BIRTH TRAUMA FROM THE PERSPECTIVE OF PERINATAL COUNSELLORS: A MINI FOCUS GROUP STUDY

Grace Baptie, Elena Mueller Januário, Alyson Norman
University of Plymouth

Abstract
One in five women in the UK develop mental health problems during pregnancy or in the first year after childbirth. 'Birth trauma' is a common birth-related mental health issue which stems from perceiving childbirth as a traumatic experience; the term 'birth trauma' also encompasses living with and experiencing the accompanying symptoms of trauma after childbirth. A mini focus group study was conducted with two experienced perinatal counsellors to discuss their experiences working with parents struggling with birth trauma. Analysis of the focus group revealed five key themes: the complexity of birth trauma; the power of communication; changes in culture; falling through the gaps and coping with trauma. The themes identified reflect previous academic research on parent and clinician experiences of birth trauma as well as national reports aimed at improving maternity care for parents.

I. Introduction

Perinatal mental health is a societal issue affecting one in five women in the UK with an estimated cost of £1.2 billion to NHS and social services each year (Bauer *et al*. 2014). A recent national report revealed suicide as the leading cause of maternal deaths occurring within the first year after giving birth (MBRRACE-UK 2019), and it is estimated that in approximately 40% of these cases, improvements in maternity care may have made a difference to the outcome (Royal College of Obstetricians and Gynaecologists 2017). To address this, new initiatives have increased capacity of specialist mother and baby units nationally and ensured specialist perinatal mental health teams operate in maternity units across England (NHS 2020). These initiatives are heading in the right direction and point towards safer maternity care. However, gaps remain in perinatal mental health services, predominantly in addressing women's mental health needs after giving birth (Care Quality Commission 2020). This is particularly important in light of recent research reporting approximately one third of mothers appraising their birth experiences as traumatic (Baptie *et al*. 2020).

A recent review suggests 4-6% of women will develop postnatal posttraumatic stress disorder (PTSD) following a traumatic birth experience, yet many more women present with sub-clinical trauma symptoms and report significant distress related to their birth experience (Ayers, 2004; White *et al*. 2006; Dekel *et al*. 2017). The most dominant factor associated with birth trauma relates to the mother's subjective experience, namely her perception of feeling supported and in control during labour and birth (Garthus-Niegel *et al*. 2013, Czarnocka and Slade 2000). This emphasises the need for appropriate birth aftercare and support for all women regardless of birth outcome or level of medical intervention experienced during birth.

The provision of specialised maternity care across the UK is patchy, and there is a great deal of variation both within and between distinct geographical areas

Mental Health Alliance 2014). Many women experiencing birth trauma are cared for in primary care through psychological therapy services (IAPT) or private therapy rather than specialised maternity services. As a result, a large number of different, independent agencies are involved in the commissioning and provision of specialised mental health care during the perinatal period (Bauer *et al*. 2014). Therefore, in order to gain an understanding of perinatal mental healthcare, it is important to document the experiences of healthcare professionals both within and outside of NHS services. Equally important is the method of data collection from healthcare professionals to ensure healthcare worker voices are not lost within the statistics. This study aimed to provide a platform for perinatal counsellors from an independent organisation to discuss their perspective and experiences in working with parents struggling after experiencing a traumatic childbirth. The purpose of this focus group was to garner a more in-depth understanding of birth trauma from perinatal mental health counsellors. This study runs parallel to an interview study with mothers during the perinatal period conducted by the same research group. The focus group method was also deemed as a more appropriate approach to collect meaningful data on the specific issue of birth trauma, as opposed to individual interviews or surveys (Jayasekara 2012).

II. Methods

In order to gather information about birth trauma from the perspective of perinatal counsellors, a mini focus group was conducted with volunteer counsellors from a local perinatal mental health charity in the South West of England. The charity provides counselling support for parents experiencing difficulties during pregnancy, after difficult childbirth or after baby loss. Counsellors from the charity were invited to take part in the study via email, and were sent an information sheet detailing the purpose of the study three weeks prior to the focus group. The counsellors consented to participation at the beginning of the meeting and were reassured that all information provided would be kept confidential and anonymised.

Data Collection

The mini focus group was conducted on January 28th 2020. Two counsellors were unable to attend the meeting and so the focus group was conducted with two perinatal counsellors (S and J). Counsellor J has 12 years counselling experience and counsellor S has 9 years counselling experience. A moderator (first author) conducted the mini focus group and an observer (second author) took detailed notes. A discussion guide containing questions regarding the counsellors' experiences of working with birth trauma was used to conduct the focus group. The discussion guide included the following topics: symptoms clients typically present with; commonalities in client experience; changes or trends in clients using the service and views on current practice. Discussions proceeded for 1.5 hours and the counsellors talked about their experiences openly and freely. The moderator balanced the discussion so that all topics in the discussion guide were addressed but allowed freedom of conversation between the counsellors. Notes were made throughout and the meeting was recorded on a Zoom microphone.

