim. Alice is trying hard to reconcile what she believes to be right with what she sees happening, and when this is not possible she feels she has to fight for it.

4.4.3.1.3. Reconciling safety and women's wishes

Rosie, Kerry, and Mandy talk at length about the challenges they experience when women have strong demands that they feel jeopardise safety. Rosie finds it very difficult when women have very detailed birth plans, which often results in *'massive conflict between what she wants, what she expects, and what the advice is at that point'*. Mandy, like Kerry, describes interactions with particular women who had *'very strict'* birth plans. Mandy feels unable to act, and *'very useless because what do you do with a patient who is declining everything? (...) I couldn't go with her birth plan safely'*. In contrast, Kerry finds it particularly difficult to reconcile her concerns about the baby's wellbeing, when the woman declines monitoring: *'she didn't want any interference (...) she wouldn't let us do anything'*. Susan echoes the others when she describes the difficult dilemma between wanting a safe outcome and respecting women given that *'ultimately it is their choice and the path that they take'*. Kerry struggles with the reality that sometimes women's wishes just cannot be met, and that the time comes when the safety of the baby becomes priority and they need to apply pressure to get the woman to accept: *'to say that we want this rather than the way they're doing it'*. Kerry tries to reconcile these decisions with the woman's feelings: *'she was so disappointed but...I'm sure it was the right outcome overall'*. Mandy struggles to believe that a woman would decline something that would be *'safer for her, for the baby'*. Mandy further describes, (Box 4.4.21.)

**Box 4.4.21. Extract from Mandy 12:4-10**

*'And this is hard because during the birth, where you could be very supportive, and you could be...like flexible or you could...you could, em...I mean we can adjust and we can discuss stuff, but if they're not flexible then you feel that you're just pushing, you're just pushing through something that they don't want to consider.'*

Mandy is feeling very stuck, with nowhere to turn. She is open to finding a path, but it seems that there are times when she finds the woman to be holding fast in a way that restricts Mandy. Mandy therefore feels she has to break through and disrupt, and is aware that this is not good, but it seems she feels she has no option. Mandy expresses her need for women to meet her halfway perhaps, which fits within the sub theme *Others need to do their bit*. This sense of pushing women into something they don't want was clearly important for Kerry: (Box 4.4.22.)

**Box 4.4.22. Extract from Kerry 12:1-17**

*'Yeah...I think I always say I know you really want this or...em...or I know you'd, like that girl that really wanted the VBAC, I know you really want this but we've got to weigh up all the problems that are happening now and things that we can't control like the sepsis that you've got, and your waters have gone and baby's not happy and...so we're looking at the timescale of how long we can let you labour for, and looking at how baby...and then...see...you're trying to acknowledge that you hear what they want, but you can't actually give them it or you think it's unsafe to give them what they want at that point. So I just try and always yeah I think always try and acknowledge what they want and explain to them why it's not always possible to give them what they want...and...but you have that pressing time factor as well like you only have, you know, how long can you wait, that's the weighing it up...and it's never an exact science...that's the thing...kinda...'*

This extract encompasses the sub themes *We cannot control* and *Let's talk*, together with and illustrating the complexity of the midwife's situation. There is a clear sense of not having any control over the situation and being at the mercy of how things unfold, but within this Kerry is feeling the pressure of trying to acknowledge the woman, involve her and communicate, while feeling the pressure to act. Underlying Kerry's experience is a strong thread of fear.

In terms of negotiating and working out with women, Rosie hesitantly reflects that discussing the *'same scenario, over and over again'* leads to her feeling *'a bit impatient at times'*. While Susan believes finding a solution is sometimes possible: *'you can balance things, you can, not maybe not always'*.

#### 4.4.3.1.4. Abandoning women, loss and grief

As discussed in the sub theme *Building relationships*, *The Midwives* highly value their relationships with women. Kerry, Brenda, and Rosie struggle with being moved quickly on to care for the next woman as soon as a baby is born. Rosie feels, *'it's kinda like 'next' and off you go'*, and she struggles with the loss of relationship and putting onto women a sense of *'you're not important to me now that you've had your baby'*. Brenda finds it very difficult to be *'bounced from one room once the placenta's out you know, and you're shoved into another room with another labourer'*. She feels she has *'completely abandoned that woman'*, often moving her on without her *'having had a shower'*. Brenda is anxious about how this might impact on the woman's perception of her experience, which could turn *'negative really easily em...cos she's em...got no one'*. For Rosie, knowing that you have someone else waiting and beginning to connect with them in her head, leaves her *'a bit more disengaged'* from the woman she is with. Kerry notes that this imminent separation can lead to barriers, with even just small things affecting the whole relationship: *'it doesn't matter how small they are, but once you start having barriers there, it's...it's difficult to, you know, take them away again, yeah...once they're there I think sometimes that's it'*. Kerry expresses great regret and sadness, feeling as though she is *'leaving them'*: (Box 4.4.23.)

#### **Box 4.4.23. Extract from Kerry 6:51-53,7:1-10**

*'But it's very frustrating if you've looked after a woman, delivered her baby and you have no time afterwards with them at all...you know...someone else is 'Oh, I'll put the note through and I'll get them tea and toast and look after them and you go and look after that woman' so yeah we don't see them again...so...in that shift, you know, because we just can't get back to them, because you're looking after someone else...so that...that is...I find that frustrating...I think that that's the one I find the worst, because I feel like you should have that time with your woman afterwards and...just, just do everything with them, check the baby and just give a nice wee bit of peaceful and they can discuss things as well...yeah...'*

Kerry is obviously frustrated and also distressed at what seems to be a forced separation in her relationship with the woman. There is a sense of a bond created over time, and through the shared experience of childbirth. Yet, just as the relief, joy, and reward for all the hard work is about to be shared, Kerry feels torn away against her will. There is a great sense of loss and grief at not being able to see the woman again. Kerry is expressing a need for simple peace. She is simply saying *let me be with woman, let me be midwife*.

#### 4.4.3.1.5. Summary of sub theme 1: Torn in two

*The Midwives* reflect that within childbirth the system policies and protocols cannot be a one size fits all. It is clear across all six *Midwives*, that they struggle to meet the needs or desires of women while adhering to their workplace demands in terms of policies and expectations from other health professionals. Emotions such as frustration and finding things difficult are threaded through this theme. *The Midwives* describe conflict and battles with medical staff to uphold women's choices, or to maintain care pathways that they as midwives consider appropriate. With regard to safety, *The Midwives* find it distressing to push women into actions they don't want, and *The Midwives* are most conflicted when women's choices do not allow for any flexibility in action, even as *The Midwives* concerns grow. One of the strongest tensions is being separated from women very shortly after the birth, which closely echoes *The Women's* distress during this early postnatal period.

#### **4.4.3.2. Sub theme 2: We cannot control**

*The Midwives'* repeated uses of language such as, '*hopefully, might, chance, and can't*', reflect the uncertainty that surrounds childbirth. This sub theme explores how *The Midwives* find the nature of and circumstances surrounding childbirth impact on their way of being with women.

##### 4.4.3.2.1. Women want control, but we can't give it, we can't control childbirth

Brenda notes that women's previous experiences of childbirth, particularly if they are negative, influence their way of being with midwives, and often women arrive with fixed ideas as a way of '*having some control*'. Kerry emphasises that, '*nature isn't*

*always cooperative (...) nature does these strange things that we don't always have control over'. For Mandy, women trying to maintain control through having fixed birth plans is a particular challenge, not because Mandy did not want to support women, but simply because she sees childbirth as inherently unpredictable and uncontrollable: 'there is no way we can prepare a woman for the exact birth of her baby', because both women and midwives have 'a very small say in the matter'. Yet these very fixed ideas create a 'lot of work' for Brenda when things start to be different from what women desire or envisage. Mandy feels deeply that it is not possible to have control over childbirth: (Box 4.4.24.)*

**Box 4.4.24. Extract from Mandy 3:13-14,18-19,27-32,35-37, 15:28-30**

*'But...there's lots of, lots of, lots of interactions in there em...and we cannot...we cannot control everything (...) I am not responsible for...everything happening there, like I cannot decide...what the issues gonna be (...) is not my...choice, and It's not her choice either. (...) I don't think you can really decide for whatever is going to happen to you (laughs). There's too many, there's too many factors, to take into consideration there in that you're not, you're not, you cannot act on (...) they're part of something, which is bigger than them and they cannot, they cannot decide, for lots of that, what will happen to them (...)\_this is not their fault, this is not our fault, this is just the way, the way it is, the way the labour's going.'*

While Mandy clearly emphasises the unpredictable nature of childbirth, sounding somewhat overwhelmed with the potential complexity of the associated issues, there is an underlying sense that Mandy feels blamed by women for not managing to make it different. Mandy needs to make it known that often things are out of her hands as much as they are out of women's hands.

**4.4.3.2.2. When things do not go to plan**

Inherent within the unpredictable nature of childbirth, is that sometimes things just don't go to plan, and certain actions or interventions become necessary or else there will be a poor outcome: *'this is not going any other way'* (Mandy). Susan is aware that nothing is guaranteed and *'you can't 100% say if I did this that wouldn't have happened'*. While Brenda is disappointed when she is unable to turn things around *'to make that a positive experience'* for the woman, she realistically notes that there can be *'factors in the woman's care that were out with my control'*. In the case of an

emergency situation, Alice says, *'it's completely different'*, since midwives have no option but to act as required. Kerry and Rosie note that in emergency situations, *'you're not always able'* to communicate or support women because you're *'busy doing things'*, which is echoed by Mandy: *'we are too busy to do, you know, stuff to help them'*. Susan says, (Box 4.4.25.)

**Box 4.4.25. Extract from Susan 22:25-30,36-40**

*'You just need to get that baby out very, very quickly and...as a result you know there might be a lot of people come in the room at the one time which can be overwhelming, the dim lighting gets suddenly bright em...in an emergency situation it's not always...feasible to...explain (...) but sometimes you know if it...if it all happens so quickly it's, it's very, very difficult, em...I think in those situations...where you've felt things have come out with your control to be able to...demonstrate that at the time.'*

Here Susan reflects on her ability to be present to women in the way she would like to, with but giving information and managing the environment secondary to the requirement for emergency action. While Susan might be trying to justify why she cannot communicate in a way that perhaps women hope for, there is also the sense that Susan feels frustrated or even distressed at how things can be, and that she cannot relate with the woman as she might prefer.

However, while Alice feels that often in childbirth situations, control *'kinda it runs away'* and sometimes that's *'necessary'*. Alice also feels that, *'it doesn't need to be...it can be a positive experience whatever happens can't it?'* which suggests that sometimes there are ways of managing it all.

**4.4.3.2.3. Time and timing**

All *The Midwives* speak in different ways about the timing of their interaction with women, either in terms of the amount of time they have with women or the nature of the circumstances in which they encounter women. The point at which the midwife takes over care for the woman impacts on what is possible. Brenda is delighted when she meets women either before labour or in early labour, because there is time to discuss things *'before anything happens so before they're in pain, before their journey of labour started'*. For Susan, long shifts sometimes give her the opportunity to get to

know women, but if the woman arrives at a late stage of labour this is much more difficult. This is echoed by Alice who finds meeting a woman at an advanced stage of labour can limit what is possible, with being *'a bit late really, they're halfway down that road anyway'*. Similarly, Kerry finds there's often not a lot of time to *'keep her informed if you've just taken a handover at a really difficult time when they're pushing or something'*. For Mandy, the circumstances and *'atmosphere in the room'* during the *'first few minutes'* of interacting, determine how she will care for a woman. Mandy describes having little choice but to work within a short period of time, alongside the reality of circumstances.

#### 4.4.3.2.4. Being unable to change the workplace culture

The negative workplace culture was raised by five *Midwives*. From the start Rosie *'absolutely hated it'* and *'still'* finds her workplace *'a really, really, brutal place to work'*, with *'various barriers'* that stop her doing her job as she would like. Susan was initially happy in the workplace, but over the last few years became *'really quite frustrated with a lot of things. In contrast'*, Brenda describes feeling *'quite small in comparison'* to the *'huge culture of lots of very negative things'*. Rosie describes everybody *'trying to take some control back'*. Alice and Brenda often attempt to *'change things'* (Alice), but Brenda describes it as *'utterly impossible'*, and while feeling frustrated that she *'couldn't maybe do more'*, she believes that it will not *'change things for woman by continuing'* to try. Susan describes being worn down trying to change the culture, claiming that it is *'like banging your head against a wall'*, feeling there's only so much midwives can do *'when you're just constantly getting beat down and beat down'*.

Rosie, Brenda, and Kerry reflect on how their workplace culture impacts on their way of being with women. Rosie feels that NHS politics *'play a big part'* in how women feel about their births. She expresses deep sadness that her *'passion for being a midwife'* is negatively impacted by the *'politics of where I work'*. Rosie believes the negative culture builds cynicism in midwives, and she reluctantly shared, *'I'm not going to lie, I can be guilty of that...at times myself'* reflecting that, *'you don't always do it perfectly and I'm the same'*. Similarly, Brenda says, (Box 4.4.26.)



**Box 4.4.26. Extract from Brenda 16:28-36, 17:1-3**

*'It makes me really sad that that's how our unit is and that's it's one of the biggest kind of units around and...for some reason we can't seem to make it a good place to work em...and I don't know I don't know exactly what the...what will change it and what the factors are that keep making it like that but I feel like it's em...it's got a very...it's got a huge knock on effect and I've seen very junior staff coming in and being...kind of...changed in a way, and I've noticed that, that people can be changed em...or their behaviour can be changed...by the environment and I think that's really sad as well.'*

Brenda is clearly frustrated at the nature of the workplace culture and seems to be grieving over the loss of midwives' ways of being. She expresses a sense that things could be better yet is struggling to see how. Brenda seems to blame the culture for the change in her colleagues. It is unclear whether she believes this happens because midwives find it easier to cope by choosing to conform to the culture, or whether some midwives don't even question the culture.

Interestingly Mandy was the only midwife who did not express strong negative feelings about the workplace. Mandy had initially trained and worked in a different country, and in fact found this unit easier to work in.

**4.4.3.2.5. At the mercy of the medical staff**

Alice, Kerry, and Rosie describe having little power in the face of medical staff. Alice perceives herself and women to be at the mercy of doctors once they are in the room: *'they want to do something...otherwise somebody will say 'why didn't you do something?'*. Rosie feels as soon as some doctors come in *'they have to be in control, they have to set the pace'*. However, Kerry finds that rather than *'overrule everything'* as they did in the past, doctors now sometimes *'discuss things'* and *'it's more like a joint decision'*.

**4.4.3.2.6. Moving on, claiming control**

For three of *The Midwives*, the inability to change the workplace drove them to take control by moving on and leaving labour ward, although Brenda only spoke of this after her interview. Alice chose to work elsewhere as she feels unable to do it anymore: *'(sad laugh) I can't'*. She is clearly saddened and *'disappointed'*, but

'resigned' to reality: 'it's just getting worse and worse'. Susan also changed to a different environment and this was instrumental in rediscovering her own autonomy. She 'welcomed not working against such strict policies and procedures', particularly the freedom to 'offer more choice'.

#### 4.4.3.2.7. Summary of sub theme 2: We cannot control

The tensions and dilemmas *The Midwives* face as described in the sub theme *Torn in Two* implies a certain level of choice and needing to make decisions within this. However, *The Midwives* reflect on the uncontrollable nature of childbirth and their resultant inability to meet women's needs for control over the experience. This lack of control means that at times things do not go to plan and *The Midwives*, while feeling responsible for taking everything in a positive direction, realise that often it is just not possible. Living up to their ideals of relationships, individuality, and communication become impossible in the face of childbirth circumstances, such as unfolding events or the timing of their interaction with women. They are further constrained by workplace realities, including staffing levels, workload, and being at the mercy of medical staff. Five *Midwives* speak of the impact of the negative culture of their workplace. Alongside their own sense of lack of control, *The Midwives* are aware that women desire some control within the process of childbirth, and indeed as described previously, lack of control is an important factor in the development of PTSD-PC.

#### **4.4.3.3. Sub theme 3: The pressures we face**

This sub theme explores *The Midwives'* feelings about what they perceive as unrealistic expectations from workplace workloads, and women's demands.

##### 4.4.3.3.1. Numbers of women and staffing

Four *Midwives* emphasise how busy their workplace is. It is a unit that provides care for over 8,000 women annually. Mandy describes the ward as 'very busy' and Susan said, 'the place is so busy'. Rosie echoes this, 'they're so busy up in the wards', noting that this is compounded by poor staffing levels. Brenda particularly laments being 'very understaffed', being unable 'to document things', and being 'often asked to come out of your room'.

#### 4.4.3.3.2. Practicalities of the workload, looking after more than one woman

*The Midwives* looked after women during labour and the early postnatal period, including in the High Dependency Unit (HDU) where babies also require attention. All *The Midwives* emphasise their preference to focus on one woman at a time, continuing through to the early postnatal period. Three *Midwives* speak at length about the pressures resulting from the expectation, often as a consequence of being short staffed and being expected to simultaneously look after more than one woman, particularly within HDU. Susan says she could be *'supporting someone in early labour and also have a postnatal woman, you could have an HDU patient'*, leaving her with so much to do that she is unable to *'spend the time'* with women. Susan is anxious when unable to spend time with women in labour, fearing an impact on childbirth outcomes: *'if only I'd had the time (...) she might have had a normal delivery'*. When looking after three, sometimes four, women in HDU, all requiring one-to-one care, Kerry feels pressured *'going between people'* and *'trying to get round everyone'*. She describes, *'running between'* women feeling *'you're just not got the time that you would like with everyone'*. Kerry reluctantly uses the word, *'neglected'*, feeling she is unable to give *'best care'* due to holding the needs of several women *'in the back of your head'*, especially if she has someone she is *'really concerned about'*, which leaves her unable to *'totally shut off to be with someone else'*. Brenda describes, (Box 4.4.27.)

#### **Box 4.4.27. Extract from Brenda 12:29-41,13:1-5,12-15**

*'It's impossible utterly impossible, especially if some of those women have babies and feeding issues as well. It's not doable you are missing things left right and centre and you know, I've had experiences as well of you know, having maybe four high dependency women one of whom's, you know, at very high risk of having a seizure, so you don't particularly want to be out of the room with her at all because she might be about to have a fit. But you can't, you can't stay in the room because you've got these other women that you need to go and do observations on, and em...you know, give their medications to and things like that, but you literally just feel as if that's all you're doing, you're just going from one room to another and doing the things that need to be done. (...) If I'm in the room for an hour with one woman spending time with her, the other three women are missing things that they should have had done.'*

There is a real sense of Brenda feeling stretched in many directions, incorporating physical tasks and emotional dilemmas regarding the care needs of all women, alongside her responsibility as a midwife to meet these. Brenda expresses trying to simultaneously hold all these needs and potential outcomes, but to some extent with her hands tied. There is a sense of fragility, creating distress for Brenda at not being able to be the midwife she wants to be in the face of the expectation to make sure no one is missed, nothing drops, overlaid by an intense sense of it all being unrealistic and unmanageable.

#### 4.4.3.3. Practicalities of the workload, ticking the boxes

Alice's sentiment that the system is '*not really geared for the women*' suggests a primary focus on other tasks. For *The Midwives*, pressure arises not just from the number of women they look after, but the number of tasks they are expected to complete. There is some overlap here with the sub theme *Torn in two*, in that *The Midwives* describe being torn between trying to complete these '*task-based exercises*' (Rosie), while being with and present to women. Nevertheless, the focus here is on the reality of completing tasks and what this means to *The Midwives* in terms of how they can be with women. *The Midwives* experience pressure from management to comply with designated tasks and procedures. Rosie describes it as being pushed '*to have things done in a management structure way*', suggesting pressure from above or outside, and that it is not Rosie's wish to work in this way. Having to '*tick boxes, to fill out paperwork*' leaves her very '*frustrated*' and feeling her '*hands are tied*', with women's priorities being unacknowledged. Brenda also describes having to give her attention to '*ticking the boxes and signing the boxes that need to be signed*'.

Consequently, *The Midwives* experience distress at not being able to be with women in the way they feel they need to be, in terms of relationships and communication. Kerry notes the impact on '*getting round and caring*'. Rosie feels unable to '*give people more time if we felt they needed it*'. In terms of communication, Susan finds being busy writing notes means she is not fully present to the woman and she may not '*pick up on a lot of her cues or...if she's actually physically said something*'. Susan feels, '*stretched*'

and *'really frustrated'*, and unable to *'listen to the women as well because I've got too much on my mind'*. She depicts the busyness in her head: (Box 4.4.28.)

**Box 4.4.28. Extract from Susan 18:24-31, 36-37, 19:1-2**

*'And I'm thinking ahead you know, like "I'll come in here, I'll listen to the FH, I'll do this, do that and then I'll go through there, I'll do the antibiotics, then I'll do that, then I'll do that, so that's fine". So you'd be in the room to do the task that you've decided to do and the woman'll start speaking to you (laughs) and like "Oh, I haven't got time for this" you know. (...) It's not that you're not hearing, it's just that you're...too busy to take it on board really cos you're thinking about everything else.'*

There is a real sense of Susan running around like a headless chicken, from one task to the next and then, on top of it all the woman wants to talk to **her**. The sense of overload and impossibility described by Brenda, is echoed here. When relating this, Susan's tone expressed disappointment at both the level of expectations, and her inability to manage it all and be there for the woman. And yet she also displays a sense of self defence: *'how can I be expected to do this?'*

Ultimately, Rosie describes a sense of futility in the face of it all and giving up and coping by only doing the essentials, which in this case involves the tasks rather than relationships: *'you start stopping engaging with anybody and you just go in and do your work, and tick your boxes, fill out your paperwork and get home'*.

**4.4.3.3.4. Practicalities of the workload, pressure to move onto the next woman**

As described in the sub theme *Torn in two*, *The Midwives* find the immediate postnatal period particularly challenging in that they feel torn away from women. Kerry feels she has no choice when management give instructions to move to the next women: *'you've just got to get on and do the next thing'*. Likewise, for Rosie, *'there's someone coming up for you and there's nothing you can do'*. While Brenda, *'resented'* the ward coordinators for this, Kerry and Rosie have sympathy for them, aware that they are equally at the mercy of circumstances, often having a limited supply of midwives. Rosie recognises that while coordinators might like to make it better *'they can't because of the traffic that's coming through the door'*. Mandy speaks at length about the practical pressures within the first hours after the birth (Box 4.4.29.).

**Box 4.4.29. Extract from Mandy 16:35-40, 17:1-15, 18-23**

*'As soon as the placenta's out sometimes, you know...you would be expected to have everything done within half an hour, and that is, that is just not possible, you know what I mean? Like you just need to get the woman...like a bit clean, so she feels a bit better and then...if she needs stitches, then you would do stitches and then, you know by the time you get organised for that, you get the stitches done and then...you get everything back together, the bed and all of that. And it's an hour...and then you would need to get her tea and toast...make sure the baby would go on the breast...if she's breastfeeding...I think the breastfeeding in labour ward...when you've got stitches to do or when it's not straightforward, is very challenging...mostly when it's a first woman, who had an long labour or had a long induction process, is exhausted, doesn't know what to do, got a baby who doesn't know what to do either, em...(sigh). If you've got like you know, if it's your seventh or eighth hour of that shift and you've done that delivery, you've stitched her...and everything (...) and she's got no idea about what she's doing, and the baby's crying maybe, and it's distressing, that is very, and you've got your band 7 trying to (laughs) get you to do your notes and to get her away, it's, that...that is...laughs.'*

Like Susan, Mandy depicts a complex and demanding picture. The tasks outlined are very much within the remit of a midwife, and there is no sense that Mandy is complaining about the tasks in themselves, but more the pressure to squeeze them into a very short time and move the woman on. This working against the clock is what Mandy finds difficult to reconcile and like the other situations, the cost is in the quality of time and relationship that can be given to the woman. Mandy is very aware of the vulnerability and needs of the woman and feels a level of injustice at being expected to just manage the tasks efficiently without fully taking on board the needs of the woman.

**4.4.3.3.5. Unrealistic demands from women**

*'It's probably more that they're more likely to have an expectation from me'*

Rosie 10:31-33

As well as pressure from management, Rosie, Alice, Susan, and Mandy express a sense of pressure and sometimes disbelief at women's expectations, and the impact of this on how they as midwives are able to be with them. *The Midwives* knew that PTSD-PC formed the basis of this study, and they appear to understand or believe that to some extent finding childbirth traumatic is related to women's expectations being unmet.

Each midwife refers to women's expectations, either highlighting how unrealistic these are or being very accepting of them. *The Midwives* appear to need to defend their own views, knowledge, or actions, by questioning women's preparation, motives, ideas, and fixed attitudes.

#### 4.4.3.3.6. Being open to women

As described in the sub theme *Seeing women as individuals*, *The Midwives* emphasised that they are very open to women and whatever expectations and desires they have. However, *The Midwives* speak about the pressure and concerns they feel when women are very fixed in their ideas or made very little preparation. Alice and Mandy feel that fixed ideas leave women more vulnerable to disappointment or shock, and '*feeling bad about it I think*' (Alice) when things are not as expected. Rosie feels that many women and their partners are '*just shocked*' and not at all prepared for the reality of childbirth, as they '*didn't realise it was going to be as long, em as painful...maybe...didn't know it was going to be as complicated*'. Alice notes this shock more in relation to induction of labour. She feels that women have very unrealistic knowledge or appreciation about '*how much of a difference that's gonna make to the way that they labour*'. Mandy finds women with a '*very strict, strict birth plan who don't want to consider anything else*' challenging, with this inflexibility putting them at risk of developing PTSD-PC. There is a sense that Mandy feels pressure and that she wishes to emphasise that she is not to blame for trauma, that she is doing her best, but the woman's lack of openness is creating the vulnerability. She goes on to say that women need to be prepared for things going in a way they perhaps didn't want, because '*that might still happen*'. When women decline to change their expectations, Rosie is concerned not to show that she feels '*frustrated and maybe a bit impatient*'.

#### 4.4.3.3.7. What do women want from me?

Sometimes women made direct demands of *The Midwives*, which they find to be unrealistic. Susan notes that some women seem to '*practically want you to have the baby for them...and...make all the decisions*', but she is quite relaxed and happy to '*go with the flow*'. However, Mandy deeply questions the expectations of some women, feeling uncertain about what exactly women want from her, and unclear about how

best to respond or provide care. Mandy speaks at length about one particular woman who seemed unwilling to negotiate any aspects of her care, as she declined all monitoring and interventions, and kept herself to the 'corner of that room' (Box 4.4.30.).

**Box 4.4.30. Extract from Mandy 13:40-47, 21:42-44**

*'This patient obviously seemed to think that the midwives and the doctors wouldn't be safe for her, you know if she's got that kind of birth plan, super strict and this is not flexible, why is she not free birthing then? Why does she need us? Because she seemed to know what she wants...and she's not going to negotiate anything anyway, so why, why does she want us there? (...) Not just...I don't know what (laughs), I mean I don't know what, what they think we are (laughs)...if it's not for that.'*

While this was just one woman, and presumably not all women are like this, for Mandy, this left a deep impression. Mandy is struggling to reconcile her understanding of her midwifery role and the almost antagonistic approach of this stubborn woman. It depicts a stand-off between the two sides. The fact that there are two sides, suggests a lack of connection and relationship, and certainly a lack of trust. Mandy clearly feels the woman's expectations are unrealistic and, with this placing pressure on Mandy, who just doesn't know how to manage her. There is a need to keep things safe, alongside the woman's apparent refusal to take any advice. It could be considered that Mandy's focus on safety and guidelines, discussed earlier, is limiting her ability to tune into the individuality of this woman and work to find a pathway through.

**4.4.3.3.8. I am not a robot**

*The Midwives'* perceptions in this sub theme present a sense that they feel expected to function efficiently like machines, managing a range of tasks including spatial and resource management, time management, clinical competency, alongside personal attention and focus on women and their babies. Susan expresses that these expectations and resulting pressures *'have a negative effect on...midwives, women and the way we are with women (...) it does have a negative impact on how you respond to each other'*. For Kerry, a particular pressure arises when she is expected to share her care between someone in early labour and someone who has just lost their baby, finding it *'very difficult'* to *'chop and change your emotions'* appropriately. Kerry feels it



takes time to recover from a loss and *'move onto something else'*. Both Brenda and Mandy speak of the impact of negative outcomes on their care given to subsequent women: *'you're gonna be a bit more, very, very careful'*, influencing her *'way of being'* and what she is *'going to say'*. Also, with regard to their personal lives Brenda feels it is difficult not to *'take that home with you and take it on board a bit'*. Alice feels that being *'exhausted'* determines *'how much energy'* she can give to women. Mandy reflects, (Box 4.4.31.)

**Box 4.4.31. Extract from Mandy 1:19-25**

*'It's better not to bring personal life...but we are human beings, so we're like...we're just one. So, basically when you...when something nice happens to you then...you're gonna be like in a good mood at work as well, and when something not very nice happening to you then I guess you get a bit...a low mood...at work as well and you're bringing that with you.'*

Mandy is somewhat uncomfortable to talk about being affected by her personal life, perhaps because this is unacceptable in her professional role. However, she is depicting a sense of connection with the humanity of women. This is potentially one of the most honest reflections of *The Midwives*, showing that as human beings the ways midwives relate to women is very likely to be impacted by whatever is going on in the life of the midwife.

**4.4.3.3.9. Protecting myself and my registration**

Given this humanity of midwives, it is not surprising that *The Midwives* also sometimes refer to protecting themselves. Mostly, this impacts on how open and communicative they are with women. When Susan feels guilt for not managing to give women time and attention she feels she will *'probably clam up a bit, you probably don't communicate as well'*. Similarly, when Brenda is unable to meet all the expectations, she needs to step back a little and feels that women might think she *'is not engaging with them very well but it's, it's like a personal...protection...of me because I can't, I know I can't'*. Alice echoes this, (Box 4.4.32.)

**Box 4.4.32. Extract from Alice 8:3-7,14-15**

*'To be completely honest sometimes I just switch off a little bit and take a wee step back because I can't...that's a really bad thing to say but I think it's just maybe like a self-protecting thing you know just gotta take a wee step back from it maybe (...) you do need to protect yourself when you have that all the time don't you?'*

Like Mandy and the others, Alice expresses a level of discomfort at being honest about her limitations but is aware that at times it can all become too much. There is a sense of a relentless expectation to be the professional, and to be there and do what is required, but in the face of the unrealistic expectations, she experiences vulnerability and a need to withdraw and keep herself safe.

Four *Midwives* feel threat to their registration when their decision-making is 'questioned' (Susan), when you're 'doing things' or 'not doing things' (Brenda), or women's demands are preventing them from following policies (Mandy). When Rosie tries to play for time with women amongst all the pressures, she feels she can be putting herself 'at a little bit of risk'. Mandy worries she 'won't be able to do my job any more'.

4.4.3.3.10. Summary of sub theme 3: The pressures we face

*The Midwives* feel pressure related to the actual workload in their unit, finding the place very busy and understaffed. As a result, they often find themselves looking after more than one woman, which makes it impossible to provide the level of care they desire. Further to this, there are too many tasks to be completed leaving them ticking boxes rather than being with women. Again, the pressure to complete care fast after the baby is born and move onto the next woman is raised by *The Midwives* as a source of great distress. *The Midwives* also express pressure from women having unrealistic expectations that they as midwives cannot meet and sometimes wonder what it is women want from them. Lastly, *The Midwives* express the impact these pressures have on them as human individuals, who are not robots and need to protect themselves.

#### **4.4.3.4. Summary of master theme 2: What we have to work within**

*The Midwives* are frustrated and distressed by being torn between simultaneously balancing and meeting the needs of women, the workplace policies, and expectations from other staff. *The Midwives* are conflicted and unhappy about pushing women to conform to systemic demands, and particularly grieve over being separated from women after birth. While, *The Midwives'* ways of being with women is impacted directly by the many uncontrollable aspects of childbirth, they nevertheless sometimes feel impotent to support women. However, the greatest impact on being with women, is the daily workload midwives face, which is threaded through quotes about trying to meet the sometimes, unrealistic expectations of women and colleagues. Embedded throughout *The Midwives* express their humanity and vulnerability.

#### **4.4.4. Master theme 3: Enable me as a midwife**

This master theme explores what *The Midwives* feel they need to enable them to carry out their role in the way they desire, whilst facing the realities of the role. *The Midwives* express a range of needs to enable them to be with women as they desire, which fall into three sub themes (Box 4.4.33.)

##### **Box 4.4.33. The sub themes of *Enable me as a midwife***

1. Others need to do their bit
2. Support me
3. Trust and respect me

#### **4.4.4.1. Sub theme 1: Others need to do their bit**

This sub theme explores *The Midwives'* needs for both healthcare providers and women to play their role appropriately.

##### **4.4.4.1.1. Colleagues need to carry their fair share of the workload**

Three *Midwives* describe situations where their colleagues' behaviour resulted in a greater workload for them. For Brenda this is simply being unable to rely on colleagues taking their fair share of answering the buzzer. While Rosie was uncomfortable saying so, she feels it is not so much staffing shortages that are the problem, but that some staff '*could do more, that would make the situation better*'. This is strongly echoed by

Susan who speaks at length about her disappointment that often one of the senior midwives does not carry out her role as required, but instead spends her time sitting at the desk: *'not doing an awful lot, which really meant the reality for the rest of the staff is that you were a member of staff down'*.

#### 4.4.4.1.2. Distress at the behaviour of colleagues

All *The Midwives* express concern and distress at the way their colleagues sometimes treat women. Rosie wishes doctors would *'just come in and listen'* to women, she feels frustrated that doctors *'exacerbate'* the situation when they don't look at the bigger picture. They only see *'snapshots of people'*, and at times form *'prejudices from what other people have said'*. Both Kerry and Alice share this view, feeling that everyone should *'be a bit more listening to people'* (Kerry), and not just judging women. Alice worries that a *'lack'* of listening to women, leaves them *'traumatised cos they're not involved in their decision'*. She is also keen to avoid *'forcing them down the way I want them to be'*. Alice describes, (Box 4.4.34.)

#### **Box 4.4.34. Extract from Alice 3:5-16,37-39, 4:8-10, 6:32-33**

*'I feel there's...there can be a lotta that goin' on, judgement and people and you know you should...this is, you should...you should want this, or you should do that, you know? (...) I do feel like women are bullied a bit and especially when it comes to medicalisation, and the birth the whole birth journey, I do feel like they...they're a bit...they're coerced at best and bullied at worst. (...) I feel...I feel really protective of the women in that situation...em...and it annoys me that the medical staff won't do...won't, won't do it you know (...) that is a difficult thing for me in the labour ward...to...to try and protect the women and get them what they need. (...) Em...it makes me sad...that em....I'm going to cry actually, it makes me sad.'*

Alice is clearly distressed by how women are treated by medical staff and strongly aligns herself with them. Alongside experiencing anger and grief, her desire to protect suggests her empathy for women, which reflects her sense of responsibility and sense that her relationships with women are made more challenging by the actions of the other staff.

Although Susan qualifies her feelings: *'I don't mean to say they've had substandard care'*, there is a strong sense that sometimes she finds the way others care for women,

frustrating and distressing, and not the level of care that *'I would want to give'*. Susan feels she then has to work to turn this around for women. Similarly, Kerry says, *'sigh...it sounds really bad, but you feel that they're not going to get the care that they would have got with you'*. While Susan is reluctant to say care has been substandard, both Rosie and Brenda are disturbed by observing poor care and the subsequent impact on their relationships with women, and at being unable to influence events. Following an incident during which Brenda said there were *'factors in the woman's care that were out with my control'* and Brenda perceived that things were *'badly managed and very...she was very badly treated'* by medical staff, Brenda describes, (Box 4.4.35.)

**Box 4.4.35. Extract from Brenda 9:25-26, 29, 10:2-3**

*'It's so frustrating I was so **angry** when I went home after that particular incident I was so **angry** (...) I was just angry on her behalf em...and frustrated for me.'*

Brenda's emotional response suggests a deep sense of injustice and distress on behalf of the woman, but also a sense of impotence in the face of what happened. There is clearly ongoing distress, which spills into her personal life and Brenda's own sense of self.

Rosie speaks at length about her distress when others carry out examinations or interventions without regard for the woman or her consent. She describes wishing people would have more *'thought and respect for actually what they were doing'*. She is particularly distressed when examinations are carried out *'brutally'*, and women's requests for staff to *'stop'* are ignored and *'they **persist** despite the woman showing that she is really uncomfortable and sore'*. Rosie describes the strength of her personal distress when she witnesses brutal examinations or staff not stopping when requested to by the woman, (Box 4.4.36)

**Box 4.4.36. Extract from Rosie 13:2-5,9-13, 14:4-7,9-11**

*'Em...well my big, my big personal, and this again it's quite personal, it's not probably a uniform thing, but I think my personal...real...that I feel really strongly about is I really, really, get angry. (...) Em...so that's just, I, I just think that's so horrible, I just I hate it and em...when I first started, and I saw that happening, I always felt like em...like I was watching something and not saying anything, so I always felt really awful (...) with somebody that they perceive...em...as going to be no problem to them, you know, sort of someone that, as I said isn't aware of their rights (...) and I think (cough) that's...that for me I find really awful and I don't want to be part of that scenario as well or be considered to be part of it.'*

While Rosie expresses a deep sense of injustice towards women through behaviour that she perceives as abusive, what is notable is her personal distress and need to distance herself from this. Rosie really does not wish to be viewed as part of the problem, but feels she has no say in the matter, which potentially portrays her as much a victim as the woman.

**4.4.4.1.3. Impact on how women interact with the midwife**

Kerry notes that many women *'have just a general distrust of health professionals'*, possibly as a result of previous bad experiences. Rosie is upset when the communication or actions of other health professionals as described above, means she's *'got to make better as soon as they disappear'*. She finds this disturbs her relationships with women, making it *'very tricky'* to *'rebuild that relationship'*. Susan is annoyed and upset by what she calls *'lazy midwifery'*, where other midwives *'look after a labourer from the desk and limit the woman's choices'*, and are relying on the use of epidurals to calm women. Consequently, Susan feels that when taking over care she has to work harder to build relationships or give information to women that they should already have had.

**4.4.4.1.4. When colleagues do it well**

While *The Midwives* describe uncertainty regarding colleagues: *'you pray that you've got one of the more reasonable medical staff'* (Rosie), they are keen not to bring their colleagues down. Alice highlights that doctors are not all *'heartless'*, and that some really do listen well to women. Yet Brenda notes that while some have *'amazing communication skills, a lot of them didn't'*. Rosie realises she is perhaps *'painting them all in a bad light'*, but in fact it is only a few who are *'heavy handed'* with women.

While Susan does not want to suggest that midwives provide ‘*substandard care*’, she is clear that the standard does vary across midwives. Rosie feels when ‘*everybody works together as a team, it feels...a lot better for everybody, for you as the midwife in that room, for the woman and the partner*’. This is echoed by Kerry, who now finds that ‘*lots of staff are very good*’ and that everyone works together to come to a ‘*joint decision*’. Mandy feels that there are ‘*lots of good midwives and doctors*’ who she can rely on and who work well with women. Susan expresses joy when she sees midwives or students working in a way she feels is good and as a result sees the woman coping well.

#### 4.4.4.1.5. We need to stop accepting things the way they are, it’s not the way it should be

Within the sub theme *We cannot control, The Midwives* describe the impact of workplace culture on how they are able to be with women and their failed attempts to change this culture. Here, *The Midwives* talk about what they need from others in terms of refusing to accept things as they are, which are viewed as not being as they should be. There is a clear sense that *The Midwives* need others to step up and work with them to improve things so that they can work better with and for women. For Brenda, ‘*it’s a bit of a bug bear*’ that there continues to be ‘*acceptance of the environment*’ and the negative culture, noting that other maternity units do not have the same ‘*negative feel*’, nor any acceptance of such a culture. She feels everyone should be ‘*pushing for change all the time and making our care the best that we can*’. Susan feels that the way things are currently managed ‘*probably is **prolonging things***’, but she struggles to see ‘*how you change that type of...culture at all*’. Alice is deeply ‘*frustrated*’ by lack of individual interpretation of guidelines, with a blanket ‘*everyone must do this*’. Alice repeatedly expresses frustration that the call within midwifery guidelines to **consider** just ‘*does not happen*’. Rather, she observes that women are told their ‘*baby’s in danger and on your head be it*’, resulting in interventions that may be avoided if things are considered. Alice laments, (Box 4.4.37.)

**Box 4.4.37. Extract from Alice 10:4-10**

*'I don't really see the point of it either d'y'know. I think we give ourselves a load of work for absolutely no reason and you know for a service that's supposed to be on its knees we do a lot of unnecessary stuff.'*

Alice seems somewhat dismayed at why 'we' (midwives) do this. When already within a pressured system the blanket interpretation of guidelines and subsequent potentially unnecessary interventions, deepen this pressure that weighs upon her as a midwife, other staff, and ultimately women too.

4.4.4.1.6. Preparation and expectations of women

All *The Midwives* clearly express their need for women to play their part. The level of preparation women undertake determines their expectations, which in turn influences how *The Midwives* must respond. Alice finds it worse when women sometimes just *'don't know what they're letting theirselves in for'* and disbelieves that they could go *'nine months and not even have a clue about labour'*. Brenda finds that the amount and type of preparation *'makes a big difference'*, preferring women to have carried out some preparation, so she doesn't have to *'start from scratch'* with a *'lot of work to do in sometimes a very short amount of time'* to support women who either are totally unprepared or terrified. Similarly, Susan prefers women to have *'given a little bit thought to kinda what they want'*, while Rosie can find it irritating to keep going over and over things: *'you can't help it, you're only human'*. In contrast, women who are unwilling to shift from their very *'fixed'* (Brenda) expectations and *'very set ideas'* (Kerry) pose a significant issue for *The Midwives*. Mandy wants women to be open, ready to face reality and present with *'not too strict birth plan'*, although compared to where she previously worked, she feels women are *'very well prepared'*.

4.4.4.1.7. I need communication and feedback from women

*The Midwives* highlight the need for women to communicate their needs as well as feedback to the midwife, as part of their relationships. They express how this gives them a sense that they are probably doing their job well. Positive feedback from women about the information they gave or the time they spent with them, enables Brenda to *'feel really good about'* her care, Kerry to know she *'succeeded in what I've*



*set out to do*, and Susan to believe she provided *'a good level of care'*. Kerry finds it *'really...really upsetting'* when women do not or cannot communicate how they are feeling, and they keep *'a lot of things hidden'*. Kerry's distress reflects her empathy for women's needs and how difficult it can be for them, with a sense of frustration that without this information it is much harder to provide appropriate care. Susan feels sometimes it is *'a bit like drawing teeth'* and expresses how she feels more relaxed with women when they *'communicate really well back to me'*. Susan echoes the feeling of the other *Midwives* when she says, (Box 4.4.38.)

**Box 4.4.38. Extract from Susan 3:17-22, 11:1-4**

*'I suppose I feel much more relaxed if people talk back to me because I feel they are...em...what's the word I'm looking for? I feel they are...not necessarily having a good experience, but I feel that they are relaxed and they're at ease and I'm...providing...a good level of care. (...) I suppose what I am...not necessarily expecting, but what I'm hoping for perhaps is...for...her to come in and...you know again, communicate, be open with me as I can be open with her and their expectations.'*

Susan's need for reassurance and affirmation is clear, reflecting her own humanity and vulnerability within her desire to care for women well. While Susan is careful about making demands of women, she clearly expresses her need for women to play the communication game and meet her halfway. In other words, the effort should not be all from the midwife, but needs to come from women also.

Susan's feelings link closely with how Alice feels when advocating for women in the face of conflict with medical staff, described in the sub theme *Torn in two*. Alice feels it helps when it also comes from women: *'cos if women come in and say no...they can't they can't em...argue with that'*.

Brenda is the only midwife to highlight her need for not being taken advantage of by women. She finds that in some situations *'it's just more difficult'* to remain women focussed, for instance when a woman returns from going out for a cigarette and buzzes to have *'her baby passed to her'*.

#### 4.4.4.1.8. Summary of sub theme 1: Others need to do their bit

*The Midwives* are affected by the behaviour of both colleagues and women. Colleagues' actions or inactions impact on their emotions and their interactions with women. *The Midwives* all describe needing colleagues to carry out their fair share of the workload, and to treat women appropriately and in a way that does not require *The Midwives* to come and sort it out later. *The Midwives* want to know that staff they hand women on to will continue to provide a good standard of care, which includes providing respect, communication, and trust. *The Midwives* note how improved things are when others do things well, going on to exhort a move away from accepting the current negative culture. The behaviour of women at times makes it difficult for *The Midwives* to interact in the way they wish to. *The Midwives* desire that women are realistic in their preparation and expectations, meeting *The Midwives* half way with regard to communication.

#### **4.4.4.2. Sub theme 2: Support me**

This sub theme explores *The Midwives'* expressed need for support from colleagues.

##### 4.4.4.2.1. Support to have time with women

Having time with women is a strong thread that runs through many of the sub themes and indeed being supported to have time with women, is emphasised by all *The Midwives*. Susan gratefully recalls being enabled to remain with a woman because the senior midwife left her office to do 'all the other stuff that I would have been flying around doing'. For Brenda, Mandy, and Alice it depended which senior midwife was on duty and how much she supports them to be with women and gives the 'time you need' (Mandy), or 'rushing you' not giving time to 'talk things through' (Brenda). As in the sub themes *Building relationships and Torn in two*, the early postnatal period is key, and the level of support is reflected in whether or not unrealistic time restrictions are placed on processing women after childbirth. Brenda and Kerry feel their ability to spend appropriate time with women is impacted by 'mostly the lack of staffing' (Kerry), and that the management's failure to remedy this, through remaining unresponsive to repeated requests for increased staffing reflects a lack of support for them in their role with women. Brenda feels management 'don't seem to want to pay

(...) they would rather it was unsafe, and they saved some money'. Kerry feels this has 'an impact overall', with no 'relief in the system': (Box 4.4.39.)

**Box 4.4.39. Extract from Kerry 6:1-7,37-39, 7:20-24**

*'If it's busy and you're short staffed, then you feel the stress before you go on you know because sometimes you'll be walking up the corridor and people go 'Oh no, you don't want to be coming on' (laughs) which is a big downer when you turn up for your shift. So, you're like yeah and there's that kind of...stress even to start with and then there's obviously the skill mix how, you know (...) there's no one else to help you...so you're always chasing someone to help you make up antibiotics and that (...) yeah...yeah that does make it more stressful. I think you really need your breaks when it's like that and that's another problem you don't always get your breaks...you don't get that time to kinda get your head sorted and get back into it again.'*

Kerry sounds pressured and weighed down. From the moment of arriving at work she can feel undermined both in terms of maintaining a positive outlook, and availability of practical help when needed. There is a mounting development of stress piling on with no safety valve, just never-ending pressure.

**4.4.4.2.2. Support from colleagues, being dismissed, undermined, and bullied**

All *The Midwives* recount experiences of seeking support from colleagues in terms of feedback, reflection, and guidance relating to clinical scenarios and events. Kerry is the only midwife who feels her colleagues are '*really supportive*', relating this to her length of experience and knowing who to ask. As described above, Kerry relates lack of support more to everyone being impacted by lack of staffing: '*if it's busy then that's what's missing*'. The other *Midwives* lament the negative responses they receive from colleagues, consistent with the negative culture within their workplace that they feel extends beyond a lack of staffing to a lack of '*positive feedback from anyone*' (Brenda). Ultimately, Susan and Brenda speak of having to '*stop asking*' (Susan) and learning '*to probably not go to colleagues now cos it's not always very helpful*' (Brenda). Rosie and Brenda see support as necessary to ensure that they are able to be the best they can be for women and to manage complex scenarios. They desire supportive colleagues with whom they can reflect and explore alternative ways to '*try and resolve or move forward*' (Rosie). Brenda articulates that she feels unable to find '*a good kind of network support network*'. Brenda describes colleagues as patronising: '*Oh of course*

*she trusts you, don't be silly' and 'not really listening', with support 'never really been forthcoming' (Box 4.4.40.).*

**Box 4.4.40. Extract from Brenda 10:8-9,18-23**

*'I've been met with quite a lot of undermining behaviour (...) I've been met with with eh...quite negative response and...em...almost a...a questioning of me and who I am and how I am as a midwife and my experience and...em...quite a kind of eh...undermining em...response.'*

Brenda clearly feels not only unsupported, but actively undermined. This appears to be her primary sense, and it happens a lot. But, it appears that she is only just taking this on board as she speaks. There is a hesitancy, as if she is just recognising the extent of this lack of support and the impact it has had on her. There is also a sense of grief and loss at what might have been.

Rosie finds that with no support, she sometimes has to make the best call she can and then finds that this could later be questioned and interpreted as failure, which often leaves her feeling *'undermined in front of the woman'* and serving to weaken her relationship with the woman. Similarly, Susan reflects that going to the desk for help, especially if junior, can result in receiving *'a bit of a mouthful "deal with that yourself" or 'what's wrong now'*, which also leaves her feeling *undermined*. In contrast, Mandy sought support in terms of protecting herself when faced with a woman who was unwilling to follow advice and was relieved to have support from the charge midwife who was *'great with that (...) she stayed with me and she was there'*. Rosie feels that more support would make it easier to keep the *'passion alive'* and *'motivate more midwives to keep the belief in what they're doing is important and valuable'*: (Box 4.4.41.)

**Box 4.4.41. Extract from Rosie 12:2-11**

*'I feel that the job that we do, we need to be supported. It's very emotionally demanding. It's, it's, it's very tough a lot of the time the outcomes are...devastating for people and we don't have any support. We kind of just have to come home and hope that we've got a good family network or support network at home and a lot of the time, you know, getting support from your family is great, but they don't understand your job like your colleagues do, or your managers do.'*

Aside from being supported in clinical actions and choices, Rosie expresses the need for support within the emotional aspects of her job. The devastating outcomes for women, clearly impact on Rosie too, which highlights the connection and empathy she carries with women and which reflects the unique quality of the midwifery role that non-midwives just don't get. Rosie is crying out to be heard and supported by all those who live and breathe this emotional demand.

**4.4.4.2.3. Support from colleagues to advocate for women**

Alice mostly experiences support with regard to listening to women and giving them control, except when she disagrees with the actions or approach of the doctor, as discussed in the sub theme *Torn in two*. In this situation, whether she is backed up or not 'depends what kind of sister's on'. Rosie echoed this, (Box 4.4.42)

**Box 4.4.42. Extract from Rosie 10:1-8**

*'Well, I think a lot of the time you don't have the support of your charge midwife or your medical staff. You, you don't have their...em...support for you in that situation, for being a difficult situation, or you don't have the support of them with actually what's going on in the room, and you know that, and the couple perhaps know that as well, so...em you kind of feel a bit...on a limb to be honest, a lot of the time.'*

Rosie sounds abandoned, stating that there is no one there for her to help her work through a challenging situation. It seems she just has to make her own decision, but may be isolated in doing so, having to put herself out there in front of all. Rosie is also feeling undermined in front of the couple, suggesting that lack of support, might mean the couple start to question her and her care.

When Susan tries to vocalise support for women, against what her colleagues support, she may find herself *'alienated from senior midwives, like band 7 midwives, and medical staff'*. When asked to tell me more. Her response more widely reflected her experience regarding support: (Box 4.4.43.)

**Box 4.4.43. Extract from Susan 15:1-12**

*'Yeah...I got to the stage where...I feel the place...runs on stress. And as a result, there is a lot of bickering and...there's more...bickering than there is support amongst the staff. I think if we all just supported each other, and looked out for each other, and worked as a team, you know, half the nonsense would go, and we would actually have more time, you know, without all the...kinda, cos I think there is a...there is a, there is a huge bullying culture, I feel, in, within the staff there, and...I mean there's different, obviously, degrees of bullying em but just feeling...you know.'*

Susan seems exasperated by somewhat immature behaviour, with bickering being the most silly and senseless and lacking rational reflection. It is as if she wants to shake everyone and get them so see that this behaviour is weakening everything, eating away at the core strength of the team. Her reference to bullying implies a more sinister depth, suggesting this is not always just silly, but can be directed and intentional.

**4.4.4.2.4. We need resources and training**

Lastly, Brenda is the only midwife to raise the issue of equipment access. In terms of being able to remain present to women, she finds this an important disruptive factor, acknowledging that leaving the room frequently has *'huge impact'*. Brenda is frustrated that *'you literally go to look for something and it's not there and you have to go and hunt for it'*, expressing strongly that everything should *'be in your room'*.

Three *Midwives* speak of the loss of opportunity for staff development and training due to staffing shortages. Kerry notes that sometimes there's *'nobody there to ask the question'*, which echoes Brenda's frustration that this is compounded by being no longer able to attend mandatory study days and clinical meetings, as staff *'won't get time back within their jobs'*. Rosie expresses that there is little opportunity or *'incentive for us to develop ourselves and better ourselves'*, which she is keen to do.

To compound this, Brenda believes that positive training initiatives by colleagues are being '*just stepped on*'.

#### 4.4.4.2.5. Summary of sub theme 2: Support me

*The Midwives* all desire practical support to have time with women, either through appropriate staffing levels or direct support from senior staff in terms of structuring the ward workload. They also desire emotional support in terms of clinical decision making, debriefing, reflecting, and listening. There is a strong thread of being undermined and somewhat patronised by the words and action of colleagues, serving to bring *The Midwives* mood and optimism down, which sometimes leaves them lacking confidence or motivation to do the job. *The Midwives* directly desire support from midwifery colleagues when trying to advocate for women in the face of medical demands. Three *Midwives* note the need for better resourcing and training.

#### **4.4.4.3. Sub theme 3: Trust and respect me**

This sub theme explores *The Midwives'* needs to be trusted and respected for their effort and ability, by both women and colleagues.

##### 4.4.4.3.1. Trust is essential

All *The Midwives* understand trust to be an essential component within their relationships with women. Alice feels it is '*the most important thing*' to establish. Brenda feels, '*trust was the big thing*' but difficult to develop, especially if '*you haven't had a chance to develop that relationship*' or previous distrust of health professionals exists. Alice echoes this in her concern that sometimes women assume midwives are not '*on their side*' and that they are not '*going to listen*'. Brenda recognises that for women the worst outcome is probably going through childbirth without '*someone you feel can support you and that you trust*'. Kerry is distressed that the busyness of the system might mean some women '*perceive it as she's too busy to bother, you know, or care*'. Brenda expresses concern that women must question why midwives '*keep coming in and out*' of the room. Aside from this she is particularly anxious not to be '*bundled up in the in the...what the medical staff are doing*' and wants women to trust that she is there for them. Susan takes it '*a bit personally*' if women appear upset.

#### 4.4.4.3.2. I am doing my best

Throughout *The Midwives'* narratives they repeatedly use the words '*I try*', which clearly expresses the effort they put into being their best for women. *The Midwives* are keen to emphasise that they often succeed. However, the word '*try*' in itself suggests uncertainty, accompanied by a sense of holding on. Kerry: '*tried to make the most of*', claiming some power to '*try to allow the woman*'. Awareness at times of powerlessness and possibly futility arises when '*I try*' is expressed through the appending of '*as possible*'. Efforts are at times challenging: '*I go out of my way*' (Susan) and exhausting.

