Kate Rhodes BSc Hons

EXPERIENCES OF WOMEN WHO ELECT FOR A CAESAREAN SECTION FOLLOWING A PREVIOUS TRAUMATIC BIRTH.

Section A: A Review of the Extant Literature Exploring the Impact of Traumatic Childbirth.

Word Count: 5483(plus an additional 121 words)

Section B: Experiences of Women Who Elect For a Caesarean Section Following a Previous Traumatic Birth.

Word Count: 7992 (plus an additional 237 words)

Section C: Critical Appraisal
Word Count: 1968

Overall Word Count
15 443 (plus an additional 358 words)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2013

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

I would first and foremost like to thank all of the women who bravely shared their stories of birth with me and without whom this project would not have been possible. I can only hope that I have done their experiences justice within my analysis and write-up.

I would like to thank my supervisors Professor Margie Callanan and Dr Sarah Finnis who have inspired and supported me throughout this project.

I would like to thank my husband Ryan who has been so supportive during clinical training and has put up with my anxieties and tantrums whilst writing-up this project! His patience and help have been invaluable and much appreciated.

Finally, I would like to thank my parents Sian and Joe Rhodes who have loved and supported me unconditionally in all that I have done. They have always encouraged me to strive to reach my full potential and without them I would not have had the belief in myself to have reached this point in my education. Diolch yn fawr iawn.

Summary Portfolio

Section A provides a systematic review of the extant literature exploring the impact of traumatic birth on women and their families. An introduction to the prevalence and predictors of traumatic birth is provided along with an overview of the psychological theory that has been referenced in this area. The review highlights methodological limitations and gaps in the research base, providing a rationale for directions for future research within this field.

Section B is a qualitative study exploring women's experiences of elective caesarean section following a previous traumatic birth. Interpretative Phenomenological Analysis was used to analyse data from accounts of thirteen women. Five themes were interpreted from their narratives, 'cautiously moving forward into the unknown: the drive to reproduce', 'attempting to make the unknown known', 'the longed for, positive birthing experience', 'a different post-natal experience' and 'the interaction of the two experiences'. These results are discussed in relation to existing literature, psychological theory and their clinical implications. Finally limitations of the study and directions for future research are addressed.

Section C provides overall critical and reflective consideration of the study 'Experiences of Women Who Elect for a Caesarean Section Following a Previous Traumatic Birth.'.

Contents

Tables

Major Research Project

Section A: Literature Review

A Review of the Extant Literature Exploring the Impact of Traumatic Childbirth.

ACCURATE WORD COUNT

5483 (plus an additional 121 words)

Abstract

Aim: Research indicates that there may be a number of event specific and intrapersonal variables relevant to the aetiology of trauma symptoms following childbirth. The current review aimed to synthesize and evaluate the extant literature investigating the impact of Traumatic Birth (TB). It focussed on empirical research and conceptual understandings of the immediate and longitudinal psychological impact that TB can have on women and/or their families.

Methods: Psych INFO, Ovid, Medline, Web of Knowledge, Cochrane Database of Systematic Reviews and Google Scholar were searched for relevant research in this area. Studies were chosen for inclusion and review based on specific criteria.

Results: Following a comprehensive literature search 27 papers were deemed suitable for review, these were conceptualised as falling under three categories: impact on relationships, impact on future pregnancies and births and impact on mental health and wellbeing.

Conclusion: Traumatic Birth (TB) can impact on women's relationships with their child, partner and wider network. It can lead to avoidance behaviours concerning subsequent childbearing such as voluntary infertility, prolonged intervals between births and women requesting a caesarean section for future births. For some women a successful subsequent birth can be a redemptive experience. Overall, women's wellbeing is affected by a TB, with increased psychopathology among this cohort. The highlighted consequences of post-traumatic stress reactions to birth emphasise the importance of clinical recognition and understanding of this phenomenon.

INTRODUCTION

Beck (2004a) defines birth trauma as:

> An event occurring during the labour and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror. (p.28)

Research suggests that of those who report a Traumatic Birth (TB), between 2 to 21% develop symptoms meeting criteria for Post-Traumatic Stress Disorder (PTSD) (Alcorn, O'Donovan, Patrick, Creedy & Devilly, 2010; Ayres, Harris, Sawyer, Parfitt & Ford, 2009; Ayres & Pickering, 2001; Creedy, Shochet & Horsfall, 2000; Verreault et al., 2012) and up to a fifth display Post Traumatic Stress (PTS) symptoms at a sub–clinical level (Czarnocka & Slade, 2000; Davies, Slade, Wright & Stewart, 2008).

A literature review exploring risk factors for developing PTS symptoms following childbirth highlighted high-levels of obstetric intervention, low-levels of support, inadequate pain relief, loss of control and lack of information as aspects of birth women perceived as traumatic (Olde, Hart, Kleber & Van Son, 2006). Personal risk factors increasing susceptibility, include previous trauma (Verreault et al. 2012), a history of sexual or physical abuse (Rhodes & Hutchingson, 1994), mental health difficulties (Soderquist, Wijma & Wijma, 2006), personality characteristics (Zaers, Waschke & Ehlert, 2008; Soet, Brack & Dilorio, 2003) and nulliparity (Ayres, Harris, Sawyer, Parfitt & Ford, 2009).

Appraisals of birth experience are an important factor in the development of PTS symptoms, including incongruity between expectation and experience (Maggioni, Margola & Fillippi, 2006) and the role of pre-existing cognitive schemas (Ayres , 2007; Edworthy, Chasey & Williams, 2008). Many of these variables fit with models of PTSD e.g. Ehlers and Clark (2000) propose that prior experiences and beliefs and negative appraisal of the trauma and its

sequelae, participate in the development and maintenance of PTSD. Ford, Ayres and Bradley (2010) found that this model predicted PTS symptoms following childbirth at one month postpartum and three months postpartum, with the additional variable of social support.

As illustrated, research indicates that there may be a number of event specific and intrapersonal variables relevant to the aetiology of trauma symptoms following childbirth. The current review aims to synthesize and evaluate the extant literature investigating the impact of Traumatic Birth (TB). It will focus on empirical research and conceptual understandings of the immediate and longitudinal psychological impact of TB on women and their families.

SUMMARY OF FINDINGS

Following a comprehensive literature search 27 papers were deemed suitable for review. A full description of the search methodology can be found in Appendix A, a summary table of research reviewed can be found in Appendix B.

As the phenomenon of TB is still in its infancy there is a paucity of research in this area, therefore research was deemed suitable for review based predominantly on relevancy to the question, rather than methodological merits. However, the quality of the research was considered based on guidelines for critical appraisal appropriate to the type of research (Yardley, 2000; Mays & Pope, 2000).

The findings were conceptualised as pertaining to three categories: Impact of TB on relationships, future childbearing and women's well-being.

Impact on Relationships

Research investigating the impact of TB indicates that the ensuing sequelae of this phenomenon have implications for a woman's ability to form and maintain relationships. Literature focuses on the mother-infant relationship, the couple relationship and relationships with others.

Mother-infant relationship.

Postpartum psychological difficulties have implications for mothers' responsiveness and attunement to their infant, influencing the attachment with the child and affecting development. In their first few months an infant is dependent on an attuned and sensitive caregiver to interpret their behavioural signals to meet their needs and to internalize behavioural and emotional regulation experiences (Davies, Slade, Wright & Stewart, 2008). A mother's responsiveness to her infant's distress facilitates the process of co-regulation and increases their ability to cope with aversive environmental stimuli (Sroufe, 2000). The quality of the mother-infant dyadic and the formation of the subsequent attachment is therefore a vital aspect of the child's development and well-being (Bowlby, 1988).

Much of the research in the area of attachment and psychopathology of mother postpartum has focussed on mother-infant bonding in women experiencing Post-Natal Depression (PND) (Hart, Stanley, Murray & Stein, 2004; Murray, 2006). There is however, a small body of research that explores the potential impact of TB on the mother-infant bond; 12 papers discussed this phenomenon.

One of the main features of on-going trauma is 'avoidance of stimuli' which may trigger reminders of the distressing event (American Psychiatric Association, 2000). The infant may be identified as a constant reminder of the trauma resulting in the mother distancing herself,

or perceiving them in a negative light. Indeed research seems to support this theory. Ballard, Stanley and Brockington (1995) explored 4 women's experiences of the first 48 hours following TB. All presented with symptom profiles concordant PTSD as per DSM-III-R (American Psychiatric Association, 1987). Two women reported avoiding emotional contact with their infants, stating that contact triggered vivid recollections of the traumatic delivery. One of these women experienced such distancing from her infant the authors reported a disorder of attachment to her son. Both women also reported resentment towards their child. Knapp (2011/12) presented a case study of Sarah who felt constantly anxious regarding the wellbeing of her daughter following her TB e.g. needing to check she was breathing throughout the night. This profile fits with knowledge of PTS reactions where the individual experiences increased levels of arousal and anxiety potentially leading to hyper-vigilance (American Psychiatric Association, 2000).

Six qualitative studies highlighted the impact of TB on the mother-infant relationship revealing similar patterns of detachment and / or hyper-vigilance towards the infant. Allen (1998) and Moyzakitis (2004) reported resentment, detachment, anxiety and hyper-vigilance towards infants in both their samples of women who had experienced a TB. These were often longitudinal and led to women feeling marginalised and guilty within a society perceived to hold an idealised construct of motherhood. Beck (2004b) investigated women's experiences of PTSD following childbirth and reported symptoms such as numbing, distanced women from their infants. This varied from a temporary reaction in the first few months up to three years postpartum.

Nicholls and Ayres (2007) again reported women feeling detached from their child following TB. However, their participants discussed acting out the mother role and interviews with partners uncovered that they often compensated for the mother's emotional detachment. Therefore, while women may experience difficulties bonding, the consequences for the infant

are less clear. Ayres, Eagle and Waring (2007) found similar negative feelings from mother to infant following a TB. However, in their study they reported that over time, ranging from one to five years, feelings of resentment, detachment and rejection significantly decreased. However, the time between 12 and 36 months are critical periods for mother-infant attachment relationships (Bowlby, 1988). Indeed longitudinally the researchers interpret women's narratives as displaying signs of either avoidant or anxious attachments to their child.

Beck and Watson (2008), asked women to write about experiences of breast-feeding following a TB. Women described increased efforts to breast-feed; a sense that they needed to atone the birth or that to succeed at breast-feeding would promote 'mental healing'. Conversely, other participants described resentment towards the infant, perceiving breast-feeding as yet another violation of their body. Some discussed intrusions of thoughts and images of the TB during breast-feeding and some experienced reduced or delayed lactogenesis. These findings are concerning given that research highlights that breast-feeding is significant for infants' nutritional needs (Department of Health and Human Services, Department of Women's Health, 2003) and mother-infant attachment (Zetterstrom, 1999).

Qualitative research fairly consistently illustrates that PTS symptoms following TB negatively impact on the mother-infant bond, quantitative research presents more variation. Ayres, Wright and Wells' (2007) questionnaire study measured symptoms of PTSD using an adapted version of the PTSD Diagnostic Scale (Foa, Cashman, Jaycox & Perry, 1997), the couple's relationship and the parent-infant bond nine weeks post-partum. Regression-analysis found no association between symptoms of PTSD and the parent-infant bond. However, it may have been too early for the impact of PTSD symptoms to be fully realised. Also, the measure of the parent-infant bond administered focussed on behavioural rather than emotional aspects of the relationship. As highlighted in Nicholls and Ayres (2007) qualitative

study, women reported acting out the mother role, therefore these results may not be representative of the entire spectrum of parent-infant bonding i.e. practical and emotional.

Parfitt and Ayres (2009) investigated the association between post-natal depression and PTS (measured using the PTSD Diagnostic Scale; Foa, Cashman, Jaycox & Perry, 1997) on both the couple's relationship and the parent-infant bond. They found that symptoms of PTSD had a direct negative effect on the parent-infant bond. The effect size was small and similar to that of depression symptoms making it hard to distinguish which may be more significant. The influences of the two are complex as their co-morbidity is high (74% in this study). It seems however that for parents experiencing high levels of PTS and depression symptoms there are associations with a poorer parent-infant bond.

Davies, Slade, Wright and Stewart (2008), explored whether PTS symptoms related to TB affected women's perceptions of their infants. Participants who met the criteria for PTSD as per the Post Traumatic Disorder Questionnaire (Watson, Juba, Manifold, Kucala & Anderson, 1991) reported more negative perceptions of their infants and the attachment relationship. In addition to PTSD theory which may explain these results as the mother perceiving the child as a trigger to an increase in PTSD symptomatology, one may also consider cognitive biases that are inherent in depressive and anxiety disorders decreasing the mother's ability to process information in an objective manner.

McDonald, Slade, Spiby & Iles (2011) used the Post-Traumatic Stress Disorder-Questionnaire (PTSDQ; Czarnocka & Slade, 2000) and the Impact of Events Scale (IES; Horrowitz, Wilner & Alverez, 1979) to measure PTS symptoms. They found consistency in PTS symptoms after a TB recorded at 3, 6 and 24 months postpartum. There were no links between the symptoms and women's perceptions of their infant. A moderate correlation was

found between PTS symptoms and distress and difficulty in the mother-infant interaction; however, once the analysis accounted for depression these effects were largely eliminated.

Critique and future research.

The majority of research in this area indicates that PTS symptoms following a TB impact upon the mother-infant relationship. There is discrepancy between quantitative and qualitative findings. This may be explained by the use of questionnaires in quantitative research which limit conclusions regarding prevalence and presentation of diagnostic disorders; qualitative research in this domain seems better equipped to capture the unique spectrum relationships. The quantitative studies used different measures of PTS symptoms within their studies limiting the ability to compare their results or draw conclusions from their collective findings.

Unmeasured variables limit conclusions that can be drawn from this research e.g. Parfitt and Ayres highlight that in their model the variance in the mother-infant bond was only accounted for by PTS symptoms by 16.6%, suggesting that factors not measured in their study are likely to be influential. These may include adult attachment patterns, the characteristics of the individual child and previous trauma history. There would also be a proportion of relationships which would experience initial difficulties regardless of TB.

Future research in this area may include directly observing the mother-infant interaction to objectively assess attachment following TB. Comparisons between these and the large body of similar research conducted with women experiencing PND would also be of interest to begin to disentangle the overlap between the two phenomena. Longitudinal studies are also warranted to investigate the course and future impact of PTS symptoms following TB.

Impact on couple and other relationships.

Research suggests that social support can mediate the effects of PTS symptoms, with higher levels of support thought to increase individual's coping capacity (Solomon, Mikulincer and Avitzur, 1988). However, PTS symptomatology may impact upon relationships. Following birth women are particularly vulnerable and known to require additional emotional and practical support, therefore the effects of TB on relationships are imperative to consider. Seven of the papers reviewed discussed the impact of a TB on couple relationships and relationships with others.

Qualitative studies conducted by Allen (1998), Moyzakitis (2004), Beck (2004b) and Ayres, Eagle and Waring (2007), found that women who described, or scored highly on measures of PTSD following a TB felt their relationships became distant and that significant others were unable to empathise with their distress. Many women reported a reduced libido, impacting on the quality of their romantic relationships. There was a commonality of women feeling so emotionally depleted by the PTS symptoms that they were unable to support their partners or engage with their other children. This often extended to wider family and friends whom they felt distanced from, leading to isolation. In some cases women felt that their negative experiences were not socially acceptable to speak about and this silence isolated them, rather than the PTS presentations per-se.

Nicholls and Ayres (2007) sample of six couples provided interesting insights. Women's partners reported feeling rejected, helpless and blamed since the TB. Four men reported clinical symptomatology of PTSD themselves; while this may increase empathy for their partner, it's unclear if this is helpful for the resolution of symptomatology as the individual stress reactions may negatively impact on one-another (Nelson, Wangsgaard, Yorgason, Kessler & Carter-Vassol, 2002).

Two quantitative studies provide conflicting results to the qualitative research. Ayres, Wright and Wells (2007), did not find any association between PTSD symptomatology and couples relationship at nine weeks post-partum. Parfitt and Ayres (2008) however, found a significant correlation between symptoms of PTSD and difficulties in the dyad, but only when mediated by depression. Post-natal depression has been found to negatively affect couple relationships (Wenzel, Haugen, Jackson & Brendle, 2005).

Critique and future research.

Relationships are complex and difficult to measure quantitatively using scales and questionnaires. However, narratives concerning relationships in the qualitative research may reflect difficulties due to symptoms of depression rather than PTSD; even if this is the case depression may be a product of TB and is therefore still relevant to consider. Future research may benefit from considering the distinctions or overlap of the two psychopathologies as this may impact on interventions. Temporal differences in recruitment of participants and the use of differing subjective and objective measures of PTS symptoms also limit conclusions that can be drawn.

Many relationships in the period of transition to parenthood will experience trials and tribulations (Mitnick, Heyman & Slep, 2009) and sexual difficulties, regardless of birth experience (Handa, 2006). Therefore, it's difficult to isolate the direct impact of TB. Studies employing control groups are indicated.

Researchers have referenced theories on male behaviour e.g. men are less sensitive to emotion (Shaffer, 1993), to understand women feeling unheard and emotionally under-supported by their partners following a TB. This explanation is limited and stereotyped, but it also highlights the lack of diversity in the research base regarding cultural and sexual orientation. Similar research with diverse populations would prove interesting.

Impact on Future Pregnancies and Births.

Journalist Denis Campbell (2010) reported on the rise of birth trauma and the fear this engendered in women for future child bearing. Interviews with midwives reported growing concerns regarding women's choices to postpone or abandon plans for more children following a TB. Reference by midwives was also made concerning the growing population of women who are Electing for a Caesarean Section (ECS) following a TB. The article concluded with an interview with a woman who, following a TB, felt empowered by a successful subsequent birth.

Thirteen studies highlighted the impact of TB on future pregnancies. The four key findings from this research support the themes that emerged in Campbell's (2010) article: Fear of pregnancy and birth, avoidance of future pregnancy and birth, mode of delivery for future birth and future pregnancy and birth as a restorative process.

Fear of future birth.

Six studies were identified directly exploring fear of future childbirth (tokophobia[1]) following a TB.

Beck (2004b) and Beck and Watson (2010) reported participants responded to a subsequent pregnancy following a TB with fear, terror, anxiety, panic, dread and denial; some to the extent that they experienced psychopathological reactions such as panic attacks and suicidal thoughts. Saisto, Ylikorkala and Halmesmaki (1999) analysed data regarding the first deliveries of women who reported severe tokophobia in their second pregnancies and found an association with previous TB. Hofberg and Brockington (2000) conducted a series of 26 case studies of tokophobic women and found that for 14 of these women TB was the trigger.

[1] Tokophobia refers to fear of childbirth.

For each of these studies tokophobia was diagnosed based on participant's qualitative descriptions of fear regarding childbirth.

Nilsson, Bondas and Lundgren (2010), interviewed parous pregnant women recruited from a clinic for tokophobia. Women reported that prior to their first birth they had not held substantial fears regarding delivery, all described their previous TB as the trigger to their current anxieties, again tokophobia was determined based on women's qualitative accounts of fear of birth. Nilsson, Lundgren, Karlstrom and Hildingsson (2012), explored tokophobia in a longitudinal population based study and found that TB most strongly predicted fear of childbirth during pregnancy and one year post birth. In this study tokophobia was measured using a quantitative questionnaire developed by the researchers.

The implications of anxiety during pregnancy have been well researched and provide evidence that tokophobia be taken seriously. As with clinical levels of anxiety, sleeplessness and fatigue (Hall et al., 2009) have been found to affect women with tokophobia. Depression has been commonly found to be co-morbid with such anxiety (Martini, Knapp, Beesdo-Baum, Lieb & Wittchen, 2010) as has social isolation and low self-esteem (Nilsson & Lundgren, 2009). During delivery women who experience tokophobia are at increased risk of emergency CS (Nilsson, Lundgren, Karlstrom & Hildingsson, 2012), increased duration of labour (Adams, Eberhard-Gran & Eskild, 2012), higher rates of epidural analgesia and more negative, painful experiences of birth (Haines, Rubertsson, Pallant & Hildingsson, 2012). They are more likely to feel personal failure regarding the delivery (Nilsson & Lundgren, 2009) and to continue to feel fearful of childbirth after delivery (Alehagen, Wijma & Wijma, 2006).

A growing body of research highlights the effects of maternal stress and anxiety to the child in-utero and post-natally. Infants born of women suffering from PTSD may have lower birth

weights and lengths and decrements in head circumference compared to controls at birth (Engel, Berkowitz, Wolff & Yehuda, 2005; Lederman et al., 2004). Foetal-origins hypothesis (Kinsella & Monk, 2009) proposes that maternal stress may affect foetal growth and development. There are also links between high anxiety levels, consequent cortisol secretion and foetal brain development. This may impact upon emotional and behavioural responses in the new-born and subsequent development of psychopathology (Douglas, 2010). A full review of literature in this area is beyond the scope of this report, but is worth considering when contemplating the longitudinal impact of TB.

Critique and future research.

TB cannot be singled out as the sole or even predominant variable creating tokophobia or its ensuing sequelae; many other associations have been found concerning personality, psychopathology and external variables, which may each interact with experiences of TB or impact upon women's hopes and fears for birth.

It cannot be ruled out that these women had a longstanding fear of birth which increased their likelihood of experiencing the first birth as traumatic. However, it is no surprise that after having a traumatic experience of birth women report fear of future birth regardless of their prior perceptions. Given the potential physiological and psychological outcomes to mother and infant of raised anxiety during pregnancy, development of effective interventions is imperative.

There is also a lack of consensus regarding the best tool to screen for, and assess severity of, tokophobia. Future research could aim to develop and trial such a measure that could be used consistently across services.

Avoidance and control of future birth.

Of the papers reviewed six explored what may be perceived as experiential avoidance behaviours in response to TB; these include prolonged intervals between births, taking steps to prevent future birth and efforts to control future birth experiences.

Qualitative research exploring the impact of TB consistently highlights the effect it has on future childbearing. Fones (1996) presented the case of a woman who nine years post-partum requested tubal ligation to avoid re-experiencing TB. Allen (1998) also identified TB impacting on future pregnancy; 13 of 20 participants reported that they would not have any more children, 8 of these explicitly stated TB was the reason for this. Of the seven women who did wish to have more children, two stated they would only do so if an ECS was made available. The woman Knapp (2011/12) presented in her case study reported feeling relieved by two miscarriages she had since the TB. Gottvall and Waldenstrom's (2002) quantitative study found that women who rated their first birth negatively had fewer subsequent children and longer intervals between births.

While most women represented in the literature report experiencing fear of birth following a TB, not all women will actively avoid future pregnancies. One factor that may mediate this is the level of control women believe they have in preventing further trauma; this may explain the increase of women in this cohort requesting an Elective Caesarean Section (ECS). Indeed, Campbell's (2010) article stated that Liverpool women's hospital (UK) reported a 40% rise in women requesting an ECS following a TB. Empirical research supports this finding; Ryding (1993) interviewed 33 women exploring their reasons for an ECS and found 28 of the parous women reported a previous TB as the reason for their decision. Tschudin et al. (2009)

replicated this finding; of 201 pregnant women recruited in a cross-sectional survey, 19 reported a preference for an ECS, the strongest predictor of this was a TB experience.

Caesarean section on maternal request is presently an area of international debate and has been posed as an ethical dilemma amongst medical communities (Nilstun et al., 2008). However, mortality rates for ECS have been found to be equal to those of vaginal delivery (Wax, 2006). Several physiological benefits to mother and infant have also been documented e.g. decreased maternal and foetal endocrine stress response (Vogle et al., 2006). Studies investigating psychological aspects of ECS have focussed mainly on quantitative measures of satisfaction. Satisfaction with ECS experience has been found to be significantly higher than that of natural birth and emergency CS (Schindl, Birner, Joura, Husslein & Langer, 2003; Blomquist, Quiroz, Macmillan, McCullough & Handa, 2011). No differences have been found in levels of PND between women who have natural and ECS births (Wiklund, Edman & Andolf, 2007). These studies include samples of women with varying reasons for an ECS; therefore they are limited in the conclusions that can be drawn regarding the psychological outcomes of this procedure following a TB.

Critique and future research.

There may be differences in levels of avoidance of future childbearing along a continuum depending on the severity of PTS symptoms; these have not been consistently measured in the current research. Other variables may impact on the severity of the reactions such as resilience or personality characteristics e.g. neuroticism has been found to be commonly associated with subjective health complaints and negative outcomes (Costa & McRae, 1985). Theoretically, this trait could influence women's experience of their initial birth and decisions regarding subsequent childbearing. It is difficult to control quantitatively for all

potential variables involved in future childbearing and qualitative research may be best placed to reflect women's experiences in this arena.

For women who have experienced a TB the option of an ECS may mediate the decision to bear subsequent children. Therefore, careful contemplation of the balance of medical and psychological risks and benefits to an ECS should be considered for such women. Psychological models of PTSD (Ehlers and Clarke, 2000) advocate exposure to avoided stimuli to break the maintenance cycle of the disorder. However, for women who find themselves in vulnerable state such as pregnancy this confrontation may be argued as unethical. Exposure to stressors is known to increase anxiety within individuals prior to desensitisation (Foa, Hembree & Rothbaum, 2007); as discussed earlier increased anxiety during pregnancy can have detrimental effects on maternal and infant outcomes, complicating the dilemma further. Currently such conjecture is purely based on hypotheses; there is no research which explores women's motivations for, or experiences of, an ECS following a TB. Such research is warranted given the current interest and debate concerning increased ECS rates and to add to the evidence base regarding psychological input for subsequent childbirth following previous TB.

Future birth as a redemptive experience.

Future pregnancies may present an opportunity to recover from TB. Amongst the predominantly negative narratives represented in Beck's (2004b) study there were glimpses of hope of recovery from the trauma via a redemptive subsequent birth. Beck and Watson's study (2010) further highlighted the concept of future pregnancy and birth as an opportunity for growth and healing. Three quarters of the women in this study reported a positive and healing experience of the subsequent birth.

Thomson and Downe (2010) interviewed women who experienced a self-defined redemptive birth following a TB. Women talked about the subsequent birth as cathartic enabling them to re-discover their identities and feel whole again. Despite these experiences all of the participants acknowledged that the TB would never be forgotten.

Critique and future research.

These studies could be conceptualised in terms of their relation to theories of Post-Traumatic Growth (PTG), whereby positive growth and development following trauma surpasses that which was present prior to the trauma (Tedeschi & Calhoun, 2004). Of Tedeschi and Calhoun's (2004) model proposing five domains of PTG, women in the studies touched on a sense of personal growth developed from the positive experiences of birth; further research exploring these domains in relation to this cohort would prove interesting and may add to understandings of recovery and growth following trauma generally.

Further research investigating the longitudinal impact of a redemptive birth is also warranted. Does such an experience repair potential difficulties in relationships with the infant from the TB or with partners? Does is alter cognitions about birth? Is redemption possible through all modalities of birthing?

Impact on Women's Wellbeing.

Thus far relationships and future childbearing have been implicated as key areas which are affected by TB. It is clear that each of these factors will also affect the wellbeing of the woman. Traumatic birth may lead to psychopathological reactions such as the development of PTSD (Alcorn, O'Donovan, Patrick, Creedy & Devilly, 2010; Ayres & Pickering, 2001; Creedy, Shochet & Horsfall, 2000; Verreault et al., 2012). There is some evidence to suggest

that it may also elicit symptoms of other psychopathologies such as PND. Seven studies were reviewed which discussed the impact of TB on women's wellbeing.