Data Processing and Analysis

The recording of the mini focus group was transcribed, and notes made by the observer and moderator were collated and compared. The transcripts were analysed separately by the moderator and another

member of the research team who was not present at the focus group, to improve consistency and protect against contamination of projection (Roberts *et al*. 2019). Both analysts followed a sophisticated reflexive approach to thematic analysis of the transcript (Braun and Clarke 2012). The first phase involved immersing in the data by listening to the audio recording of the meeting and reading and rereading the transcripts whilst noting any potential points of interest. The next step involved sorting the data into codes before clustering codes into broader categories that reflect a meaningful pattern in the data. Tentative categories were then compared between the two analysts and themes were checked against the collated extracts of data. Any differences between analysts were discussed and resolved after further scrutiny of the data. This led to further distinction of themes that were then reviewed by the observer (second author) for external validation of the analysis. For further validation, the thematic framework was sent to both counsellors who partook in the mini focus group to ensure their experiences had been correctly understood and interpreted, (member checking), (Doyle 2007).

Ethical Considerations

The departmental ethics committee at the University of Plymouth approved this study. Participants were informed that all information would be kept confidential and anonymised. A £50 donation was gifted to the charity after the focus group as a gesture of thanks to the counsellors for their time.

III. Results

Five main themes were identified: 1) The complexity of birth trauma; 2) The power of communication 3) Changes in culture; 4) Falling through the gaps and 5) Coping with trauma.

Table 1: Table of themes and subthemes generated from thematic analysis

The Complexity of Birth Trauma
Guilt, jealousy and self-blame
Hypervigilance and avoidance of environmental triggers
Fear of future pregnancy
Disrupted memory of the birth
Change in Culture
Partners seeking help
Vicarious trauma
Changes in what is considered 'traumatic birth'
Recognising the diversity of birth experiences
Falling Through the Gaps
Not reaching the high threshold for referral
Inconsistency in healthcare experience
Fragmented healthcare pathways
Coping with Trauma
Importance of accepting emotions
Recognition, sharing your story and helping others
Raising awareness of alternative outcomes
Partner differences in coping
Visualising an alternative outcome
Recognising and remembering baby loss

Theme 1. The Complexity of Birth Trauma: 'It has a knock-on effect to every area of your life'

This theme summarises the counsellors' discussion of the difficulties and symptoms presented by clients experiencing trauma. Guilt was a recurring theme surrounding parents' experiences of traumatic childbirth and in cases of baby loss. For example, being around other pregnant women or families with babies can evoke guilt, which may subsequently trigger feelings of jealously. There was also in-depth discussion surrounding parents' self-blame regarding the trauma they have experienced.

"a lot of people generally will blame themselves for whatever has gone on and then feel very guilty, about- they should have done this or done that or maybe they should have done this - and maybe they should have recognised this and then blamed themselves, so there's a lot of unpicking of that that has to happen."

Counsellor J: 508-512.

Additionally, there were discussions surrounding the challenges mothers face when accepting and processing the emotions they feel in terms of guilt; more specifically, guilt for having negative thoughts or feelings after the birth of their baby.

"…they've survived, they're ok now, the baby's ok now, but they're still suffering with flashbacks, or can't sleep, or can't eat, or can't go out, or absolutely petrified of a future pregnancy, because what if it happens again?"

Counsellor J: 587-589.

The complexity of birth trauma was expressed in the cumulative nature of trauma symptoms affecting all aspects of clients' lives.

"…she was very overprotective of both of them, so much so that she'd be checking them constantly all through the night. So, obviously that had a knock on effect because then she wasn't sleeping, but still having to function and work."

Counsellor S: 322-324.

The counsellors also recollected the range of difficulties presented by clients, and discussed women experiencing hypervigilance and avoidance of their birth environments as well as fear of future pregnancy.

"…if she needed anything from the house she sent her partner… because she said I just can't go back there to where it happened."

Counsellor S: 679-681.

The final subtheme surrounded clients' vulnerability to memory disruption in the form of intrusive flashbacks of their birth experience or disrupted memory of the birth. The counsellors discussed clients who had reoccurring or fragmented memory of their birth or who had experienced memory aberrations: seeing themselves as the perpetrator of the trauma they experienced. Clients' vulnerability to memory disruption coincided with the importance of communicating or reiterating the event that occurred during their birth with healthcare professionals.

