A qualitative investigation of the experiences and impact of negative healthcare provider interactions during a traumatic birth

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ABSTRACT

Background: The experience of birth trauma is common and can have a detrimental impact on a birthing person's psychosocial wellbeing. Research exploring the aetiology of birth trauma has highlighted that negative interactions with healthcare providers is a key risk factor for birth trauma. However, there is limited research exploring the nature of these interactions within the context of NHS maternity services.

Aims: The current study aimed to gain a deeper understanding of how birthing people experience negative interactions with healthcare providers and how negative interactions may contribute to the experience of birth trauma.

Method: Eleven semi-structured interviews were conducted with birthing people who had given birth using NHS services in the last five years. These were analysed using a thematic analysis.

Results: The study identified three main themes: 1) hospital centred care 2) power and the maternity system 3) the lasting impact.

Conclusion: The study findings indicate that negative interactions with healthcare providers during childbirth is central to the experience of birth trauma. Negative interactions were associated with a lack of personalised care and the epistemic privileging of healthcare providers. The experience of negative interactions had a significant impact on participants' wellbeing and altered their trust in health systems.

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1. INTRODUCTION

1.1. Overview/Context Setting

Childbirth is typically positioned as a natural or routine medical event, however in the last 20 years there has been increasing recognition for its potential to be experienced as traumatic. Research has highlighted that around 30% of births are experienced as psychologically traumatic (Alcorn et al., 2010; Soet et al., 2003); with 4% of birthing people describing responses that would meet clinical thresholds for post-traumatic stress disorder (PTSD, Yildiz et al., 2017). As such, research exploring the experience and impact of birth-related trauma has gained considerable traction in recent years. Many potential risk factors for a traumatic birth have been highlighted in the literature, with interactions with healthcare providers being one of the most consistent findings. The current study explores the experiences and impact of negative interactions with healthcare providers during a traumatic birth. Additionally, it looks to understand how negative interactions contribute to the experience of birth trauma.

1.2. Terminology

This thesis will discuss the people using and the people staffing maternity services, with a particular focus on NHS services.

1.2.1. Birthing People

Historically, discourses around pregnancy and birth have been heavily gendered and as such perinatal services have been developed with fixed, binary understandings of who can conceive and carry a child. This has been reflected in the language used in service literature (e.g. patient leaflets), national policy and academic writing. However, in recent years there has been growing acknowledgment of how this language results in exclusion and harm. As such, there has been a push towards using more inclusive language. Many maternity services have adopted a ‘gender-additive’ approach that uses gender-neutral terms alongside terms relating to being a woman, for example ‘women and birthing people’ (e.g. Brighton and Sussex University Hospital, 2021).

This thesis will predominately use the terms ‘birthing people’ or ‘birthing person’ to describe people who are accessing maternity services. However, it is recognised that the birth trauma literature predominately focuses on cisgendered women, with a paucity of research exploring the experiences of trans and non-binary people. As such, descriptions of individual pieces of research will use the language of the paper.

1.2.2. Healthcare Providers

‘Healthcare provider’ is a broad term that can be used to refer to individual professionals or a healthcare service as an organisation. Healthcare provider will be used in the thesis to describe the professionals providing care to birthing people, their baby and their family. The healthcare professionals a birthing person may encounter will somewhat depend on the setting they deliver in (i.e. midwife-led unit, hospital or home), their individual medical needs and the type of birth they have. However, generally NHS labour and delivery services are staffed by a multidisciplinary team (MDT) of Midwives, Maternity Support Workers/Healthcare Assistants, Obstetricians, Anaesthetists and Sonographers. Depending on the baby’s health needs, there may also be input from neonatal and paediatric teams.

1.3. Care of Birthing People – The NHS Context

In the UK, the vast majority of births use NHS services; this includes births taking place in hospital, midwifery units or birth centres and at home. The National Institute for Health Care and Excellence (NICE) sets out evidence-based guidance and decision-making recommendations for antenatal (2021a), intrapartum (2021b) and postnatal (2021c) care of birthing people based on medical needs and clinical risk.

1.3.1. Ethos and Priorities of NHS Maternity Services

Over the last twenty years there has been an increasing recognition of the need for tailored and sensitive care within maternity services. A 2016 national review of maternity services consulted with birthing people and their families, healthcare professionals and stakeholders to produce the Better Births Report (National Maternity Review, 2016). The vision of the Better Births Report was to create maternity services which were “safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care”. A key recommendation of this report was to prioritise personalised care that centres the needs of the birthing person and their family and promotes informed choice. Implementation of the recommendations made has been carried out through a national Maternity Transformation Programme. The NHS Long Term Plan (NHS, 2019), which sets out the NHS's priorities for the next ten years, commits to the work carried out in the Maternity Transformation Programme and places similar emphasis on delivering personalised care.