Allen (1998) highlighted the effect of PTSD following TB on women's wellbeing. Participants felt anger and frustration towards those around them which they were later able to identify as unjustified, leading to self-deprecation and guilt. Women talked about feeling highly aroused, experiencing panic attacks and tearfulness, leading to social avoidance or use of distraction techniques. Such reactions ultimately maintained arousal levels and led to vicious cycles (Ehlers and Clarke, 2000). Participants in Moyzakitis' (2004) study reported an impact on self-image and identity following a TB; women experienced grief for the loss of the self. Participants also reported PND following the TB; it's unclear whether this was directly attributable to the experience of the trauma or the resulting sequelae e.g. feeling isolated and experiencing difficulties in relationships.

PND has been found to be co-morbid with PTSD across various research domains (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). White, Matthey, Boyd and Barnett (2006) measured levels of PTSD and PND at 6 weeks, 6 months and 12 months postpartum in a sample of 400 women. They found that prevalence of PTSD symptoms at around 2.4% remained stable across 12 months. Comorbidity between PTSD and PND stayed high during this period. Similarly, Zaers, Waschke and Ulrike (2008) found high levels of co-morbidity between PTSD and PND in women six months post-partum and found experience of delivery to be one of the main predictors of these.

Lemola, Stadlmayr and Grob, (2007) assessed subjective birth experience, post-natal emotional support from partner, and obstetric variables in participants six weeks post-partum. They followed this up with measures of PND and PTSD five months postpartum. They found high levels of poor psychological adjustment in women who had experienced a TB;

furthermore this effect was mediated by partner support. Women who found their partners support to be lacking, critical or complaining were more likely to report symptoms of avoidance, intrusion and depression after a TB. The authors reference the 'Buffering Hypothesis' (Cohen & Wills, 1985) to explain the importance of support from partners at a time when women are emotionally vulnerable.

Beck (2006), asked participants to write about the anniversary of their TB. Women reported an increase in PTS symptoms and talked about experiencing "dread, anxiety, stress, sadness, grief, loss, fear and guilt" (p.385) leading up to the anniversary. Women in the study did not feel supported or understood in their trauma. Beck suggested that birth trauma is glossed over in all capacities, particularly so at anniversaries where a child's birthday celebrations take centre stage.

Nesca and Dalby (2011) presented a case of a young woman who smothered her infant soon after birth. Assessments concluded an acute stress reaction brought on by TB led to the tragedy. Eleven months postpartum the woman was deemed to be suffering from PTSD related to TB.

Critique and future research.

Again this area of research highlights the overlap in symptoms of PTSD and PND creating difficulties establishing whether the two separately function and are comorbid, or whether there is confusion regarding diagnosis for some individuals. As PND is the more widely researched concept PTSD may be misdiagnosed as depression, the treatment of which differs significantly.

It is difficult to establish causal explanations for mental-health or wellbeing difficulties as there are numerous variables that may contribute to their development. Most assessments of

mental-health prior to TB are retrospective and therefore flawed in their reliability. Additionally, the direction of the relationship between TB and these difficulties is difficult to ascertain i.e. did the trauma trigger problems in mental health or are women who experience birth as traumatic psychologically vulnerable to start with? Future large scale, prospective, quantitative studies may increase understanding of such relationships.

CLINICAL IMPLICATIONS

Given the longevity, persistence and severity of the consequences of TB, clinical management and care of women and their families in this position seems imperative. There are a number of interventions that have been trialled to reduce or overcome the sequelae associated with TB, including debriefing, counselling, Cognitive Behavioural Therapy and Eye Movement Desensitisation and Reprocessing (Lapp, Agbokou, Peretti & Ferreri, 2010). However research investigating their effectiveness is sparse, in its infancy and inconsistent.

The research reviewed indicates a number of clinical considerations. Firstly, the primary priority for services must be prevention of TB. As discussed in the introduction there is a fair body of research which highlights risk factors for the development of symptoms of trauma following childbirth. Service related predictors of TB e.g. poor communication with women, poor pain management etc… are factors which could be addressed and improve the experience of birth for women and their families.

Idiosyncratic features which increase the risk of TB e.g. prior trauma should be routinely screened and compensated for by care staff sensitive to the extra support and psychological interventions these individuals may require. Additionally all maternity staff would benefit from training in the phenomenon of TB and its sequelae. It is currently maternity staff who predominantly manage and care for women who are at risk, or experiencing the impact of

TB; given the psychopathological difficulties that may arise at this time there is an under-filled role for psychologists to contribute to research and interventions in this area (Lapp, Agbokou, Peretti & Ferreri, 2010).

Symptoms of trauma following birth are hypothesised to be underreported or misdiagnosed. This may be due to women being discharged from care soon after birth. Formal criterion for PTSD includes the presence of symptoms for at least a month prior to trauma, therefore it may benefit women to screen for TB and monitor these women up to a month post-partum. Early identification of symptoms of trauma may increase access to services and interventions aimed at reducing their impact.

A common theme within studies of subsequent childbirth is the important role of caregivers. The literature suggests that clinically, future childbirth may be an opportunity for healthcare professionals to help women recover from the trauma starting from pregnancy. The importance of identification of such women is therefore crucial and tactful questions regarding prior birth experience should form part of the key framework for initial meetings with newly pregnant women. Equally, sharing redemptive experiences through communication with health professionals or via support groups may encourage women who wish for more children but feel too anxious about re-traumatisation, to begin to consider that future birth and recovery from trauma may be possible with the right support and planning.

CONCLUSION

A Traumatic Birth (TB) can impact on women's relationships with their child, partner and wider network. It can lead to avoidance behaviours concerning subsequent childbearing such as voluntary infertility, prolonged intervals between births and women requesting a caesarean section for future births. For some women a successful subsequent birth can be a redemptive

experience. Overall, women's wellbeing is affected by a TB, with increased psychopathology among this cohort. The highlighted consequences of PTS reactions to birth emphasise the importance of clinical recognition and understanding of this phenomena. Research in the field of TB and its sequelae is still in its infancy and future research within each of these domains is indicated.

References

Adams, S., Eberhard-Gran, M., & Eskild, A. (2012). Fear of childbirth and duration of labour: A study of 2206 women with intended vaginal delivery. *British Journal of Obstetrics and Gynaecology,* 01/02/2013. doi:10.1111/j.1471-0528.2012.03433.x

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

Alehagen, S., Wijma, B., & Wijma, K. (2006). Fear of childbirth before, during and after childbirth. *Acta Obstetricia Et Gynecologica Scandinavica, 85*, 56-62.

Allen, S. (1998). A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology, 16*(2/3), 107-128.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders.* (3rd Edition, Revised ed.). Washington DC: American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders.* (4th ed. Text rev. ed.). Washington, DC: Author.

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

Ayres, S., Eagle, A., & Waring, H. (2007). The effects of childbirth related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health and Medicine, 11*(4), 389-398.

Ayres, S., Harris, R., Sawyer, A., Parfitt, Y., & Ford, E. (2009). Post-traumatic stress disorder after childbirth: Analysis of symptom presentation and sampling. *Journal of Affective Disorders, 119,* 200-204.

Ayres, S., & Pickering, A. (2001). Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. *Birth: Issues in Perinatal Care, 28,* 111-118.

Ayres, S., Wright, D., & Wells, N. (2007). Symptoms of post-traumatic stress disorder in couples after birth: Association with the couple relationship and parent-baby bond. *Journal of Reproductive and Infant Psychology, 25*(1), 40-50.

Ballard, C., Stanley, A., & Brockington, I. (1995). Post-traumatic stress disorder (PTSD) after childbirth. *British Journal of Psychiatry, 166,* 525-528.

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

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

Beck, C. T. (2006). The anniversary of birth trauma: Failure to rescue. *Nursing Research, 55*(6), 381-390.

Beck, C. T., & Watson, S. (2008). Impact of birth trauma on breast-feeding. A tale of two pathways. *Nursing Research, 57*(4), 228-236.

Beck, C. T., & Watson, S. (2010). Subsequent childbirth after a previous traumatic birth. *Nursing Research, 59*(4), 241-249.

Blomquist, J., Quiroz, L., Macmillan, D., Mccullough, A., & Handa, V. L. (2011). Mothers satisfaction with planned vaginal and planned cesarean birth. *American Journal of Perinatology, 28*(5), 383-388.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory.* Hove, United Kingdom.: Brunner- Routledge.

Campbell, D. (2010, 14/11/10). Too scared to push: Big rise reported in birth traumas. *The Guardian.*

Cohen, S., & Wills, T. A. (1985). Stress, social support and the buffering hypothesis. *Psychological Bulletin, 98*, 310-357.

Costa, P. T., & McCrae, R. R. (1985). Hypochondriasis, neuroticism, and aging: When are somatic complaints unfounded? *American Psychologist, 40*(1), 19-28. doi:10.1037/0003-066X.40.1.19

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

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

Davies, J., Slade, P., Wright, I., & Stewart, P. (2008). Post-traumatic stress symptoms following childbirth and mothers perceptions of their infants. *Infant Mental Health Journal, 29*(6), 537-554.

Department of Health and Human Services, Department of Women's Health. Benefits of breastfeeding (2003). *Nutrition in Clinical Care, 6,* 125-131.

Douglas, A. J. (2010). Baby on board: Do responses to stress in the maternal brain mediate adverse pregnancy outcome? *Frontiers in Neuroendicrinology, 31*(3), 359-376.

Edworthy, Z., Chasey, R., & Williams, H. (2008). The role of schema and appraisals in the development of post-traumatic stress symptoms following birth. *Journal of Reproductive and Infant Psychology, 26,* 123-138.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of post- traumatic stress disorder. *Behavior Research and Therapy, 38,* 319-345.

Engel, S., Berkowitz, G., Wolff, M., & Yehuda, R. (2005). Psychological trauma associated with the World Trade Centre attacks and its effect on pregnancy outcome. *Pediatric Perinatal Epidemiology, 19*(5), 334-341.

Field, T. (1992). Infants of depressed mothers. *Developmental Psychopathology, 4,* 49-66.

Foa, E.B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessments, 334,* 1147.

Foa, E., Hembree, E., & Rothbaum, B. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences.* New York: Oxford University Press.

Fones, C. (1996). Posttraumatic stress disorder occurring after painful childbirth. *Journal of Nervous and Mental Disease, 184*(3), 195-196.

Ford, E., Ayres, S., & Bradley, R. (2010). Exploration of a cognitive model to predict post-traumatic stress symptoms following childbirth. *Journal of Anxiety Disorders, 24*(3), 253-259.

Gottvall, K., & Waldenstrom, U. (2002). Does a traumatic birth experience have an impact on future reproduction? *British Journal of Obstetrics and Gynaecology, 109*, 254-260.

Haines, H., Rubertsson, C., Pallant, J., & Hildingsson, I. (2012). The influence of women's fear, attitudes and beliefs of childbirth and experience of birth. *Biomed Central. Pregnancy and Childbirth, 12*(55), 1-14.

Hall, W., Hauck, Y., Carty, E., Hutton, E., Fenwick, J., & Stoll, K. (2009). Childbirth fear, anxiety, fatigue, and sleep deprivation in pregnant women. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 38*(5), 567-576.

Handa, V. L. (2006). Sexual function and childbirth. *Seminars in Perinatology, 30*(5), 253-256.

Hart, S., Stanley, C., Murray, L., & Stein, A. (2004). The effect of postnatal depression on mother infant interaction, infant response to still-face perturbation, and task performance on an instrumental learning task. *Developmental Psychopathology, 16*, 1-18.

Hofberg, K., & Brockington, I. (2000). Tokophobia: An unreasoning dread of childbirth. *British Journal of Psychiatry, 176*, 83-85.

Horrowitz, M., Wilner, N., & Alverez, W. (1979). Impact of Events Scale: A measure of subjective stress. *Psychosomatic Medicine, 41(3),* 209-218.

Kessler, D., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (1995). Post-traumatic stress disorder in the national co-morbidity survey. *Archives of General Psychiatry, 52*, 1048-1060.

Kinsella, M., & Monk, C. (2009). Impact of maternal stress, depression and anxiety on fetal neurobehavioral development. *Maternity and Infant Care Clinical Obstetrics and Gynaecology, 52*(3), 425-440.

Knapp, E. (Winter 2011/2012). Acute distress and PTSD following childbirth: A complex longitudinal case study. *Midwifery Today*, 44-68.

Lapp, L., Agbokou, C., Peretti, C., & Ferreri, F. (2010). Management of post-traumatic stress disorder after childbirth: A review. *Journal of Psychosomatic Obstetrics and Gynaecology, 31*(3), 113-122.

Lederman, S., Rauh, V., Weiss, L., Stein, J., Hoepner, L., Becker, M., & Perera, F. (2004). The effects of the World Trade Centre event on birth outcomes among term deliveries at three lower Manhattan hospitals. *Environmental Health Perspectives, 112*(17), 1772-1778.

Lemola, S., Stadlmayr, W., & Grob, A. (2007). Maternal adjustment five months after birth: The impact of the subjective experience of childbirth and emotional support from the partner. *Journal of Reproductive and Infant Psychology, 25*(3), 190-202.

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

Martini, J., Knapp, S., Beesdo-Baum, K., Lieb, R., & Wittchen, H. (2010). Anxiety disorders before birth and self-perceived distress during pregnancy: Associations with maternal depression and obstetric, neonatal and early childhood outcomes. *Early Human Development, 86*, 305-310.

Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal, 320*, 50-52.

McDonald, S., Slade, P., Spiby, H., & Iles, J. (2011). Post-traumatic stress symptoms, parenting stress and mother -child relationships following childbirth and at 2 years postpartum. *Journal of Psychosomatic Obstetrics and Gynaecology, 32*(3), 141-146.

Mitnick, D., Heyman, R., & Slep, A. (2009). Changes in relationship satisfaction across the transition to parenthood: A meta-analysis. *Journal of Family Psychology, 23*, 848-852.doi:10.1037/a0017004

Moyzakitis, W. (2004). Exploring women's descriptions of distress and/or trauma in childbirth from a feminist perspective. *Evidence Based Midwifery, 2*, 8-14.

Murray, L. (1992). The impact of postnatal depression on infant development. *Journal of Child Psychological Psychiatry, 33*, 543-561.

Nelson, B., Wangsgaard, S., Yorgason, J., Kessler, M., & Carter-Vassol, E. (2002). Single and dual- trauma couples: Clinical observations of relational characteristics and dynamics. *American Journal of Orthopsychiatry, 72*(1), 58-69.

Nesca, M., & Dalby, T. (2011). Maternal neonaticide following traumatic childbirth: A case study. *International Journal of Offender Therapy and Comparative Criminology, 55*(7), 1166-1178.

Nicholls, K., & Ayres, S. (2007). Childbirth related post-traumatic stress disorder in couples: A qualitative study. *British Journal of Health Psychology, 12*, 491-509.

Nilsson, C., Bondas, T., & Lundgren, I. (2010). Previous birth experience in women with intense fear of childbirth. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 39*, 298-309. doi:10.111/j.1552-6909.2010.01139.x

Nilsson, C., & Lundgren, I. (2009). Women's lived experience of fear of childbirth. *Midwifery, 25*(1-9) doi:10.1016/j.midw.2007.01.017

Nilsson, C., Lundgren, I., Karlstrom, A., & Hildingsson, I. (2012). Self- reported fear of childbirth and its association with women's birth experience and mode of deliver: A longitudinal population based study. *Women and Birth, 25*, 114-121.

Nilstun, T., Habiba, M., Lingman, G., Saracci, R., Da Fre, M., & Cuttini, M. (2008). Cesarean delivery on maternal request: Can the ethical problem be solved by a principlist approach? *Biomed Central. Medical Ethics, 9*(11), 02/03/2012. doi:10.1186/1472-6939-9-11

Olde, E., Van der Hart, O., Kleber, R., & Van Son, M. (2006). Posttraumatic stress following childbirth: A review. *Clinical Psychology Review, 26*, 1-16.

Parfitt, Y., & Ayres, S. (2009). The effect of post-natal symptoms of post-traumatic stress and depression on the couple's relationship and parent-baby bond. *Journal of Reproductive and Infant Psychology, 27*(2), 127-142.

Rhodes, N., & Hutchinson, S. (1994). Labour experiences of childhood sexual abuse survivors. *Birth, 21*, 213-220.

Ryding, E. L. (1993). Investigation of 33 women who demanded a caesarean section for personal reasons. *Acta Obstetricia Et Gynecologica Scandinavica, 72*, 280-285.

Saisto, T., Ylikorkala, O., & Halmesmaki, E. (1999). Factors associated with fear of delivery in second pregnancies. *Obstetrics and Gynaecology, 94*(5), 679-682.

Schindl, M., Birner, P., Joura, E., Husslein, P., & Langer, M. (2003). Elective cesarean section V's spontaneous delivery: A comparative study of birth experience. *Acta Obstetricia Et Gynecologica Scandinavica, 82*, 834-840.

Shaffer, D. R. (1993). *Developmental psychology: Childhood and adolescence.* (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Soderquist, J., Wijma, B., & Wijma, K. (2006). The longitudinal course of post-traumatic stress after childbirth. *Journal of Psychosomatic Obstetrics and Gynaecology, 27*(2), 113-119.

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

Solomon, Z., Mikulincer, M., & Avitzur, E. (1988). Coping, locus of control, social support, and combat-related posttraumatic stress disorder: A prospective study. *Journal of Personality and Social Psychology, 55*(2), 279-285.

Sroufe, L. (2000). Early relationships and the development of children. *Infant Mental Health Journal, 21*, 67-74.

Tedeschi, R., & Calhoun, L. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Enquiry, 15*(1), 1-18.

Thomson, G. M., & Downe, S. (2010). Changing the future to change the past: Women's experiences of a positive birth following a traumatic birth experience. *Journal of Reproductive and Infant Psychology, 21*(1), 102-112.

Tschudin, S., Alder, J., Hendriksen, S., Bitzer, J., Popp, A., Zanetti, R., . . . Geissbuhler, V. (2009). Previous birth experience and birth anxiety: Predictors of caesarean section on demand? *Journal of Psychosomatic Obstetrics and Gynaecology, 30*(3), 175-180.

Verreault, N., De Costa, D., Marchand, A., Ireland, K., Banack, H., Dritsa, M., & Khalife, S. (2012). PTSD following childbirth: A prospective study of incidence and risk factors in Canadian women. *Journal of Psychosomatic Research, 73*, 257-263.

Vogle, S., Worda, C., Egarter, C., Bieglmayer, C., Szekeres, T., Huber, J., & Husslein, P. (2006). Mode of delivery is associated with maternal and fetal endocrine stress response. *British Journal of Obstetrics and Gynaecology*, *113*, 441-445.

Watson, C., Juba, M., Manifold, V., Kucala, T., & Anderson, P. (1991). The PTSD interview: Rationale, description, reliability, and concurrent validity of a DSM- III based technique. *Journal of Clinical Psychology, 47(2),* 179-188.

Wax, J. (2006). Maternal request cesarean verses planned spontaneous vaginal delivery: Maternal morbidity and short term outcomes. *Seminars in Perinatology, 30*, 247-252.

Wenzel, A., Haugen, E., Jackson, L., & Brendle, J. (2005). Anxiety symptoms and disorders at eight weeks postpartum. *Anxiety Disorders, 19*, 295-311.

White, T., Matthey, S., Boyd, K., & Barnett, B. (2006). Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence. *Journal of Reproductive and Infant Psychology, 24*(2), 107-120.

Wiklund, I., Edman, G., & Andolf, E. (2007). Cesarean section on maternal request: Reasons for the request, self-estimated health, expectations, experience of birth and signs of depression amongst first-time mothers. *Acta Obstetricia Et Gynecologica Scandinavica, 86,* 451-456.

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

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

Zetterstrom, R. (1999). Breast feeding and infant-mother attachment. *ACTA Paediatrica Supplement, 88,* 1-6.

Major Research Project

Section B: Empirical Paper

Experiences of Women Who Elect For a Caesarean Section Following a Previous Traumatic Birth.

ACCURATE WORD COUNT

7992 (plus an additional 237 words)

Abstract

Objective: The aim of this phenomenological study was to explore women's experiences of an Elective Caesarean Section (ECS) following a previous Traumatic Birth (TB).

Method: Thirteen women who had undergone an ECS following a TB were either interviewed or provided written accounts of their experiences. Data from these sources were analysed using Interpretative Phenomenological Analysis (IPA) (Smith, Flowers and Larkin, 2009).

Results: Five main themes were identified: 'cautiously moving forward into the unknown: the drive to reproduce', 'attempting to make the unknown known', 'the longed for, positive birthing experience' , 'a different post-natal experience' and 'the interaction of the two experiences'. These findings were considered in relation to previous research; relevant theoretical perspectives were considered including those attached to Post-Traumatic Stress Disorder (PTSD).

Conclusions: Post-traumatic stress reactions may increase during subsequent pregnancy impeding on women's ability to consider facing another 'unknown' natural birth and domineering their decision to elect for a CS. An ECS following a TB may provide women with the controlled experience and high levels of care they long for. Such experiences could be redemptive and have positive outcomes for women's relationships and wellbeing. These results highlight the importance of providing women in this position with information and choice regarding a subsequent birth. They also stress that prevention of women carrying Post Traumatic Stress (PTS) reactions into their subsequent pregnancies is imperative. Future research would benefit from focussing on the development and trialling of effective screening tools for PTS reactions following birth.

INTRODUCTION

Within recent years an increasing body of psychological research has investigated the phenomena of childbirth as a traumatic event. Women's subjective appraisals of the birthing experience as seriously threatening to the physical wellbeing of themselves or their infant, alongside feelings of helplessness, horror, lack of control and anxiety can trigger Post-Traumatic Stress (PTS) reactions (Beck & Watson, 2010). Research indicates that between 2 and 21% of women who report Traumatic Birth (TB) develop Post-Traumatic Stress Disorder (PTSD) (Ayres & Pickering, 2001; Ayres, Harris, Sawyer, Parfitt & Ford, 2009) and between a quarter and a fifth present at a subclinical level (Czarnocka & Slade, 2000; Davies, Slade, Wright & Stewart, 2008). Post-Traumatic reactions can include re-experiencing of the trauma, avoidance of trauma stimuli, numbing of responsiveness, increased arousal and hyper-vigilance (American Psychiatric Association, 2000).

Such sequelae can have longitudinal consequences, including impacting on future childbirth. A TB has been cited as one of the reasons women elect for a Caesarean Section (CS; ECS: Elective Caesarean Section) (NICE, 2011; Ryding, 1993; Tschudin et al., 2009); a procedure currently the topic of debate and controversy within medical communities (Nilstun et al., 2008; Nama & Wilcock, 2011). The 'ethics' of ECS have been deliberated by medics weighing up data on physical and medical risks and benefits, economic factors and patient choice. These tend to tip in favour of granting an ECS as a last resort and there is still a drive to encourage women to try for a natural birth where a CS is not medically indicated. Psychological motivators and experiences of ECS have been sparsely researched and are therefore under-represented in the debate.

Studies investigating psychological aspects of ECS have focussed on quantitative measures of satisfaction. They indicate that women electing for a CS have high levels of maternal satisfaction with the birthing experience (Robson, Carey, Mishra & Dear, 2008). When

comparing women who undergo an ECS with women experiencing other births, the satisfaction with the experience of the ECS has been found to be significantly higher than that of women who have a natural birth and emergency CS (Schindl, Birner, Joura, Husslein & Langer, 2003; Blomquist, Quiroz, Macmillan, McCullough & Handa, 2011). No differences have been found in levels of post-natal depression between women who have natural and ECS births (Wiklund, Edman & Andolf, 2007). Pre-birth expectations have been found to influence birth experience (Soet, Gregory, Brack & Dilorio, 2003); women electing for a CS have been found to have high expectations for the birth which are more likely to be met (possibly due to the standardised nature of the operation), compared to women with equally high expectations of vaginal birth often not matching their experiences (possibly due to its less predictable nature). The use of questionnaires in all of these studies limits responses and the conclusions that can be drawn. Motivations and experiences are likely to be ideographic in nature; therefore qualitative research in this domain is indicated.

There is also a lack of clarity in the sampling within studies investigating psychological aspects of ECS, with results for nulliparous and parous women often combined. For women who have experienced a TB the motivations for, and psychological experiences of, an ECS are likely to be different to those of nulliparous women. Requests for CS from women who have experienced TB may be directly linked to PTS symptoms and their sequelae. Having felt helpless and out of control in their previous births women may perceive an ECS to be controlled and predictable given that it is a standardised medical procedure. Women may also be requesting a procedure which they perceive to be significantly different from their previous experience, therefore avoiding stimuli associated with the trauma.

For this cohort the desperation to avoid re-experiencing the TB may result in complete avoidance of childbirth, causing distress and disappointment amongst those who had hoped for larger families (Gotvall & Waldenstrom, 2002). Allen (1998) found that for some women

the option of an ECS could mediate this decision and provide hope of fulfilling their families. Women may also perceive the ECS to be less likely to cause them further psychological and/or physical trauma and therefore enable them to avoid the negative post-natal impact associated with the TB. For example psychological trauma during birth is associated with difficulties bonding with baby (Ayres, Eagle & Waring, 2007) and physical trauma to the vagina can lead to decreased self-esteem and sexual problems (Allen, 1998; Beck, 2004; Moyzakitis, 2004). Practice evidence also suggests that women who request an ECS following a TB are doing so in order to secure the 'care by necessity' that is provided by a CS and may have been lacking previously contributing to the subjective experiences of trauma (Nightingale, 2013).

NICE Guidelines (2011) recommend that women who request an ECS be offered perinatal mental-health support and have requested that research be conducted to explore what psychological interventions are appropriate for women who display anxiety around childbirth. Recommendations for treatment of anxiety and phobias centre on Cognitive Behavioural Therapy (CBT). This approach has been found to be effective for nulliparous tokophobic women; challenging maladaptive cognitions and beliefs, psycho-education and relaxation techniques can lower anxieties, therefore increasing chances of a successful birth (Saisto, Toivanen, Salmela-Aro & Halmesmaki, 2006; Sydsjo, Sydsjo, Gunnervik, Bladh & Josefsson, 2011).

However, for women who have had a TB their beliefs and cognitions are grounded in experience, providing a real basis for their fears, which may prove difficult to work with. The likelihood of the trauma re-occurring cannot be guaranteed against; indeed research has found that PTS symptomatology during pregnancy and labour increases the likelihood of further trauma reactions (Lev-Wiesel, Chen, Daphna-Tekoah & Hod, 2009). Additionally, heightened levels of anxiety have been found to increase rates of emergency CS (Nilsson,

Lundgren, Karlstrom & Hildingson, 2012), increase duration of labour (Adams, Eberhard-Gran & Eskild, 2012) and result in more negative and painful experiences of birth (Haines, Rubertsson, Pallant & Hildingsson, 2012). Maternal stress and anxiety in pregnancy has also been found to have detrimental effects on infants in-utero and post-natally (Engel, Berkowitz, Wolff & Yehuda, 2005; Lederman et al., 2004).

Another option may be to offer women who have experienced TB treatment for PTSD. However, models of PTSD found to predict PTS symptoms following childbirth such as Ehlers and Clarke (2000) (Ford, Ayres & Bradley, 2010) advocate exposure to avoided stimuli to break the maintenance cycle of the disorder. For women who find themselves in a physically and psychologically vulnerable state such as pregnancy this confrontation may be argued as unethical. Exposure to stressors during therapy for PTSD are known to increase anxiety prior to desensitisation (Foa, Hembree & Rothbaum, 2007); as highlighted earlier, increased anxiety during pregnancy can have detrimental effects on maternal and infant outcomes. Women are aware of their vulnerability and these risks, therefore uptake of such therapy during pregnancy is low (Sandstrom, Wiberg,Wikman, Willman & Hogberg, 2008).