"…there is the Afterbirth service at the Hospital isn't there, and people can talk through their experience with them, and I guess some people haven't got a full memory of what happened, because it's quite distressing, but then they can talk through their labour and get some understanding. I know for one lady that was really helpful - to go over exactly what happened and make sense of it. Because she'd remembered it slightly differently to the reality of what had happened."

Counsellor J: 259-262.

Theme 2. The Power of Communication: 'After a few months of counselling, and being heard, she did gradually get stronger'

The second theme concerns the healing and cathartic nature of clients communicating their trauma. A recurring theme surrounded the power of feeling heard and the importance of helpful, supportive relationships in which clients feel comfortable in sharing their stories without fear of judgement.

"…it's really important for people to have their stories heard, and I think they need to be heard, even though we don't want to re-traumatise people, but I think they need to be heard and they need to tell their story."

Counsellor J: 222-225.

"…some people will just live with it on their own, and don't have anyone to talk to, and other people have got others around them who can be supportive. But then also, that can be hard, because if they're talking to them, and they're being very, I don't know, judgemental or not listening, or you know "you should have got over that, it happened 3 months ago, you know you should get on with that now," you know, that's not helpful."

Counsellor J: 565-570.

Communicating their trauma allowed clients to process their emotions and rebuild connections with their partners who may otherwise avoid talking about their traumatic birth experience.

"…talking it through together they- again they don't realise the other one felt like that, and then that facilitates conversation. So they both feel heard, and they both feel understood then, so then that opens up some sort of connection."

Counsellor J: 206-209.

The power of communication coincided with the importance of finding the right medium for clients to tell their story. The counsellors recollected the diversity in channels used by clients that allow them to communicate their trauma and raise awareness of their experiences. These outlets included poetry; blogging; journaling; radio and fundraising events, all of which were described as ways to help clients to recognise and normalise their experience or emotions, whilst also helping others going through similar experiences.

"…one of our clients, previous clients, she wrote a poem about envy, and it was really powerful and she gave permission for other people to read it, so that it helped them know it was normal, given what they were going through. And then, once they accept that kind of thing, then it moves away usually"

Counsellor J: 334-338.

'…We always recommend journaling, don't we, to clients, because…I know, you know, how helpful it can be, and most people do try or give it a go don't they. For the men I've found, that they don't so much want to do it. So a couple of the men I've seen have done a blog and found that really helpful'

Counsellor S: 679-681.

A contrasting subtheme that arose regarding clients' communication of their experiences was the challenge many clients faced when recounting the story of their traumatic birth. This particularly related to clients who had a disrupted memory of their birth, and clients who found the process of sharing their story too distressing. However, these anecdotes were often paired with the sense of relief that followed from a client finally being able to disclose what happened to them.

"…her client wanted to share her story but didn't know how to, because it was so traumatic"

Counsellor J: 219-220.

"…there's lots of people - that we know of, who have just sat on things for several years, and never shared it. And when they have come to share it, it's been really difficult because they've shut it down so much. But then the relief again of sharing it, and then they can move on again, it just feels- I guess important for people to know it's ok to share something if they need to."

Counsellor J: 284-289.

Theme 3. Changes in Culture. Recognising Trauma and Partner Trauma: 'They are not physically experiencing it, but they were there witnessing it, which can be just as traumatic'

The third theme describes the expression of a cultural shift in either partner experience of trauma or what is considered a traumatic birth experience. Although discussions were largely focused on women's experience of birth trauma throughout the mini focus group, both counsellors recounted their experience working with couples or with fathers individually, which was noted as a relatively recent change in their perinatal counselling practice.

"…a few years ago, like when couples came in, often the man would, you know, come for the first session with the woman, the first few sessions, and then they would drop off and the woman would come on her own. But actually more recently - it's the guy who's actually got in contact to organise the counselling and – kind of instigated it, really. And they've both come together, and they've come together throughout all the sessions, it's been really consistent. So that's quite interesting isn't it."

Counsellor S: 113-123.

The impact of birth trauma on the father was discussed with reference to men's mental health and the difference in coping styles and responses to trauma between men and women.

"…the guys are actually quite traumatised from the birth and can't talk about it, but are clearly visibly shocked over things that have happened. And there doesn't appear to be any dedicated support for the guys"

Counsellor J: 108-110.

Discussion of secondary trauma typically surrounded the fathers' experience of birth trauma and the impact it has on fathers and their relationships with their partners. However, in addition to fathers' secondary trauma, there was also mention of vicarious trauma experienced by other family members present at the birth.

"…a young girl who'd gone through a traumatic birth, and her mum and her grandma were there supporting her, so then they were all traumatised as well, so they've been coming in for counselling too, so it was like three generations coming in. So I guess it shows it has an effect on people in a room."

Counsellor J: 297-301.