#### 4.4.4.3.3. I am skilled at identifying women's needs and advocating for them

There was a sense, given the context of this research, that PTSD-PC can be related to women's negative interactions. That is, *The Midwives* are keen to emphasise both their awareness of the individual and their particular skills in being with women. Four *Midwives* highlight their skills in terms of focussing on the individual. Kerry intends to always '*kind of do it differently*', and Brenda can straight away '*get a sense from someone*' about their emotional state, being open to '*soaking up*' and '*taking on board*' women's specific needs and being '*positive*' in supporting these. Like Brenda, Rosie recognises the vulnerability in women who are often considered challenging: '*these are the women for me that I'm particularly interested in*'. Susan is keen to convey her skill to '*quickly build up a rapport*' and her ability to sense women's needs, especially in terms of knowing '*when you're needed*'. Susan feels that as a midwife it is '*a great skill being able to pick that out of people*', which requires her highly developed '*observational skills*'. Three *Midwives* speak about their advocacy skills. Alice sees advocacy as a key aspect of her role and speaks of her growth in experience as a midwife, and her ability to advocate more for women because she knows '*it's the right thing to do*'. Alice emphasises her aim to do her best and to '*protect*' women. Susan reflects that she hopes, by listening and being open, she is able to '*communicate well*', which results in her being able to advocate appropriately and '*always respect people's choices*'. Advocating for women is not straightforward and sometimes involves questioning the actions of others. This is something Susan feels much more able to do with '*the more experience*' gained. Kerry views advocacy in another way: (Box 4.4.44.)



**Box 4.4.44. Extract from Kerry 13:24-27**

*'You've always got to...say it I think, especially for the woman that you've said it and she knows that you've said it to the medical staff or whatever and that you're trying to get what she wants.'*

Even if it was unlikely that this woman's wishes could be met, Kerry sees it as important that the midwife was seen to try and communicate what she wanted, which is part of the development and maintenance of trust in their relationship

**4.4.4.3.4. See my skills in comparison to others**

Alice reflects her perception that not every midwife is as motivated, and that women might not always be in good hands when she says, *'I'm glad you're with me because I will stand up for you'*. Susan echoes this sentiment, given that she is upset if she feels women have not *'had the level of care that I would want to give'*: (Box 4.4.45.)

**Box 4.4.45. Extract from Susan 22:2-5**

*'I think, I think some of us are better than others at picking these things up, and I suppose it's a lot to do with your own sort of level of emotional intelligence and how...you, how you perceive others.'*

Susan is keen to convey she is a midwife that identifies women's needs well. She emphasises her skill and wisdom as a midwife in her suggestion that other midwives are not doing this, and she is knowledgeable and skilled enough to recognise this.

**4.4.4.3.5. I need women to trust and respect my clinical knowledge**

Kerry is keen to emphasise her many years of experience and her awareness of *'the more I do midwifery'* the reality of the uncontrollable nature of childbirth becomes more apparent. While Kerry tries to get *'the balance right'* in terms of meeting women's desires, it is clear she wishes they would trust and respect her knowledge and skills as a midwife. Mandy really wants women to trust and respect her clinical knowledge, placing emphasis on how much she needs women to realise that risk is real and that she only suggests actions or interventions *'because we would think this is the best care at that point'*. There is a sense that Mandy feels women put her at risk of

blame if something goes wrong, by not respecting why she is there and needing to battle to get women to *'understand that we're here for safety reason'* and *'nothing else'*. Mandy really wants women to realise that she cannot do her job, and care for them unless they *'let us'*. She said, (Box 4.4.46.)

**Box 4.4.46. Extract from Mandy 22:29-33**

*'We're not here to like ruin...you know, to like, to make their experience awful or to ruin their life or, you know what I mean like, we all want, we all want the best for the, for the, for the woman and the patient we are looking after.'*

Mandy wants women to trust her and to realise that her intention is to get what is best out of the situation. There is a sense of conflict and a sense that Mandy feels women are sometimes against her or misjudging her. This could be due to the context of this research, given that Mandy is worried that women's negative opinions of interacting arise because midwives or doctors did something women didn't want. She is keen to put the record straight and emphasise how she really sees herself as on the side of the woman.

4.4.4.3.6. I need colleagues to trust and respect my clinical knowledge

For four *Midwives* it is important that their colleagues and the medical staff trust and respect their skills. Susan expresses her disappointment that when she tries to stand up for women or advocate for them, she is viewed as *'being somewhat radical'* and feels that rather than being respected that there will *'be a lot of talk going on at the desk about you'*. Susan feels that respect has not always been forthcoming. Yet, having trained as a *Supervisor of Midwives (SoM)*, she now feels she has a *'wee bit more clout'*. Kerry is aware that her seniority affords her more respect. Similarly, Alice finds it much easier now that she is a senior midwife: *'people just leave me to it'*. For Brenda, how well the medical staff know her impacts on her ability to advocate for women, finding that if they trust her *'they'll work with'* her better. Alice also emphasises the need for medical staff to respect the information she passes on: *'cos I've listened to her I know what she wants'*. She further expresses, (Box 4.4.47.)

**Box 4.4.47. Extract from Alice 3:41-43, 4:1-6.**

*'But I think they should respect the women more maybe and respect the midwives more that the midwives have spoken to the women, cos they, they, don't really do that it's us that do that eh? We talk to the women about their feelings and what's going on before, and all that kind of stuff em...so we're, the ones that kind of know what's going on with them I think, more I think, the doctors should listen to us a wee bit more.'*

Alice expresses a need for doctors to recognise that she is well placed to advocate for women, because she is the person who builds the relationships, communicates, and identifies women's individual needs. Alice is effectively summarising her vision of the role of the midwife, her skills in enacting this, and a subsequent need to be respected for her knowledge.

**4.4.4.3.7. Summary of sub theme 3: Trust and respect me**

All *The Midwives* view trust as essential when being with women. To this end they all strongly desire to convey their own efforts to do their best for women, using a range of skills to build relationships, communicate, and identify women's needs. Advocating for women is another way of enabling women to trust midwives. Across *The Midwives*, some emphasise their skills over those of colleagues, whilst others desire to be trusted and respected by women for their knowledge. Four *Midwives* want this trust and respect to come from their colleagues.

***4.4.4.4. Summary of master theme 3: Enable me as a midwife***

The *Midwives'* needs are sometimes stated directly, but mostly they emerge from their narratives. Mostly, *The Midwives* need others to play their part appropriately, which relies upon colleagues sharing the workload and caring for women well, so that *The Midwives* can safely hand over care without needing to repair damage caused by others. *The Midwives* need supported to have time with women throughout the whole childbirth continuum through appropriate staffing and direct practical support. They desire colleagues to be there for them in terms of reflection and decision making, and in advocating for women. Ultimately, all *The Midwives* need to be trusted by women and colleagues for their skills and efforts in caring for and being with women.

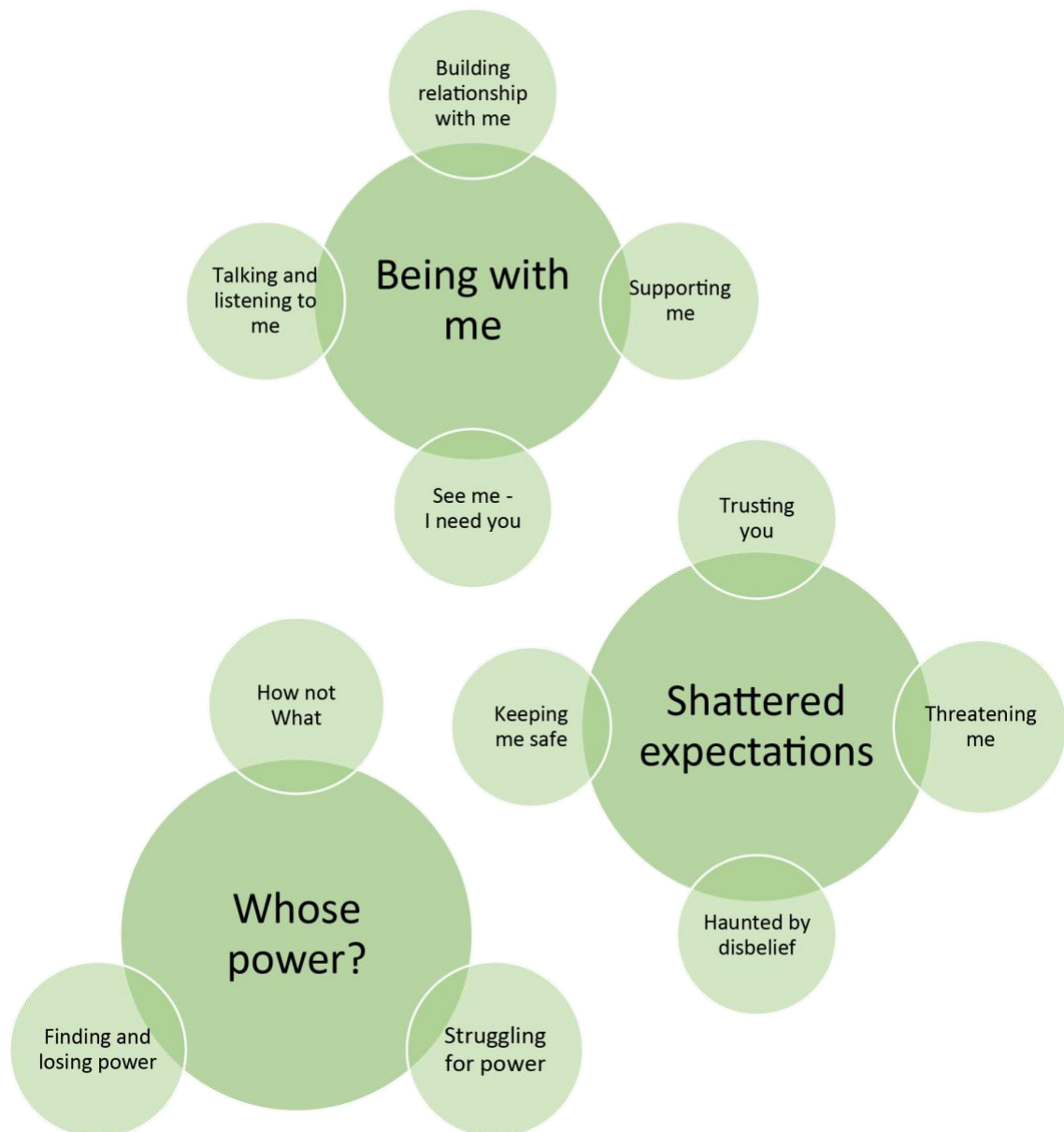
**4.5. The Women's experiences of interacting with their care providers during labour, birth, and the early postnatal period.**

**4.5.1. Introduction**

*'I dunno, there is something wrong in a system that doesn't allow you to feel like a human being'* Julie 35:7-22

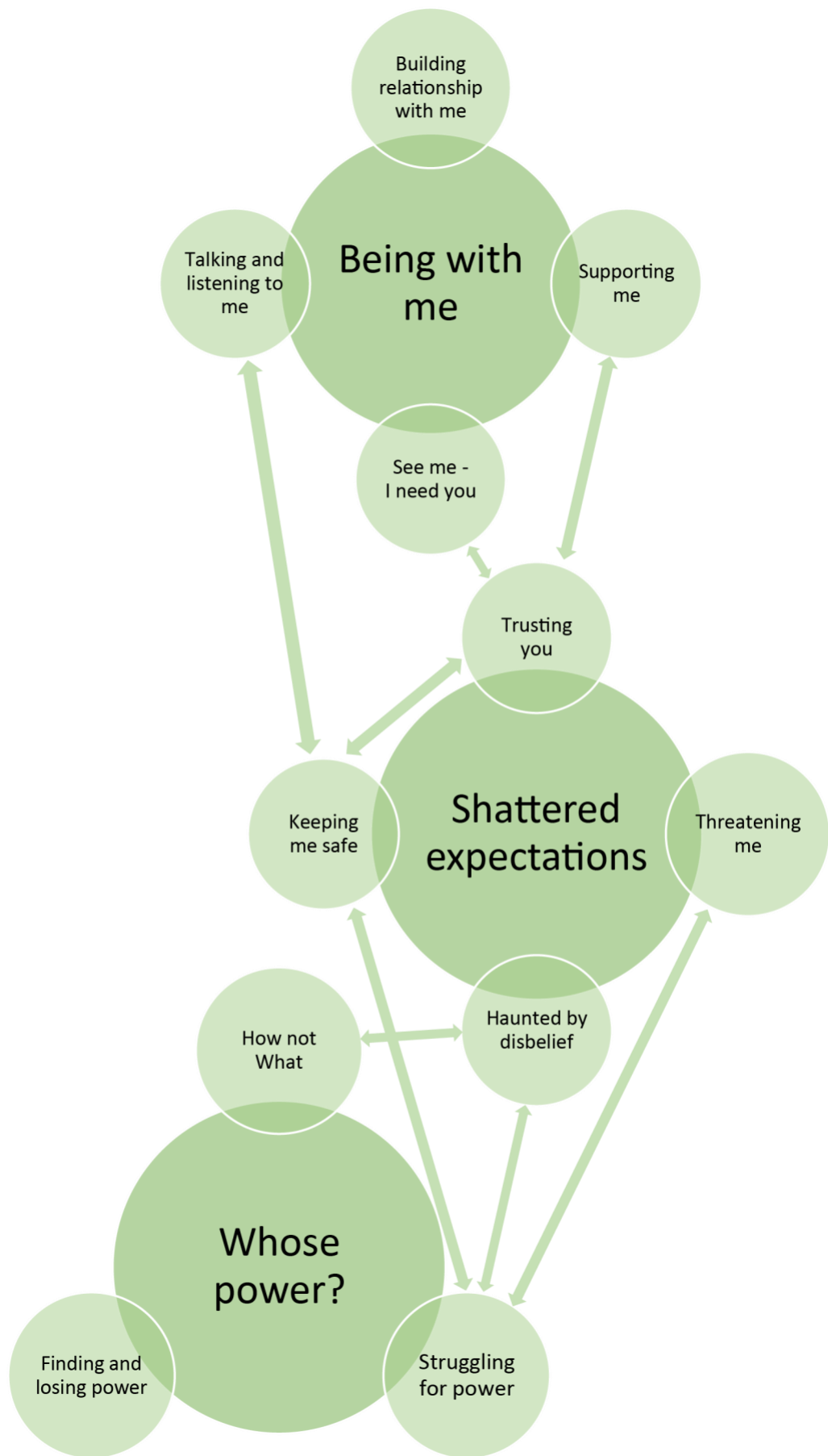
The master themes and sub themes identified for *The Women* are shown in Figure 4.6.

Figure 4.6. *The Women's* master and sub themes



Again, as discussed in Chapter 3, distinguishing between sub themes was challenging as often overlap existed. By definition the sub themes within each master theme are somewhat related. Connections also exist across sub themes of different master themes as shown in Figure 4.7.

Figure 4.7. Connections between *The Women's* sub themes in different master themes



## 4.5.2. Master theme 1: Shattered expectations

### 4.5.2.1 Introduction

Within the context of childbirth, there exists a strong rhetoric suggesting that women are often poorly prepared for the reality of childbirth or have unrealistically high expectations (Kirkham, 2017a). This was reflected within *The Midwives'* online survey (Section 4.2.3.) and *The Midwives* data (Section 4.4.). All *The Women* emphasised their realistic awareness and preparation for childbirth. Valerie '*wasn't afraid of giving birth (...) I knew it was going to be messy and I knew it was going to be painful*', while Julie found, '*it was very painful, but I was **fine** I didn't panic with the pain*'. Furthermore, all *The Women* expected to have their care needs provided for appropriately and competently. This expectation is realistic given that they were entering an environment that existed solely for the purpose of caring for childbearing women, which was staffed by trained professionals whom *The Women* felt justified in expecting to be both fully competent and trustworthy. This master theme therefore explores *The Women's* expectations around care provision and the reality they perceived, which was represented by four sub themes (Box 4.5.1.).

#### Box 4.5.1. The sub themes of *Shattered expectations*

1. Haunted by disbelief
2. Trusting you
3. Keeping me safe
4. Threatening me

While each sub theme deserves individual focus, overlap does exist with several threads running across and between (Figure 4.7.). Each sub theme encompasses elements related to the physical reality of childbirth, medical interventions, and subsequent recovery. However, all *The Women* emphasised that most often the main content of their hotspots was the nature of QPI during these difficult episodes.

### 4.5.2.2. Sub theme 1: *Haunted by disbelief*

A major feature of PTSD is the involuntary reliving of hotspots. Therefore, this sub theme presents *The Women's* sense of being haunted by certain moments in their care.

#### 4.5.2.2.1. Expectations being met

As presented within all three master themes, *The Women* described very positive experiences of QPI. These positive experiences highlight that at times *The Women's* expectations of their midwives or other care providers were fully met. Valerie and Marie both felt that their midwives '*were fantastic*'. Valerie expressed that she '*had someone on my side*'. Nevertheless, running through all sub themes is a clear thread of shock and disbelief with regard to QPI. *The Women's* descriptions of experiencing shock were significant and deserve to be highlighted as a sub theme in themselves.

#### 4.5.2.2.2. The need for obstetric interventions

*The Women* required a variety of obstetric interventions, ranging from VE's to caesarean delivery. All *The Women* were prepared for interventions such as a vaginal examination (VE) (an internal examination to check the extent to which the cervix has opened, which reveals the progress of labour), and aware of the potential for other interventions. Catriona '*didn't have a problem with that* (having to have a caesarean section) *because it was starting to become a medical emergency*'. Some shock occurred in relation to physical outcomes and interventions in and of themselves, such as the sudden need for general anaesthetic (Catriona, Lesley); becoming aware of the reality of the situation after drugs wore off (Julie); or coming around from the anaesthetic and realising emergency action was being taken (Valerie, Catriona). For all of *The Women*, their shock at the need for some interventions occurred because they either did not understand fully why this intervention was required, or they were unaware of any preparation or communication telling them it was becoming a possibility. Geraldine described, (Box 4.5.2.)

#### **Box 4.5.2. Extract from Geraldine 2:10-14, 15:5-8**

*'We then got transferred from the labour ward into theatre, It was all a big shock, because she hadn't been communicating with me, all of a sudden we're going to labour ward and...it was...(sigh)...it was, it was pretty horrendous. (...) She just sort of went "No, we're gonna have to go to theatre" and I went "S'cuse me?" Because this was the first mention of it. "What's happening?"'*



Geraldine expressed a sense of being imposed upon, and of things just happening to her. She cannot believe what is happening, with the need for intervention coming out of the blue and inconsistent with what had gone before. It is a course of action that is potentially threatening for Geraldine, within which there exists a level of horror and loss of control. In relating this experience, Geraldine is re-experiencing the disbelief and shock, which gives a taste of the intensity of the reality.

Similarly, Julie was in a state of disbelief when she was told out of the blue that she was could only push for another hour, particularly when she had no memory of being told she could start pushing. Her shock was deepened by a subsequent need for forceps: *'it was so shocking you know, because suddenly they brought all the equipment'*, which left Julie feeling she had missed something and had lost out on options or possibilities. Here the interventions themselves were not so much the issue, as the lack of understanding of the need for the intervention, or the lack of opportunity to work towards avoiding the intervention. This relates to issues with communication and control, explored in the sub theme *Talking and listening to me* and the master theme *Whose power?*

#### 4.5.2.2.3. I can't believe you did this to me

Some of the disbelief *The Women* expressed relates to the physical environment and is not related to QPI. Valerie found herself in what she described as a *'utility closet'*, and Marie expressed shock at a total lack of accessible *'facilities'* to go to the toilet or wash. Whilst Geraldine sought seeking help after collapsing in the toilet and found the *'emergency cord'* not to be attached to anything.

All of the traumatised *Women* were haunted by certain direct actions of midwives, which formed the main content of trauma hotspots. Marie's shock at a lack of accessible toilet facilities was heightened by the midwife's refusal to bring water or to assist in providing access to getting it herself. This was particularly difficult because during pregnancy Marie had prepared with a *Supervisor of Midwives (SoM)* for these facilities to be available. Marie further experienced *'humiliation'* at passing urine into her sanitary pad, as well as *'having to lie'* that she needed to change her baby's nappy

in order to get water to wash herself. Geraldine, when collapsed in the toilet, was shocked to 'be reprimanded' by two midwives for locking the toilet door, with no concern expressed for her wellbeing. During labour Geraldine was told to 'move onto a trolley' unaided, when she was physically incapacitated. This shock was compounded by a later discovery that aids in the form of glide sheets were available. During her induction of labour, Marie described being shocked when the midwife performing a VE with consent, proceeded to carry out a painful vaginal sweep to which Marie had not consented. For Marie, who has a history of rape that was detailed in her notes, this was further compounded as the midwife did not stop this examination when asked but continued until Marie's husband shouted at her: (Box 4.5.3.)

**Box 4.5.3. Extract from Marie 15:4-15, 27:17-24**

*'She didn't...she didn't ask me if I wanted to have a sweep she didn't tell me that that's what she was gonna do em...I completely froze, and the pain was like nothing on earth. The pain was like worse than when I was in labour, it just shot right through my body. I completely shut down, like I looked at my partner, he said he could just tell by the way I was looking at him that, he said my lips were moving but I wasn't saying anything. I was in total shock and he said "Stop". So he'd said stop twice and then he had to shout at her, and then she stopped em...but he stood up and shouted "Stop that right now" (...) But I didn't know what a sweep was...I'd no idea how painful it was either, and I no idea that a member of hospital staff would just do it without asking me...especially when it was on the front of your birth plan that...you're a...a survivor and that something like that going to be deeply traumatic to you...em...and they did it anyway. It's just disbelief. I still have disbelief about it to this day.'*

Marie repeatedly describes disbelief. Disbelief that she wasn't asked, wasn't informed, at the disregard for her prior experience and her communication of this, the level of pain, and the lack of attention to her husband's attempts to help her. She emphasises her vulnerability, but also her own attempts to communicate via the birth plan. Marie emphasises shock that the midwife, as a member of hospital staff, should have proceeded in this manner, suggesting an implicit expectation of behaviour contrary to what was experienced. Marie's shock is palpable, with her experience of freezing and shutting down demonstrating tonic immobility, which is a key aspect of the fear and helplessness cycle connected with PTSD (Levine, 2010). This strong experience is potentially heightened by Marie's prior experience of rape, and it is possible Marie had somehow missed communication about the possibility of a sweep being carried out.

Nevertheless, Marie's description suggests that clarification of her understanding was not made.

Other *Women* described disbelief that midwives refused to help or support them. Lesley, while in the High Dependency Unit (HDU) following her caesarean section, could not believe the response of the midwife to her request to have her baby passed to her: (Box 4.5.4.)

**Box 4.5.4. Extract from Lesley 12:20-28**

*'I buzzed after 3 hours and asked for the baby to feed him and they said "Oh you never wake a sleeping baby" and they actually walked away and I had to wait 20 minutes to build up the courage to buzz again and say "No, I actually want to feed my baby now"...so I mean to be honest it wouldn't even matter if they were right, it's my baby so I feel like they should just give me him, not tell me what to do.'*

Lesley cannot believe the midwives '*actually walked away*'. She perceived that she was in a vulnerable situation and at the mercy of others, whilst also dependent on them. There is an implicit sense that Lesley fully expected support and help during this time, but this expectation was shattered. Her expectation for help seems realistic and given that the midwife had made the time to physically attend, it is conceivable that Lesley would interpret her response as related to more than resource limitation. Notice also the link to powerlessness, as Lesley had to work hard to buzz again, driven by a need to exert authority over her own baby and her sense of right as a new mother.

**4.5.2.2.4. The contrast and inconsistency in the behaviour of midwives**

For Geraldine, Catriona, Valerie, and Julie, their core expectation that midwives would be positive towards them was strengthened by very positive QPI during pregnancy or periods of labour: '*I'll never forget her (sobbing) she's an amazing person*' (Valerie). This appreciation was expressed by desire for the midwife to return: '*I was dreaming of the other midwife coming back*' (Julie). This positive expectation heightened their sense of shock when they subsequently perceived negative behaviour. Geraldine says, '*it was going great and then, shift **change***', she perceived an '*overt distance*' and lack of support, and felt the new midwife '*was such a contrast to the other two*'. As a nurse herself, Catriona could be considered to have a very realistic expectation of QPI. Yet

she sums up the shattering of her world view with describing the contrasting QPI as a game of *'fortunately/unfortunately: fortunately, the nice midwife was there, but then unfortunately the bad midwife'*. In comparison to the relief expressed above, Catriona described the actions of a midwife (Moirira) that included being shouted at to wait for help when very frightened (see section 4.5.3.4.5.); being told just to take a medication with no explanation; and being chastised for not sitting still enough for an examination, while in strong labour. Catriona described the impact this had for her: (Box 4.5.5.)

**Box 4.5.5. Extract from Catriona 20:9-27**

*'Not remembering the good people. (...) What was left was glaringly the bad interactions I had they are what stayed with me and I haven't even thought about Lily (the perceived good midwife) again until even telling the story and like oh yeah she was really nice actually and yeah she came to see us afterwards, but I was haunted by the frustration of Moira's behaviour...you know for...for over a year afterwards and just you know, and even it just works me up again whenever I even think about them. (...) But yeah just everything about my whole career my whole attitude to nursing, my whole attitude to life and to people, she just offended every single element of how I feel anyone should be. So yeah that's how powerful that is when people are like that...that totally...just sticks with you.'*

Catriona emphasises being haunted for a long time by Moira's behaviour, to the extent of loss of memories of positive QPI. For Catriona the midwife's behaviour was an enigma to her. The extent of offence and shock was total and impossible to remove. Catriona's sense of the power of the midwife suggests a susceptibility that was not acknowledged by the midwife. This was a further shock to Catriona.

4.5.2.2.5. The pressure on midwives

Meanwhile Valerie expressed shock at the demands and pressures placed on midwives. She reflected that the reality this creates potentially leaves midwives unable to work in the way she *'presumed they would want to'*.

4.5.2.2.6. Summary of sub theme 1: Haunted by disbelief

While *The Women's* expectations of QPI were often fully met, there were many times when they all experienced shock and disbelief with regard to QPI. While the need for some interventions was shocking, the extent was deepened by poor information or

preparation. *The Women* were shocked by midwives refusing care and making unrealistic demands, and at being reprimanded by midwives. *The Women* were shocked when midwives acted without consent, especially if it was in total violation of the woman's expressed wishes. *The Women* were shocked by the utter contrasting behaviour between midwives.

#### **4.5.2.3. Sub theme 2: Trusting you**

This sub theme explores *The Women's* experiences of QPI that influenced their sense of trust or their ability to rely on their care providers.

##### 4.5.2.3.1. Placing oneself in the hands of midwives

*The Women* wanted to trust that they could place themselves into the hands of midwives, to be cared for competently and adequately: '*to place your trust in someone who knows more than you*' (Catriona). *The Women* expected midwives to have hold of the situation and to '*take charge*' (Julie) of all that they need to hand over. This leaves women free to let go in the process, knowing they are competently cared for. With the exception of Lesley, all *The Women* expressed joy and relief when either a midwife, or sometimes another maternity health professional, paid attention and took on board what was needed. It was then that *The Women* felt able to trust the midwife on all levels. Victoria felt '*like they were going to do what was best for me*' and Julie says, '*she was giving me a lot of reassurance, but it wasn't this kind of empty one*'. Yet, all *The Women* highlighted the contrast between different midwives, as explored in the sub theme *Haunted by disbelief*. This contrast left *The Women* feeling unable to rely on the behaviour of the next midwife. Geraldine was left floundering with anxiety: '*I couldn't let myself trust that the next person would be nice to me*'. In direct contrast to their desire to '*hand over*', Julie, Catriona, Marie, and Lesley realised they would have to advocate for and help themselves, and on occasion protect themselves from midwives, which is further explored in sub themes *Keeping me safe* and *Struggling for power*. In contrast, Geraldine and Valerie felt they would be much better cared for at home. Catriona's perception of it being like a game of '*fortunately/unfortunately*', left her on a rollercoaster of uncertainty regarding the behaviour of the midwife. On arrival at triage Catriona described: (Box 4.5.6.)

#### Box 4.5.6. Extract from Catriona 1:15-27

*'I felt totally vulnerable, and totally freaked out and upset and stressed. So when I came into the birth centre the two midwives were just standing there...and I kind of I think somewhere in me I think...'It's alright, it's alright, any minute I'll be enveloped in this warm welcoming...kind of' you know "These lovely people will take care of me and all will be safe and nice"...and I think I was just kind of...just needed that to feel OK. And they just stood there staring at me...blankly...hands on hips and one just kind of sighed...and went..."Oh (Sighs) Why are you in a wheelchair?" and it just felt like, "Oh God (sighs) I can't rely on them to look out for my wellbeing".'*

Catriona was desperately needing and anticipating being held and protected and to be able to place herself in safe hands. There is a sense of holding on until it was safe to let go. She expressed palpable disbelief that these first midwives were not 'lovely', and not ready to take care of her. In contrast, Catriona later highlighted her trust of staff during her Caesarean section: *'these people all knew what they were doing that was fine'* and expressed her total trust in her midwife Lily, with whom she felt able to *'open up, relax, and felt confident'*.

#### 4.5.2.3.2. Competent midwives caring for me

All *The Women* described times when the healthcare provider (not always midwives) listened, explained, responded, and acted in a way that left them feeling competently cared for. Valerie felt, *'he (obstetrician) cared about me and he cared about Katy (the baby) and he wanted to make sure we got through this'*. For Catriona: *'everything she (midwife) did made me feel like she really actually cared and so I felt completely...I just felt that I felt cared for'*. While *The Women* did not often mention specific actions, Julie and Valerie note feeling that midwives were *'checking things appropriately'* (Julie), while Marie highlights the efforts of the SoM at caring for her physical needs. Catriona was relieved when the geneticist recognised that her severe headache was in fact a post dural puncture headache (NHS, 2014). Also, when in theatre Catriona felt *'everyone was being pretty competent'*, while Julie felt the midwife *'was kind of adequate to what is happening'*, which contrasted in some way to that of others. Julie's sense of competence and ability in this midwife, contributed to the sense that the midwife was making things safe.

#### 4.5.2.3.3. Lack of competent care

However, a strong thread of perceived incompetence or lack of essential care was described by all *The Women*. They described unidentified medical issues, such as bladder damage, retained placenta, and Catriona's post dural headache. *The Women* highlighted a perceived lack of knowledge amongst midwives regarding conditions such as thrombophilia and Factor V Leiden, and an inability to site an intravenous cannula. Lesley feels that incorrect identification of the position of the baby, and the dilatation of her cervix, led to negative consequences regarding the birth process. Procedural incompetence was also described such as, not checking charts, forgetting to do a blood transfusion for three days, missed medications or over medication, being left in one's own incontinence mess for over an hour, and a lack of follow up regarding significant postnatal conditions. Valerie was greatly distressed by a badly carried out VE: (Box 4.5.7.)

#### **Box 4.5.7. Extract from Valerie 2:12-17**

*'She (midwife) gave me an internal examination that was very rough and actually made me bleed...and she had long fingernails as well, and I, just the whole thing was just quite off putting. I mean internal examinations are horrific enough as it is, um, but, um, it really felt like I was being manhandled.'*

Valerie, while aware of the potential horror of a VE, was further distressed by the physical attributes and behaviour of the midwife and the fact that she had caused her harm. She seems to have anticipated that the midwife would have acted in a way so as to minimise the potential horror, but instead compounded it by not taking appropriate physical care, nor proceeding in a way that exhibited care towards Valerie.

Marie expressed perceived incompetence, albeit more strongly when she likens the situation to '*a total shit show*' articulating that the '*lunatics have taken over the asylum*'. Lesley voted with her feet. Her lack of confidence in the hospital and midwives led to her going to local hospital for sick children when concerned about her baby's health a day after going home, rather than going back to postnatal ward, which friends subsequently told her would have been better.

#### 4.5.2.3.4. The integrity and honesty of care providers

For two *Women*, the ability to trust went deeper and related to the honesty and integrity of staff. Julie '*liked*' the honesty of the anaesthetist's assistant, while Marie remarks that one consultant was the '*only person who'd actually been straight with me the entire time*'. Marie's comment relates to her experience of midwives lying about the availability of a birth pool or a room with disabled facilities, which Marie had seen during an antenatal meeting with the SoM. This was further compounded by discovering that much of her medical and maternity documentation was false. For Julie, a culmination of events during labour and the lack of correct information regarding her poorly performed and repaired episiotomy, left her feeling that '*nobody is was honest (...) it's as if everybody was slightly lying and...and like minimising what, what it is*'. Furthermore, Marie's experience of being held down on the trolley when alone in theatre, while her husband was changing into scrubs, was not only horrific as explored in the sub theme *Keeping me safe*. This experience instilled a total lack of trust in the integrity of the staff: (Box 4.5.8.)

#### **Box 4.5.8. Extract from Marie 22:5-9**

*'If he'd (partner) have been there, I don't know, if he'd have been there or my doula had been in, I fully suspect that wouldn't have happened...em...yeah I think that wouldn't have happened if there had been someone else in the room.'*

The sense of what if and suspicion highlights Marie's perception that the behaviour of the staff took advantage of her vulnerability, with a lack of witnesses. Marie's is clearly questioning the integrity of the staff. Marie's mistrust and suspicion of midwives is possibly heightened due to her history of rape. Nevertheless, she expressed a real sense of being let down and of having misplaced her trust.

#### 4.5.2.3.5. Summary of sub theme 2: Trusting you

*The Women* expected their care providers to be trustworthy and competent professionals, into whose hands they could place themselves, relying on them to take care of their physical and emotional needs and those of their babies. This expectation was met when care providers listened, explained, responded, and acted with honesty and integrity, which would leave them feeling competently cared for. *The Women's*



expectations were undermined by the contrast in midwives' ways of being with them, realising that they may not be able to rely on the next midwife. This was compounded when care providers did not meet their physical and emotional care needs, and in fact put them at risk, resulting in important negative impacts on *The Women*. At times *The Women* realised they could not trust the integrity and honesty of their care providers.

#### **4.5.2.4. Sub theme 3: Keeping me safe.**

This sub theme explores *The Women's* expectations and perceptions of safety during their childbirth experience. The loss of safety often related to the direct behaviours of care providers, which left *The Women* feeling threatened. This is explored more fully in the next sub theme *Threatening me*.

##### 4.5.2.4.1. Expecting to be safe

Within the wider population of childbearing women, many report that they do not view hospital or maternity professionals as being safe (Favrod et al., 2018). However, all *The Women* did anticipate being welcomed into a place of sanctuary, believing they could place themselves in the hands of those who knew how to help them safely through the process of birth. Marie, a survivor of rape, felt strongly that the hospital was 'a place where you expect to be safe'.

##### 4.5.2.4.2. Women feeling safe

Consistent with other positive perceptions, all *The Women* identified times when they felt safe, or indeed: 'very safe' (Catriona), usually with a particular midwife. This concept of feeling safe was referred to only fleetingly by Lesley. Julie felt 'very safe with her, in her hands', even during a painful examination: 'she was making me feel safe and nice and it was quite ok'. Valerie speaks highly of the head midwife and the midwife Hilary, whom she found to be 'solid and very grounding'. This statement reflected a need in Valerie to feel anchored and secure, thus preventing her from drifting or being lost. Having someone to anchor oneself to was also raised by other *Women*, who refer to trying to focus on the face of their partner, or a specific care provider at moments of distress. Whilst in theatre, Julie, like Geraldine, notes feeling safer with the anaesthetist than the midwife: 'he was trying to make me feel safe (...)

*emotionally he was actually involved a lot more than my midwife'. In theatre Catriona notes that: 'apart from that one woman Moira, I was feeling ok with the other staff'.*

#### 4.5.2.4.3. The loss of safety

Again, the contrast in midwives was highlighted and sometimes the sense of safety shifted when a new midwife came on duty. Geraldine felt, *'there was a complete change of feeling in the room'*, which resulted in a loss of the warm safe space, and Valerie objected to *'not feeling comfortable, not feeling safe anymore'*. For Julie the sense of safety was not only lost, but shifted to *'very unsafe'*, when her midwife took a break and the cover midwife insisted on the use of gas: (Box 4.5.9.)

#### **Box 4.5.9. Extract from Julie 31:10-18**

*'She, she was just telling "Breathe. Gas. Now." And, she was like this kind of...bossy I suppose it was better to have the one that left me alone...than this you know? So that would, that would just set...set...I would get angry and (raises voice) but you know she definitely made me feel quite...very unsafe...and very...vulnerable and very, I needed to protect myself and Euan (baby) from her That's how I felt. I thought "God she's going to hurt me or something".'*

Julie was very emotional when recounting this episode. Her sense of danger was palpable and totally unexpected within this environment. Midwives were people of safety, no? There is a sense that even though the other midwife was perhaps not as present as desired (feeling abandoned?), Julie did not feel unsafe until she was faced with this contrasting invasive behaviour. Julie desires to escape, although that was potentially not possible. Being unable to escape seems to have reinforced the sense of danger and possibly a sense of helplessness, which is a core feature related to PTSD-PC.

#### 4.5.2.4.4. Keeping themselves safe from midwives

For all mammals, danger instils fear and fear initiates the adrenal response. In response, the adrenaline released overrides the optimum release of oxytocin, which is the most central hormone at play during childbirth. The need to hide, protect, and seclude oneself is a deep limbic response to perceived danger (Anderson, 2002).

Valerie expressed this as: *'the animal part of me was just constantly on alert and I felt*

*snarly and just (sighs) I felt like I had to be on guard all the time'. Valerie was unable to let go and feel safe and felt the need to be hypervigilant even though this was not what she wanted. This was evident for Valerie who says, 'that animal part of me decided "You know what? this is not the time or the place, we're not safe, we're going to wait"'. Also, Marie is clear that the lack of labour progress following her experience of having a vaginal sweep performed without consent, was her body's way of saying, 'this is not a safe place for you to have your babies, so just stay in there until...there is a safe place'.*

All *The Women* actively sought safety at various point during labour. At times this was related to the environment and involved responses such as, locking the toilet (Geraldine) or repeatedly closing their curtains to create privacy on the postnatal ward. Yet, five *Women* expressed a strong need to protect themselves from midwives. Julie identifies this at the outset during her interaction with the triage midwife: *'I felt she's against me and I need to defend myself somehow'*. One way to seek safety is to withdraw to an isolated place out of the reach of danger. Julie described wanting to hide in the toilet: *'somehow in that toilet I would be left alone'* and *'almost hiding a little bit'* in the birth pool. Catriona and Geraldine withdrew psychologically by disassociating and putting themselves into a safe bubble. Valerie fantasised about being alone in another safe space: (Box 4.5.10.)

**Box 4.5.10. Extract from Valerie 2:36-44**

*'After that internal examination it felt like my body just kinda said "Nope we are not doing this" um (laughs) and I didn't really feel...well it comes down to not feeling safe, um, it reminded me of a, a, (weepy) sorry, anecdote, um a story my grandmother told me about one of her sheep who would only give birth far away, hidden away you know, in this, the most dense little thicket she could find, and I felt like that. I felt like that's what I wanted. Um so (weepy)...(sigh) that's what I wanted (big breath in).'*

Valerie's strong emotion and grief highlighted how unexpected and inappropriate the rough VE was for her. The actions of the midwife left her feeling very unsafe. Valerie expressed a deep physiological reaction to feeling unsafe during childbirth, with the need to withdraw and hide. As a result, she shut down, closed off, and withdrew, and then placed her mind in an associated context of safety. There is a deep sense of

longing, but also awareness of the reality that this is impossible, which worsened her grief.

Catriona expressed just needing to *'get out of there (...) just wanting to go home'*. Marie and Valerie escaped by self-discharging. Marie felt *'there was no way I was staying there so I just went home'*, and Valerie described her conversation with staff: *'the words I actually used is 'I want to go home where I feel safe and looked after'*.

#### 4.5.2.4.5. Impact on future choices

For Julie and Marie, feeling unsafe in hospital or with maternity professionals, not only impacted on the related experience, but resulted in no longer feeling safe to choose to have another baby. Their experiences were so strong that they both deserve to be represented here. Marie questions hospital as a place to have a baby, because it seems *'a very dangerous place'*, and she can see no way to *'prevent all this sort of madness happening again'*. Marie explains further: (Box 4.5.11.)

#### **Box 4.5.11. Extract from Marie 10:35-43, 16:34-40**

*'But it was literally one of the worst experiences, I'd say actually it was worse than my rape, it was much worse em, in terms of how it how it affected me, how it made me feel, it was much worse em...because...the place whe...the...the...when that happened em, it was in a situation where...it's a place where you expect to be safe, you feel you expect to be safe, you don't expect people to overstep your physical boundaries, you expect people to...to not be **awful** (small laugh) (...) I think I would just em...in terms of trying to create a safe environment for myself, if I would maybe end up putting my baby in danger by having an unassisted birth, so it's easier just to never be pregnant again, than I actually have to make that decision. So em...so yeah it was that's pretty much it...that's pretty much all of it...'*

Marie is initially hesitant in the articulation of her feelings, which highlights the struggle she had in accepting the total loss of trust and sense of safety in a place where she felt certain she would be safe, especially in terms of how she was treated. This was not about physical harm, but about the interpersonal violation she felt. Even though midwives may have been acting with good intent to protect Marie and her baby, Marie moved from expecting the hospital to be a safe place to no longer feeling she could safely contemplate another pregnancy. There is a deep sense of loss, fear, and

resignation. This extract is particularly strong given that it brings in all the sub themes of this master theme.

Julie experienced a poorly performed and sutured episiotomy, which was still not healed at the time of interview, six months after the birth. Julie while '*terrified at the thought*' of resuming sexual relations with her husband and the possibility of another pregnancy, considers giving birth at home to be the only possibility if she was pregnant in the future: (Box 4.5.12.)

**Box 4.5.12. Extract from Julie 20:18-21,37-51**

*'With this part being so mutilated that's what I feel. I felt that they just hurt me there I went to the hospital to give birth and I was hurt. Properly. Cut and everything. (...) I feel quite... quite... like... incomplete...like as if my...some part of my body was actually torn away together with, they dragged out my...my baby and they, they...they took something away from me. Something **really** big and they left a hole, and it's like a hole metaphorically and physically and all, all ways. And they didn't stitch me right and they didn't, that's what the midwife said that's what everybody said that, that they didn't that it's, it's not properly done you know so, so this is really horrible when this because this was kind of my fear in many ways and eh and I felt a lot that it was all my fault for a long time it's only now that I'm able to see no. But for a long time, I felt this maybe I should have you know not gone to the hospital.'*

There is a clear sense that Julie feels that she was totally damaged, when in fact all she did was come in to have a baby. Her sense of expecting to be safe and cared for is strong, and equally her outrage at the reality being so different evident. Her expectation that the care providers would have looked after her and kept her safe is shattered. At first, she cannot believe the hospital was so unsafe, and blames herself in some way. She proceeds to emphasise her realisation that she was potentially in danger in hospital, rather than safe. While this experience also relates to the clinical competence of care providers and violation, which are issues discussed in sub themes *Trusting you* and *Struggling for power*, it was included here as the expectation of being safe was so totally shattered.

#### 4.5.2.4.6. Summary of sub theme 3: Keeping me safe.

All *The Women* expected to be welcomed into a place of sanctuary where they would be guided safely through the process of childbirth. Sometimes, *The Women* felt safe in the hands of individual midwives or other staff, through a sense of involvement and stability. Yet, *The Women* more often experienced a lack of safety, which they expressed explicitly in relation to midwives' actions or implicitly through their expressed desires or fantasies about escaping and hiding from midwives. *The Women* attempted to find safety by connecting with particular individuals, or self-discharging home. The perceived lack of safety impacted on *The Women's* decisions about future pregnancies.

#### **4.5.2.5. Sub theme 4: Threatening me.**

Menace and threat, while closely related to danger, emerged as somewhat distinct within *The Women's* experiences. Being threatened relates to direct words or actions that serve to undermine or initiate a required behaviour. This sub theme explores *The Women's* experiences of feeling threatened through their interaction with their care providers.

##### 4.5.2.5.1 Putting baby at risk

Valerie was told by the consultant that she had put her baby at risk by becoming pregnant in the first place when she had '*fibroids*'. Julie perceived threat from the midwife telling her that if she chose to stay at home and not come in to have her baby checked after her waters had broken, she was creating risk for her baby: '*it's quite dangerous for you to stay home*'. Also, if she was not able to be sure about her baby's movements she could not use the pool: '*the message or tone of the voice was "better feel the moves otherwise we put you somewhere"*'. At other times Julie felt her interaction with '*these people*' (midwives) was like being pressured into passing some kind of '*exam, you didn't push in two hours well you're going for forceps*'. Geraldine while physically incapacitated by epidural anaesthesia and a painful wrist condition, was told to move herself across onto the theatre bed: (Box 4.5.13.)

**Box 4.5.13. Extract from Geraldine 2:30-39, 15:32-36,42-44**

*'And I said well (sigh) "I can't do it"...and I, I remember that, what I don't remember is screaming, my husband was outside waiting in scrubs, and he remembers hearing screaming, and this took over an hour. Em...and eventually, she told me, that if I didn't move myself I was going to hurt my baby. And...I moved myself (sarcastic laugh). How I did it I don't know I had no feeling below the waist, I had my wrists...locked, they wouldn't, they wouldn't work. How I did it, I don't know. (...) Em...and when I was in that room, with her (midwife), it was her and two theatre nurses that were to get me onto the theatre bed em...she (midwife) stood very, very close to my face and she was looming...over me and I started to feel very claustrophobic. (...) she, you know she was very threatening, obviously telling me I was going to hurt my baby.'*

Geraldine was astonished when recounting this scenario, not only at the expectation placed on her, but the apparent amount of time she struggled within it and that she had been oblivious to the true depth of her distress. The menace is apparent from Geraldine's strong discomfort with the physical proximity of the midwife. The perceived threat, both physically and verbally was enough to spur her into action, which had seemed impossible.

**4.5.2.5.2. Threat of interventions**

The implied risk to their babies was further emphasised when *The Women* felt threatened with interventions if they did not progress in a determined time period. Potential interventions included induction of labour, forceps, and caesarean section. Lesley felt threatened that unless she started labour over the weekend she would be induced: *'better hope you have had that baby by Monday morning otherwise it's all going to go horribly wrong'*. *The Women* also perceived risk to themselves through the threat of interventions. Valerie says, (Box 4.5.14.)

**Box 4.5.14. Extract from Valerie 1:27-29, 2:46-51, 6:9-18, 13:8-12**

*'I felt almost threatened um that if I didn't manage to give birth I was going to have a c section it felt, it felt more threatening than helpful (...) I was given the option you know um we can induce you or we can do a c section and because of the fibroids they said if we do a c section you will possibly need a hysterectomy so you won't be able to have more children (crying) and I have always wanted two (sobs)...so that wasn't an option (...) it was this almost like lying under a guillotine it was really it felt like this this threat, this constant threat on the horizon and I don't know how anyone is supposed to relax (laughing) when they've got that hanging over them um you know...er...do this or we'll stab you (laughs) that's really what it, it felt like and we'll sterilise you in the process that's not the right word but you know just this...the consequences um I mean relax at gun point it was really that silly...(...) and they were saying I was endangering my child by not doing what they were saying um and that...it was fear I really felt like like...like I was being blackmailed with fear basically. '*

There is a sense that Valerie is aware that the information communicated is realistic, but rather than being helpful, she perceived a total closing down of options. Valerie appears to be totally stuck and weighed down by the dilemma of choosing between threat to baby or to herself and any future children. There is an implied injustice and impossibility to the demands being place on her. Ultimately the sense that it is blackmail, which highlights the deep sense of threat.

**4.5.2.5.3. Threatened by the staff**

Julie was frightened by the midwife's insistence that she use the gas and air more, particularly a fear of losing control within this. Catriona found one midwife, Moira, to be constantly very menacing in her language and attitude and regrets not being strong enough to ask her to leave. A sense of menace arose for three *Women* (Geraldine, Julie, Marie), while surrounded in theatre by many people talking to them through masks. This was a major hotspot for Julie and left both Geraldine and Marie feeling claustrophobic. Whilst wearing masks might be essential to maintain a sterile environment, it may be that women need to be able to see the staff as humans first. Julie described, (Box 4.5.15.)



**Box 4.5.15. Extract from Julie 13:3-5, 34:1-21**

*'I couldn't get it out of my head like all those there. So I had these people standing around me with the masks (...) (big breath) Now the doctors, the obstetricians they weren't nice. And that's their faces that I mostly see. I see all the faces, but these are the faces that are scary ones with the masks. They were with the masks, the anaesthiologist I don't remember him being in a mask, I remember they were like normal people. And these two women (...) I remember her make-up and eh...she looked quite scary you know, she just came, and she spoke to me with that mask, so I found it quite like 'I don't know who you are. You're looking at me from the mask.'*

There is a strong sense of threat and fear of being surrounded by others who are powerful, but who are faceless and unreachable. Julie expressed a need to connect, interact and communicate with real people. The anaesthetist stood out because, without a mask she could connect with him as a person. For the others, the threatening barrier of masks and scary partial faces seemed to render Julie unable to see them as normal non-threatening humans, which make it impossible for her to connect and feel safe. Furthermore, the presence of the masks serves to highlight the imbalance of power.

**4.5.2.5.4. Horror**

Horror, which is an extreme sense of threat, was expressed by two *Women*. For Julie fears coming true regarding the condition of her perineum, and for Marie the horror she felt at the humiliating and dirty state she was left in postnatally. Marie also described when the staff were holding her down on the bed in theatre: (Box 4.5.16.)

**Box 4.5.16. Extract from Marie 5:7-16.**

*'It was the only time that my partner was out of the room and I kept thinking to myself no one can see this that this is happening like, I couldn't believe it was happening...it felt like em...it was like...a horror film or something...I was like stop and they wouldn't stop and for me that's a massive trigger I'm a survivor...em...of rape and that was...I was just totally like I don't know, I don't...em...I just couldn't believe it was happening. I was in a hospital and I was telling people to stop, and they wouldn't stop.'*

Marie is struggling to articulate her total horror in a place of perceived safety, amongst responsible professionals, that her demands to stop were not being responded to. Marie's expressed horror directly relates to the actions of staff, the conflict of power,

and Marie's subsequent lack of power. There is a direct association with the abuse of rape and the fact that Marie perceived her will to be totally overridden.

#### 4.5.2.5.5. Summary of sub theme 4: Threatening me.

All *The Women* recounted times when the words or actions of midwives served to leave them feeling threatened by negative consequences. Primarily they felt threatened by being told that their baby would come to harm, usually as a consequence of something they either failed to do or refused to comply with. However, *The Women* also felt threatened with interventions, within which they perceived threat to their own wellbeing. Sometimes the required action was something out with the control of *The Women*, such as augmenting progress in labour. This sense of threat contributed to fear and at times horror. *The Women* felt that midwives used this threat of risk to force compliance or action. Sometimes *The Women* felt threatened by the demeanour of care providers, particularly when they were wearing masks. Extreme threat, in the form of horror, was perceived by two *Women*.

#### **4.5.2.6. Summary of master theme 1: Shattered expectations**

As noted in each of the sub themes, *Haunted by disbelief, Trusting you, and Keeping me safe*, *The Women* sometimes found their midwives behaviour to be as they hoped for and needed, and that they were the competent health professionals that *The Women* expected them to be. Yet, within this group of six women who have developed PTSD-PC, each experienced a shattering of their world view regarding their expectations of the experience of childbirth. Notably, *The Women* related this more to how midwives and other staff provided their care and less with the process of childbirth. *The Women's* primary expectations lay not in lovely candlelit gentle births, but in being able to hand themselves over into the safe hands of trustworthy midwives who were there for them. Midwives who knew their job, and who would strive to support and empower *The Women* during the challenging journey of childbirth. While all *The Women* experienced this at times throughout their journey, there were many more times when they were unable to trust their midwife or other care providers. Furthermore, *The Women* sometimes felt directly threatened by midwives, resulting

perceptions of danger for both self and baby. The sense of threat contributed to fear and horror, which are core emotions of PTSD. *The Women* remained haunted for several months and even years by these hotspots within their childbearing event.

#### **4.5.3. Master theme 2: Being with me.**

*'I just needed someone to like...pick me up and say 'It's all going to be ok and I'm" you know "I know what's happening I'll guide you through it".'* Catriona  
11:31-33

The word 'midwife' means to be 'with woman' and so it is unsurprising that *The Women's* sense of 'being with' midwives should be a strong theme expressed within their experience of QPI. *The Women* strongly desired to feel a connection or relationship with their midwife and this was by far the most frequent sub theme identified within this master theme. The development of connection or relationship necessitates being present with the other. Also, being related to as an individual through the use of effective communication enables each individual to be seen and heard. The sub themes reflect this (Box 4.5.17.).

##### **Box 4.5.17. The sub themes of *Being with me***

1. Building relationship with me
2. See me – I need you
3. Talking and listening to me
4. Supporting me

#### **4.5.3.1. Sub theme 1: Building relationship with me.**

This sub theme explores *The Women's* expressed desires for connection and relationships with midwives, and the nature of the relationships they experienced.

##### **4.5.3.1.1. Desire for relationship**

All *The Women* strongly anticipated and desired to connect with and establish a level of relationship with midwives during labour and birth. For Catriona and Geraldine, this followed on from a positive connection with midwives during pregnancy. Lesley reflected that while her physical outcomes may not have changed: *'if I'd formed a*

*better relationship with the midwives at the start I might have felt better about it'. All The Women were aware of how present and tuned in midwives were, and that this contributed to the nature of their sense of connection and relationships with midwives. While communication is explored more deeply as a separate sub theme, it was very much at the heart of connection and relationship. Lesley relied on the midwife to see her as an individual and make the effort to build a relationship: 'I'm an introvert so I'm not gonna be like "Hey midwife".'*

#### 4.5.3.1.2. Positive relationships

Each woman at some point during her labour and birth, experienced and highly valued, positive relationship with at least one midwife, albeit that for Lesley this is minimal. For Valerie, the midwife's *'body language, eye contact'* alongside awareness that the midwife was *'focussed'* directly on her, built a sense of connection. Julie described the *'emotional presence'* of one midwife who spent time *'speaking'* and *'getting'* to know her. Catriona described relief and fondness for Lily who had a *'great vibe about'* her, and *'greeted'* and *'connected in'* with her. Lesley finally experienced positive connection once on the postnatal ward, noting that even though midwives were still *'rushed off their feet'*, they *'put a lot more time'* into *'forming relationship'* by just *'talking and chatting'*.

#### 4.5.3.1.3. Lack of relationship

However, more frequently each woman lamented a lack of connection or bond with midwives that resulted in distress and a sense of loss. Valerie feels that the *'human connection was missing'*, with the midwife being *'like a foreign body in the room'*. Geraldine and Catriona reflected that even though midwives were professional, they found them *'cold, sterile'* and *'dispassionate'* (Geraldine), with *'absolutely no bond'* (Catriona). For all *The Women*, a sense of disconnection arose because they felt midwives did not speak with them (Marie, Catriona), look at them (Catriona), nor focus on them (Valerie, Julie, Marie). Geraldine felt midwives were as interested in her as *'women stacking supermarket shelves'* might be. Similarly, Catriona said, (Box 4.5.18.)