A subsequent positive birth experience following a TB can have redemptive effects (Thomson & Downe, 2010; Beck & Watson, 2010). Based on the research outlined earlier indicating high levels of satisfaction and fulfilment with an ECS, supporting women to have an ECS following a TB may be psychologically beneficial. However, as has also been highlighted, the samples for such studies may include nulliparous women with qualitatively different fears of birth.

Currently such conjecture concerning the psychological motivators, experiences and outcomes of ECS following TB are predominantly based on hypotheses derived from theoretical groundings or related research; there is no known research which directly explores

or investigates women's motivations for, or experiences of, requesting and having an ECS following a TB. Without thorough understanding of these motivators and experiences, it is difficult to make an informed judgement concerning the most appropriate response to requests for ECS following a TB and to know what support should be offered to such women.

Aims and Research Questions

With this gap in the literature identified, the current study explored women's experiences of Elective Caesarean Section (ECS) following a previous Traumatic Birth (TB), with the aim of better informing maternity staff and mental-health practitioners concerning the most beneficial ways to support such women.

The following questions were addressed:

What are women's hopes and expectations for an ECS following a TB?

What are women's experiences of ECS following TB?

Are there post-natal differences between women's experiences of their TB and ECS?

Can an ECS following a TB affect women's thoughts, emotions and memories of the previous trauma?

METHODOLOGY

Research Design

The design of the study was exploratory, qualitative and inductive; it utilised semi-structured interviews or written accounts, analysed using Interpretative Phenomenological Analysis (IPA). To respect the experiences of participants and represent their voices fairly within the research it seemed imperative to consider that as a researcher one can only attempt to make sense of participants through one's own representation of reality, including contexts of

culture, experience and prior knowledge. An IPA approach encourages transparency of the researcher's bias via reflexivity. However, there is an acknowledgment that even with this transparency one cannot completely bracket off their role in the construction of meaning; the researcher is inevitably an inclusive part of the world the participant is describing (Larkin, Watts & Clifton, 2008). With this in mind IPA employs a 'double hermeneutic' (Smith, Flowers & Larkin, 2009); the researcher is making sense of the participant, who is making sense of the experience, acknowledging the influence of the researcher in the process of interpretation.

The personal demands and circumstances of the sample were considered when designing the study. Women were offered either face-to-face, phone or Skype interviews, or to complete a written account of their experiences, providing flexibility and increasing participation opportunities. Offering the option of completing written accounts also afforded the expression of views privately and anonymously, encouraging participation from those unwilling to partake in face-to-face interviews given the personal nature of the subject (Gilzean, 2011).

Participants

A purposive and homogeneous sample of 13 women participated. Eight provided written accounts of their experiences and five were interviewed. The sampling method and size was consistent with recommendations for IPA studies (Smith, Flowers & Larkin, 2009). Inclusion criteria required that participants had an ECS within the last five years and that the primary reason was a subjectively TB. Women were excluded from the study if they had experienced a TB due to death or severe postnatal ill-health of the infant. Women were also excluded if the CS was medically indicated.

Participants were recruited from two NHS hospital sites (N: 3), and via the internet (N:10). The participants' mean age was 32 years old. All participants had their TB and ECS in the UK. The length of time between their TB and ECS ranged from two to seven years (mean: 4yrs) and time between their ECS and participation ranged from two weeks to four years (mean: 13 months).

For a table detailing participant characteristics please see Appendix C.

Measures

As per recommended design for IPA studies the data for this research were gathered using a semi-structured interview schedule. The schedule (Appendix D) was developed reflecting the exploratory nature of the research and guided by the aims and questions. It included questions exploring participant's experiences of requesting and having an ECS following a TB, including experiences post-natally. The schedule was adapted to act as a guide for written accounts of experience (Appendix E). Four women contacted through a support site for TB commented on the schedule and assisted in its development.

Procedure

Participants recruited via NHS sites were identified by a senior midwife in an ante-natal clinic and a clinical psychologist in an obstetrics and gynaecology department. Women were told about the study and if they expressed an interest permission was sought to pass on their details to the researcher. Participants recruited online responded via email to adverts placed on TB support websites and social networking sites for mothers (Appendix F).

Potential participants were contacted by the researcher and asked their preference for method of participation; they were then sent the relevant information sheet (Appendix G-J). Women who wished to participate were asked to contact the researcher to arrange an interview time, or were sent a guide for the written account. Women recruited via the NHS were offered the

opportunity to be interviewed at home or at the recruiting hospital; all declined this option, choosing telephone interviews instead. All participants agreed to a consent form outlining ethical information (appendix Q). General demographic information was obtained. Interviews conducted via Skype or telephone were preceded by a conversation concerning what to do if connection was lost. Oral interviews were recorded (ranging from 58-146 minutes). All participants were offered an opportunity to reflect on the experience of participation.

Analysis

Interviews were transcribed and texts from written accounts were formatted into transcripts. Data were analysed following IPA procedures (Smith, Flowers and Larkin, 2009). Individual transcripts were read thoroughly several times. Once familiar with the transcript the researcher began annotating initial thoughts regarding descriptive, linguistic and conceptual facets of the data. Transcripts were re-read including the researcher's added interpretations; themes resulting from both participants and researcher's data were identified. IPA is committed to ideographical analysis so each individual transcript was read and analysed separately in this way. Following this process the themes from each transcript were finalised, transferred to a separate document and considered as a whole. The researcher clustered themes across transcripts and embarked on a period of exploring how themes could be organised to develop subordinate and superordinate themes; this comprised of manually moving themes around, constructing various diagrams and connections until a best-fit representation of the researchers interpretation of the data was achieved. Transcripts were re-read to confirm that themes were captured in the verbatim text and to note down quotations to illustrate each theme (Appendix K).

Quality Assurance Checks

Yardley's (2008) principles for assessing the quality of qualitative research were considered. For example, 'transparency and coherence' is evidenced through the inclusion of a coded

transcript (Appendix L) and the inclusion of the reflexive diary (Appendix M). Two clinical psychologists and a trainee were also involved in the discussion of themes and interpretations. 'commitment and rigour' were demonstrated by following guidelines for conducting IPA research (Smith, Flowers and Larkin, 2009) and providing evidence of the systematic nature of the analysis in the form of a paper trail and pictures depicting stages of exploration of data in the analysis (Appendix N).

Ethical Consideration

Ethical approval was received from the Department of Applied Psychology Ethics Panel, Canterbury Christ Church University and from NHS Ethics and the local NHS research departments (appendix O & P) . The BPS Code of Ethics and Conduct (2009) was adhered to throughout.

Ethical procedures for online recruitment were adhered to throughout; this was predominantly informed by guidance from Jones (2011). These included online participants verbally consenting to take part in the study, proof of the researchers credentials being sent via email prior to participation, a conversation regarding what would be done if internet connection were to be lost during Skype interviews and finally, a conversation about where the participant could obtain further support if needed (e.g. from their GP).

FINDINGS

Descriptive information regarding the participant's previous birth will be presented, followed by the results of the interpretative phenomenological analysis of participant's experiences of ECS.

The Previous Traumatic Birth (TB)

Participants were asked about their experiences of the TB. Descriptive data were extrapolated to provide context to their requests for the ECS (Table 1.).

Table 1. Descriptive data regarding participant's previous Traumatic Birth (TB).

		Number of women
Mode of previous birth	Emergency C-section.	5
	Instrumental delivery.	3
	Episiotomy.	5
Experiences of birth perceived as traumatic	Feeling uncared for by staff.	7
	Poorly communicated with and not listened to by staff during and/or after birth.	8
	Feeling de-humanised and violated.	2
	Inadequate pain relief.	5
	Feeling out of control and helpless.	7
	Perceiving their or their baby's life to be at risk.	6
	Expectations of birth out of sync with experiences.	8
Perceived Impact of traumatic birth	Impact on relationship and bonding with baby.	7
	Impact on relationship with partner and sex life.	4
	PTSD and PTS symptoms.	8
	Low mood and depression.	4
	Low self-esteem and feelings of guilt about birth.	6
	Longitudinal pain/ physical damage.	7
	Fear of future birth	9

Experiences of the Elective Caesarean Section

Thirteen subordinate themes were identified which were subsumed under five superordinate themes: 'cautiously moving forward into the unknown: the drive to reproduce', 'attempting to make the unknown known', 'the longed for, positive birthing experience', 'a different post-natal experience' and 'the interaction of the two experiences'. Table two depicts superordinate and subordinate themes including the number of participants these relate to.

Table two: A table depicting superordinate and subordinate themes including the number of participants these relate to.

Superordinate themes	Subordinate themes	Number of participants
Cautiously moving forward into the unknown: the drive to reproduce.	Fear and avoidance.	8
	Requesting a CS a necessary but difficult decision.	9
	Subsequent pregnancy: a time of excitement, anxiety and increased trauma symptoms.	10
	Request for ECS supported or opposed: a battle which can mediate anxiety.	11
Attempting to make the unknown, known.	A request for perceived control.	8
	A perceived medically safer and less physically traumatic experience.	9
	Avoidance of stress, emotional trauma and its sequelae.	6
The longed for, positive birthing experience.	A surreal experience	7
	The importance of care and communication	11
A different post-natal experience.	Painful recovery: "A price I could pay".	12
	Bonding with baby and maternal wellbeing.	9
The interaction of the two experiences	The good highlighting the bad	7
	A redemptive experience	7

Superordinate Theme One: Cautiously Moving Forward into the Unknown: The Drive to Reproduce

The superordinate theme 'cautiously moving forward into the unknown: the drive to reproduce' represents the sentiment of women's reflections upon their subsequent pregnancy following the Traumatic Birth (TB). Women reported initial fear and avoidance of sexual

relationships and future childbirth as a consequence of their TB. For some, an ECS permitted thoughts of future childbirth. During the subsequent pregnancy women reported feeling excited about the prospect of having another baby, but this was marred by anxiety and an increase in trauma symptoms. This anxiety was often mediated by the support they received in their decision for an ECS.

1.1. Fear and avoidance.

Many women talked about the TB impacting on their hopes to have more children. The majority of women whose narratives encompassed this theme talked about general avoidance of re-experiencing birth.

> It affected us quite badly we were not sure we would want any more children…I didn't want to relive anything like that in the future. (Paula).

Some women could not consider having more children because they felt unable to engage in sexual intercourse with their partners due to on-going pain from the TB and due to an association of their vagina as stimuli linked with the trauma. Carey described her reactions to her vagina following her TB:

> I never looked. I was so obviously… traumatised by what had gone on…it affected my relationship with my husband. I wouldn't sleep with him… for like a year after.

She later linked this to the TB impacting on her hopes for more children:

> I always thought I would have two; in the immediate aftermath and certainly the first 6-12 months after, I was just like no way! And that was part of the no way… this is now a no-go zone [points to groin].

1.2 Requesting a caesarean section, a necessary but difficult decision.

For some women an ECS enabled them to entertain thoughts of future childbearing. After a year of believing she would be unable to face having more children Carey reported:

> And then it was…we do want another baby…I can always have a CS, in my mind that was going to solve the problem for me.

The decision for an ECS was not however straight-forward; women expressed that they did not necessarily want a CS, but they felt the trauma symptoms left them with little other choice:

> I kept changing my mind about what I wanted. Part of me wanted to give birth naturally…I didn't want to feel like a failure and that my experience had beaten me...I struggled with reliving it all over again though. (Amanda)

1.3 Subsequent pregnancy: a time of excitement, anxiety and increased trauma symptoms.

All women reported initial excitement upon falling pregnant again. However, the majority talked about this being marred by anxiety regarding the prospect of giving birth.

> I was surprised to be pregnant again. Happy but daunted, maybe terrified at the thought of the birth. (Ali)

For some this anxiety extended into re-surfacing or increase of symptoms associated with the TB. Carey described avoidance behaviour while waiting at a surgery reading birth magazines:

> I couldn't look at pictures of women doing positions you needed to be in for labour. I got really upset and started to cry, I had to put the magazine down, put it at the other side of the room.

Jess experienced episodes of re-living the trauma, of feeling unheard in her pleas for help during her previous birth:

> Around 16 weeks I was having horrific dreams and felt the trauma of being silenced again…I threatened to end our pregnancy… the trauma was almost disabling...I couldn't even step foot in the previous hospital.

1.4 Request for caesarean section supported or opposed: a battle which can mediate anxiety.

Women discussed their experiences of requesting an ECS; a theme interpreted from these narratives was the request dividing opinion, the outcome of which mediated further symptoms of anxiety and distress.

Most women were supported by their families and friends in the decision. However, there was a split amongst women's experiences of support from services. Some were offered or granted the choice of a CS immediately; for these women anxiety quickly diminished and some even talked about feeling relaxed as a result throughout the pregnancy:

> My obstetrician was happy to support me… She even booked a date for me when I was 16 weeks pregnant so I could relax and not be anxious about it during my pregnancy. (Nina)

However, for other women they experienced resistance, leading to frustration and negativity towards services and further increased anxiety through the pregnancy. They felt doctors did not understand their experiences and were focussed on physical risk, rather than considering the psychological effects of facing a perceived unknown birth:

> The consultant I saw got the full story….. I cried and everything… he was just saying no… it was really bringing the fear back and making my mind race...what I should have been saying is… what about me, the effects on my mental-health? (Carey)

Once the ECS was agreed there was a decrease in anxiety. For some women they perceived the resistance toward their decision to extend into societal opinions and beliefs, adding to their feelings of being misunderstood.

Superordinate Theme Two: Attempting to Make the Unknown, Known.

The second superordinate theme represents women's hopes and expectations for the ECS. It encompasses themes relating to women hoping for increased certainty about what their birth may entail and reducing the chances of further physical and psychological trauma.

2.1 A request for perceived control

Many women talked about the ECS being directly related to control. This was often linked to feelings of helplessness that led to their experience of the previous birth as traumatic:

> The speed and rigidity shown by the medical team [during the previous birth] took away all my delusions about choice during labour and left me feeling totally out of control. By making the choice [for an ECS] I felt I was exercising control. (Ali)

For others it was linked to the ability to plan when the baby would be born, reducing the chances of repeating the circumstances which facilitated the TB. Some perceived the process of an ECS to be a more predictable and therefore controlled procedure compared to natural birth; the psychological benefits of this were thought to outweigh the medical risks:

> I can look up what a CS is and know what's going to happen from beginning to end… how the medical staff are going to respond …which might end up in a hysterectomy

> for me, I might even end up dying...I was completely comfortable with all of that. (Carey)

2.2 A perceived medically safer and less physically traumatic experience.

Many women perceived an ECS to be a physically less traumatic and safer procedure in comparison to their experiences of natural birth. Many had feared for either their or their baby's life during the TB, for some of these women an ECS minimised this risk from re-occurring. For other women their decision was in part linked to fears of further trauma to their vagina:

> Fear of tearing again; after the natural birth it took a year to heal…I wanted a CS so that my vagina wouldn't suffer anymore. (Jane)

The physical damage was often associated with its resulting sequelae which women wanted to avoid, for example affecting relationships with partners:

> One thought was [when requesting a CS] … sex with my partner, it was so incredibly painful after what happened the first time and it's still not right now. I was conscious I didn't want any further damage. (Becky)

Women talked about wanting to avoid the pain experienced during the TB and believed the ECS would achieve that.

2.3 Avoidance of stress, emotional trauma and its sequelae.

Many women talked in abstract terms about wanting to avoid the psychological trauma they had experienced. This was sometimes conceptualised as a 'stress' reaction that they felt an ECS would prevent. Other women linked the psychological trauma of the TB to consequences post-natally they hoped to avoid by an ECS.

> What I ultimately hoped was that if the birth was a more positive experience I would avoid a second case of post-natal depression. (Nina)

Becky reflected on the negative effect the trauma had on her relationship with her first baby and linked this to wanting a CS with her second:

> I think the biggest thing for me was not wanting to feel the way I did afterwards again, in terms of the relationship with the baby… wanting the relationship to be the way it should be from the start, that's what drove my decision.

Superordinate Theme Three: The Longed for Positive Birthing Experience

Eleven women reported that overall their ECS was a positive experience which they would choose again. They described the ECS as a surreal experience. The important role of maternity staff in facilitating a positive experience was highlighted; the level of support and communication received was interpreted to mediate women's perceptions of control through the procedure.

3.1 A surreal experience.

The word 'surreal' was used by multiple women to sum-up the experience of the ECS. They expressed disbelief that the experiences could be so polarized. For many there were elements of emotional disconnectedness associated with their ECS in comparison to the extreme emotions of fear and pain during the TB.

For some women their experience of a positive birth went beyond that of having their child in a safe and uncomplicated manner; there was an idealised component to how they perceived the experiences. One may not expect these same idyllic perceptions to be shared by women

who had undergone a primary CS having not experienced a TB. Carey described "a feeling of calmness and serenity" throughout the ECS.

3.2 The importance of care and communication.

The supportive role of the maternity team was consistently linked to perceptions of the ECS as a positive experience. Women who felt cared for through the procedure felt safer and less anxious. The ECS permitted a level of care not possible throughout labour in busy maternity wards:

> I got a lot more care by necessity because I was a CS patient…and that was one of the things I was requesting… to be looked after. One of the things I didn't feel at any point after I had given birth to my first was cared for. (Carey)

The experience of feeling helpless and out of control in their TB had facilitated the onset of post-traumatic reactions, during the ECS this was counteracted by communication and explanation of the procedure by staff. Women felt in control during the birth via this reassurance, support, increased choice and understanding:

> I was given as much information as I needed and even had choices about various aspects…The anaesthetist showed me my vital signs all along and when my blood pressure dropped she showed me what medication she was giving (Jess)

The procedure itself was perceived to be more controlled leading to staff reacting more predictably and calmly, impacting on women's reactions:

> This one was a lot more controlled and everyone seemed calm… it was a process and procedure everyone in the room had done many times, it made me relaxed. (Lucy)

There was also a sense of women feeling relieved at being able to relinquish control and responsibility of the birth handing it safely to the medical staff:

> Everyone is looking after you and is there for you, they were saying don't worry this is our job, we are looking after you. That made me feel better. (Jennifer)

However, for some while their hopes for control and predictability from staff and the procedure were met, the reality of the procedure as a clinical operation led to grief over the loss of a sentimental birth, Becky reflected:

> I remember thinking I can't believe this is how my baby is going to be born, because it was so clinical and militant and was just so un-romantic…I think I was crying.

For Emma her expectations of control and predictability were shattered when she had to be put under general anaesthetic as a course of emergency. The trauma of this experience was exacerbated by the reaction from staff who she felt were unsympathetic "It was on my notes, elective, so I felt they were just like get on with it, you wanted it".

Superordinate Theme Four: A Different Post-Natal Experience

Following the ECS women's experiences of physical and psychological recovery were markedly different from their post-natal period for the TB. The differences in recovery between the two births were linked to differences in bonding with baby and maternal wellbeing.

4.1 Painful recovery: "A price I could pay"

Many women acknowledged that the recovery period following a major operation could be long and painful, however for most this was perceived to be "a price I could pay" (Carey) for having avoided re-experiencing the TB and by the benefits to their psychological wellbeing. Jess highlights this, "The CS has been slower to recover from physically but much quicker psychologically".

Some felt the physical recovery time was quicker and less painful following the ECS compared with the damage caused by forceps deliveries, episiotomies and on-going medical complications to the pelvic floor caused by their previous births.

Most of the women felt the longitudinal physical impact of natural birth had been hidden from them and this had contributed to their distress and perceptions of trauma. Prior to ECS women were well informed about its physical impact, having these expectations enabled better coping and removed fear about the meaning of pain, the unknown nature of which following the TB felt terrifying.

4.2 Bonding with baby and maternal wellbeing.

Many of the women talked about differences in bonding with infants following the ECS compared to the TB. For some the imposed rest and feeling less physically traumatised enabled them to spend time with, and focus on, their babies:

> I enjoyed my first few days with her, rather than just having to look after myself which happened with the first one, I wasn't well enough that time to look after the baby, but this time I felt well (Lucy)

For others the difference in bonding was attributed to the birth being less traumatic psychologically:

> I had more of a bond with this baby; it has to have something to do with the birth… me feeling happier after my second that's my opinion. (Jennifer)

Many women reported that breastfeeding was easier after the ECS and attributed this to feeling psychologically better in themselves following the birth:

> I had a much easier time breastfeeding my second child… due to how much less stressed I was post-delivery. (Nina)

Women highlighted specific differences in their wellbeing following the two births; in contrast to her TB Jennifer did not experience post-natal depression following the ECS, something she attributed to the different birth experiences. Carey encompassed many women's experiences when reflecting on the differences she noticed post-natally between the two births:

> Instead of feeling like I had been in a major accident… feeling horrific, that soul-scooped out feeling that didn't go away for weeks or months afterwards, that draining feeling, my daughter being terribly ill and not feeding, GONE! I felt well, I felt calm, my daughter breastfed brilliantly, I had no problems whatsoever.

Unfortunately, for Emma complications during her ECS resulted in further trauma and PTS reactions such as avoidance of future birth through sterilisation and hyper-vigilance towards the new baby:

> I was always checking her or always touching her a little bit which there was no need for. I needed the reassurance that she was OK, kind of she was alright I was alright, it was upsetting.

Superordinate Theme Five: The Interaction of the Two Experiences

Many women reflected upon how the experience of the ECS impacted on their memories, thoughts and feelings of the TB. For some the positive experience stirred up grief for 'what could have been' during and following their first birth. For many the experience of the ECS was redemptive; they still reflected upon the previous birth as a distressing experience but the trauma symptoms associated with it were lessened, they felt they had a new perspective on the birth, one which relinquished them of the responsibility and guilt they had previously felt.

5.1 The good highlighting the bad

The positive experience of the ECS and the impact this had on women's wellbeing and relationship with their baby post-natally, brought with it grief at the loss of this experience in their TB.

> Since having such a nice experience the second time it has made me realise how horrible my first birth was and makes me think why does it have to be like that? (Paula)

For Nina the strong bond she felt toward her second child after the ECS brought with it a grief for 'what could have been' with her first baby:

> It was only as I noticed my strong bond with my second that I realised how much I had struggled first time. It made me sad to think that I had less of a bond initially with my first baby… I wondered if I'd had her by CS if I would have been able to enjoy her more in the first few months

The concept of the good highlighting the bad was multidirectional and for Emma her negative experience of the ECS put her thoughts, feelings and memories of her previous birth into perspective; since the ECS she remembered her first birth in a more positive light. Having experienced two traumatic births she attributed the 'failure' of these to herself and as such reported depression, low self-esteem, anxiety and poor confidence in her maternal abilities.

5.2 A redemptive experience.

The positive experience of the ECS did not change women's perceptions of their previous birth as distressing. However, it often diminished their PTS symptoms such as flashbacks and re-experiencing; memories of the trauma were less erratic, vivid, painful and present:

> It's almost like watching it through a window, I can say that was the experience that happened without it trawling up the primary sensations it used to for me. (Carey)

The experience was described as cathartic by some women; it allowed them to gain perspective on the TB and reframe it as an unfortunate experience, rather than something they were responsible for:

> I think having second baby has made me realise… the first time could not have been prevented; it was just one of those things that happened to happen to me. (Amy)

This relinquished women from feelings of guilt, distress and shame:

> I'm more confident now that my first experience was a bad experience and I wasn't just being a wimpy first timer. (Ali).

This redemption extended to relationships with services. Previous ruptures were forgiven following a positive experience with caregivers during the ECS. For many of the women who had started the journey into their second pregnancy feeling unsure and anxious, the positive experience of their ECS changed their cognitions and emotions about birth:

> After my first I felt very strongly that falling pregnant again would be my worst nightmare… Now after the second I feel less daunted at the idea of future pregnancies. (Ali)

DISCUSSION

The current study is thought to be the first to explore women's experiences of an Elective Caesarean Section (ECS) following a previous Traumatic Birth (TB). It sought to uncover women's hopes and expectations for an ECS, their experiences of the ECS and postnatal psychological outcomes of the ECS, with the aim of increasing healthcare practitioners'

understanding of this client group and therefore informing the support provided to such women.

In line with previous research and Post Traumatic Stress (PTS) symptomatology, the current study found that women who had experienced a TB delayed subsequent pregnancy due to high levels of fear and avoidance (Fones, 1996; Knapp, 2011/12; Gotvall & Waldenstrom, 2002). For some of these women the knowledge that a CS was an option for subsequent birth permitted thoughts of future childbearing. Subsequent pregnancy represented a vulnerable time for all women in this study; previously inaccessible memories of the trauma may be retrieved during this time due to increases in trauma-related stimuli, heightening levels of arousal, flashbacks and nightmares (Brewin, Dalgleish & Joseph, 1996). The decision for an ECS was often motivated by such distress and not by women's birth preferences. Battling for the ECS with healthcare providers increased the emotional burden these women carried, adding to ruptures in this relationship and potentially increasing risks during pregnancy.

One of the main hopes and expectations women had for an ECS was that it would increase control. Control can be defined as "belief that one has at one's disposal a response that can influence the aversiveness of the event" (Thompson, 1981, P.89). Women held beliefs that in choosing the procedure they were executing control over their birth and reducing the chances of further trauma. They also perceived an ECS to be a more controlled and predictable procedure. Seeking such control may be a response to the perception of loss of control in their TB, a common experience for women in this study and a variable consistently linked to TB in previous research (Olde, Van der Hart, Kleber & Van Son, 2006).

Striving for control may also be directly linked to PTS reactions of re-experiencing and arousal which can be unpredictable, distressing and out of the sufferer's control. Information processing theories of PTSD suggest that traumatic events lead to formation of fear structures

in long-term memory. Individuals with this fear structure lack predictability and controllability in their lives (Foa, Steketee & Rothbaum, 1989). Women may be striving to re-align the balance of control and predictability in electing for a CS.

The majority of participant's experiences of the ECS met or exceeded their expectations and provided them with the positive, controlled and predictable birth they desired. For one of the participants who reported further trauma following the ECS her expectations of a controlled birth were shattered; unmet expectations of birth, particularly expectations of control have been found to produce adverse emotional outcomes including trauma, disappointment and guilt (Beaton & Gupton, 1990; Quine, Rutter & Gowen, 1993).

This study and previous research highlights the core role of engaged and caring maternity staff in facilitating a positive and redemptive experience of subsequent birth (Beck & Watson, 2010; Thomson & Downe, 2010). Effective care and communication can positively mediate perceptions of control, empower individuals, increase self-efficacy and therefore lower anxiety (Walker, 2001). Emotional support may be argued to be provided by a partner or family during birth, however while such support is important it does not substitute the role of an attentive, knowledgeable midwife (Melender, 2002). Partners are also susceptible to experiencing traumatic reactions to birth (Nicholls & Ayres, 2007) and cannot provide women the reassurance, medical knowledge and birthing skills they need to feel safe during labour.

Perceptions of care are subjective; it is therefore difficult to determine the actual standard and quality of care received during each birth, PTS symptomatology such as fragmented memories and high levels of arousal may contribute to retrospective perceptions of poor care. Likewise women who experienced the ECS as an overall more positive experience may be more likely to reflect on their care team favourably. The reality is however, that an ECS

requires one-to-one care by necessity, whereas midwives themselves acknowledge barriers to continuous care during labour such as under-resourcing and high demand within maternity units (Royal College of Midwives, 2012).