A recurring theme throughout the focus group involved observing what birth experiences are considered as 'traumatic enough' by healthcare professionals as well as by clients. A shift in birth counselling practice has seen greater diversity in client experience reflecting a more general cultural shift of what is considered traumatic birth.

"…the diversity of things that people are coming in for has changed as well. So, I don't know if you'd say it's got more complex, but we've seen more people who come in because they've gone through more traumatic birth, so they haven't necessarily suffered a loss, but they've gone through a really traumatic time, and then are struggling, and then maybe get pregnant again, and there are lots of anxieties around that."

Counsellor S: 50-55.

Stories of clients' birth experiences were unique and diverse, but typically involved high levels of fear and feelings of lacking control or feeling let down by the people around them. This highlighted the significance of a woman's perception of her birth environment as a key factor for the appraisal of her birth as traumatic.

"…they probably just didn't think did they. In the chaos of it all they wouldn't have thought that it might have an effect on her."

Counsellor S: 617-618.

Discussion of what is regarded as 'traumatic enough' coincided with clients experiencing difficulties in processing their emotions, leading clients to feel ashamed for having negative thoughts and feelings after a traumatic birth.

"…particularly with traumatic birth, because, it's a traumatic situation, but they've had their baby, and everything seems fine, but they're left with all these other feelings, that nobody else experienced… 'why should I be saying all this, why should I be feeling all this?' But actually they are, and somehow they need to process that."

Counsellor J: 577-581.

Theme 4. Falling Through the Gaps: 'If you don't meet that high threshold, that doesn't mean you haven't got distress going on'

The fourth theme describes discussions of current healthcare practice and ways parents struggling with birth trauma may fall through the gaps, resulting in parents not accessing the help they need. This includes cases of mothers with mild-to-moderate trauma symptoms falling below the threshold for referral to mental health services, or women whose existing mental health difficulties were not appraised by health care professionals during and/or before their birth.

"The perinatal mental health team, I think, take - care of the women who are very - have very severe difficulties, because there's quite a high threshold. So I think there's probably a bit of a gap in the services somewhere."

Counsellor S: 64-67.

"…she'd (client) had a traumatic birth and treatment at the hospital wasn't very good. She was discharged when she shouldn't have been because she'd had a mental health issue, so there were so many things going on."

Counsellor S: 409-411.

Additionally, within this theme were conversations surrounding the disparity in healthcare experience, reflecting the inconsistencies in aftercare procedures for postnatal mental health following childbirth.

"…there seems to be a disparity with how people are treated. So some people get really, really good treatment some people are very supported and helped very sensitively, after whatever they've experienced. But other people, you know, have been left in a room on their own when they're really distressed."

Counsellor J: 27-31.

Particularly salient during the mini focus group was the inconsistency in method of referrals made to the charity, highlighting one of the symptoms of a fragmented healthcare pathway. Discussions of the ways in which clients are referred to the counselling service revealed a disjointed system that relies on awareness of individual healthcare professionals to direct patients to the charity, or through word of mouth from previous or existing clients.

"…there is a referral form that we've received from the Hospital for a couple of people, haven't we, I don't know where that's come from? Probably the midwifery team… But quite often people come through their colleagues or people who've been here, you know, if their friend is going through something similar"

Counsellor J: 82-94.

During discussions regarding improvements that could be made to better support parents struggling with birth trauma, both counsellors identified joining perinatal health services as an important change to create a more robust healthcare pathway for parents struggling with mental health difficulties during the perinatal period.

"…we've been around for 12 years, and although lots of people do know of us, I mean we're a small charity and we can't- haven't got the resources or time to go out to doctors all the time. And people change, people move on don't they, so some- some people in the city really know us well don't they, some people in the midwifery services know us well. And then there's others that don't, so, you know there's people who've came along recently who said, "I never knew anything about you, you know, nobody told us about you"- so, you know I guess making sure there's a robust care pathway for people that need different help for different stages of pregnancy and beyond."

Counsellor J: 689-699.

Theme 5. Coping with Trauma: 'It helped them know it was normal, given what they were going through. And then, once they accept that kind of thing, then it moves away'

The final theme from the mini focus group concerns how clients cope with trauma following either a traumatic birth experience or baby loss. Learning to accept emotions was recognised as a key factor for clients coping with trauma.

"…we found in terms of people owning whatever emotion it is, that that helps them to move through it, otherwise they hold onto it and try and push it all away."

Counsellor J: 333-334.

The counsellors recollected coping strategies used by clients, and discussed the significance of clients recognising what they had been through. Clients recognising their experiences often preceded the motivation to share their story and raise awareness of their experience in the hope of informing and helping other parents.