**Box 4.5.18. Extract from Catriona 2:32-37, 11:41-43, 12:1-3**

*'but I just remember this feeling really like I just wished they (midwives) would leave me alone almost cos I was just it was like there were two ladies at the bus stop that had suddenly, who seen me naked and vulnerable...not...you know...two health professionals that were happy to take care of my wellbeing (...) and these women were just...so perfunctory it almost felt like I'd gone into labour in the supermarket queue and it was the checkout women...they probably would have been warmer to be honest. They were just cold, and it felt so, I felt ten...and I didn't...I didn't' want to interact with them.'*

Catriona's heightened awareness of vulnerability suggests a real sense of discomfort in the presence of these midwives. There is a sense of basic duty from them, carrying out their required roles officially, but with no sense of personal engagement with the individual before them. There is a real sense of Catriona's exposure and yet possibly an expectation of self to build connection. However, Catriona struggled to express that subsequently she herself had no interest in engaging with these midwives, which is a reference that further highlights the lack of connection or relationship.

A perceived lack of connection is somewhat passive, whereas all *The Women* perceived some of midwives to be actively expressing dislike for them, while preventing them from accessing what they felt they needed. Julie described some midwives as *'horrible'*, while Catriona found some *'useless'*. Geraldine felt that one particular midwife *'just didn't care'*. This is explored more fully in the sub theme *How not what*.

**4.5.3.1.4. Language *The Women* used**

When *The Women* perceived a particularly strong positive, connection or relationship, they expressed a lasting fond memory for the individual midwife, remembering her by name and referring to her with emotional gratitude, using words such as, *'lovely, warm'*, and *'grounding'*. Victoria says, *'I'll never forget her (sobbing) she's an amazing person'* and Catriona likened her midwife Lily to an *'old friend'*. In contrast, when *The Women* perceived connection or relationship to be absent, or negative, they all referred to midwives using impersonal words such as, *'they, her, that women, these women, and those ones'*. This can be seen clearly in Marie's narrative: (Box 4.5.19.)

**Box 4.5.19. Extract from Marie 1:3-7,15-24,29-37**

*'I had almost no interaction with the midwife at all. I had a doula with me...em...the midwife just...was writing she was writing down in a book the whole time that I was in labour, em so I didn't have an interaction with her. (...) and then they said they would just move me to labour suite so that was one lady, no there was two...two separate ones...one who sort of brought me in and got me settled, and another one who came and did the examination....but...I don't really...I don't really recall anything...about that. Then when I went to the labour suite...it was a different midwife...well hang on she changed they...that midwife just wrote in her book all the time.'*

Marie struggles to articulate her sense of these midwives, or even really to remember them at all. In contrast to other *Women's* expressions of fond connection or very negative connection, Marie exhibits a sense that they were impersonal and somewhat faceless. Nothing stood out about them except that they were somewhat distant and anonymous, and she felt a lack of interaction with them. In this extract, Marie does not particularly exhibit trauma. However, it could be considered that this lack of connection contributed to the trauma she exhibited in later experiences, due to a sense of no one really being with her.

Lesley was unable to remember any midwives' names, because they '*all seemed the same*'. One exception was Catriona, who when describing an overtly negative relationship with an individual midwife, was desperate to tell me her name. She described her as the biggest issue throughout her childbirth experience, noting that she '*stood out from her colleagues*'. *The Women's* use of language reflects the strength of importance they placed on their relationships with midwives, about which much has been written (Kirkham, 2010).

**4.5.3.1.5. The role of continuity**

All *The Women* identified lack of continuity as a major issue. Lesley and Julie lamented not being able to '*get to know*' their midwives. Julie, Catriona, and Valerie all expressed grief and loss when midwives, with whom they had built relationships, left at the end of a shift. They found it '*quite stressful and disturbing*' (Julie) to get used to new people and build relationships. For Julie, Catriona, and Valerie, this grief deepened to distress when the new midwife contrasted negatively to the previous midwife. For Geraldine, her positive connection with her community midwives and

first two labour ward midwives, with whom she had felt able to *'let herself relax in the environment'*, switched to a very strong sense of negative connection with the next midwife. Geraldine was left searching for the previous positive experience: *'where, where's the midwife?'* and felt unable to *'recognise'* this *'person'* as a midwife. Geraldine's negative connection, reinforced by subsequent midwives, served to transform her experience into one of distress and trauma. However, sometimes the change to a new midwife was just what was needed. Catriona described at length a deep sense of relief and joy at the positive contrast between the earlier two *'strangers'* and her next midwife Lily (Box 4.5.20.).

**Box 4.5.20. Extract from Catriona CD 3:5-15**

*'Then I remember Lily the night midwife came in and everything changed and she was just...she was what I had hoped and wanted and needed (...) she was just, just the right level of warm and friendly and greeted me and was reassuring and just yeah everything that I needed she was just lovely (...) I felt in a nice way I felt facilitated by her she was like right okay this is what's going with you and she connected in with me'.*

Catriona's sense of relief is palpable and accentuates the extremes of experience regarding relationships with her midwives. Catriona's description highlights the role these relationships play in terms of meeting her needs during labour.

4.5.3.1.6. The impact on labour progress

In order for childbirth to progress optimally, women need to feel safe and relaxed (Buckley, 2015, Uvnas-Moberg, 2015). Overall, a lack of positive connection or relationship with their midwives led to *The Women* feeling uncared for, and thus unable to relax or feel safe, as discussed in sub themes *Trusting you* and *Keeping me safe*. It is therefore physiologically possible that a lack of connection not only affected *The Women* emotionally, but potentially impacted on labour progress, with this possibly contributing to subsequent obstetric interventions. This was demonstrated when the midwife with whom Valerie had built a strong positive relationship had to go home for the night: (Box 4.5.20.)

**Box 4.5.20. Extract from Valerie 4:40-41, 5:14-18, 20-24, 6:3-4**

*'That's when I had the wonderful midwife called Hilary and um I had her for the entire shift and labour was progressing while she was there. (...) The next midwife was fine, there was nothing wrong with her, but she just kind of did her own thing and she didn't really check on me very much, and she didn't talk to me, and she didn't seem to engage with me very much. Um she was just sitting in a corner typing, (...) um so through the night gradually my labour just came to a complete halt again um and then the next morning Hilary's shift began again, and she requested me, and as soon as Hilary walked in the door labour started again. (...) We actually were making progress.'*

Valerie's strong positive relationship with her midwife, is clear from her language, the sense of time and referring to Hilary by name, alongside a sense of reciprocation by Hilary's request to be with her the next day. With Hilary there is a sense of working together, whereas with the other midwife, although nothing is actively negative, Valerie expressed a loss and sense of being alone. Valerie appears to perceive the link between the level of connection with her midwife and her progress in labour.

4.5.3.1.7. The Women acknowledging midwives

*The Women* recognised that some midwives attempted to develop a connection: *'Oh you know we're mums (...) we always put our children first'*. Geraldine reflected that she had perhaps misunderstood *'what I heard was "stop being lazy, it's not about you"'*. Marie acknowledged that the presence of her doula perhaps left midwives feeling unneeded. *The Women* struggled to come to terms with the lack of relationship and were aware of other pressures on midwives and systemic issues, which included the lack of potential for continuity.

4.5.3.1.8. Summary of sub theme 1: Building relationship with me

All of *The Women* desired to connect with and establish a level of relationship with their midwives. Five *Women* experienced strong positive relationships, which they highly valued. However, more frequently, *The Women* expressed distress at a lack of connection or bond with their midwives. Sometimes this lack of connection was not passive, with *The Women* perceiving some midwives as actively disliking them. A lack of continuity was a major obstacle to building relationships and connecting with midwives.



#### **4.5.3.2. Sub theme 2: See me – I need you**

From the Master themes 1 and 2, the sub themes, *Haunted by disbelief*, *Trusting you*, and *Building relationship with me*, showed that *The Women* sometimes had their needs recognised and met, and yet this was not always the case. Women's perceptions regarding midwives' awareness of their needs as an individual is now explored.

##### 4.5.3.2.1. Being seen as an individual and having one's needs recognised

Mostly, when women's needs were recognised this was not explicitly stated by *The Women*, but implicit within their descriptions of being supported and cared for, and so is presented within the sub themes *Trusting you* and *Supporting me*.

##### 4.5.3.2.2. Misunderstanding needs

Sometimes unrecognised needs appeared to result from a mismatch between midwives' assumptions and women's actual needs. *The Women* acknowledged that misunderstanding may have occurred due to their own way of being. For Lesley, who is a quiet introverted person, her appearance of being withdrawn potentially disguised her need to be talked to, possibly because she appeared to be '*in the zone of labour*'. Geraldine's calm demeanour potentially suggested she was coping well, leaving midwives unaware that she desperately needed support and was only coping by putting herself in a safe '*bubble*'. For Valerie and Julie, midwives misinterpreted signs of distress as being related to pain, but Julie was distressed by not understanding why she needed forceps: '*because at that stage I was fine (...) it wasn't...unbearable you know like I, I could still manage*', while Valerie says, '*I don't mind pain I know that's a strange thing to say but especially with labour that pain has a purpose and its fine*'.

##### 4.5.3.2.3. My emotional needs were not seen

For Julie, a planned and anticipated check-up at 40 weeks of pregnancy, which is full term, was cancelled as the midwife felt there was '*no point*' because Julie had declined a vaginal sweep. Julie felt dismissed and that her desire for a check-up and reassurance was not recognised. Once home, after her baby was born, Julie desired information and support regarding her low mood: '*I was holding my tears until that midwife comes*', but she felt this was not seen and instead her anxieties were fuelled by

inappropriate communication. For Catriona, her need to be *'enveloped'* in a *'warm, motherly presence'* on arrival to triage, appeared unrecognised as midwives fixated on what to do with the wheelchair she had arrived in *'Oh God (Sighs)'*. For Lesley and Julie, their sense of being questioned and stalled: *'I don't want to take paracetamol and I've tried a bath it doesn't work'* (Julie), or sent home by triage staff, repeatedly jarred with their perceived needs to be welcomed, supported, and to feel safe, which left them fearful and uncertain. This was further compounded by each woman incurring large taxi costs. Lesley said, (Box 4.5.21.)

**Box 4.5.21. Extract from Lesley 8:10-21**

*'Em...and I think I would have preferred to stay in when I first went in. I didn't feel like I was given the option and it wasn't 'How do you feel? Do you want to stay here even though it's really early?' It was just 'There's no point in you being here, just go home and come back when something happens.' And although some women might progress much better at home because they are relaxing, I was not at all relaxed because I was in pain and I didn't know what was happening, it was my first baby. So, I feel like I would have felt better just staying in from the start or at least the second time I went in.'*

Lesley expressed a clear need for someone to notice her as an individual and take time to understand what is important to her. She felt that routine assumptions were being made about what was best for her. These assumptions may have reflected practical systemic issues that were unseen by Lesley. However, Lesley expressed that her needs were priority in her eyes, but not in the eyes of her midwives. Also, she felt that no one was really taking on board the emotional impact on her from sending her home.

**4.5.3.2.4. My physical needs were not seen**

All of *The Women* found it very distressing when their physical needs were not recognised, especially when this occurred following repeated strong requests for help. Geraldine expressed her inability to move herself onto a trolley when she felt physically incapable: *'How? how am I supposed to do it?'* Catriona called for help on waking up in recovery, tangled in monitoring equipment, in pain, and without her baby: *'help, help, where's the baby?'* Five *Women* experienced a lack of recognition of medical needs: appropriate pain medication was missed for Valerie, Catriona, and Lesley; a necessary blood transfusion was missed for Valerie; and anti-thrombotic

medication was missed for Marie. Catriona explicitly notes that her post dural puncture headache (NHS, 2014) was finally picked up by the geneticist, after repeatedly telling maternity staff about her severe headache. For Valerie it was only when she threatened to discharge herself from hospital that somebody finally noticed significant care needs, which until then had been overlooked: *'they were so shocked...that...they hadn't checked on me before'*. Geraldine described, (Box 4.5.22)

**Box 4.5.22. Extract from Geraldine 20:12-25**

*'The head of obstetrics, he was the one who was doing rounds, bawled out a midwife by the end of my bed, about why I wasn't wearing compression stockings, and two minutes later, I was handed a pair. And at this point I couldn't sit down ... without crying, because ... I was so badly cut and damaged, and infection was setting in that nobody knew, and prolapsed bits, and nobody was really paying any attention to that. Em ... and my pelvis was so bad as well, and I was still contracting, so I couldn't, I couldn't have bent over to tie my shoelace, never mind getting full length compression stockings ... on ... and I said "(sigh), I'll need help" and she was gone, until I buzzed the buzzer, to say "I'll need help, getting them on", "tut/sigh".'*

Here Geraldine emphasises a catalogue of unrecognised and overlooked physical needs. Geraldine seems to be despairing and distressed that no one had acknowledged the help she needed and the effort it took for her to make her needs known. Geraldine expressed that she felt her needs were not just missed, but that no one actively paid attention to her condition, or appropriately assessed her needs.

Four *Women* experienced emotional distress when both their desire to hold their baby, and physical inability to do so without help, went unrecognised. This was compounded further when their direct requests for help were met with refusal, ridicule, or reprimand (Lesley, Marie, Valerie, Julie). Lesley and Valerie expressed grief at not being offered skin to skin contact with her baby, alongside a lack of explanation for this not happening. This left Valerie feeling that the attendant midwives did not recognise the importance of this to her. Most significantly, Marie felt that her pre-existing physical disabilities, compounded by the effects of childbirth, were completely unrecognised and unaddressed in the postnatal period. She was angry and astounded as plans had been put in place via a SoM, and Marie had communicated her needs

through her unread birth plan. Marie's distress increased when her emotional needs to bathe her own baby were also unrecognised (Box 4.5.23.).

**Box 4.5.23. Extract from Marie 17:12-14, 26:6-16**

*'I wanted to hold him, but nobody would come and give him to me (...) I don't know if she was a midwife or a nurse or a whatever. She came along, and she was like 'Oh they said that em...you've got some mobility issues'...I said "Yeah" and she said 'Is it ok if I use your baby for the demonstration of how to bath the baby?' I went "Yeah, that's fine"...cos I couldn't do it myself so...it was like...it was the best I was going to get so...'*

**Researcher:** *How did you feel about that?*

*'I wanted to do his bath by myself...em...but I felt that was something that had been taken from me simply because they didn't...the facilities weren't available.'*

There is a deep sense of loss and grief in this extract. Marie's need to hold and to bathe her baby is evident, as is her dependence on the support of midwives. There is no connection with the apparently random person who, while on the face of it was being supportive, in fact fails to recognise Marie's need to be assisted in bathing her baby, and not having it done for her. Marie's acceptance speaks to her resignation and regret at the loss of this opportunity.

**4.5.3.2.5. Ticking boxes**

Contributing to women's perceptions of not being seen as individuals, or having their needs recognised, was the sense that often midwives were primarily focussed on routine tasks and workplace responsibilities. Marie observed that the midwife was *'writing in a book the whole time'*, whilst Julie and Valerie both used the expression: *'ticking the boxes'*. Catriona notes the midwife's focus *'on paperwork, forms, and files'*, and Julie felt uncared for as an individual because the midwife focussed more on *'putting things in the form'* rather than asking her how she was feeling. Overall, *The Women* described feeling processed, and moved on: *'right we've done her she's okay, next one'* (Valerie). In summary, they were dealt with according to hospital routines, with little acknowledgement of their unique individual needs: *'they weren't caring for what was happening to me'* (Julie). This was especially difficult for Lesley, who on arriving at the birth centre after her waters had broken, felt no one recognised her

need for guidance and support, and '*basically sent her home with a letter*'. Geraldine noted, '*they weren't concerned about the emotional distress. They were concerned about the particular incidences that I could sue about.*'

#### 4.5.3.2.6. Summary of sub theme 2: Seeing me

At times *The Women* found that their emotional and physical needs were unrecognised and remained unmet, sometimes for days. This included their needs to be welcomed, reassured, guided, and supported in attending to their care needs or those of their babies. *The Women* found it very distressing when their needs were not recognised, especially when repeated requests for help were met with refusal, ridicule, or reprimand. All of *The Women* described a sense of being part of a system or process, in which clinical roles and responsibilities took precedence over their needs as individuals.

#### **4.5.3.3. Sub theme 3: Talking and listening to me**

*'It felt like nobody was listening a lot of the time.'* Marie 26:30

This sub theme presents women's experiences regarding communication with their care providers.

#### 4.5.3.3.1. Good communication

*The Women* identified some excellent communication from which they expressed relief, along with trust in their midwives. This happened when midwives or others made eye contact, asked questions, listened, and explained things well. Catriona appreciated one midwife: '*I remember she did totally explain, "Right we will do this, and we will do that", she gave me a rationale that made total sense*' and Marie spoke highly of the haematologist who '*knew what she was talking about and she just gave me the information I needed*'. Valerie experienced positive communication with her midwife Hilary and the head midwife: (Box 4.5.24.)

**Box 4.5.24. Extract from Valerie 14:22-26,37-39 15:1-4**

*'Body language is a big part of it, eye contact very much checking in with me they, when they asked me a question they looked at me directly and they listened to the words, but they also read my body language...so um there was a...an intensity of communication (...) I felt, I felt safe in their care. I felt like they were going to do what was best for me and they were going to make sure that they checked on me to make sure that that was still what was best for me you know they...they...asked me and they listened to my answers you know they asked questions they listened to my answers.'*

Valerie is clearly emphasising her need for the focus to be on her as an individual. Valerie was left in no doubt that these midwives were completely tuned towards her, interpreting and prioritising her needs. She perceives the communication to be intense, perhaps reflecting such a direct gaze towards her. Nonetheless, this direct gaze left her feeling that she was in safe hands.

4.5.3.3.2. Contrast in communication

All *The Women* noted a variation in the quality and presence of communication. For four *Women* (Geraldine, Catriona, Marie, Julie), positive communication was perceived from care providers other than midwives, which was notable in that it contrasted with a previous lack of communication from midwives. Marie said, *'some people did listen...em...some people didn't and there wasn't any like messing about around it'*. Catriona echoed this, noting a marked difference between her perception of communication from the *'lovely'* midwife Lily, who patiently discussed things, and the difficult midwife Moira, who impatiently issued instructions.

4.5.3.3.3. Lack of communication

A lack of communication was a major feature of all *The women's* experiences. Often midwives were uncontactable (Julie, Lesley), did not introduce themselves (Catriona), and did not come to the room for hours (Valerie). Most of *The Women* described: *'nobody telling'*. Marie felt, *'there was all the stuff I wanted to ask...and just nobody would give me any answers...em...nobody'*. Julie felt these midwives were not proactively listening, particularly to the emotional side of things. Lesley who felt particularly strongly that her need for communication was not being met at all, thought perhaps midwives did not think it was worth telling her things. This was

strengthened by her perception that *'she didn't feel like there was any attempt'* at discussion by midwives: *'it was always for me to say'*. Lesley frequently acknowledges that midwives were *'busy'*, but this did not lessen her distress at the lack of opportunity to discuss options.

#### 4.5.3.3.4. Timing of communication

Three *Women* highlighted that they were not informed in good time of the need for interventions, finding themselves *'suddenly'* in a challenging situation (Marie, Geraldine, Julie). For Geraldine, this was when told she was going to theatre and for Julie, it was on hearing she only had an hour left to push: *'but I never was told I need to push When did I? when was I supposed to push?'*. Lesley, Julie, and Marie were unable to fully comprehend or discuss information given when they were in advanced labour, under the influence of strong medication, or distressed, which is discussed further in sub theme *Finding and losing power*. For Lesley, the timing, content and approach to communication, left her fearful and uncertain, compounded by her lack of knowledge about her options and negative impact on her childbirth outcome.

#### 4.5.3.3.5. Birth plans

Julie, Marie, and Lesley highlighted the lack of interest paid to their birth plans: *'nobody ever looked at my birth plans'* (Julie). They had spent time creating these, valuing them as a communication tool for self-advocacy, particularly when the process of labour made it difficult to effectively give consent (Julie). Having the birth plan ignored was challenging. Marie used her birth plan to highlight *'in capital letters on the front'* that she was a survivor of rape, accompanied by a request to be asked before any procedures were undertaken. Marie's delight that one consultant had *'obviously read'* her birth plan, contrasted with her distress that the others did not and proceeded to act against her wishes on more than one occasion.

#### 4.5.3.3.6. Nature of communication

The nature of the communication was critical for all *The Women*. They described feeling unable to communicate with some midwives (Julie), or midwives just *'telling'* with no option for dialogue or *'discussing'* (Lesley). Others felt shut down (Julie), or

overruled (Geraldine), with midwives appearing defensive. Catriona felt communication '*stopped feeling like an exchange of adults*', with midwives being '*the gatekeepers of information*'. Others described having to '*keep asking*' or '*shout*' (Marie), '*lie*' (Julie, Marie) or '*complain*' (Julie) to be heard. For Julie, people communicating from behind masks in theatre was '*scary*', as was the facial expression of the midwife examining her perineum.

#### 4.5.3.3.7. Impact of communication

*The Women* relied on sharing of information and the opportunity to discuss options. Lack of or inadequate communication left Lesley and Valerie '*distressed*', while Geraldine was unprepared for the reality of the '*placenta will come away by itself*' and thought she was dying when it happened. For Julie, lack of communication contributed to fear: '*I was afraid if I gave birth at home or in the taxi because it's going so fast*', doubt, and '*total lack of trust towards the system*', as well as torment and self-blame: (Box 4.5.25.)

#### **Box 4.5.25. Extract from Julie 16:28-33, 19:8-9, 21:25-27**

*'And I think what would be really, really helpful and needed would be that somebody comes afterwards and explains what's happened, and show why this happened...and eh...and make sure that you're ok, and instead they just...take you out there...to your own devices (...) I still don't know why they had to use the forceps (...) So nobody came. Nobody explained, and I think for me that was crucial to not blame myself. To have an explanation of what was outside of my control.'*

Julie expressed a total lack of communication regarding why she had forceps. She desperately needs to understand and seems to be floundering in uncertainty. She emphasises the need to have an explanation, but because this was not forthcoming she shifts this uncertainty onto herself, alternating between whether she had failed, or the situation was out with her control. There is a sense of torment in Julie that appears still evident at the time of interview, which was 6 months after the birth.

However, for Geraldine the impact of what the midwife said when trying to get her to move onto a theatre trolley, haunted her for over a year: (Box 4.5.26.)



**Box 4.5.26. Extract from Geraldine 2:42-46, 12:35-36, 15:44-48, 16:1-2.**

*'Sorry this makes me emotional this bit, em...because she told me I was going to hurt my baby, if I did not move myself. I thought I had...em...and that feeling persisted for...over a year. (...) How they spoke to me, is what took me away from my baby for a year emotionally. (...) When we've had meetings about that, and spoken to the head of midwifery it's been "You know, sometimes things like that are said to motivate" and it's like "Do you realise that...6 months after Annie was born, if Annie would cough at night, I would get up and sleep on the floor next to her cot because I thought, that she was dying".'*

When recounting this story Geraldine was very tearful, and it was clear that this event remained a very important hotspot in her experience. She took at face value what the midwife said, perhaps because she saw her as the knowledgeable professional. The depth of impact is reflected in the emphasis on the length of time that it remained strong and current in her belief. There is a real sense of loss and grief regarding her relationship with her baby, who in fact was not hurt in the event. When Geraldine reflected back later with the head midwife, it is clear she was beginning to see the reality for what it was and acknowledge that the issue had been what was said.

Geraldine's experience highlights just how susceptible women are to what is said during labour and birth, especially if it is directly connected with their wellbeing or that of their baby. All *The Women* expressed that how they had been made to feel, meant that speaking out took effort and courage. This aspect of QPI is explored in the sub theme *Supporting me*.

**4.5.3.3.8. Summary of sub theme 3: Talking and Listening to me**

*The Women* expressed a clear and strong need for appropriate and accurate communication between both themselves and their care providers. Most *Women* highlight times of very positive communication, but often there was a distinct lack of communication. *The Women* were distressed when midwives remained absent for long periods, did not introduce themselves, did not provide nor seek information, nor proactively listen. The timing of communication was often problematic, with *The Women* in a compromised condition unable to understand or be understood. The nature of communication was often such that, *The Women* felt told rather than

involved in discussion. The impact of what was said could be devastating and long lasting.

#### **4.5.3.4. Sub theme 4: Supporting me**

The presence or lack of support was a strong emerging theme in the experiences of the *The Women*.

##### **4.5.3.4.1. Feeling supported**

Four *Women* identified times of good support from their midwives. Marie found very positive support from a SoM, while Lesley experienced limited support. Positive support was expressed when the midwife was present, both physically and emotionally, and *The Women* found her 'super supportive' (Valerie) or 'reassuring' (Julie) and in response they described feeling 'empowered' (Geraldine), 'capable' (Valerie) and 'grateful' (Catriona). Geraldine, while anaesthetised by an epidural, fondly remembers her midwife helping her to know 'when to push', while Catriona felt her midwife positively transformed her labour room with 'tweaks here and there' and was always checking for what she needed. Julie experienced reassurance and practical guidance regarding progression of labour: (Box 4.5.27.)

##### **Box 4.5.27. Extract from Julie 6:39-47**

*'Now the midwife, the initial midwife that was there, she was good despite the fact that she didn't ask me for the birth plan. She was pretty...she was quite a stable and friendly, and she...I felt safe with her. So, I was in the pool and everything that was happening that I...at some point there was lots of blood and she said that's fine, this is a show, this is a good progression em...and things were happening they were helping me to go in and out of the pool.'*

Julie emphasised a strong sense of support, perceiving that this midwife was very right for her, notwithstanding the lack of interest in her birth plan. This suggests a greater weight of importance on how the midwife made her feel. The midwife created a sense of security and approachability and even though labour was happening, and there existed some potentially alarming aspects, Julie expressed feeling safe and guided. She appears to feel accompanied and well supported.

#### 4.5.3.4.2. Shifting sense of support

The contrast between midwives was emphasised by four women, with each expressing deep distress and loss when moving away from a situation of positive support.

Catriona described the contrast in perceived support as '*black and white*', with some midwives being present and ready to facilitate, while others were '*right, you have come into my space, I tell (...) I decide*'. Geraldine found her community midwives and first two labour ward midwives very positive and supportive, and she felt able to '*relax in the environment*', only to find that the next midwife was completely different.

#### 4.5.3.4.3. Poor support

Sometimes, *The Women* felt midwives responded to requests for support or help with limited information, or in a way that felt patronising or belittling. This left some *Women* feeling that they could not ask for help or support, and that they had to work it out by themselves, however challenging the issue was. Geraldine strongly felt she needed support for postnatal pain but felt put down by the midwife's sighing '*tut*' and '*there, there*' tone of voice. In response she decided she needed to '*stop asking for help because she doesn't want to help me*'. Geraldine's perception of being a bother persisted and left her afraid to speak up: '*it would take me so much to build up to say (...) and if nobody did anything about it, I couldn't say again*', while the contrast in midwives left her feeling '*so scared to ask for anything*'. Catriona was scared to say anything that would '*rock the boat*', while Valerie felt shut down, not knowing if she was '*allowed to ask for help because when I did ask for help I was met with this dismissive stop making a fuss attitude*'.

A lack of support was experienced when *The Women* felt midwives were not responding to requests for support or help.

#### 4.5.3.4.4. Lack of support during labour and birth

For five *Women* (not Geraldine), this lack of support or a negative response occurred during their first encounter with a midwife in labour, either on the phone to triage or in person at the hospital. For Julie and Lesley, being repeatedly sent home for '*not being properly in labour*' was very distressing. Once admitted to hospital in labour or

for induction of labour, all *The Women* expressed that they sought support and guidance in terms of positions, actions and ways to move things on, and all *The Women* felt lost and unsure when this was not forthcoming. Lesley desired support with *'different positions some sort of toing and froing that I didn't really feel like I got until the last one'*. Valerie felt she needed a *'cheering section to get me going again'*, and that this did not happen. Julie felt *'responsible constantly'* for herself when in fact she wanted someone to *'take charge when I wasn't able to, so that I could focus on what was going on for me'*.

#### 4.5.3.4.5. Lack of support during the early postnatal period

For all *The Women* the early postnatal period was particularly difficult. *The Women* were suffering physical consequences from childbirth and obstetric interventions, which left them somewhat incapacitated. Also, the physical environment and conditions were often not easy for *The Women* to navigate. They needed help to pick up or feed their babies and access washing and toilet facilities. However, often support was withdrawn in the first hour or two after birth and was not forthcoming during much of the postnatal period in hospital. Catriona described waking up in recovery after her Caesarean section: (Box 4.5.28.)

#### **Box 4.5.28. Extract from Catriona 7:38:57**

*'But I remember it was Moira (midwife) and I remember she was sat behind a desk and she calling, and I was looking round to see where the voice was coming from saying "Help, help where's the baby?" and she call...just went (raises voice) "You're fine" from across the room and then like "Baby's fine, don't move, don't move" and then because I was so in such pain I was desperately trying to like pull my...I remember like that feeling like whe...cos...asking her like "Please, please, please help me, please help me" and then she wasn't coming so I was like right I've got to do this myself...try and work out where my limbs where and what was happening and...cos I remember holding on to the...railing, the side bar...and thinking, right I'll hold that and this arm here, and I'll slide my bum backwards, and I was trying to do it, and I was all tangled up, and I was really like struggling and then that was when she came over, and again with the tutting and sighing and like "Oh look I said don't move", and you know "Oh God" and you know "Your baby's fine be with you in a minute, just...ahh God".'*

Catriona felt vulnerable and helpless and was clearly desiring and attempting to communicate a need for help both physically and emotionally. While the midwife does

respond, it is from a distance and her response does not reassure Catriona. Catriona feels isolated and unsupported and musters her own resolve to sort herself out. This resolution suggests Catriona is strong and capable, but also possibly wilful and impatient. Nevertheless, when Catriona related this incident and exhibited strong emotional distress, this suggested that lack of support was not merely annoying or inconvenient, because it made her feel very afraid and alarmed. When the midwife did finally come over, Catriona's sense of being unsupported was reinforced by the midwife's attitude. This extract is very rich and links across the sub themes of *Talking and listening to me* and *How not what*. The tone or way of communication was highlighted by all women, with this discussed in more detail in the sub theme *How not what*.

For Valerie, who experienced significant physical discomfort after the birth, it was '*agonising physically and mentally*' to go to the toilet, since she had to leave her baby and navigate many obstacles in the room. Marie felt her physical needs, due to pre-existing disability, were not provided for during the postnatal period, despite prior arrangements being put in place via the *SoM*. This lack of support was particularly acute in the few hours after giving birth to her baby, when she was unable to wash as a result of inaccessible facilities. Also, the midwives refused to provide water for washing by her bedside: '*they said they couldn't because of health and safety*'. She also was not allowed to pick up and hold her baby. This was a '*horrible*' source of distress and trauma, which led to her feeling '*totally humiliated*'. This situation was exacerbated by the fact that she was a survivor of rape, and unable to wash away the evidence of a traumatic birth experience. Lesley's postnatal experience emerged as a key traumatic part of her experience, especially while in the high dependency unit: (Box 4.5.29.)

**Box 4.5.29. Extract from Lesley 9:24-27, 30, 10:21, 24-26, 33-34, 11:4-6, 16:5**

*'The only other things that I think particularly upset me were sort of post birth em...this was another time where I just felt completely out of control ended up in the high dependency unit (HDU) (...)...and.... didn't really feel like I was supported by the midwives there (...) Don't really feel like they were there for me at all (...) I felt sick and dizzy and I was in a lot of pain and I had to buzz for everything I had to buzz if I wanted to pick him up (...) I had no support at all, there was no breastfeeding support there...then things I wanted to do after he was born I wasn't given the opportunity to do wasn't given the opportunity to do skin to skin I wanted to do (...) Em yeah I didn't feel particularly supported at all.'*

Lesley speaks of feeling very unsupported, as help was not generally forthcoming, and she did not receive the opportunities or support that she strongly desired. This could be read as a woman whinging about no one helping her, but underlying is a deep sense of being vulnerable, lost and in need of help. Lesley was physically incapacitated in HDU and was limited by strong pain medication. She exhibits a real sense of grief and loss.

Lesley later reflected on the busyness of midwives: *'I don't know if they were stretched thin?'* Lesley notes that once she arrived in the postnatal ward, she received more support with breastfeeding.

4.5.3.4.6. The role of partners and doulas

Often women's partners provide significant support, and this did happen for *The Women* to an extent. However, Julie, Marie, Lesley and Geraldine described their partners as not being in a fit state to support them during labour, and they experienced distress when they felt their partners were unsupported. Julie felt her husband was left alone *'like a piece of furniture'*. Not being allowed to have their partners present throughout the postnatal period was particularly difficult for Lesley, Geraldine and Marie, especially as midwives seemed unavailable to provide necessary support at this time. Marie sought the help of a doula as a result of her first interaction with midwives during the early stages of induction of labour. Originally, Marie had not felt the need for a doula, but the total lack of support during her first encounter with midwives had left her anxious and afraid. Similarly, Valerie decided that having a doula next time was the only way to *'have that consistent support'*.

#### 4.5.3.4.7. Being abandoned and isolated

A sense of being abandoned and isolated most often related to not having anyone there, no one to ask or speak to, sometimes because the midwife had left with no communication or explanation. Catriona says her midwife finished her paperwork and *'shuffled them all up and went off'* leaving her and her partner *'bewildered and feeling unwelcome'*. For Lesley, it was being repeatedly sent home and feeling unable to make contact again. During induction of labour Valerie described: (Box 4.5.30.)

#### **Box 4.5.30. Extract from Valerie 3:12-17, 28:32, 4:1-6**

*'We (woman and husband) were left in this room with a monitor. It was the morning...we were exhausted I hadn't slept all night before and um...we just weren't told what was going on, and um my husband tried to find out whether we were going home or what was happening, and we were there all day. (...) The fact that nobody came, nobody informed us, nobody asked us what we wanted, or what we needed or anything. It just it made me feel quite forgotten. (...) That was the worst thing about the entire experience is that there frequently seemed to be hours, or half of days on end with absolutely no communication and no doctor in sight.'*

There is a clear sense of abandonment to the attention of a machine rather than midwives. Valerie and her husband appear vulnerable from the demands of the long process, which highlights a need for attention and information that was not at all forthcoming over a long period of time. There is a strong sense of endurance and holding out, but also of seeking and searching, which emphasises an extended period of being lost and isolated. Valerie identified this sense of abandonment as a hotspot within her trauma.

For all *The Women*, a sense of abandonment was experienced during the early postnatal period, in the first few hours, sometimes days. Valerie said, *'I felt like they were done with me um yeah the baby was born the baby was fine and I didn't really matter'*. All *The Women* perceived midwives to move on and to be no longer interested once the baby was born. This perception arose because sometimes nobody responded to calls for help, or these requests for help were denied. At other times midwives were just unavailable. All *The Women* described being *'left'* in places or situations, and not having their needs addressed. Marie said, *'I pressed the bell,*

*nobody would come*'. Geraldine acknowledged the busyness of midwives but felt that *'generally you were left on your own'*. She accounted being particularly distressed when they *'left me, sat in my own mess for over an hour'* following an incident of incontinence. Julie tearfully expressed that she and her husband, as a family, were not given a chance, but that they were *'left in the corner'*. For Julie the abandonment was emotional rather than physical, since during the last hour of her labour it became clear she would need forceps. She felt that everyone just *'resigned'* and *'gave up'* on her and her baby, because *'she's not going to make it'*, with this breaking a previous sense of support and connection.

#### 4.5.3.4.8. Summary of sub theme 4: Supporting me

All *The Women* identified times of good support from their care providers. They identified a shifting sense of support, which was never guaranteed. Often, they felt lost and uncertain, with a sense that they had to get on with things by themselves. Sometimes *The Women* felt requests for support were either responded to in ways that felt patronising or belittling, or were not responded to at all, which ultimately left them feeling abandoned. *The Women* most keenly felt this lack of support in the early postnatal period, when they required help to care for and be with their babies. They strongly lamented not being able to have partners present to assist them, especially as other help was minimal or lacking.

#### **4.5.3.5. Summary of master theme 2: Being with me**

This master theme explored *The Women's* experiences of how midwives were with them. *The Women* strongly desired to build positive relationships with their midwives, and for them to tune in and recognise their needs. They could then work together, through communication and support to meet these needs. When this occurred, *The Women* expressed very positive emotion and wellbeing. However, they all more frequently felt a lack of, or indeed negative relationship with their midwife. They felt that midwives appeared to neither see, nor even attempt to acknowledge their physical or emotional needs. Their experience of communication with midwives was often very one sided and directed by midwives or provided in a way that was unmanageable for them in their current situation. As a consequence, *The Women's*



support needs sometimes remained unmet, which left them feeling isolated and abandoned.

#### 4.5.4. Master theme 3: Whose power?

*'There I was...trying to have a baby'* Marie 19:40-41

Feeling vulnerable and powerless were the most frequent themes across all of *The Women*. This is unsurprising as helplessness is a core experience within the definition of PTSD, and the literature review identified that lack of control was a key contributing factor in the development of PTSD-PC. Vulnerability is somewhat intrinsic to the physiological process of childbirth and this was highlighted by *The Women*. While not identified as a sub theme, the background context of vulnerability is presented first and then each sub theme is presented. Within the context of QPI, emerging themes included the attitude of the midwife, power struggles and conflict, and *The Women's* experiences of power or powerlessness. These informed the sub themes (Box 4.5.31.).

##### Box 4.5.31. The sub themes of *Whose power?*

1. How not what
2. Struggling for power
3. Finding and losing power

#### 4.5.4.1. Introduction: the vulnerable context of childbirth

Although not identified as a full sub theme, vulnerability was an important thread across women's experiences, and gives context to women's perceptions of QPI. The unique vulnerability of women during childbirth is well documented (Simkin, 1992) and was highlighted by Valerie: *'I don't think a woman feels that vulnerable at any other stage'*, while Catriona described being *'at my most vulnerable'*.

##### 4.5.4.1.1. Physical vulnerability

*The Women* most often described physical vulnerability, but this was rarely associated with pain. Three *Women* entered childbirth with physical pregnancy complications that contributed to their vulnerability, Marie required a wheelchair, Valerie had Symphysis

Pubis Dysfunction, and Geraldine had De Quervain's Tenosynovitis. Childbirth increased *The Women's* vulnerability. Geraldine, Valerie, Catriona, and Lesley were physically exhausted due to lack of sleep, often for days: '*so extremely tired*' (Valerie). Geraldine was unable to eat or drink for 18 hours due to nausea. Julie struggled to cope at times in labour, as she '*just couldn't like walk comfortably*'. *The Women* described increased vulnerability as a result of birth interventions and medication. Repeated attempts to site a cannula left Valerie's hands '*so swollen I couldn't actually hold Katy*'. Strong analgesia left Marie feeling as though she was in '*another dimension*' and '*rendered useless*', while Lesley felt '*drugged up*'. All *The Women* experienced significant physical restrictions and limitations, such as being strapped to monitoring equipment (Geraldine, Catriona), and the consequences of childbirth created further physical vulnerability in the first few postnatal days. Geraldine said she '*couldn't sit down...without crying, because...I was so badly cut and damaged*'. Marie was physically unable to get to the only available bathroom due to her disability, but she '*certainly couldn't do it after...after all that had happened*'.

#### 4.5.4.1.2. Emotional vulnerability

Being physically vulnerable within the process of labour often left *The Women* feeling emotionally vulnerable in relation to fear for self or baby, and distress. They felt incapable of meeting demands placed on them, feeling exposed, worn out, and unable to continue. Catriona was '*sick of it*' and '*totally spaced out*'. Catriona and Geraldine felt unable to take in what was going on. Catriona '*had no clue what it meant*', and Geraldine described not being '*in my right mind*'.

#### **4.5.4.2. Sub theme 1: How not what**

*The Women's* positive perceptions of midwives' attitudes were embedded within their positive experiences of relationship, connection, communication and support. This has been explored more fully within the related sub themes. However, *The Women* more frequently perceived midwives as having negative attitudes towards them, usually through observing the tone and content of both verbal and body language. While this closely links with the sub theme of communication, the emphasis here is on the

perceived implicit communication. This sub theme presents *The Women's* perceptions of their care provider's attitude towards them.

#### 4.5.4.2.1. Being nice with me

All *The Women* took time to single out particularly positive attitudes in care providers for whom they had a subsequent deep affection. Julie emphasised that even when the midwife had to perform checks that Julie found difficult, it was ok because '*how she was with me was very nice*'. Valerie felt respected by the head midwife whom she called '*amazing*', and who took her '*very seriously*'. Valerie and Marie felt respected and cared for by individual consultants, who they described as '*calm*'. Julie felt respected by her first midwife in labour, as she seemed interested in her, was patient, '*friendly*' and '*nice*', and took time to explain things and accommodate her needs. She felt welcomed and '*facilitated*' by her, in contrast to her later experiences of being '*bossed*' or '*criticised*'. Catriona described enjoying the interaction with Lily, which left her more relaxed and confident: '*I opened up a bit more*'. While Lesley notes the contrasting positive attitude and interest from midwives on postnatal ward.

#### 4.5.4.2.2. Tutting and sighing

All *The Women* at times perceived midwives to be sighing and tutting in response to their requests: '*I'll need help, getting them on, 'tut/sigh*' (Geraldine). Valerie says they '*kind of hummed and hawed and huffed*'. Marie felt they '*rolled*' their eyes at her. When preparing to go to theatre, Catriona notes that Moira stood out from the others because of her '*tutting and huffing*'.

#### 4.5.4.2.3. Being a bother

Feeling as though they were a bother or a nuisance emerged clearly for all *The Women*, although it was particularly strong for Geraldine, Catriona, and Julie. This perception usually arose when midwives displayed huffiness and impatience, or when *The Women* perceived midwives to prioritise workplace tasks over women's needs. Julie says, '*what my experience is doesn't really matter against those facts or criteria*'. Catriona picked up that if she didn't just do as she was told, she was '*messing with*' the midwife's job, and that '*everything was an issue*' and '*it was the last place (the*

*midwife) wanted to be*. Marie felt that the negative attitude related to her additional health issues, causing midwives to feel she was *'making their jobs more difficult em...and wasting their time or being em...dramatic'*. Valerie felt rushed through processes being left with the impression that she was wasting midwives' valuable time whilst they could be doing *'something more worthwhile'*. For Geraldine it was more *'a culmination of things...it was too much (...) it just made me feel like...basically I was a bother, and I shouldn't be there'*. This perception of negative attitudes left *The Women* feeling unable to seek support as described in the sub theme support. Geraldine described trying to get some support from the midwife during labour: (Box 4.5.32.)

**Box 4.5.32. Extract from Geraldine 13:20-25, 14:12-15,21-22,31-34, 20:35-37**

*'So, you know "We have gone through the latent phase and we were told to be active again can you help us try to feel the contraction?". "Sigh". "Sorry can you help me?" "You're doing fine (in raised voice)"...it wasn't just a personality clash, there was an overt...distance, there was definitely something. (...) And we would ask her questions and I would ask, and she would ignore me, and I would look at Mark and I would say (whispers) "Would you ask her?" (...) "Oh She's doing fine" and it was just...we were a bother, (...) cos, she was just so like "Ahhh, auhh, she's such a bother" you know it was just so overtly "Why are you bothering me with this? I'm busy. I'm writing my paperwork" (...), "I just want to get on" and that was, it just always kind of reinforced, the...the, the "You're being a bother".'*

Throughout this extract there is a clear sense of disinterest and distance from the midwife. Geraldine perceived the midwife to have more important things to do and felt that she was somehow interrupting this and getting in the way. There is a sense of this attitude persisting over time and Geraldine's perception being reinforced.

**4.5.4.2.4. Annoying the midwives**

When *The Women* perceived sharp impatient tones from midwives, they perceived midwives to be angry and exasperated with them. This left Geraldine feeling *'nobody was approachable enough to...speak to'*, while Julie and Valerie thought midwives were not only *'angry'* but were *'disgusted'* by them. Valerie felt guilt tripped when told the doctors were busy with other more severe cases. Both Julie and Geraldine perceived their midwife to be using a sharp or *'angry'* tone of voice when asking questions or discussing options. Catriona described the midwife Moira who was trying to put a probe on the baby's head during labour: (Box 4.5.33.)

**Box 4.5.33. Extract from Catriona 4:456-51**

*'She was going "Right I need you to lie down" and so I tried but I would have a contraction and so I'd have to...I'd just have to move and it was again "Ohhh God (sigh) You just need to lie down" (raised voice) that kind of thing "Right just lie down just it won't take long, tut, Oh God (sigh)"...you know. Just totally I need to do this and you need to comply.'*

Catriona seems totally frustrated by the midwife's behaviour. There seems to be no sense of compassion in the midwife for Catriona's predicament. Catriona clearly portrays feeling that the midwife was totally impatient and antagonistic towards her for not complying. There is a real sense of powerlessness for Catriona as a result.

4.5.4.2.5. Feeling patronised or chastised

Three *Women* described times when they felt put down by midwives, either through a sense of being patronised: '*poo pooed*' (Lesley), '*she was looking at me with this kind of patronising*' (Julie), or being reprimanded. Geraldine was reprimanded for locking the door after collapsing in the toilet: '*Oh for God's sake why did you lock the door?*' (...) *I felt like such a silly little girl*'. All *The Women* described feeling dismissed by midwives or sometimes not being believed. Geraldine, Valerie, Julie, and Lesley felt actively moved on: '*off you go now*' (Lesley). With Geraldine feeling '*kind of cast adrift*' after being told '*physically you should be fine now*'. By being put in the '*utility closet*' Valerie felt that she had '*served (her) function and (laughs) they were just going to try to get rid of me*'. Others felt punished by midwives for being in labour too long (Julie), coming in too early (Julie, Lesley), or just demanding too much as Lesley described: (Box 4.5.34.)

**Box 4.5.34. Extract from Lesley 10:1-7, 11:25-28 12:12-16,17-25.**

*'I'd have to buzz someone every time I needed to feed him or change him and I was told things like "Oh, oh you shouldn't wake a sleeping baby just wait until he wakes up to feed", which I disagreed with but felt like I couldn't question even though it was my baby and I'm the one that's incapacitated, and can't lift him up. (...) Whenever I buzzed to ask for something...em...whether it was more water or please give me my drugs it was always, just seemed like "Right there you go." (...) Those first few days are really important, and I knew that, but they didn't seem to take that seriously. I felt poo poed whenever I asked for something. (...) I had set an alarm on my phone to feed him every 3 hours...em...particularly since I'd had a c-section I was well aware that was quite important. Em...so I buzzed after 3 hours and asked for the baby to feed him, and they said, "Oh you never wake a sleeping baby" and they actually walked away, and I had to wait 20 minutes to build up the courage to buzz again and say, "No I actually want to feed my baby now".'*

Lesley's vulnerability is clear. However, while she felt totally reliant on midwives for physical support, she emphasises her own knowledge and desires regarding caring for herself and her baby. Lesley is trying to do what is best, as she perceives it. Yet, she believes in her right to make decisions about when to lift her baby, and so struggles in the face of the midwife's attitude. She clearly felt dismissed, and finally reprimanded for wanting to feed her baby. There is a sense of loss in that she is missing out on getting it right for her baby in the first few days.

Due to disability, Marie was unable to use the only available toilet. Marie described her experience of midwives refusing to bring her water to wash with after the birth and having to pass urine into a pad: (Box 4.5.35.)

**Box 4.5.35. Extract from Marie 6:50-51, 7:1-4, 11:37-51, 12:16-22**

*'I asked them to bring me a basin with some hot soapy water they said they couldn't because of health and safety I'm looking after a newborn and I'm filthy em...so that was horrible that made me feel totally humiliated em...it was really terrible (...) it made me feel like you're actually mad when you're not...they...but what you're asking for is ridiculous em...like just that asking for hot water and soap like that's not a crazy thing to be asking for em...but you're made to think that you're, Oh God it was so humiliating, sorry I'm going to cry...em...but just like to do basic things like just to get washed you've got a new baby and you want to get washed after...having this whole horrible experience like where you've actually feel like you've like I felt like...it made me remember my rape in a way that I hadn't remembered it for years all these people holding me not letting me go and I...I really just wanted to get clean get washed it had like I had an urge that I had to clean myself (...) I think that out of all of it like that might have been the worst thing not being able to get washed...em...and I'd gone I'd had to just do...I'd had to just do the toilet like where I was...like...because there wasn't any toilet facilities I could use em. So things like that were really they were probably...mentally some of the worst things that happened.'*

There are several depths to Marie's sense of humiliation and distress. Marie believed she was asking for things that would enable her to meet her basic human needs, and yet this is being disregarded, which contributed to her sense of being worthless. This is deepened by her interpretation that the refusal suggested she is foolish for even asking, as if there is something lacking in her. Then the memory of her rape served to deepen her distress more and illuminates the possibility that this issue is more pronounced for Marie than it might be for another woman. Nevertheless, Marie was deeply humiliated, and this is a clear hotspot of trauma for her.

Consequent to feeling dismissed, chastised, and generally made to feel a nuisance, all *The Women* felt that they had to stop pestering midwives, as described in the sub theme support. There was a clear sense of *The Women* feeling disempowered as a result and this was directly expressed by Catriona.

**4.5.4.2.6. Focus on midwives needs**

Notably, two *Women* momentarily reflect on the unmet needs of midwives, which leave them 'grumpy' (Julie) and 'rolling their eyes' (Marie). Geraldine acknowledged: '**know** they were understaffed, and I **know** they were under pressure'. She also reflected that an expression of impatience and annoyance is very human when enduring a 'long, hard' day.

#### 4.5.4.2.7. Summary of sub theme 1: How not what

As noted at the start of this sub theme, all *The Women* took time to single out particularly positive attitudes in care providers for whom they had a subsequent deep affection. Yet, *The Women* more frequently perceived midwives as having negative attitudes towards them, usually through observing the tone and content of both verbal and body language, with emphasis placed on perceived implicit *communication*. *The Women perceived a negative attitude through observing behaviour such as tutting, sighing or direct actions, such as refusal to support or walking away. The Women* subsequently experienced a variety of negative emotions, which included feeling patronised, chastised, and humiliated. They felt they were a bother to midwives or were annoying them and consequently stopped feeling they could ask for help.

#### **4.5.4.3. Sub theme 2: Struggling for power**

This sub theme explores *The Women's* experiences of direct power interactions with midwives, and their perceptions of physical and emotional struggle.

##### 4.5.4.3.1. Psychological power struggle

*The Women* recognised the necessity of some actions, such as emergency intervention during Valerie's haemorrhage, but at other times they all felt the opportunity to explore other options was not given. Lesley described: '*I didn't really feel like I was given any options, just this is what you have to do*'. Sometimes, *The Women* struggled to question or challenge the authority of midwives or when they attempted to exert their own view they found themselves in conflict. During the postnatal period, Valerie struggled to stop midwives sending her husband home: '*they kept trying to chuck Charlie (husband) out*'. This for Valerie meant breaking up the family unit and losing the only person who provided help. Julie who desired an antenatal check-up but had declined a vaginal sweep, had '*quite a discussion, quite an exchange*' with her community midwife who said, '*there's no point in seeing you then*'. In contrast, later when phoning triage after her waters had broken, Julie struggled to be given the option to continue at home: (Box 4.5.36.)



**Box 4.5.36. Extract from Julie 3:41-51, 4:1.**

*'I phoned em...and here was that triage midwife who was pretty unfriendly, and she said you need to come to the hospital now because we need to check if the waters are the waters. I said I'm pretty sure these are waters...and she said "No, no, no you need to come it's quite dangerous for you to stay home, but we will send you back home. So, come but we will send you back home". And I said "Well we don't, we need to take a taxi to get to the hospital we don't...hassle"..."eh...oh well you might stay but it's at your own risk', and then "You come em...but you definitely need to come in the morning".'*

While Julie called into the hospital, presumably for some information or guidance, she perceived she was being demanded to come into the unit, with little room for discussion. Julie's lack of acceptance of this demand suggested that she valued her own knowledge and was not happy to relinquish her autonomy. What follows suggests that both Julie and the midwife had standpoints from which they needed to negotiate. However, Julie was somewhat overpowered by the midwife's reference to risk and ultimatums. Julie's own knowledge and understanding was questioned and yet she also questioned the midwife's certainty when the midwife relented.

Marie and Julie struggled to assert their own choice about positions in labour. Both *Women* felt tuned into their bodies and wished to squat, but midwives appeared to contradict their wish to do so. While Julie felt strong and capable, her midwife argued that she wouldn't be able to squat for long. Marie asserted her desire to squat: *'No! I don't, I know I don't need to lie back, I'm having a baby I want to squat'*. Geraldine's experience of being told to move onto the theatre bed while physically incapacitated, described in the sub theme: Threatening me, demonstrated a conflict in needs between the woman and the midwife, with an ensuing power struggle where Geraldine repeatedly asks *'How am I supposed to?'* and the midwife repeatedly responds, *'You've got to'*, culminating in the threat of harming her baby that impacted so heavily on Geraldine. During labour, Catriona struggled to get information about a medication: *'Here take this'...I just was like "What?...why?"...you know, I don't wanna take like...take something what is it? and so, to be told "look everyone has it" didn't feel, you know I, it stopped feeling like an exchange of adults'*. In contrast, while on the postnatal ward she struggled to obtain medication: (Box 4.5.37.)

**Box 4.5.37. Extract from Julie 8:46-56**

*'I had a really awful night and the midwives were too busy and forgot my...they forgot one dose of my painkillers which and I was like please can I have them, and they were like we'll just give you the next one, and I was like "No, no, no, seriously please can I have them", and they were like "look we'll just give you, just leave it now, skip a dose and we'll do a drug round at 10" and I was just like "I'm really not happy with that and I'm" and then I did get shirty with them and apologised, I remember apologising to the midwife "Sorry I got really shirty, sorry." 'it's alright.'" (high pitched mimic).'*

Catriona acknowledges the pressure on these midwives and does not ascribe blame to their predicament. However, what she finds difficult is the midwife's use of power to refuse her request, even when she pleads. Catriona perceives a stand-off with the midwife and attempts to shift her power by being angry. However, it appears this did not work, and the prevailing power of these midwives cause her to question herself and her actions. Catriona is subdued into apologising, and she seems to perceive that even then these midwives need to have the last word.

Not all psychological struggle was negative. Valerie experienced a very positive power interaction with a midwife, while undergoing emergency procedures following haemorrhage. Valerie tearfully recounts hallucinating whether to join her deceased mother or remain with her baby: (Box 4.5.38.)

**Box 4.5.38. Extract from Valerie 7:40-45**

*'The um head midwife was, was watching me and she had this really intense look on her face (inward sob)...this very intense "Don't you dare" look on her face (sobs) and I...I told my mother of course I was going to stay with Katy (sobs).'*

Here Valerie is keenly aware of her midwife '*demanding*' that she stay with her. Her midwife was fighting for Valerie and Valerie knew this. While this highlights the intense relationship that can exist between a woman and her midwife, it also points to the individual survival instinct. Grasping the lifeline from her midwife was another way Valerie was claiming power over the situation.

**4.5.4.3.2. Physical power struggle**

Three *Women* experienced physical power struggles with care providers. Twice Catriona struggled in theatre to remove her oxygen mask, first because she thought it

wasn't working, and next to communicate that she could feel the incision: *'the person behind me...I think it was a woman...was kind of pushing it on going and I remember her saying "No, no you need this" and then it being sort of pushed down'*. Catriona continued trying to remove the mask, but the woman *'was really pushing it onto my face'*. Catriona experienced panic and fear and when they finally removed the mask she struggled to articulate about the pain. Similarly, during her main midwife's break, Julie experienced physical conflict with the cover midwife: (Box 4.5.39.)