Alongside the work being done to improve personalised care, there is an increasing acknowledgment of the importance of maternity services becoming trauma-informed systems. Trauma-informed care describes the integration of trauma knowledge into all aspects of the delivery of care, including actively avoiding retraumatisation of service users (SAMHSA, 2012). Best practice guidelines for implementing trauma informed care in the perinatal period aim to support the goals of the Maternity Transformation Plan and NHS Long Term Plan (Blackpool Better Start, 2021). These guidelines set out four key principles of delivering trauma-informed care in maternity services: 1) compassion and recognition; 2) communication and collaboration; 3) consistency and continuity; 4) recognising diversity and facilitating recovery. Each principle is relational in nature and connects to the "development of trusting, respectful and collaborative person-practitioner relationships" (Blackpool Better Start, 2021). Working in line with these principles provides opportunities for better care for all people entering maternity services, irrespective of a person's trauma history.

1.3.2. Medicalisation of Birth

The journey through maternity services for birthing people is continually evolving. For example, compared to the 1990's birthing people will have an appointment with a healthcare professional earlier in their pregnancy, receive a higher number of scans and generally receive more information (Henderson & Redshaw., 2017). Advances in medical technology over the last 50 years has been one of the drivers of such changes in maternity systems. Medical technologies can be used to optimize birth outcomes and support clinicians in their care of birthing people by aiding clinical decision making and risk management (Miesnik & Stringer, 2002). For example, developments in ultrasound technologies have improved care by allowing for the accurate dating of pregnancies, opportunities for bonding, and detection of growth and skeletal abnormalities in unborn infants (Sholapurkar et al., 2021). Although such technological advances have led to significant improvements to antenatal care, their use can also result in dilemmas and challenges for staff.

The widespread availability and use of medical technologies to aid childbirth has promoted a global shift towards biomedical models of birth over the last 200 years (Johanson et al., 2002). The application of the biomedical model is shaped by the socio-cultural contexts in which it is applied (Scamell et al., 2017). The UK, like many other Western cultures, privileges knowledge acquisition through ‘science’ and is ever-increasingly technology orientated. These cultural ideals underpin the development of healthcare systems and have resulted in a ‘hegemonic technocratic model of care’ (David-Floyd, 2001). David-Floyd (2001) used interviews with nurses to illustrate how this model of care can foster a reliance on technological support and results in medical intervention dominating care. Nurses spoke to the power given to the technology they used and described worrying that a baby’s heart may stop if they were to remove the electrical foetal monitoring from the birthing person.

Today intervention during childbirth is common. In the last ten years, the number of spontaneous vaginal deliveries in the NHS have decreased by 19%, with the number of caesareans increasing by 8% and labour inductions increasing by 11% (NHS Digital, 2021). One in three birthing people delivering their first baby will have an assisted vaginal delivery (i.e. with forceps and/or ventouse) (RCOG, 2020). Whereas, one in seven birthing people are given an episiotomy, a surgical incision of the perinium during the second stage of labour (Djanogly et al., 2022).

Despite intervention during childbirth being commonplace, research has highlighted how it may be at odds with the desired culture shift towards prioritising personalised care. For example, individuals who have experienced an episiotomy expressed concerns about lack of true consent and an absence of information sharing (Djanogly et al., 2022). Similarly, nearly one in five people who had an instrumental delivery felt that they received inadequate information on the risks and benefits of the procedure (Avasarala & Mahendran, 2009). A lack of shared-decision making, and a healthcare provider-patient power struggle has also been described in research exploring caesarean delivery (Byron-Daniel, 2021). It could be argued that the routine use of interventions within maternity services leaves birthing people and their families vulnerable to depersonalised care. As models of care are shaped by socio-cultural contexts (Scamell et al., 2017) it is important to consider how the relationship between interventions and depersonalised care may be exacerbated by the current challenges experienced by maternity systems (see section 1.3.3. for a summary of current challenges).

1.3.2.1. *Assumptions of the biomedical model, personalised care, and epistemic injustice:* To understand how the biomedical and technocratic models of birth can lend themselves to depersonalised care, it is helpful to consider the underlying assumptions of the models. In the NHS, maternity care falls under the umbrella of healthcare services referred to as 'women's health'. Throughout history women have assumed to be inherently irrational and pathologically emotional, thus lacking in objectivity (Villarmea & Kelly, 2020; Ballesteros, 2022). Ballesteros (2022) illustrates how this idea is perpetuated in maternity systems through common assumptions made in biomedical models of birth: '(1) childbirth is a process fraught with risk, particularly to the babies; (2) labouring women's reports are unreliable and their subjective perspective does not constitute a source of valuable information; (3) medical knowledge and procedures are the safest means to give birth'.