"…as well as telling her story she wants to raise awareness about that… she has found that really helpful and really healing to be able to go, although obviously it's really painful, you know going over some of that stuff. Like you said it's about being heard isn't it?"

Counsellor S: 250-255.

Raising awareness of alternative outcomes during pregnancy was a particularly salient discussion point; this topic arose during recollections of clients who had experienced miscarriage and went on to raise awareness of pregnancy warning signs for expectant mothers. During discussion of improvements to current

perinatal practice, the counsellors deliberated the importance of informing expectant parents, in a sensitive manner, about all eventualities of pregnancy and birth and the potential danger of focusing on a rigid birth plan without awareness of alternative outcomes.

"it's obviously a very sensitive thing to bring in, because you want someone to go through that pregnancy and be positive, hopeful and supported all the way through and hopefully they'll have a live baby, but the- I don't know, lack of awareness of people, that something could go wrong. People don't seem to know that, and it's a really fine area because you don't want someone to have to experience that."

Counsellor J: 707-712.

The counsellors considered how raising awareness and raising money for relevant charities, or causes in line with clients' own perinatal experiences, seemed particularly cathartic to fathers who had experienced traumatic birth or baby loss.

"So it always seems to be the guy who maybe wants to be really proactive, and do something really physical and you know raising awareness and raising money at the same time."

Counsellor S: 493-495.

This overlapped with a more general discussion surrounding the differences in coping strategies between male and female clients. The counsellors recalled how fathers were more likely to withhold from sharing their trauma stories, and may take longer to communicate their feelings to try to remain strong for their partners.

"...guys don't like to always share, because they don't wanna upset their partners, because they know their partners are already upset as well, so they will withhold a little bit don't they."

Counsellor J: 178-180.

Regarding traumatic birth experiences, the counsellors discussed the value of visualising an alternative birth story that more closely resembled both parents' ideal birth.

"...we really broke it down, and wrote it down-- and then how they would have liked it to have been if they could visualise that positive birth, how they - you know in their ideal world what they would have liked to have worked out, just to give them that kind of alternative image in their mind. But they—both of them found that really helpful, but they kind of want to take it on from that and be able to put that story out there"

Counsellor S: 238-243.

The final subtheme for coping with trauma describes the importance of recognising and remembering baby loss. The counsellors discussed the various techniques used in their practice to encourage and support remembrance as well as local baby bereavement charities that offer space for parents to remember their lost baby. There was also particular emphasis put on the value of having the space and time to grieve the loss of a baby through miscarriage.

"We have that memory book over there don't we that they can write in- people don't very often but they can write in that if they want to as well, so the baby is remembered here in some way. And they've got 'Little Things' up at Derriford as well where they can place a pebble with the baby's name or date of birth on."*

Counsellor J: 333-334

**Little Things and Co. A baby bereavement charity based in Devon who set up 'Little Haven', a dedicated space for bereaved families..*

IX. Discussion

This mini focus group study aimed to provide a platform for perinatal counsellors to voice their unique perspective and experiences of birth trauma. The first theme comprised the myriad of symptoms presented by clients who have experienced birth trauma. Many of the symptoms mentioned match the symptom profile of PTSD (American Psychiatric Association 2013): re-experiencing the birth; avoidance of environmental triggers; memory disturbances of the birth; hypervigilance with the baby and fear of future pregnancy. In addition to the presentation

of trauma symptoms, this focus group emphasised the significance of guilt and shame following traumatic birth experience. Trauma research suggests that intense feelings of shame and guilt impede emotional processing of a traumatic event and can prolong symptoms of PTSD (Lee *et al*. 2001). This may be particularly salient in traumatic childbirth due to the dominant cultural representations of motherhood as a time of joy conflicting with the tendency for mothers to experience maternal guilt after having a baby (Sutherland 2010).

The second theme reflects the power of communication in the context of clients being able to share their birth story and the significance of feeling heard. Qualitative research concerning traumatic birth highlights the detrimental impact of poor communication between women and clinicians; this leaves mothers feeling invisible and ignored during labour and after birth (Coates *et al*. 2014; Beck 2004). In this mini focus group, counsellors S and J placed particular emphasis on the cathartic nature of clients being able to share their stories and talk through their birth experiences in a safe and non-judgemental environment. Counsellor J recollected signposting a client to a 'Birth Afterthoughts' service at the local hospital which offers mothers the opportunity to talk through their birth with a midwife; this helped the client process what had happened to her during her birth.

"...I know for one lady that I know of, that was really helpful - to go over exactly what happened and make sense of it."