**Box 4.5.39. Extract from Julie 8:44-51,9:1-4, 31:31-39,47, 32:1-11**

*'So, I had a system I was using gas just at the beginning of the contraction for like one breath, and then halfway through I was stopping and I was screaming that was my...my rhythm. Now this woman came, and she didn't like me screaming at all. So, she kept shovelling the gas in my mouth, and she kept saying I need to use the gas a lot more, and I was getting very angry at her because I said you are interrupting me totally, it's very horrible. So I was almost like saying "No I'm gonna scream and like it or not" that was what was going on in my head (...) here was suddenly her like saying take more gas and breathe in, breathe in, breathe more, breathe more and she wasn't allowing me to have that second bit that I was screaming because I was, that was my rhythm, you know.(...) I was trying not scream and when I was screaming she was saying to take that gas, and I said "No, I don't want it".'*

Julie feels powerful and capable having found a system for coping with the pain. Julie's anger reflects her sense of emotional and physical intrusion by the midwife, and her need to assert her own authority. Even though Julie's resistance does not appear to be voiced out loud at first, the repeated nature of the midwife's demands suggests Julie does not comply and keeps trying to continue her own rhythm. Finally, Julie does voice her resistance and assert her wishes.

The physicality of struggle was most pronounced for Marie, who after arriving in theatre for forceps, felt sure her baby was coming and wanted to get up off the trolley to give birth, but experienced being held down against her will and anaesthetised (Box 4.5.40.).

**Box 4.5.40. Extract from Marie 4:34-35,38-47, 5:1-3,11-22**

*'Then I could feel my son's head coming while we were moving to theatre (...) I was like 'He's going to come, he's coming right now' I was like "No Stop Stop" I didn't want this finally I could literally...I had my hands here (demonstrates) and I was like, right actually...I don't need this now...and it seemed like they were just determined I was in theatre now, so I was getting it (incredulous chuckle). Em, so somebody took my arm, and pulled my arm that way and it hurt my shoulder, em like by the elbow, and it was she was sort of to this side, it was definitely a woman, but I don't I don't know who it was, and there was somebody else to this side. So, they were like pulling me back onto the bed to get me to sit to get the spinal (...) I was like stop and they wouldn't stop and for me that's a massive trigger, I'm a survivor...em...of rape and that was...I was just totally like, I don't know, I don't...em...I just couldn't believe it was happening. I was in a hospital and I was telling, people to stop and they wouldn't stop...and they were actually like I'm trying...I was stood up I was about to have my baby, and they were preventing me...from doing it and grabbing me (...) I had bruises on my arms where they had been holding me, em...phreww.'*

Marie paints a very physical and tumultuous picture, full of struggle and conflict. Marie clearly felt that the staff attempted to exert their authority over her body and her options. She felt pulled in all directions physically, by many unidentified people, which intensified her sense of struggle. When she failed to get them to stop, she was thrown back to her prior experience, which compounded the intensity of the experience. She became angry and distressed when they would not stop. Marie emphasised the physical bruising as a way of proving what happened, in itself a struggle for power. This suggested a vulnerability regarding being disbelieved.

4.5.4.3.3. Violation

The above three women's experiences carry an inherent sense of violation. Julie's earlier description of being 'cut', while not a direct consequence of a power struggle, also relates to violation. Catriona was haunted by the midwife Moira's behaviour: *'Oh God, how could you do that to me, like it feels like a violation of, like that's just so horrible, my most vulnerable'*. Geraldine felt the periodic moments when the midwife *'came over, and she examined me'*, contrasted with being left alone. The midwife's subsequent arrival felt intrusive and sudden, and Geraldine perceived her *'space'* to be violated. Valerie's experience of the rough VE, left her feeling *'invaded'* and *'manhandled'*.

#### 4.5.4.3.4. Summary of sub theme 2: Struggling for power

Most often *The Women* expressed verbal and psychological conflict with midwives. This occurred when they perceived threats and demands from midwives and were unable or unwilling to comply due to their own knowledge or understanding. Sometimes the struggles took the form of asking, declining, arguing, demanding, refusing, telling lies, and for two *Women*, self-discharging from hospital during their postnatal care. Sometimes the power struggle during labour was physical, and related to *The Women's* coping strategies, positioning, and *The Women's* physical actions when asserting their choices. *The Women's* language highlights a demarcation between them and us, with concerns regarding personal safety. *The Women* sometimes perceived their care providers to be a source of conflict from which they had to defend themselves. Consequently, some of *The Women* felt violated.

#### **4.5.4.4. Sub theme 3: Finding and losing power**

During the course of *The Women's* experiences, power struggles and their perceived attitudes of midwives, impacted on *The Women's* sense of power. *The Women's* perceptions of power and powerlessness is now explored.

##### 4.5.4.4.1. Being powerful

*The Women's* positive experiences with individual midwives regarding relationship, support, and communication, as described in the related sub themes, contributed to *The Women being* strengthened and sustained their sense of power and control. Geraldine felt very empowered by her community midwife, and her first two labour ward midwives, she described being '*a strong woman and being empowered in birth and I thought yeah, yeah, I can do this*'. Once supported to have her baby beside her, Julie was '*really happy, you know, I was looking at him and he was looking at me and he fed, and it was all very, very lovely*'. Catriona, at a time of complete powerlessness, while constrained to remain flat on her back for several hours recovering from a post dural headache, felt very empowered by the round the clock support of maternity care assistants: '*taking it in turns to hold the baby next to me (...) keeping my spirits up*'.

#### 4.5.4.4.2. Moving from powerful to powerless

However, consequent to many of the experiences described in the sub themes: *Threatening me*, *How not what*, and *Struggling for power*, all of *The Women* experienced an ultimate loss of power. Throughout their narratives, *The Women's* language suggested they felt ruled over or imposed upon by some midwives, which left them perceiving that they had no choice. For four *Women*, this loss of power began on arrival at the hospital. Valerie felt she lost authority over herself as soon as she stepped into the hospital: '*other people told me what was best for me and my baby...and there was very little dialogue about it*'. Julie's and Catriona's interactions with triage midwives left them both feeling undermined and lost. Lesley described her initial interactions with the hospital midwives: (Box 4.5.41.)

#### **Box 4.5.41. Extract from Lesley 3:11-27**

*'Yep well when I first went to the birth centre I was waiting for about 45 minutes with waters broken everywhere and changing pads every 2 minutes, em and then just to be sent home, basically with a letter saying that if you don't progress by Monday morning then your gonna have to be induced.'*

**Researcher:** *So how did you feel about that?*

*'Confused and frustrated I think would summarise it. No real information on what to do, and what to expect, and what to look out for, other than better hope you have had that baby by Monday morning otherwise it's all going to go horribly wrong. (...) I didn't feel like I had much of an option because if the baby wasn't out by their set time period, then it was kind of dangerous to go any further and we would have to be induced so like there was a bit of pressure there...like...we really need things to progress and that made me feel antsy.'*

Lesley seems very lost and bewildered. There is a sense that she needed and anticipated a different response from her midwives. Not only does she feel dismissed, but she is left feeling unable take any further action, except to wait helplessly for some fearful deadline. She seems to be caught between a rock and a hard place, with no one she feels able to approach for help.

#### 4.5.4.4.3. Powerless within the process of labour and birth

Each woman experienced a sense of powerlessness with regard to the process of labour and birth. For each woman this frequently arose as a consequence of perceiving

there was no option to communicate with the midwife and that they just had to comply. Valerie and Geraldine assimilated that having no communication left them *'just absolutely helpless and absolutely powerless'* (Valerie) and *'completely out of control, completely...lack of...any...sense that I was in charge of the process, any more'* (Geraldine). Julie described being transferred to theatre as one of her worst moments: *'what is happening people are taking me somewhere'*. *The Women* perceived that even in non-emergency situations options were often limited, all of which was potentially distressing: *'we can induce you or we can do a c section (...) if we do a c section you will possibly need a hysterectomy, so you won't be able to have more children (crying)'* (Valerie). The options such as to wait and see: *'somehow waiting wasn't an option'* (Valerie), were seldom or never discussed, which left Julie feeling as though it was *'game over'*. *The Women* sometimes felt unable to challenge or question their care providers. Catriona was scared to get *'in the way of the doctors'*, and Lesley *'didn't feel I could question'* people in authority. Marie did try to challenge the process, when she tried to get off the table, as discussed in sub theme power struggles, but her experience left her feeling totally powerless. Catriona described a complex mix of power and powerlessness in relation to her experience of feeling the caesarean incision and then being told she required to have a general anaesthetic: (Box 4.5.42.)

**Box 4.5.42. Extract from Catriona 17:36-44, 18:1-11.**

*'But it all became very kind of matter of fact and so, so, yeah I just felt kind of, I just wanted it to be over, and at that point it just felt like a step we need to get through, and just comply and let them do their thing, and then we'd have the baby and we could just the hell out of there. And so when it all started to go wrong and I think part of the panic was...emotionally for me, not that I didn't trust him, but emotionally it was to say 'oh my god I just don't want to be unconscious...because then I won't have any control, I won't know what's going...they'll be you know, I don't know maybe somewhere, it was just like "Oh God"...cos I just I remember hearing myself wailing and saying "Nooo...Please..." and like ridiculously "Please, please, please, no I'm fine, I'm fine, just carry on, just carry on, really it will be fine" sort of thing. And like cos I just desperately didn't want to be unconscious, just cos I'd been, over all I didn't feel very em safe in a kind of emotional way, not in a dramatic "God. No. They don't know what they were doing" way...I just didn't feel reassured or, and you know, nurtured by them in a way that I'd be like "Oh, okay yeah give myself up to it all".'*

Although Catriona's spinal anaesthetic is not working effectively, being faced with unconsciousness renders her willing to suffer the pain, because the thought of surrendering herself to the care providers is worse. Notably, she emphasises that it is not a lack of trust in clinical competence, but more the cumulative effect of lack of support and care provided to her. Catriona felt vulnerable in the hands of the staff and unwilling to place herself in their hands, to the point of being willing to endure what is likely to be significant pain. Catriona fought against becoming powerless in the hands of these people, almost as if she is questioning their integrity. It could also be that she just really wishes to retain control over the birth or her baby through being able to experience and recall the birth process.

Being powerless and oblivious regarding the moment of birth was distressing for three other women. For Lesley, like Catriona it was hard to accept the position of receiving a general anaesthetic. Geraldine continued to feel that '*Abby was **removed** from me. Em...like you would take out a growth or something, it wasn't, it wasn't a powerful process*'. For Julie it related to her perception of how the doctors performed the forceps delivery: (Box 4.5.43.)

**Box 4.5.43. Extract from Julie 13:35-45**

*'I think one of...the other horrible moments for me was that, that Charlie (husband) thought that the baby's there, and I found it so difficult because wanted to feel it....you know I...I didn't mean, I didn't mind the pain you know, but I wanted to...have that moment that he...that he's out (crying) you know...like I had him, like oh (longer pause), like I had him all pregnancy, and I had like this, this bond with him you know. Then it felt like somebody just took him...(crying)...and didn't even know he was out (crying).'*

Julie expressed horror, grief, and loss. The total lack of power over the birth, not only was her baby '*taken*' from her, but the experience of birthing her baby was removed and she was totally unaware of the moment of birth. The deep bond and preparation during pregnancy seemed to have been snatched from her irrevocably.

Julie went on to describe journeying through pregnancy, in tune and connected to her baby. This subsequent process of birth left her feeling that she had totally failed her



baby, as if they (the care providers) had said: *'no you haven't done it right, we just need to do it' like 'we have to do this most horrible thing ever' (crying).*

#### 4.5.4.4.4. Powerless to comply with demands or give consent

Women's physical and emotional vulnerability contributed to their feelings of powerlessness in the face of *'unrealistic'* demands from midwives. For example, when Geraldine was asked to move onto the theatre bed: *'well (sigh) 'I can't do it'*. Giving consent for medical interventions is a legal necessity. However, *The Women* described their distress at being asked this when they are vulnerable. The distress at needing surgery was compounded for Julie by being unable to see the consent form without her glasses, which left her in no fit state to give consent. Julie reflected again on the lack of attention to her birth plan, and that this emergency moment was not the time to give consent: *'not when you are in this state'*. Similarly, Lesley described, (Box 4.5.44.)

#### **Box 4.5.44. Extract from Lesley 13:18-21.**

*'I couldn't read it cos there was tears in my eyes and I didn't really need to read it cos I didn't feel like I had a choice, cos the baby's in trouble and you need to get him out that's it. (...) but I'm clearly not in a position to make this decision or certainly not in a position to read the form on my back with tears streaming down my face when they're wheeling me into surgery.'*

Lesley expressed total vulnerability and incapacity. She couldn't physically see and felt that even if she had there was no point, as she really had no choice. She was astonished at being expected to make this decision and how it could even be referred to as consent. Yet, what option did she really have? There is obvious grief, loss, and powerlessness.

#### 4.5.4.4.5. Powerless to be with or care for their baby

Physical vulnerability combined with the experiences described in the sub theme *Support me*, resulted in *The Women* feeling powerless to see or hold their baby, with subsequent feelings of grief and loss. For Valerie: *'held here (...) at the back of my head like I was craning my neck (...) I couldn't see her'* and Julie: *'I couldn't really hold him he was just lying there on me'*. Geraldine felt powerless at being separated from her baby

in the first few days, due to a rule that babies were not allowed into the high dependency ward. In the postnatal ward Valerie was not physically fit to work with her baby: *'I just I couldn't really hold her (...) I couldn't change her'*. Lesley felt *'really out of control'* because her incapacity left her unable to *'jump and pick him up without being in extreme pain'*, which was compounded by the refusal of help from midwives. When Marie's husband was not allowed to stay she felt totally incapacitated: *'Shit...I can't get up out of this bed, I can't get the baby out of the bassinet,'* while Valerie said, *'I'm the one that's incapacitated and can't lift him up could you just give me him'*.

#### 4.5.4.4.6. Worn down to total powerlessness

For all *The Women* there was a cumulative effect of their experiences: *'just as a culmination of things...it was too much'* (Geraldine). *The Women* felt worn down by the way they had perceived the situation, such as for Valerie feeling *'quite forgotten'* and as if she *'didn't matter'*. Julie reached the *stage* where she had had enough of people *'doing things'* to her, and Lesley finally stopped feeling as if she had any control: *'with pretty much any of the decisions.'* Lesley described feeling *'pushed over the edge'* by the *'last straw'*. Catriona described just wanting to leave the situation: (Box 4.5.45.)

#### **Box 4.5.45. Extract from Catriona 11:5-7, 19:29-32.**

*'Like I was desperate to go home...desperate...every time the guy (doctor) came I was crying like "Please let me go home" (weepy voice) (...) but then by that point I was just like okay I almost got to like I just need to jump through these hoops cos I need to get out of here and I just felt totally lost and I just wanted to go home. I just could not.'*

Catriona expressed total exhaustion and perceiving that she was at the end of her power. Her powerlessness is reflected in her pleading and sense of just needing to totally comply with whatever, regardless of her feelings, just so she can escape. In some ways this is a sense of her claiming power to finally get away.

#### 4.5.4.4.7. The Women claiming their own power

While Julie at times felt empowered to stand up and say no, she also felt that going to this length was an unfair expectation in labour: *'you can't have, be expected to do that'*. Nevertheless, at times all *The Women* attempted to claim power and sometimes

they succeeded. During labour Julie asked for time to discuss options with her husband and felt *'like I was a lot in charge there'*. Marie attempted to be in control by communicating *'in capital letters on the front'* of her birth plan that being a survivor of sexual assault signalled her need to be asked before any VE's were carried out. When this past experience was ignored, she further claimed her own power by stating: *'right no more VE's, we're not having any more'*. Marie claimed control about getting into the birth pool by threatening: *'If I don't hear that tap running I'm just going, I'm just leaving, I came here in a taxi and I will leave in a taxi'*. A few days after having their baby, Valerie and Marie claimed power by actually walking out of the maternity unit. Valerie's declaration: *'I am going home I am not doing this anymore'*, prompted care providers to notice the reality of her situation for the *'first time in three days'*. This gave Valerie a renewed sense of being in control of the situation.

Two *Women* chose to lie in order to claim back power. Due to the lack of an accessible toilet or bathroom, along with having been refused a basin of water to wash herself, Marie *'pretended that I had to do another nappy change'* and proceeded to use the provided water to wash herself. Later Marie passed urine into a pad and told the midwife she had gone to the toilet, in order to get home. While both actions enable Marie to claim power, she nevertheless felt *'humiliated'*. Julie, who was confident of her baby's wellbeing, asserted her need to be in the pool by *'lying'* to her midwife that she could feel her baby's movements.

#### 4.5.4.4.8. Summary of sub theme 3: Finding and losing power

*The Women* entered the process of childbirth feeling powerful and capable.

Subsequent positive experiences reinforced this sense of power. However, as a result of many negative experiences, all of *The Women* felt worn down and had experienced an ultimate loss of power. *The Women* perceived that their care providers held and imposed ultimate authority, often through options not being communicated or discussed, compounded by *The Women's* physical and emotional vulnerability. *The Women* experienced feeling powerless within the moment of birth and a lack of support provision contributed to their feelings of powerlessness to be with or care for

their babies. However, they often attempted to claim back their power, as discussed in the sub theme power struggles, and sometimes succeeded.

#### **4.5.4.5. Summary of master theme 3: Whose power?**

There are times for each *Woman* when they experienced being empowered, capable and strong, usually in connection with their own internal confidence or positive interaction with a midwife. All of *The Women* expressed a strong sense of vulnerability, often intrinsic in the physiological processes of childbirth, but it was also linked to being in an environment that was alien and not conducive to their needs. Within this context, all *The Women* highlight times when they felt they had to struggle to gain or maintain some power over their experience. For some this struggle was about not having options and choices, for others this experience encompassed violation. The perceived negative attitudes of some midwives served to undermine *The Women*, who constructed this to be a potential power tool. When *The Women* perceived that their midwives were acknowledging their needs and working with them, they felt less vulnerable.

### **4.6. Bringing together both sides of the story**

#### **4.6.1. Introduction**

This study enabled a multi-perspective exploration of the lived experience of interacting during labour, birth, and the early postnatal period, from the perspectives of women experiencing PTSD-PC and midwives. In keeping with the guidance from IPA expert Michael Larkin (Larkin, 2018), the findings have first been presented separately for each side. It is essential to acknowledge the idiographic nature of IPA (Section 4.3.2.). The study is not about understanding the general nature of QPI but deep exploration of individual lived experience in the context of this interaction (Section 3.5.1.3.). It is acknowledged that *The Women* had PTSD-PC while the mental health of the midwives is unknown. Also, *The Women* described their lived experience of a particular childbirth event, while *The Midwives* describe a much broader lived experience of a variety of events. Nevertheless, it is important to identify key issues that resonate within and between each group as these indicate areas that may require attention or have potential to be modified. Therefore, how these perspectives

converge and diverge is now presented. Convergent themes spotlight issues that demand attention within maternity care, while divergent themes deepen the understanding about the unique perspectives and enable appropriate education and preparation for both midwives and women.

The Master theme *Shattered Expectations* encapsulates the main QPI trauma hotspots for *The Women* that potentially contributed to PTSD-PC, consistent with wider PTSD-PC literature (Janoff-Bulman, 1992). Issues of trust and safety were also present for *The Midwives*, in keeping with the presence of trauma and PTSD within midwives (Pezaro et al., 2016). *The Midwives* needed to trust woman and be trusted by women, colleagues, and management. *The Midwives* sought safety with regard to their own wellbeing and job registration, while carrying the ever-present responsibility for the safety of women and their babies.

#### **4.6.2. Human need as a converging theme with diverging pathways**

Reflection on the content of the master and sub themes within each group of informants, identified four convergent human needs clearly expressed by both groups: safety, respect, power, and support. These were brought together under the convergent theme *Being Human*. The converging aspects of each core need are presented together with how these needs are experienced differently by each group. Figure 4.8. presents each of the four core human needs down the centre. On each side are the related sub themes and associated emotions and concerns for each group.

##### **4.6.2.1. Keeping safe**

###### **The need to protect self:**

The human vulnerability of all informants is clear in the expressed needs to protect themselves. While *The Women* felt threat for their physical wellbeing, *The Midwives* struggled when torn in two and subsequently needed to protect their psychological wellbeing and job by withdrawing from women.

###### **Divergence in understanding about safety:**

While *The Midwives* were strongly motivated to keep women safe, *The Women's* contrasting experiences of feeling unsafe, threatened, or violated suggest that the

actions of some midwives did not always convey an understanding of what *The Women* required to feel safe. *The Women* stopped feeling safe when they perceived their physical or psychological needs unrecognised or when they felt abandoned or actively threatened. While *The Midwives* acknowledge the value and impact of QPI, especially communication, they are torn when they feel that women's desires potentially jeopardise physical safety. They find that protecting physical safety sometimes requires sacrificing psychological safety.

#### **4.6.2.2. Being respected**

##### **Respect me for what I know:**

There is a shared need to be respected as competent, autonomous adults, with acknowledgment of the unique individual, their personal wisdom, and what is important to them. *The Women* desired respect from midwives for being realistic and prepared and *The Midwives* desired respect from women, colleagues, and management for being skilled and knowledgeable.

##### **Divergence in understanding about knowledge:**

Interestingly, *The Women* all described feeling realistic about the process of birth and that this was not the problematic issue for them, it was realising that in this process the people they expected to be with them and keep them safe, were behaving in a way that left them feeling more vulnerable. However, *The Midwives* focussed on situations where they feel women are unrealistic about the nature of birth, particularly its uncontrollable nature, describing the challenge of interacting with women who have fixed birth plans. *The Midwives* surmise that this inflexibility is an important source of trauma when things do not go to plan.

#### **4.6.2.3. Having power**

##### **Powerlessness:**

Feeling powerless through a lack of control is a key factor in the development of PTSD-PC. Both sides acknowledged being at the mercy of the uncontrollable nature of childbirth. However, each struggled with interpersonal powerlessness, for *The Women* when engaging with some midwives and for *The Midwives* when engaging with colleagues, management, systemic demands, or the workplace culture. When trust

was present, *The Women* felt able to relinquish control to midwives. Equally when *The Midwives* feel women trust them, they are able to control how they provide care. Both sides remarked on the pressures of tasks and the negative impact this had on their power to develop relationships.

**Divergence in understanding about control and trust:**

*The Women* sometimes wanted to hand over control and entrust themselves to midwives, but *The Midwives* sometimes feel they have little control due to extrinsic workplace pressures, or women's fixed birth plans that they feel powerless to influence. However, *The Women* did not express concern at birth not going the way they expected, so much as not being informed about and involved in the process.

**4.6.2.4. Receiving support**

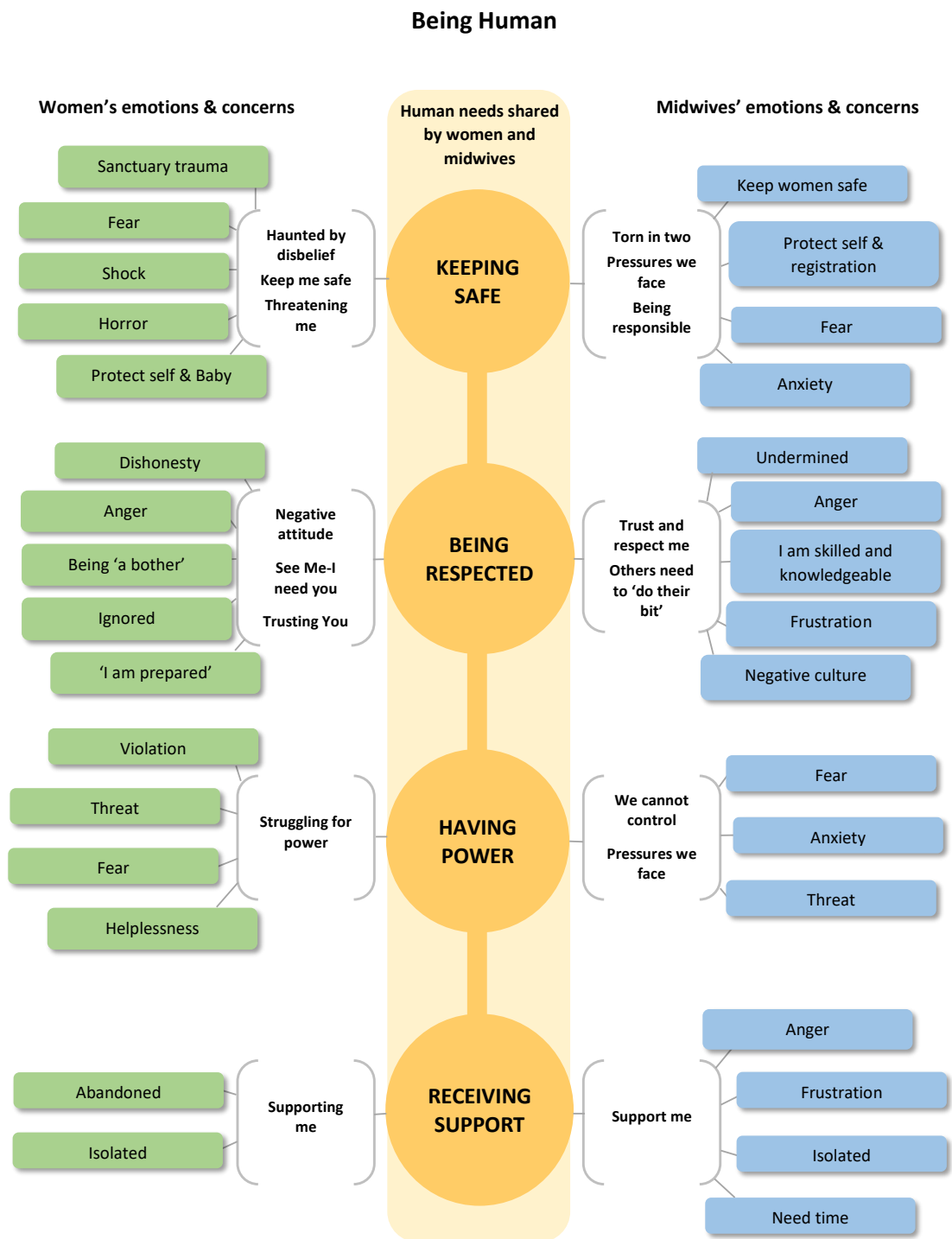
**Support:**

The presence of safety, respect, and control are dependent to some extent on the support of others. *The Women* sought support from midwives and other care providers, in keeping with the literature review that showed lack of support to be a contributing factor in the development of PTSD-PC. Of value in this study is the emerging finding that *The Midwives*, also require support from colleagues and management to optimally fulfil their role.

**Divergence in understanding about support:**

For each side the nature of required support differed in both content and importance. Directly within QPI *The Women* were looking for personal, practical support in terms of physical, emotional, and informational needs during a uniquely vulnerable life experience. Their focus was primarily on themselves and their babies, with other people's needs being secondary or unimportant. In contrast, *The Midwives* are expected to provide support to women, while their personal needs become secondary or even unacknowledged. This contrast is potentially problematic as will be explored in the discussion.

Figure 4.8. The convergent human needs of *The Women* and *The Midwives*, the associated sub themes, and the expressed human emotions and concerns.





#### 4.6.3. Relationship as a converging theme

The clearest convergence occurred in the master themes *Being with me* (women) and *Building relationships* (midwives). It is likely that any exploration of an interaction between people may unearth themes related to relationship, and indeed the woman/midwife relationship is recognised as an important consideration for all births (Kirkham, 2010). It is important to note that for *The Women*, who all had PTSD-PC, the contrast in perceived positive/negative interactions with midwives and the associated hotspots and strong emotions, suggest that relationship is also central within the context of traumatic childbirth. This is consistent with the identified significant role of interpersonal factors and association of QPI in the development of PTSD-PC. The convergent findings for *The Midwives* in terms of the weight of importance they place on relationships with women, further highlight the centrality of the woman/midwife relationship. As both groups expressed, the nature of these relationships impacted on quality of care provided and received, influencing both the childbirth experience for *The Women* and job satisfaction for *The Midwives*.

The depth of distress when relationships are dysfunctional, absent, or lost serves to illuminate the shared strength of desire for positive relationships. The findings show that both sides were reaching out to one another, wanting to connect and journey through the process together, to truly and exclusively be with, but often felt thwarted. Most striking is the distress expressed by both sides at the premature separation from each other directly after the baby is born, highlighting a key issue to be addressed.

*'You feel you've completely abandoned that woman.'* Brenda (midwife) 12:16

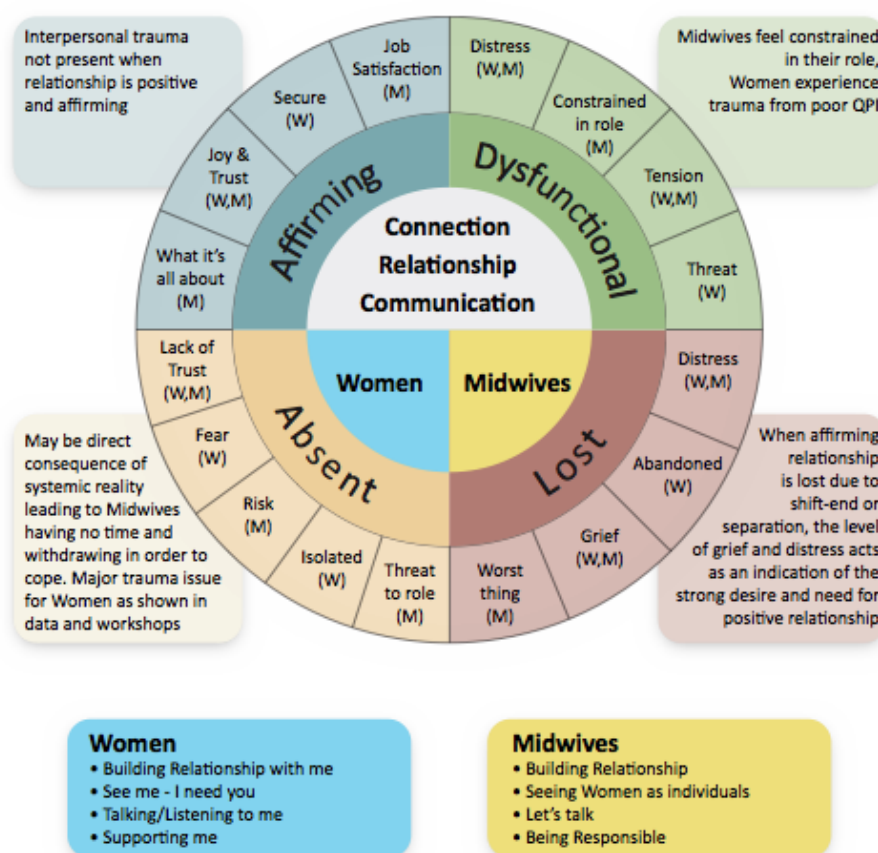
*'That's the one I find the worst...'* Kerry (midwife) 7:6-7

*'I wasn't sure why I had to recover in that broom cupboard by myself (...) I really... I really didn't know why I had to be separate from everyone and um (laughs)'*  
Valerie (woman) 17:12-16

Consistent with interpersonal factors being the strongest predictor of PTSD-PC (Harris and Ayers, 2012), dysfunctional, absent, or lost relationships were potentially the most detrimental aspects of QPI and featured as strong hotspots of trauma for *The Women*. These aspects reflect a lack of power on both sides albeit weighted more towards *The Women*. Nevertheless, for *The Midwives*, dysfunctional, absent, or lost relationships are consequent to having no time to spend with women, either physically due to being instructed to be elsewhere or psychologically due to the multiple demands of other tasks, as represented in the master theme *What we have to work within*.

Figure 4.9. presents suggested potential for trauma within the four possible forms of relationship, in the context of connection and communication. It shows the associated concerns and emotions for *The Women* (W) and *The Midwives* (M), that were present in the related sub themes (shown below the figure).

**Figure 4.9. How relationship was experienced by each group**



#### **4.6.3.1. Ticking boxes**

The references to Ticking boxes from both *The Midwives* and *The Women* (Sections 4.4.3.3.3. and 4.5.3.2.5.) highlight, both practically and emotionally, the shared impact on relationships of a surfeit of extraneous tasks. The consequent pressures on *The Midwives* and realities experienced by *The Women* distracted from and damaged relationships. This is a key practical issue that highlights the need to prioritise creating time for building relationships, thereby providing the rationale to implement policy that can reduce this overload of tasks.

*'The woman was totally focussed on her paperwork and her forms and files'*

Catriona (woman) 2:6-7

*'... ticking the boxes ... signing the boxes (...) you can't develop relationships'*

Brenda (midwife) 13:5-8

#### **4.6.3.2. Communication**

The convergence regarding communication *Talking and Listening to me* (women) and *Let's talk* (midwives) highlights the core importance of communication for both sides. This communication facilitates the development of relationships and the exchange of information necessary to enable optimal recognition and response to the needs of women.

#### **4.6.4. Summary of both sides of the story**

Within these convergent themes regarding human needs and relationships, areas of immediate practical concern such as Ticking boxes, in keeping with the call for reduced bureaucracy by initiatives such as the Compassion in Practice strategy in 2012 (DoH, 2012), must continue to be addressed. Nevertheless, it is crucial to note that the negative QPI *The Women* described related more deeply to the personal behaviour and attitude of midwives. Underlying the variety of needs expressed by *The Midwives* and *The Women*, exists the fundamental discovery that not having these needs met potentially impacted negatively on the perception of QPI and therefore trauma for *The Women*, and *The Midwives'* abilities to provide optimal QPI. Rather than brushing aside shared human needs as too wide or general an issue, I suggest that this clear

shared humanity has been overlooked and is essential to recognise as the cornerstone from which the way forward must be established. This is in keeping with wider calls within the NHS following the Francis Inquiry ([West, 2013a](#), [West, 2013b](#)). The desire for a positive and affirming relationships was strong for both *The Women* and *The Midwives*, further reflected by the depth of distress expressed by both when relationships were dysfunctional, absent, or lost. Truly *Being with* was fundamental and encompassed a functioning flow in communication.

The humanity of midwives and women and the nature of their relationships will be explored more deeply in the discussion (Chapter 5) and form the foundation of the arguments upon which the recommendations will be based (Chapter 6).

Chapter Five  
Discussion of the study findings

## **5.1. Introduction to the discussion**

### **5.1.1. How the discussion is presented**

The starting point of this thesis was to explore PTSD Post childbirth (PTSD-PC). How this thesis identified and addressed a gap in the PTSD-PC research literature, a summary of the study findings, the novel contribution these make to PTSD-PC literature, and a discussion of key findings grounded on underpinning theories and wider research is now presented (Box 5.1.).

#### **Box 5.1. A discussion in two parts**

**Part 1: How this thesis Identified and addressed a gap in the PTSD-PC research literature:**

Section 5.2. How the literature review identified a gap in the PTSD-PC research literature.

Section 5.3. How the study addressed the identified gap in the PTSD-PC research literature.

Section 5.4. A summary of the study findings.

Section 5.5 The novel contribution the thesis makes to the PTSD-PC research literature.

**Part 2: Discussion of the key study findings:**

Section 5.6. Foundational theories that inform an understanding of the key study findings.

Section 5.7. Discussion of the key study findings in relation to these foundational theories and wider midwifery research.

### **5.1.2. The language used within the discussion**

The feminine pronoun *she* is used when referring to midwives, with acknowledgement that some midwives are male and are thus equally recognised. A reference to *women* means childbearing women who seek maternity care. Study informants are referred to as *The Midwives* and *The Women*, as distinct from the general populations of midwives and women.

### **5.1.3. Why the discussion is primarily focussed on midwives**

Within the women/midwife interaction, each person's perception is influenced by their education or preparation. Maternity services offer childbirth education to women but may have limited influence over their expectations, knowledge, and behaviour as women are not required to attend and often access further variable sources of information. However, maternity services and midwifery educators share responsibility for the requisite education of midwives, through a standardised education and preparation. In other words, maternity services and midwifery educators have control over the education and qualification of midwives, but less control regarding women's

preparation. Effectively targeted recommendations for optimising midwives' knowledge and behaviours regarding QPI, necessitates understanding of what impacts, motivates, and drives midwives. Therefore, while *The Women's* experiences are embedded throughout the discussion, the greater weight of focus will be on *The Midwives'* experiences and needs.

#### **5.1.4. Moving from findings to theory: the context within which the discussion rests**

In December 2012, the UK Government Department of Health launched the Compassion in Practice strategy (DoH, 2012), aiming to improve patient and staff experiences of care quality, whilst creating a system that fully supported staff to meet the strategy vision. Ideally over the subsequent three years this would, *change the way we work, transform the care of our patients, and ensure we deliver a culture of compassionate care* (Cummings, 2012). Regrettably, five years later alongside wider childbirth trauma literature, the informants reflect a shortfall from this vision. Therefore, the discussion explores theories and practices that underpin women's and midwives' expectations and behaviours, with particular attention towards those that hinder full implementation and potentiality of this strategy.

#### **5.1.5. Balancing the negative weight in the discussion**

The literature review showed that most women perceive positive QPI and experience midwives as affirming. Alongside the informants' positive experiences, this reflects a high quality of maternity care and QPI. Nevertheless, it also showed that PTSD-PC develops in a minority of women, with a negative perception of QPI being a significantly correlated factor. Understanding these negative perceptions is necessary to inform recommendations for improving QPI.

#### **5.1.6. Summary of the Introduction to the discussion**

The discussion is presented in two parts. While acknowledging that the most common experience of QPI is positive, the focus is directed towards areas for improvement in QPI and midwives' experiences, as maternity services and midwifery education have a responsibility to educate and support midwives. Discussion of *The Midwives'* findings, contextual to *The Women's* findings and wider research and theory will inform

appropriate recommendations for maternity services, midwifery education and future research.

## **Part 1: How a gap in the PTSD-PC research literature was identified and addressed**

### **5.2. How the literature review identified a gap in the PTSD-PC research literature**

The literature review identified that a woman's subjective experience of childbirth is the most significant contributing factor in the development of PTSD-PC (Garthus-Niegel et al., 2013), within which interpersonal factors are the strongest predictors for PTSD-PC (Harris and Ayers, 2012) and a negative perception of QPI significantly correlated with PTSD-PC. The literature review identified specific areas regarding QPI as yet unaddressed in PTSD-PC research literature (Box 5.2.):

#### **Box 5.2. Specific research areas regarding QPI not yet addressed in the research literature**

- Within PTSD-PC literature specifically, no research was identified that explored midwives' experiences of interacting with women during the provision of maternity care.
- Within PTSD-PC literature specifically, only quantitative research was identified that had QPI as the primary focus. There is a need for qualitative research that explores QPI from the perspective of women who have subsequently developed PTSD-PC.

### **5.3. How the study addressed the identified gap in the PTSD-PC research literature**

The use of qualitative methodology enabled understanding of women's and midwives' lived experiences of QPI, how they felt and what it meant to them. The use of Interpretative Phenomenological Analysis (IPA) enabled rich data from the informants. In-depth analysis of their accounts provided deep exploration of emerging themes. From this it was possible to identify key issues that influence the needs and expectations of women and midwives, noting crucial areas to be addressed within maternity services.



### 5.3.1. A reminder of the research questions, aims, and objectives

A reminder of the study aims and research questions and how they were met are given in Boxes 5.3. to 5.6.

#### Box 5.3. The research questions

##### Overarching question

How do childbearing women who develop PTSD-PC and midwives experience their interactions during labour, birth, and early postnatal care provision?

##### Specific questions

1. How did childbearing women experiencing PTSD-PC experience interacting with their midwives during labour, birth, and early postnatal care provision?
2. What meaning do childbearing women experiencing PTSD-PC, who perceived their childbirth experience as distressing or traumatic, ascribe to their experiences of interacting with their midwives during labour, birth, and early postnatal care provision?
3. How do midwives experience interacting with women whilst providing their labour, birth, and early postnatal care in the context of knowing that women may find childbirth distressing or traumatic?
4. What meaning do midwives ascribe to their experiences of interacting with women whilst providing their labour, birth, and early postnatal care, in the context of knowing that women may find childbirth distressing or traumatic?

The above questions were addressed through the informant interviews, and the IPA qualitative analysis of the interview transcripts. The lived experiences of the women and midwife informants is presented in Chapter 4.

#### Box 5.4. The research aims.

1. To understand from women with Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) how they experienced their interaction with their midwives during labour, birth, and early postnatal care provision.
2. To understand from midwives what they know about PTSD-PC, and how they experience their interaction with women during labour, birth, and early postnatal care provision.
3. To use the findings from this research to develop recommendations for maternity services in terms of minimising the risk of trauma that potentially results from women's subjective experience of labour, birth, and early postnatal care provision.

Aims 1 and 2 have been achieved and the results are presented in Chapter 4.

Aims 3 will be addressed in chapter 6.

**Box 5.5. The research objectives regarding the experiences of childbearing women**

1. To invite childbearing women who perceived their childbirth experience as distressing or traumatic to take part in the study.
2. To assess the level of birth satisfaction using the Revised Birth Satisfaction Scale (BSS-R) for the childbearing women who accepted the invitation to the study, met the eligibility criteria, and consented to complete the BSS-R.
3. To screen for PTSD-PC using the City Birth Trauma Scale (City BiTS), the childbearing women who accepted the invitation to the study, met the eligibility criteria, and consented to be screened for PTSD-PC.
4. From a sample of the women screened for PTSD-PC and who met the diagnostic criteria for PTSD-PC using the City BiTS, to obtain descriptions of their lived experience of interacting with the midwives providing their labour, birth, and early postnatal care.
5. To analyse, using Interpretative Phenomenological Analysis (IPA), the obtained descriptions of the women's lived experiences of interacting with the midwives providing their labour, birth, and early postnatal care.

All the above objectives were achieved. The results are presented in chapter 4.

**Box 5.6. The research objectives regarding the experiences of midwives**

1. To generate an overview of what is known or understood by midwives about Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) by using a short quantitative survey and to use this data to provide pointers for the semi-structured interviews with midwives.
2. To obtain descriptions from a sample of midwives about their experience of interacting with women whilst providing their labour, birth and early postnatal care in the context of women finding childbirth distressing or traumatic.
3. To analyse using Interpretative Phenomenological Analysis (IPA), the descriptions from this sample of midwives about their experience of interacting with women whilst providing labour, birth, and early postnatal care in the context of knowing that women may find childbirth distressing or traumatic.
4. To use the findings from these analyses to provide recommendations for maternity services to support midwives in optimising their interaction with women during labour, birth, and early postnatal care provision, which meets the needs of women and may reduce the potential for them to perceive childbirth as traumatic.

All the above objectives were achieved. The results presented in chapter 4.

### **5.3.2. Study limitations**

#### ***5.3.2.1. The impact of previous life experiences***

Individual perception does not exist in isolation within a particular experience but is built upon layers of prior experiences and preconceptions, that have informed their lives and created particular lenses through which they view and interpret the world (Chapters 1 and 3). A frequently posed question is whether *The Women* were pre-disposed to perceiving only negative QPI (Chapter 4, section 4.3.3.). However, all *The Women* clearly recounted positive QPI. Notably, five of the six *Women* disclosed no pre-existing risk factors for developing PTSD-PC and their sociodemographic backgrounds reflected low risk (Chapter 4, section 4.2.1.).

#### ***5.3.2.2. Inability to determine the cause of the PTSD-PC in The Women***

While study inclusion criteria aimed to limit confounding effects from mental ill health, severe maternal morbidity, neonatal complications, or neonatal loss, it is possible that development of PTSD-PC in *The Women* resulted from childbirth factors other than QPI, as they also underwent obstetric interventions. However, the high incidence of obstetric interventions in the UK ([Humphrey and Tucker, 2009](#)), alongside the literature review evidence that positive QPI mediates objective childbirth factors and reduces risk of developing PTSD-PC, situates the study in a realistic context. Furthermore, this concern is lessened as all *The Women* highlighted QPI related trauma hotspots.

#### ***5.3.2.3. Not interviewing the woman/midwife dyads***

Not interviewing the woman/midwife dyads from *The Women's* traumatic childbirth events, (Chapter 3, section 3.7.3.4.), made it impossible to truly see each side of the story. *The Women's* perspectives may inaccurately reflect objective reality, and not hearing their actual midwives' perspectives is an important limitation.

#### ***5.3.2.4. The retrospective nature of the research***

Memories of childbirth remain strong and coherent (Chapter 1, section 1.1.4.4.), which suggests that *The Women's* narratives are reliable. Yet, *The Women* are likely to have

been making sense of their experience for some time, possibly refining their narrative. Nevertheless, to improve women's perceptions of QPI, it is essential to understanding how a negative perception of QPI might arise, whilst considering individual lenses.

#### **5.3.2.5. Self-selection of informants**

The process of self-selection for participation may create a level of bias (Denscombe, 2014). Given the sensitive nature of the research, self-selection of women was unavoidable but meant only strong or secure women may have volunteered. Yet, two *Women* had clearly risen above insecurity, seeing the research as valuable. For midwives, research participation was likely low priority within their demanding role, within which they also experience trauma and PTSD (Pezaro et al., 2016, Warren and Hunter, 2014, Edwards et al., 2016, Favrod et al., 2018). Thus, only deeply motivated midwives with the necessary head space may have responded. Indeed, all *The Midwives* were passionate about their role and clearly women-centred. While four *Midwives* struggled with systemic influences on their ability to be women-centred, two *Midwives* were more system orientated, enabling some balance in representation. The snowball sampling of midwives initiated via my personal contacts had potential to be biased. Yet, snowball sampling encouraged midwives to pass the information beyond my list of contacts. Consequently, some midwives unknown to me completed the survey.

The self-selected samples resulted in highly homogenous groups with potential biases in terms of their perspectives on the experience of interacting during childbirth. While homogeneity is strongly desirable for IPA research (Smith et al.), there are important limitations in generalising the conclusions and subsequent recommendations. However, as discussed in Sections 3.5.1.3, 3.5.3, and 3.7.2, the strength of IPA research is the idiographic depth of detail, and as consistent within qualitative research the aim is for transferability rather than generalisability. Deeply exploring the particular offers valuable insight into the whole and the potential considerations and recommendations for maternity services.

### **5.3.2.6. Limited socio-demographic of the samples**

The lack of socio-demographic data for *The Midwives* limits the understanding of wider influencing factors in their experiences. However, all *The Midwives* were white, Caucasian, and aged between 30 and 50 years, so shared a similar demographic to *The Women* (see table 4.2b). This reduced potential confounding factors related to cultural differences and enabled a multi-perspective exploration of the nature of QPI in the context of PTSD-PC for this demographic. However, further research is needed to explore the experience of QPI from women and midwives from different socioeconomic, education, or ethnic backgrounds, alongside midwives who perhaps view their role to be more medical or obstetric. This would shed light on a wider range of human and relationship needs and how maternity services might need to respond.

### **5.3.2.7. Potential influence of the interview schedules**

The interview schedules, particularly for *The Midwives*, appear closely related to the final themes identified. The interview schedules were based on the pre-conceptions reflected on (section 3.6.3. box 3.4.), and the midwives' online survey data. The schedules were simply a guide in case informants were not sure how to continue during interview. In reality, following the opening question all informants spoke passionately at length and the schedules were hardly referred to. Instead, as described in section 3.7.5.2., aide-memoire notes directed any necessary deeper probing directly reflecting what the informant expressed.

## **5.3.3. Study strengths**

### **5.3.3.1. The comprehensive nature of the literature review**

The two-stage process enabled a comprehensive examination of the contributing factors in the development of PTSD-PC.

### **5.3.3.2. The in-depth qualitative analysis**

The qualitative methodology provided a strong platform for researching lived experience. The in-depth exploration of QPI facilitated by IPA, enabled a rich understanding of informants' feelings and sense-making. Exploring both perspectives enabled identification of the issues that influence both women's perceptions of QPI,

and midwives' abilities to optimise QPI, and thus inform areas for attention by maternity services.

#### **5.3.3.3. *The use of reflexivity***

Key within IPA are the double hermeneutic layers of both the informant's sense-making of their experience and the researchers' sense-making of the informant's narrative. The process of reflection (Chapter 3, section 3.5.5.) enabled deep exploration of these layers.

#### **5.3.4. Ethical considerations during the study**

Although all effort was made to ensure the physical and psychological comfort of informants, some did experience distress. However, all *The Women* found being interviewed cathartic and were relieved to have someone listen to their whole story. *The Midwives* expressed grief at being unable to be the midwives they envisioned, but again were eager to tell their story. As the researcher, I maintained a calm countenance throughout each interview, but afterwards experienced deep levels of grief, anger, and frustration, further compounded when transcribing and analysing the data. The reflective diary and discussion with supervisors, successfully enabled self-care.

#### **5.4. Summary of the study findings**

Chapter 4 presented the summary background data and the IPA findings related to the informants' interviews. The study provides rich information and deep understanding of the lived experience of QPI and its meaning for each informant. Whilst the research questions included antenatal care, *The Women's* interviews, which occurred prior to those of *The Midwives*, identified the intrapartum and early postnatal periods as key regarding trauma. To elicit comparable perspectives, only midwives who provided intrapartum and early postnatal care were interviewed. As they did not also provide antenatal care, this aspect of the research questions remains unaddressed. An overview of how the findings answered the research questions is now presented.

#### **5.4.1. *The Midwives* lived experiences and the meaning these had for them when interacting with women?**

*The Midwives* find joy and job satisfaction when they can build relationships with women and make a difference. Yet, the unrelenting intense workload frequently leaves them unable to *be with* women and they express distress at being torn between unrealistic expectations to simultaneously meet the desires of women, the demands of management, to follow systemic procedures, and to keep women safe. They also expressed threat and lack of safety with respect to their registration. Situated in the context and awareness of the uncontrollable nature of childbirth, these pressures leave *The Midwives* with a lack of control over care provision, including QPI and women's subsequent experiences. *The Midwives* express their own innate drive to *be with* women and understand this to be their *raison d'être* alongside a fundamental drive to keep women and babies safe. They desire to develop and maintain relationships through being present over time and tuning into individual needs by listening to women. They see relationship and communication as the mechanisms through which they can fulfil their acknowledged responsibility for each woman's quality of childbirth experience and safety. *The Midwives* express their needs to be seen as humans not machines, to be trusted, respected, and supported through being allocated appropriate time and resources. Furthermore, they need colleagues and women to fulfil their roles appropriately. See Box 5.7.

**Box 5.7. Main findings from *The Midwives*: associated master or sub themes**

***The Midwives* lived experiences of interacting with women**

- *The Midwives* found joy and job satisfaction when they could build relationship with women and make a difference.
- *The Midwives* frequently felt torn in two between unrealistic expectations and demands.
- *The Midwives* sometimes felt we cannot control regarding the care they could provide and women's experiences.

**The meaning of these experiences for *The Midwives***

- *The Midwives* saw relationship and communication as core to midwifery care and strongly desired this.
- *The Midwives* want to be recognised as humans who are vulnerable to the pressures we face and expectations.
- *The Midwives* need to be able to rely on others need to do their bit to provide resources, support, and fulfil their roles.
- *The Midwives* need to be respected and trusted by women and colleagues.

**5.4.2. *The Women's* lived experiences and the meaning these had for them when interacting with women?**

*The Women's* shattered world views, a core component of trauma and the potential for PTSD (Chapter 1, section 1.1.4.2.), lay in their experiences of midwives' behaviours being unexpectedly negative and inconsistent, leaving *The Women* feeling abandoned and fearful. When the anticipated and sought sanctuary of having a midwife *be with* them who recognised and responded to their needs was unmet, or perceived as actively withheld, *The Women* experienced what is known as sanctuary trauma (Silver, 1986, Bloom, 2018). Poor, negative, mistimed, or absent communication or support, contributed to this sanctuary trauma, which further deepened to fear, horror, and helplessness through perceived threat or danger from midwives' behaviours. As *The Women* embarked on childbirth their initial power and strength was undermined by negative attitudes from midwives as well as explicit power struggles including physical violation. *The Women* expressed vulnerability within their childbearing state and strongly desired to place themselves safely into the hands of midwives, to develop positive relationships with them, and to be kept informed throughout the childbirth process. They needed to perceive their midwives as competent, available, and focussed on *The Women's* needs with their best interests at heart. They also needed to



trust the intentions, integrity, and honesty of midwives. When these things occurred, *The Women* perceived positive QPI. See Box 5.8.

**Box 5.8. Main findings from *The Women*: associated master or sub themes**

***The Women's* lived experiences of interacting with midwives**

- *The Women's* shattered expectations were related to QPI.
- *The Women* experienced trauma when they perceived negative attitudes towards them from midwives, how not what.
- *The Women* experienced trauma when they perceived explicit power struggles with midwives struggling for power.

**The meaning of these experiences for *The Women***

- *The Women* expressed vulnerability due to the childbirth experience struggling for Power.
- *The Women* desired midwives to positively *be with* them, build relationship with me.
- *The Women* needed to trust that they were the focus of care and attention during their childbirth experience, see me, I need you.

**5.4.3. Findings that converge**

Both sides expressed explicitly or implicitly that they are first and foremost human, and as such are vulnerable. This vulnerability impacts on each one's ability to obtain power and control and to have one's needs recognised and met within the childbirth interaction. Both *The Women* and *The Midwives* strongly desired a positive, affirming relationship, through which care is provided and received in a manner that optimised the psychological and physical outcomes for women, while maintaining optimal wellbeing and job satisfaction for midwives (Box 5.9.).

**Box 5.9. Main convergent findings from both sides:**

- Both women and midwives need to have their human needs acknowledged.
- The relationship between women and midwives is of central importance.

**5.4.4. Findings that diverge**

Within these converging findings important divergent themes emerged. The mutual desires for safety are often intrinsically opposed. For *The Women*, being safe requires a continuous and trustworthy presence from their midwives, which is not always possible for midwives. *The Midwives* desire to keep women and their job registration safe but this can conflict with the demands of women and the system. Also, the preparation and knowledge that each side carry is not always fully recognised,

understood, or accounted for by the other. Importantly, the human need to maintain some power, usually informed by the need for safety, often resulted in emotional or physical conflict. This reflects a divergence in power needs and expectations. Finally, while both sides require support, the source of such support differs in that *The Women* needed support from midwives and *The Midwives* need support from colleagues and the system (Box 5.10.).

**Box 5.10. Main divergent findings from both sides:**

- Women and midwives may not fully comprehend the safety priorities of the other.
- Women and midwives experience conflict with regard to prior or perceived knowledge.
- Women and midwives experience conflict with regard to power.
- Women and midwives have different support needs.

**5.4.5. Validation of the study findings**

*The Women's* experiences are in keeping with and reinforce the literature review findings with regard to QPI and PTSD-PC. *The Midwives'* experiences echo wider literature (Edwards et al., 2018, Byrom and Downe, 2015, Edwards et al., 2016, Pezaro et al., 2016). The key convergent finding of the centrality of the woman/midwife relationship is consistent with other research (Thomas, 2006, Hunter, 2006, Kirkham, 2010, Crowther et al., 2018). In particular, the findings parallel those from a recent study exploring the woman/midwife interaction at the start of labour (Shallow et al., 2018, Shallow, 2018b). This consistency, alongside feedback following dissemination of the study findings through conference presentation and two public engagement workshops (Appendix 3.2.), serves to validate the findings.