Another expectation that was met for women was the ECS providing a different post-natal outcome to their TB in terms of better emotional and physical wellbeing and their relationships with infants. Research has speculated whether poor bonding with infants or maternal mental-health difficulties may be inaccurately attributed to TB, suggesting that such outcomes may have occurred regardless of birth experience as sources of such problems are located in individual traits and experiences e.g. parental attachment style or previous experience of trauma. That this cohort of women had such different experiences following the ECS may suggest that previous post-natal experiences were directly attributable to the TB and subsequent PTS symptoms such as avoidance and hyper-arousal. However, these relationships are complex with numerous variables that may impact on such outcomes; further research is warranted before firm conclusions can be drawn.

For most women the positive ECS experience highlighted to them ‘what could have been’ in their previous births. However, this sense of loss was outweighed by the redemptive effect of the ECS; reducing guilt for the TB, resolving ruptures in relationships, diminishing PTS symptoms and improving cognitions and emotions of birth. Core theoretical models of memory suggest that related experiences do not retain individual identities in memory but become merged into overarching schematic representations (Bartlett, 1932). In line with this and cognitive theories of trauma, a positive experience may facilitate re-structuring of ‘birth’ schemata. As such, when women are consequently faced with birth stimuli the original traumatic schematic representations would be diluted with recent, more ‘positive’ representations of birth, therefore reducing PTS symptomatology.

Limitations and Directions for Future Research

Women in the sample all had their TB and ECS in the UK; given the role cultural and societal norms play in birth preferences and choice it would be difficult to generalise results. Future research may look to recruit different populations to examine the role of societal/ cultural norms and expectations on both experiences of TB and subsequent ECS.

Recruiting participants online and the use of Skype interviewing is a relatively new phenomenon. There are some limitations to online research, including potentially restricting the pool of participants able to partake in the study to those who have access to, and are knowledgeable in, using computers and the internet (Thomas, Stamler, LaFreniere & Dumala, 2000). However, recruiting via NHS sites in addition to online provided the opportunity for women who were less technologically driven, or economically advantaged, to participate. The research could be improved by expanding the NHS recruitment sites and recruiting within the community.

Participants were recruited at different time points post-natally following their ECS and asked to reflect retrospectively. Women's appraisals of childbirth can alter over the post-natal period (Martin & Fleming, 2011). This research suggested that symptoms of PTSD may lead to requests for an ECS and that PTS symptoms reduce following a redemptive birth experience. However, these conclusions are limited given that the study did not include a PTSD measure. To improve on these limitations future designs may include interviewing women prior to the ECS and at a unified time point post-natally, including a measure of trauma at both of these intervals.

Future research could also focus on developing and evaluating a screening tool which highlights markers for the development of trauma to be administered in the immediate

aftermath of birth. Additionally, a tool to screen for trauma reactions in this cohort six months post-natally, when PTSD symptoms may emerge, is also necessary.

Further research exploring the effects of traumatic birth on mother-infant attachments is warranted, including comparing attachment relationships of infants born of TB and subsequent infants born via an ECS. Tracking the course and quality of the redemptive effects of the ECS would also prove interesting to follow up longitudinally, this could ward against the potential impact of cognitive dissonance within these reflections.

Clinical Implications: How can this Study Better Inform the Support Offered to Such Women?

One of the key findings from this study was that ECS was not a preferred birth choice but the only bearable option for some women due to PTS symptomatology. Reproduction is a primary drive, being unable to fulfil this drive can negatively impact upon emotional wellbeing in women and their partners (Valentine, 1986). Therefore, supporting women to realise their ambitions for larger families is imperative.

Screening for PTS reactions following birth is indicated; if trauma can be promptly identified, therapeutic input can be offered prior to women considering future childbearing. This would eliminate the potential risk involved in offering such treatment during a vulnerable time such as pregnancy and if successful allows women to feel freer in their choices for future birth. Post-natal care should include asking women brief questions regarding their subjective experiences of the birth, if these highlight potential for trauma the healthcare support-worker could conduct a follow-up six months post-natally to screen for further PTS symptoms and where relevant refer women on for therapeutic intervention.

Where women find themselves in the position of facing birth whilst experiencing PTS symptoms, they would benefit from an honest and empathetic consultation with a member of

the maternity team who can listen to their reasons for the ECS, explain the risks and benefits of the procedure and check this is the most suitable option for women, physically and psychologically. NICE guidelines (2011) recognise the potential psychological harm denying an ECS may cause and highlight the cost implications for the NHS in terms of an increase in the provision of long-term psychological input that may be required. The guidelines have been updated to reflect this:

> If vaginal birth is not an acceptable option to the women after discussion and the offer of support, she should be supported in her choice of a planned CS. (pp.101).

It is now a matter of ensuring such guidance is implemented across all maternity services.

Trauma reactions to birth should however be considered on a spectrum. Where women feel able to try for a natural birth, joint work between maternity staff and a specialist clinical psychologist would be beneficial. Talking women through their medical notes and facilitating understanding of why the birth was experienced as traumatic may be advantageous. Psychological interventions for anxiety such as relaxation techniques, CBT or mindfulness may also benefit such women.

The vital role maternity staff play in mediating the birth experience stresses the importance of the provision of continuous care for all births. One-to-one continuous care in labour where the midwife is providing reassurance, support, advice and encouragement, will increase the woman's sense of control and competence during birth, reducing anxiety, consequently reducing incidence of TB. The latest Cochrane review in this area supports this "continuous support during labour should be the norm, rather than the exception" (Hodnett, Gates, Hofmeyr & Sakala, 2009, P. 11).

Finally, for those women who experience further trauma during subsequent birth, specialist psychological input is indicated. Given the impact that TB can have on women's relationships with their partners and children (Ayres, Eagle & Waring, 2007) and on their mental-health and wellbeing (Lemola, Stadlmayr & Grob, 2007), each of which may have cost implications for health services long-term, the provision of a psychologist specialising in obstetrics and gynaecology should be an essential requirement for maternity teams.

CONCLUSION

This qualitative study explored women's experiences of Elective Caesarean Section (ECS) following a previous Traumatic Birth (TB), with the aim of better informing support offered by maternity staff and mental-health practitioners. Results indicated that participants often experienced an increase in trauma symptoms during a subsequent pregnancy, which in some cases limited their ability to consider trying for a natural birth. These trauma symptoms were often exacerbated by women feeling that they had to fight for an ECS. In opting for an ECS women hoped to avoid the physical and psychological trauma of their previous birth and the sequelae that followed this. The majority of women in this study did obtain the longed for birthing experience via an ECS, they appreciated the high-levels of care this procedure afforded them and the controlled nature of the operation. For these women this birth was redemptive and had positive outcomes for their relationships and wellbeing. These results highlight the importance of providing women in this position with information and choice regarding a subsequent birth. They also stress that prevention of women carrying PTS reactions into their subsequent pregnancies is imperative. Future research would benefit from focussing on the development and trialling of effective screening tools for PTS reactions following birth.

References

Adams, S., Eberhard-Gran, M., & Eskild, A. (2012). Fear of childbirth and duration of labour: A study of 2206 women with intended vaginal delivery. *British Journal of Obstetrics and Gynaecology* , 01/02/2013. doi:10.1111/j.1471-0528.2012.03433.x

Allen, S. (1998). A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology, 16*(2/3), 107-128.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. Text rev. ed.). Washington, DC: Author.

Ayres, S., Eagle, A., & Waring, H. (2007). The effects of childbirth related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health and Medicine, 11*(4), 389-398.

Ayres, S., Harris, R., Sawyer, A., Parfitt, Y., & Ford, E. (2009). Post-traumatic stress disorder after childbirth: Analysis of symptom presentation and sampling. *Journal of Affective Disorders, 119*, 200-204.

Ayres, S., & Pickering, A. (2001). Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. *Birth: Issues in Perinatal Care, 28*, 111-118.

Bartlett, F. C. (1932). *Remembering: A study in experimental and social psychology.* (2nd ed.). Cambridge, UK: Cambridge University Press.

Beaton, J., & Gupton, A. (1990). Childbirth expectations: A qualitative analysis. *Midwifery, 6*, 133-139.

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

Beck, C. T., & Watson, S. (2010). Subsequent childbirth after a previous traumatic birth. *Nursing Research, 59*(4), 241-249.

Blomquist, J., Quiroz, L., Macmillan, D., Mccullough, A., & Handa, V. L. (2011). Mothers satisfaction with planned vaginal and planned cesarean birth. *American Journal of Perinatology, 28*(5), 383-388.

Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of post-traumatic stress disorder. *Psychological Review, 103*, 670-686.

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

Davies, J., Slade, P., Wright, I., & Stewart, P. (2008). Post-traumatic stress symptoms following childbirth and mothers perceptions of their infants. *Infant Mental Health Journal, 29*(6), 537-554.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of post- traumatic stress disorder. *Behaviour Research and Therapy, 38*, 319-345.

Engel, S., Berkowitz, G., Wolff, M., & Yehuda, R. (2005). Psychological trauma associated with the World Trade Centre attacks and its effect on pregnancy outcome. *Paediatric Perinatal Epidemiology, 19*(5), 334-341.

Foa, E., Hembree, E., & Rothbaum, B. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences.* New York: Oxford University Press.

Foa, E., Steketee, G., & Rothbaum, B. (1989). Behavioral/cognitive conceptualizations of post-traumatic stress disorder *Behaviour Therapy, 20*(2), 155-176.

Fones, C. (1996). Posttraumatic stress disorder occurring after painful childbirth. *Journal of Nervous and Mental Disease, 184*(3), 195-196.

Ford, E., Ayres, S., & Bradley, R. (2010). Exploration of a cognitive model to predict post-traumatic stress symptoms following childbirth. *Journal of Anxiety Disorders, 24*(3), 253-259.

Gilzean, T. (2011). Communicating chaos, regaining control: The implications for social work of writing about self-injury. *Journal of Social Work Practice. Approaches in Health, Welfare and the Community, 25*, 31-46.

Gottvall, K., & Waldenstrom, U. (2002). Does a traumatic birth experience have an impact on future reproduction? *British Journal of Obstetrics and Gynaecology, 109*, 254-260.

Haines, H., Rubertsson, C., Pallant, J., & Hildingsson, I. (2012). The influence of women's fear, attitudes and beliefs of childbirth and experience of birth. *Biomed Central. Pregnancy and Childbirth, 12*(55), 1-14.

Hodnett, E., Gates, S., Hofmeyr, G., & Sakala, C. (2009). Continuous support for women during childbirth (review). *Cochrane Library,* (1).

Knapp, E. (Winter 2011/2012). Acute distress and PTSD following childbirth: A complex longitudinal case study. *Midwifery Today*, 44-68.

Larkin, M., Watts, S., & Clifton, E. (2008). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*, 102-120.

Lederman, S., Rauh, V., Weiss, L., Stein, J., Hoepner, L., Becker, M., & Perera, F. (2004). The effects of the World Trade Centre event on birth outcomes among term deliveries at three lower Manhattan hospitals. *Environmental Health Perspectives, 112*(17), 1772-1778.

Lemola, S., Stadlmayr, W., & Grob, A. (2007). Maternal adjustment five months after birth: The impact of the subjective experience of childbirth and emotional support from the partner. *Journal of Reproductive and Infant Psychology, 25*(3), 190-202.

Lev-Wiesel, R., Chen, R., Daphna-Tekoah, S., & Hod, M. (2009). Past traumatic events: Are they a risk factor for high-risk pregnancy, delivery complications and postpartum posttraumatic symptoms? *Women's Health (Larchmt), 18*, 119-125.

Martin, H., & Fleming, V. (2011). The birth satisfaction scale. *International Journal of Healthcare Quality Assurance, 24*, 124-135.

Melender, H. L. (2002). Experience of fears associated with pregnancy and childbirth: A study of 329 pregnant women. *Birth, 29*(2), 101-111.

Moyzakitis, W. (2004). Exploring women's descriptions of distress and/or trauma in childbirth from a feminist perspective. *Evidence Based Midwifery, 2*, 8-14.

Nama, V., & Wilcock, F. (2011). Ethics caesarean section on maternal request: Is justification necessary? *The Obstetrician and Gynaecologist, 13*, 263-269.

National Institute for Clinical Excellence. (2011). *Caesarean section*, London: RCOG Press.

Nicholls, K., & Ayres, S. (2007). Childbirth related post-traumatic stress disorder in couples: A qualitative study. *British Journal of Health Psychology, 12*, 491-509.

Nightingale, P. (2013, 11th June 2013). NICE urges more info on pros and cons of C-section. Message posted to http://www.nursingtimes.net/nursing-practice/clinical-zones/womens-health/nice-urges-more-info-on-pros-and-cons-of-c-section/5059657.article

Nilsson, C., Lundgren, I., Karlstrom, A., & Hildingsson, I. (2012). Self- reported fear of childbirth and its association with women's birth experience and mode of deliver: A longitudinal population based study. *Women and Birth, 25*, 114-121.

Nilstun, T., Habiba, M., Lingman, G., Saracci, R., Da Fre, M., & Cuttini, M. (2008). Cesarean delivery on maternal request: Can the ethical problem be solved by a priciplist approach? *Biomed Central. Medical Ethics, 9*(11), 02/03/2012. doi:10.1186/1472-6939-9-11

Olde, E., Van der Hart, O., Kleber, R., & Van Son, M. (2006). Posttraumatic stress following childbirth: A review. *Clinical Psychology Review, 26*, 1-16.

Quine, L., Rutter, D. R., & Gowen, A. (1993). Women's satisfaction with the quality of the birth experiences: A prospective study of social and psychological predictors. *Journal of Reproductive and Infant Psychology, 11*, 107-113.

Robson, S., Carey, A., Mishra, R., & Dear, K. (2008). Elective caesarean delivery at maternal request: A preliminary study of motivations influencing women's decision making. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 48*, 415-420.

Royal College of Midwives. (2012). *State of maternity services*, London, UK.: Royal College of Midwives.

Ryding, E. L. (1993). Investigation of 33 women who demanded a caesarean section for personal reasons. *Acta Obstetricia Et Gynecologica Scandinavica, 72*, 280-285.

Saisto, T., Toivanen, R., Salmela-Aro, K., & Halmesmaki, E. (2006). Therapeutic group psychoeducation and relaxation in treating fear of childbirth. *Acta Obstetricia Et Gynecologica Scandinavica, 85*, 1315-1319.

Sandström, M., Wiberg, B., Wikman, M., Willman, A., & Hogberg, U. (2008). A pilot study of eye movement desensitisation and reprocessing treatment (EMDR) for post-traumatic stress after childbirth. *Midwifery*, *24*(1), 62-73.

Schindl, M., Birner, P., Joura, E., Husslein, P., & Langer, M. (2003). Elective cesarean section V's spontaneous delivery: A comparative study of birth experience. *Acta Obstetricia Et Gynecologica Scandinavica, 82*, 834-840.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

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

Sydsjo, G., Sydsjo, A., Gunnervik, C., Bladh, M., & Josefsson, A. (2011). Obstetric outcome for women who received individualized treatment for fear of childbirth during pregnancy. *Acta Obstetricia Et Gynecologica Scandinavica, 91*, 44-49.

The British Psychological Society. (2009). Code of ethics and conduct. Retrieved May, 2011, from www.bps.org.uk/document-download...64&ext=pdf.

Thomas, B., Stamler, L., LaFreniere, K., & Dumala, R. (2000). The internet: An effective tool for nursing research with women. *Computers in Nursing, 18*, 13-18.

Thompson, S. C. (1981). Will it hurt less if I can control it? A complex answer to a simple question. *Psychological Bulletin, 90,* 89-101.

Thomson, G. M., & Downe, S. (2010). Changing the future to change the past: Women's experiences of a positive birth following a traumatic birth experience. *Journal of Reproductive and Infant Psychology, 21*(1), 102-112.

Tschudin, S., Alder, J., Hendriksen, S., Bitzer, J., Popp, A., Zanetti, R., . . . Geissbuhler, V. (2009). Previous birth experience and birth anxiety: Predictors of caesarean section on demand? *Journal of Psychosomatic Obstetrics and Gynaecology, 30*(3), 175-180.

Valentine, D. (1986). Psychological impact of infertility: Identifying issues and needs. *Social Work in Health Care, 11*(4), 61-69.

Walker, J. (2001). *Control and the psychology of health.* Suffolk, UK: Open University Press.

Wiklund, I., Edman, G., & Andolf, E. (2007). Cesarean section on maternal request: Reasons for the request, self-estimated health, expectations, experience of birth and signs of depression amongst first-time mothers. *Acta Obstetricia Et Gynecologica Scandinavica, 86,* 451-456.

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

Major Research Project

Section C: Critical Appraisal

ACCURATE WORD COUNT

1968/2000

SECTION C: CRITICAL APPRAISAL

What research skills have you developed from undertaking this project and what do you think you need to learn further?

I had very limited and negative experiences of conducting research prior to this project. I was therefore quite anxious about embarking on an independent, major piece of research for the doctorate. From the outset I hoped for a different experience of research and hence took the decision to source ideas for a project from a previous supervisor I had as an assistant, whose speciality in obstetrics and gynaecology had always interested me, rather than signing up to one of the proposals offered via the course. This was a risky decision and at times one I questioned, however I learnt far more than I expected and fulfilled my goal of igniting my interest in research.

I developed the research aims and questions in conjuncture with my supervisors and a consultant midwife, based on an identified need within their practice for research in this area. This was also supported by NICE guidelines (2011) and felt timely given the current interest in the area of Elective Caesarean Section (ECS). This early process taught me much about the initial development of ideas and practical considerations necessary when creating a proposal. I started out with quite a complex design which I had to reconsider once I realised it was too ambitious given the time frame I had to work in as a trainee. I learnt the importance of considering practical aspects of research and being flexible and amenable to changes that may need to be made to ideas given constraints and resources.

Using the internet within the research design was not something I had originally intended but was borne through problems recruiting within the NHS alone. This brought a new dimension to the project and developed my research skills further. I had to consider potential differences in ethical guidelines between recruiting via the NHS and online. Ethical guidelines for online research are in their infancy (James & Busher, 2009), privacy and public availability, anonymity and confidentiality, and informed consent are issues that have been

highlighted as important to consider for internet designs (Jones, 2011). Consideration was given to each of these domains in the current study; however, as Jones (2011) highlights in his guidance, the pace at which technology is moving at means that issues to consider in this arena are continually changing. Having to hold this in mind and work to this protocol in addition to the usual ethical and practical challenges of recruiting service users through the NHS was challenging but rewarding. Additionally, utilising a relatively new form of interviewing via Skype brought with it its own set of challenges. I furthered my abilities in setting boundaries and managing difficult situations, for example people in their homes inviting their partners into the conversation or having to leave the interview mid- flow to check on their baby.

Despite the challenges, I learnt so much from recruiting through two different routes and gathering data in different forms. It provided me with experience of writing up ethical proposals for both NHS and university panels, including presenting my proposal to individuals with different levels of knowledge concerning research and the subject area. Changing the design of the project half way through the research further added to my experience of applying for ethics; I had to submit a major amendment. This felt like a stressful period but I have since appreciated the extra experience this process afforded me.

Consulting with women who had experienced a traumatic birth during the design period of the study was invaluable and something I will take forward into any future research. I not only built up my confidence in conversing with women who had experienced such trauma, but they raised issues to consider that I could not have thought of or known as an individual who has not experienced childbirth, they also introduced me to language used in this area, something I was unfamiliar with.

At times I struggled with the differences between interviewing clinically and for research. I had to resist the urge to validate, normalise and summarise during the conversations. Reflecting on the transcripts I can see that I became more able at this as I gathered experience. I think that this was also helped by doing my own transcriptions and writing these up soon after each interview, enabling me to reflect on my interview style before embarking on the next one. I would hope to further develop my skills in research interviewing in future qualitative projects.

This was the first time I have used IPA and I struggled at times to keep the epistemological stance in mind and relate that to my research. Throughout the study I wondered what effect I had, as a researcher who was also a woman of child bearing age, on the narratives participants shared with me. I wondered whether a male researcher would have elicited a different narrative from this client group. Such thoughts helped me to consider the benefits of IPA and highlighted to me the appropriateness of this form of analysis and its resultant epistemological stance as a design for this study; the reality of the participants' experiences was co-constructed in the context of me as a female researcher with my own preconceptions and assumptions of birth.

I would certainly like to embark on another IPA study as I feel I have now built a foundation of understanding of its principles and process to move forward from. For this study I used IPA quite prescriptively in that I followed step by step guidance. However, Smith, Flowers and Larkin (2009) suggest that as researchers gain experience and confidence in the technique of IPA there is potential to become more creative with the process. I also think that I would conduct the next project with fewer participants to really hone my analytic skills (Smith, flowers & Larkin, 2009**).**

If you were able to do this project again what would you do differently and why?

The initial research proposal included a longitudinal design whereby I had planned to recruit women prior to their ECS and administer a standardised measure of PTSD at this point, in addition to a phase one interview exploring their reasons for and expectations of the ECS. I had then planned to follow up these women all within the same time period post-natally, for phase two of the interview exploring their experiences of the ECS and reflections on the different post-natal outcomes between the traumatic birth and ECS. Re-administration of the PTSD measure at this stage was planned to enable further data on changes in their trauma presentation. I had also hoped to follow these women up a year on from their ECS for a phase three interview to gather information on the longitudinal nature of any redemptive effects of the ECS and long term outcomes such as relationship with child and mothers' mental health and wellbeing.

I gained NHS ethics approval for this design and had planned on recruiting all participants from one site. Unfortunately, recruitment was slow and I became anxious about completing the project within the allotted time frame for the course. On reflection I still think that this design would have been preferable and addresses many of the limitations to the current study. If I were to do this project again I would widen the number of NHS sites I was recruiting from as well as gaining approval to recruit online from the start of the project. I would also start the ethics procedures sooner into the process as I had underestimated the time this would take to complete.

I included questions regarding women's experiences of their previous traumatic birth into my interview schedule as it was important to understand the previous trauma to set the context for the ECS, I had planned on pulling descriptors out from the data regarding this. However, I found that these emotive conversations dominated women's narratives, consequently the

interviews either lasted longer than I had warned women to expect or the experiences I was looking to actually analyse concerning the ECS sometimes felt rushed. Similarly, responses to written accounts were longer for questions regarding the experience of the previous birth in comparison to the ECS. I felt guilty that I had obtained such rich data from these women that I would not be using thoroughly. If I were to do the project again I would consider asking women to list the key factors they felt contributed to their experience of the previous birth being traumatic and its resultant sequelae.

Clinically as a consequence of doing this study would you do anything differently and why?

The IPA epistemology fits well with social constructionist approaches which promote a curious and open stance, consider the participant to be an expert in their own experience and emphasise the importance of context in the construction of meaning. During the process of this research I have noticed that I have been using these principles more with clients, including reflecting on my assumptions and potential prejudices prior to meeting with them, rather than just reflecting after sessions as I would have previously.

I have also developed an appreciation of the importance of flexibility within clinical practice. The participants I recruited would have been unable to take part in the research had I only offered sessions during the day, in the week, at a clinical location. Many commented that they had not pursued therapeutic input for their trauma as they had such little free time being new mums. This feels like a continual challenge within all services and creates a bias toward those who are economically able to miss work or to pay for childcare to access services; this misses a huge and possibly more vulnerable proportion of society. I would like the opportunity to be more flexible within clinical practice and would advocate for this within whatever service I end up working in. Access to a crèche within NHS services may also help with this difficulty.

Finally, I feel this project has highlighted to me the important role of psychologists in consulting and educating other healthcare professionals. Certainly, within this field a psychological understanding of women who have experienced trauma during childbirth would undoubtedly promote a more empathic, supportive and thoughtful response from midwives and consultants who have been trained to predominantly weigh up medical risk and benefit.

If you were to do further research in this area what would this project seek to answer and how would you go about doing it?

I would first and foremost like to replicate this study using the design described in question two. However, as this research was exploratory it opened up avenues for further research in many different directions. My personal interests lie within the effects of traumatic birth on mother-infant attachment.

This study found that women experienced difficulties bonding with their infants born of a traumatic birth, the extent of which was highlighted by perceived improved attachments with their subsequent child following an ECS. One of the key areas I would like to focus on is the effect of birth experience on subsequent mother-infant attachment. There is limited research in this area which is reliant on qualitative, self-report data from women on their perceptions of bonding (Ballard, Stanley and Brockington, 1995; Nicholls and Ayres, 2007). It is therefore unknown whether the experience of a TB has longitudinal consequences for attachment, whether such difficulties could be avoided if trauma were treated quickly and effectively, or indeed whether these difficulties could be repaired through a subsequent redemptive birth. Longitudinal research comparing attachment patterns of children born of births experienced as traumatic, with those born subsequently of perceived redemptive births, using objective measures of attachment, would add to evidence base and theory in the area of PTSD following childbirth and attachment theory.

References

Ballard, C., Stanley, A., & Brockington, I. (1995). Post-traumatic stress disorder (PTSD) after childbirth. *British Journal of Psychiatry, 166*, 525-528.

James, N., & Busher, H. (2009). *Online interviewing* (First ed.). London, UK: SAGE Publications Ltd.

Jones, C. (2011). Ethical issues in online research. *British Educational Research Association on-Line Resource,* 15th March 2012.

National Institute for Clinical Excellence. (2011). *Caesarean section*. London: RCOG Press.

Nicholls, K., & Ayres, S. (2007). Childbirth related post-traumatic stress disorder in couples: A qualitative study. *British Journal of Health Psychology, 12*, 491-509.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Section D: Appendix of Supporting Material

APPENDIX OF SUPPORTING INFORMATION

Appendix A: Search methodology for section A.

Literature Search strategy

Case studies in the 1990's first highlighted the possibility of PTSD as a reaction to a traumatic child birth (White et al., 2006) therefore the current literature search's chronological parameters were from this point onwards: 1990-2013.

The following databases were searched for relevant information: Psych INFO, Ovid, Medline, Web of Knowledge, Cochrane Database of Systematic Reviews and Google Scholar.

As this phenomena is still in its infancy there is a paucity of research exploring the impact of traumatic birth, therefore research was deemed suitable for review based predominantly on its relevancy to the question rather than its methodological merits and included qualitative, quantitative research and case studies.

Figure.1 displays a flow chart tracking the literature search strategy.

Search terms used included [trauma] OR [traumatic] OR [acute stress] OR [PTSD] OR [post-traumatic stress disorder] AND [childbirth] OR [birth]. A second search included the terms [tokophobia] OR [tocophobia] OR [parturiphobia] OR [fear OR phobia OR anxiety AND birth OR childbirth]

These results were filtered via a brief scan of titles and abstracts to immediately exclude research based on medical/physiological trauma to the woman or child during birth.

Abstracts of the remaining results were read. Of these, research which investigated or explored objective or subjective, psychologically traumatic birth experiences were read in entirety. These papers were further filtered to exclude research which only explored

prevalence and/or aetiology of traumatic stress reactions to childbirth. Papers presenting empirical research and conceptual understandings of the immediate and longitudinal psychological impact that traumatic childbirth has on women and/or their families were considered for review based on inclusion and exclusion criteria.

The reference sections of these identified studies were reviewed manually to locate additional articles not immediately found on the database and also considered in light of the criteria.