Providing women the opportunity to talk about their birth experiences and ask about the care they received are recommended practices in current UK guidelines for delivery of maternity care (NICE 2015). A large majority of maternity units in the UK now offer a listening service (Ayers *et al*. 2006), yet research into the effectiveness of postnatal debriefing has garnered mixed results (Bastos *et al*. 2015). This is suggested to be due to the variance in the level of skill/training of care providers to deliver appropriate debriefing rather than an inherent issue with talking about the birth experience (Kitzinger and Kitzinger 2007). This echoes the prerequisite of a safe and non-judgemental environment for parents to communicate their birth experiences. In a recent national maternity survey, postnatal care was an area highlighted as needing improvement, particularly concerning women's mental health needs with 20% of women reporting that they were not given contact information for perinatal mental health advice after their birth (Care Quality Commission 2020). This highlights the need for specialist postpartum maternity care and consistency of referrals to empower women with the choice to discuss their birth experience and alleviate some of the pressure on general mental health services and small independent perinatal mental health charities.

The inclusivity of all mothers to access birth aftercare, as opposed to limiting aftercare to physical care for mothers who experienced obstetric complications, reflects an acknowledgement of the diversity of birth experiences and the subjective nature of birth trauma (Garthus-Niegel *et al*. 2013). Throughout the mini focus group, the counsellors recollected clients' various accounts of unique birth experiences that have detrimentally impacted clients' mental health. The diversity of birth experiences was discussed in the context of a wider cultural change in the recognition of what is considered a 'traumatic birth'.

"...the diversity of things that people are coming in for has changed as well."

The cultural shift acknowledging the diversity of traumatic birth experiences is complemented by research documenting birth trauma as a unique and highly subjective experience (Beck 2004). That is to say, what healthcare professionals may consider routine practice may be perceived to a woman as traumatic. This further emphasises the importance of recognising the overall birth environment as a potentially traumatising event, regardless of the level of obstetric complications or positive outcome of the birth.

A second cultural shift described by the counsellors is the increase of fathers accessing perinatal mental health support alone and/or with their partners. A review of paternal perinatal mental health estimates that approximately 10% of men experience postnatal depression during the perinatal period, moderately positively correlating with maternal depression (Paulson and Bazemore 2010). Qualitative research with fathers suggest that men prioritise their partners' needs and question the legitimacy of their own perinatal mental health struggles; this leads to a reluctance to seek support and perceived exclusion from support services (Darwin *et al.* 2017; White 2007). The emergence of research into paternal mental health has highlighted the need for a paradigm shift to focus on perinatal mental health from a family-perspective (Wong *et al.* 2016). It is important to note that discussions concerning partner trauma during the mini focus group were with reference to fathers only. There is limited research on the impact of partner trauma in LGBTQ couples (Darwin and Greenfield 2019); therefore, it is difficult to discern whether the trauma responses discussed are typical of birth partners or of men specifically. Further research is warranted on the impact of birth trauma in LGBTQ couples to ensure appropriate support be offered to all parents.

The fourth theme encapsulates discussions of the UK's current maternity practice that may leave parents vulnerable to 'falling through the gaps' of the healthcare system by not receiving the support they need. The high threshold women need to reach to access post-birth support as well as inconsistencies in maternity care were also discussed within this theme.

"...there seems to be a disparity with how people are treated. So some people get really, really good treatment some people are very supported and helped very sensitively, after whatever they've experienced. But other people, you know, have been left in a room on their own when they're really distressed."

A report by the Royal College of Midwives (RCOM) stated that nearly one third of student midwives did not feel they had sufficient theoretical knowledge to recognise issues relating to perinatal mental health (RCOM 2014). A recent poignant statistic revealed that 80% of midwives felt they needed more support with workload management and risk-assessment (RCOM 2020). The report posits the solution of including greater emphasis on mental health in the pre-registration syllabus for midwifery and employing at least one specialist perinatal mental health midwife in every maternity unit. Alongside this, a prerequisite in supporting women in maternity care is appropriate staff numbers to provide personalised care for mothers in labour and ensure consistency of care (Smith *et al.* 2009). The need for greater personalisation is also highlighted in the NHS guidelines for Better Births (Cumberlege *et al.* 2016). Amid discussions of ways to improve maternity care, counsellors S and J highlighted the need to join-up perinatal services to create a more

robust and consistent care pathway.

"...making sure there's a robust care pathway for people that need different help for different stages of pregnancy and beyond."

The need to integrate maternity care services has been echoed in the most recent 'Better Births' report which calls for digital maternity records across England. Electronic maternity records make it easier for healthcare professionals to share data with other clinicians and the women in their care (Cumberlege *et al.* 2016). In addition to joining antenatal and postnatal services, providing a digital platform for maternity records can also reassure women that healthcare providers have access to previous mental health concerns or previous birth trauma, as well as a clear and recent outline of their personalised care and support plan. NHS England have committed to expand this platform to all women by March 2024 (NHS 2020), a positive step in narrowing the gap in perinatal mental healthcare and creating a more robust care pathway for every family.