**5.5. The novel contribution to the PTSD-PC research literature:**

Through the literature review, the study approach and findings, and the subsequent dissemination of these findings, this thesis provides a novel contribution to the existing PTSD-PC literature. Each aspect is now presented.

### 5.5.1. The novel contribution from the literature review

***Key finding 1:** Interpersonal factors are the strongest predictor of PTSD-PC in women and a negative perception of QPI is significantly correlated with the development of PTSD-PC in women.*

The literature review showed that interpersonal factors are the strongest predictor of PTSD-PC and a negative perception of QPI is a frequent feature of maternity care provision that significantly correlates with psychological harm, specifically PTSD-PC. This is in keeping with the aetiology of PTSD in that women are more susceptible to PTSD following interpersonal experiences compared to extrinsic objective events (Charuvastra and Cloitre, 2008).

### 5.5.2. The novel contribution regarding how the research gap was addressed

By utilising qualitative methodology and including midwives' perspectives this study makes a novel contribution to PTSD-PC literature with regard to the lived experience of the woman/midwife interaction.

### 5.5.3. The novel contribution from the study

***Key finding 2:** Failing to recognise and meet the human needs of both women and midwives, may result in poor QPI from midwives and poor perception of QPI by women.*

The finding that both women and midwives need to feel safe and be acknowledged as human could be considered obvious and too general, but I argue that it is the failure to fully comprehend and encompass this reality that sits at the heart of poor QPI. The discussion of the key findings in the context of prior research and maternity care policies (section 5.7.), suggests that current maternity services strategies may be ineffective unless this reality is fully addressed. As distinct from other creatures, human beings ascribe meaning to trauma (Charuvastra and Cloitre, 2008). It is precisely this human meaning making that the informants express.

***Key finding 3: Both The Midwives and The Women identified the quality of their relationship as central to positive QPI.***

The value of the woman/midwife relationship has been highlighted throughout childbirth literature (section 5.4.7.). Situated in the context of PTSD-PC, this study adds that the role of this relationship and the associated QPI is central to women's subjective perception of childbirth. Since a negative perception contributes to the risk of developing PTSD-PC, the woman/midwife relationship is fundamental to the psychological wellbeing of women.

#### **5.5.4. The novel contribution through creative dissemination of study findings**

The study findings have been widely disseminated through local, national, and international conferences (Appendix 3.1.). In particular, the writing and production of a short film depicting the study findings through interpretative movement, and the use of interactive theatre in two public engagement workshops, one for women and one for midwives, serve as novel contributions to research dissemination (Appendix 3.2). The film can be accessed through vimeo link <https://vimeo.com/223027840> with password: ipaptsd. Also, a physical DVD of the short film has been submitted with this thesis (attached in envelope to back page).

#### **5.5.5. Moving towards the discussion**

Key finding 1 provided the incentive for the study and forms the basis for consideration 1 in Chapter 6. To reduce the potential for iatrogenic harm the maternity services should optimise QPI. The discussion focusses on the key study findings (2 and 3) and creates a robust foundation for the recommendations, from which effective and sustainable changes can be initiated (Box 5.11.).

### **Box 5.11. The key findings**

- **Key finding 1: From the literature review**  
*Interpersonal factors are the strongest predictor of PTSD-PC in women and a negative perception of QPI is significantly correlated with the development of PTSD-PC in women.*
- **Key finding 2: From the study**  
Failing to recognise and meet the human needs of both women and midwives, may result in poor QPI from midwives and poor perception of QPI by women.
- **Key finding 3: From the study**  
Both *The Midwives* and *The Women* identified the quality of their relationship as central to positive QPI.

## **Part 2: Discussion of the key study findings**

### **5.6. Foundational theories that inform an understanding of the key study findings**

#### **5.6.1. Introduction**

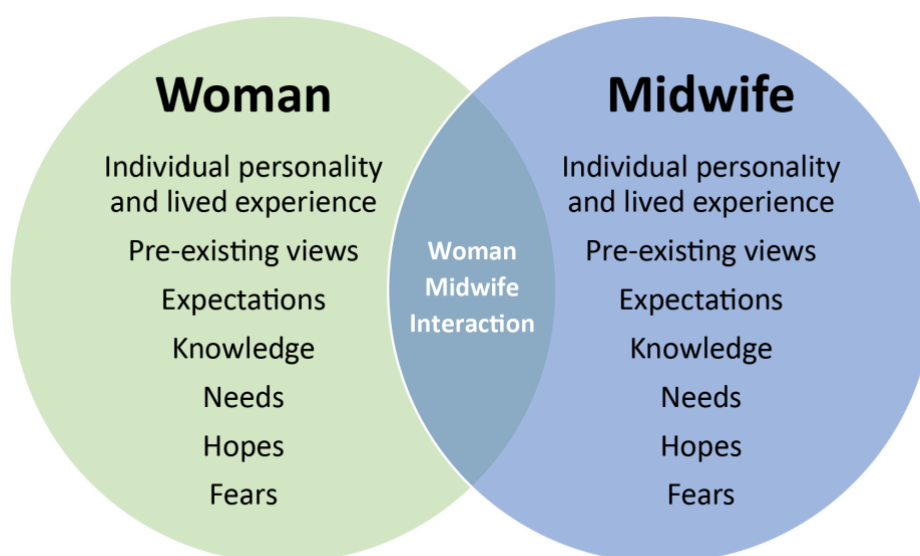
The study findings, alongside Chapter 1, emphasis the uniquely human response to trauma and the significant role of interpersonal human factors in the development of PTSD-PC. The study findings regarding QPI and relationship quality emphasise the interpersonal nature of childbirth. Before discussing the key findings, factors that influence individual behaviour and expectations during human interaction are explored, followed by an overview of foundational theories that inform the understanding of the woman/midwife interaction.

The theories of Heidegger, Merleau-Ponty, and Gadamer, as discussed in Chapter 3, section 3.3.3., illuminate the influence of time, context, the physical body, and human interaction, on human lived experience. At any particular moment of *being-in-the-world*, people are subject to past and present experiences, and visions of the future. The phenomenological strategy in this study acknowledged this *being-in-the-world* as perceived through the human body. The interpretative hermeneutic dimension acknowledged the human need for meaning- making during trauma and the ongoing sense-making of lived experience. This ongoing sense-making informs development of individual characteristics, which include beliefs, assumptions, expectations, and future behaviour.

### 5.6.1.1. Embarking on interaction: factors influencing behaviour and expectations

Each individual embarking on the woman/midwife interaction is influenced by a complex mix of factors, which are wider than those proposed by Hildegard Peplau in her theory of patient/nurse relationship (Wayne, 2014). Peplau proposed that both parties are influenced by values, culture, race, beliefs, past experiences, and expectations, while only nurses have preconceived ideas. Peplau's factors are primarily cognitive or extrinsic to the person. The informants' narratives suggest that deeply intrinsic human needs also exist such as hopes and fears. Furthermore, *The Women* also carried preconceived ideas, related to midwives and maternity services, developed from their childbirth culture context, and antenatal preparation. Therefore, a wider set of influencing human factors is proposed (Figure 5.1.).

Figure 5.1. Human factors influencing the interaction between women and midwives



### 5.6.1.2. During interaction: factors influencing behaviour and expectations

Four key influencing factors have been proposed in relation to midwifery, particularly in terms of human interaction (Box 5.12.)

Box 5.12. Key influences on behaviour of midwives and women (Paradice, 2002)

**Social influence:** You do as you are told, conformity.

**Prejudice or stereotyping:** Classifying information in order to make sense of it.

**Social cognition:** Perceptions of ourselves and others, making assumptions about people.

**Communication:** Verbal, non-verbal.

An individual's behaviour at any moment during interaction with another, will consist of a combination of action, inaction, and communication both verbal and non-verbal. The study findings suggest that behaviour strongly influences experience, which in turn builds expectations. Women's childbirth trauma is often attributed to their *unrealistic* expectations, which set them up to fail (Kirkham, 2017a), as noted in *The Midwives'* survey (Chapter 4, section 4.2.4.). Women's expectations are influenced through other women's experiences, childbirth literature, or antenatal classes. Unrealistic expectations may predispose women to having their world view shattered, a core element within trauma and the development of PTSD (Janoff-Bulman, 1992). In the study, expectations regarding QPI ran high on both sides. The demands and constraints from external sources, especially the oft-conflicting cultural discourses of childbirth and maternity services, strongly influence realisation of these expectations for both women and midwives. This is discussed next.

### 5.6.2. Four theories that inform the cycle of experience, expectation, and behaviour

In relation to expectations and experiences during human interaction, four theories inform an understanding around resulting behaviour, relationship, and communication (Box 5.13.).

#### Box 5.13. Four theories that inform human experience, expectation, and behaviour

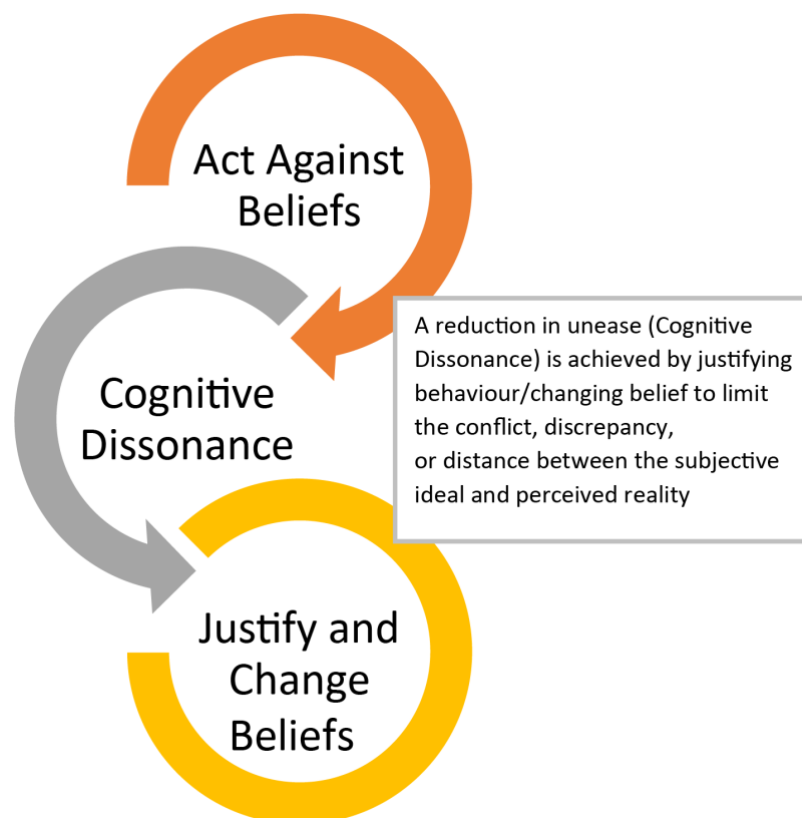
- **Cognitive dissonance:** when reality does not match the ideal.
- **Emotional labour:** which informs the management of relationship.
- **The reasonable person model:** which informs attitude.
- **Transactional Analysis:** which informs communication.

#### 5.6.2.1. Cognitive dissonance: when reality does not match the ideal

The master themes of *Shattered Expectations* and *Reality of being a midwife*, illuminate the gap that often exists between the *Ideal* and the *Reality*. When this ideal/reality gap relates to one's *ideal* image of self and one's *real* behaviour, inner conflict may arise, usually resulting in one feeling *bad* alongside the use of strategies to reduce discomfort (de Vries and Timmins, 2017). Cognitive Dissonance is the dominant theory regarding how humans deal with this inner conflict (Festinger, 1957, Aronson,

2011). Humans determine reality from those around them (Aronson, 2011), and even when things do not feel right peer influence can lead to changing one's attitude to reduce discomfort, changing previously held beliefs, justifying one's inconsistent behaviour as being the only way forward, and eventually not feeling discomfort (Timmins and de Vries, 2015). People are more likely to move towards modifying perceptions or attitudes rather than behaviours (Cooper, 2007). In other words, people reduce discomfort by finding ways of telling themselves their behaviour was acceptable. Ultimately, this results in altered beliefs and the continuance of behaviour that was previously unacceptable to self. Figure 5.2. presents a visual representation of cognitive dissonance.

Figure 5.2. The pathway of cognitive dissonance



Similarly, emotional dissonance between felt emotions and those required to be displayed, often through surface acting (Hochschild, 2012, Delgado et al., 2017), creates discomfort. Consistent with IPA (Smith et al., 2009), the study explored informants' feelings, emotions, and meanings attached to their experiences. Notably,



both *The Women* and *The Midwives* expressed distress at how others made them feel. An overview of theory around emotions is now presented.

#### **5.6.2.2. Emotional labour: which informs the management of relationship**

*'I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.'* (Maya Angelou Quotes, 2018)

Hochschild (1979) developed a theoretical framework that identifies and explains how emotions are central to some occupations and impact on workers management, raising the concept of *feeling rules* and the understood and accepted boundaries within which emotions are managed. Hochschild later differentiates between *emotion work* as being carried out in one's private life, and *emotional labour* that exists within an organisational setting (Hochschild, 2012). Noting that compared to one's private life, feeling rules are required to be followed more closely in the workplace, *emotional labour* can involve managing one's feelings by presenting an outward observable display of appropriate emotion, regardless of one's real emotions, since a display of irritation or fatigue could impact negatively on the client (Hochschild, 2012). This possibility is reflected in *The Women's* feelings of *being a bother*. Within midwifery, the boundary between emotional work (private) and emotional labour (organisational) can become blurred due to the unique nature of the woman/midwife relationship (Hunter, 2006). Only relatively recently has midwifery literature acknowledged the emotional labour of midwives (Healy et al., 2016, Kirkham, 2010, Edwards, 2005, Hunter and Deery, 2009b, Hunter, 2010, Patterson and Begley, 2011), with any sense of priority (Edwards, 2009, Hunter and Deery, 2009a), beyond being the shadow work of midwifery (John and Parsons, 2006). Acknowledged to be an omnipresent feature of midwives' daily lives (Hunter and Deery, 2009a), emotional labour is often gendered, being seen as women's work (Hochschild, 2012), with professional, intrapersonal, collegial, organisational, and socio-cultural sources (Riley and Weiss, 2016, Kirkham, 2009, Hunter, 2010). *Emotion work* or *emotional labour* are therefore powerful and intense aspects of the woman/midwife interaction. The connection between

workplace agendas and *emotional labour* suggests a level of individual response. How the environment might influence human response is discussed next.

### **5.6.2.3. The Reasonable Person Model (RPM): which informs attitude**

Although focussed on links between environmental factors and human behaviour, the RPM highlights the centrality of human informational needs (Box 5.14.), which connects with the study sub themes that relate to communication, trust, and control.

#### **Box 5.14. Three highly correlated categories of informational needs (Kaplan and Kaplan, 2003)**

- **Exploration and understanding:** Acquisition and comprehension of information – basic survival mechanisms of humans
- **Meaningful action:** Acting effectively on the information one has.
- **Restoration:** Maintaining capacity to focus on, select and respond appropriately to the information.

Having one's informational needs met, alongside the opportunity to act effectively and respond appropriately, engenders reasonableness. The meaningful action component is of particular interest, as this arose from noting the harmful effects of helplessness, with strong parallels to feeling disregarded and not mattering, and that often people just want to be heard and be part of the process (Kaplan and Kaplan, 2003).

Helplessness is a core component of PTSD and lack of control is a significant feature of subjective childbirth experience in women experiencing PTSD-PC (Chapter 2, section 2.1.2.4.2.). Yet, within the RPM it is argued that control is an unsatisfactory antidote to helplessness (Box 5.15.).

#### **Box 5.15. Control as an unsatisfactory antidote to helplessness (Kaplan and Kaplan, 2003)**

- People don't always want the responsibility that comes with control, more often they want things to be *under control*.
- Control is a zero-sum situation, when one party has more control the other has less.
- Control is often unrealistic, especially when related to forces of nature.

The sub themes related to *control* reveal existence of each of these three situations during childbirth, for both women and midwives. Furthermore, Kaplan and Kaplan

(2003) suggest that unreasonableness undermines trust, and lack of trust was a theme threaded throughout all informants' experiences. The RPM suggests the complex interaction between cognition, emotion, and environment informs the diverse aspects of the inner self. Interaction between people necessarily involves engagement with these inner selves and is discussed next.

#### 5.6.2.4. Transactional Analysis (TA): which informs communication

TA is a psychotherapy method for studying interactions between people (Berne, 1964), with a largely unnoticed, fundamental role in nursing (Whitley-Hunter, 2014). TA offers an understanding of the possible patterns of human interaction and the influence of each person's inner self, which Hargaden and Sills (2002) believe is central to the ego. As with other experiences, humans store memories from past communication events. During a new, or current, communication event, older stored memories may be reawakened by an associated stimulus. The old memories are then relived within the current experience, sometimes subconsciously (Hollins Martin, 2011). Stored feelings from communication in infancy form the basis of *Ego states*, each of which has two primary components. Each person has a combination of Parent, Child, and Adult ego states (Table 5.1.). The goal within TA is to have both parties communicating as Adult to Adult (Whitley-Hunter, 2014), because when the transaction is Parent-to-Child or Child-to-Parent communication can be challenging (Widdowson, 2010, Berne, 1964).

**Table 5.1. The ego state model** (Hollins Martin, 2011, Lister-Ford, 2002, Berne, 1964)

<b>Parent</b> reflects messages from our parents, values, opinions and judgements	<b>CP</b> Critical or Controlling Parent	Focus on rules, error and punishment with view to create safe boundaries and protect. Could be over controlling.
	<b>NP:</b> nurturing parent.	Unconditional positive regard. Focus on openness, learning and development, but could be smothering.
<b>Adult</b> The present, unemotional, rational.	An integration of the child and parent.	Serves to mediate between the parent and child.
<b>Child</b> Our inner core emotions. Seeks to meet its own needs	<b>Free child</b>	Carefree, trusting and unbound by rules.
	<b>Adapted child</b>	Structured, seeks to adapt to imagined or real demands of others, conforms to rules.

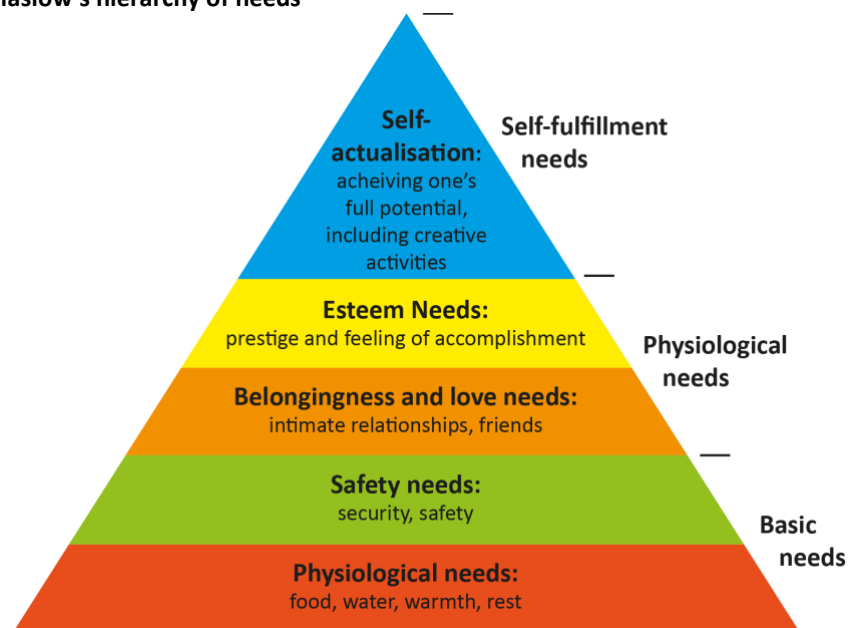
### 5.6.3. Summary of foundational theories that inform understanding of the key study findings

The foundation from which the woman/midwife interaction can be understood is rooted in the interplay between human experience, expectation, and behaviour. The unfolding of this interplay is informed by intrinsic emotional responses alongside cognitive and rational processes. While *being human* is a wide fundamental phenomenon, it is nevertheless core within maternity services. The theories of *Cognitive Dissonance*, *Emotional Labour*, *the Reasonable Person Model*, and *Transactional Analysis* provide a basis from which discussion of the key findings can be developed with a view to identifying a way forward.

### 5.7. Discussion of the key study findings in relation to foundational theories and wider midwifery research

The discussion is built on the unshakeable truth that everyone who engages in the process of childbirth, be they women, midwives, medical staff, or management are first and foremost *human*. Maslow's hierarchy of needs (Maslow, 1943) (Figure 5.3.) reflects how once basic human needs are met more complex human needs emerge, including relationship and power. The study findings show that failing to account for basic and complex human needs of women and midwives contributes to poor QPI and the development of PTSD-PC.

Figure 5.3. Maslow's hierarchy of needs



### 5.7.1. Being human

*'I dunno there is something wrong in the system that doesn't allow you to feel like a human being.'* Julie (woman informant) 35:20-22

*'I suffer from a condition called being human.'* (Pezaro, 2018)

*'The woman giving birth is a human being, not a machine and not just a container for making babies.'* (Wagner, 2001)

*'Humanity is important in any culture and within the NHS it feels like humanity should be core.'* (West, 2013a) and transcript (West, 2013b)

#### 5.7.1.1. Shared human background

Consequent to the Mid-Staffordshire Foundation Trust Inquiry (Francis, 2013), the acknowledgement of the humanity individuals within the NHS, patient or staff, is considered of core importance (West, 2013a, West, 2013b). The many layers that need to be understood in the woman/midwife interaction include personal histories, the current situation, other people involved, and the situated context (Paradice, 2002). That women, midwives, and all maternity staff, are at the mercy of human life experience related to a range of features (Box 5.16.), forms the basis of the considerations for maternity services presented in Chapter 6.

#### Box 5.16. Possible features of life experience

- Prior trauma.
- Socio-demographic background and current situation.
- Pre-existing or current mental health.
- Pre-existing or current physical health.

The first three features correlate with the categories associated with the development of PTSD-PC (Chapter 2, section 2.1.2.4.), and represent a wide range of issues including but not limited to, childhood sexual abuse (CSA), interpersonal violence (IPV), rape, accident, bereavement, birth trauma (personal or vicarious), ethnicity, age, socioeconomic status, education, depression, anxiety, and PTSD. For midwives, prior

personal or vicarious birth trauma can be related to fear of responsibility for causing harm (Beck and Gable, 2012, Davies and Coldridge, 2018, Pezaro et al., 2016, Favrod et al., 2018). Nevertheless, there exist distinctions between women's and midwives' needs.

#### **5.7.1.2. Women's human needs**

Women are enduring a painful, physical process, with ever-present concern for both their own and their baby's wellbeing, leaving them vulnerable, and at the mercy of their body and those around them. *The Women's* expressions of vulnerability and need for connection, relationship, security, and safety, reflect more than basic needs for food and drink. This may be because basic needs are assumed, or indeed acknowledged to be somewhat suspended during childbirth, only coming back into play afterwards, while the higher levels of security, safety, and relationship become central. For women safety is considered much wider than physical wellbeing, extending to encompass mental wellbeing (Edwards, 2010). Many women anticipate continuity of care and inherent relationship (Edwards, 2018).

#### **5.7.1.3. Midwives' human needs**

Midwives are conducting a professional role for which they share a common training. While in a comparable position of strength, midwives carry the weight of professional responsibility, and engage from within both personal and organisational contexts. *The Midwives* strongly expressed the weight of this responsibility and seeking to have their emotional needs acknowledged and supported by colleagues, reflecting their desire for psychological safety and security, alongside their desire to build relationships with women. Many of *The Midwives* expressed that being *a person* who matters and not just a machine or robot is important. In keeping with this, in his presentation at the Royal College of Midwives (RCM) national conference, Michael West of The King's Fund, lamented the expectation for midwives to be *super human*; '*We cannot run an organisation without paying attention to the humanity of the staff. We cannot keep piling more and more onto the people*' (West, 2016). Another presentation at this same conference regarding women's experiences of poor care, elicited a heated, emotive response from several audience midwives who protested that their basic needs for

food and drink were unmet during work. This was reinforced by the Royal College of Midwives Caring for You Campaign survey (RCM, 2016a) (Box 5.17.).

**Box 5.17. How well midwives' needs are met while on shift (RCM, 2016a)**

**Out of 1361 responses:**

- Only 21% take their entitled breaks most or all of the time
- 62% delay using the toilet at work because they don't have time
- 62% find they are dehydrated at work because they don't have time to drink
- 38% work shifts that are always 12 hours long or more
- 18% did not take all their annual leave entitlement

**5.7.1.4. The power inequalities at the outset**

The power differential embodied within the woman/midwife interaction (Murphy-Lawless, 1998, O'Boyle, 2014, Barker, 2011) and between midwives and their regulatory bodies (Wagner, 2007) has been widely raised and was clearly reflected by *The Women*. Midwives' surveillance of maternal and fetal wellbeing that reflects a *Vigil of Care* approach (Fox, 1999, Walsh, 2011), implies their authoritative knowledge and power over women, which can undermine relationships (Kirkham, 2010, Thomas, 2006). Reinforced by the reality that women only briefly pass through the system, often caught up in a conveyor belt system, and are rendered passive while power lies with the institution (Kirkham, 2010). A rare exception occurs when a woman can deselect a midwife, or self-discharge, as did two of *The Women*. While this surveillance imparts a power that midwives are professionally expected to maintain (O'Boyle, 2014), this power can be undermined by senior staff (Hollins Martin and Bull, 2010, Kirkham, 2010). and as *The Midwives* reflected, the behaviour of women. In most settings, women and midwives have little choice about who they are thrown together with. The unremitting nature of childbirth, alongside limited resourcing of staff, mitigate against picking and choosing. If one does not *get on* with the other, it is generally not possible to walk away and find someone else. While women will occasionally deselect a midwife, midwives rarely have the option to deselect a woman.

## 5.7.2. The shared human experience of reality not meeting the ideal

*'Midwives struggle to cope in a system which does not share their professional values, and which exploits their commitment to those values.'* (Kirkham, 2015a)

*'It's (hospital) a place where you expect to be safe, you feel you expect to be safe'* Marie (woman informant) 10:40-42

Conflicting ideologies is a recognised source of cognitive dissonance (Festinger, 1957) that exists within oneself, or between oneself and others. Major conflict exists between the *medical/technocratic/business* models of midwifery and the *social* model of midwifery, around which exists a widespread and deeply embedded debate of which a small representation includes: (Wagner, 2001, Murphy-Lawless, 1998, Buckley, 2009, Odent, 2002, Kirkham, 2018). The ideologies of a *Vigil of Care* approach or a *Care as Gift* approach (Fox, 1999, Walsh, 2011) mirror this contrast between the biological, technical aspects of the professional role versus the kind, compassionate, and comforting aspects of being *with woman* (Barker, 2011), and the contrast in emotional labour between basing one's emotional management on personal gift, rather than a business contract (Hochschild, 2012). The language of the *social* versus *medical* or *business* models provide a structural cognitive perspective, while the terms *Vigil of Care* and *Care as Gift* respectively suggest a distinction between *Care done to* and *Care offered with*. *Care as Gift* speaks more to the heart of care, the emotional, human, interactional aspects of midwifery care.

### 5.7.2.1. The desired ideal

While all the informants recognised safety, *Vigil (care done to)*, as important, they all strongly desired *Gift (care offered with)*. This was evident in clearly expressed desires from both sides to build relationship, listen, and talk, further reflected in their joy and grief respectively when these were met or lost. *The Midwives* strongly valued *Vigil of Care* to keep women safe, particularly observed in Mandy's reference to women as *patients* suggesting a need to *look after*. Yet, *Care as Gift* embodied through



relationship was valued alongside or possibly over and above a functional *Vigil of Care*, highlighted by the strength of feeling about abandoning (*The Midwives*) or being abandoned (*The Women*), described as the *worst* by both groups, especially in the first hours following the baby's birth. The depth of trauma from abandonment was further emphasised during the public engagement workshops.

#### **5.7.2.2. The ideal/reality gap**

Standing back from the data, trying to see through it, like squinting one's eyes to get the sense of an image or the gist of what is happening, it feels as though much of the conflict, distress, disappointment, exhaustion, and fear described, relates in some way to three particular aspects of conflict between these approaches to care (Box 5.18.), echoing the findings of (Thomas, 2006) regarding the emotional impact of conflict between workplace and personal/professional ethics.

#### **Box 5.18. Three aspects of conflict between *Vigil of Care* and *Care as Gift* approaches**

- The responsibility to maintain a *Vigil of Care* for safety
- The lack of systemic or collegial support to do more than simply maintain a *Vigil of Care*
- A deep wish to engage with *Care as Gift*

#### **5.7.2.3. The organisational context of ideal/reality gap**

Maternity services in Scotland, where this study was located, reflect the increased medical and technological focus on midwifery observed across the western world in the last 50 years (Kirkham, 2010, Johanson et al., 2002, Christiaens et al., 2013). Despite repeated calls to redirect focus towards women (DoH, 1993, NICE, 2008, Renfrew et al., 2014), prioritising physical safety and fear of litigation have driven the spiralling medicalisation and centralisation of maternity services, which results in greater inflexible standardisation and constricts midwifery care (Kirkham, 2018). The prioritising of efficiency over relationship and commitment (Health Service England, 2012) conflicts with the NMC's requirement to *prioritise people* and all that entails (NMC, 2015b). Yet, this requirement is unrealistic in the current culture and resource stretched NHS, particularly with regard to staffing and time (Mander and BPG, 2018, RCM, 2016a). It is argued that the highly fragmented NHS service functions more smoothly when there is minimum engagement with women as individuals, leaving

midwives with limited options or time to develop relationships (Kirkham, 2015a). Consequently, midwives' approaches to care become more *Vigil* than *Gift* (Bolton, 2000). Worryingly, within a healthcare system, the gradual erosion of care or standards arising from cognitive dissonance may not be seen until something adverse happens (de Vries and Timmins, 2016a). Much exploration of the *ideal/reality gap* within nursing and midwifery has arisen following the following the Mid-Staffordshire Foundation Trust Inquiry (Francis, 2013) and Morecombe Bay Trust Inquiry (Kirkup, 2015), with the experiences of *The Women* echoing some of the highlighted poor care (Timmins and de Vries, 2015).

#### **5.7.2.4. Women's experiences of the ideal/reality gap**

*The Women* were crying out for *Care as Gift*, eloquently expressed by Catriona in her desire to be *enveloped in this warm motherly embrace*, alongside their very great distress and trauma when this sense of *Care as Gift* is lacking, and only a very distant, humanly disconnected, seemingly fragmented, and inadequate, *Vigil of Care* is available. When women cannot believe the reality of QPI and care, some may suspend their disbelief, so they can reconcile the reality with their anticipated confidence in the maternity services. In other words, in order to cope they tell themselves it was all ok (de Vries and Timmins, 2016b). *The Women* attempted to reconcile the QPI *ideal/reality gap* by reflecting that midwives' actions or inactions were due to staff being busy. Much emotional work by *The Women* lay in managing the *fortunately/unfortunately* uncertainty about the next midwife's approach, oscillating between feeling supported or *being a bother*. Feeling vulnerable yet responsible for self and baby, sometimes feeling strong, often fearful, demanded incredible emotional work to remain a *reasonable person*, and present oneself to the next midwife as amiably as possible to elicit a positive interaction. Women's emotional needs and work are often not priority over obstetric practices (Edwards, 2009), reflecting the primacy of *Vigil* over *Gift*, and a blindness to the necessity for psychological health as well as physical health. The sub theme *shattered expectations* highlights the major psychological cost for women related to the ideal/reality gap, and their associated emotional work.

#### **5.7.2.5. Midwives' experiences of the ideal/reality gap**

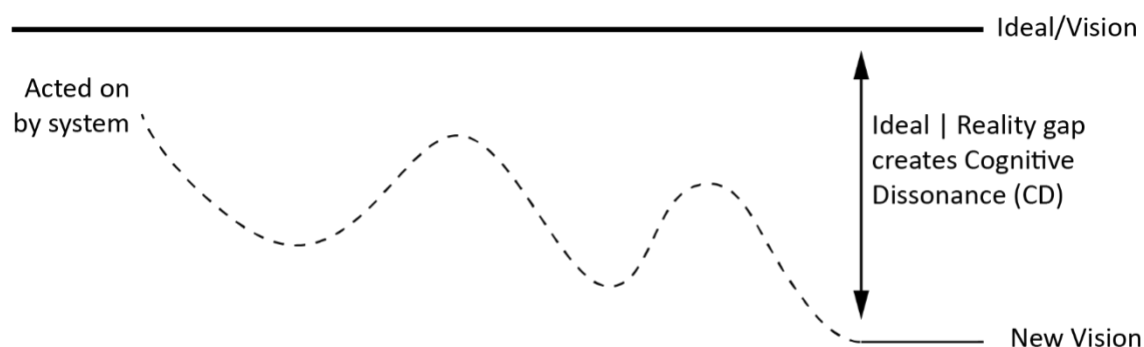
*The Midwives'* sub themes *Torn in Two* and *Being responsible* reflect their cognitive dissonance. Midwives enter the profession with passion strengthened by inspiring midwifery rhetoric upholding choice, control, and women centred care, with reality sometimes leading to disappointment and distress (Kirkham, 2010, Davies and Coldridge, 2018). When needing to cope within workplace pressures such as time and resource limits (Gilson, 2015), public service professionals, termed *street-level bureaucrats* (Lipsky, 1980), exercise discretion about core, complex, policy directed aspects of their work, while responding to the human dimension of situations (Harrison, 2016). The recent NHS move towards more classical bureaucracy has constrained professional discretion (Harrison, 2016), creating a wider ideal/reality gap for midwives. Their sub theme *We cannot control* highlights the dissonance created by feeling responsible to be in control and yet feeling powerless in the face of unfolding childbirth events, colleagues' actions, or the behaviour and demands of women. This echoes the findings of (Thomas, 2006). The presence of senior staff can lead to obedience even when this conflicts with being women-centred (Hollins Martin and Bull, 2010), thus highlighting midwives' tensions between being women centred and conforming to organisational social norms. Furthermore, *The Midwives* strongly expressed collegial and managerial failures to meet NMC requirements to 'be supportive of colleagues who are encountering health or performance problems' (NMC, 2015b), when they referred to the closing down of time back to attend even mandatory training. However, the demand that support must never compromise or be at the expense of patient or public safety (NMC, 2015b), is at best vague and at worst a get out of jail free card, as within the overstretched NHS system with frequent understaffing, providing collegial support may be impossible in the face of just trying to achieve the required tasks to maintain safety.

#### **5.7.2.6. Midwives' responses to the ideal/reality gap**

In the sub themes *Torn in two*, *The pressures we face*, and *Support me*, *The Midwives* cope by withdrawing to protect themselves or focussing on tasks or policies, subsequently compromising their ideals. These findings echo those of midwife Helen Shallow whose recent research showed that cognitive dissonance due to limited time

and resources, and perceived risk to registration, means midwives protect themselves by changing ways of thinking, withdrawing from women, and seeking control by aligning with guidelines, in order to meet their basic human need to feel safe, secure, and happy about their job performance (Shallow et al., 2018, Shallow, 2018b, Shallow, 2018a). Helen’s findings reflect core elements of *street level bureaucracy* (Gilson, 2015). As a way to understand the impact of the organisational context on midwives’ lived experiences of the *ideal/reality gap* and their subsequent behaviour, I created the model as shown in Figure 5.4. It shows that the amount of cognitive dissonance (CD) depends on how far one has to move away from one’s Ideal/Vision to accommodate the influence of the maternity services system. In order to cope, midwives may eventually change their Ideal/Vision, through altering their beliefs or behaviour. Thus, cognitive dissonance is reduced.

**Figure 5.4. Model of Cognitive Dissonance**



To alleviate the unease caused by CD, changed behaviours and changed beliefs are adopted and the subsequent New Vision is a lower expression

#### **5.7.2.7. Consequences for midwives due to the ideal/reality gap**

*The Midwives* expressed a lack of self-esteem with a sense of failing in their role, consistent with findings by (Shallow, 2018b), and midwives’ tendency for self-blame (Kirkham, 2017a). Midwifery culture of service, self-sacrifice, and emotional labour is strongly identified by Pezaro et al. (2016) and reflected in their article title: ‘*Midwives Overboard! Inside their hearts are breaking, their make-up may be flaking but their smile still stays on.*’ Cognitive and emotional dissonance for midwives results in stress (Hunter, 2006, Riley and Weiss, 2016, Delgado et al., 2017) and *guilt that hurts midwives* (Kirkham, 2015a), who then become worn down and experience burnout (Kirkham, 2010, Riley and Weiss, 2016, Delgado et al., 2017, Favrod et al., 2018). The

tragedy is that these outcomes are more likely for committed and caring midwives (Kristjánsson et al., 2017), with a subsequent loss of valuable midwives because they cannot achieve their ideal quality of care (RCM, 2016d, Ball et al., 2003, Curtis et al., 2006, Hawkins-Drew, 2017, Barker, 2016). This reality was underlined when three of *The Midwives* described leaving their job because they could no longer cope.

### 5.7.3. Developing relationship

*'Being with is more than a passive presence, it is an active engagement with the deliberate aim of promoting the woman's power to birth (...) being with is a relational concept.'* (O'Boyle, 2014)

*'The relationship is the conduit through which midwives provide their care, including emotional care.'* (Barker, 2011)

#### 5.7.3.1. Women and midwives shared desire for relationship

Most days humans interact with someone providing a service, such as a bus driver or supermarket checkout operator. Developing relationship is usually unnecessary in these contexts, although polite, professional interaction is generally desirable. Interaction is defined as *reciprocal action or influence*, while relationship is defined as *the way in which two people are connected* (Oxford Dictionary, 2018f, Oxford Dictionary, 2018d). Within connectedness, the demand to know and be known is central for reciprocity (Kirkham, 2010, Campbell, 1984). While reciprocity is a complex issue, closely woven with emotional work/labour, it remains potentially important in the woman/midwife interaction where acknowledgement of the humanity of the other forms a connection from which a reciprocal partnership can exist (Hunter, 2006), and from which relationship might grow. (Table 5.2.)

**Table 5.2. Reciprocity in woman/midwife relationship (adapted from Hunter (2006))**

Type of exchange	Woman	Midwife	Midwifery role	Emotion work
Balanced.	Gives and takes.	Gives and takes.	Legitimated. In control of reciprocal exchange.	Rewarding.
Rejected.	No take, no give back. Unresponsive or hostile.	Gives.	Advice rejected.	Required.
Reversed.	Gives. Attempts to support midwife.	Gives, no take. See's support as inappropriate, over-familiar.	Challenge to midwife's boundaries.	Required.
Unsustainable.	Takes, may give back, wants to take more. Unrealistic expectations of midwife.	Gives. Over involvement.	Challenge to midwife's boundaries.	Considerable work required.

However, reciprocity is not a guaranteed component of the woman/midwife interaction in that both sides do not introduce equal influence (Hunter, 2006). When the weight of power is maintained on the professional side it can drive 'a wedge between the mother midwife relationship' (O'Boyle, 2014). Valuing Care as Gift (section 5.7.2.), is reflected in the shared desire for relationship. The formation of a unique relationship is recognised within the woman/midwife interaction (Lundgren, 2004) and deemed central to midwifery (Barker, 2011, Kirkham, 2010), where meaningful trusting relationships are crucial to positive experiences (Homer et al., 2017, Sandall et al., 2016, Kirkham, 2010). The informants' desires for relationship suggest it is not guaranteed just because interaction takes place and indeed all informants experienced interaction, but not all identified relationship. When positive relationship did occur, all informants expressed joy and satisfaction reflecting its value.

### **5.7.3.2. Women's and midwives' perspectives on relationship**

The shared desire for relationship results in emotional work/labour for women and midwives, which can be experienced as coercive or gift depending on the organisational context (Hunter, 2010). Yet, this relationship, as shown by all the informants, is highly desired and can be extremely rewarding (Thomas, 2006). Women

interact with the *professional* midwife, within whom lies a *human* whose needs may be suppressed during the interaction. While women have a role to play in developing relationship, as expressed by *The Midwives* in the sub theme *Others need to do their bit*, deeper exploration of this is not the focus of this discussion. Rather, with a view to developing recommendations for maternity services the gaze is directed towards midwives.

*'Ticking the boxes and signing the boxes that need to be signed and that's, that's all you can really do you can't, you can't develop relationships with those women at all.'* Brenda (midwife informant) 13:5-8

### **5.7.3.3. The impact on relationship from midwives' emotional labour**

Individual human background, institutional demands, and dissonance generated by conflicting ideologies, all lie at the heart of midwives' emotional labour (Hunter, 2004, Hunter, 2005) and affect midwives' capacities for listening to women and engaging in feelings within their relationships with women (Hochschild, 2012).

Midwives, as humans, experience wide ranging emotions, but socialisation into their workplace involves internalising their organisation's *feeling rules*, often requiring midwives to keep their emotions hidden and present a professional façade (Hochschild, 2012), which as expressed in the sub-theme *Torn in two*, is presented to women, colleagues, and management, and can result in women also suppressing their emotions (Edwards, 2009). As a coping strategy and defence against anxiety (Lythe, 1988), disengagement enables midwives to create a boundary, distancing themselves from both women and colleagues (Edwards, 2009). Referred to by *The Midwives* as *Switching off* and known as '*going into robot*' (Hochschild, 2012), this is widely documented in midwifery literature (Berg et al., 1996, Hunter and Deery, 2009a, Edwards, 2009), and can result in many midwives protecting themselves and appearing to become hardened (Hunter and Deery, 2009a). As noted before, minimum engagement enables smoother running of a highly fragmented NHS, yet disengagement is destructive as it acts against the very relationship that makes kindness possible, and which leads to job satisfaction (Kirkham, 2015b, Thomas, 2006).

#### **5.7.3.4. Managing risk within relationship**

Most midwives provide *Care as Gift* at great cost to themselves within a healthcare system that already demands an impossible, constant level of maximum effort (Kirkham, 2015b, Kirkham, 2018) with minimal resources, especially staffing and consequently time (Mander and BPG, 2018). Having time for positive engaged interactions with women is not valued (Bryson and Deery, 2010) and is a primary factor in midwives' fear of compromised safety due to things being missed and being unable to form relationships with women (Mander and BPG, 2018, Shallow, 2018b). A further emotional burden is clear in *The Midwives* expressed conflict between trying to balance women's desire for shared decision-making with their own perceptions of risk, responsibility, and fear of consequences should an adverse event arise. This either removes the option to share decision-making or leaves midwives reluctant to do so (Healy et al., 2016).

#### **5.7.3.5. The rewards of relationship**

Whilst emotional labour related to conflicting ideologies within midwives' workplaces is demanding and anxiety provoking (Hunter, 2010, Hunter and Deery, 2009a, Shallow, 2018b), there are circumstances in which they can manage their emotions authentically, away from management gaze, which gives rise to positive experiences of emotional labour (Bolton, 2000). *The Midwives* expressed strong positive emotions when they were able to build relationships with women, or felt they made a positive difference to women's experiences, in particular women who were challenging. This echoes the findings of Thomas (2006) that midwives gain satisfaction when able to make a positive difference to women's experiences.

#### **5.7.4. Women's and midwives' shared desire for communication**

*'I feel like listening to what the woman's saying is the very! first! thing that you need to do' Alice (midwife informant) 3:9-12*

*'the worst thing about the entire experience, is that there frequently seemed to be hours, or half of days on end, with absolutely no communication' Valerie (woman informant) 4:3-5*



Like relationship, good communication was strongly desired by all informants. Whilst this mainly related to the effective imparting of information to enable informed care and consent, the way of communicating was critical, in particular for *The Women*.

#### **5.7.4.1. *The Women's desires for communication***

Women's desires for good communication are well recognised (Kirkham, 1993), and *The Women's* desires not only for effective communication of information but high-quality communication, reflects findings that women's perceptions of a good midwife are based on both the effectiveness *and* quality of their communication skills (Nicholls and Webb, 2006). Both features are promoted by the NMC (NMC, 2015b) and NICE guidelines (NICE, 2017) that emphasise good communication and respect, particularly in terms of words and behaviour, and note the impact on psychological outcomes. Mobbs et al. (2018) highlight the impact of language on psychological outcomes and subsequent physical outcomes. In addition to effective sharing of information, active listening from midwives is important for women as is the use of non-verbal communication, including tone of voice (Barker, 2011, Price, 2013, NMC, 2015b).

#### **5.7.4.2. *The Midwives' desires for communication***

Listening was emphasised by all *The Midwives* as probably the most important feature of their interaction with women. Active listening enables understanding of the individual and facilitates an appropriate response (Therpe, 2016). Alongside listening, *The Midwives* valued *chatting*. Chatting has been identified as a way of midwives giving emotional support to women (Bone, 2009, John and Parsons, 2006) and has been labelled as Phatic communication, where the language is free and aimless yet facilitates connection (Coupland et al., 1992) and the building of rapport (John and Parsons, 2006). Mehrabian's interpretative theory tells us that the percentage of value one attaches to different forms of communication is: words 7%, tone and delivery 38%, and facial expression 55% (Whitley-Hunter, 2014). In keeping with this, non-verbal communication and especially *huffing* and disapproving tone, fuelled *The Women's* perceptions of negative attitudes from midwives. For midwives, being able to adjust one's words through interpreting the non-verbal response of women, as described by Fogel's co-regulation theory (Fogel, 1993), further validates non-verbal

communication as a critical nursing skill (Whitley-Hunter, 2014). *The Midwives* often found this challenging, especially when trying to discern if a woman was coping in her *labour zone* or was isolated and desiring engagement.

#### **5.7.4.3. The role of TA in communication**

TA takes account of all that has been discussed above in terms of individual humanity, life experience, relationships, cognitive dissonance, and emotional labour. These features can mean women and midwives are often unable to engage in optimal verbal and non-verbal communication, yet sometimes it is up to midwives to have the tools to manage their emotions and adjust to the woman's mindset (Whitley-Hunter, 2014). Understanding the principles of TA may optimise midwives' abilities to recognise a person's ego, state of mind, and body language, thus improving their communication with women and colleagues.

#### **5.7.5. Where does the reasonable person model fit in?**

For all informants, the environment of their experience was an NHS consultant led maternity unit. Many organisational factors impact on the cognitive and emotional experiences of human beings within the environment. Of the three categories of informational needs (Box 5.14. section 5.6.2.3.), basic survival as a labouring woman or overstretched midwife, demands an ability to *make sense* of the information available, in the associated context. When an *ideal/reality gap* exists within the circumstances of childbirth or the maternity services, the resulting negative emotions and helplessness challenge one's ability to remain reasonable. This human shift to being unreasonable was reflected in *The Women's* perceptions of midwives' *negative attitudes*, or *The Midwives'* perceptions of *unrealistic demands* by women, with an associated loss of trust between both sides. Taking account of dissonance and emotional labour experienced by women and midwives, this model shows that becoming unreasonable is in fact a reasonable outcome. The study themes *trust*, *negative attitudes*, and *unrealistic expectations* can be seen as appropriate human responses within an environment that fails to meet basic human informational needs.

### 5.7.6. Summary of discussion of the key findings

The human reality for women and midwives while seemingly basic knowledge, is in fact essential to consider, encompassing inherent influences from an interplay between pre-existing and current social, personal, and organisational factors. This common human background is often unacknowledged, with midwives' needs being overlooked, and calls exist across the NHS for the consideration of the humanity of patients and staff to be central. While within the woman/midwife interaction a power imbalance exists, with the weight of power most often, but not always falling towards midwives. Yet, women need midwives, more than midwives need women. Women are in a state of vulnerability and require care. Midwives only *need* women in the sense that they cannot provide their role without them, with this need being more a professional directive to fulfil their role appropriately and safely. This was strongly expressed by *The Midwives'*. Dealing with the ideal/reality gap features for both women and midwives and while sources of dissonance vary, the conflicting ideology between viewing midwifery as a *Vigil of Care* or *Care as Gift* appears particularly relevant to QPI. The informants' strong desires for relationship, encompassing connection and reciprocity, reflect a wish to receive and provide *Care as Gift*. Living out this relationship creates emotional work/labour, in particular for midwives in the context of conflicting ideologies, management of risk, and organisational agendas. The shared desired for positive *way* of effective communication, was expressed by *The Women* who sought a positive attitude, and *The Midwives* who value active listening and the role of *chatting*. Systemic pressures and lack of support leave midwives burned out and fearful for their registration, causing them to disengage from relationship in order to cope. Consequently, QPI, relationship, and communication with women can be negatively impacted leading to trauma and PTSD-PC.

## Chapter Six

### Recommendations from the study findings

## **6.1. Introduction to the recommendations**

The recommendations were developed in consideration of the literature review, the study findings, and the discussion. They are presented in 2 parts (Box 6.1.). As discussed in section 5.3.2.5., while this IPA study of 12 self-selected and fairly homogenous informants has limitations, the strength of the idiographic depth of exploration into the particular provides valuable insight into the whole. Considering this alongside: the finding that interpersonal factors and QPI are significantly correlated with the development of PTSD-PC; the identified key convergent findings are consistent with wider research in terms of the needs of midwives and childbearing women; and the face validity gained from dissemination and public engagement regarding study findings; there are potential considerations and recommendations for maternity services. Grounded on this, the argument for key considerations and recommendations within maternity services is now presented.

### **Box 6.1. The presentation of the recommendations**

- **Part 1: Developing the recommendations**  
Section 6.2. Considerations to be addressed by the maternity services
- **Part 2: The recommendations**  
Section 6.3. Recommendations to address the considerations presented in Part 1

## **Part 1: Developing the recommendations**

### **6.2. Considerations to be addressed by the maternity services**

Perinatal mental health policies and research primarily focus on identification, assessment, and treatment as ways of preventing perinatal mental illness (RCOG, 2017, Galloway and Hogg, 2015), and are primarily focussed on women's pre-dispositions or reactions. The literature review and study show that they must also focus on the direct actions or inactions of midwives and other maternity services staff during their interactions with women. In other words, to reduce women's negative perceptions of QPI and subsequent PTSD-PC, a mirror must be held up to maternity services and staff to enable honest reflection on their role within these perceptions. *The Midwives* narratives provide some reflection and show that maternity services need to meet midwives' needs in order to meet those of women. This includes the

promotion and safeguarding of connected relationship and positive communication between women and midwives. To activate this shift, there exist four considerations (Box 6.2.). The argument for each consideration is now presented.

**Box 6.2. Considerations to be addressed by the maternity services**

**Consideration 1: The prevention of psychological harm must be prioritised within maternity services.**

- *Iatrogenic psychological harm must be avoided.*
- *Equal status must be accorded to both psychological and physical wellbeing.*
- All women must be assumed to be at risk of psychological harm.
- The woman/midwife relationship must be protected

**Consideration 2: Interpersonal skills are not nice extras but are fundamental**

- Good interpersonal skills are not nice extras.
- Good interpersonal skills include compassion, empathy, and ultimately love.
- Emotional Intelligence is a foundation from which interpersonal skills can be developed and maintained.

**Consideration 3: A woman-centred service requires a midwife-centred organisation.**

- Midwives' needs must be met before they attend to women.
- Midwives' prior history and humanity must be acknowledged.

**Consideration 4: A toxic culture undermines maternity services and QPI. It should not be tolerated.**

- The presence of a toxic culture
- The organisational responsibility for tackling this toxic culture.
- There should be zero tolerance towards individuals who persist in perpetuating it.

**6.2.1. Consideration 1: The prevention of psychological harm must be prioritised within maternity services.**

*'First do no harm'* [Hippocrates of Kos c 460 B.C.](#)

**6.2.1.1. Iatrogenic psychological harm must be avoided.**

Failing to optimise the emotional wellbeing of women during childbirth potentially disturbs the intricate physiological process. Feeling unsafe can inhibit the childbirth process ([Buckley, 2009](#), [Anderson, 2002](#)), thereby increasing obstetric intervention ([Buckley, 2009](#), [Uvnas-Moberg, 2011](#)) and the risk of physical and psychological morbidity ([Uvnas-Moberg, 2015](#), [Mobbs et al., 2018](#)). The consequences were evident in the *The Women's* narratives. Neglecting the emotional and psychological wellbeing

of midwives may result in sub-optimal QPI and associated psychological harm in women. Thus, the understanding that *doing no harm* to women and staff is key to safer maternity services (Prochaska, 2015) must include psychological harm, in keeping with NHS Scotland's quality ambition: *Safe - there will be no avoidable injury or harm to people from healthcare they receive* (NHS Scotland, 2010). The literature review and *The Women's* data showed that development of PTSD-PC is associated with poor QPI. As such, PTSD-PC could be considered a result of *harm* or *injury* rather than *disorder*. *Injury* acknowledges extrinsic contributing factors, thus removing *blame* or *responsibility* from women. *Injury* highlights inherent responsibilities of maternity services to avoid both psychological and physical harm. It is suggested that PTS symptoms following childbirth should be named Post Traumatic Stress Injury (PTSI-PC), in keeping with calls regarding general PTSD (PTSiNJURY, 2018).

#### **6.2.1.2. Equal status must be accorded to both psychological and physical wellbeing**

The increased recognition of the importance of maternal mental health (WHO, 2017) is reflected in the Lancet series on midwifery, which suggest it is not a question of mortality *versus* health and wellbeing, but mortality *and* health and wellbeing (Renfrew, 2016, Homer et al., 2014). The *Vigil of Care* approach and *The Midwives'* sub themes *Torn in Two* and *Being responsible*, reflect the prime drive toward optimal physical outcomes. Full recognition of the role of psychological wellbeing in overall outcomes is necessary to provide the incentive to reduce psychological harm.

#### **6.2.1.3. All women must be assumed to be at risk of psychological harm.**

To optimise women's outcomes, effectively identifying women at risk of developing PTSD-PC (Simpson et al., 2018) is necessary, but not sufficient. This thesis shows that women with no known pre-existing risk factors can develop PTSD-PC. A key aspect of trauma is the shattering of one's world view (Janoff-Bulman, 1992). Prior trauma can predispose women to anxiety or fear of a negative experience, a subsequent negative experience would confirm rather than shatter their world views. Conversely, as for *The Women*, an expectation of good care, or that hospital is a safe place may predispose to one's world view being shattered, when the perceived reality differs. Contrary to the belief that women are traumatised by a shattering of unrealistic expectations

regarding childbirth (Kirkham, 2017a). *The Women* experienced this *shattering* from a shocking reality of negative QPI, contrasting an anticipated positive and caring QPI.

Assessing risk factors relies on disclosure from women, yet Birthrights uphold that women should not need to disclose prior trauma (Schiller, 2017). Also, women may be unaware of prior trauma such as CSA or choose not to disclose through fear and lack of trust in others, including health professionals (Montgomery et al., 2015, SafetoSay, 2018). Furthermore, optimal QPI has been shown to reduce the development of PTSD-PC in high risk women (McKenzie-McHarg et al., 2014, Garthus-Niegel et al., 2013), and so would likely benefit women perceived as low risk. Since women's risk factors may be unknown, and optimal care pathways can mitigate risk, treating all women as if they are at risk is good practice, in keeping with the call by (Beck, 2004a). Thus, optimal QPI is not just *a nice extra*.