Inclusion:

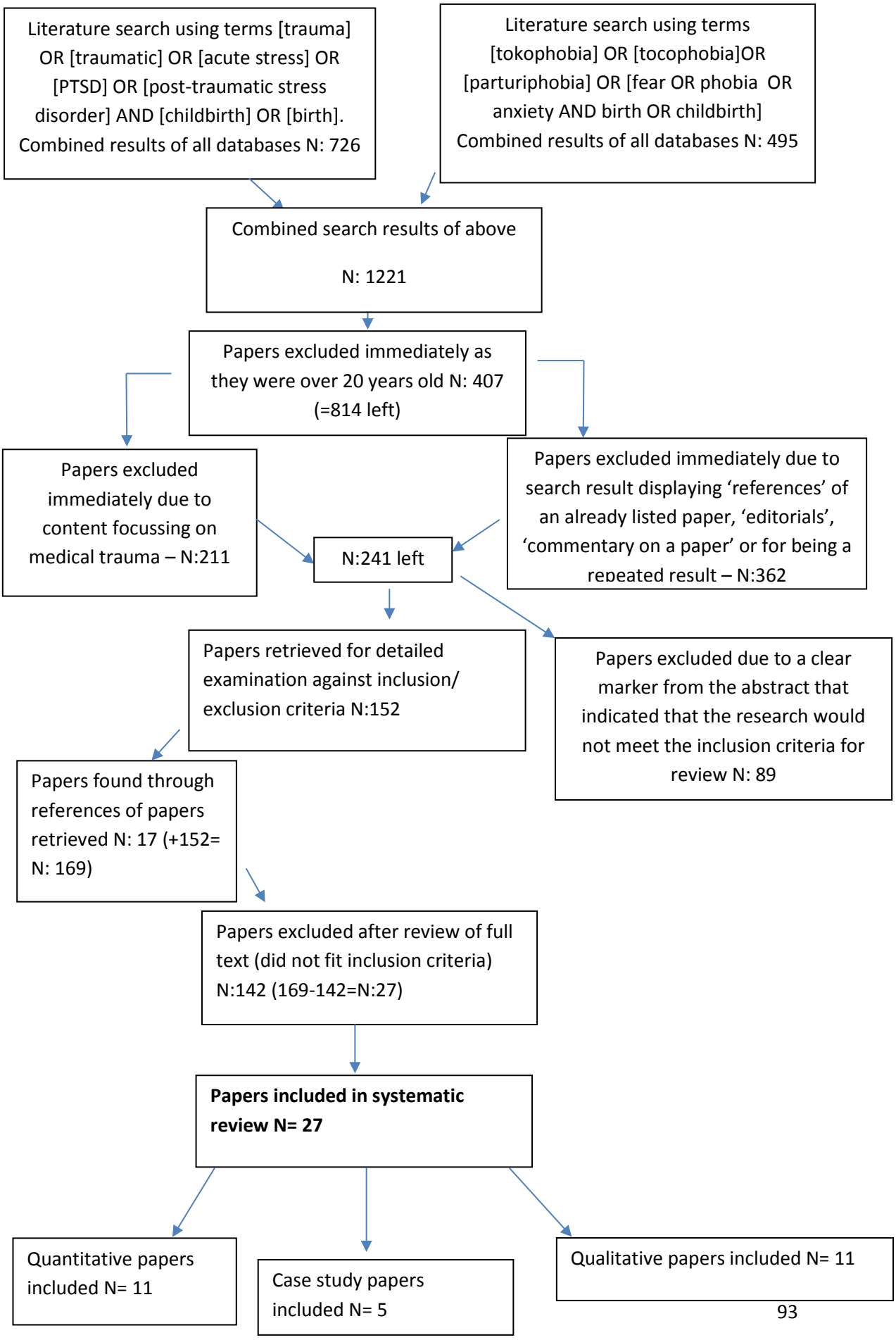
- Qualitative/quantitative/ case studies/ case series papers.
- All research which explores investigates or by proxy increases the understanding of the impact that an objectively or subjectively traumatic childbirth may have on women and their families.

Exclusion:

- Papers focussing on specific samples e.g. women who experience their births as traumatic due to variables predominantly unrelated to the act of giving birth, for example those who give birth to premature or stillborn infants. There may be too many confounding and mediating variables within these specific populations to generalise results.
- Research that investigates the physiological impact of TB on women and/or their infants.

Following the search 27 papers were identified as suitable for review.

Figure 1: Search and selection of studies



Appendix B: A summary table of characteristics of all studies included in section A literature review.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
Allen, 1998	Specific research questions un-identified. Aims were to identify whether women experience clinically significant PTSD symptoms and to explore the processes occurring during traumatic labour, factors predicting and mediating the development of PTSD symptoms and the impact on post-partum adaptation 10 months post-childbirth.	Two stage design. Stage one involved PP's completing quantitative measures of PTSD including a self-report questionnaire designed for the study which measured levels of distress and joyfulness during labour, at the time of labour and at the time of the study. The Revised Impact of Events Scale (Horowitz et al., 1979) was also used to measure avoidance and intrusion experiences.	Participants were recruited from one hospital catchment area by health visitors during an eight week period when accompanying their infants to their eighth month developmental check-up. 145 women participated in stage one of the study, from this 20 women were recruited for the second stage.	Quantitative data was presented descriptively in terms of mean scores. Qualitative data was analysed using principles of grounded theory (Strauss & Corbin, 1990)	The mean score on the IES was 24 for participants recruited to stage two. Six of the PP's scored over Horrowitz et al's (1979) mean of 42 as a cut off for clinically indicated PTSD. Results of self-report questionnaire were not reported. The grounded theory analysis identified 'out of control' as the core category. Three main factors were identified which lead to the core category: pain, past experience	Good literature review and research justification including theoretical basis. No explicit research questions. Good appropriate sample size and selection criteria. The sample were of all of higher socio-economic grouping than general population. Ethical considerations alluded to. Clear description of methods and data analysis. Clear presentation of findings, however reflexivity was

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		Stage two involved identifying women whose responses in stage one indicated that they experienced a traumatic birth; they were then invited to participate in a semi-structured interview.			and belief baby will be harmed. Distress reducing strategies were identified: talking and thinking about the event to gain knowledge and emotional support following labour. Dependant on the use of distress reducing strategies and level of PTSD symptomatology were consequences of traumatic birth: effects to self, relationship with partner, relationship with infant and future pregnancy.	not addressed. Good linking of findings with theory.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
Ayres, Eagle & Waring, 2007	What is the long-term impact of a traumatic birth on women who have clinically significant PTSD after birth? What is the effect on themselves? What is the effect on their relationship with their partner and child?	Qualitative interview study. Childbirth related PTSD was measured using an adapted version of the PTSD Diagnostic Scale (Foa, Cashman, Jaycox & Perry, 1997).	Purposive sample derived from responses to media articles, via the Birth Crisis Network and from word of mouth. Six participants were recruited; all retrospectively reported clinically significant levels of PTSD following childbirth.	Inductive thematic analysis. Included use of WinMax software.	Three themes identified: (i) Effects on women: physical effects of birth, changes in mood and behaviour, fear of childbirth and sexual dysfunction, social interaction and trust. (ii) Effects on relationship with partner: support, strain on relationship. (iii) Effects on mother-child bond: Differences in attachment (avoidant or overanxious), early feelings about child (Majority felt rejecting of	Good literature review leading to coherent argument for study. Clear aims and research questions. Reflexivity addressed. Clear findings and good links to theory. Retrospective nature of study means unable to draw and conclusions about women's premorbid characteristics and how much these influenced post-natal difficulties.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					child), later feelings about child (Feelings became more positive toward child over time, however there were still some women who reported difficulties in the relationship).	
Ayres, Wright, & Wells, 2007	Aimed to examine (i) what proportion of men have severe symptoms of PTSD after Birth (ii) what impact postnatal PTSD symptoms have on the parent-baby bond (iii) what impact postnatal PTSD symptoms have on the couple's relationship and (iv) what factors are associated with PTSD in men and women.	Questionnaire survey of PTSD symptoms, the couple's relationship and parent baby bond nine weeks postpartum. Impact Of Events Scale (IES; Horrowitz et al., 1979) used to measure PTSD. Experience of Birth Scale (EBS;	Sixty-four couples identified from maternity registers at London hospitals participated. Inclusion criteria: Couples had to be co-habiting, married or in a long term relationship.	Symptoms of PTSD and a few birth subscales were skewed so nonparametric statistics were used to look at differences between men and women (Wilcoxon signed rank tests) and bivariate associations between variables	Found that men and women reported similar levels of intrusion and avoidance nine weeks after birth and approximately 5% have severe PTSD symptoms. PTSD symptoms were bets predicted by reports of something going wrong in the	Clear rationale for study, good literature review and coherent research questions. Fair sample size, could be expanded on in future studies. Included a mix of ethnicities in the sample. There was a low response rate to

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		Slade et al., 1993) used to measure experience of birth. The self-report version of the Bethlehem Mother-Infant Interaction Scale (BMIIS; Pearce & Ayres, 2005) was used to measure parent-infant attachments. The Dyadic Adjustment Scale (DAS; Spanier, 1976) was used to measure couples relationships.	Male partner had to have attended the birth. Baby had to have been born between 6-12 weeks before contact. Couples were excluded if baby was stillborn or transferred to specialist care.	(Spearmans correlation). Multiples regressions were conducted to examine which variables best predicted symptoms of PTSD in men and women.	birth, emotions during the birth and delivery problems. Symptoms of PTSD were not associated with the parent-baby bond or the couple's relationship. The mother-baby bond was not associated with any of the variables measured in the study. The father-baby bond was associated with the couple's relationship.	the questionnaires meaning the sample were likely self-selecting, introducing bias. Exclusion of participants whose infants were transferred to special care likely excludes couples who may have experienced PTSD reactions to the birth; therefore prevalence of symptoms may be an underestimate.
Ballard, Stanley, Brockington,1995	Aims to describe the clinical picture and course of PTSD in a group of subjects with stress reactions after	Series of four case studies with a symptomatic profile suggestive of PTSD	It is unclear how the case studies were chosen, where from or who by.	Descriptive.	All four cases had symptoms concordant with a diagnosis of PTSD (DSM-III-	Very short introduction to the paper, minimal literature review (although

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
	delivery.	commencing within 48 hours of childbirth are presented.			R criteria) although there was a marked variation in presentation and severity. Three of the four mothers felt the need to avoid their infants. Problems in mother/infant relationships persisted for two of the four cases "because the infant reminded them of the unpleasant birth experiences" (p. 528).	the date of this paper highlights that PTSD following childbirth was just starting to emerge in research therefore there would have been minimal previous studies to refer to). No background description of where cases were seen or by whom was provided. No acknowledgement of consent issues. Cases described clearly and in depth. No reference made to limitations, practical applications or future research.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
						Case studies are obviously difficult to generalise; they provide a platform from which to develop further research with larger samples and more specific questions.
Beck, 2004	Aimed to describe the essence of mothers' experiences of PTSD after childbirth.	Descriptive phenomenology used to describe women's experiences of traumatic birth. Women asked to write about her experiences and send back to researcher via the internet.	Participants were recruited from websites offering support to women who had experienced traumatic birth. The sample was international and included 38 women from New Zealand, USA, Australia and the UK.	Colazzi's (1978) phenomenological method of data analysis was used to analyse data. This method draws out themes, significant statements and formulated meanings.	Five themes were identified: (i) Going to the movies: Please don't make me go! Referring to flashbacks associated with the trauma and the distress these caused. (ii) A shadow of myself: Too numb to try and change. Referring	Good literature review and justification for current study including clear aims and theoretical links. Good description of methodology. Reflexivity and process of analysis discussed in depth. Large sample for

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					to numbing of the self and dissociation experienced by some women. (iii) Seeking to have questions answered and wanting to talk, talk, talk. Referring to the mother's intense need to know details of their traumatic births and to find answers. This took on obsessive forms for some women. (iv) The dangerous trio of anger, anxiety and depression: spiralling downward. Referring to this trio of emotions	qualitative research. Use of helpful and clear diagrams aiding written descriptions of data. Good explicit links to practical implications. Sample self-selecting introducing bias. Characteristics or history of participants prior to trauma not addressed so it is unknown what other variables may have contributed to their presentations.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					permeating the daily lives of women. (v) Isolation from the world of motherhood: Dreams shattered. Referring to the effects of the trauma on relationships with the infant, social circle and hopes for future childbearing.	
Beck, 2006	Aimed to determine the essence of mothers experiences regarding the anniversary of their birth trauma.	Descriptive phenomenology. Women asked to write about experiences of traumatic birth and send back to researcher via the internet.	Participants were recruited from a website offering support to women who had experienced traumatic birth. The sample included 37 women who had experienced at least one	Colazzi's (1978) phenomenological method of data analysis was used to analyse data. This method draws out themes, significant statements and formulated meanings.	Four themes were outlined: (i) The prologue: An agonizing time. Referring to an increase in trauma symptoms leading up to the anniversary of birth trauma. (ii) The actual day: A celebration of a	As with all of Becks studies she makes good links to theory and previous literature in her introduction. Reflexivity, an important part of the Collazi method is extensively

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
			anniversary of birth trauma.		birthday or the torment of an anniversary. Referring to the difficulty women experienced trying to manage the torment of the anniversary of birth trauma alongside the celebration that the day represented for their child's birthday. (iii)The epilogue: A fragile state. Referring to the toll of surviving the anniversary of birth trauma, women needed time to heal and recuperate. (iv) Subsequent anniversaries: For	referred to. An audit trail is provided to enable replication of the methodology. Results are presented clearly with good use of diagrams and practical applications are suggested.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					better or for worse. Referring to an inconsistent pattern of some women finding anniversaries getting easier with time, others feeling they stayed as traumatic as always and some women saying they varied.	
Beck & Watson, 2008	Aimed to explore the impact of birth trauma on mothers' breast-feeding experiences.	Descriptive phenomenology. Women asked to describe their experiences of breast-feeding following a traumatic birth. They sent these narratives as attachments to emails via the internet.	Participants were recruited from a website offering support to women who had experienced traumatic birth. The sample included 52 women who had experienced a traumatic birth and perceived it	Colazzi's (1978) phenomenological method of data analysis was used to analyse data. This method draws out themes, significant statements and formulated meanings.	Eight themes were described: (i) Proving oneself as a mother: Sheer determination to succeed. Referring to women feeling like after they had failed to give birth correctly they needed to get	As with all of Becks studies she makes good links to theory and previous literature in her introduction. Reflexivity, an important part of the Collazi method is extensively referred to. An

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
			to have impacted on their breast-feeding in some way were recruited.		the breast feeding right. (ii) Making up for an awful arrival: Atonement to the baby. Referring to a need to make amends for the infants traumatic start in life. (iii) Helping to heal mentally: Time of from the pain in one's head. Referring to the healing and soothing nature of breast-feeding. (iv) Just one more thing to be violated: Mothers' breasts. Referring to women feeling further violated by breast-feeding following the	audit trail is provided to enable replication of the methodology. Results are presented clearly with good use of diagrams and practical applications are suggested. Internet samples may be more highly educated and of higher socioeconomic class than non-internet samples. Women were all accessing support via the website they were recruited from, therefore women without access to this resource may

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					traumatic birth. (v) Enduring the physical pain: Seeming at times an insurmountable ordeal. Referring to the physical pain from birth trauma impacting on breast feeding. (vi) Dangerous mix: birth trauma and insufficient milk supply. Referring to women's beliefs that one of the repercussions of their traumatic birth was inadequate milk supply. (vii) Intruding flashbacks: Stealing anticipated joy.	present differently.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					Referring to the detrimental domino effect flashbacks had on women's breast feeding experiences. (viii) Disturbing Detachments: An empty affair. Referring to women feeling distanced and detached from their infants which further impacted on breast feeding.	
Beck & Watson, 2010.	Aimed to describe the meaning of women's experiences of a subsequent childbirth after a previous traumatic birth.	Descriptive phenomenology. Women asked to write about her experiences of subsequent pregnancy, labour and delivery following your	Participants were recruited from a website offering support to women who had experienced traumatic birth. The sample included 35	Colazzi's (1978) phenomenological method of data analysis was used to analyse data. This method draws out themes, significant statements and	Four themes were described: (i) Riding the turbulent wave of panic during pregnancy. Referring to the anxiety and dread women	As with all of Becks studies she makes good links to theory and previous literature in her introduction. Reflexivity, an important part of

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		previous traumatic birth, and send back to the researcher via the internet.	women who had experienced a traumatic birth and had gone on to have a subsequent birth.	formulated meanings.	experienced during the subsequent pregnancy. (ii) Strategizing: Attempts to reclaim their body and complete the journey into motherhood. Referring to women's attempts to make the subsequent birth different. They used cognitive techniques, relaxation and hobbies to distract and prepare themselves. (iii) Bringing reverence to the birthing process and empowering women. Referring to positive and	the Collazi method is extensively referred to. An audit trail is provided to enable replication of the methodology. Results are presented clearly with good use of diagrams and practical applications are suggested. Internet samples may be more highly educated and of higher socioeconomic class than non-internet samples. Women were all accessing support via the website they were

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					healing experiences of subsequent birth. (iv) Still Elusive: The longed for healing birth experience. Referring to women who did not experience the healing subsequent birth they had hoped for.	recruited from, therefore women without access to this resource may present differently.
Davies, Slade, Wright & Stewart, 2008	Examined the relationship between self-reported posttraumatic stress and depressive symptomatology at six weeks postpartum and mother's perceptions of their infants, their behavioural characteristics, mother to infant attachment and the quality of the early	Quantitative. Using labour and childbirth as the stressor criterion, women were assessed at 6 weeks postpartum for symptoms of intrusions, avoidance, hyper-arousal and depression (IES; The Post	209 women participated. The sample was recruited from a population of postpartum inpatients at a maternity hospital. Participants had to be over 16 years old and have a good	Much of the analysis utilised descriptive statistics. One way ANOVAS were used to analyse differences between groups across measures of mother's perception of her infant, her	3.8% of women fulfilled full diagnostic criteria and a further 21.3% reported clinically significant symptoms on at least one dimension of PTSD. Those meeting full of partial criteria	The paper was coherently written with good theoretical and empirical referencing. The method of recruitment of participants was not entirely clear. Most of the measures used were standardised

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
	dyadic interaction.	Traumatic Disorder Questionnaire; Watson, Juba, Manifold, Kucala & Anderson, 1991; The Edinburgh Postnatal Depression Scale; Cox, Holden & Sagovsky, 1987). Their perceptions of their infants & of mother infant attachments (The Mothers Object Relations Scale-Short form; Oates & Gervai, 2003; The Maternal Postnatal Attachment Scale; Condon & Cokindale, 1998). Infant behavioural characteristics	grasp of the English language. Participants were excluded if there were significant clinical complications during birth, if the mother had significant social problems or a history of MH difficulties or if their babies were in intensive care following birth.	infant's behavioural characteristics and temperament and her perception of attachment to her infant, infant directed hostility, pleasure in interaction and infant behavioural characteristics. Correlational analysis was used between measures of postpartum PTSD and maternal measures of perceived attachment, infant characteristics and mothers working model of their infants.	perceived there attachment relationships to be significantly lest optimal and reported more negative maternal representations in terms of their infants being less worm and more invasive. They also rated them as being temperamentally more difficult, prone to distress, and less easy to sooth. However, when the effects of depression were partialled, only the effect for perceived warmth remained.	and found to have adequate levels of internal consistency and test-retest reliability. The results were quite complicated to decipher, however the comprehensive and clear discussion compensated for this, good links were made to clinical implications and suggestions for future research. The study was dependent on maternal self-report assessment of the early mother-infant relationship,

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		(The Infant Characteristics Questionnaire; Bates, Freeland & Lounsbury, 1979) were also evaluated.				introducing the possibility of a social desirability response bias. Exclusion off women with major social or prior mental health problems or who have not been exposed to a major adverse clinical event during labour or delivery limits the generalizability of the results.
Fones, 1996	This case report aimed to highlight the possible predisposing risk factors and potential sequelae of childbirth related PTSD.	Case study.	Case study of Mrs T a forty year old Chinese housewife who presented with symptoms of PTSD related to childbirth nine years	Case study.	Mrs T complained of symptoms consistent with chronic type PTSD since she gave birth to her son nine years earlier. She requested tubal ligation to avoid	This case study is presented as a brief report. It is unknown how Mrs T came to be recruited for this study or whether there were comorbid mental health difficulties

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
			previously.		future child bearing and reported significant sexual difficulties.	prior to and post birth, regardless of the trauma.
Gottvall & Waldenstrom, 2002	Aimed to investigate whether women's experiences of their first birth affects future reproduction.	Perspective cohorts study. A global measure of women's experiences of their first birth assessed two months postpartum was available from a birth centre trial, together with information on background variables. This information was linked to the Swedish Medical Birth Register, which included information on	Details of 617 women who gave birth to their first child between 1989 and 1992 and took part in a birth centre trial were accessed.	The association between women's birth experience and subsequent reproduction was studied by means of Kaplan Meier curves, which take into account not only whether a women has one more baby or not, but also the time interval to the next birth.	Women with a negative experience of their first birth had fewer subsequent children and a longer interval to their second baby. Being thirty five and older or single was also associated with subsequent infertility.	The paper including a very short introduction which made no reference to theoretical or empirical literature. The methodology and the results section were clearly and comprehensively presented with coherent and helpful graphs. Women were drawn from a birth centre trial therefore had a stronger focus on psychological

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		the number of subsequent births during the following 8 – 10 years.				aspects of childbirth including more positive expectations on the approaching birth than other women. It cannot be excluded that the child birth experience was more important to these women compared with the general population. Despite controlling for a wide range of variables, other important compounders may have been overlooked. The paper did not address clinical implications or

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
						directions for future research.
Hofberg & Brockington, 2000	Aimed to classify tokophobia for the first time in medical literature.	A preliminary, qualitative interview study of a series of 26 cases'. No structured interviews were used. A psychiatrist conducted an open interview to investigate trends in presentation and past history that may identify women with tokophobia. Direct questions were asked regarding depressive episodes, anxiety disorders and PTSD. Enquiries were made about	26 women noted to have an unreasonable dread of childbirth were referred from obstetricians at two sites in the West Midlands (UK).	Undisclosed qualitative analysis.	Phobic avoidance of pregnancy may date from adolescence (primary tokophobia), be secondary from a traumatic delivery (secondary tokophobia) or be a symptom of prenatal depression (tokophobia as a symptom of depression). Pregnant women with tokophobia who were refused their choice of delivery suffered higher rates of psychological morbidity than those who	This was a preliminary study. There was no literature review or comprehensive introduction. The procedure was unclear as was the method of analysis. Discussion was coherent with good reference to clinical implications. The sample size was small, all women were Caucasian with English as their first language. They were all in enduring relationships and

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		obstetric history and the relationship with each baby was examined. Questions about childhood sexual abuse were investigated.			achieved their preferred delivery method.	therefore not representative of the population as a whole.
Knapp, Winter 2011/2012	Aimed to examine the signs and symptoms of PTSD following childbirth and its impact on the transition to motherhood.	A complex longitudinal case study.	A case study of Sarah, who experienced a traumatic birth at 27 years old, is presented from the time of the traumatic birth until 5 years postpartum.	Case study	Sarah presented with symptoms of PTSD immediately after the traumatic birth until five years postpartum. She discussed the impact of the symptoms on her and her daughter's relationship (hyper vigilance and feeling as though her daughter could not be soothed). It	This case study was clearly presented and interwoven with good links to theory and empirical literature. Good links are made to clinical implications and directions to future research. Obviously conclusions are limited for all case studies.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					impacted on Sarah's wellbeing (PTSD symptomology, feelings of low self-esteem and inadequacy), and her future child bearing (she felt grateful to have miscarried twice in the five years since the trauma).	
Lemola, Stadlmayr & Grob, 2007	Aimed to investigate the impact of the subjective childbirth experience on maternal adjustment five months after delivery and to test whether this relationship is moderated by postnatal emotional support from the partner.	Participants were assessed for subjective childbirth experience, measured with the German version of the Salmons Item List (SIL-GER; Stadlmayr et al., 2001) and postnatal emotional support from partner (a	The study was part of a longitudinal study designed to investigate predictors of psychological adaption in women and infant mental health after childbirth in an unselected sample.	After examination of preliminary descriptive statistics and zero-order correlations moderated hierarchical multiple regressions were computed to predict maternal psychological adjustment.	Postnatal emotional support form a partner acted as a moderator of the effect of subjective childbirth experience on the development of symptoms of avoidance, intrusive thoughts and depression.	This paper presented a fair review of previous theoretical and empirical literature. It was easy to read and predominantly used standardised measures. The discussion was comprehensive and addressed

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		short likert scale questionnaire developed for the study) six weeks after childbirth. Five months after childbirth the same participants were asked to complete measures of trauma and depression (IES-R and the EPDS).	Participants were recruited after their birth was announced in a newspaper. Six weeks after birth 458women were assessed on several background variables, obstetric variables and their subjective childbirth experience. Five months after birth 374 women completed questionnaires on their psychological adjustment.		The direct influence of emotional partner support was stronger regarding symptoms of depression and hyperarousal than regarding avoidance and intrusive thoughts. No direct association between intranatal physical discomfort/labour pain and later maternal adjustment could be found.	clinical implications and directions for future research.
McDonald, Slade, Spiby, & Iles, 2011	Aimed to examine the prevalence of childbirth-related post-	Quantitative design. Measures of childbirth-	One hundred and twenty one women who	Regression analysis.	17.3% of participants reported some	This paper presented a fair review of

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
	traumatic stress (PTS) symptoms at 2 years postpartum and the relationship between such symptoms and both self-reported parenting stress and perceptions of the mother-child relationship.	related PTS symptoms at 6 weeks and 3 months postpartum were completed. These results were used in an exploration of their predictive links with mother-child relationship and parenting measures at 2 years, including: Post-Traumatic Stress Disorder-Questionnaire (PTSDQ; Czarnocka & Slade, 2000). Impact of Events Scale (IES; Horrowitz, Wilner & Alverez, 1979). Hospital Anxiety	participated in a previous study on child-birth related PTS symptoms agreed to be contacted about further research and at two years postpartum were contacted about the current study. Eighty one women completed the measures for this study.		PTS symptoms at a clinically significant level at 2 years postpartum. However, these symptoms were only weakly linked to parenting stress and were not related to mothers' perceptions of their children. However, earlier PTS symptoms within 3 months of childbirth did show limited associations with parenting stress at 2 years but no association with child relationship outcomes once current depression	previous theoretical and empirical literature prior to clearly stating the research aims and questions. The methodology and results were easy to read and clear. The discussion section made clear links to clinical implications, suggestions for future research and limitations to the study. Limitations highlighted included the self-report nature of the questionnaires, being unable to exclude

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		and Depression Scale- Depression (HADS-D; Zigmond & Snaith, 1983). Mothers Object Relation Scale-Short form (MORS-SF; Oates & Gervai, 2003). Parenting Stress Index-Short Form (PSI-SF; Loyd & Abidin, 1985). Demographic data was also collected.			was taken into account.	confounders such as subsequent events since birth which may have influenced responses to symptom scales and prioritising the role of depressive symptoms over PTSD.
Moyzakitis, 2004	Aimed to explore women's experiences of distress and/or trauma in childbirth, to consider the depth and meaning of birth that was 'awful', birth that 'changed women forever'.	Exploratory, descriptive qualitative study. Semi-structured interviews conducted with women who personally identified	Six women self-selected to participate in the research which was advertised for in shops covering a wide geographical	The data was analysed using a phenomenological approach with a feminist lens.	Four themes were identified: (i) Role of the caregivers. Referred to feeling there was a lack of explanations and information	This study included a good introduction: empirical and theoretical links made. The aims of the study were not referred to in the body of the