Finally, the counsellors in this mini focus group recount the ways parents cope with the trauma they experienced. The counsellors discussed how clients found strength in pragmatic approaches of fundraising and raising awareness to educate other expectant parents of all birth eventualities. These included teaching 'counting kicks' in pregnancy to raise awareness of foetal distress and sharing poetry to vocalise unexpected postpartum emotional responses (such as jealousy or guilt). This final theme highlights the importance of considering the narrative surrounding childbirth and what is presented to women as a normal or ideal pregnancy and birth. Women may be more reluctant, or find it more uncomfortable, to communicate their traumatic birth when the reality of their experience deviates from their perceived ideal (Peeler *et al.* 2018). Therefore, it may be more appropriate to open the discourse of all birth eventualities, in a sensitive and supportive manner, throughout the perinatal period.

X. Conclusion

The findings from this mini focus group highlight the complexity of birth trauma in a changing perinatal culture, and the ways parents can be vulnerable to 'falling through the gaps' in terms of accessing appropriate maternity care. Additionally, the findings highlight clients' resilience in their methods of coping with birth trauma and the power of communication as a form of catharsis for suffering parents. The themes identified reflect previous academic research on parent and clinician experiences of birth trauma as well as national reports aimed at improving maternity care for parents.

Acknowledgements

We would like to give a special thank you to counsellors 'S' and 'J' for their time, dedication and honesty.

Birth Trauma Support

Below is a short list of support services available for those suffering with birth trauma:

- Birth Trauma Association (BTA): https://www.birthtraumaassociation.org.uk/
- Make Birth Better: https://www.makebirthbetter.org/
- Birthrights: https://www.birthrights.org.uk/

References

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders*, Washington, DC.

Ayers, S. 2004. Delivery as a traumatic event: prevalence, risk factors, and treatment for postnatal posttraumatic stress disorder. *Clinical Obstetrics and Gynecology*, 47: 552-567. https://doi.org/10.1097/01.grf.0000129919.00756.9c

Ayers, S., Claypool, J. and Eagle, A. 2006. What happens after a difficult birth? Postnatal debriefing services. *British Journal of Midwifery*, 14: 157-161. https://doi.org/10.12968/bjom.2006.14.3.20577View article

Baptie, G., Andrade, J., Bacon, A. and Norman, A. 2020, *in press*. Trauma after childbirth: The mediating effects of perceived support. *British Journal of Midwifery*.

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

Bauer, A., Parsonage, M., Knapp, M., Iemmi, V. and Adelaja, B. 2014. *Costs of perinatal mental health problems*. http://everyonesbusiness.org.uk/wp-content/uploads/2014/12/Embargoed-20th-Oct-Final-Economic-Report-costs-of-perinatal-mental-health-problems.pdf.

Beck, C.T. 2004. Birth trauma: in the eye of the beholder. *Nursing research*, 53: 28-35. https://doi.org/10.1097/00006199-200401000-00005

Braun, V. and Clarke, V. 2012. Thematic analysis. In Cooper, H., Camic, P.M., Long, D. L., Panter, A.T., Rindskopf, D., and Sher, K.J. Eds. A*PA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological*. Washington DC: American Psychological Association. https://doi.org/10.1037/13620-000

Care Quality Commission, C.Q.C. 2020. *2019 survey of women's experiences of maternity care*. January 2020. https://www.cqc.org.uk/sites/default/files/20200128_mat19_statisticalrelease.pdf.

Coates, R., Ayers, S. and de Visser, R. 2014. Women's experiences of postnatal distress: a qualitative study. *BMC Pregnancy and Childbirth*, 14: 359. https://doi.org/10.1186/1471-2393-14-359

Cumberlege, J., Chantler, C. and Baum, A. 2016. Better Births: Improving Outcomes of Maternity Services in England–A Five Year Forward View For Maternity Care. *The National Maternity Review*, https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf.

Czarnocka, J. and Slade, P. 2000. Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology*, 39(1): 35-51. https://doi.org/10.1348/014466500163095

Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L. and Gilbody, S. 2017. Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: a qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC Pregnancy and Childbirth*, 17: 45. https://doi.org/10.1186/s12884-017-1229-4

Darwin, Z. and Greenfield, M. 2019. Mothers and others: The invisibility of LGBTQ people in reproductive and infant psychology. J*ournal of Reproductive and Infant Psychology*, 37(4): 341-343. https://doi.org/10.1080/02646838.2019.1649919

Dekel, S., Stuebe, C. and Dishy, G. 2017. Childbirth induced posttraumatic stress syndrome: a systematic review of prevalence and risk factors. *Frontiers in Psychology*, 8: 560. https://doi.org/10.3389/fpsyg.2017.00560

Doyle, S. 2007. Member checking with older women: a framework for negotiating meaning. *Health Care for Women International*, 28(10): 888-908. https://doi.org/10.1080/07399330701615325

Garthus-Niegel S., von Soest, T., Vollrath, M.E. and Eberhand-Gran, M. 2013. The impact of subjective birth experiences on post-traumatic stress symptoms: a longitudinal study. A*rchives of Women's Mental Health*, 16(1): 1-10. https://doi.org/10.1007/s00737-012-0301-3.