#### **6.2.1.4. The woman/midwife relationship must be protected**

The practice of moving midwives on to the next labouring women as soon as the physical birth process is complete, interrupts their vital relationship and is described as *the worst* by both groups (Chapter 4, section 4.4.3.1.4.), This point was also emphasised during the public engagement workshops, where enactment of this separation triggered strong emotional distress in women, and despair in midwives. While this appears to make best use of limited resources, long-term implications for maternity services exist, related to poor psychological consequences for women (PTSD-PC) and midwives (distress, leaving the profession). This practice reflects the prioritisation of physical wellbeing and fails to acknowledge the impact on psychological wellbeing. Furthermore, evidence suggests that the protected skin-to-skin hour between mother and baby directly after birth (magical hour) reduces the risk of developing PTSD-PC following a traumatic childbirth (Abdollahpour et al., 2016). Acknowledgment of the important status of psychological wellbeing determines the early postpartum period as an intrinsic component of the childbirth process, within which the continued presence of the midwife is necessary. The recent maternity services strategies, *Better Births* (NHS England, 2016a) and *The Best Start* (Scottish Government, 2017), hold potential to address this situation, but without consideration



of midwives' needs (consideration 3) these strategies and their subsequent policies may fail.

#### **6.2.1.5. Summary of consideration 1**

Failing to optimise psychological wellbeing can result in poorer labour progress, subsequent obstetric interventions, with risk to both physical and psychological wellbeing. To *first do no harm*, the status of psychological wellbeing must be raised alongside physical wellbeing. All women should be treated as though they are at risk of poor psychological outcomes, as it will not always be possible to identify those at risk, although this should always be attempted. As a means of protecting women's psychological wellbeing, positive, supportive relationships with midwives must be prioritised and safeguarded.

#### **6.2.2. Consideration 2: Interpersonal skills are not nice extras but are fundamental**

*'The Wind and the Sun were disputing which was the stronger. Suddenly they saw a traveller coming down the road, and the Sun said: "I see a way to decide our dispute. Whichever of us can cause that traveller to take off his cloak shall be regarded as the stronger, you begin." So, the Sun retired behind a cloud, and the Wind began to blow as hard as it could upon the traveller. But the harder he blew the more closely did the traveller wrap his cloak round him, till at last the Wind had to give up in despair. Then the Sun came out and shone in all his glory upon the traveller, who soon found it too hot to walk with his cloak on.'*

*'Kindness effects more than severity.'*

Aesop's Fables (6<sup>th</sup> century B.C.) ([Simondi, 2013](#))

##### **6.2.2.1. Good interpersonal skills are not nice extras**

Wagner (2001) warned that calls to improve midwifery care quality through kindness or compassion are commendable, but these qualities must not be seen as nice extra's or above and beyond what is essential. [Stones and Arulkumaran \(2014\) p.1169](#) echoed this in his comments on the Lancet series on midwifery, hoping that the identified '*blind-spot* of respectful care would be taken seriously by those *designing and*

*commissioning services*, and not seen as an *optional extra*'. Furthermore, Mary Renfrew suggested that overlooking care and compassion is integral to system failure (Renfrew, 2016). Care goes beyond clinical skills that maintain safety, to engaging the holistic, intuitive skills that ensure the essential positive components of staff behaviour, attitudes, and quality relationships with women (Beattie et al., 2013). The NMC guidance for intrapartum care refers to *care* as a noun and a verb and highlights the *way* of care as being important alongside the *what* of care, including respect and awareness of one's tone, demeanour and language (NMC, 2015b). Definitions of caring clearly incorporate kindness, concern, and emotional support, as distinct from functional, practical care (Box 6.3.).

#### Box 6.3. Definitions of caring

1. Displaying kindness and concern for other (Oxford Dictionary 2018)
2. A caring person is kind and gives emotional support to others (Cambridge Dictionary 2018)
3. Feeling or showing concern for or kindness to others (Merriam-Webster 2018)
4. if someone is caring they are affectionate, helpful and sympathetic (Collins Dictionary 2018)

In 2010, NHS Scotland prioritised compassionate person-centred care, and recognised the correlation of staff experience and wellness, with patients' experiences and outcomes (Box 6.4.) (NHS Scotland, 2010, Beattie et al., 2013).

#### Box 6.4. Priorities and ambitions of NHS Scotland Healthcare Quality Strategy (NHS Scotland, 2010)

##### Peoples priorities

**Caring** and **compassionate** staff and services

Clear **communication** and explanation about conditions and treatment

Effective **collaboration** between clinicians, patients and others

A **clean** and safe care environment

**Continuity** of care

**Clinical** excellence

##### The Quality Ambitions

**Person centred:** Mutually beneficial partnerships between patients, their families and those delivering healthcare services that respect individual needs and values, and that demonstrate compassion, continuity, clear communication and shared decision-making

**Safe:** There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

**Effective:** The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

The holistic and intuitive aspects of caring form the basis of perceived care quality but are difficult to measure. A patient-centred approach that focusses on patient involvement rather than QPI, risks marginalising essential components of staff behaviour, attitudes, and relationships with service users (Beattie et al., 2013). These essential components are reflected in Carl Roger’s person-centred approach (Box 6.5.).

**Box 6.5. Carl Roger’s person-centred care**

**Three qualities** (Paradice, 2002)

unconditional positive regard, empathy, congruence

**Four principles** (The Health Foundation, 2016)

Care is personalised and coordinated

Care enables the person to be treated with dignity, compassion, and respect

Unfortunately, the *Person-Centred* strand of the Scottish Patient Safety Programme’s (SPSP) Maternity and Children Quality Improvement Collaborative (MCQIC) launched in 2013 (MCQIC, 2013a), was reduced to a *supplementary* measure, in favour of identified physical health priorities following their 2017 review (MCQIC, 2013b). In other words, limited resources to attain and maintain physical safety drive the focus away from the lesser valued holistic and intuitive measures of caring and relationship, potentially compromising psychological safety. Linking to consideration 1.

**6.2.2.2. Good interpersonal skills include compassion, empathy, and ultimately love.**

In 2015, the book *Roar Behind the Silence* (Byrom and Downe, 2015), roared across social media and the childbirth world. It explores women’s and care provider’s desires, emphasising the need for interpersonal skills including compassion, kindness, and respect, which are all upheld by the NMC (NMC, 2015b). An overview of interpersonal skills considered fundamental for positive QPI, the *How* or *Gift* of care, is now presented.

**6.2.2.2.1. Compassion**

The *Compassion in Practice* strategy (DoH, 2012) (Chapter 5, section 5.1.4.), aimed to build a culture of compassionate care in nursing, midwifery and care staff, calling for

recruitment in line with the 6C's (Table 6.1.). Distinct from empathy, compassion encompasses both sympathy and sorrow, and a clear *desire to act*, with *pity* considered a component (Box 6.6.). Although, Michael West (The King's Fund) defines compassion as meaning to '*Listen with fascination, understand the cause of distress, empathise with the cause of distress, do something thoughtful and appropriate.*' (West, 2016), which closely resembles the definition of empathy proposed by Krznaric (2015) (Box 6.7.).

**Table 6.1. The 6C's (DoH, 2012)**

<b>Care</b>	Care is our core business and that of our organisations, and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them, consistently, throughout every stage of their life.
<b>Compassion</b>	Compassion is how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness and is central to how people perceive their care.
<b>Competence</b>	Competence means all those in caring roles must have the ability to understand an individual's health and social needs and the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.
<b>Communication</b>	Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do and essential for 'no decision about me without me'. Communication is the key to a good workplace with benefits for those in our care and staff alike.
<b>Courage</b>	Courage enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working.
<b>Commitment</b>	A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients, to take action to make this vision and strategy a reality for all and meet the health, care and support challenges ahead.

Of direct interest in midwifery is the link between showing or receiving compassion, and oxytocin secretion (Keltner, 2010, Keltner, 2012). Childbirth physiology is orchestrated by the optimal release of oxytocin (Buckley, 2009, Uvnas-Moberg, 2011), therefore compassion is a vital component of midwifery care for both psychological and physical wellbeing and outcomes. Linking with consideration 1.

#### Box 6.6. Definitions of compassion

1. Sympathetic pity and concern for the sufferings or misfortunes of others ([Oxford Dictionary, 2018a](#)).
2. A strong feeling of sympathy and sadness for the suffering or bad luck of others and a wish to help them ([Cambridge Dictionary, 2018a](#)).
3. Sympathetic consciousness of another's distress together with a desire to alleviate it ([Merriam-Webster Dictionary, 2018](#)).
4. Compassion means to *suffer together* the feeling that arises when confronted with another's suffering and feel motivated to relieve that suffering ([Greater Good Magazine, 2018a](#)).
5. A sensitivity to the suffering of self and others, with a deep commitment to try to relive and prevent it' ([Gilbert, 2015](#)) (from Chapter 1)

#### 6.2.2.2. Empathy

*The Midwives* express empathy through trying to connect with women by remembering themselves during childbirth. Roman Krznaric defines Empathy as *the art of stepping imaginatively into the shoes of another person, understanding their feelings and perspectives, and using that understanding to guide your actions* ([Krznaric, 2015](#)) which like definition 4 (Box 6.7.) suggests an active component.

#### Box 6.7. Definitions of empathy

1. The ability to share someone else's feelings or experiences by imagining what it would be like to be in that person's situation ([Cambridge Dictionary, 2018b](#)).
2. The ability to understand and share the feelings of another. Note they differentiate between empathy and sympathy, in that sympathy has feelings of pity and sorrow for misfortune ([Oxford Dictionary, 2018b](#)).
3. The action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experiences fully communicated in an objectively explicit manner; also: the capacity for this ([Merriam-Webster, 2018a](#)).
4. Having empathy doesn't necessarily mean we'll want to help someone in need, though it's often a vital first step ([Greater Good Magazine, 2018b](#)).

Paul Bloom argues against empathy, not in terms of the social intelligence of understanding others and getting into their heads, but that feeling what you think others feel is different from being compassionate, kind, or good. He suggests that real distinctively human action exists in our capacity to override gut feelings and to think through issues, creating the potential to be better to one another (Bloom, 2017). Often midwives speak of *not gelling* with women or colleagues. The ability to override that *feeling* might be an important skill to enable positive QPI regardless of whom one is

interacting with. This may further enable midwives to avoid personal risk from empathic identification (Leinweber and Rowe, 2010).

#### 6.2.2.2.3. Kindness and respect

Following an accident, Peter Levine considered having his hand held to be an ‘act of kindness’ that enabled him to feel emotionally supported, process the trauma, and avoid developing PTSD (Levine, 2010). Definitions of *kind* or *kindness* (Box 6.8a.) and *respect* (Box 6.8b.) somewhat overlap, and definition 3 for respect incorporates kindness and care.

##### **Box 6.8a. Definitions of kindness**

1. The quality of being friendly, generous and considerate (Oxford Dictionary, 2018c).
2. The quality of being gentle, caring and helpful. Synonyms goodwill, understanding, charity and grace (Collins Dictionary, 2018a).
3. The quality or state of being kind (Merriam-Webster, 2018b, Cambridge Dictionary, 2018c).

##### **Box 6.8b. Definitions of respect**

1. Due regard for the feelings, wishes, or rights of others (Oxford Dictionary, 2018e).
2. If you respect someone’s else wishes, rights or custom, you avoid doing things they would dislike or regard as wrong (Collins Dictionary, 2018b).
3. An act of giving particular attention (Merriam-Webster, 2018c).
4. To treat someone with kindness and care. To accept the importance of someone’s rights or customs and to do nothing that would harm them or cause offence (Cambridge Dictionary, 2018d).

Note that midwifery regulations call for midwives to prioritise people and to always treat them with kindness, respect, and compassion (NMC, 2015b).

#### 6.2.2.2.4. A word about love

*‘Some people consider the practice of love and compassion is only related to religious practice and if they are not interested in religion they neglect these inner values. But love and compassion are qualities that human beings require just to live together.’ (Dalai-Lama, 2018)*

Care, compassion, empathy, kindness, and respect are all acceptable mainstream words, but one powerful four-letter word is rarely used within healthcare, perhaps because it is deemed *unprofessional*?

### *Love*

A deeply scientific basis exists for why love matters (Gerhardt, 2004). The passionate worldwide popularity of the BBC series *Call the midwife* has been put down to the core theme of love, following several conversations with UK medical and midwifery staff (McGann, 2017). Theologians consider professional care to be a form of love, which entails personal commitment, not entirely encapsulated by the contract of care (Campbell, 1984). Sue Barker, in her research of midwives' emotional care of women, wrote at length about the love component, highlighting that unique to midwifery, care is a form of *moderated love* or *loving relationship* (Barker, 2011).

#### **6.2.2.3. Emotional Intelligence is a foundation from which interpersonal skills can be developed and maintained.**

*'Emotional intelligence refers to an ability to recognize the meanings of emotion and their relationships, and to reason and problem-solve on the basis of them. Emotional intelligence is involved in the capacity to perceive emotions, assimilate emotion-related feelings, understand the information of those emotions, and manage them.'* (Mayer et al., 1999)

People vary in their ability to appreciate the subtler versions of emotional communication (University of New Hampshire, 2017). Emotional Intelligence (EI) is the ability to recognise our emotions and those of others, to manage these effectively in our interactions, and maintain the capacity to perform optimally (Patterson and Begley, 2011). First described by Mayer et al. (1999), its profile was raised by Goleman (1996). Four branches of EI provide the building blocks for interpersonal and communication skills (Table 6.2.). Further areas of reasoning within these branches have been recently added (Mayer et al., 2016).

**Table 6.2. Salovey and Mayer model of EI (Whitley-Hunter, 2014)**

Perceive	Most essential. Relates to receptiveness of non-verbal communication, expression of emotion.
Use	Capacity to allow emotions to enter and guide the cognitive system to prioritise a creative emotional response towards matters of importance: emotions convey information.
Understand	Capability to read the message associated with the actions and determines the best course to manage the overloaded emotional situation.
Manage	Recognises emotional signals and decipher the information to maintain self-regulation within a person's personal comfort zone.

David Goleman's model of EI (Goleman, 2004) promotes five key components: self-awareness, self-regulation, motivation, empathy, and social skill. In the general workplace, people are now being measured on how well they handle themselves and each other as well as workplace expertise and skills, with emotional competencies being twice as important as intellect and expertise (Goleman, 2004). Within healthcare, EI is now viewed as an undeniable technical skill and critical in nursing (Whitley-Hunter, 2014). EI has evolved from *nice to have* to *need to have*, regarding improvement in patient (Stanton and Douglas, 2010). EI fosters the ability to focus on and engage fully with a patient and provide an emotionally intelligent response, the lack of which impacts on clinical care quality, decision making, and care outcomes (Whitley-Hunter, 2014, Patterson and Begley, 2011).

Thus, EI can provide midwives with emotional tools for self-care within a pressured environment, to manage emotional labour and cognitive dissonance, and to cope with bullying (Patterson and Begley, 2011). Whitley-Hunter (2014) considers the foundation skill of empathy to be a main constituent of EI, noting it is typically taught to nursing students. However, empathy may be a risk factor for secondary or vicarious trauma in midwives (Leinweber and Rowe, 2010). Ongoing research suggests that for midwives, the negative correlation between empathy and resilience, and the risk of PTSD symptoms are reduced with high EI (Nightingale et al., 2018).

#### **6.2.2.4. Summary of consideration 2**

The quality of QPI is integral to safe care, not a *nice extra*. The holistic and intuitive aspects of *caring* form the basis of perceived care quality and encompass a range of interpersonal skills including compassion, empathy, kindness, respect and love.



Emotional intelligence, now highly valued in healthcare, forms the foundation from which these skills can be developed and provide maternity care staff with essential emotional tools.

### **6.2.3. Consideration 3: A woman-centred service requires a midwife-centred organisation.**

*'Charity begins at home'* [Proverb](#)

#### **6.2.3.1. Midwives needs must be met before they attend to women**

This section considers why the maternity services first responsibility is for the needs of their own staff.

##### 6.2.3.1.1. Introduction with a personal reflection

As a mother, contrary to accepted norms, I learned to put myself first, my relationship with my children's father next, then consider our children ([Biddulph, 1997](#)). Shocking as this seems, the logic is strong. If the mother is well in mind and body and if the relationship that forms the foundation of the family home is healthy, then children can flourish. Therefore, like the call to attach one's own oxygen mask before helping others, in an emergency aircraft situation, midwives' needs must be met before attending to women.

##### 6.2.3.1.2. Why the focus is not on improving midwives

Rigorous guidelines and threat of disciplinary action are potentially counterproductive and doomed to fail if midwives' needs are not recognised and met. Human Factors refers to processes, devices, and systems designed to support caregivers to improve safety, efficiency, and effectiveness ([Medstar Health, 2018](#)). Human Factors aim to recognise and mitigate for natural human error ([NHS England, 2013](#)). While Human Factors have potential to improve the working environment, midwives can be seen as cogs in a big machine, an observation shared by [Kirkham \(2015b\)](#) who feels that viewed as *cogs* rather than people, midwives are treated unkindly. For example, the increased use of documentation lamented by all the informants as *ticking boxes*, is a

Human Factors approach to reducing error (McGuire, 2018). The study suggests *ticking boxes* is of questionable value, due to the direct negative impact on the highly desired midwife-woman relationship.

#### 6.2.3.1.3. Putting midwives first

DoH (1993) initiated a shift in priority towards women's needs, further emphasised in various UK Government and midwifery policy documents (DoH, 2004, ICM, 2006, NMC, 2015b), and most recently reflected in the *Better Births* and *The Best Start* strategies. The Lancet series on midwifery calls for a system that meets the needs of women and babies first (Renfrew et al., 2014). However, Cathy Warwick, as Chief Executive of the Royal College of Midwives, stated '*We need active committed midwives, supporting each other, centred on women.*' (Warwick, 2016). Cathy's reference to midwives *supporting each other* alongside reflection on the humanity of midwives (Chapter 5, section 5.7.), suggests that to get it right for women we must first get it right for midwives. Michael West when reflecting on the launch of the RCM Caring for You Campaign reinforced this view: '*If we want to treat women with compassion, respect, and dignity we need to treat the staff like this too.*' (West, 2016, RCM, 2018). Thus, the tenet *first do no harm* must be applied to the cultural and systemic treatment of midwives.

#### 6.2.3.1.4. Why the focus is not on improving women

*The Midwives* sub theme *Others need to do their bit* suggests women need to improve and that women should be educated and prepared to have realistic expectations of QPI and childbirth, thus reducing their ideal/reality gap. Yet, beginning motherhood from a strong, capable place may require women to have high expectations along with help to achieve this, and so the problem may not lay with women's expectations, but in a standardised system that does not encourage midwives to support the visions and voices of women (Kirkham, 2017a). Furthermore, lowering women's expectations of QPI or care quality may increase anxiety and fear, and lead them to reject services (Feeley and Thomson, 2016). While *Better Births* (NHS England, 2016a) and *The Best Start* (Scottish Government, 2017) strategies reflect a shift at NHS and government level towards prioritising women and continuity of care, without a shift towards

addressing midwives needs through a midwife-centred organisation, shorter term solutions are unlikely to sustain midwives for long.

### **6.2.3.2. Midwives' prior history and humanity must be acknowledged.**

*'Yet whilst people do bad things they are not necessarily bad people'*

(Pezaro, 2017)

Placing oneself in the hands of health professionals requires trust. Yet, as discussed much of what happens in childbirth is out with anyone's control, including midwives. Henry Marsh in his astonishing book reflecting on life as a brain surgeon, notes that being human means mistakes are inevitable. Learning to be objective at the same time as maintaining one's humanity, seeking the balance between detachment and compassion, hope and realism, are all necessary (Marsh, 2014). As *The Midwives* described, their many responsibilities (Box 6.9.) exist in a pressured, emotionally charged, and challenging environment.

#### **Box 6.9. Midwives responsibilities (NMC, 2015, NICE, 2017)**

- Maintain a professional demeanour.
- Communicate effectively.
- Provide optimal clinical care and judgement.
- Be respectful and compassionate.
- Engage positively and effectively with other care providers in a multi-disciplinary context.

*The Midwives'* narratives alongside discussion in Chapter 5, sections 5.6. and 5.7., highlight the need for maternity services to recognise that midwives, like women do not begin from a blank canvas, they are not programmable robots, but are human beings with a background story. Negative QPI may result from an inability to deal with emotional and sexual aspects of childbirth, personal unresolved trauma, or professional burnout (Fernández, 2013). The human background, personality, and lived experience of each midwife matters and must be embraced, respected, and supported to enable her to provide optimal QPI. When midwives are recruited and educated with a view to developing the necessary abilities as promoted above by Marsh (2014), there is hope of embracing the humanity of midwives and working together to optimise QPI.

Midwives would be enabled to find the necessary balance, rather than react out of a place that leaves them afraid and vulnerable, and unable to interact optimally.

#### 6.2.3.2.1. Human rights for midwives

Much focus is rightly placed upon upholding women's human rights in childbirth (Birthrights, 2018, BIHR, 2016). However, the treatment of midwives often falls far below the call by Emmanuel Kant to '*Treat humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means.*' (Kerstein, 2009). To meet this directive, it is essential to uphold midwives' human rights, failing to do so contributes to poor QPI and a *toxic* culture in maternity services.

#### **6.2.3.3. Summary of consideration 3**

The priority of the maternity services is not to alter women's expectations, but to optimise the holistic wellbeing of midwives through acknowledging the human issues that impact on them, rather than increasing systemic processes under they become buried. Placing midwives psychological and emotional wellbeing at the heart of maternity services will enable them to provide optimal QPI.

#### **6.2.4. Consideration 4: A toxic culture undermines maternity services and QPI. It should not be tolerated.**

##### **6.2.4.1. The presence of a toxic culture**

While considering that midwives needs must be put first, it is essential to also recognise when negative behaviour by midwives and other staff creates harm and detriment to colleagues and service users. A policy of caring for midwives must never condone this toxic and damaging behaviour. This is now discussed.

##### 6.2.4.1.1. Acknowledging the primarily positive culture of midwifery

As shown by the literature review most women perceive QPI positively and do not develop PTSD-PC. This is testament to powerful work by many midwives, often to the detriment of their own lives and wellbeing (Pezaro et al., 2016, Edwards et al., 2016,

RCM, 2016a). This dedication and commitment must be recognised, supported, and built upon. Nevertheless, a darker side of midwifery must be acknowledged.

#### 6.2.4.1.2. The dark side of midwifery services organisation

It is argued that midwifery in the UK exists within a toxic and broken system (Edwards et al., 2011), which continues to erase midwives' commitment to work in equal partnership with women (Kirkham, 2010). The vision and rhetoric in midwifery continues to uphold the centrality of the woman/midwife relationship (Edwards et al., 2018), further strengthened by recent government reviews (NHS England, 2016b, Scottish Government, 2017), and midwifery professional bodies (NMC, 2015b, ICM, 2017, RCM, 2016b). Yet, women and midwives currently engage within the context of a *Business Model* or *Vigil of Care* approach (Kirkham, 2018), within which multiple obstacles to positive QPI exist (Edwards et al., 2018, Mander and Murphy-Lawless, 2013), consider the accepted *usual view* of how maternity care is offered or could be improved, to be a product of many levels of policy, monitoring, and regulation that represent the attempts through Human Factors to reduce error. The 2012 Health and Social Care Act reduced focus on relationship and commitment, in the name of efficiency, adversely affecting maternity care (Mander and BPG, 2018). Yet, alongside the drive towards ever-greater efficiency (Kirkham, 2017b), the result is that the focus is on scientific institutional discourse, rather than seeing women and midwives as partners in care (Mander and Murphy-Lawless, 2013). The NMC's requirement to *prioritise people* and all that this represents, is unrealistic in the current toxic culture and a resource stretched NHS, particularly with regard to staffing and time (Mander and BPG, 2018). Just as *The Midwives* expressed, and recent midwifery surveys have identified (Edwards et al., 2018, RCM, 2016a), NHS midwives are being torn apart (Kirkham, 2017a).

#### 6.2.4.1.3. The impact of a toxic culture of midwifery

There exist a small minority of midwives, as described by the informants and observed in my practice, whose interpersonal behaviours and attitudes are potentially detrimental to women and colleagues. The converse to consideration 3, is that the lack of a midwife-centred system and associated neglect of midwives' needs, risk the

development of *Worn-Down* midwives, and a negative impact on their interactions with women and colleagues. Nevertheless, some midwives seem to be uncommitted to positive QPI or women-centred care, I will refer to these midwives as *Awry* midwives. Negative interactions with colleagues featured in all *The Midwives* narratives, especially in the sub themes *Others need do their bit* and *Support me*. This impacted on their functioning both practically and emotionally, and QPI. The *toxic* and *broken* system contributes to bullying (Kirkham, 2017a, Hughes, 2017), which continues to be a serious issue within maternity services (RCM, 2016d), reflected in *The Midwives'* narratives. As discussed, midwives often prioritise obeying senior staff, over and against being women-centred (Hollins Martin and Bull, 2010), which potentially breaches NMC regulation to make the woman the primary focus (NMC, 2015b). While calls exist for bullying and undermining to be addressed (RCOG/RCM, 2015), this negative behaviour by some midwives and midwifery managers, has persisted unchallenged for many years (Hughes, 2017).

#### **6.2.4.2. The organisational responsibility for tackling this toxic culture**

Moving towards a midwife-centred system in which midwives can master interpersonal skills and optimise QPI, requires eradication of this toxic culture.

##### 6.2.4.2.1. Organisational responsibilities

As found by Hunter (2010), the context of midwifery care impacts on the quality of midwives' relationships with women and colleagues. Across the NHS, there now exists a receptiveness to new visions and recommendations (West, 2013a, West, 2013b) in the wake of the Francis report (Francis, 2013), with calls for a shift from a damaging, hierarchical, punitive, and toxic command and control culture, to one in which respecting humanity is valued as core (West, 2013a, West, 2013b), along with five further values (Box 6.10.).

**Box 6.10. Recommended core values for the human community of the NHS** (West, 2013a, West, 2013b).

- 1) Wisdom and learning.
- 2) Courage to have the vision and persistence for change and innovation.
- 3) Justice: open, honest, fair and equal treatment of everyone.
- 4) Prudence and self-regulation to prevent overwhelm regarding initiatives and change.
- 5) Express and encourage appreciation, humour, wonder and spirituality.

Also, a study of the English NHS culture highlighted the link between good support and treatment of staff and good patient experiences, with recommended key priorities for management staff (Box 6.11.).

**Box 6.11. Key priorities to be addressed within NHS culture** (Dixon-Woods et al., 2014)

- Continually reinforce an inspiring vision of the work of their organisations
- Promote staff health and wellbeing
- Listen to staff and encourage them to be involved in decision making, problem solving and innovation at all levels
- Provide staff with helpful feedback on how they are doing and celebrate good performance
- Take effective, supportive action to address system problems and other challenges when improvement is needed
- Develop and model excellent teamwork
- Make sure that staff feel safe, supported, respected and valued at work.

These values and priorities link with consideration 3 and suggest that organisational issues such as, staffing, resources, and bullying must be remedied. However, rather than reducing what we pile onto midwives, a strong clarion call is for midwives to build resilience, that is their capacity to bounce back and ameliorate the effects of stress (Hogan et al., 2015).

#### 6.2.4.2.2. Is it up to midwives to become resilient?

Debate exists regarding how much to look beyond individuals to the system, and the reality of organisational responsibility alongside personal responsibility, with the suggestion that rather than blaming individuals, understanding is needed about how and why individuals behave as they do (Timmins and de Vries, 2015). As has been discussed in Chapter 5, Section 5.6. and 5.7., the need for resilience in midwives continues to be emphasised across recent midwifery literature (Killingley, 2016, Hunter and Warren, 2014). Indeed, developing EI the skills and knowledge outlined in section

6.2.2.2. may support midwives to prosper within challenging systems with the potential to enable them to optimise their interpersonal skills both with women and colleagues. Thus, this may create the potential to heal the toxic culture from within.

However, the response to this clarion call for resilience, has been to ask why midwives should have to develop resilience to cope within a system that originally failed to recognise their humanity or needs? (Murphy-Lawless, 2016, Edwards et al., 2018). The three *Midwives* who described leaving their job reflected the system wide loss of midwives (RCM, 2016d, Hawkins-Drew, 2017). An organisational level solution is therefore needed and may require a serious rethink of government priorities regarding the NHS, in keeping with the suggestions by Kristjánsson et al. (2017). In other words, the buck must not stop with midwives (Patterson, 2018, Byrom and Downe, 2015).

**6.2.4.3. A policy of zero tolerance towards individuals who persist in perpetuating the toxic culture is required.**

Considerations 1,2, and 3 assume that the majority of midwives enter the profession passionate about providing optimal care to women and families. Yet, the study shows that the provision of high quality psychological and physical care is not guaranteed. Of most concern, a minority of Awry midwives may not recognise or may actively ignore the importance of positive QPI and remain resistant to education (Graham, 2018). More worryingly they may negatively influence the actions of other midwives and destroy themselves in the process (Hughes, 2017). Whether this is due to individual personalities, the toxic culture, or systemic pressures is uncertain.

Nevertheless, it is one thing to accept that complex human experiences may contribute to this behaviour, and another to ignore it. In keeping with the NMC directive to prioritise safety, as discussed in section 5.7.2.3., It is essential that maternity services do not turn a blind eye to inappropriate and damaging behaviour by any staff, in particular by those who are in a management clique or considered untouchable (Hughes, 2017). This blindness allows perpetuation of a negative and toxic culture, which can no longer be tolerated.



#### **6.2.4.4. Summary of consideration 4**

The responsibility for change lies with the system not just individual midwives. The current toxic culture that exists within UK maternity services must be addressed through recognition of major organisational issues that undermine midwives, lead to stress and burnout, and contribute to bullying. A positive, supportive culture is essential to enable midwives to flourish and provide optimal care to women. There must be zero tolerance for the toxic culture or for individuals who perpetuate it. Healing the toxic culture is not the sole responsibility of midwives, but a responsibility of all those who hold power within the maternity services system.

### **Part 2: Recommendations**

*‘Changing ourselves, our behaviour, individually and institutionally, is difficult, but we pledge to do so. Healthcare is not like any other job. It touches the hearts of people’s lives, can do immense good but also immense harm’ (DoH, 2013) Statement of common purpose no. 11.*

### **6.3. Introduction**

The following recommendations are made in response to the four presented considerations (Box 6.12. provides a reminder). These considerations are inter-related. Prioritising the prevention of psychological harm, necessitates a consideration of how individuals are treated. How women, midwives, medical staff, and management interact with each other is influenced individual human factors. These human factors necessitate a shift to a midwife-centred system, and a positive, supportive culture. The recommendations are presented in connection with midwifery education, practice, policy, and research.

#### **Box 6.12. The four considerations to be addressed by the maternity services (See Part 1)**

- 1: The prevention of psychological harm must be prioritised within maternity services.
- 2: Interpersonal skills are not nice extras but are fundamental
- 3: A woman-centred service requires a midwife-centred organisation.
- 4: A toxic culture undermines maternity services and QPI. It should not be tolerated.

### 6.3.1. Recommendations for midwifery education

Table 6.3. Recommendations for midwifery education

Area to be addressed	Recommendation	Links to the considerations above	Notes
Language	<b>1. Use of the terms Training or Trained should be replaced with Education or Educated.</b>	2,4	<i>Training</i> suggests automated behaviour following stimuli. <i>Education</i> encompasses knowledge and autonomous thinking. Referring to <i>Education</i> will foster respect for knowledge and evidence, and weaken entrenched, damaging behaviour.
midwifery student recruitment	<b>2. The screening and selection of students for midwifery training should incorporate assessment of Emotional Intelligence and interpersonal skills.</b>	2	It is beneficial to identify those who show potential for understanding and developing EI and interpersonal skills, in addition to the usual screening criteria of academic and communicative ability.
midwifery curriculum	<b>3. The importance of women’s psychological wellbeing throughout the childbirth process and the key influence of QPI must be core to the midwifery education and Continuous Professional Development (CPD).</b>	1,2,4	The curriculum should highlight the core role of QPI as more than a <i>nice extra</i> and the potential for negative cognitions or emotions to disturb childbirth physiology, risking obstetric interventions and further trauma.
	<b>4. The development of EI and key interpersonal skills must be core to the midwifery education and Continuous Professional Development (CPD) and extended to all midwifery education staff. Specifically:</b>  <b>a) EI and the interpersonal skills toolkit should be developed and taught by qualified teaching teams.</b>  <b>b) EI and interpersonal skills must be assessed effectively throughout midwifery education and CPD.</b>	2,4	It is recommended that this toolkit will at least comprise the skills outlined in Appendix 4.1.  Quality education must be provided by qualified personnel. This may be midwives or midwifery educators who have completed specialist education or specially qualified teams.  This may be through Objective Structured Clinical Examinations (OSCE’s) and placement assessment by using assessment scales such as suggested by (Wilson, 2015)

### 6.3.2. Recommendations for midwifery practice

Educating students and midwives in EI and interpersonal skills will be meaningless if the practice environment does not support enactment of these skills or actively mitigates against this. Therefore, the following recommendations refer to midwifery practice, particularly in terms of meeting the human needs of midwives so that they are enabled to optimise QPI. Urgent steps must be taken to comprehensively review the practicalities of the midwifery role and reconfigure these with the woman/midwife relationship as core. Non-relational aspects of midwifery such as administration and organisation should be reviewed and possibly allocated to other maternity staff.

**Table 6.4. Recommendations for midwifery practice**

Area to be addressed	Recommendation	Links to the considerations above	Notes
The care of women	<p><b>5. Treat all women as if they are at risk of poor psychological outcomes following childbirth</b></p> <p><b>6. Prioritise and protect the women/midwife relationship by supporting midwives to be with women</b></p>	<p>1</p> <p>2,3,4</p>	<p>Through the implementation of trauma focussed care (Moore, 2018, Yusko, 2018) for all women the risk of iatrogenic harm to women unknown to be at risk will be reduced.</p> <p>Urgently required actions in direct response to the study findings:</p> <ol style="list-style-type: none"> <li>1. Safeguarding against separation of mother and midwife in the hours directly after childbirth.</li> <li>2. During obstetric interventions or emergencies, prioritise the role of the midwife as <i>being with</i> the woman.</li> <li>3. Revision of midwifery tasks to remove unnecessary <i>Ticking of Boxes</i>.</li> </ol>

**Table 6.4. Recommendations for midwifery practice (continued)**

Area to be addressed	Recommendation	Links to the considerations above	Notes
Continuous professional development of midwives.	<b>7. Safeguard and prioritise access to quality education for all midwives and midwifery educators.</b>	1,2,3,4	The successful implementation of education depends upon access, in terms of time, resources, and appropriately qualified educators (McInnes and Mc Intosh, 2012). Study leave must be supported and safeguarded to ensure access to CPD to maintain skills and confidence.
The support of Midwives.	<b>8. Meet the physical and psychological needs of midwives and wider maternity care staff by prioritising time for support and restoration.</b>  <b>9. Support midwives in their role by optimising the workplace environment.</b>	1,3,4  1,3,4	A range of suggested actions to meet the needs of midwives and wider maternity care staff is given in Box 6.13a.  Address aspects of the workplace environment that compromise midwives' abilities to provide positive QPI. Priority should be given to creating and safeguarding practices such as those in Box 6.13b.

**Box 6.13a. suggested ways to meet the physical and psychological needs of midwives**

- Encourage breaks and safeguard timing and quality.
- Create restorative spaces within the workplace e.g. greenery/garden/ restful environment.
- Easy, affordable access to nutritious food and drink during breaks.
- Consider 'Dinner Lady' a trolley service for the ward so midwives can access food and drink even when they wish to remain with women.
- Providing Safe space and non-stigmatised counselling service.
- Respect and anticipate individual needs of midwives in relation to experiences of workplace trauma from poor obstetric outcomes, life circumstances such as family care needs of children or other relatives, menopause, illness, and financial stress.

**Box 6.13b. Workplace environment practices to support midwives**

- Address staffing shortages.
- Protect rest breaks and study leave.
- Uphold honesty/integrity/openness.
- Challenge negative QPI.
- Create *Safe to Speak Out* culture (Graham, 2016).
- Cultivate supportive teamwork, advocate for one another.
- Lead by example.
- Encourage and support reflective practice.
- Cultivate respect not blind obedience
- Implement supportive management and monitoring of midwives' interpersonal skills

**6.3.3. Recommendations for midwifery policy development**

The above recommendations for midwifery practice need to be facilitated by appropriate midwifery policies built upon the recognition of the importance of QPI. The order of presentation of the following recommendations does not denote priority, rather all recommendations should be considered simultaneously as each is somewhat dependent on the others. As described in recommendation 6.9. all policies must address the needs of all maternity services staff, recognising that each person is not a machine. Developing a compassionate culture, requires compassionate leadership at all levels.

**Table 6.5. Recommendations for midwifery policy development**

Area to be addressed	Recommendation	Links to the considerations above	Notes
Improving psychological wellbeing of women.	<b>10. Prioritise reducing iatrogenic harm due to poor QPI for all women regardless of perceived risk.</b>	1,2	Treating all women as if they are at risk of psychological harm necessitates optimal QPI for all. This policy will form the foundation from which recommendation 6.12. can be actioned.
Improving the psychological and physical wellbeing of midwives.	<b>11. Prioritise the creation of a midwife centred system in order to optimise the quality of care, particularly QPI.</b>	2,3	The recent government strategies provide the context for relationship-based care to succeed. However, until the system is fully midwife centred, it may fall short of achieving its goals.
Building a positive culture within midwifery services.	<b>12. Prioritise the Development of a culture of zero tolerance for negative interpersonal behaviour by midwives towards women, colleagues and other maternity care staff.</b>	4	<ul style="list-style-type: none"> <li>• Acknowledge the presence and impact of a persistent toxic culture and prioritise the removal of this.</li> <li>• Develop policies that support the removal of barriers to disclosure of undermining, bullying behaviour. Develop a culture of support for those who speak out.</li> <li>• Develop a supportive rather than punitive approach to investigating negative behaviour, cognisant of the potential human needs of individual midwives.</li> <li>• Examples include:               <ul style="list-style-type: none"> <li>○ Buurtzorg Model: Humanity over Bureaucracy (Buurtzorg, 2016)</li> <li>○ Family Nurse Partnership (FNP, 2018)</li> <li>○ Staff engagement (Collins, 2015)</li> </ul> </li> </ul>

### 6.3.4. Recommendations for midwifery research

Table 6.6. Recommendations for midwifery research

Area to be addressed	Recommendation	Links to the considerations above	Notes
The Interpersonal skills toolkit.	<b>13. Develop, implement and assess an interpersonal skills toolkit for midwives.</b>	2	Consider new Virtual Reality tool currently undergoing trial ( <a href="#">Heys, 2018</a> ) Or An educational strategy to lead to the development of woman-centred midwives ( <a href="#">Thomas, 2006</a> )
Supporting midwives in their role.	<b>14. Design and implement a program to introduce midwife centred features into maternity services and evaluate the impact of this program for midwives.</b> <b>15. Urgent examination of the factors that prevent midwives having time with women, especially in the immediate postnatal period.</b>	3,4	Consider approaches such as What Matters to You ( <a href="#">Healthcare Improvement Scotland, 2018</a> )  Particular attention to the influence of the current infrastructure and funding limitations. Possibly through a cost-benefits analysis.
Promoting the psychological wellbeing of midwives.	<b>16. Explore the wider needs of midwives, including those arising from prior trauma or mental health illness.</b> <b>17. Identify and implement organisational steps that can meet these wider needs of midwives.</b>	3,4	Explore the value of the new supervision model ( <a href="#">Dunkley-Bent, 2017</a> ) Build from the RCM Caring from you Campaign and survey ( <a href="#">RCM, 2018</a> , <a href="#">RCM, 2016a</a> ) to identify target areas for research, implementation, and evaluation.

### **6.3.5. Considerations regarding the recommendations**

These recommendations represent the overarching goals with a view to optimising QPI between women and midwives. It is recognised that the human and organisational realities will impact on the potential for these to be accepted, enacted, and effective. Until QPI is acknowledged across all members of maternity services as vital to improve, the impetus to challenge the toxic culture will not be as strong. The toxic culture is not a result of bad maternity staff, and so all recommendations must be addressed cognisant of the human reality that predisposes to negative QPI.

### **6.3.6. Summary of the recommendations**

The recommendations promote recruiting and educating midwives with an emphasis on emotional intelligence, interpersonal skills, and the critical importance of women's psychological wellbeing. Together with supporting midwives and tackling the thread of toxic culture, the aim is to optimise midwives psychological and physical wellbeing and thus reduce the number of worn-down and awry midwives. The result will be an improvement QPI and subsequent reduction in PTSD-PC from this particular source.



Chapter Seven  
Conclusion of the thesis

## **7.1. Introduction**

This chapter provides an overview of the afore discussed thesis, an outline of the contribution to knowledge relative to the key findings, and suggested implications for midwifery practice, policy, and education.

## **7.2. Background**

This thesis has shown that PTSD is now a recognised disorder that can follow childbirth. Also shown is that PTSD-PC potentially has both long and short-term implications for women, their children and families, and healthcare providers.

## **7.3. Contribution to knowledge**

### **7.3.1. The role of QPI**

The initial scoping exercise and the two-stage systematic literature review identified that of the range of factors that contribute to the development of PTSD-PC in women, women's subjective birth experiences are the most important. Also, that within these subjective experiences, women's negative perceptions of QPI are significantly correlated.

This conclusion highlights that the *way or how* midwives are with women is not an optional extra but is a key factor that influences their subsequent psychological wellbeing. In addition, wider literature shows that psychological wellbeing during labour and birth impacts on physical outcomes. This evidence together with the premise *first do no harm*, suggests that QPI should not be ignored and acknowledges that it may be central to providing optimal midwifery care.

### **7.3.2. The gap in knowledge**

Of importance within midwifery practice is the recognition that QPI is a potentially modifiable factor. The literature review showed that a gap existed regarding the deeper understanding of the lived experience of QPI from the perspective of both women who have developed PTSD-PC and midwives. Both these considerations informed the focus of this study.

### **7.3.3. Addressing this gap in knowledge**

By using in-depth qualitative analysis to hear *both sides of the story* (from both women and midwives), this study has deepened the understanding of what women and midwives need to respectively experience and provide optimal QPI.

### **7.3.4. The key findings from the study**

Results have shown that the human needs of midwives must be acknowledged and met to enable midwives to interact optimally with women. Also, the midwife/woman relationship that is widely discussed in midwifery literature is highly valued by both women and midwives and is the core mechanism through which QPI is offered and perceived. Yet, the needs of midwives and the required time to build relationships with women are often sacrificed within a busy and pressurised maternity service.

Consequently, QPI can be suboptimal, which may contribute to trauma and PTSD-PC in women. Also, midwives can become *worn down* or *go awry*, which brings everything full circle in terms of midwives being unable to provide optimal QPI.

### **7.4. Acknowledging limitations**

While the study is limited regarding generalisability due to small numbers and the qualitative approach strategy, it does allow transferability given that the key findings are consistent with wider literature. Furthermore, this study delved below the surface experiences of women and midwives, to understand their feelings and the meaning they attach to their experiences and uncover some underlying issues that influence these experiences.

### **7.5. Implications for midwifery education, practice, and policy**

Given that QPI is a potentially modifiable and associated factor in the development of PTSD-PC, the proposed recommendations for midwifery education, practice, and policy serve to work towards addressing the underlying issues. The key areas to address are: optimal QPI is a key requirement, midwives' needs must be met, and the midwife/woman relationship must be prioritised.

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## **Appendix 1.1. Comparison of the ICD-10 PTSD Diagnosis with the DSM-IV-TR Criteria**

(U.S. Department of Veteran's Affairs, 2016)

Criterion within ICD-10	Description of the ICD-10 criterion	Contrast with the DSM-IV-TR
A: Stressor	Exposure to a stressor.	<i>Unlike the DSM there is no subjective stressor criterion (A2).</i>
B: re-experiencing	Persistent remembering of the stressor in one of: Intrusive flashbacks; Vivid memories or recurring dreams; Experiencing distress when reminded of the stressor.	<i>Same as in the DSM-IV-TR.</i>
C: avoidance	Requires only one symptom of actual or preferred avoidance.	<i>The DSM-IV-TR requires three symptoms from this cluster and includes both numbing and avoidance symptoms whereas the ICD-10 does not.</i>
D: hyperarousal	Either D1, or two of D2. <i>D1: Inability to recall.</i> <i>D2: Two or more of: Sleep problems, irritability, concentration problems, hypervigilance, exaggerated startle response.</i>	<i>The DSM-IV-TR requires two symptoms from this entire hyperarousal cluster.</i>
E: Time of onset	Onset of symptoms within six months of the stressor.	<i>This differs from the DSM-IV-TR, which specifies symptom duration of greater than one month.</i>



## **Appendix 1.2. The DSM-IV diagnostic criteria B to F for PTSD (APA, 1994)**

Criterion B: The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
4. Intense psychological distress on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

Criterion C: Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings or conversations associated with the trauma.
2. Efforts to avoid activities, places or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect (e.g., unable to have loving feelings).
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children or normal life span).

Criterion D: Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hyper vigilance.
5. Exaggerated startle response.

Criterion E: Duration of the disturbance (symptoms criteria B, C and D) is more than one month.

Criterion F: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

**Acute:** if duration of symptoms last less than 3 months.

**Chronic:** if duration of symptoms is 3 months or more.

Specify if:

**Delayed onset:** if onset of symptoms is at least 6 months after the stressor.

### **Appendix 1.3. The DSM-V diagnostic criteria for PTSD (APA, 2013)**

Criterion A: Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

**Note:** criterion A4 does not apply to exposure through electronic media, television, movies or pictures, unless the exposure is work related.

*(Note the DSM-IV A2 The person's response involved intense fear, helplessness or horror, removed from the DSM-V)*

Criterion B: Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s). Beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and /or effect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings).
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolise or resemble an aspect of the traumatic event.

Criterion C: Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts or feelings about or closely associated with the traumatic event(s).

Criterion D: Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs).
4. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs).

### **Appendix 1.3. The DSM-V diagnostic criteria for PTSD (continued)** (APA, 2013)

Criterion D continued: Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

5. Persistent and exaggerated negative beliefs or expectations about oneself, others or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
6. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the person to blame himself/herself or others. (*New in the DSM-V*).
7. Persistent negative emotional state (e.g., fear, horror, anger, guilt or shame). (*New in the DSM-V*).
8. Markedly diminished interest or participation in significant activities.
9. Feelings of detachment or estrangement from others.
10. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction or loving feelings).

Criterion E: Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression towards people or objects.
2. Reckless or self-destructive behaviour. (*New in the DSM-V*).
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Criterion F: Duration of the disturbance (criteria B, C, D, and E) is more than one month.

Criterion G: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Criterion H: The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

**With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of the following:

1. **Depersonalisation:** Persistent or recurrent experiences of feeling detached from, and as if one were outside observer, of one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealisation:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

**Note:** to use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behaviours during alcohol intoxication) or another medical condition (e.g. complex partial seizures).

Specify if:

**With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

#### **Appendix 1.4. List of studies used in the scoping findings**

1	<a href="#">Adewuya et al. (2006)</a>
2	<a href="#">Alcorn et al. (2010)</a>
3	<a href="#">Anderson and McGuinness (2008)</a>
4	<a href="#">Anderson (2010)</a>
5	<a href="#">Ayers (2007)</a>
6	<a href="#">Ayers et al. (2015a)</a>
7	<a href="#">Ayers et al. (2009)</a>
8	<a href="#">Ayers et al. (2014)</a>
9	<a href="#">Ballard et al. (1995)</a>
10	<a href="#">Beck (2004a)</a>
11	<a href="#">Boorman et al. (2014)</a>
12	<a href="#">Czarnocka and Slade (2000)</a>
13	<a href="#">Dale-Hewitt et al. (2012)</a>
14	<a href="#">Denis et al. (2011)</a>
15	<a href="#">Dodgson et al. (2014)</a>
16	<a href="#">Fairbrother and Woody (2007)</a>
17	<a href="#">Fenech and Thomson (2014)</a>
18	<a href="#">Ford et al. (2010)</a>
19	<a href="#">Furuta et al. (2012)</a>
20	<a href="#">Furuta et al. (2014)</a>
21	<a href="#">Gamble and Creedy (2005)</a>
22	<a href="#">Garthus-Niegel et al. (2013)</a>
23	<a href="#">Garthus-Niegel et al. (2014a)</a>
24	<a href="#">Garthus-Niegel et al. (2014b)</a>
25	<a href="#">Grekin and O'Hara (2014)</a>
26	<a href="#">Haagen et al. (2015)</a>
27	<a href="#">Halperin et al. (2015)</a>
28	<a href="#">Harris and Ayers (2012)</a>
29	<a href="#">Hoedjes et al. (2011)</a>
30	<a href="#">Iles and Pote (2015)</a>
31	<a href="#">Leeds and Hargreaves (2008)</a>
32	<a href="#">Lev-Wiesel et al. (2009)</a>
33	<a href="#">Lyons (1998)</a>
34	<a href="#">Menage (1993)</a>
35	<a href="#">Modarres et al. (2012)</a>
36	<a href="#">O'Donovan et al. (2014)</a>
37	<a href="#">Olde et al. (2006)</a>
38	<a href="#">Paul (2008)</a>
39	<a href="#">Polachek et al. (2015)</a>
40	<a href="#">Slade (2006)</a>
41	<a href="#">Söderquist et al. (2006)</a>
42	<a href="#">Söderquist et al. (2009)</a>
43	<a href="#">Soet et al. (2003)</a>
44	<a href="#">Stramrood et al. (2011)</a>
45	<a href="#">Verreault et al. (2012)</a>
46	<a href="#">White et al. (2006)</a>
47	<a href="#">Wosu et al. (2015)</a>
48	<a href="#">Zaers et al. (2008)</a>

**Appendix 2.1. Keywords, subject headings and terms used for the systematic literature search**

<b>PTSD</b>	<b>Childbirth/Labour</b>	<b>Midwifery approach</b>
<p><b>Subject Headings</b>            Stress Disorders, Post-Traumatic            Life Change Events            Stress, Psychological</p>	<p><b>Subject headings</b>            Childbirth+/PF*            Delivery, Obstetric            Caesarean Section            Episiotomy            Obstetrical forceps            Vacuum Extraction, Obstetrical            Pregnancy Complications, Psychiatric+            Labor+/PF            Labor Stages            Management of Labor            Labor, Premature            Labor, Induced            Labor Support            Labor Stage, Third            Labor Stage, Second            Labor Stage, First            Labor Pain            Labor Complications</p>	<p><b>Subject headings</b>            Midwife attitudes            Holistic care</p>
<p><b>Terms</b>            "traumatic life event*"            "traumatic experience*"            "psychological trauma"</p>	<p><b>Terms</b>            "traumatic birth"            "birth trauma"            "traumatic delivery"            "traumatic childbirth"            "childbirth trauma"            "tokophobia"            "tocophobia"            "fear of childbirth"            "childbirth fear"            "fear of birth"            "birth fear"            "childbirth expectation"            "birth expectation"            "childbirth experience"            "birth experience"            "birth satisfaction"            "forceps"            "forceps delver*"            "obstetric variable*"            "kiwi cup" or ventouse</p>	<p><b>Terms</b>            woman centred            Midwife led</p>

Note some subject headings varied according to the database being searched, to match the requirements of the database (e.g. the American spelling of labor) but the core meaning of the heading was retained.

\* /PF is a database expanding term and refers to Psychological Factors.

## **Appendix 2.2. List of the 96 studies included in stage one of the review**

### **The 14 studies from the 96 that were included in stage two of the review**

Allen (1998)  
Anderson and McGuinness (2008)  
Ayers (2007)  
Ballard et al. (1995)  
Beck (2004a)  
Cigoli et al. (2006)  
De Schepper et al. (2015)  
Ford and Ayers (2011)  
Harris and Ayers (2012)  
Menage (1993)  
Nicholls and Ayers (2007)  
Nyberg et al. (2010)  
Sorenson and Tschetter (2010)  
Tham et al. (2010)

### **The 82 studies from the 96 that were excluded from stage two of the review**

Primary focus being on prevalence and cause of PTSD-PC, not subjective experience or QPI.

<b>Study</b>	<b>Reason for exclusion from review</b>
Adewuya et al. (2006)	Prevalence and risk
Alcorn et al. (2010)	Prevalence
Andersen et al. (2012)	Prevalence and factors
Ayers (2004)	Review of causes and risk
Ayers et al. (2008)	Review of causes and risk
Ayers et al. (2009)	Prevalence and risk
Ayers et al. (2014)	not QPI, attachment styles
Ayers et al. (2015a)	not QPI, memory processes
Ayers et al. (2016)	Meta-analysis/model factors
Ayers and Pickering (2001)	Prevalence
Srkalović Imširagić et al. (2017)	Factors
Bailham and Joseph (2003)	Prevalence and factors
Beck (2006b)	Secondary further to the 40 in Beck 2004 no measure PTSD
Beck (2011)	Meta ethnography of 6 studies (included living with PTSD and BF)
Beck et al. (2011)	Prevalence and factors
Boorman et al. (2014)	Prevalence
Cohen et al. (2004)	Factors
Creedy et al. (2000)	Prevalence and factors
Czarnocka and Slade (2000)	Prevalence and factors
Dale-Hewitt et al. (2012)	not QPI - attentional bias to words
Denis et al. (2011)	Prevalence and factors
Edworthy et al. (2008)	Factors
Elmir et al. (2010)	Review (not all papers re PTSD)
Fairbrother and Woody (2007)	Predictors
Ford et al. (2010)	Prediction
Furuta et al. (2012)	Prevalence and objective experience
Furuta et al. (2014)	Factors and Severe morbidity
Furuta et al. (2016)	Causes
Gamble and Creedy (2005)	Factors – type of birth
Garthus-Niegel et al. (2013)	Prevalence and risk
Garthus-Niegel et al. (2014b)	Preferences for mode of birth
Garthus-Niegel et al. (2014a)	Factors - pain
Ísbir et al. (2016)	Factors
Goutaudier et al. (2012)	Factors – negative emotions
Grekin and O'Hara (2014)	Prevalence and factors

## **Appendix 2.2. List of the 96 studies included in stage one of the review (continued)**

### **The 82 studies from the 96 that were excluded from stage two of the review (continued)**

Primary focus being on prevalence and cause of PTSD-PC, not subjective experience or QPI.