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		themselves as having had a traumatic birth.	area. Women were aged between 23 and 39 and had given birth anything from the previous 6 months and 12 years.		related to interventions and events during birth. Women felt powerless as a result of misuse of power by professionals. They felt their caregivers had let them down and not been supportive enough. (ii) Impact on self-image. Referred to the impact birth had on their self-image and integrity. (iii) Impact on relationships. Referred to the impact the traumatic birth had on women's relationships with	text (just in the abstract). The methodology section was comprehensive and well referenced. However, reflexivity was not addressed and the data analysis section was relatively unclear. There was a good discussion and some links were made to clinical implications and suggestions for future research, although these could have been expanded on. Women in the sample were all self-selecting, introducing bias.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					their infants (avoidance and detachment), partners (sexual problems, feeling distanced), and relationship with others (feeling isolated and not understood). The author also talks about occurrence of PND for five of the six women within this theme. (iv) Severity of experience. Referring to women reporting many symptoms of PTSD related to their experience.	
Nesca & Dalby, 2011	Aimed to describe a case of maternal neonaticide that was directly linked to PTSD	Case study derived from legal documents	Case study of Ms X, a 19 year old woman who gave birth alone	Case study	Ms X gave birth alone without pain relief; she recalled the	This paper included a very comprehensive literature review.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
	without any other concomitant mental disorder.		following a concealed pregnancy. Ms X had no previous history of mental health problems		experience as extremely painful and terrifying. Her emotional reactions during labour including feelings of isolation, helplessness and the fear of dying. She recalled the process of giving birth as dream like. In the hours following the birth Ms X's emotional distress became so intense she smothered her baby and concealed the body. She recalled feeling dazed, confused and oddly detached from her surroundings. In	The authors clearly set the context of the case, including information regarding where Ms X's details were obtained from, there was an extensive discussion, with good practical links for application and suggestions for future research. While the authors highlight that there were no previous mental health problems for Ms X, it is difficult to be retrospectively certain of this or any potential additional

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					the days that followed she described intense PTSD symptomatology. Ms X was arrested and detained in a mental health facility. Assessments concluded that the events leading to the death of her baby had occurred within the context of an acute stress disorder which led to on-going PTSD. These were both thought to be a direct result of the child birth.	confounding variables.
Nicholls & Ayres 2007	Aimed to explore the experience and impact of child birth related	This was a qualitative interview study.	Six married couples (all heterosexual)	Transcripts were analysed for each individual rather	Four major themes were identified: (i)	This study presented a comprehensive

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
	PTSD in women and their partners.	Semi structured interviews were conducted individually with each member of the couple. Child birth related PTSD was measured using an adapted version of the PTSD Diagnostic Scale (PDS: Foa, Cashman, Jaycox, & Perry, 1997)	Who reported a traumatic birth and here on member of the couple fulfilled diagnostic criteria for childbirth related PTSD in the first year after birth. Three couples reported PTSD in the female but not the male partner, two couples reported PTSD in both partners and one couple reported PTSD in the male but not the female partner. Ages range from 26 to 50 years all participants	than by couple, Gender or PTSD status. Qualitative analysis of interview transcripts was performed using inductive thematic analysis.	Birth factors. Referred to factors of birth women found traumatic such as adequate pain relief, negative emotions in labour, perceived lack of control, lack of choice or lack of involvement in the decision making, restricted movement or physical restraint, and expectations not being met. (ii) Quality of care. Referring to aspects of care affecting their experience including inadequate information, poor	literature review including theoretical links prior to introducing the research aims and questions. Methodology was coherent and reference was made to interrater reliability. The results and discussion section was clearly written and included a good overview of clinical implications, limitations and suggestions for future research. The authors acknowledge that the results of the study need to be

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
			were Caucasian, time since the traumatic birth ranged from 9 months to 10 years. Four women and three men reported a previous trauma history.		staff care and communication, lack of continuity of staff and unpleasant physical environment. (iii) Perceived effects on relationship on partner. Referring to effects of traumatic birth on the physical relationship, communication within the relationship, negative emotions within the relationship, support from partners, coping together as a couple and the overall effect on the relationship (which was	place in the context of the impact of birth on couple without PTSD or other mental health problems. Also there is a large difference in the time past since the trauma, retrospective reflection is likely to differ longitudinally.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					primarily negative). (iv) Perceived effects of relationship with child. Referring to the perceived effect of the birth experience on the parent-infant bond including feelings of resentment and attempted avoidance of the infant by the women, this was often compensated for by partners. Some women subsequently developed behaviour and emotions consistent with an over	

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
					protective/anxious bond or persisted in an avoidant/anxious bond up to five years after the birth.	
Nilsson, Bondas & Lundgren 2010	Aimed to describe the meaning of the previous experiences of childbirth in pregnant women who have exhibited intense fear of childbirth such that had an impact on their daily lives.	Descriptive phenomenological study utilising semi-structured interviews.	Participants included nine women with intense fear of childbirth who were pregnant with their second child and considered their previous birth experiences negative. Recruitment was conducted at a clinic for fear of childbirth in Sweden. Ages of participants	Data was analysed using a phenomenological approach as outlined by Dahlberg, Dahlberg & Nystrom (2008) *Reflective lifeworld research.*	Essential meanings that arose from the data included a sense of not being present in the delivery room and an incomplete experience of childbirth. The women felt that they had no place there, that they were unable to take their place and that even if the midwife was present she did not provide enough support.	This study included a comprehensive literature review, introduction, methodology and results section. Although the analysis section was a little unclear and reflexivity was not addressed. The discussion made good links to previous research and theory and there was helpfully a separate section

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
			ranged from 26-36 and time since the previous birth ranged between 1-4 years ago.		The experience remained etched in women's minds and gave rise to feelings of fear, loneliness and lack of faith in their ability to give birth and diminished trust in maternity care.	devoted to clinical implications.
Nilsson, Lundgren, Karlstrom & Hildingsson, 2012	Aimed to explore fear of childbirth during pregnancy and one year after birth and its association to birth experience and mode of delivery.	A longitudinal population based study. Data was collected by means of a questionnaire administered at four points in time including mid pregnancy, late pregnancy, two months and one year post-natally Questionnaires were developed	Seven hundred and sixty three pregnant women were recruited from three hospitals in Sweden. Only women who completed all four questionnaires were included in the study.	Multivariate logistic regression analyses were used.	Fear of pregnancy in multiparous women was associated with a traumatic birth experience and previous emergency caesarean section. Associated factors for fear of childbirth one year after birth were: a negative birth experience, fear of childbirth	This study's longitudinal prospective design is a definite strength. The paper included a comprehensive introduction and literature review, The methodology was confusing in parts. Good discussion, implications for clinical practice

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		for the study and included questions regarding demographic data, information about previous birth experiences, fear of childbirth and its impact.			during pregnancy, emergency caesarean section and primiparity.	and suggestions for future research. The study was observational therefore can only describe associations between variables. It is a regional design therefore difficult to generalise to other areas. The concept of fear of childbirth was not measured using standardised tools- there is no consensus for the best way to measure this.
Parfitt & Ayres, 2009	Aimed to examine the potential effects of PTSD symptoms on the couple relationship and parent-baby bond.	This was an internet-based questionnaire study. Demographic and	A convenience sample of 126 women aged between 19 and 45 years and 26	Mann-Whitney U-tests were conducted to investigate the differences	Symptoms of PTSD and Depression were significantly correlated with	The paper included a comprehensive introduction including good

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		obstetric date was collected. PTSD symptoms were measured using Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995). Symptoms of depression were measured using the Edinburgh Post-natal Depression Scale (EPDS; Cox, Holden, & Sagovski, 1987). Quality of the couple's relationship was measures using the Dyadic Adjustment Scale (DAS; Spanier, 1976). Parent-baby bon was measured using the Postpartum	men, aged between 22 and 54 years were recruited via the internet. Participants were recruited from websites supporting those who had experienced a traumatic birth. It was a requirement that men had attended the birth. Time since the traumatic birth ranged from 1 to 24 months.	between men and women and differences between those with and without PTSD. Chi square analyses were also applied to compare categorical variables. Associations between continuous variables were examined using Spearmans rank order correlation test. Structural equation modelling was used on transformed data to model their relationship between PTSD, depression,	the couple's relationship and parent-baby bond. Structural equation modelling found the model that best fitted the data was one where PTSD symptoms had a direct effect on the parent-baby bond, but the effect of PTSD on the couple relationship was mediated by depression.	links to theoretical and empirical literature. Methodology and result section were coherently presented. Measures used were standardised with good reliability. The discussion section made good links to theory and research however clinical implications and suggestions for future research were sparse. The study was limited by the small number of men compared to women in the sample. The use

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		Bonding Questionnaire (PBQ; Brockington, Oats, George & Turner, 2001) Participants completed questionnaires on the internet.		dyadic adjustment and postpartum bonding.		of questionnaires limited conclusions that could be drawn regarding prevalence of diagnostic disorder.
Ryding, 1993	Aimed to obtain a better understanding of women who demand a caesarean section when obstetricians do not think it is necessary.	Information regarding pregnant women's reasons for electing for a caesarean section was gathered from notes made by a psychologist observing therapeutic contacts made with a midwife who included an interview on reasons for the request for CS.	Thirty three pregnant women aged between 18 & 42 years old and all of whom were requesting a CS for their birth, consented to their information being used for the study. Five of these were nulliparous, twenty eight were parous.	Descriptive statistics and general information was drawn from the data.	The 28 parous women referred to previous traumatic childbirth experiences and feared mainly for intractable labour pain and for the life and health of their child. The most prevalent fear for the five nulliparous women was vaginal rupture. At term 14	This paper did not include a literature review or outline much of a rationale for the study. The methodology section was very unclear, particularly in reference to the procedure. The questions asked of the participants were not presented and there was no

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
			Participants all requested a CS between the years 1988-1990 at a hospital in Sweden.		women chose vaginal delivery and 19 had elective CS.	mention of rigour or how data from interviews were extrapolated.
Saisto, Ylikorkala, & Halmesmaki, 1999	Aimed to identify factors associated with fear of child birth during and after first labour.	Quantitative interview design including a control group. Pregnant primiparas women admitted to an outpatient clinic in Finland for fear of childbirth (manifesting as demand for caesarean) were recruited. Participants were interviewed regarding their experiences and reasons for fear or demands for	100 pregnant women were recruited aged between 20 and 40 years old; these were matched with a tightly controlled group of 200 women.	Logistic regression analyses were conducted for socioeconomic variables and those related to first delivery, to investigate antecedence of secondary fear of vaginal delivery.	First deliveries that ended with caesarean or vacuum extraction were the most important causes of subsequent fear of delivery, and subjects own views of the entire labour as terrifying and traumatic supported this. The authors suggested that women who experienced these methods of delivery	This paper made no reference to previous literature or theory, it was difficult to read with a lack of sub headings to aid sign posting. The results were comprehensive with helpful tables. The discussion was fairly brief but did make some theoretical links. The use of control groups in the study was beneficial. However it was

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		caesarean, and hospital files of first pregnancies and deliveries were scrutinised. For every subject two controls not reporting fear of childbirth were recruited. Socioeconomic background variables were also collected.			developed PTSD in some cases.	limited by its exclusion of standardised measures additionally the fear of child birth prior to the first birth cannot be ruled out with certainty.
Thomson & Downe, 2010	Aimed to explore how women prepared for, experience, and internalised a positive birth following a traumatic birth event.	An interpretative phenomenological approach was used. Unstructured in depth interviews were conducted across two recruitment phases. One interview at 36 weeks gestation of pregnancy	Purposive sampling was used to recruit women. In phase one Eight participants who had experienced both the self-defined traumatic and positive birth were selected. Two women	An interpretative phenomenological approach was adopted for this research, based on Gadamers (2004) philosophical hermeneutics. This approach emphasises human experiences of understanding and	The constitutive theme of the study was 'changing the future to change the past'. Four themes underpinned this: (i) Resolving the past and preparing for the unknown. Referring to an increase in trauma	The introduction to this paper was very short however the methodology section was comprehensive particularly the data analysis information which included reference to reflexivity. The

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		followed by one 3 months post-natally.	who ended their child birth experiences with a traumatic birth were also recruited to explore differences in maternal accounts when a positive birth had not been experienced. In phase 2 four women were recruited who had had a traumatic birth and who were pregnant with another child. All participants were recruited from one maternity ward in England. Women were	interpretation.	symptoms at the start of the subsequent pregnancy which women had to find ways to cope with alongside priming themselves for a future birth. (ii) Being connected. Referring to the importance of care givers in the experience of a positive birth. (iii) Being redeemed. Referring to resolution of distress guilt and self-blame attached to the previous trauma, as well as a transformation of women's perceptions. (iv)	results and discussion section were clear and there were good links to clinical implications and suggestions for future research. The findings are limited by the small sample of women with self-defined experiences from a limited geographical area. The time between women's experiences of their first birth and date of interviews may have influenced the findings.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
			aged between 27 and 40 years old. The interval between the traumatic birth and the interview for the study varied between 15 months and 19 years.		Being transformed. Referring to the transformative quality of the redemptive experiences. Women who did not have a subsequent positive birth continued to experience trauma symptoms and were left contemplating sterilisation.	
Tschudin, Alder, Hendriksen, Bitzer, Popp, Zanetti, . . . Geissbuhler, 2009	Aimed to investigate pregnant women's intentions for opting for Caesarean Section (CS), their experiences regarding previous births and their expectations for subsequent delivery.	Cross-sectional survey conducted at two centres in Germany over a two month period. The questionnaire was developed specifically for the survey. It consisted of 24	Two hundred and one pregnant participants were recruited from one of two hospital sites in Germany.	Logistic regressions were computed to investigate the predictive value of medical variables, birth experience and birth anxiety on the demand for	Nineteen of the 201 women preferred to deliver by CS on demand and 15 felt uncertain about their decision. How the preceding delivery had been	This paper included a very short introduction and literature review; however its research questions were clearly laid out. There was no 'participants'

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		structured questions regarding sources of information about CS on demand and pregnant women's attitudes, history and experience of previous and on-going pregnancies, expectations regarding subsequent delivery and preferred mode of delivery and sociodemographic data.		CS.	experienced was significantly better in the vaginal group than the CS group. A traumatic previous birth experience and a preceding CS were predictors for the wish to deliver by CS	section within the methodology and generally this part of the paper was complicated to read. The results and discussion section were comprehensive and clear. A standardised battery of measures may have benefited this study. Additionally, there was no follow up to determine how many of the participants actually had the CS on demand and how many changed their minds; women's birth preference

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
						can change over the course of pregnancy.
White, Matthey, Boyd & Barnett, 2006	Aimed to provide further evidence regarding the prevalence and longitudinal course of PTSD symptoms resulting from traumatic birth experiences. It also aimed to investigate the extent to which symptoms of trauma and depression occur together in the postnatal period.	Quantitative questionnaire design. Questionnaires given to participants at birth, 6 weeks, 6 months and 12 months postpartum. Questionnaires included: The posttraumatic Stress Symptom Scale – Self-report version (PSS-SR; Foa,Riggs, Dancu & Rothbaum, 1993). The Edinburgh Postnatal Depression Scale (EPDS). A	Four hundred women were recruited form a general maternity ward in Sydney. Participants included English speaking women who had given birth to a healthy baby. Women were aged between 17 and 41 years old.	Descriptive and inferential statistics were used for analysis.	The prevalence of having a PTSD profile at 6 weeks postpartum was 2%. A further 10.5% of women reported experiencing significant distress related to childbirth and several symptoms of post-traumatic stress without meeting full diagnostic criteria. The prevalence of a PTSD profile remained relatively stable across the first 12 months post-partum, with	This paper was comprehensive and made clear links through to previous research and theory in this area. The methodology section was particularly impressive with great detail and critique provided on each of the measures used. The discussion made good reference to clinical implications and suggestions for future research. Limitations included a well-

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		background questionnaire investigating demographic information was also administered.			estimates being 2.6% at 6 months and 2.4% at 12 months. The comorbidity between PTSD and PND was high at all three time points.	educated sample from a single geographical base potentially leading to underestimates of PTSD. The lack of a validated self-report measure which can be easily referred to DSM-IV criteria for PTSD may again lead to under-estimates.
Zaers, Waschke & Ehlert, 2008	Aimed to examine the course of psychological problems in women from late pregnancy to six months postpartum, the rates of psychiatric symptoms and possible related antecedent variables.	Quantitative questionnaire design with four phases. T1: 32-40 weeks gestation, T2: first few days after delivery, T3: Six weeks after delivery, T4: six months after delivery. The	Participants were recruited from childbirth classes in Germany, all were between 32-40 weeks gestation. Mean age of women was 30.6 years old. A total of	Multivariate tests of the different psychological and psychiatric problems in women during the course of the four time periods were conducted.	In general women recovered from psychiatric and somatic problems over the period of investigation. However, depressive and post-traumatic stress symptoms in particular were	This paper was introduced well, with good links to empirical and theoretical literature. Methodology, results and discussion were also comprehensive.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		following measures were used: The General Health Questionnaire (GHQ; Goldberg & Hillier, 1979) (at T1,3, 4). The State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene et al., 1983) (T1,2,3,4). The Edinburgh Postnatal Depression Scale (EPNDS; Cox, Holden & Sagovsky, 1987) (T3, 4). Posttraumatic Stress Diagnostic scale (PDS) (T3, 4). An adjective	60 women participated in the study.		not found to decline significantly. Six weeks postpartum 22% of women had depressive symptoms, remaining at 21.3 % at six months postpartum. Six percent of women reported clinically significant PTSD symptoms at six weeks postpartum with 14.9% reporting such symptoms at 6months postpartum. The most important predictor for depressive and post-traumatic stress symptoms was the block variable “anxiety	The authors acknowledge the studies limitations including the sample of highly educated married women and a possible overestimation of symptoms due to the use of questionnaires rather than clinical interviews.

Appendix B: A summary table of characteristics of all studies included in section A literature review.

Reference	Aims of research/ Research Question	Methodology: Design and measures.	Participants: Sample and numbers.	Analysis	Results	Critical appraisal of the paper.
		list for the assessment of women's experiences of birth developed by the authors for the study. Additional questions regarding demographic data (T1 & T2) and information about levels of support (T1,2,3,4) were also administered			in late pregnancy", "critical life events" and the "experience of delivery".	

Appendix C: A table depicting participant's demographic information.

Appendix C: A table depicting participants demographic information.

PSEUDONYM	Age	Marital status	Employment status	No of children	Date of traumatic birth	Method of delivery for, experiences perceived as contributing to and perceived impact of, traumatic birth.	Date of elective Caesarean Section (CS)	Recruited from. Response format.	Received therapeutic input?
Carey	36	Married	Recently resigned to be stay at home mum.	2	2009	Forceps delivery. Felt healthcare staff communicated poorly with her during and following birth. Felt uncared for. Felt out of control. Expectations prior to birth did not match experience of birth. Longitudinal physical damage and pain. Impact on sexual relationship with husband, self-esteem, mood, fear of future birth, PTS symptoms such as: numbing, avoidance, jumbled memories.	2012	Internet. Skype interview.	Yes: Had sessions of CBT for anxiety due to stress at work, during this therapy she discussed the trauma of her first birth. Then had one counselling session during the second pregnancy before she was "allowed" to have elective CS.
Amy	29	Lives with partner	Part time Employment	2	2010	Long 3rd stage labour, baby back to back, episiotomy. Inadequate pain relief during birth and post-natally. Perceived poor care and support during birth and post-natally. Impact on self-esteem and sexual	2012	Internet. Written account.	NO

All participant names have been anonymised

Appendix C: A table depicting participants demographic information.

PSEUDONYM	Age	Marital status	Employment status	No of children	Date of traumatic birth	Method of delivery for, experiences perceived as contributing to and perceived impact of, traumatic birth.	Date of elective Caesarean Section (CS)	Recruited from. Response format.	Received therapeutic input?
						relationship with partner. Longitudinal physical damage and pain. Fear of future birth.			
Jess	37	Lives with partner	Employed	2	2010	Pre-eclampsia, baby distressed, induced, Cat 3 CS. Felt disempowered, out of control, not listened to, poorly communicated with, felt violated and uncared for, felt her and baby's life was under threat. PTS symptoms including: flashbacks, nightmares, fear of future birth, avoidance and hyper-arousal. Felt it affected relationship with baby, experienced low mood.	2012	Internet. Written account	1 hour birth reflection a year after birth with senior midwife
Ali	32	Divorced	Self-employed	2	2006	Breech, Emergency CS. Felt out of control and not given choices. Expectations of birth out of sync with experience.	2013	Internet. Written account	NO

All participant names have been anonymised

Appendix C: A table depicting participants demographic information.

PSEUDONYM	Age	Marital status	Employment status	No of children	Date of traumatic birth	Method of delivery for, experiences perceived as contributing to and perceived impact of, traumatic birth.	Date of elective Caesarean Section (CS)	Recruited from. Response format.	Received therapeutic input?
						Relationship with husband broke down, fearful of future birth, felt on-going guilt at not 'giving birth correctly',			
Jane	39	Married	Self-employed	2	2009	Home birth, episiotomy and tearing. Expectations of birth out of sync with experience, baby distressed at birth and having to be separated, feeling out of control. Difficulty bonding with baby, difficulty breastfeeding, guilt at having pushed for home birth, longitudinal pain and physical damage. PTS symptoms including rumination and avoidance.	2012	Internet. Written account.	Two sessions with midwife after birth to tell the birth story.
Nina	33	Married	PT employment	3	2006	Fast labour, no pain relief, episiotomy. Inadequate pain relief, speed of labour and birth, expectations out of sync with experience, long term pain and slow recovery.	2012	Internet. Written account	NO

All participant names have been anonymised

Appendix C: A table depicting participants demographic information.

PSEUDONYM	Age	Marital status	Employment status	No of children	Date of traumatic birth	Method of delivery for, experiences perceived as contributing to and perceived impact of, traumatic birth.	Date of elective Caesarean Section (CS)	Recruited from. Response format.	Received therapeutic input?
						Difficulties bonding with baby and breastfeeding, post natal depression, impact on relationship with partner, commented that partner also felt traumatised. PTS symptoms including nightmares, rumination, hypervigilance and avoidance.			
Rini	27	Single	Stay at home mum	2	2006	Baby distressed, emergency CS Expectations out of sync with experience. Fear of future birth,	2011	Internet. Written account	NO
Amanda	35	Living with partner	Stay at home mum	2	2009	Baby distressed, mum contracted infection, forceps delivery with episiotomy, baby unwell immediately after birth. Expectations out of sync with	2011	Internet. Written account	NO

All participant names have been anonymised

Appendix C: A table depicting participants demographic information.

PSEUDONYM	Age	Marital status	Employment status	No of children	Date of traumatic birth	Method of delivery for, experiences perceived as contributing to and perceived impact of, traumatic birth.	Date of elective Caesarean Section (CS)	Recruited from. Response format.	Received therapeutic input?
						experience, feared baby would die, inadequate pain relief, felt out of control and helpless. Diagnosis of PTSD, symptoms included: flashbacks, jumbled memory, avoidance of stimuli related to birth, nightmares, rumination and hyperarousal. Difficulty bonding with baby, fear of future birth, longitudinal physical pain and damage,			
Lucy	34	Married	Maternity leave, usually full time employment.	2	2009	Back to back birth. Lots of pain. Forceps delivery with no pain relief. Felt she wasn't communicated with or supported well enough during birth. Post birth felt uncared for by staff. Became very ill due to blood loss and perceived threat to life. Felt initial anger at and bonding	2012	NHS. Phone interview	Saw Clinical psychologist prior to ECS for six sessions

All participant names have been anonymised

Appendix C: A table depicting participants demographic information.

PSEUDONYM	Age	Marital status	Employment status	No of children	Date of traumatic birth	Method of delivery for, experiences perceived as contributing to and perceived impact of, traumatic birth.	Date of elective Caesarean Section (CS)	Recruited from. Response format.	Received therapeutic input?
						difficulties with child. PTS symptoms: jumbled memories, avoidance, rumination, hyperarousal and nightmares.			
Emma	25	Lives with Partner	Part time employment	2	2007	Emergency C-section Felt out of control, expectations out of sync with experience, Inadequate pain relief, perceived threat to baby's life, felt she wasn't listened to. Fear of future birth.	2010	NHS Phone Interview	Yes- Once for assessment prior to ECS then eight sessions following ECS.
Jennifer	24	Partner	Full time employment	2	2006	Episiotomy, baby in distress. Felt uncared for, un-communicated with and depersonalised. Felt violated. Felt helpless and feared for her life. Post natal depression, isolation, questioned ability to cope as a parent, difficulty bonding and problems in relationship with baby, PTS symptoms	2012	NHS Phone interview	3 appointments with clinical psychologist prior to ECS

All participant names have been anonymised

Appendix C: A table depicting participants demographic information.

PSEUDONYM	Age	Marital status	Employment status	No of children	Date of traumatic birth	Method of delivery for, experiences perceived as contributing to and perceived impact of, traumatic birth.	Date of elective Caesarean Section (CS)	Recruited from. Response format.	Received therapeutic input?
						including: avoidance, hyper-arousal, nightmares, rumination. Fear of future birth.			
Paula	31	Married	Stay at home mum	2	2007	Overdue, sweeps, epidural, baby distress, emergency CS Felt uncared for, poorly communicated with, out of control and helpless. Felt babies life was at risk. Long recovery time. Fear of future birth, PST symptoms: re-experiencing, rumination, avoidance. Guilt and self-esteem difficulties.	2009	Internet Written account	NO
Becky	30	Lives with partner	Maternity leave, part time employment	2	2009	Tearing and episiotomy. Felt unsupported and poorly communicated with by staff. Felt violated and out of control.	2012	Internet Skype interview	NO

All participant names have been anonymised

Appendix C: A table depicting participants demographic information.

PSEUDONYM	Age	Marital status	Employment status	No of children	Date of traumatic birth	Method of delivery for, experiences perceived as contributing to and perceived impact of, traumatic birth.	Date of elective Caesarean Section (CS)	Recruited from. Response format.	Received therapeutic input?
						Longitudinal pain and damage, felt TB directly affected bonding with baby. Felt isolated in her experiences.			

All participant names have been anonymised

Appendix D: Interview schedule

Skype interview schedule

- Explain rationale and procedure
- Read through Consent form and request verbal consent
- Ask if they have any questions about the research project
- Collect basic demographic data:
- Age -
- Year of PTB -
- Date of caesarean section -
- Marital status – *Married/ single/ divorced/ separated/ widowed.*
- Number of children -
- Employment status- *Employed full/ part time/ full time mum not working.*
- Received psychological input in the past in the context of their traumatic birth or choice to elect for a CS? *Yes/ No, for how long?*

1. Could start by telling me about your previous pregnancy of which you found the birth traumatic, what you had hoped for the birth, what you had planned?

2. Could you talk me through the experience of why this birth was traumatic for you?

Prompts: what was that like?

How did that feel at the time?

What happened next?

How did that leave you feeling?

Was that what you expected?

What were you thinking?

3. In what ways has that experience affected your life?

4. How did you feel when you found out you were pregnant again?

5. Could you tell me a little bit about your reasons for electing a caesarean section?

Prompts: What were your hopes for the caesarean?
How did you expect the caesarean to be different from your previous birth experience?
Were you been supported with this decision? Who supported you?

6. Could you tell me about how the experience of having the caesarean was for you?

Prompts: what was that like?
What were you thinking?
How did that feel at the time?
What happened next?
How did that leave you feeling?
Was that what you expected?
What were you thinking?
Are you pleased you made this choice?