Jayasekara, R.S. 2012. Focus groups in nursing research: Methodological perspectives. *Nursing Outlook*, 60(6): 411-416. https://doi.org/10.1016/j.outlook.2012.02.001.

Kitzinger, C. and Kitzinger, S. 2007. Birth trauma: Talking with women and the value of conversation analysis. *British Journal of Midwifery*, 15(5): 256-264. https://doi.org/10.12968/bjom.2007.15.5.23397

Lee, D.A., Scragg, P. and Turner, S. 2001. The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD. *British Journal of Medical Psychology*, 74(4), 451-466. https://doi.org/10.1348/000711201161109.

Maternal Mental Health Alliance, M.M.H.A. 2014. *UK specialist community perinatal mental health teams.* https://maternalmentalhealthalliance.org/wp-content/uploads/UK-Specialist-Community-Perinatal-Mental-Health-Teams-2017.pdf.

MBRRACE-UK 2019. *Saving Lives, Improving Mothers' Care.* https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf.

NHS. 2020. *Better Births Four Years On: A review of progress.* NHS England. https://www.england.nhs.uk/wp-content/uploads/2020/03/better-births-four-years-on-progress-report.pdf.

NICE. 2015. *Postnatal care up to 8 weeks after birth.* National Institute for Health and Care Excellence https://www.nice.org.uk/guidance/cg37/resources/postnatal-care-up-to-8-weeks-after-birth-pdf-975391596997,

Paulson, J.F. and Bazemore, S.D. 2010. Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. *JAMA*, 303(19): 1961-1969. https://doi.org/10.1001/jama.2010.605.

Peeler, S., Stedmon, J., Chung, M.C. and Skirton, H. 2018. Women's experiences of living with postnatal PTSD. *Midwifery*, 56: 70-78. https://doi.org/10.1016/j.midw.2017.09.019.

Roberts, K., Dowell, A. and Nie, J.B. 2019. Attempting rigour and replicability in thematic analysis of qualitative research data; a case study of codebook development. *BMC Medical Research Methodology*, 19: 66. https://doi.org/10.1186/s12874-019-0707-y.

Royal College of Midwives, R.C.O.M. *Maternal Mental Health: Improving emotional wellbeing in postnatal care.* https://www.rcm.org.uk/media/2356/pressure-points-mental-health.pdf.

Royal College of Midwives, R.C.O.M. 2020. *First Five Years Forum (FFYF): Developing a preceptorship programme for newly qualified midwives in Scotland.* https://www.rcm.org.uk/media/3778/first-five-years-forum-ffyf-a4-24pp-2020_10.pdf.

Royal College of Obstetricians and Gynaecologists, R.C.O.G. 2017. *Maternal Mental Health - Women's Voices.* https://www.rcog.org.uk/globalassets/documents/patients/information/maternalmental-healthwomens-voices.pdf.

Smith, A., Dixon, A. and Page, L. 2009. Health-care professionals' views about safety in maternity services: a qualitative study. *Midwifery*, 25(1): 21-31. https://doi.org/10.1016/j.midw.2008.11.004.

Sutherland, J.A. 2010. Mothering, Guilt and Shame. *Sociology Compass*, 4(5): 310-321. https://doi.org/10.1111/j.1751-9020.2010.00283.x

White, G. 2007. You cope by breaking down in private: fathers and PTSD following childbirth. *British Journal of Midwifery*, 15(1): 39-45. https://doi.org/10.12968/bjom.2007.15.1.22679

White, T., Matthey, S., Boyd, K. and 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. https://doi.org/10.1080/02646830600643874

Wong, O., Nguyen, T., Thomas, N., Thomson-Salo, F., Handrinos, D. and Judd, F. 2016. Perinatal mental health: Fathers–the (mostly) forgotten parent. *Asia-Pacific Psychiatry*, 8(4): 247-255. https://doi.org/10.1111/appy.12204

Biography

Grace is currently completing a PhD in applied psychology. Her research is on predisposing factors for the development of trauma symptoms, with a particular focus on traumatic childbirth and the significance of factors such as support, control and dissociation during birth.