<b>Study</b>	<b>Reason for exclusion from review</b>
Haagen et al. (2015)	Factors
Halperin et al. (2015)	Prevalence and factors
Hauer et al. (2009)	Not QPI, memory specificity
Iles and Pote (2015)	Factors and model for PTSD-PC
James (2015)	Review, PTSD, CBT, calls for IPA
King et al. (2017)	Causes, model
König et al. (2016)	Causes
Leeds and Hargreaves (2008)	Prevalence and factors
Lev-Wiesel et al. (2009)	Factors
Lev-Wiesel and Daphna-Tekoah (2010)	Factors, dissociation
Lyons (1998)	Prevalence
Maggioni et al. (2006)	Prevalence and factors
McKenzie-McHarg et al. (2015)	Review of issues
Milosavljevic et al. (2016)	Prevalence and cause
Modarres et al. (2010)	Prevalence
Modarres et al. (2012)	Prevalence
Moghadam et al. (2015)	Prevalence
Noyman-Veksler et al. (2015)	CS and bonding
O'Donovan et al. (2014)	Factors
Olde et al. (2005)	Prevalence and factors
Olde et al. (2006)	Prevalence and factors
Oliveira et al. (2016)	Causes
Paul (2008)	Prevalence and ethnicity
Polachek et al. (2012)	Prevalence
Polachek et al. (2015)	Prevalence and factors
Ryding et al. (1997)	Prevalence after CS
Ryding et al. (1998)	Factors
Ryding et al. (2000)	No measure of PTSD
Sawyer et al. (2010)	Review of prevalence
Simpson and Catling (2015)	Factors – highlights QPI
Skinner and Dietz (2015)	Prevalence and factors
Slade (2006)	Review of issues
Söderquist et al. (2002)	Prevalence and factors
Söderquist et al. (2006)	Prevalence and factors
Söderquist et al. (2009)	Risk factors
Soet et al. (2003)	Prevalence and factors
Stramrood et al. (2011)	Prevalence and factors
Tham et al. (2007)	Factors
Theroux (2009)	Review of excluded studies
van Son et al. (2005)	Factors
Verreault et al. (2012)	Prevalence and factors
Vossbeck-Elsebusch et al. (2014)	Model of risk
White et al. (2006)	Prevalence and course
Wijma et al. (1997)	Prevalence
Wosu et al. (2015)	CSA and prevalence
Yildiz et al. (2017)	Prevalence
Zaers et al. (2008)	Prevalence and factors

## **Appendix 2.3. CASP checklists**

CASP checklist for qualitative studies      Need to answer **Yes, can't tell or no** to each:

**1: Was there a clear statement of the aims of the research?** Consider:

- What was the goal of the research?
- Why is it thought important?
- It's relevance

**2: Is a qualitative methodology appropriate?** Consider

- If the research seeks to interpret or illuminate the actions and or subjective experience of research participants?
- Is the qualitative research the right methodology for addressing the research goal?

**3: Was the research design appropriate to address the aims of the research?** Consider:

- If the researcher has justified the research design e.g. Have they discussed how they decided which method to use?

**4: Was the recruitment strategy appropriate to the aims of the research?** Consider:

- If the researcher has explained how the participants were selected.
- If they explained why the participants they selected, were the most appropriate to provide access to the type of knowledge sought by the study.
- If there are any discussions around recruitment e.g. Why some people chose not to take part.

**5: Was the research collected in a way that addressed the research issue?** Consider:

- If the setting for data collections was justified.
- If it is clear how the data were collected e.g. Focus group, semi-structured interview.
- If the researcher has justified the methods chosen.
- If the researcher has made the methods explicit e.g. For the interview method, is there an indication of how the interviews were conducted, or did they use a topic guide?
- If methods were modified during the study. If so has the researcher explained how and why?
- If the form of data is clear e.g. Tape recordings, video material, notes etc.
- If the researcher has discussed saturation of data.

**6: Has the relationship between research and participants been adequately considered?** Consider:

- If the research critically examined their own role, potential bias and influence during
  - (a) Formulation of the research questions.
  - (b) Data collection, including sample recruitment and choice of location.
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design.

**7. Have ethical issues been taken into consideration?** Consider:

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained?
- If the researcher has discussed issues raised by the study e.g. Issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study.
- If approval has been sought from the ethics committee.



## **Appendix 2.3. CASP checklists (continued)**

CASP checklist for qualitative studies continued      Need to answer **Yes, can't tell or no** to each:

### **8. Was the data analysis sufficiently rigorous?** Consider:

- If there is an in-depth description of the analysis process
- If thematic analysis was used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original samples to demonstrate the analysis process.
- If sufficient data are presented to support the findings.
- To what extent contradictory data are taken into account.
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation.

### **9: Is there a clear statement of findings?** Consider:

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher arguments
- If the researcher has discussed the credibility of their findings e.g. Triangulation, respondent validation, more than one analyst.
- If the findings are discussed in relation to the original research questions.

### **10: How valuable is the research?** Consider:

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. Do they consider the findings in relation to current practice or policy? or relevant research-based literature?
- If the identify new areas where research is necessary.
- If the researchers have discussed whether or how the findings can be transferred to other populations or have considered other ways the research can be used.

CASP checklist for Cohort Study      Need to answer **Yes, can't tell or no** to each:

### **1: Did the study address a clearly focussed issue?** Consider:

- The population studied.
- The risk factors studied.
- The outcomes considered.
- Is it clear whether the study tried to detect a beneficial or harmful effect?

### **2: Was the cohort recruited in an acceptable way?** Consider:

- Was the cohort representative of a defined population?
- Was there something special about the cohort?
- Was everybody included who should have been included?

### **3: Was the exposure accurately measured to minimise bias?** Consider:

- Did they use subjective or objective measurement?
- Do the measurements truly reflect what you want them to (have they been validated?)
- We're all the subjects classified into exposure groups using the same procedure?

### **4: Was the outcome accurately measured to minimise bias?** Consider:

- Did they use subjective or objective measurements?
- Do the measures truly reflect what you want them to (have they been validated?)
- Has a reliable systems been established for detecting all cases (for measuring disease occurrence)?
- We're the measurement methods similar in the different groups?
- We're the subjects and /or the outcome assessor blinded to exposure (does it matter)?

### **Appendix 2.3. CASP checklists (continued)**

CASP checklist for Cohort Study Need to answer **Yes, can't tell or no** to each:

**5:**

**(a) Have the authors identified all important confounding factors?**

List the ones you think might be important, that the author has missed

**(b) Have they taken account of the confounding factors in the design and/or analysis?** Consider:

- Look for restriction in design, and techniques e.g. Modelling, stratified, regression, sensitivity analysis to correct, control or adjust for confounding factors.

**6:**

**(a) Was the follow up of subjects complete enough?**

**(b) Was the follow up of subjects long enough?** Consider:

- The good or bad effects should have had long enough to reveal themselves.

**Appendix 2.3. CASP checklists continued**

- The persons that are lost to follow up may have different outcomes than those available for assessment.
- In an open dynamic cohort, was there anything special about the outcome of the people leaving, or the exposure of the people entering the cohort?

**7: what are the results of the study?** Consider:

- What were the bottom line results?
- Have they reported the rate or the proportion between the exposed/unexposed, the ratio/the rate different?
- How strong is the association between the exposure and the outcome (RR).
- What is the absolute risk reduction (ARR).

**8: How precise are the results?** Consider:

- look for the range of the confidence intervals, if given.

**9: Do you believe the results?** Consider:

- Big effect is hard to ignore.
- Can it be due to bias, chance or confounding.
- Are the design and methods of this study sufficiently flawed to make the results unreliable?
- Bradford Hill criteria e.g. Time, sequence, dose-response gradient, biological plausibility, consistency.

**10: Can the results be applied to the local population?** Consider:

- A cohort study was appropriate method to answer this question.
- The subjects in this study could be sufficiently different from your population to cause concern.
- Your local setting is likely to differ much from that of the study.
- You can quantify the local benefits and harms.

**11: Do the results of this study fit with other available evidence?**

**12: what are the implications of this study for practice?** Consider:

- One observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making.
- For certain questions observational studies provide the only evidence.
- Recommendations from observational studies are always stronger when supported by other evidence

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies**

<b>Study 1 Allen 1998 Qualitative</b>		<b>Meets CASP – High</b>	<b>Comments</b>
1	Clear statement of aims	Yes	Important early exploration of experience of traumatic birth in relation to PTSD.
2	Qualitative is appropriate	Yes	Exploring experience.
3	Design is appropriate	Yes	While Grounded theory informed the design, there was a fixed sample size and so recruiting till saturation was not within the design.
4	Recruitment strategy appropriate	Yes	Described rationale in detail.
5	Data collection addressed research issue	Yes	Subjective experience explored alongside other aspects. Appropriate measure of PTSD as per DSM.
6	Influence of researcher considered	Yes	No expression of response to events in study or implications of change.
7	Ethical issues considered	Yes	Ethical approval from local health district. Info provided, and consent received.
8	Analysis is sufficiently rigorous	Yes	No discussion of researcher being reflective re their potential for bias.
9	Clear statement of findings	Yes	See Table 2.6. (Chapter 2, section 2.2.4.4.)
10	Value of the research	Yes	Very Valuable. Frequently cited early study highlighting the importance of subjective experience.

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 2</b>	<b>Anderson and McGuinness 2008</b>	<b>Quantitative</b>	<b>Meets CASP - Low</b>	<b>Comments</b>
1	Addresses clearly focussed issue		Yes	
2	Cohort recruitment acceptable		Yes	
3	Exposure accurately measured to minimise bias		Yes	Objective measures were used and reflect the aims of the study.
4	Outcome accurately measured to minimise bias		Yes	Objective and subjective measures were used and reflect the aims of the study.
5	(a) Identified important confounding factors (b) Taken account of confounding factors in design and analysis		(a) No (b) n/a	Authors note that they did not measure incidence of PTS prior to birth.
6	(a) Was follow up of subjects complete (b) Was follow up long enough		n/a	Follow-up not required.
7	What are the results?		Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)
8	How precise are the results?		Describe	The summary statistics are purely descriptive, so precision is not applicable.
9	Are the results believable?		Yes	Appropriate to the population and outcomes being studied.
10	Can results be applied to local population		No	Only really valid for teenage population, cannot be generalised to other childbearing women.
11	Do results fit with other evidence		Yes	Fit with other evidence regarding teenagers only.
12	What are the implications for practice?		Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 3 Ayers 2007 Qualitative</b>		<b>Meets CASP - Mod</b>	<b>Comments</b>
1	Clear statement of aims	Yes	
2	Qualitative is appropriate	Yes	Exploring experience.
3	Design is appropriate	Can't tell	No explicit design is described, except that thematic analysis was used.
4	Recruitment strategy appropriate	Yes	
5	Data collection addressed research issue	Yes	
6	Influence of researcher considered	Can't tell	No description of reflection on potential bias.
7	Ethical issues considered	Can't tell	Obtained in original study. No mention of info provided, or consent obtained for the participants in this study.
8	Analysis sufficiently rigorous	Can't tell	No discussion of researcher being reflective re their potential for bias.
9	Clear statement of findings	Yes	See Table 2.6. (Chapter 2, section 2.2.4.4.)
10	Value of the research	Yes	Valuable and regularly cited, although does not include Criterion A of the DSM criteria. The authors note this.

<b>Study 4 Ballard 1995 Qualitative</b>		<b>Meets CASP - Low</b>	<b>Comments</b>
1	Clear statement of aims	Yes	
2	Qualitative is appropriate	Yes	
3	Design is appropriate	Yes	
4	Recruitment strategy appropriate	Can't tell	Method of selection of cases is not described.
5	Data collection addressed research issue	Yes	
6	Influence of researcher considered	No	No description of awareness of bias in selection of cases.
7	Ethical issues considered	Can't tell	Not described.
8	Analysis sufficiently rigorous	No	Short summary of case studies.
9	Clear statement of findings	No	See Table 2.6. (Chapter 2, section 2.2.4.4.)
10	Value of the research	Yes	Frequently cited early study of 4 case studies adding to the awareness of PTSD existing in connection with childbirth and the importance of the subjective experience.

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 5 Beck 2004 Qualitative</b>	<b>Meets CASP - Mod</b>	<b>Comments</b>
1 Clear statement of aims	Yes	
2 Qualitative is appropriate	Yes	
3 Design is appropriate	Yes	
4 Recruitment strategy appropriate	Yes	
5 Data collection addressed research issue	Yes (partial)	Although study states that 32/40 women have PTSD and 8 have PTS symptoms, no details are provided re method of diagnosis.
6 Influence of researcher considered	Yes (partial)	No expression of response to events in study or implications of change.
7 Ethical issues considered	Yes	Ethical approval received. Participant info provided, and consent received.
8 Analysis sufficiently rigorous	Yes (partial)	The use of bracketing according to Husserl is referenced, but not made explicit if or how it was used in the study.
9 Clear statement of findings	Yes	See Table 2.6. (Chapter 2, section 2.2.4.4.)
10 Value of the research	Yes	This is an important study highlighting aspects of the subjective experience which women describe in connection with a traumatic birth.

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 6</b> Cigoli et al. 2006 <b>Quantitative</b>	<b>Meets CASP - Mod</b>	<b>Comments</b>
1 Addresses clearly focussed issue	Yes	
2 Cohort recruitment acceptable	Yes	
3 Exposure accurately measured to minimise bias	Yes	Objective measures were used and reflect the aims of the study.
4 Outcome accurately measured to minimise bias	Yes	Objective and subjective measures were used and reflect the aims of the study.
5 (a) Identified important confounding factors (b) Taken account of confounding factors in design and analysis	(a) n/a (b) n/a	This study was mainly descriptive in exploring correlations and while confounders are discussed in general i.e. The crossover and inter relationship between many factors – the analysis does not formally assess or build these in.
6 (a) Was follow up of subjects complete (b) Was follow up long enough	(a) n/a (b) n/a	Follow-up not required.
7 What are the results?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)
8 How precise are the results?	Describe	Confidence intervals are not presented.
9 Are the results believable?	Yes	Many correlations are significant to the 1% level.
10 Can results be applied to local population	Yes	
11 Do results fit with other evidence	Yes	
12 What are the implications for practice?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 7</b> De Schepper et al. 2015 <b>Quantitative</b>	<b>Meets CASP - High</b>	<b>Comments</b>
1 Addresses clearly focussed issue	Yes	
2 Cohort recruitment acceptable	Yes	
3 Exposure accurately measured to minimise bias	Yes	Objective measures were used and reflect the aims of the study.
4 Outcome accurately measured to minimise bias	Yes	Objective and subjective measures were used and reflect the aims of the study.
5 (a) Identified important confounding factors (b) Taken account of confounding factors in design and analysis	(a) Yes (b) Yes	
6 (a) Was follow up of subjects complete (b) Was follow up long enough	(a) Yes (b) Yes	Timing of measurement appropriate for PTSD per DSM (although authors acknowledge PTSD reduces by 3 months).
7 What are the results?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)
8 How precise are the results?	Describe	Only 3 confidence intervals presented and the one for 'traumatic birth' as factor for PTSD is very small (precise).
9 Are the results believable?	Yes	
10 Can results be applied to local population	Yes	May not fit my population due to cultural and religious differences.
11 Do results fit with other evidence	Yes	
12 What are the implications for practice?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)



**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 8 Ford and Ayers 2011 Quantitative</b>	<b>Meets CASP - High</b>	<b>Comments</b>
1 Addresses clearly focussed issue	Yes	
2 Cohort recruitment acceptable	Yes	
3 Exposure accurately measured to minimise bias	Yes	Objective measures were used and reflect the aims of the study.
4 Outcome accurately measured to minimise bias	Yes	Objective and subjective measures were used and reflect the aims of the study.
5 (a) Identified important confounding factors (b) Taken account of confounding factors in design and analysis	(a) Yes (b) Yes	
6 (a) Was follow up of subjects complete (b) Was follow up long enough	(a) Yes (b) Yes	
7 What are the results?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)
8 How precise are the results?	Describe	Significance levels are very high, 0.1% for the main findings. confidence intervals are not presented.
9 Are the results believable?	Yes	
10 Can results be applied to local population	Yes	May not fit my population due to cultural differences.
11 Do results fit with other evidence	Yes	
12 What are the implications for practice?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 9 Harris and Ayers 2012 Quantitative</b>	<b>Meets CASP - High</b>	<b>Comments</b>
1 Addresses clearly focussed issue	Yes	
2 Cohort recruitment acceptable	Yes	
3 Exposure accurately measured to minimise bias	Yes	Objective and subjective measures were used and reflect the aims of the study.
4 Outcome accurately measured to minimise bias	Yes	Objective and subjective measures were used and reflect the aims of the study.
5 (a) Identified important confounding factors (b) Taken account of confounding factors in design and analysis	(a) Yes (b) Yes	
6 (a) Was follow up of subjects complete (b) Was follow up long enough	(a) n/a (b) n/a	Follow-up not required.
7 What are the results?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)
8 How precise are the results?	Describe precision	Significance levels for the main findings were above the 0.1% level.
9 Are the results believable?	Yes	
10 Can results be applied to local population	Yes	
11 Do results fit with other evidence	Yes	
12 What are the implications for practice?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

Study 10 Menage 1993	Quantitative	Meets CASP - Mod	Comments
1	Addresses clearly focussed issue	Yes	
2	Cohort recruitment acceptable	Yes	
3	Exposure accurately measured to minimise bias	Yes	Objective and subjective measures were used and reflect the aims of the study.
4	Outcome accurately measured to minimise bias	Yes	Objective and subjective measures were used and reflect the aims of the study.
5	(a) Identified important confounding factors (b) Taken account of confounding factors in design and analysis	(a) Yes (b) Yes (partial)	Does not address pre-existing psychological issues.
6	(a) Was follow up of subjects complete (b) Was follow up long enough	(a) Yes (b) Yes	
7	What are the results?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)
8	How precise are the results?	Describe	Significant results were above the 5% level.
9	Are the results believable?	Yes	
10	Can results be applied to local population	Yes (partial)	The study included experience other than that associated directly with childbirth.
11	Do results fit with other evidence	Yes	
12	What are the implications for practice?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 11 Nicholls and Ayers 2007 Qualitative</b>		<b>Meets CASP - Mod</b>	<b>Comments</b>
1	Clear statement of aims	Yes	
2	Qualitative is appropriate	Yes	
3	Design is appropriate	Yes	
4	Recruitment strategy appropriate	Yes	
5	Data collection addressed research issue	Yes - partial	Method of recording (hand or audio) is not detailed.
6	Influence of researcher considered	(a) Can't tell (b) Can't tell	No expression of response to events in study or implications of change.
7	Ethical issues considered	Yes	Ethical approval received. Participant info provided, and consent received.
8	Analysis is sufficiently rigorous	Can't tell	Basic thematic analysis not fully described. No reflection described, but a 3 <sup>rd</sup> researcher coded.
9	Clear statement of findings	Yes	
10	Value of the research	Describe	Adds to the growing awareness of the importance of 'how' care is provided. Even though the quality of care was not enquired about in interviews, it emerged as an important feature.

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 12 Nyberg et al. 2010 Qualitative</b>		<b>Meets CASP - Mod</b>	<b>Comments</b>
1	Clear statement of aims	Yes	
2	Qualitative is appropriate	Yes	
3	Design is appropriate	Yes	
4	Recruitment strategy appropriate	Yes	
5	Data collection addressed research issue	Yes	
6	Influence of researcher considered	(a) Can't tell (b) Can't tell	No expression of response to events in study or implications of change.
7	Ethical issues considered	Yes	Ethical approval received. Participant info provided, and consent received.
8	Analysis sufficiently rigorous	Yes	Detailed thematic analysis outlined. 2 <sup>nd</sup> reading carried out and compared.
9	Clear statement of findings	Yes	
10	Value of the research	Describe	This is the only study exploring midwives experience of relating to women with PTSD. However, while this study provides useful insight for the researcher and the participating midwives, it does not explore the midwives experience of relating to women while providing their maternity care.

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 13</b> Sorenson and Tschetter 2010 <b>Quantitative</b>	<b>Meets CASP - Mod</b>	<b>Comments</b>
1 Addresses clearly focussed issue	Yes	
2 Cohort recruitment acceptable	Yes	
3 Exposure accurately measured to minimise bias	Yes	Objective and subjective measures were used and reflect the aims of the study.
4 Outcome accurately measured to minimise bias	Yes	Objective and subjective measures were used and reflect the aims of the study.
5 (a) Identified important confounding factors (b) Taken account of confounding factors in design and analysis	(a) Yes (b) Yes (partial)	measures depression, but not anxiety  Does not address prior trauma or whether depression was pre-existing.
6 (a) Was follow up of subjects complete (b) Was follow up long enough	(a) Yes (b) Yes	
7 What are the results?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)
8 How precise are the results?	Describe	Significant results were above the 5% level.
9 Are the results believable?	Yes	
10 Can results be applied to local population	Yes (partial)	Study participants were white from one area in USA.
11 Do results fit with other evidence	Yes	
12 What are the implications for practice?	Describe	See Table 2.6. (Chapter 2, section 2.2.4.4.)

**Appendix 2.4. Scoring on the CASP criteria for each of the stage two review studies (continued)**

<b>Study 14</b> Tham et al. 2010 <b>Qualitative</b>		<b>Meets CASP - Mod</b>	<b>Comments</b>
1	Clear statement of aims	Yes	
2	Qualitative is appropriate	Yes	
3	Design is appropriate	Yes	But not described why.
4	Recruitment strategy appropriate	Yes	Described what, but not why.
5	Data collection addressed research issue	Yes	
6	Influence of researcher considered	(a) Can't tell (b) Yes	Interviewer did not know women's PTSS status at time of interview. No Expression of response to events in study or implications of change.
7	Ethical issues considered	Yes	Ethical approval received. Participant info provided, and consent received.
8	Analysis sufficiently rigorous	Yes	Authors analysed texts separately until consensus was reached.
9	Clear statement of findings	Yes (Partial)	Somewhat partial and contradictory. Vague reference to 'about half' or 'a majority'. Statements are not all backed up by tables of results.
10	Value of the research	Describe	

### **Appendix 3.1. Dissemination of research findings**

#### **Conference oral presentations**

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2018) Post Traumatic Stress Disorder Post Childbirth. Women's and midwives' experiences of interacting during labour and birth. An Interpretative Phenomenological Analysis. *Society of Reproductive and Infant Psychology 38<sup>th</sup> Annual conference* Łódź, Poland 13<sup>th</sup> September 2018.

Patterson, J. (2017) Extracting and writing up themes: use of colour and font coding. *IPA international conference*. Glasgow, 26<sup>th</sup> July 2018.

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2018) Post Traumatic Stress Disorder Post Childbirth. Women's and midwives' experiences of interacting during labour and birth. An Interpretative Phenomenological Analysis. *Birth Trauma Conference*. Liverpool 18<sup>th</sup> May 2018.

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2018) Post Traumatic Stress Disorder Post Childbirth. Women's and midwives' experiences of interacting during labour and birth. An Interpretative Phenomenological Analysis. International week, *Metropolia University of Applied Sciences*. Helsinki 15<sup>th</sup> March 2018.

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2018) Post Traumatic Stress Disorder Post Childbirth. Women's and midwives' experiences of interacting during labour and birth. An Interpretative Phenomenological Analysis. *Band 7 meeting (senior midwives), Edinburgh royal Infirmary*. 22<sup>nd</sup> February 2018.

Patterson, J. (2018) Nurturing the Carer - caring for ourselves as healthcare professionals. *Presentation and wellbeing workshop, Maternity and Midwifery Festival*. London 13<sup>th</sup> February 2018.

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2018) Post Traumatic Stress Disorder Post Childbirth. Women's and midwives' experiences of interacting during labour and birth. An Interpretative Phenomenological Analysis. *3<sup>rd</sup> Annual Birth Trauma Conference*. London 5<sup>th</sup> January 2018.

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2017) Post Traumatic Stress Disorder Post Childbirth (PTSD-PC). *Perinatal Mental Health: The facts and the feelings study day*. Royal Infirmary of Edinburgh 4<sup>th</sup> December 2017.

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2017) Post Traumatic Stress Disorder Post Childbirth. Women's and midwives' experiences of interacting during labour and birth. An Interpretative Phenomenological Analysis. *Maternity Midwifery Festival*. Edinburgh, 28<sup>th</sup> November 2017.

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2017) Post Traumatic Stress Disorder Post Childbirth (PTSD-PC). *WACHAW meeting. Edinburgh Napier University (Sighthill campus)*. 14<sup>th</sup> November 2017.

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2017) Post Traumatic Stress Disorder Post Childbirth. Women's and midwives' experiences of interacting during labour and birth. An Interpretative Phenomenological Analysis. *Royal college of Midwives annual conference*. Manchester, 31<sup>st</sup> October 2017.

Patterson, J. (2017) Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) the interaction between women and midwives. A short film of expressive movement. Presented at: *Out of Sight/Out of Mind Festival, Scottish Mental Health Arts and Film Festival*. Summerhall and ENU Merchiston campus, Edinburgh, 11<sup>th</sup> – 29<sup>th</sup> October 2017



### **Appendix 3.1. Dissemination of research findings (continued)**

#### **Conference oral presentations**

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2017) Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) the interaction between women and midwives. Three-minute thesis presentation at: *Edinburgh Napier University research conference*. Edinburgh, 21<sup>st</sup> June 2017.

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2017) Post Traumatic Stress Disorder Post Childbirth (PTSD-PC). *Edinburgh Napier Midwifery society. Midwifery Care in Challenging Circumstances*. Edinburgh, 24<sup>th</sup> May 2017.

Patterson, J. (2017) Using IPA to explore PTSD-PC: Women's and midwives' experiences of interacting during childbirth. *IPA international conference*. Glasgow, 19<sup>th</sup> May 2017.

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2017) Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) A literature review. Three-minute thesis presentation at: *Edinburgh Napier University research conference*. Edinburgh, 15<sup>th</sup> June 2016.

Patterson, J. Hollins Martin, C.J. Karatzias, T. Post Traumatic Stress Disorder Post Childbirth (PTSD-PC): A Literature Review. *Edinburgh Napier University School of Nursing and Midwifery PhD student Conference* 31<sup>st</sup> May 2016. (awarded best oral presentation)

I also now provide a regular presentation at NHS Lothian *Perinatal Mental Health: The facts and the feelings study day*, which runs every 3-4 months and alternates between Edinburgh Royal Infirmary and St. John's Hospital, Livingston.

#### **Conference poster presentations**

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2017). Post Traumatic Stress Disorder Post Childbirth (PTSD-PC). A systematic review and narrative synthesis of women's subjective experiences of the associated childbirth event. *Royal college of Midwives annual conference*. Manchester. 31<sup>st</sup> October – 1<sup>st</sup> November 2017

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2017). An interpretative Phenomenological Analysis of the experience of provider interaction from the perspectives of women with Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) and midwives. *Society for Reproductive and Infant Psychology 37<sup>th</sup> annual conference*. York, 12<sup>th</sup>-13<sup>th</sup> September 2017

Patterson, J. Hollins Martin, C.J. Karatzias, T. (2017). Post Traumatic Stress Disorder Post Childbirth (PTSD-PC). A systematic review and narrative synthesis of women's subjective experiences of the associated childbirth event. *Society for Reproductive and Infant Psychology 37<sup>th</sup> annual conference*. York, 12<sup>th</sup>-13<sup>th</sup> September 2017

Patterson, J. Hollins Martin, C.J. Karatzias, T. Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) the interaction between women and midwives. *World Congress on Women's Mental Health*, Dublin, 8<sup>th</sup> March 2017.

Patterson, J. Hollins Martin, C.J. Karatzias, T. Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) the interaction between women and midwives. *Royal college of Midwives annual conference*. Harrogate, 19<sup>th</sup> October 2016.

Patterson, J. Hollins Martin, C.J. Karatzias, T. Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) the interaction between women and midwives. *Edinburgh Napier University postgraduate conference (Craiglockhart Campus)*. 15<sup>th</sup> June 2016

### **Appendix 3.2. Original creative contributions to research and dissemination**

I designed, wrote, and produced a short film depicting the research findings through expressive dance. This film can be accessed through the vimeo link <https://vimeo.com/223027840> with password: ipaptsd

The film was first presented at

Patterson, J. (2017) Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) the interaction between women and midwives. A short film of expressive movement. Presented at: *Edinburgh Napier University research conference*. Edinburgh, 21<sup>st</sup> June 2017

And subsequently at:

Patterson, J. (2017) Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) the interaction between women and midwives. A short film of expressive movement. Presented at: *Edinburgh Napier University International Bazaar (Sighthill campus)*. Edinburgh. 28<sup>th</sup> November 2017

Patterson, J. (2017) Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) the interaction between women and midwives. A short film of expressive movement. Presented at: *Out of Sight, Out of Mind festival*. Summerhall, Edinburgh. 9<sup>th</sup>-30<sup>th</sup> October 2017

The film has also been screened at all oral presentations since June 2017. See Appendix 3.1.

#### **Public engagement with the research findings**

Following the Daily Mail Online publication regarding my presentation at the RCM conference in November 2017 (Appendix 5.2.), I was invited to speak on Radio Newcastle about PTSD following childbirth:

Patterson, J. (2018) Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) the interaction between women and midwives. *Radio interview*. BBC radio Newcastle, 10<sup>th</sup> January 2018

I applied for and received funding from Edinburgh Napier Public Engagement Team and used this to provide two public engagement workshops:

Patterson, J. (2018) Hearing Both Sides of the Story: Interactive workshop for women. St. Bride's Centre, Edinburgh. 8<sup>th</sup> June 2018.

Patterson, J. (2018) Hearing Both Sides of the Story: Interactive workshop for midwives. Edinburgh Royal Infirmary, Edinburgh. 18<sup>th</sup> June 2018.

### **Appendix 3.3. Postnatal groups who advertised the study**

Group or organisation	Lead contact	Details
Juno Perinatal Mental Health support  And  NurtureMe	Tricia Murray tricia@nurtureme.uk.com <a href="http://www.juno.uk.com">http://www.juno.uk.com</a> <a href="https://www.facebook.com/junopmhseдинburgh/">https://www.facebook.com/junopmhseдинburgh/</a> <a href="http://triciamurray.co.uk">http://triciamurray.co.uk</a>	Juno Perinatal Mental Health Support was founded in February 2015 by a group of mums in Edinburgh who all have personal experience of perinatal mental health difficulties.  Tricia Murray is owner of <i>NurtureMe</i> and co-worker for Juno Edinburgh. She is widely connected with many postnatal groups and advertised further via: <ul style="list-style-type: none"> <li>• Edinburgh Birth and Baby</li> <li>• Positive Birth Edinburgh</li> <li>• Edinburgh Gossip Girls</li> <li>• Birth Trauma Association</li> </ul>
Birth and Beyond	Sarah Wheatley sarah@birhandbeyond.org.uk <a href="http://www.birhandbeyond.org.uk">www.birhandbeyond.org.uk</a>	Sarah Wheatley is a counsellor who provides specialist support for postnatal women.
KnotStressed Therapies Ltd. 40-42 Montrose Terrace, Edinburgh.	Onie Tibbit onie@knotstressed.com <a href="http://www.knotstressed.com/pregnancy-birth-and-postnatal/">http://www.knotstressed.com/pregnancy-birth-and-postnatal/</a>	KnotStressed specialise in supporting pregnant women, their partners and families through pregnancy, childbirth, and the postnatal period.
Pregnancy and Parents Centre (PPC) 10a Lower Gilmore Place, Edinburgh.	PPC coordinator info@pregnancyandparents.org.uk <a href="http://www.pregnancyandparents.org.uk">www.pregnancyandparents.org.uk</a>	The Pregnancy and Parent's Centre is a Charity that has provided support for women and families for over 30 years in Edinburgh.
CrossReach Palmerston Place PND Centre, Annan House, 10 Palmerston Place, Edinburgh.	Joyce Linklater joyce.linklater@crossreach.org.uk <a href="http://www.crossreach.org.uk">http://www.crossreach.org.uk</a>	Postnatal Depression Services in four locations across Edinburgh. Although I received written agreement that they would advertise, I in fact never received any further replies from my communications to them.

## Appendix 3.4. Women's advertising poster



# Did you find aspects of your pregnancy or birth distressing or traumatic?

## We need to hear your story

We want to improve things for women, but we need to know what is  
important to you

You are invited to participate in a confidential one to one interview with  
an Edinburgh Napier University researcher

For more information please contact:

Jenny Patterson



School of Nursing, Midwifery and Social Care at Edinburgh Napier

My name is Jenny Patterson, I am a PhD student at Edinburgh Napier University. I am interested in finding out from women who found their birth experience traumatic, about how they experienced their interaction/relationship with midwives during their maternity care. My research is intended to help women in the future and inform practice. If you would like to take part, you will be asked to complete two short questionnaires and may be invited to an interview with me. The research is confidential and your identity will remain anonymous.



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## **Appendix 3.5. Women's information leaflet for initial screening, page 1**

### **Participant information sheet for women Stage 1**

#### **Invitation**

You are being invited to participate in a research study. Before you decide whether or not to participate, it is important for you to understand why the research is being carried out and what will be involved. Please take time to read the following information carefully and discuss it with others should you wish. Please ask if there is anything that is not clear. Please take up to one week to consider whether or not to participate.

#### **Title of the study**

The interaction between women and midwives – perspectives from women with Post Traumatic Stress Disorder post childbirth and midwives. A qualitative study of their experiences.

#### **Who is organizing and funding the study?**

The study has been organised by Jenny Patterson who is a PhD student at Edinburgh Napier University (ENU). Jenny is undertaking this study for a PhD thesis. The study is being funded by ENU and has been reviewed and approved by ENU research ethics committee.

#### **What is the purpose of the study?**

The aim of the study is to further understand women's experiences of interacting with midwives during pregnancy or during the birth of their baby (babies). The researcher will also ask midwives about their experience of providing care for women.

#### **Who can take part in the study?**

This study is open to women aged 18 years or more, who can speak and read English fluently. Women will have given birth at term (at least 37 weeks of pregnancy) to a [well baby](#) (or babies). Women will have given birth at least one month ago and found this birth experience distressing or traumatic. Women will not be currently receiving medical treatment for any mental health conditions (e.g. anxiety or depression) which existed prior to giving birth. Women will not have been diagnosed with Puerperal Psychosis since the birth.

#### **Why have I been chosen and do I need to take part?**

You have been invited to participate in this study because you meet the inclusion criteria for the study. It is up to you to decide whether or not you want to participate. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. In addition, you are still free to withdraw from the study at any time and without giving a reason why. A decision to withdraw, or a decision not to participate, will in no way affect any further care you receive from the maternity or healthcare services.

#### **What will happen to me if I take part and what will be involved?**

There are two stages to the study. This information is about stage 1 and you may be invited to take part in stage 2, in which case further information will be given.

Your involvement in stage 1 of the study will involve completing two short questionnaires, each will take no more than 15 minutes of your time. You may also be asked whether you would be willing to be interviewed. If you are willing to be interviewed, this is stage 2 and you will receive further information about this before agreeing to take part.



**What happens to the data?** All the information that is collected about you during the course of the study will be kept strictly confidential and will have your name removed so you cannot be recognised in any way.

All data collected will be kept in a secure place (paper data will be kept in a locked cabinet and electronic data will be stored on a pc that is password protected), which only the researcher will have access to. These will be kept till the end of the research process, 3 years, following which all data that could identify you will be destroyed.

**How are the results used?** The information that we gain from this study will help us understand more about women's experiences of interacting with their midwives during pregnancy and childbirth. As a consequence, we are hoping that future care for others will be improved. When the results of the study are published, your contribution will not be recognised as yours in any way. The results will be written up in Jenny Patterson's PhD thesis. Results may be published in a journal or presented at a conference.

#### **Contacts for further information**

If you have any questions or concerns, you are welcome to discuss this with either of the following people:

The researcher: Jenny Patterson at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN

Research supervisor: Prof Caroline Hollins Martin at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

Research supervisor: Prof Thanos Karatzias at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

Independent advisor: Barbara Neades at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

**What is the next step?** If you have read and understood this information sheet, and any questions you have had have been answered, and you would like participate in the study, please now see the consent form.



## Appendix 3.6. Women's eligibility form

### Eligibility to take part in the study

You have accepted the invitation to take part in a research study being carried out by Jenny Patterson (PhD student at Edinburgh Napier University). The aim of the study is to explore what women felt was distressing or traumatic about the way the midwives related to them during their care in pregnancy or during the birth of their baby (babies). Before continuing with the first part of the study, please can you confirm your eligibility to take part by completing the following short questionnaire. Please ask if there is anything that is not clear.

**Please answer the following questions:**

- |   | <b>Please tick</b>       |
|---|--------------------------|
| 1. I gave birth to a well baby (babies) at least one month ago, who is (are) still well now.  | <input type="checkbox"/> |
| 2. I was 37 weeks pregnant or more when I gave birth to my baby (babies).   | <input type="checkbox"/> |
| 3. I found the birth of my baby (babies) distressing or traumatic.  | <input type="checkbox"/> |
| 4. I am NOT currently receiving treatment for any mental health conditions which existed prior to the birth of my baby (e.g., anxiety or depression). | <input type="checkbox"/> |
| 5. I have not been diagnosed with Puerperal Psychosis since the birth of my baby (babies).  | <input type="checkbox"/> |
| 6. I can speak and read English fluently.   | <input type="checkbox"/> |
| 7. I am aged 18 or over.  | <input type="checkbox"/> |

If you have ticked all 5 categories, then you are eligible to participate in the study and are now invited to read the participant information sheet for stage 1 and if happy to participate to complete the consent form.

If you have not ticked all 5 categories I am afraid you do not meet all the inclusion criteria for the study and therefore cannot be invited to participate. Thank you very much for your interest and taking the time to complete this form.



### Appendix 3.7. Women's consent form for initial screening



#### Edinburgh Napier University Research Consent Form

**The interaction between women and midwives – perspectives from women with Post Traumatic Stress Disorder post childbirth and midwives. A qualitative study of their experiences.**

Edinburgh Napier University requires that all persons who participate in research studies give their written consent to do so. Please read the following and sign it if you agree with what it says.

1. I freely and voluntarily consent to be a participant in the research project on the topic of The interaction between women and midwives to be conducted by Jenny Patterson, who is a postgraduate student at Edinburgh Napier University.
2. The broad goal of this research study is to explore women and midwives' experiences of relating to one another during maternity care provision. Specifically, I have been asked to take part in the first stage of the above study which is to complete two assessment questionnaires that should take no longer than 15 minutes each to complete.
3. I have been told that my responses will be anonymised. My name will not be linked with the research materials, and I will not be identified or identifiable in any report subsequently produced by the researcher.
4. I also understand that if at any time during the completion of the assessment forms I feel unable or unwilling to continue, I am free to leave. That is, my participation in this study is completely voluntary, and I may withdraw from it without negative consequences. However, after data has been anonymised or after publication of results it will not be possible for my data to be removed as it would be untraceable at this point.
5. In addition, should I not wish to answer any particular question or questions, I am free to decline.
6. I have been given the opportunity to ask questions regarding this first stage of the research and the assessment forms and my questions have been answered to my satisfaction.
7. I have read and understand the above and consent to participate in this study. My signature is not a waiver of any legal rights. Furthermore, I understand that I will be able to keep a copy of the informed consent form for my records.

---

Participant's Signature

---

Date

I have explained and defined in detail the research procedure in which the respondent has consented to participate. Furthermore, I will retain one copy of the informed consent form for my records.

---

Researcher's Signature

---

Date



## **Appendix 3.8. Women's interview information**

### **Participant information sheet for women Stage 2**

#### **Title of the study**

The interaction between women and midwives – perspectives from women with Post Traumatic Stress Disorder post childbirth and midwives. A qualitative study of their experiences.

#### **Invitation**

You are receiving this information because you have participated in stage 1 of the above named research study and have met the diagnostic criteria for PTSD on the City Birth Trauma Scale which you completed in stage 1. You are now being invited to take part in an interview. Before you decide whether or not to participate, it is important for you to understand why the research is being carried out and what will be involved. Please take time to read the following information carefully and discuss it with others should you wish. Please ask if there is anything that is not clear. Please take up to one week to consider whether or not to participate.

#### **As a reminder of the study details:**

##### **Who is organizing and funding the study?**

The study has been organised by Jenny Patterson who is a PhD student at Edinburgh Napier University (ENU). Jenny is undertaking this study for a PhD thesis. The study is being funded by ENU and has been reviewed and approved by ENU research ethics committee.

##### **What is the purpose of the study?**

The aim of the study is to further understand women's experiences of interacting with midwives during pregnancy or during the birth of their baby (babies). The researcher will also ask midwives about their experience of providing care for women.

##### **Who can take part in the study?**

This study is open to women aged 18 years or more, who can speak and read English fluently. Women will have given birth at term (at least 37 weeks of pregnancy) to a well baby (or babies). Women will have given birth at least one month ago and found this birth experience distressing or traumatic. Women will not be currently receiving medical treatment for any mental health conditions (e.g. anxiety or depression) which existed prior to giving birth. Women will not have been diagnosed with Puerperal Psychosis since the birth.

##### **What do I do if I wish to take part in stage 2?**

If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. In addition, you are still free to withdraw from the study at any time and without giving a reason why. A decision to withdraw, or a decision not to participate, will in no way affect any further care you receive from the maternity or healthcare services.

##### **What will happen to me if I take part and what will be involved?**

There are two stages to the study. This information is about stage 2

Your involvement in stage 2 of the study will be to participate in an interview. The researcher is very aware of the intense demands on your time as a new mother and therefore the interview can take place in a location and at a time of your choosing and will last no more than 1 to 1.5 hours.



## Appendix 3.8. Women's interview information (continued) page 2



This can be your home, Edinburgh Napier University or other place of your choice. The interview will last for 1 to 1.5 hours and will be audio recorded. The recording will be transcribed verbatim

The researcher is aware that reflecting on a traumatic experience can be difficult and upsetting and so you will be free to decline to answer any questions or stop the interview at any time without needing to give a reason. All interviewees will also be provided with the contacts of follow up resources or support which they can access if they require.

**What happens to the data?** All the information that is collected about you during the course of the study will be kept strictly confidential and will have your name removed so you cannot be recognised in any way. All data collected will be kept in a secure place (paper data will be kept in a locked cabinet and electronic data will be stored on a pc that is password protected), which only the researcher will have access to. These will be kept till the end of the research process, 3 years, following which all data that could identify you will be destroyed.

**How are the results used?** The information that we gain from this study will help us understand more about women's experiences of interacting with their midwives during pregnancy and childbirth. As a consequence, we are hoping that future care for others will be improved. When the results of the study are published, your contribution will not be recognised as yours in any way. The results will be written up in Jenny Patterson's PhD thesis. Results may be published in a journal or presented at a conference

### **Contacts for further information**

If you have any questions or concerns, you are welcome to discuss this with either of the following people:

The researcher: Jenny Patterson at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN

Research supervisor: Prof Caroline Hollins Martin at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

Research supervisor: Prof Thanos Karatzias at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

Independent advisor: Barbara Neades at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

**What is the next step?** If you have read and understood this information sheet, and any questions you have had have been answered, and you would like to participate in the study, please now see the consent form.



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### Appendix 3.9. Women's interview consent form



#### Edinburgh Napier University Research Consent Form

**The interaction between women and midwives – perspectives from women with Post Traumatic Stress Disorder post childbirth and midwives. A qualitative study of their experiences.**

Edinburgh Napier University requires that all persons who participate in research studies give their written consent to do so. Please read the following and sign it if you agree with what it says.

1. I freely and voluntarily consent to be a participant in the research project on the topic of The interaction between women and midwives to be conducted by Jenny Patterson, who is a postgraduate student at Edinburgh Napier University.
2. The broad goal of this research study is to explore women and midwives' experiences of relating to one another during maternity care provision. Specifically, I have been asked to take part in the second stage of the above study which is to participate in an interview with the researcher that will last no longer than 1 to 1.5 hours.
3. I have been told that my responses will be anonymised. My name will not be linked with the research materials, and I will not be identified or identifiable in any report subsequently produced by the researcher.
4. I also understand that if at any time during the interview I feel unable or unwilling to continue, I am free to leave. That is, my participation in this study is completely voluntary, and I may withdraw from it without negative consequences. However, after data has been anonymised or after publication of results it will not be possible for my data to be removed as it would be untraceable at this point.
5. In addition, should I not wish to answer any particular question or questions, I am free to decline.
6. I have been given the opportunity to ask questions regarding this second stage of the research and the interview and my questions have been answered to my satisfaction.
7. I have read and understand the above and consent to participate in this study. My signature is not a waiver of any legal rights. Furthermore, I understand that I will be able to keep a copy of the informed consent form for my records.

---

Participant's Signature

---

Date

I have explained and defined in detail the research procedure in which the respondent has consented to participate. Furthermore, I will retain one copy of the informed consent form for my records.

---

Researcher's Signature

---

Date

### **Appendix 3.10. Women's debrief information sheet (initial screening)**



**Thank you for your participation in stage 1 of this research study.**

Your completion of both the Birth Satisfaction Scale and the City Birth Trauma Scale will provide important information to enable greater understanding of the development of Post Traumatic Stress Disorder following childbirth.

This study is particularly exploring the role of the interaction with the midwife during receipt of maternity care, in terms of the woman's perception of her experience of childbirth.

All the information collected from these questionnaires will be kept strictly confidential and will have your name removed so you cannot be recognised in any way. The questionnaires will be kept in a locked cabinet, which only the researcher will have access to. These will be kept till the end of the research process, 3 years, following which they will be destroyed.

Your participation today is appreciated. If you have any questions or concerns, you are welcome to discuss this with either of the following people:

The researcher: Jenny Patterson at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN

Research supervisor: Prof Caroline Hollins Martin at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

Research supervisor: Prof Thanos Karatzias at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

Independent advisor: Barbara Neades at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

If taking part in this interview has raised any difficult feelings for you or you wish to speak to someone further about how you are feeling there is a list of resources and follow up contacts overleaf.



## **Appendix 3.10. Women's debrief information sheet (initial screening) (continued)**

### **page 2**



#### **Juno Perinatal Mental Health support**

<http://www.juno.uk.com>

<https://www.facebook.com/junopmhseдинburgh/>

Juno Perinatal Mental Health Support was founded in February 2015 by a group of mums in Edinburgh who all have personal experience of perinatal mental health difficulties. We support mums through

- Weekly [peer support groups](#) across the city where we offer advice and information
- One-to-one befriending through our outreach program
- Access a subsidised counselling service out with our groups with a trained professional.

Our main aim as Juno is to help mums with perinatal mental health difficulties realise that they are not alone in how they feel and what they feel is indeed a very real illness. It is very common to think 'why me?' 'why can everyone else cope?' 'will I ever feel normal again?' 'it's not supposed to feel like this...is it?'

#### **Crossreach**

[http://www.crossreach.org.uk/sites/default/files/pnd\\_lothian\\_general\\_information\\_leaflet\\_mar14\\_0.pdf](http://www.crossreach.org.uk/sites/default/files/pnd_lothian_general_information_leaflet_mar14_0.pdf)

Wallace House,  
3 Boswall Road, Edinburgh EH5 3RJ tel: 0131 538 7288,  
the Postnatal Depression Services head office, based on the North side of the City.  
Palmerston Place PND Centre, Annan House, 10 Palmerston Place, Edinburgh EH12 5AA  
tel 0131 220 3547, in the city centre of Edinburgh.  
East Edinburgh PND Centre,  
The Gate Lodge, 27 Milton Road East, Edinburgh EH15 2NL tel: 0131 454 4315, near Portobello.  
We also provide an Outreach Service at Craighour in Gracemount, Edinburgh.

#### **You can find a further list of support resources for women, partners and families at:**

<http://maternalmentalhealthscotland.org.uk/resources/links-to-charities-and-support-groups>

#### **You can contact your GP or Health Visitor**

**Breathing Space 0800 83 85 87** <http://breathingspace.scot>

**N.B. If you have serious concerns regarding your current mental health you can contact:**

#### **Mental Health Assessment Service (MHAS)**

<http://www.nhslothian.scot.nhs.uk/MediaCentre/Publications/YourHealthService/Documents/MentalHealthAssessmentServiceLeaflet.pdf>



# Calling all Midwives

Please help us improve things for  
women who are traumatised by birth

Short, easy to complete, anonymous online survey

This is your opportunity to participate in a research study and  
make a difference

The link for the survey is at the end of the attached information sheet.

For more information, please contact:

Jenny Patterson 

School of Health and Social Care at Edinburgh Napier

My name is Jenny Patterson, I am a PhD student at Edinburgh Napier University. I am interested in finding out from midwives about how they experience their interaction/relationship with women during provision of women's maternity care. My research is intended to help women and midwives in the future and inform practice. If you would like to take part, please complete the online survey, within which you will have the opportunity to tell me if you would like to be considered for an interview with me. The research is confidential, and your identity will remain anonymous.



### **Appendix 3.12. Midwives' online survey**

1. **I consent to completing this questionnaire** Yes [ ] No [ ]
  
2. **How long have you been a practising midwife ?** Years [ ] months [ ]
  
3. **Have you been practising for at least 6 of the previous 12 months?** Yes [ ] No [ ]
  
4. **Where is your main location of work ?**
  - a) Consultant led unit AN / PN ward [ ]
  - b) Consultant led unit labour ward [ ]
  - c) Birth centre [ ]
  - d) Community [ ]
  - e) Other [ ]
  
5. **What proportion of the last 12 months have you worked in this location?**
  - a) Less than 50% [ ]
  - b) More than 50% [ ]
  
6. **Prior to this study, were you aware that some women develop PTSD following childbirth?**
  - a) Have known for more than 5 years [ ]
  - b) Have known for more than 1 year [ ]
  - c) Have known for less than 1 year [ ]
  - d) Only became aware as a result of encountering this study [ ]
  
7. **Have you provided care for a woman who you 'think might have had' or 'had been diagnosed with' PTSD from a previous childbirth or following this childbirth?**
  - a) Not that I am aware [ ]
  - b) Yes [ ]

The respondent is directed to subsequent questions as follows:

If answered 'Yes' to no. 7 – taken to questions 8,9, and 10

If answered 'Not that I am aware' taken to question 11

8. **Which aspect of the woman's maternity care were you involved in? Please choose all that apply.**
  - a) Antenatal care [ ]
  - b) Intranatal care [ ]
  - c) Postnatal care [ ]
  
9. **When did you become aware that the woman was (or may have been) suffering PTSD following childbirth?**
  - a) During antenatal care - PTSD was related to a previous pregnancy [ ]
  - b) During Intranatal care - PTSD was related to a previous pregnancy [ ]
  - c) During postnatal care. - PTSD was related to a previous pregnancy [ ]
  - d) During extended postnatal care (beyond 4 weeks) and or from feedback from the woman's Health Visitor or GP. The PTSD related to this childbirth experience [ ]

### **Appendix 3.12. Midwives' online survey (continued)**

**10. What do you 'believe' or 'know' contributed to the trauma which led to PTSD for the woman? (Tick all that apply)**

- a) Woman experienced a physically traumatic birth [ ]
- b) Woman experienced an emotionally traumatic birth [ ]
- c) Woman experienced significant physical morbidity as a result of the birth [ ]
- d) Woman had unplanned obstetric interventions [ ]
- e) The baby was premature, stillborn or required transfer to NNU [ ]
- f) The woman's expectations regarding birth experience were not met [ ]
- g) The woman was unprepared for the reality of birth [ ]
- h) The woman had a history of previous traumatic experience and this influenced her birth experience [ ]
- i) The woman had a history of previous or current mental health conditions and this influenced her birth experience [ ]
- j) Other [please describe]

**11. If you have not been aware of a woman experiencing PTSD following childbirth what do you think are the potential contributing factors. (Tick all that apply)**

- a) Woman experiencing a physically traumatic birth [ ]
- b) Woman experiencing an emotionally traumatic birth [ ]
- c) Woman experiencing significant physical morbidity as a result of the birth [ ]
- d) Woman having unplanned obstetric interventions [ ]
- e) The baby being premature, stillborn or required transfer to NNU [ ]
- f) The woman's expectations regarding birth experience not being met [ ]
- g) The woman being unprepared for the reality of birth [ ]
- h) The woman having a history of previous traumatic experience and this influenced her birth experience [ ]
- i) The woman having a history of previous or current mental health conditions and this influenced her birth experience [ ]
- j) Other [ please describe]

**12. When you consider the potential contributing factors you have chosen in question 10 or 11 please list the four most important things midwives could do to reduce the risk of a woman developing PTSD-PC (*free text*)**

- 1)
- 2)
- 3)
- 4)

**13. When you consider these four most important things you have identified that midwives could do to reduce the risk of PTSD-PC, do you feel supported in achieving this within your workplace?**

- a) rarely [ ]
- b) some of the time [ ]
- c) frequently [ ]
- d) all of the time [ ]



**Appendix 3.12. Midwives' online survey (continued)**

**14. Would you be willing to participate in a face-to-face interview with the researcher to discuss this more closely, particularly in terms of your experience of being with women and how you are supported in providing the care you see as necessary?**

a) Yes [ ]

b) No [ ]

**If you have answered yes please give your contact details here**

Email (not NHS):

Phone:

Address:

**Thank you for completing this questionnaire**

**Please follow this [link](#) for a debrief sheet and follow up resources**

## **Appendix 3.13. Midwives' interview information leaflet**

### **Participant information sheet for midwives regarding the research interview**

#### **Title of the study**

The interaction between women and midwives – perspectives from women with Post Traumatic Stress Disorder post childbirth and midwives. A qualitative study of their experiences.

#### **Invitation to take part in an interview**

You are receiving this information because you have completed the online survey and have declared an interest in participating in an interview for this research project and are now being invited to do so. You also meet the inclusion criteria of being a registered midwife who has practiced for at least 6 months of the previous 12. A reminder of the research information is given on page 2. Before you decide whether or not to participate, it is important for you to understand why the research is being carried out and what will be involved. Please take time to read the following information carefully and discuss it with others should you wish. Please ask if there is anything that is not clear. Please take up to one week to consider whether or not to participate.

**What will this next stage involve for you?** The researcher is very aware of the intense demands on your time as a practising midwife and therefore the interview can take place in a location and at a time of your choosing. This can be your home, Edinburgh Napier University or other place of your choice. The interview will last for 1 to 1.5 hours and will be audio recorded. The recording will be transcribed verbatim. The researcher is aware that reflecting on a relational experience may bring up workplace or personal issues, you will be free to decline to answer any question and stop the interview and withdraw from the study at any stage without needing to give a reason.

**What happens to the data?** All data will be anonymised, but you may be identifiable from tape recordings by your voice, which will only be accessible to the researcher and her two PhD supervisors. Your name will be replaced with an informant number and pseudonym, and it will not be possible for you to be identified in any reporting of the data gathered. All data collected will be kept in a secure place (paper data will be kept in a locked cabinet and electronic data will be stored on a pc that is password protected), which only the researcher will have access to. These will be kept till the end of the research process, 3 years, following which all data that could identify you will be destroyed.

**How are the results used?** The results will be written up in my PhD thesis. Results may be published in a journal or presented at a conference.

## Appendix 3.13. Midwives' interview information leaflet (continued) page 2

### Contacts for further information

If you have any questions or concerns, you are welcome to discuss this with either of the following people:

The researcher: Jenny Patterson at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN

Research supervisor: Prof Caroline Hollins Martin at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

Research supervisor: Prof Thanos Karatzias at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

Independent advisor – who knows about this study but is not involved in it:  
Barbara Neades at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

**What is the next step?** If you have read and understood this information sheet, and any questions you have had have been answered, and you would like to participate in the study, please now see the consent form.

### A reminder of the research information given on the first information sheet

**Who am I and what is my research?** My name is Jenny Patterson. I am a PhD research student from the School of Nursing, Midwifery and Social Care at Edinburgh Napier University (ENU). I am undertaking this research project for a PhD thesis.

**What do I aim to do in the research?** One strand of the research will explore midwives' awareness of the potential development of Post Traumatic Stress Disorder post Childbirth (PTSD-PC), including what midwives consider to be potential risk factors for developing PTSD-PC. This research will explore what midwives perceive women need from them to reduce risk and feel enables or hinders them to meet the needs of women during childbirth. A second strand will explore women's experiences of interacting with their midwives.

**Why am I doing this research?** The findings of this project will be valuable, since existing research tells us that women can develop PTSD-PC as a result of a negative perception of their interaction with midwives. An interaction between midwives and women is a two-way process and so it is important to me that the midwives experience is explored.