7. How was the experience different or the same as the previous birth?

8. How have things been for you since the caesarean? How is this different from how things were for you after your previous traumatic birth?

9. In what ways has this experience effected how you feel about and remember the experience of your first birth?

Prompts:
Are your memories of it better or worse? More or less painful? More or less vivid?

Has it influenced you thoughts about your past experience? How?

10. If you were to look back at your decision to elect for a caesarean would you make the same choice again?

11. Is there anything that you think I should have asked that I didn't ask?

Debrief

"Those were all of my questions"

"Do you have any questions about what we've been talking about?"

"How are you feeling?"

"Do you feel you need to talk to anyone about how you are feeling? If so you can visit your GP and ask for a referral to speak to a counsellor or a psychologist, I have also emailed you a list of organisations that may be able to offer you further support."

"Would you like to be sent a report of the results of this research?"

"Would you like to be entered into a prize draw to win gift vouchers? If you win this draw I will let you know via email and will have to ask you for an address to send the vouchers to. Once I have sent the vouchers the details of your address will be destroyed."

Yes / No

ID no -

Appendix E: Guide for written accounts of experience.

Experiences of women who request a caesarean section following a previous traumatic birth.

PLEASE NOTE: By beginning this written account, you acknowledge that you have read the information sheet and agree to participate in this research, with the knowledge that you are free to withdraw your participation at any time before the final report is submitted.

Please either complete this account electronically, save it, and email it back to Kate Rhodes at ekr5@canterbury.ac.uk . Alternatively you can send back this questionnaire to the postal address listed on the information sheet.

Background information

Age -

Year of previous traumatic birth -

Date of subsequent caesarean section -

Marital status –

Number of children -

Employment status-

Have you received psychological input in the past for support with the trauma of you previous birth or your choice to elect for a caesarean section? (Please specify)

If yes please could you give a rough estimation of how long you received psychological input for -

Instructions

Please write, in as much detail as you feel able to, your responses to the questions below.

Remember there are no right or wrong responses – what I would like to know about is your own experiences of electing for a caesarean section. Write as openly and freely as you feel comfortable with, and try to give examples from your experience wherever possible.

The spaces below are intended only as a guide; please continue on additional pages if you feel you would like to do so.

1. Please start by writing about your expectations of your previous pregnancy of which you found the birth traumatic: what you had hoped for the actual birth, what you had planned?

2. Please write about the <u>experience</u> of this birth and why it was traumatic for you?

3. In what ways has that experience <u>affected your life</u>?

4. How did you feel when you found out you were pregnant again?

5. Please write about your reasons for electing a caesarean section for your subsequent birth:

You may wish to consider: What were your hopes for the caesarean?

How did you expect the caesarean to be different from your previous birth experience?

Were you been supported with this decision? Who supported you?

6. Please write about how the <u>experience</u> of having the caesarean was for you?

7. How was the experience <u>different or the same</u> as the previous birth?

8. How have things been for you since the caesarean? How is this different from how things were for you after your previous traumatic birth?

9. In what ways has this experience affected how you feel about and remember the experience of your first birth?

You may wish to consider: Are your memories of it better or worse? More or less painful? More or less vivid? Has it influenced you thoughts about your past experience? How?

10. If you were to look back at your decision to elect for a caesarean would you make the same choice again?

11. Are there any other aspects of your experience you would like to describe?

Finally, would you like to be sent a report detailing the results of this research via email?

Yes / No

Would you like to be entered into a prize draw to win £50 worth of vouchers from a store of your choice?

Yes / No

If yes, please leave your e-mail details below:

_____

THANK YOU FOR PARTICIPATING

Appendix F: Advertisement for the study placed on websites.

Please Help!

Have You Had An Elective Caesarean Section Following A Previous Traumatic Birth?

An increasing proportion of women are choosing to have an elective caesarean section following a previous traumatic childbirth. These women's voices are virtually unheard in research that informs healthcare professionals that work within maternity and psychological services. If you are one of these women then your participation in some new research would be greatly appreciated.

Are you:

- Aged 18 years old and over?
- Have you undergone an elective caesarean section within the past five years?
- Did you elect for the caesarean section because of a previous traumatic childbirth experience?
- Are you verbally fluent in the English language?
- Do you feel ready to reflect on and share your experiences in a written or verbal format?

If the answer to these questions is yes and you would be interested in finding out more about participating in this important research please email me:

Participants of this research will be thanked for their time by being entered into a prize draw to win £50 vouchers for a store of their choice.

This research has been granted ethical approval by the department of Applied Social and Developmental ethics panel at Canterbury Christ Church University.

Appendix G: NHS participant information sheet for interviews.

Participant Information sheet

Research Title: Experiences of women who request a caesarean section, following a previous traumatic birth.

Researchers:

What is this project about?

The aim of this research is to explore women's reasons for, hopes and expectations of requesting a caesarean section following a previous traumatic birth and to explore experiences of subsequently having an elective caesarean section.

We hope that the results of this research project will better inform clinical psychologists and professionals working with women who have experienced traumatic births; enabling them to better understand the psychological reasons for women's requests and the subsequent psychological impact of having an elective caesarean section. The ultimate aim of this is to improve support for such women.

Why have I been invited to take part in the research project?

You have been invited to take part in the research project because you were identified by your healthcare professional as having undergone an elective caesarean following a previous traumatic birth.

What will I be expected to do?

We would like to invite you to take part in an interview with one of the researchers, Kate Rhodes. The interview will last approximately 1 hour and involves answering some questions about your experiences of your previous traumatic birth, your experiences of requesting to have a caesarean section for your subsequent birth and your experiences of the caesarean itself. You can say as much or as little as you would like in response to the questions.

Will my taking part in the Project be kept confidential?

All information collected during the project will be kept strictly confidential. The interviews will be recorded on an audio recorder. You will be asked to use only your first name/ or a name you would prefer to be known by, when the tape is recording, to maintain your anonymity on it. The audio recording will be transcribed and participants' names changed to pseudonyms to further protect your identity on the transcribed document. The transcripts will be accessible by the researchers only.

All data collected will be anonymous. Electronic recordings of the data will be stored on a password protected USB stick for 10 years after the research is undertaken and then destroyed.

Do I have to take part in the research project?

It is up to you whether or not you take part in the project. If you decide to take part you will be asked read a consent form and sign this consent form at the start of the interview. We also ask that you keep this information sheet to refer to. You are free to withdraw at any time from the project without giving reason.

What are the benefits of taking part?

Taking part in the project means that you have the opportunity to contribute to some new research in an under-researched area. We also hope the results can better inform services and improve the quality of care others may receive. You may find the research interesting to take part in and for some people talking through their experiences can be therapeutic.

All participants have the opportunity to be entered into a prize draw for a £50 gift voucher to a store of their choice. The draw will be independently adjudicated. If you win the draw the researcher will email or phone you and ask that you provide an address to send the voucher to, these details will not be stored.

What are the disadvantages of taking part?

You may be asked to talk about some things that could upset you. You do not have to answer any questions that you do not want to. You can stop the interview at any time, or

take a break. You can decide not to take part at any time. I will be able to talk to you and answer any questions you have before, during and after the interview.

If you feel that you need to access further emotional support you could visit your GP and ask to be referred to a primary care counselling service or psychologist. There are also various charity organisations that you could contact; I will provide you with a list of these via email. The birth trauma association has links to free support services for women who have experienced traumatic births www.birthtraumaassociation.org.uk.

What will happen with the results?

Your views will be used anonymously in the write-up of this research, which we also hope to publish in a journal used by clinicians in the field of obstetrics and gynaecology. We will also offer all participants the choice to receive a brief outline of the project's results.

What if there is a problem?

Any complaint about the way you have been dealt with during this study can be addressed by contacting xxxx.

Thank you for taking the time to read about this research and I hope that you will be interested in taking part.

Please contact the researcher, xxxx if you have any questions or concerns before you decide to take part in the project.

Project supervised by xxxx.

Appendix H: NHS participant information sheet written account

Participant Information sheet

Research Title: Experiences of women who request a caesarean section, following a previous traumatic birth.

Researchers:

What is this research about?

The aim of this research is to explore women's reasons for, hopes and expectations of requesting a caesarean section following a previous traumatic birth and to explore their experiences of subsequently having an elective caesarean section.

We hope that the results of this research project will better inform clinical psychologists and professionals working with women who have experienced traumatic births; enabling them to better understand the psychological reasons for women's requests and the subsequent psychological impact of having an elective caesarean section. The ultimate aim of this is to improve support for such women.

Why have I been invited to take part in the research project?

You have been invited to take part in the research project because you were identified by your healthcare professional as having undergone an elective caesarean following a previous traumatic birth.

What will I be expected to do?

We would like to invite you to complete a questionnaire which prompts you to write about your experiences of your previous traumatic birth, your experiences of requesting to have a caesarean section for your subsequent birth and your experiences of the caesarean itself. You can write as much or as little as you would like in response to the questions, so the time it will take for you to complete is flexible. I would then ask you to send back the questionnaire within four weeks of receiving it to a secure email address or through the post.

If I do not hear from you within four weeks I will send a short follow up email or phone call to ensure you received the relevant documentation and wish to take part, if there is no response to this email/ phone call then I will assume that you do not wish to partake in the study and your details will be deleted from the database.

Will my taking part in the Project be kept confidential?

All information collected during the project will be kept strictly confidential. You will be asked to use only your first name/ or a name you would prefer to be known by throughout the questionnaire. Following submission of the questionnaire all names will be changed to pseudonyms to maintain anonymity. The questionnaires will be accessible by the researchers only.

All data collected will be anonymous. Electronic copies of the data will be stored on a password protected USB stick for 10 years after the research is undertaken and then destroyed.

Do I have to take part in the research project?

It is up to you whether or not you take part in the project. If you decide to take part you will be asked to read a consent form and keep this information sheet to refer to. By returning you completed questionnaire it will be assumed that you have read through the consent form and are agreeing to consent to partake in the research. You are free to withdraw at any time from the research without giving reason.

What are the benefits of taking part?

Taking part in the project means that you have the opportunity to contribute to some new research in an under-researched area. We also hope the results can better inform services and improve the quality of care others may receive. You may find the research interesting to take part in and for some people thinking through their experiences can be therapeutic.

All participants have the opportunity to be entered into a prize draw for a £50 gift voucher to a store of their choice. The draw will be independently adjudicated. If you win the draw the researcher will email you and ask that you provide an address to send the voucher to, these details will not be stored.

What are the disadvantages of taking part?

You may be asked questions about some things that could upset you. You do not have to answer any questions that you do not want to. You can decide not to take part at any time. I will be able to answer any questions you have via email.

If you feel that you need to access further emotional support you can could visit your GP and ask to be referred to a primary care counselling service or psychologist. There are also various charity organisations that you could contact; I will provide you with a list of these. The birth trauma association has links to free support services for women who have experienced traumatic births www.birthtraumaassociation.org.uk.

What will happen with the results?

Your views will be used anonymously in the write-up of this research, which we also hope to publish in a journal used by clinicians in the field of obstetrics and gynaecology. We will also offer all participants the choice to receive a brief outline of the project's results.

What if there is a problem?

Any complaint about the way you have been dealt with during this study can be addressed by contacting:

I would like to take part in the research, what do I do next?

If you think you would like to take part in the research the next step is to read the consent form that has been attached along with this email/ letter, once you have read through the consent form you can complete the questionnaire any time within the next four weeks. The questionnaire is attached to this email/letter also. Once you have finished the questionnaire you can either save a copy of it and send it back to my secure university email address:. Or you can print off a copy and send it to me in the stamped addressed envelope provided to :

Thank you for taking the time to read about this research and I hope that you will be interested in taking part.

Please contact the researcher, xxxx if you have any questions or concerns before you decide to take part in the project.

Project supervised by xxxx.

Appendix I: Online participant information sheet for Skype/phone interviews

Participant Information sheet

Research Title: Experiences of women who request a caesarean section, following a previous traumatic birth.

Researchers:

What is this project about?

The aim of this research is to explore women's reasons, hopes and expectations when requesting a caesarean section following a previous traumatic birth and to explore their experiences of subsequently having an elective caesarean section.

We hope that the results of this research project will better inform clinical psychologists and professionals working with women who have experienced traumatic births; enabling them to better understand the psychological reasons for women's requests and the subsequent psychological impact of having an elective caesarean section. The ultimate aim of this is to improve support for such women.

Why have I been invited to take part in the research project?

You have been invited to take part in the research project because you responded to an advert on an online forum for women who have experienced traumatic births.

What will I be expected to do?

We would like to invite you to take part in an online interview via Skype or telephone interview with one of the researchers xxxx trainee clinical psychologist. The interview will last approximately 1 hour and involves answering some questions about your experiences of your previous traumatic birth, your experiences of requesting to have a caesarean section for your subsequent birth and your experiences of the caesarean itself. You can say as much or as little as you would like in response to the questions.

Will my taking part in the Project be kept confidential?

The researcher will be in a private setting for the Skype/ telephone interview. All information collected during the project will be kept strictly confidential. The interviews will be recorded on an audio recorder. You will be asked to use only your first name/ or a name you would prefer to be known by, when the tape is recording, to maintain your anonymity on it. The audio recording will be transcribed and participants' names changed to pseudonyms to further protect your identity on the transcribed document. The transcripts will be accessible by the researchers only.

All data collected will be anonymous. Electronic recordings of the data will be stored on a password protected USB stick for 10 years after the research is undertaken and then destroyed.

Do I have to take part in the research project?

It is up to you whether or not you take part in the project. If you decide to take part you will be asked read a consent form and verbally agree to provide consent at the start of the interview. We also ask that you keep this information sheet to refer to. You are free to withdraw at any time from the project without giving reason.

What are the benefits of taking part?

Taking part in the project means that you have the opportunity to contribute to some new research in an under-researched area. We also hope the results can better inform services and improve the quality of care others may receive. You may find the research interesting to take part in and for some people talking through their experiences can be therapeutic.

All participants have the opportunity to be entered into a prize draw for a £50 gift voucher to a store of their choice. The draw will be independently adjudicated. If you win the draw the researcher will email you and ask that you provide an address to send the voucher to, these details will not be stored.

What are the disadvantages of taking part?

You may be asked to talk about some things that could upset you. You do not have to answer any questions that you do not want to. You can stop the interview at any time, or take a break. You can decide not to take part at any time. I will be able to talk to you and answer any questions you have before, during and after the interview.

If you feel that you need to access further emotional support you could visit your GP and ask to be referred to a primary care counselling service or psychologist. There are also various charity organisations that you could contact; I will provide you with a list of these via email. The birth trauma association has links to free support services for women who have experienced traumatic births www.birthtraumaassociation.org.uk.

What will happen with the results?

Your views will be used anonymously in the write-up of this research, which we also hope to publish in a journal used by clinicians in the field of obstetrics and gynaecology. We will also offer all participants the choice to receive a brief outline of the project's results.

How do I know you are who you say you are?

I have attached both the ethical approval for this project and a letter authorising my student status at :

What if there is a problem?

Any complaint about the way you have been dealt with during this study can be addressed by contacting :

I would like to take part in the research, what do I do next?

If you think you would like to take part in the research the next step is to read the consent form that has been attached along with this email, once you have read through the consent form you can get back in touch with me via email xxxx to let me know you would like to take part, and suggest a time that would be most convenient for you to partake in the interview. We can also discuss via email what would happen if we were to lose connection during the interview. At the start of the interview I will ask you to verbally consent to partake in the research.

If I do not hear from you within four weeks of receipt of this e-mail I will send a short follow up email to ensure you received the relevant documentation, if there is no response to this follow up email I will assume that you do not wish to partake in the study and your email details will be deleted from the database

Thank you for taking the time to read about this research and I hope that you will be interested in taking part.

Please contact the researcher,xxxx if you have any questions or concerns before you decide to take part in the project.

Project supervised byxxxx.

Appendix J: Online participant information sheet for written accounts.

Participant Information sheet

Research Title: Experiences of women who request a caesarean section, following a previous traumatic birth.

Researchers:

What is this research about?

The aim of this research is to explore women's reasons, hopes and expectations when requesting a caesarean section following a previous traumatic birth and to explore their experiences of subsequently having an elective caesarean section.

We hope that the results of this research project will better inform clinical psychologists and professionals working with women who have experienced traumatic births; enabling them to better understand the psychological reasons for women's requests and the subsequent psychological impact of having an elective caesarean section. The ultimate aim of this is to improve support for such women.

Why have I been invited to take part in the research project?

You have been invited to take part in the research project because you responded to an advert on an online forum for women who have experienced traumatic births.

What will I be expected to do?

We would like to invite you to complete a questionnaire which prompts you to write about your experiences of your previous traumatic birth, you experiences of requesting to have a caesarean section for your subsequent birth and your experiences of the caesarean itself. You can write as much or as little as you would like in response to the questions, so the time it will take for you to complete is flexible. I would then ask you to send back the questionnaire within four weeks of receiving it to a secure email address. If I do not hear

from you within four weeks I will send a short follow up email to ensure you received the relevant documentation, if there is no response to this email I will assume that you do not wish to partake in the study and your email details will be deleted from the database.

Will my taking part in the Project be kept confidential?

All information collected during the project will be kept strictly confidential. You will be asked to use only your first name/ or a name you would prefer to be known by throughout the questionnaire. Following submission of the questionnaire all names will be changed to pseudonyms to maintain anonymity. The questionnaires will be accessible by the researchers only.

All data collected will be anonymous. Electronic copies of the data will be stored on a password protected USB stick for 10 years after the research is undertaken and then destroyed.

Do I have to take part in the research project?

It is up to you whether or not you take part in the project. If you decide to take part you will be asked to read a consent form and keep this information sheet to refer to. By returning you completed questionnaire it will be assumed that you have read through the consent form and are agreeing to consent to partake in the research. You are free to withdraw at any time from the research without giving reason.

What are the benefits of taking part?

Taking part in the project means that you have the opportunity to contribute to some new research in an under-researched area. We also hope the results can better inform services and improve the quality of care others may receive. You may find the research interesting to take part in and for some people thinking through their experiences can be therapeutic.

All participants have the opportunity to be entered into a prize draw for a £50 gift voucher to a store of their choice. The draw will be independently adjudicated. If you win the draw the researcher will email you and ask that you provide an address to send the voucher to, these details will not be stored.

What are the disadvantages of taking part?

You may be asked questions about some things that could upset you. You do not have to answer any questions that you do not want to. You can decide not to take part at any time. I will be able to answer any questions you have via email.

If you feel that you need to access further emotional support you can could visit your GP and ask to be referred to a primary care counselling service or psychologist. There are also various charity organisations that you could contact; I can provide you with a list of these on request. The birth trauma association has links to free support services for women who have experienced traumatic births www.birthtraumaassociation.org.uk.

What will happen with the results?

Your views will be used anonymously in the write-up of this research, which we also hope to publish in a journal used by clinicians in the field of obstetrics and gynaecology. We will also offer all participants the choice to receive a brief outline of the project's results.

What if there is a problem?

Any complaint about the way you have been dealt with during this study can be addressed by contacting:.

I would like to take part in the research, what do I do next?

If you think you would like to take part in the research the next step is to read the consent form that has been attached along with this email, once you have read through the consent form you can complete the questionnaire any time within the next four weeks. The questionnaire is attached to this email also. Once you have finished the questionnaire you can either save a copy of it and send it back to my secure university email address: . Or you can print off a copy and send it to me at :

Thank you for taking the time to read about this research and I hope that you will be interested in taking part.

Please contact the researcher, xxxx if you have any questions or concerns before you decide to take part in the project.

Project supervised by xxxx.

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
1. Cautiously moving forward into the unknown: the drive to reproduce.	1.1 Fear and avoidance.	*"I'm humble to birthing now and always wanted three* to four children, but after that experience just wanted *one…it completely put me off having more children"* (Jess) *"It effected my life my thinking I would never have* another baby ever again after that *experience"(Amanda)* *"I felt ugly and unwomanly. I was very reluctant to* have *sex as I just didn't feel attractive because of how I perceived things to look down there"(Amy)* *"I won't be touched down there, I can't bear it, I can't* touch myself either, it makes me, cringe is the wrong *word, but shudder, I don't like my partner* to touch *me…..It's a mental thing I associate it with my first labour" (Becky)* *"I waited six years before I had another one, I couldn't get past the fact that I had to do that all over again"* (Jennifer)
	1.2 Requesting a CS a necessary but difficult decision.	*"I made it clear I didn't want a vaginal delivery*. I *didn't particularly want a section either but it had to come out some way" (Amy)* *"It wasn't a decision I took lightly, it took me a few*

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
		weeks to finally say OK in my head, we are going back *through, it's scary" (Emma)* *"I had doubt's, I thought it wou*ld be nice to try for a *VBAC" (Paula)* *"I probably always knew I wanted a CS, but when it* came to making the decision it was probably harder than I thought, because of the sentimental reasons for *having the baby come naturally"(Becky)* *"I felt trapped with* my choices, I knew the labour and the thought of it was terrifying, however on the other *hand a CS was major surgery and that was frightening"* (Jennifer)
	1.3 Subsequent pregnancy potentially a time of excitement, anxiety and increased trauma symptoms.	*"I was happy and excited, but also scared, anxious, filled with fear!"* (Paula) *"I was very* pleased [to be pregnant] but very nervous *about having a natural birth" (Jane)* *"Straight away I was anxious and worrying about the delivery" (Amy)* *"I was happy when I found out I was pregnant again but*

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
	1.4 Request for ECS supported or opposed: a battle which can mediate anxiety.	*initially didn't give the birth much thought. I tri*ed to *block it out for as long as possible and wouldn't let myself think about it" "After a couple of appointments* at the hospital the memories of it started coming back and I left the waiting room in tears because it made me *anxious and panicky" (Amanda)* *"I was often not sleeping well…. I would often lie there* from 4am,until I had to get up for work just *panicking"(Carey)* Family and friends supportive: *"My partner and family supported my decision" (Amy)* *"My partner was very much this is your decisi*on, I *don't mind what you choose to do and so were my* family. I think my family were keen for me to have a CS, they had come to see me the first time around and commented on how bad I looked and were aware of how *difficult it was afterwards" (Becky)* Services supportive: *"I went to speak to a consultant at the NHS hospital and* she asked me why I wanted a CS, we talked a little about why I wanted it and she referred me to the psychologist and said to come back and see how I feel" (Lucy)

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
		"I was able to discuss my concerns with the midwife who would help me with questions I had about electing for a CS or trying for a VBAC" (Paula) "I was fully supported by my midwives and consultant, it made it relaxing, we were able to plan so much"(Jane) Battle against services: *"The consultant said my TB was down to bad luck and* was unlikely to happen again. But no-one will ever know *for certain, and they hadn't walked a mile in my shoes to understand. Personally I didn't want to take the risk* so it was a shame I had to battle so much to get the CS agreed" (Amanda) *"I know doctors, consultants and midwives were like, if you are healthy enough for a natural birth they're not referring you for a CS" (Jennifer)* *"At 16 weeks the trauma was triggered again, hence* threatening abortion unless the midwife referred me to a *sympathetic consultant from a different hospital" (Jess)* *"I had to push for it to be honest…. But once they said I could have the CS a weight was lifted"* (Emma) *"The midwife and consultant tried to persuade* me to

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
		have a natural delivery…I stuck to what I wanted and really pushed for a CS however…. I definitely think I could have been supported better and felt I was *constantly fighting to have the section" (Amy)* Battle against culture/society: *"I didn't want* people to judge me by not giving it a go *[natural birth]" (*Amanda) *"I feel that both of my CS's were justifiable in my opinion. Everyone has their opinion, I didn't do it for fashion"* (Emma) "There is this sort of expectation that there is on one hand CS bad! Vaginal birth on the other hand good! But *nobody explains the spectrum of vaginal birth."* (Carey)
2. Attempting to make the unknown, known.	2.1 A request for perceived control.	*"I needed to be in as much control as I possibly could…* I would rather have abdominal surgery and a three day stay than an unknown natural birth" (Jess) "I hoped that by having a (elective) CS the experience would be more calm and controlled" (Nina) "My hopes were that a CS would be easier to plan" (Rini) "I would know exactly when she was coming the date I

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
		had to hold out for, the date I had to pack for, if *everything was under control I wouldn't be as terrified* as I was before" (Emma) "I thought rather than it be unexpected, if it is booked I *know I am ready to go into hospital and it's not a surprise and I'm ready and prepared,* even if It does last longer than a non-induced labour would" (Jennifer) "*I knew I wasn't going to end up in the back of an ambulance giving birth with forceps… it was controlled by professionals."* (Emma)
	2.2 A perceived medically safer and less physically traumatic experience.	*"I did not want a vaginal delivery because of* what I had *been through following X's delivery and then the operation [tearing and episiotomy]"* *"I expected the CS to be more straight forward with less* complications"(Amy) *"The trauma was disabling, I realised this time if I was* to die I would be leaving baby one. A natural birth and its risks were too much to bear" (Jess) "I was unwilling to accept the possibility of needing further surgery *With another delivery"* *"I knew the recovery time for a CS and hoped it would* be shorted than my previous healing time and that the

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
	2.3 Avoidance of stress, emotional trauma and its sequelae	pain would be more predictable" (Nina) *"I didn't want to feel the pain and go through that* pushing stage, I knew how painful the first one was, there was no way I would willingly go through that again" (Lucy) "I thought the baby would be less distressed" (Rini) *"I expected the CS to be harsh but safer, happier and a* more positive procedure with minimal trauma to us both"(Amanda) *"After my first section I felt very strongly that falling* pregnant again would be my worst nightmare, mostly due to not wanting to repeat the dramatic, stressful birth experience" (Ali) "I hoped the experience would be less stressful for my husband as I would be less stressed" (Nina) "We could not go through that again, the things that were said about my son will remain with me forever and I can still see the midwife that said this" (Paula) *"I wanted a less stressful labour*" (Jane) "*I didn't want to worry about the birth being long and*

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
		traumatic again" (Rini) "You are just in the land of the unknown and if I could just stop us from having that experience [of the previous *TB] then I just had to do whatever I could… My hopes* were that by having an ECS the stress and trauma of the previous birth would be eliminated." (Paula)
3. The longed for positive birthing experience	3.1 A surreal experience	"I had a really good, but surreal experience" (Amy) "I put in my announcement text message to all my friends and *colleagues 'born today…I feel amazing'. People talk about a natural high after birth, I don't* know I had no idea that was even possible with my first *but I felt amazing with my second. I wasn't afraid for my* boss to know that" (Carey) "It was amazing, it was everything I imagined, calm, in control. It was a very positive experience and I remember being absolutely elated in the recovery room." (Nina) "The second birth was lovely, I remember saying to family and friends how much more relaxed and comfortable I felt" (Paula) *"The experience was excellent. I felt I had the ultimate* chance to enjoy my final pregnancy and birth. I was so

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
		happy and relaxed I looked glowing. The photos show a happy and glowing mum with a big bouncing baby this time" (Ali)
	3.2 The importance of care and communication	"That was something I really needed to get through it *[communication and explanations], which I didn't have* with the first one, it had been all very uncertain from *start to finish which was very scary… it was something I* needed to happen, for them to tell me what was going on- which I got from the ECS."(Jennifer)
		"I was talked though everything and when I went into theatre all the staff introduced themselves and told me why they were there. The anaesthetist spoke to me about what she was going to do and why and was asking me questions and telling me why things happen. This immediately relaxed me and made the experience so different" (Paula)
		"The consultant and the medical staff in theatre all talked to me thoroughly about everything they were doing as well as asking me what I remembered about my *daughter's birth and giving me space to talk about how I was feeling."* (Ali)

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
		"All of the staff at the hospital were very friendly and supportive" (Amy) "All the staff at the hospital were really supportive and positive, especially during surgery" (Jane) "The midwives and staff were so supportive and some *said that they didn't blame me for choosing an elective* under the circumstances" (Amanda) "Everyone was so lovely, I remember the anaesthetist he was just really lovely and everyone was reassuring and lovely, I remember feeling grateful they were looking after me" (Paula) "Everyone was really nice, that was the other thing with *everyone that was there, they were lovely, I couldn't* fault them at all. They made sure I was fully aware of *what was going on……They were reassuring* and they said nothing terrible is going to happen, its fine."(Jennifer)
4. A different post-natal experience.	4.1 Painful recovery: "A price I could pay" or a "frustrating" experience.	"I described it as really harsh because of how immobile I was and how painful it was to stand up move and walk for a few days. *I didn't expect any different because I knew it wasn't a procedure you would chose to go* through without good reason" (Amanda) "I look back on it [the subsequent CS] and yes the

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
		recovery was terrible, really painful, but I never feared something terrible was going to happen because of it, I just expected it to get better and that was it. I also look back on it and remember more actually having my baby and it being happy more than the pain felt, which is completely opposite to the first one. With the first one all I can think about is how horrible and worrying it was" (Jennifer) "Although I was in pain it was predictable, expected pain and I was recovered in 3 weeks" (Nina) "I was less worried. I recovered so much quicker after having a planned CS. I was home the next day. I had so much more energy" (Rini) "I did struggle with the resting afterwards and it upset *me that I couldn't pick up my son or play with him, but I* had prepared myself and him for this before going in" (Amy) "The recovery time was quicker this time as well and I remember when the midwife did her rounds the following morning the catheter was taken out and I was mobile much quicker and showering and walking around" (Paula)

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
	4.2 Bonding with baby and maternal wellbeing	"I was able to breastfeed immediately and bonded with baby 2 straight away" (Jane) "We had a wonderful positive first day with our baby from the moment she emerged to the moment he [husband] went home, to the moment I fell asleep" (Carey) "I felt no guilt this time for not having given birth properly" (Ali) "Spending 2 nights in hospital rather than coming straight home like after a normal birth was also very positive. It allowed me time with my new baby before I had to deal with my toddler and helped me to establish feeding" (Nina) "They quite quickly brought her to me, which was lovely, which is the way it should have been, I definitely got it [bonding experience] with my second one, it was definitely the right decision for me. It was really lovely as it was just the two of us, I was able to have cuddles, it was just lovely. I just felt really special and I really *loved her, I couldn't stop looking at her. I definitely felt* immediately bonded and attached to her" (Becky) "*I didn't cry, the first time for months I would just randomly burst into tears, this time that didn't happen at all."* (Lucy)

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
5. The interaction of the two experiences	5.1 The good highlighting the bad	"*I wish I had a CS with the first one, that's all I can say,* it was a good experience, a positive experience it makes the first one worse now that I have had both" (Jennifer)
		"I think there will always be a certain amount of pain now when I think of how my daughter struggled with life. I craved the happy birth moment and the cuddles straight after like with my second" (Amanda)
		"My memories are full of guilt for baby one, that baby two had a better start. Perhaps there was something extra I could have done. I still remember feeling helpless" (Jess)
		"It was wonderful from beginning to end, and I felt that *it hadn't been able to be wonderful the first time around* because of all the stress and trauma and everything else that surrounded it, the on-going trauma afterwards" (Carey)
	5.2 A redemptive experience	"Memories are definitely better, less painful and less vivid" (Amy)
		"I can honestly say this is what is bad about it and this *is what wasn't my fault. I think I felt before that I had let*

Appendix K: A table of superordinate and subordinate themes and supportive verbatim quotes.

Superordinate	Subordinate	Quotes
		my daughter get into a situation where she could be *scarred for life"* *"In a way it's kind of fixed them [memories of previous TB], instead of it being this big scary thing, umm it's* still frightening and traumatic and I was out of control, but now I can talk about it and not get upset and not feel out of control" (Carey) "My memories are less vivid now" (Amanda) "My memories are less painful as I have two beautiful children and they are both healthy" (Rini) *"I feel vindicated in how I feel about the first care I received…all the staff that r*ead my notes this time *around were shocked and understood the trauma...It's* helped because it feels as though the NHS has listened to me finally and I have had the experience I *wanted."(*Jess)

Appendix L: Example of coded full transcript

This has been removed from the electronic copy

Appendix M: Excerpts from reflective diary.

Please note these are excerpts from a longer diary highlighting key stages during the research process.

11th March 2011: **AM:** I had a phone conversation with X to discuss the possibility of conducting research on non-epileptic seizures, he had some quite set ideas about the proposal and I think is looking at a quantitative design; I was really hoping to do some qualitative research since I have little experience in this area and feel it would be more beneficial for my professional development. I'm still really hoping that I can conduct research in an area that I find interesting; I'm going to spend the next three years of my life studying it so I feel it should be relevant! **PM**: I spoke to Sarah and talked about potential research projects within Obstetrics and Gynaecology at X hospital. We thought about the anxiety groups she runs for tokophobic women, another trainee is evaluating these groups for her project. Sarah talked about some of her clients for whom the group has not been particularly suitable for, namely women who have had a difficult previous birth. Sarah has found that women who fall into this category present very differently to women who are tokophobic with their primary pregnancy. Some women display signs of trauma relating to the birth which impact on their ability to make use of the group. Sarah talked about how she gets referred such women for individual therapy usually when they have requested a C-section for their next pregnancy. The drop-out rate from therapy is high though and for most women Sarah wonders if it feels like a tick box exercise to say they saw a psychologist and still need the ECS. Apparently there is very little research regarding this cohort of women and Sarah's ways of working with them comes purely from practice evidence. Sarah directed me to the NICE guidelines for ECS on request which I will look through in the next week, I am quite interested in this area though and excited about what seems to be an identified gap in the literature in this area. Sarah and I wondered together about what the experience of an ECS must be like for such women and whether it did offer them a different experience of birth. I wondered whether they went into an elective C-Section with such high hopes these could not be met and resulted in further trauma? Sarah said that practice evidence suggests not, and most women she has followed up report a good experience, often to such an extent that it seem to override somehow their trauma. She wondered whether a potential project could focus on the effects of the ECS on women's memories of the first birth. I'm definitely starting to feel more positive about the process of finding a project now; I need to do some serious reading in this area! Plan: Read Nice guidelines, look up papers by Susan Ayres (Sarah recommended) and have a look at the journals 'Birth', 'Nursing Research' and 'Journal of Reproductive and Infant Psychology'.

14th March 2011: I have seen some literature highlighting women's hopes of a 'healing birth experience' following a past traumatic birth, and how subsequent positive birth experience can facilitate 'post traumatic growth'. This is an interesting concept and fits with Sarah's wonderings regarding women's memories of the trauma changing with the ECS. Need to look up. From a quick search Sarah is right there doesn't seem to be any direct research investigating women who actually have elective caesareans following past traumatic births.

There a paper on 'Previous traumatic birth: an impetus for requested caesarean birth' but this doesn't investigate women who actually have the elective caesarean rather what could be done to prevent it. I was struck immediately by the defensive thought of ‘does it need preventing’. It made me start to think about what my thoughts are about women electing for a caesarean? My mum had two caesareans, and while not elective I can’t help but have the thought ‘it never did us any harm’. However, at the same time I know I have also sneered at headlines in magazines regarding celebrities being ‘too posh to push!’ Overall I am aware that I have a belief that if women have had such a bad experience of birth the first time and are desperate for a caesarean section for their second birth they should be allowed it, yet all the literature in the area seems to focus on how to stop them obtaining this! I need to be very aware of these beliefs through the project and try to keep in a neutral position, it’s helpful writing them here though. I guess I am also wondering at this point how many women do actually go through with an elective caesarean following a traumatic past birth? Would there be enough of a sample? As it would be qualitative I guess there wouldn't need to be huge numbers. I was also thinking there may be potential to use 'new media' e.g. internet forums (Mumsnet etc...) to recruit if there were not enough participants through the hospital.

13th May 2011:

The meeting with Margie at Salomons went well this morning. She has agreed that she will supervise the project. She put forward some good ideas which she thought would improve the chances of it being passed as a valid MRP by the team here and make it more publishable once finished. The main suggestion she made was to explore the possibility of only interviewing 5/6 women, but to interview them before and after pregnancy. Margie suggested that this may provide some more interesting data and that retrospective accounts alone may face criticism. Maybe I could interview the women between 6-8 months into pregnancy to find out about their reasons for elective caesarean. She suggested that in order to strengthen the theoretical basis for the project it would be important to investigate the beliefs that maintained the trauma e.g. the belief that the traumatic birth effected attachment with baby, affected their physical appearance, effected their relationship with partner etc..... leading them to their hope that an elective caesarean would eliminate the chances of these things reoccurring. Once the belief about what maintains trauma has been identified, along with general symptoms of trauma inc. intrusive memories etc.... (Possibly also using a diagnostic measure of trauma), these can be tracked and revisited after the birth. The idea would be to re-interview one month after caesarean focussing on whether the caesarean did prevent their fears and whether it affected their levels of trauma, what happened to their memories of the past trauma, their emotions about it, cognitions etc....

I guess the idea is that by tracking changes over time the results would be more valid and reliable. Including a before and after diagnostic test might appeal to a more medical viewpoint and increase chances of publication. There would also be the possibility of continuing to follow up these women a year post birth to find out on retrospect what affect the caesarean had on their previous beliefs and trauma (this would obviously be after I had finished the course but could lead to more publication...).

I was wondering however whether that by interviewing women before and after pregnancy recruitment would be more difficult. I called Sarah who seemed to think this was a realistic design but acknowledged that we won’t know for sure until recruitment started as while there are certainly enough women from her service who fit this criteria it is always difficult to predict uptake. I guess the retrospective accounts could always be a back-up though and

Sarah has now given me the details of a midwife at xxx hospital that I will get in touch with about using their site as a backup for recruitment.

I plan to get in touch with some women who have given permission to be contacted about their experiences of traumatic birth from the birth trauma website, they may help to shape the design of the research and answer some of my questions. I'm also aware that this is such a sensitive area their guidance could be invaluable.

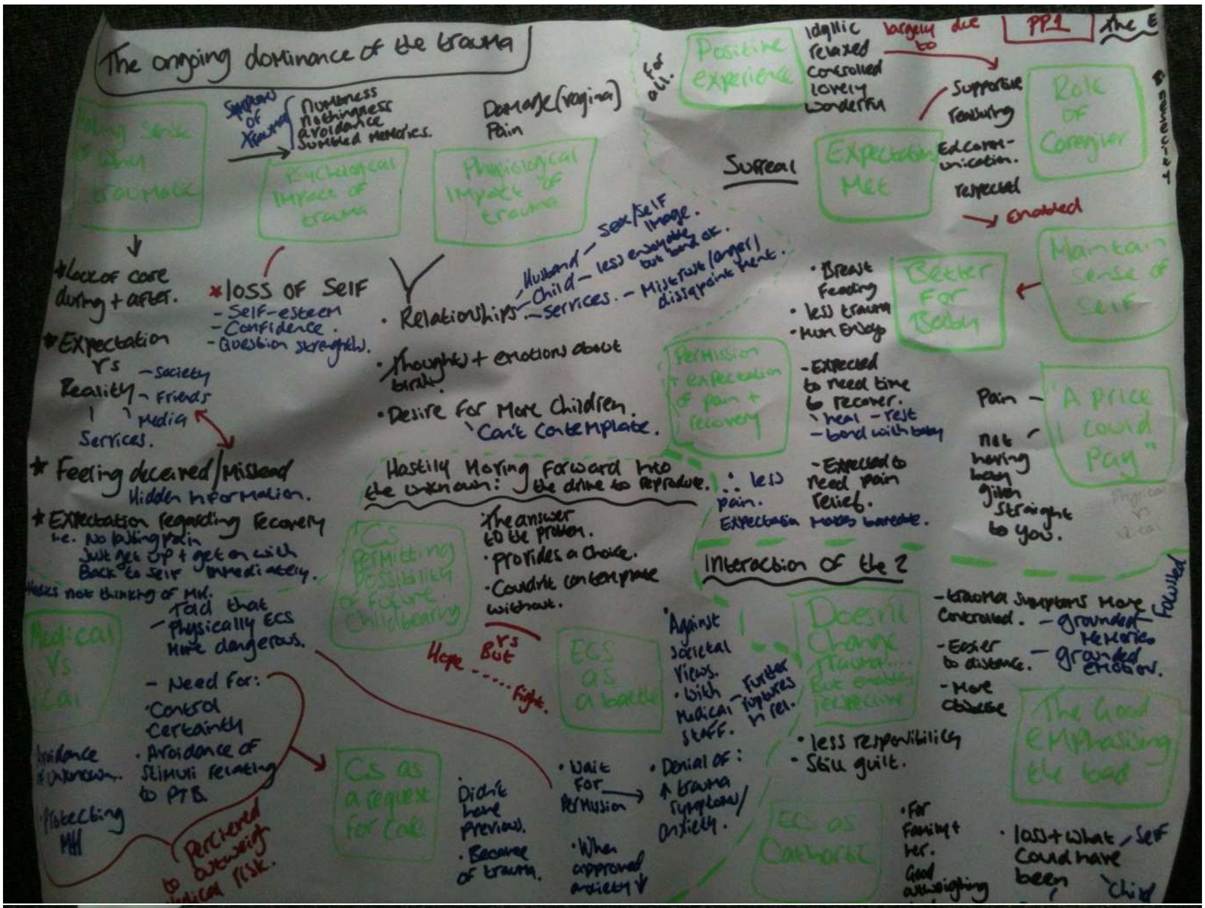
21st May 2012: I went for the ethics panel last week, it was VERY scary! I hadn't envisaged that there would be any real ethical issues with the research but I caused quite the debate apparently. There were concerns surrounding me interviewing women about an elective caesarean at 6-8 months into their pregnancy when technically the women could change their minds right up to the last minute, an anaesthetist on the panel was arguing that by taking part in my interviews women may feel pressured to go ahead with the caesarean even if they had changed their mind.Anyway, they have provisionally approved it, I need to change the protocol to say that women who have been offered therapy must have finished the therapy before I interview them (or have decided they do not wish to engage in therapy) and also to make it clear on the info sheet that women are not obliged to have an elective caesarean just because they are involved in the research. Fingers crossed once I have sent off these changes I get a quick approval letter so I can get started on the laborious process of R&D approval…time is slipping away from me fast!!

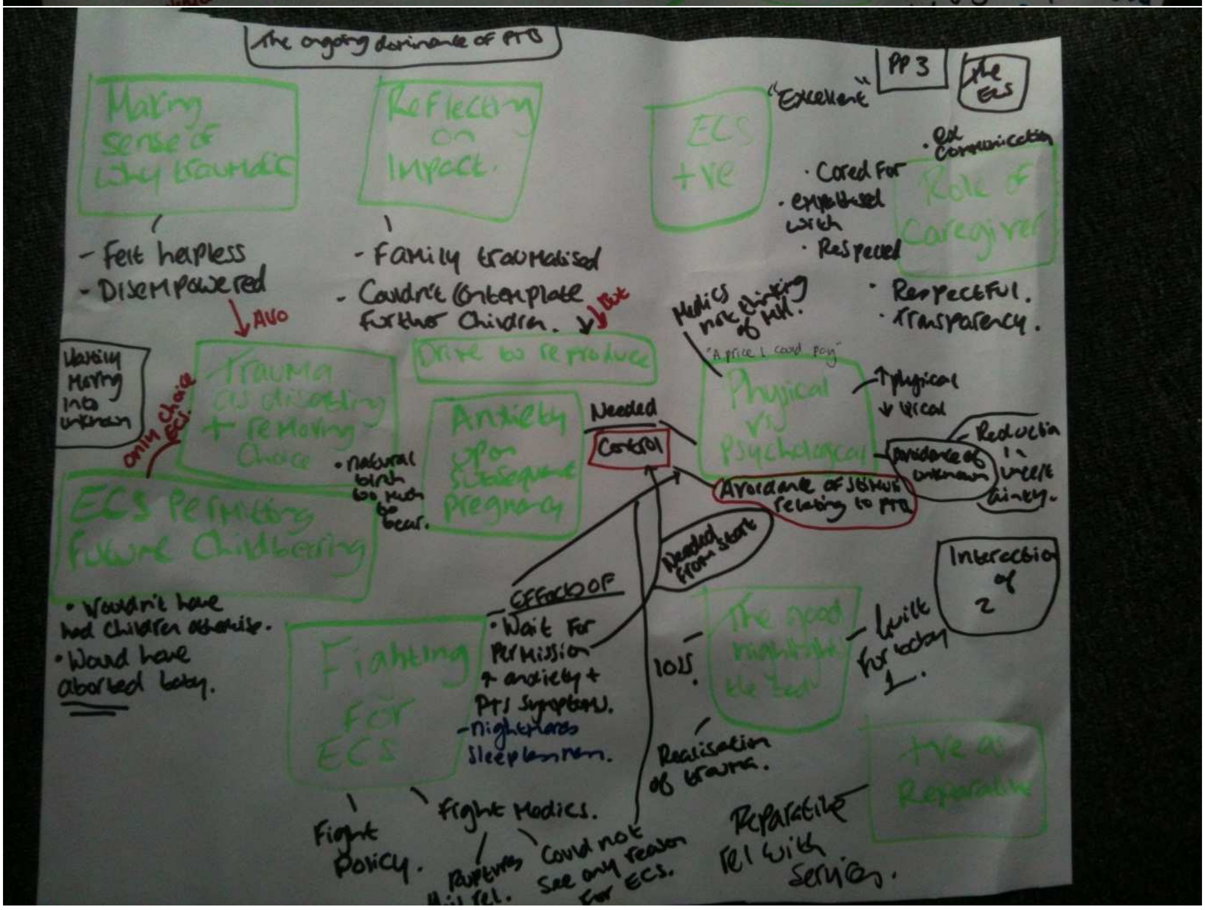
20th September 2012: I think given that it's fast approaching October and I have not yet recruited one participant it is looking like I will need to rethink the research project. My anxiety levels can't take much more of sitting around waiting for people to be recruited for me! If I was to recruit women retrospectively and use the same research question I would need to go through a major amendment process with ethics. Before embarking on this ideally I would like some idea if it is worth going down this route - i.e. will I be able to recruit 6-8 women meeting these new criteria: Women who have had an elective caesarean within the last 2 (?) years stating a previous traumatic childbirth as the main reason for this decision. I will ask Sarah and Chantelle their thoughts. I obviously don't want to go through ethics again only to find the same thing - that I cannot recruit. I wonder if I could add in more NHS sites or whether there is another way of recruiting, maybe going back to the online idea I had right at the start of the project

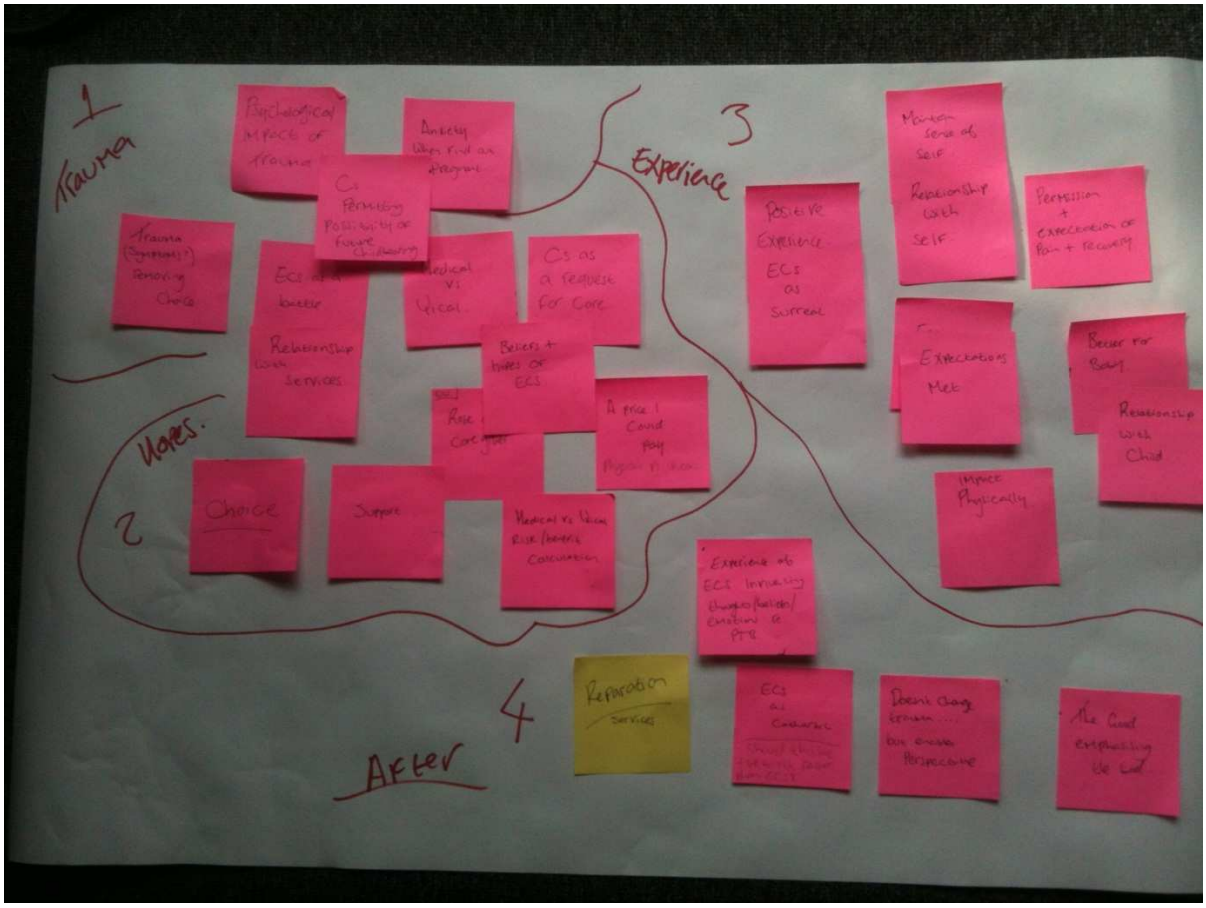
4th December 2012: I interviewed my first participant today!!!!! It made all of the hard work and stress regarding recruitment and ethics worthwhile. It went on a lot longer than I expected but was really interesting and at times quite emotional, I felt really privileged to be party to her story. Interviewing via Skype wasn't as scary or complicated as I had thought and soon into the conversation I forgot we were talking through the computer and it just felt like we were in the same room together. X's experiences were really horrific regarding her first birth and her ECS was such a polarization of this. She was VERY pro ECS and very passionate about women's rights to be allowed to make this decision. I felt completely drawn into her way of thinking and am still feeling quite fired up regarding her experience of having

to fight for her ECS. I need to keep a check on these thoughts and this experience so that I remain open and neutral to different experiences other participants may have.

Appendix N: A selection of photographs depicting process of analysis.


The ongoing dominance of the trauma
PP1
Positive experience
Role of Caregiver
Expectation Met
Surreal
Psychological Impact of trauma
Physiological Impact of trauma
Damage (vagina)
Pain
Better For Baby
Maintain sense of self
Loss of Self
- Self-esteem
- Confidence
Relationships
Thoughts + emotions about birth.
Desire for More Children.
Can't contemplate.
Hastily Moving Forward into the unknown: the drive to reproduce.
Interaction of the 2
"A price I could Pay"
Feeling deceived/Misled
Hidden information.
Medical vs


The ongoing dominance of PTB
PP3
The ECS
Making sense of why traumatic
Reflection on Impact
ECS +ve
"Excellent"
Role of Caregiver
- Felt helpless
- Disempowered
- Family traumatised
- Couldn't Contemplate further Children.
Respected
Respectful.
Transparency.
Drive to reproduce
Anxiety upon Subsequent pregnancy
Physical vs Psychological
Control
Avoidance of stimuli relating to PTB
ECS Permitting Future Childbearing
Fighting For ECS
The good highlights the bad
+ve as Reparative
Interaction of 2
Fight Medics.
Reparative rel with services.


1
Trauma
Psychological impacts of trauma
Anxiety
3
Experience
Positive Experience ECs as surreal
Mixed sense of self
Relationship with self
Permission + expectation of pain + recovery
Trauma (Symptoms?) Removing choice
Relationship with Services
Medical vs Vital
Cs as a resource for Care
Beliefs + fears of ECs
Expectations Met
Better for Baby
Relationship with Child
Hopes.
2
Choice
Support
Impact Physically
4
After
Reparation
Services
ECs as Control

Appendix O: NHS ethics and two local Research and Development departments' favourable opinion letters.

This has been removed from the electronic copy.

Appendix P: Ethics approval letter from Canterbury Christ Church University.

This has been removed from the electronic copy

Appendix Q: Consent Forms

To be sent to all participants partaking in a Skype interview to read through and agree to consent verbally.

Consent Form (Skype/telephone)

Research Title: Experiences of women who request a caesarean section following a previous traumatic birth.

Name of Researcher: Kate Rhodes

Contact Details:

Address: Canterbury Christ Church University,

Salomons Campus at Tunbridge Wells,

Broomhill Rd,

Southborough, Tunbridge Wells,

Kent.

TN3 0TG.

Tel:

Email: ekr5@canterbury.ac.uk

Participant's Statement: *Please read each statement thoroughly.*

1. I confirm that the above study has been explained to me by the researcher and via the information sheet.

2. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions which have been answered satisfactorily.

3. I understand that my participation is voluntary and that I am free to withdraw at anytime, without giving reason, without my legal rights being affected.

4. I agree to the interview being voice recorded.

5. I understand that any personal information that I provide to the researcher will be kept strictly confidential.

6. I agree to provide verbal consent to partake in this research during the Skype interview.

7. I agree to my anonymised responses being quoted in the report of the research and understand that this report may be published.

To be completed by researcher:

---------- ----------

Name Date verbal consent provided during interview

Researcher's statement:

I confirm that I have carefully explained the nature of the research project and explained what is required of the participant.

----------	----------	----------
Name	Date	Signature

Copies: 1 for participant

1 for researcher

Consent Form (questionnaire)

Research Title: Experiences of women who request a caesarean section following a previous traumatic birth.

Name of Researcher: Kate Rhodes

Contact Details:

Address: Canterbury Christ Church University,

Salomons Campus at Tunbridge Wells,

Broomhill Rd,

Southborough, Tunbridge Wells,

Kent.

TN3 0TG.

Tel:

Email: ekr5@canterbury.ac.uk

Participant's Statement: *please read thoroughly*

8. I confirm that the above study has been explained to me by the researcher and via the information sheet.

9. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions which have been answered satisfactorily.

10. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my legal rights being affected.

11. I agree to my anonymised responses being quoted in the report of the research and understand that this report may be published.

12. I understand that any personal information that I provide to the researcher will be kept strictly confidential.

13. I understand that by returning the questionnaire I am implying consent to partake in this research.

To be filled in by researcher:

---------- ----------

Participant Name / ID Date questionnaire was returned

Researcher's statement:

I confirm that I have carefully explained the nature of the research project and explained what is required of the participant.

----------	----------	----------
Name	Date	Signature

Copies: 1 for participant

1 for researcher

Appendix R-T

These have been removed from the electronic copy.

END OF DOCUMENT