**Who is funding this research?** This research is being funded by Edinburgh Napier University (ENU).

**Ethics:** this study has been passed by the ENU ethics committee.

### Appendix 3.14. Midwives' interview consent form



#### Edinburgh Napier University Research Consent Form

**The interaction between women and midwives – perspectives from women with Post Traumatic Stress Disorder post childbirth and midwives. A qualitative study of their experiences.**

Edinburgh Napier University requires that all persons who participate in research studies give their written consent to do so. Please read the following and sign it if you agree with what it says.

1. I freely and voluntarily consent to be a participant in the research project on the topic of the interaction between women and midwives, to be conducted by Jenny Patterson, who is a postgraduate student at Edinburgh Napier University.
2. The broad goal of this research study is to explore women and midwives' experiences of relating to one another during maternity care provision. Specifically, I have been asked to take part in the second stage of the above study which is to participate in an interview with the researcher that will last no longer than 1 to 1.5 hours.
3. I have been told that my responses will be anonymised. My name will not be linked with the research materials, and I will not be identified or identifiable in any report subsequently produced by the researcher.
4. I also understand that if at any time during the interview I feel unable or unwilling to continue, I am free to leave. That is, my participation in this study is completely voluntary, and I may withdraw from it without negative consequences. However, after data has been anonymised or after publication of results it will not be possible for my data to be removed as it would be untraceable at this point.
5. In addition, should I not wish to answer any particular question or questions, I am free to decline.
6. I have been given the opportunity to ask questions regarding this second stage of the research and the interview and my questions have been answered to my satisfaction.
7. I have read and understand the above and consent to participate in this study. My signature is not a waiver of any legal rights. Furthermore, I understand that I will be able to keep a copy of the informed consent form for my records.

---

Participant's Signature

---

Date

I have explained and defined in detail the research procedure in which the respondent has consented to participate. Furthermore, I will retain one copy of the informed consent form for my records.

---

Researcher's Signature

---

Date

### Appendix 3.15. Midwives' debrief information sheet



**Thank you for your participation in stage 2 of this research study.**

Your participation in the interview will provide important information to enable greater understanding of the development of Post Traumatic Stress Disorder following childbirth.

This study is particularly exploring the role of the midwife's interaction with the woman during provision of maternity care, in terms of the woman's perception of her experience of childbirth.

All the information collected from this interview, the audio recording and notes taken, will be kept strictly confidential and will have your name removed so you cannot be recognised in any way. The recordings and notes will be kept in a secure place (paper data will be kept in a locked cabinet and electronic data will be stored on a pc that is password protected), which only the researcher will have access to. These will be kept till the end of the research process, 3 years, following which all data that could identify you will be destroyed.

Your participation today is appreciated. If you have any questions or concerns, you are welcome to discuss this with either of the following people:

The researcher: Jenny Patterson at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN

Research supervisor: Prof Caroline Hollins Martin at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

Research supervisor: Prof Thanos Karatzias at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

Independent advisor: Barbara Neades at [REDACTED]  
School of Health and Social Care  
[REDACTED] Sighthill Campus, Edinburgh Napier University  
11 Sighthill Court, Edinburgh EH11 4BN  
[REDACTED]

If taking part in this interview has raised any difficult feelings for you or you wish to speak to someone further about how you are feeling there is a list of resources and follow up contacts overleaf.



## Appendix 3.15. Midwives' debrief information sheet (continued) page 2



You can contact your:

GP

Mind

<http://www.mind.org.uk/information-support/tips-for-everyday-living/work/work-and-stress/#.V03sQ5B4WrU>

Breathing Space 0800 83 85 87 <http://breathingspace.scot>

Self care suggestions by midwife and midwife researcher Sarah Wickham

<http://www.sarawickham.com/tag/self-care/>

<http://www.sarawickham.com/original-articles/eight-things-id-like-to-share-with-midwifery-students-who-care/>

Information from Billie Hunter's research on resilience in midwifery

<https://www.rcm.org.uk/news-views-and-analysis/analysis/one-to-one-bouncing-back>

N.B. If you have serious concerns regarding your current mental health you can contact:

Mental Health Assessment Service (MHAS)

<http://www.nhslothian.scot.nhs.uk/MediaCentre/Publications/YourHealthService/Documents/MentalHealthAssessmentServiceLeaflet.pdf>

If taking part in this research has raised any difficult feelings for you regarding your workplace or you wish to speak to someone further about your workplace, you may consider contacting your:

Supervisor of midwives

Local branch of the RCM or Unison

## Appendix 3.16. City BiTS PTSD-PC screening scale

### Appendix 3.16.1. City BiTS form

Informant number [                      ]



## CITY UNIVERSITY LONDON

### Birth Trauma Scale

I consent to completing this questionnaire

Signature of participant:

\_\_\_\_\_

This questionnaire asks about your experience during the birth of your most recent baby. It asks about potential traumatic events during (or immediately after) the labour and birth, and whether you are experiencing symptoms that are reported by some women after birth. Please tick the responses closest to your experience.

What date was your baby born? \_\_\_\_\_

During the labour, birth and immediately afterwards:		
Did you believe you or your baby would be seriously injured?	Yes	No
Did you believe you or your baby would die?	Yes	No
Did you feel any intense negative emotions (e.g. fear, helplessness, horror)?	Yes	No

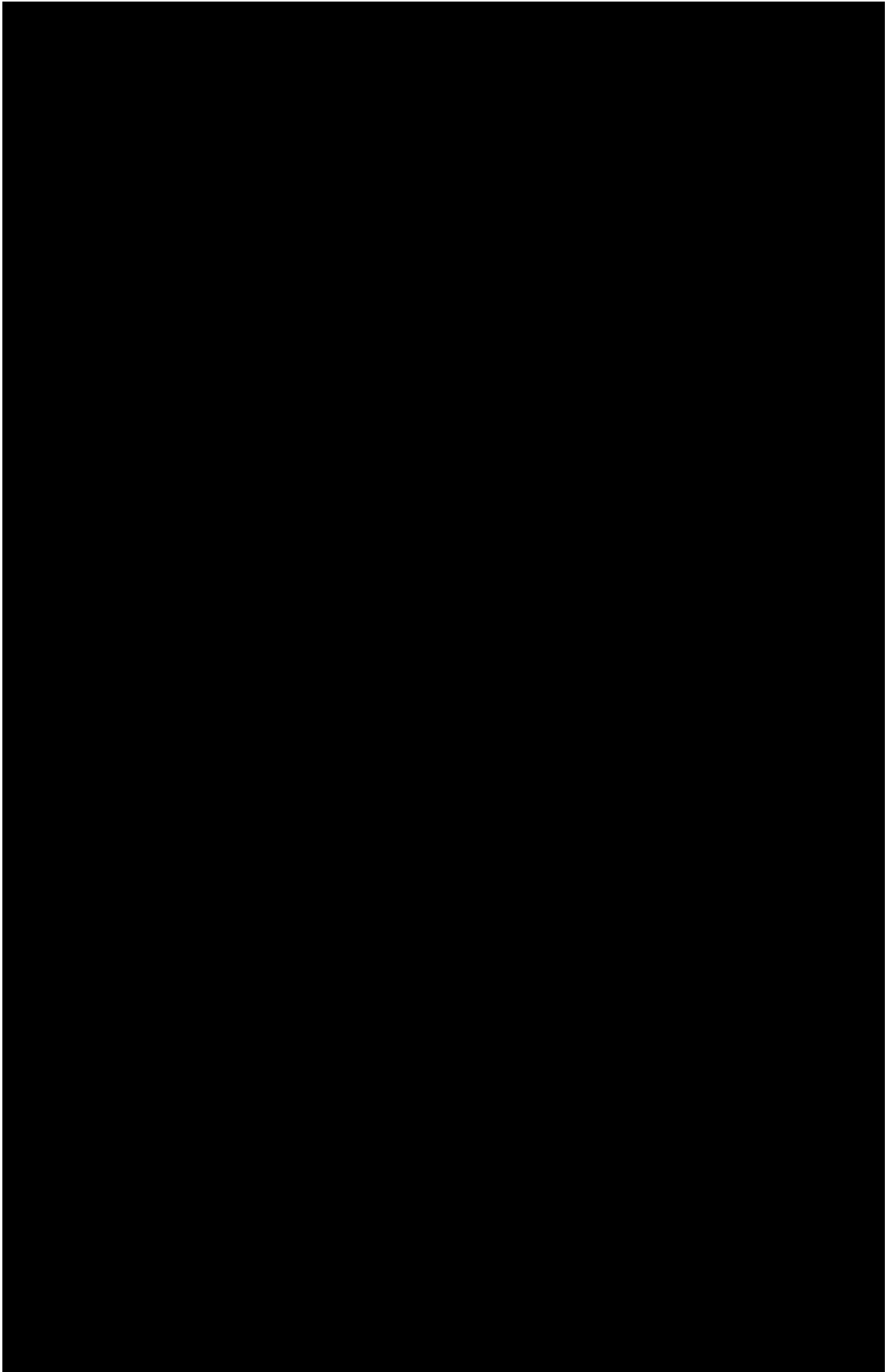
The next questions ask about symptoms that are specific to birth or general. Please indicate how often you have experienced the following symptoms in the last week:

Symptoms about the birth*	NOT AT ALL	ONCE	2 - 4 TIMES	5 OR MORE TIMES
Recurrent unwanted memories of the birth (or parts of the birth) that you can't control				
Bad dreams or nightmares about the birth (or related to the birth)				
Flashbacks to the birth and/or reliving the experience				
Getting upset when reminded of the birth				
Feeling tense or anxious when reminded of the birth				
Trying to avoid thinking about the birth				
Trying to avoid things that remind me of the birth (e.g. people, places, TV programs)				
Not able to remember details of the birth				
Blaming myself or others for what happened during the birth				
Feeling strong negative emotions about the birth (e.g. fear, anger, shame)				

\* Although these questions refer to the birth, many women have symptoms about events that happened just before or after birth. If this is the case for you, and the events were related to pregnancy, birth or the baby then please answer for these events.

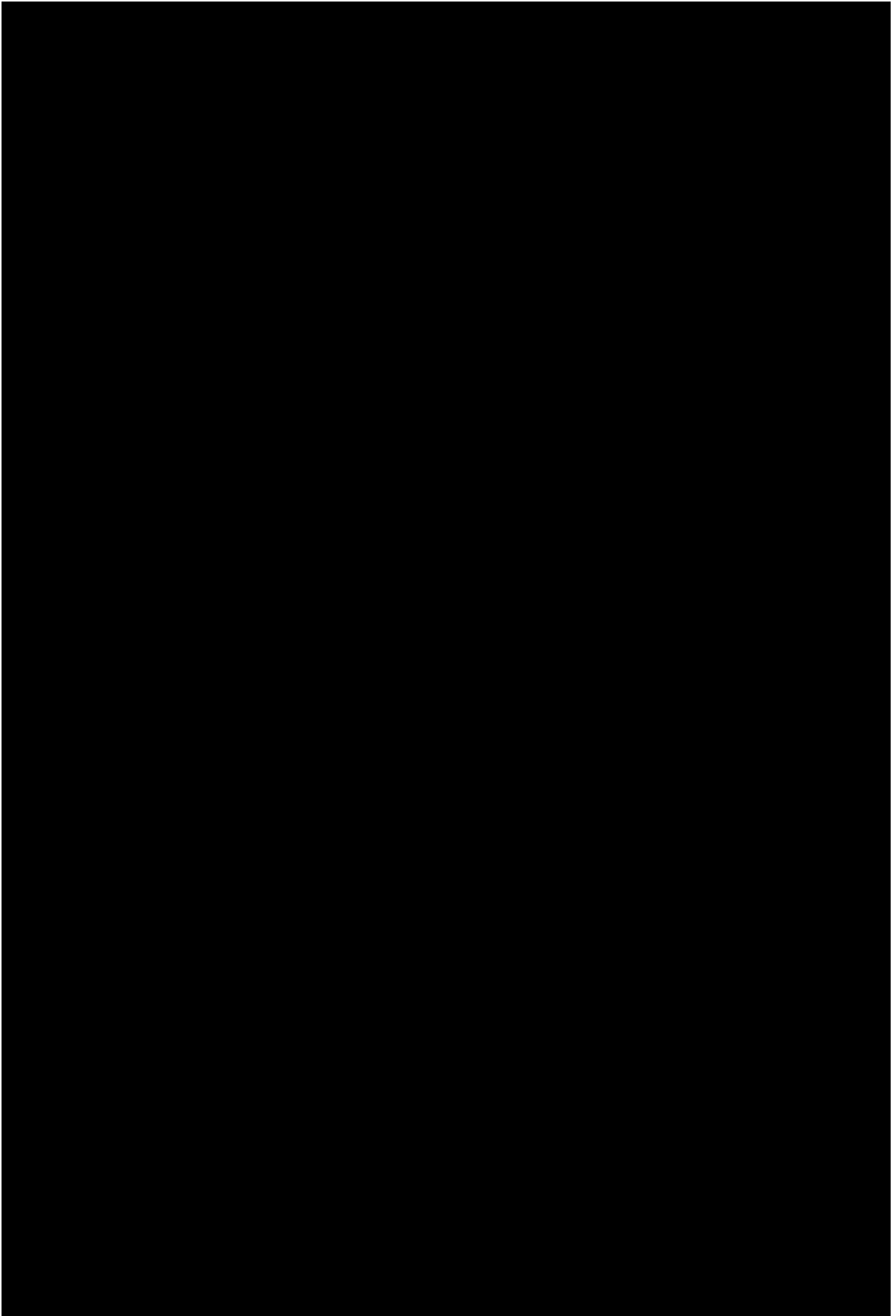
© City Birth Trauma Scale Version 1.0 2016  
Available by request from Susan Ayers

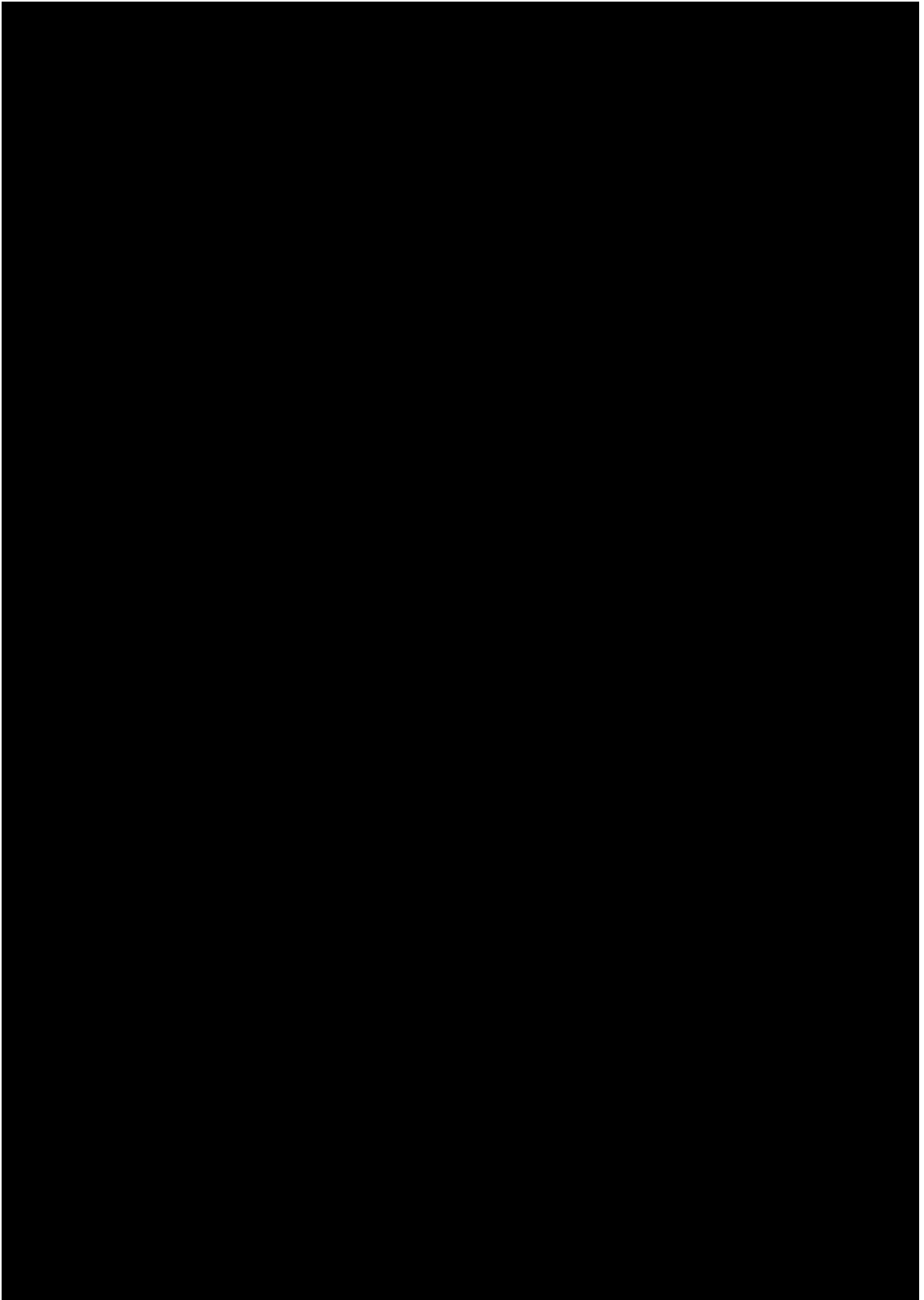
Page 1





**Appendix 3.16.2. City BiTS scoring sheet**





## Appendix 3.16.2. City BiTS scoring sheet (continued) page 3

### Scoring information

The questionnaire can be used as a measure of PTSD symptoms or diagnostic criteria as follows:

#### PTSD symptoms

##### **Symptom Subscales**

- Re-experiencing symptoms: Q4 + Q5 + Q6 + Q7 + Q8
- Avoidance symptoms: Q9 + Q10
- Negative cognitions and mood: Q11 + Q12 + Q13 + Q14 + Q15 + Q16 + Q17
- Hyperarousal: Q18 + Q19 + Q20 + Q21 + Q22 + Q23

##### **Total PTSD symptoms**

- Total score from Q4 to Q23 inclusive. Total range 0 - 60

##### **Dissociative symptoms**

- Q24 + Q25

Please note these are not symptoms of PTSD but are for diagnostic purposes or if you are interested in dissociation during birth as a separate phenomenon.

##### **Emotional numbing**

- Q26 measures emotional numbing because women said this is important although it is no longer included in DSM-5 PTSD criteria.

### Appendix 3.16.3. City BiTS Diagnostic Criteria

#### Diagnostic criteria

##### **[A] Stressor Criterion**

- Women fulfil DSM-IV criterion A if they respond yes to [Q1 or Q2] and Q3
- Women fulfil DSM-5 criterion A if they respond yes to Q1 or Q2

##### **[B] Re-experiencing symptoms (1 needed)**

- Women score 1 or more on any question from Q4 to Q8 inclusive

##### **[C] Avoidance symptoms (1 needed)**

- Women score 1 or more on Q9 or Q10.

##### **[D] Negative cognitions and mood (2 needed)**

- Women score 1 or more on 2 questions from Q11 to Q17 inclusive

##### **[E] Hyperarousal (2 needed)**

- Women score 1 or more on 2 questions from Q18 to Q23 inclusive

##### **[F] Duration**

- Women score 1 or more on Q28

##### **[G] Distress and impairment**

- Women score 1 or more on Q29 or Q30

##### **[H] Exclusion criteria**

- If women score 1 or more on Q31 then exclude them from diagnostic PTSD

##### **PTSD with dissociative symptoms**

- Q24 and Q25 measure dissociative symptoms so if women score 1 or more on either of these questions the diagnosis should be 'PTSD with dissociative symptoms'

##### **PTSD with delayed onset**

- Score of 2 on Q27 means PTSD with delayed onset

Please note a score of 0 on Q27 suggests PTSD prior to birth so is a measure of prevalence rather than new incidence of PTSD due to birth

## Appendix 3.16.4. City BiTS Rating scale information

### Information about the development of City BiTS

Ayers, Thornton & Wright (in prep) Development of the City Birth Trauma Scale

Questions were written to directly correspond to DSM-5 criteria but adapted to be specific to childbirth. Initial questions were then reviewed by two groups to check face validity, content validity and ease of comprehension. First, the questions were reviewed by a group of 9 researchers with expertise in perinatal mental health. After that, questions were revised and then reviewed by a second group of 8 women aged 21 to 34, whose youngest children were aged between 13 months and 4 years old. As a result of review by these group various changes were made to the instructions of the questionnaire and wording of items.

This development stage resulted in the final questionnaire consisting of 31 questions: 29 questions which map onto DSM-5 diagnostic criteria; and two questions from DSM-IV criteria (one for criterion A2; and one on symptoms of emotional numbing). The question on A2 was included on the basis of evidence that it is important in postpartum PTSD. The question on emotional numbing was included following review by the group of postpartum women who strongly recommended it be retained because of its potential impact on the mother-baby relationship.

The response scale measures frequency of symptoms over the last week and is scored on a scale ranging from 0 ('not at all') to 3 ('5 or more times'). A higher score indicates greater symptoms of PTSD. Diagnostic criterion A items are scored on a yes/no scale. Distress, disability and potential physical causes were rated as yes/no with a third response category of 'maybe' for women who were not sure. The 'maybe' category was added after review by postpartum women (as above).

The scale is easy to read at a level that would easily be understood by 13 to 15 year olds (Flesch Reading Ease score = 64.17). The number of years of formal education required to easily read the scale (Gunning Fog index) was 6.71.

Reliability in an online sample of 950 women who had given birth in the previous 12 months was good: Intrusions  $\alpha=.88$ ; Negative mood and cognitions  $\alpha=.83$ ; Hyperarousal  $\alpha=.84$  (alpha for Avoidance is not given because there are only 2 items in this subscale)

### **Appendix 3.17. Birth Satisfaction Scale – Revised**

Informant number [            ]



Birth Satisfaction scale Revised (BSS-R). (Prof. Caroline Hollins Martin)

**I consent to completing this questionnaire**

Signature of participant:

---

**(1) I came through childbirth virtually unscathed.**

Strongly Agree [  ] Agree [  ] Neither Agree or Disagree [  ] Disagree [  ] Strongly Disagree [  ]

Comments

---

**(2) I thought my labour was excessively long.**

Strongly Agree [  ] Agree [  ] Neither Agree or Disagree [  ] Disagree [  ] Strongly Disagree [  ]

Comments

---

**(3) The delivery room staff encouraged me to make decisions about how I wanted my birth to progress.**

Strongly Agree [  ] Agree [  ] Neither Agree or Disagree [  ] Disagree [  ] Strongly Disagree [  ]

Comments

---

**(4) I felt very anxious during my labour and birth.**

Strongly Agree [  ] Agree [  ] Neither Agree or Disagree [  ] Disagree [  ] Strongly Disagree [  ]

Comments

---

**(5) I felt well supported by staff during my labour and birth.**

Strongly Agree [  ] Agree [  ] Neither Agree or Disagree [  ] Disagree [  ] Strongly Disagree [  ]

Comments

---



## **Appendix 3.17. Birth Satisfaction Scale – Revised (continued) page 2**

Informant number [            ]



**(6) The staff communicated well with me during labour.**

Strongly Agree [  ] Agree [  ] Neither Agree or Disagree [  ] Disagree [  ] Strongly Disagree [  ]

Comments

---

**(7) I found giving birth a distressing experience.**

Strongly Agree [  ] Agree [  ] Neither Agree or Disagree [  ] Disagree [  ] Strongly Disagree [  ]

Comments

---

**(8) I felt out of control during my birth experience.**

Strongly Agree [  ] Agree [  ] Neither Agree or Disagree [  ] Disagree [  ] Strongly Disagree [  ]

Comments

---

**(9) I was not distressed at all during labour.**

Strongly Agree [  ] Agree [  ] Neither Agree or Disagree [  ] Disagree [  ] Strongly Disagree [  ]

Comments

---

**(10) The delivery room was clean and hygienic.**

Strongly Agree [  ] Agree [  ] Neither Agree or Disagree [  ] Disagree [  ] Strongly Disagree [  ]

Comments

---



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Inspiring Futures  
[www.napier.ac.uk](http://www.napier.ac.uk)

2

### **Appendix 3.18. Women's sociodemographic form**



**At the start of each interview with women the researcher will ask the following socio demographic questions. These will be posed in a conversational manner as a means of opening up into the interview. (this approach was highlight during the IPA interview training session)**

1. I understand you have had a birth experience which you found traumatic, please can you tell me when this was?
2. Do you have any other children? Were any of those birth experiences traumatic?
3. Are you happy to tell me your age?
4. How would you describe your ethnic back ground?

(may give the options to choose from the following if easier)

	Tick
White British	
White European	
White Other	
Asian British	
Asian European	
Asian Other	
Black British	
Black European	
Black other	
Chinese	
Other Ethnic groups	

5. Are you currently working or studying out with|the home?
6. If so can you tell me what you do and if this is full-time or part-time?
7. What are your current living circumstances?
8. Before your traumatic birth experience had there been any issues that you had been particularly worried about? (e.g., divorce, bereavement, illness etc.)
9. Since your traumatic birth experience have there been any issues that you have been particularly worried about? (e.g., divorce, bereavement, illness etc.)





## **Appendix 3.19. Interview schedules**

### **Appendix 3.19.1. Women's interview schedule**

#### **Main question**

Please tell me about your experience of being with and cared for by midwives or others during your labour and birth? I am particularly interested in - **How you felt and what things meant to you.**

#### **Further questions to elicit appropriate information:**

##### **Please tell me about:**

- Your experience of meeting/being with your midwives during labour
- What you hoped for/expected from your midwives
- How your Midwives made you feel
- How would have liked your midwives to make you feel?
- What was important for you during your care?
- How might things have felt different?
- What do you think the midwife felt?
- Can you tell me what you would like to say to your midwives if you had the chance now?

##### **Possible ways to go deeper**

- Can you tell me more about that?
- What do you mean by "..."

## Appendix 3.19.2. Midwives' interview schedule

### Interview Schedule

#### Opening introduction and question

I have been exploring the experience of women who feel their birth has been traumatic and who subsequently go on to develop PTSD - women tell us that the way the midwife has related to them is an important part of their experience - which can be traumatic if they feel the interaction with their midwife has been negative.

From this background, I am particularly interested in hearing from you as a midwife about how you experience being with women - so please can you tell me about your experience of interacting with women while providing their intrapartum and early postnatal care - particularly how you feel when you are with women, and what it means for you.

#### Further questions to elicit appropriate information:

#### Consider what feels good, difficult, also conflicts, joys

#### Self as (labour ward/birth centre) midwife

- What is important for you when carrying out your role as a (labour ward, Birth Centre) midwife – How does this role make you feel?
- What you expect from yourself in this role?
- What do these expectations mean to you?
- How do your expectations of your role make you feel when you are with women?

#### Your experience of being with women during labour, how women make you feel

- How do you feel about women's hopes, expectations, requests, needs?
- What do women's hopes, expectations, requests, needs mean for you when you are with them?
- What you hope for/expect from women in labour
- What do you think women feel about....

#### Workplace demands

- How does your working environment make you feel?
- How do you feel about meeting the needs of women in labour within this workplace?
- How does meeting the needs of women and the workplace make you feel when you are with women?
- How do you feel when conflicts arise between women's expectations and workplace?
- How might things feel different

#### Can you tell me what you would like to say to women if you had the chance now

#### Possible ways to go deeper

- Can you tell me more about that?
- What do you mean by "..."

Appendix 3.20. An example IPA coding page

	there's so	Description	language	Conceptual + Interpretive	My thoughts	Emergent themes	
15	1	many stuff intervening into that process and that can happen during the process, that this is, there is no way we can prepare a woman for the exact birth of her baby. This is, this is not, this is not possible. We can speak about different stuff, we can speak about what can happen, basics, but we cannot, we cannot prepare them for that exact birth. So I think what I like is... when they're... have an idea about what can happen, it's fair enough that they don't want a section, they don't want forceps, they don't want a ventouse, the suction cup, it's not really anyone would really like that em. but that... I usually tell them that they need to understand we wouldn't do that if there's no reason to do, for us to do that because this is a risk, this is a risk for the baby and a risk for the mum but we would do that because otherwise this baby might be like a lot of bad consequences for this baby and, or this mum. So this... if we take this decision at that point because we think that's the safest option for both of them. I think that's what important for me to tell them or to make them understand that were not here to go against their plan. That we're here to make sure they're gonna, they're gonna be safe, the whole way through, right up until the end. Whatever the issue is and that there's so many risks around the labour that we are going to try and manage them but then sometimes this is going very nice and smoothly and straightforward and sometimes this is not but then, this is not their fault, this is not our fault, this is just the way, the way it is, the way the labour's going and then... even if it's not in the birth plan, that they have to be prepared for that, even if they don't want to, but that can still, that might still happen.	things intervene, happen, can't prepare, not possible Discuss, not exact like women to have idea about what can happen what they want tell them why do certain things good reasons possible consequences decisions to prevent this getting women to understand here to keep safety no matter what managing risk if not easy, no ones fault way of labour if not plan, be realistic, might be the way it is	intervene, can, no way we can, exact this is not x 2 possible can speak x 2 can happen we can't x 2 exact I like, idea, can, fair enough they don't really, really tell, they need we wouldn't b. if no, risk x 3 otherwise might be lots of bad, if we about, we think safest I think, me to tell make them understand were not against we're here, make sure, right up so many risk we try but sometimes x 2 not fault x 2 way it is ways, even if plan, they have to even if don't want but, can, might	MR emphasising how valuable the process is to unknown 'stuff' - sense that women expect too much from MRs - not possible to meet exact emphasis on exploring, thinking but not totally deciding - not in control circumstances impact MR needs women to think ahead and get be realistic about how it can be - MR reflecting that she understands why women don't want! - I do understand, am not being hard sense of needing to get through to women get them to understand - We are only doing this to keep you safe we are doing our best to keep you safe - that's what we do what we don't - why not trust us. sense of having to fight against women's mistrust of MR MR carries a lot of fear of Risk + safety - + responsibility with sense she has to 'battle' to get women to see this MR feels blamed by women if doing stuff or if goes wrong - but she says it's reality - no one to blame sense that MR finds women not realistic about what can/might and that this is problem	sense of pressure to meet women's desire wants to be clearly what she can do this - rather fault wanting to be realistic - sense of having to get through to women but not wanting to appear unhelpful risk is a big concern for MR focus on safety really wants women to understand why actions are for good, needed I am only doing what is best sense of MR finding women hard to work with if they don't accept her role + risk woud women to resist and accept - what is needed, what's real MR trying to understand why PTSD - don't have nice	not we impacts we cannot know about expectations need to be realistic not we impacts can't prepare for unknown I do understand but be realistic need to get through to women Risk is real! Trust me we do this for your safety having to fight against women's mistrust Women don't trust us having to 'battle' Risk/safety Be realistic we try our best Don't blame me be realistic let me do my job trust me be open be open. both feel happier
34	34	So not too strict birth plan, I think that's what I like to have (laughs) a patient coming with	patient having not to strict plan	not too, I like with MR wants women to be open ready to face reality + let MR do her job		let me do my job trust me be open	
36	36	Openness					
36	37	Yeah. And usually it works a lot better for them... to have a very... you feel they're more, they are happier about what's happening to them... after that. Well, that's what I feel anyway.	usually better happier she feels	usually, better than they're, they, (hum) what I feel Focus on how much better women feel if open - this is what MR sees + feels are women happier or is MR happier because less tension?		be open. both feel happier	
36	38	Thank you. So I'd like you maybe to tell me a little bit... about eh... your working environment and the impact on how that feels for you in there, because you've spoken a bit about if you have time to do certain things or if you're following up on a situation or in HDU, so					

### Appendix 3.21. An example of initial lists of emergent themes

#### **Identity**

<b>(Initial page: theme)</b>	<b>Emergent theme</b>
LS1:1	self is important
LS1:2	birth journey personal
LS1:3	connection with mw
LS1:4	trust in mw
LS1:5	seeking 'care'
LS1:6	seeking support
LS1:7	lack confidence
LS1:8	need to understand
LS1:9	need reassurance
LS1:10	lack knowledge
LS1:11	vulnerable
LS1:12	putting self in hands of others
LS2:1	lack confidence in mw
LS2:2	loss autonomy
LS2:3	loss of woman in process
LS2:4	having to comply
LS2:5	having to obey
LS2:6	having to submit
LS2:7	fear/horror breaks through
LS2:8	attempts to take control
LS2:9	attempts to protect self
LS2:10	'acceptance', no choice
LS2:11	endurance
LS2:12	hopelessness
LS2:13	disconnection from baby
LS2:14	need to contain experience
LS3:1	unexpected events
LS3:2	lack of guidance
LS3:3	lack of discussion
LS3:4	lack of option
LS3:5	pressure
LS3:6	threat
LS3:7	unsupported
LS3:8	self doesn't matter
LS3:9	'dismissed' home
LS3:10	'told' not 'discussed'

### Appendix 3.22. An example colour coding of emergent themes

LS1:1 self is important  
LS1:2 birth journey personal  
LS1:3 connection with mw  
LS1:4 trust in mw  
LS1:5 seeking 'care'  
LS1:6 seeking support  
LS1:7 lack confidence  
LS1:8 need to understand  
LS1:9 need reassurance  
LS1:10 lack knowledge  
LS1:11 vulnerable  
LS1:12 putting self in hands of others

LS2:1 lack confidence in mw  
LS2:2 loss autonomy  
LS2:3 loss of woman in process  
LS2:4 having to comply  
LS2:5 having to obey  
LS2:6 having to submit  
LS2:7 fear/horror breaks through  
LS2:8 attempts to take control  
LS2:9 attempts to protect self  
LS2:10 'acceptance', no choice  
LS2:11 endurance  
LS2:12 hopelessness  
LS2:13 disconnection from baby  
LS2:14 need to contain experience

LS3:1 unexpected events  
LS3:2 lack of guidance  
LS3:3 lack of discussion  
LS3:4 lack of option  
LS3:5 pressure  
LS3:6 threat  
LS3:7 unsupported  
LS3:8 self doesn't matter  
LS3:9 'dismissed' home  
LS3:10 'told' not 'discussed'

### **Appendix 3.23. An example of grouping colour coded themes**

#### **Self needs, individual**

LS1:1 self is important

LS1:2 birth journey personal

LS2:3 loss of woman in process

LS3:8 self doesn't matter

#### **Connection, relationship**

LS1:3 connection with mw

LS2:13 disconnection from baby

LS4:1 no relationship

LS4:9 loss of relationship

LS5:7 being 'dealt' with

#### **Trust**

LS1:4 trust in mw

LS1:7 lack confidence

LS1:12 putting self in hands of others

LS2:1 lack confidence in mw

LS4:2 no trust

#### **Support**

LS1:5 seeking 'care'

LS1:6 seeking support

LS1:9 need reassurance

LS3:7 unsupported

LS6:1 seeking support

LS6:2 lack support

#### **Expectations**

LS3:1 unexpected events

LS10:7 unprepared

LS11:4 no access to desired experiences

LS12:8 distance between what known/expected and what others do

LS13:19 disbelief

LS13:20 why??

**Appendix 3.24. An example cut and paste page showing master themes groupings and interpretative processes**

**2a**

**Not heard, no one listening**

CD1:2 no one listening  
 CD1:19 needing heard  
 CD2:4 ignored *See me, no one listening*  
 CD5:17 need heard  
 CD6:19 misunderstood  
 CD6:20 making needs known  
 CD7:1 inability to communicate, be heard  
 CD7:22 ignored  
 CD8:13 not understood  
 CD8:18 unable to be understood  
 CD8:19 need to be heard  
 CD9:5 being noticed, valued, cared for  
 CD10:4 woman centred  
 CD11:8 need to be understood  
 CD11:16 not understood, not seen  
 CD12:3 need to be seen, understood  
 CD12:8 need to be believed  
 CD12:9 ignored, of no importance  
 CD12:11 needs seen, self needs are primary  
 CD12:12 feeling ignored, not seen  
 CD12:16 see me!  
 CD12:17 welcome me  
 CD12:18 see me  
 CD12:19 see me  
 CD13:2 see me  
 CD13:3 see me  
 CD13:11 seen, recognised, acknowledged (see me)  
 CD15:2 I am not a stereotype  
 CD15:3 I am not a stereotype  
 CD15:4 need to be seen  
 CD15:23 needs to be heard *See me!*  
 CD16:6 need to understand  
 CD17:5 see me  
 CD17:25 unneeded, unimportant  
 CD18:15 what about me?  
 CD19:3 ignored, of no value or importance  
 CD20:16 my individuality - see me  
 CD20:22 calling out - see me  
 CD20:28 me - see me  
 CD21:1 being seen, noticed  
 CD21:3 see me

**2b**

**Communication, info**

CD4:13 lack preparation or awareness  
 CD10:12 seeking information, need evidence based information  
 CD11:3 quality of info, consequences  
 CD14:9 need to be informed  
 CD14:17 understanding and agreement  
 CD15:8 unwilling to obey without question, need info  
 CD15:9 lack info

**2c**

**Disrespect**

CD4:10 being put down, resisting  
 CD4:12 disrespect/put down  
 CD4:15 disrespect, brought down  
 CD4:16 negativity  
 CD7:20 negative attitude  
 CD7:26 lack respect  
 CD8:1 unimportant, no longer matter  
 CD8:11 I am most important  
 CD8:14 feeling judged unfairly  
 CD10:13 lack respect, understanding  
 CD10:13 judgement  
 CD11:4 needing validation  
 CD11:15 impersonal  
 CD12:1 cold, impersonal  
 CD15:2 don't judge me  
 CD15:3 don't judge me  
 CD15:7 lack respect, not recognised as a person  
 CD15:13 acknowledgement  
 CD16:6 need to be validated  
 CD19:2 no autonomy, feel like child, no respect  
 CD19:6 see me, need to feel of value  
 CD19:9 inappropriate, see me  
 CD19:29 unacknowledged, unimportant, no value  
 CD21:4 just me

**2d**

**Connection, relationship**

CD1:6 isolated  
 CD1:6 disconnect  
 CD1:16 isolated  
 CD1:20 disconnect  
 CD2:5 disconnect  
 CD2:13 lack relationship, disconnect  
 CD2:8 abandoned  
 CD2:15 lack relationship, disconnect  
 CD2:16 uneasy, negative relationship  
 CD2:23 disconnect  
 CD3:1 lack connection  
 +ve CD3:3 relationship, connection  
 +ve CD3:4 being present, focus on woman  
 +ve CD3:5 relief/joy, connection  
 CD8:8 need to have focus on woman  
 CD5:9 prior knowledge, impact  
 +ve CD5:6 reconnecting  
 +ve CD5:14 connection, focus on woman  
 CD5:15 focus on tasks  
 CD6:3 isolated  
 CD6:6 doubting trust, no longer safe  
 CD7:8 isolated, separate  
 CD7:19 isolated, alone  
 CD7:20 isolated  
 CD7:22 abandoned  
 CD8:15 disinterested staff, no connection  
 CD8:21 abandoned  
 CD10:8 woman centred, continuous presence,  
 +ve CD11:5 connection  
 +ve CD11:11 care, connection  
 CD12:2 alienated  
 CD12:24 no connection  
 CD12:25 impersonal  
 CD13:1 disconnect, cold, functional  
 CD13:4 disconnect, separate, cold  
 CD13:5 isolated, cut off  
 +ve CD13:7 relationship, connection  
 CD13:13 safe, relationship  
 CD13:18 relationship, focus on self  
 +ve CD13:18 being cared for, connection  
 +ve CD13:19 connection, rapport  
 +ve CD13:22 fondness, connection, rapport, joy  
 +ve CD13:23 journeying together, accompanied  
 CD14:18 disconnected, isolated  
 CD17:15 impersonal, task focus  
 CD17:22 focus on task, no connection  
 CD19:10 needing connection, recognition  
 CD19:14 othering  
 CD19:18 conflict, disconnect  
 CD20:13 othering

**2e**

**Seeking help, support**

CD1:8 seeking help  
 CD1:8 seeking help sanctuary  
 CD1:9 rejected, let down  
 CD1:21 seeking help, sanctuary  
 CD2:1 lack attention to needs  
 CD2:8 lack attention to needs  
 CD2:20 inaction by mw NOT horrible action  
 CD5:7 support from others  
 CD5:1 someone there for me  
 CD5:10 being held  
 CD9:13 cared for  
 CD10:1 being held  
 CD10:2 supported, encouraged  
 CD10:5 cared for  
 CD12:22 not getting what need  
 CD12:23 not getting what need  
 CD13:15 seeking support  
 CD16:11 seeking rescue  
 CD17:24 no care  
 CD19:3 needs not me  
 CD19:13 supported, acknowledged

**Navigation**

need heard (8)a  
 ignored, not listening (9)a  
 See Me! (23)a, c, d  
 being judged (2)a (4)c  
 being understood (5)a (1)b (1)c  
 isolated (8)d  
 abandoned  
 Disrespect (12)c  
 Connection (15)d+ve (12)d+ve  
 support (7)e

**Polansalam**

if being seen ↔ being seen  
 no connection connected  
 unheard recognised

supported: held, cared  
 unsupported: no care, needs not met

**Function**

See Me!  
 'I am here, I need you to be with me, listen, care, understood and don't judge'  
 'Focus was not on me, was on tasks'

① woman  
 ② connection, relationship

**relationship (7) d**  
**Impersonal (3)c (6) d**  
**needs not, unmet (5) e**  
**prep, info**

**- see Me!**  
**- Discuss with me!**  
**- connect with me!**

## **Appendix 3.25. An example showing stages of groupings**

**110118: Revised (2nd regrouping of themes) after collating the master themes across women are given below:**

### **SHAME**

#### Being a bother

CD8:17 embarrassed	8:38-40
CD8:23 shame, embarrassment	8:53-55
CD12:17 welcome me	12:29-30
CD15:14 nuisance	15:24-26
CD17:20 fear of being nuisance	17:29
CD18:3 shame, silly	18:2-4

### **Blame**

#### I was a failure, it was my fault

CD1:15 feeling blame	1:32-33
CD1:18 feeling blame	1:36-37
CD2:11 feeling shame	2:18-19
CD3:24 questioning self	3:52-56
CD4:17 blamed, brunt	4:42-43

### Safety

CD1:8 sanctuary	1:15-17
CD1:11 sanctuary	1:19-21
CD2:14 feeling unsafe, insecure	2:27-29
CD2:17 unsafe, vulnerable, no sanctuary	2:34-37**
CD2:21 unsafe	n/a
CD3:7 sanctuary	3:12-14

### **Original set of groupings**

#### **Disrespect** Theme group 2C

CD4:10 being put down, resisting	theme quote ref
CD4:12 disrespect/put down	4:23-25
CD4:15 disrespect, brought down	4:28-31
CD4:16 negativity	4:37-43
CD7:20 negative attitude	as above
CD7:26 lack respect	7:42-44
	7:53-57

#### **Vulnerable, unsafe** theme group 1b

CD1:7 vulnerable,	1:14-16
CD2:14 feeling unsafe, insecure	2:27-29
CD2:17 unsafe, vulnerable, no sanctuary	2:34-37**
CD2:21 unsafe	n/a
CD3:7 sanctuary	3:12-14
CD3:15 safe, sanctuary	3:29-31



**Appendix 3.26. Example table of frequencies used to clarify final master themes**

		GS	VM	JE	MH	CD	LS
Control, Power, agency	Powerlessness, lack of control LACK AGENCY	31	56	46	44	37	44
5 sub	Vulnerable, worn out	49	39	27	28	29	37
	Conflict, power struggle, (add in violation)	19	33	27	44	18	28
Misuse of power by MW - mechanism	Negative attitude of the MW, dismissed, shut down, Told off, chastised, punished	56	26	19	15	21	16
Outcome of misuse of power	Failure, fault, foolish +	52	18	25	29	38	14
	Being a bother, nuisance, worthless	32	14	19	7	17	8
Being with me as an individual	Connection, relationship	44	34	59	37	36	18
4 sub	Support, abandoned and isolated	35	31	48	19	22	12
	Respect for me as individual + Needs not recognised	33	27	80	52	39	36
	Communication	28	20	27	33	20	37

## **Appendix 3.27. Example of re-grouping of themes through use of the frequency table**

### **Appendix 3.27.1. Example of groupings prior to use of frequency table**

**Original master theme groupings:**

#### **Master theme ‘Being a bother/nuisance’**

##### **SHAME, worthless**

- Not worth paying attention to, Not of value, I didn’t matter, I was not important
- I was in their way, I was annoying/too demanding
- Dismissed, cast aside

##### **BLAME, getting it wrong**

- At fault, failure, self-blame
- Judged, punished, chastised

Closely related to ‘being a nuisance’ was respect for the individual:

#### **Master theme Seeing the woman as an individual**

- Respect
- Needs not recognised, Acknowledging me, Ignored
- Communicating with me

#### **Master them Control/power/choice**

This was a clear theme arising for all women. When trying to make sense of this theme I considered the sense of ‘power struggle’ which incorporates ‘power imbalance’ – this then meant that themes such as

- Control, choice, power
- Trapped, vulnerability
- Enduring, worn out, trying, overwhelm

were all part of this master theme – all of these were identified by each woman

#### **Master theme. Connection and relationship with the midwife**

- Connection, relationship
- Ticking the boxes (focus not on woman)
- Support, isolated, abandoned

#### **Master theme Not as expected**

- I was prepared and knowledgeable, I did my bit
- Could not trust, let down
- Incompetent, uncared for
- Loss, anger, shock

#### **Master theme: danger, threat, fear**

- Danger, threat, violation
- Fear, horror
- Survive, protect, broken

### **Appendix 3.27.2. Example of revised groupings after use of frequency table**

#### **Master theme Control/Power (5)**

Vulnerability (a consequence of the situation)

Power struggle, conflict (trying to gain some power over this vulnerability) and Violation

Negative attitude

Powerlessness (consequence of failing to achieve power)

#### **Master theme Being with me as an individual (4)**

Connection or relationship

Support, abandoned, and Isolated

See Me! Needs not recognised and (respect?)

Talk to me! Listen to me! Communication

#### **Master theme Providing the care I need (5)**

Shock disbelief

Trust/rely

Care for me! Incompetence or lack of care

Safety danger

Threat, fear, or horror

### **Appendix 3.28. Example of the tracking and coding done to cross reference women's extracts used**

#### **Negative attitudes**

1 CD4:45-51 2 GS13:20-23 3 LS10:1-7 4 MH6:50-51,7:1-4 c

#### **Power struggles**

1 JE3:41-51,4:1 2 CD8:46-56 3 VM7:29-45 4 JE8:44-51,9:1-4 5 MH4:34-47,5:1-3

#### **Consequences of power struggles**

1 LS3:11-27 2 CD17:32-44,18:1-11 3 CD19:23-32 4 JE5:29-38

#### **Trust**

1 CD1:15-27 2 JE19:1-9,23:44-46,24:1-5 3 MH22:5-9 4 VM2:12-17

#### **Safety danger**

1 JE31:10-18 2 VM2:36-44 3 MH10:35-43,16:34-40

#### **Threat fear**

1 GS2:30-39,15:32-36,42-44 2 VM1:26-29,2:45:51,6:9:18,13:8-12 3 JE13:1-10,34:1-21 4 MH5:7-16

#### **Shock**

1 CD3:1-18 overlap in connection quote 3 2 GS2:10-14,15:3-8 3 MH15:4-15,27:17-28 4 LS12:20-28 5 CD20:1-27

#### **Connection**

1 CD2:25-37,11:41-43,12:1-3 2 MH1:3-10,15-24,27-36 3 CD3:1-18 overlap in shock quote 1 - keep here - change in Shock section 4 VM4:39-41,5:14-24,6:2-4

#### **Support**

1 JE6:43-47 2 CD7:38-57 3 LS6:9-11,9:24-31,10:21-35,11:1-11,16:1-7 4 VM 3:6-19,28-32,4:1-6

#### **Needs recognised**

1 LS8:10-21 2 GS20:12-25 3 MH17:11-14,26:6-16

#### **Communication**

1 VM14:22-30,35:39,15:1-4 2 JE 16:28-33,19:7-9,21:25-27 3 GS2:40-46,12:32-36,15:44-48,16:1-2

### **Appendix 3.29. Example of document for one informant showing extracts relevant to individual sub themes**

#### **Seeing woman as an individual**

CD4:25-30 I think I might of even said I'm a nurse or something just tell me what it is and what it does and it's ohh! (sigh) you know and I can't even remember now I don't even know if she did tell me but the attitude was like oh for goodness sake you know just shut up and take it

CD4:37-43 and then there was her that everything was a problem everything was an issue she was just tutting and sighing the whole way through and you know even with ..with her colleagues or stuff she was doing it was like ..(makes humph noises).. you know. it just seemed like it was the last place she wanted to be and I was just really annoying

#### **Communication**

CD15:15-18 I felt I remember feeling like ok I'm part of this you're giving me the information I'm making the decision .. but when Moira she just held out this pill " here take this" .

CD15:18-23 ..I just was like what..why.. you know I don't wanna take like .. take something what is it? And so to be told look everyone has it didn't feel you know I it stopped feeling like an exchange of adults being like right well you know we're the ones we're the gatekeepers of the of the health information you're asking questions we're answering them

#### **Needs not recognised**

CD2:1-3 Wheelchair back, oh..uh uh..you know, I don't think they even asked me how I was or how I felt or how long they didn't ask..

CD2:14-16 it was just like right we've got to get these done you have to wait while we have to get these done and then she like finished shuffled them all up and went off

**Appendix 3.30. Example page of colour coded transcript templates (midwives)**

Line no.	Text	Descriptive notes	
1	<u>Well...(Laughs)...I... feel initially...we...you know</u>	In relationship theme	
2	<u>you have to very quickly get to know someone</u>		
3	<u>and as a result of that I feel you have to have</u>		
4	<u>really good observational skills...with regards</u>		
5	<u>to...how...you're gonna build up the rapport</u>		
6	<u>with the women when you first meet</u>		
7	<u>them...you...get to know...you know I think you</u>		
8	<u>see.. first of all you are going to notice their</u>		
9	<u>body language and how they are and how</u>		
10	<u>they..how relaxed that are with you as well and</u>		
11	<u>how open they are em..sometimes that happens</u>		
12	<u>right away. Sometimes...you have to build up to</u>		
13	<u>it and you almost have to gain the woman's</u>		
14	<u>trust, and someti...very occasionally you might</u>		
15	<u>never quite...feel that you...not so much gel, but,</u>		
16	<u>you know, you don't quite feel</u>		
17	<u>you...communicate...as well as sometimes you</u>		
18	<u>do with others. Em...and I suppose the</u>		
19	<u>communication it's, it is a two way thing</u>		
20	<u>em...but women in labour I find, some of them</u>		
21	<u>because of the pain that they're going through</u>		
22	<u>at the time, some of them can be quite chatty in</u>		
23	<u>between the contractions, others just want</u>		
24	<u>to...be...in their own wee world and they..they</u>		
25	<u>want to know that you're there, but they don't</u>		Women know to ask – up to women
26	<u>necessarily want to talk to you much. Em...and</u>		
27	<u>it's I think as a midwife it's a great skill being</u>		
28	<u>able to pick that out of people you know and be</u>		
29	<u>able to say right ok I know she's not really</u>		
30	<u>wanting to talk so the best thing is for me to be</u>		
	<u>in the background but she knows I'm here, she</u>		
	<u>knows she can ask me anything, em</u>		
	<u></u>		
	<u></u>		
	<u></u>		
	<u></u>		
	<u></u>		
	<u></u>		

**Appendix 3.31. Example from document with all the extracts relating to the sub theme conflict**

*GS 10:16-22 (conflict) And they were very, very defensive and very, very ..'no that didn't happen' and very..dismissive, em..and I didn't want a debrief, because I knew what had happened and I didn't want them telling me, what had happened. But, it was almost as if they were trying to overwrite my memory, by telling me that things had happened.*

*GS 16:21-22 (conflict) she just said it to make you move. And you did move, so it worked, but, you know, at what cost.*

*GS 21:13-19 (conflict) she was the sister, or I don't even know what she was, she came over and gave me further trouble, about how I should never have locked the door and, you know, if I had been in my right mind it would have been 'well, how exactly is health and safety being adhered to if somebody goes into that toilet and collapses and cannot call for help',*

*JE 9:9-13 (conflict) I'm really glad you came back I know you need your break and you need your coffee, but it was nice to have you here and to be honest I don't want anybody else coming in to that room from now on*

*JE 10:35-43 (conflict) Now I was trying to squat but she told me squatting isn't good you're not going to manage for a long time in that position and I was telling her i'm quite strong with my legs I can probably manage for a while.. so I did and Charlie was grabbing me from behind and he was helping me a lot like that. It was quite good I felt quite well in that position eh..but I think its almost like the midwife was telling me not to do it a long time this position because its, its awkward you know*

**Appendix 3.32. Example of one-line summaries for extracts relating to the sub theme  
incompetence**

GS

Incontinence/bladder damage not identified  
Left in own mess  
Nobody taking on board back pain and sign of acreta  
Focus on locked door not fact she had collapsed  
Not feeling looked after in hospital  
GP picked up PTSD

VM

Rough painful VE  
Obstetrician who cared  
Hilary who looked after (+ve)  
Environment like third world  
Unable to find veins for venflon  
Missed blood transfusion  
Nobody looked at chart and missed forceps and needs  
Doctors were shocked about lack of checking

JE

No one checked varicose veins  
Feeling responsible for self, no one else taking responsibility  
No one checking reaction to meds, just kept giving  
PN MW not knowledgeable, quoting books, not knowing about emotional needs or impact  
on physical condition  
No follow up even though significant medical needs  
AN class only used 1 out of 2 hours



#### Appendix 4.1. Range of potential interpersonal skills to include in midwifery education

Interpersonal Skill	Rationale	Implementation	Further references
Emotional Intelligence	Foundational skill that will enhance a midwife's ability to optimise interpersonal skills.	Via specially trained midwifery educators or EI professional educators.	(Whitley-Hunter, 2014)
Compassion	Core interpersonal skill in keeping with wider NHS recommendations for care.	Draw upon existing models such as compassionate connections (ref). compassionate mindfulness (Hollins Martin 2016)	(Edinburgh University, 2018, Beaumont and Hollins Martin, 2016, NHS Education for Scotland, 2018)
Empathy, kindness and respect.	Being able to place oneself in the other's shoes enhances understanding.	Via specially trained midwifery educators or professional educators.	(Health Education England, 2018, The Point of Care Foundation, 2018)
Interpersonal communication Listening Language Transactional analysis (TA)	Not just about conveying information effectively, but important to be skilled in the <i>How</i> of communicating and the factors that influence giving and receiving of information.	Via specially trained midwifery educators or TA professional educators	(Škodová, 2016, Mobbs et al., 2018, Whitley-Hunter, 2014)
Trauma informed care (TIC)	Being knowledgeable about the potential for prior trauma in each person, both women and staff. Approaching care with this in mind.	Via specially trained midwifery educators or TIC professional educators.	(Birthrights, 2018, Yusko, 2018, Bloom, 2018, Moore, 2018)
Understanding Emotional Labour	Only a problem when not appropriately understood or acknowledged. Important to be aware of personal reactions.	Embedded within pre-registration education and CPD.	(Hochschild, 2012, Hunter and Deery, 2009a)
Understanding cognitive dissonance	Important to be aware of personal reactions.	Embedded within pre-registration education and CPD.	(de Vries and Timmins, 2017)