These assumptions result in a 'stigmatising dilemma' for birthing people, where they are likely to be viewed as irrational or selfish if they express needs or preferences that conflict with choices offered by their healthcare providers. Villarea and Kelly's (2020) container metaphor illustrates this dilemma:

> 'Some would argue that it is the presence/interest of the baby, rather than the presumed irrationality of the mother, that makes us less keen on SDM [shared decision-making] in the labour room. This sets the woman in labour up as a container whose contents the clinician must advocate for. However, the fundamental assumption underpinning that position is that the woman in labour (the container) is less than rational and would be ready to put her interest first' (p. 4).

Furthermore, endorsement of such assumptions by maternity systems prevents personalised care and true choice. For example, well-meaning but paternalistic commitments to 'doing what is best' for patients can prevent staff from acknowledging what is important to the individual in front of them (Joseph-Williams et al., 2017).

The biomedical model of childbirth positions birth as a medical event, as such birthing people occupy a role comparable to the patient role. Similarly to the ‘irrational woman’ stereotype, patients are viewed as lacking objectivity due to emotionality and cognitive unreliability (Carel & Kidd, 2014). The impact of assumptions of irrationality, emotionality and unreliability can be thought about in terms of epistemic injustice.

Epistemic injustice describes someone being wronged in their capacity as a ‘knower’ because of prejudice or bias (Fricker, 2007, cited in Ballesteros, 2022). Reducing birthing people to ‘irrational women’ or ‘unreliable patients’ results in testimonial injustice, a type of epistemic injustice where individual testimonies are deemed uncredible or irrelevant and dismissed or ignored (Carel & Kidd, 2014; Ballesteros, 2022). The biomedical assumptions in maternity systems described by Ballesteros (2022), privileges knowledge held by maternity professionals and medical technologies. As such, the value of subjective and embodied experience is diminished (Carel & Kidd, 2014; Ballesteros, 2022).

1.3.3. Current Issues

Maternity services have been under considerable scrutiny in recent years following multiple high-profile inquiries and investigations into care provided by various hospitals and NHS Trusts (Kirkup, 2015; Kirkup. 2022; Ockenden, 2020; RCOG, 2019). Each of these reports highlighted a pattern of systemic failings of the maternity services in areas such as staffing, culture and clinical processes, alongside repeated missed opportunities for learning and improvement. These failings resulted in inadequate care of birthing people and in some instances avoidable injury or death to the birthing person or their baby.

To understand why these issues persist, the governments Health and Social Care Committee carried out a ‘Safety of Maternity Services in England’ Inquiry (House of Commons, 2021a). Although the report identified that ‘England remains largely a safe place to give birth’ the government’s progress towards improving safety was rated as ‘Requiring Improvement’. The report identifies appropriate staffing as paramount to the delivery of quality care and illustrates how ongoing staff shortages impedes the delivery of safe, personalised care. Similarly, the recent ‘Safe Staffing’ report (APPG on Baby Loss & APPG on Maternity, 2022) describes staffing shortages creating a ‘conveyor belt style’ of maternity care, where there is an increased risk of ‘mistakes and failures in care’. Staffing issues within maternity services are reflective of the wider NHS landscape; currently, the NHS is experiencing significant workforce shortages impacting patient care and challenge the capacity to successfully deliver the Long Term Plan (RCM, 2016; The Health Foundation, 2019; The Kings Fund, 2022). Across the NHS, staff shortages have created a ‘chronic excessive workload’; working under such sustained demand and pressure is considered a significant factor in staff burnout (House of Commons, 2021b).

The additional pressure placed on the NHS during the COVID-19 pandemic is well documented, as is the exacerbation of longstanding inequalities of care. For maternity services, precautions taken to manage the impact of COVID-19 (such as virtual antenatal appointments) created additional barriers to the delivery of high quality, safe and personalised care (Turienzo et al., 2021; Flaherty et al., 2022). These barriers to personalised care negatively impacted on the emotional wellbeing of people accessing maternity services (Sanders & Blaylock, 2021) and left some service users feeling unsupported and ‘lost in the system’ (West Yorkshire and Harrogate Maternity Voices, 2020).

In maternity systems, systemic racism and discrimination contribute to inequalities of care, such as ‘poorer and less respectful treatment’ of people belonging to racially minoritised or socially disadvantaged groups (Turienzo et al., 2021; MacLellan et al., 2022). The impact of systemic racism and discrimination in maternity services has the potential for devastating outcomes; for example, despite national level commitments to reducing neonatal and maternal deaths in the Maternity Transformation Programme, mortality rates remain greater for birthing people belonging to ethnic minority groups. Data from 2018 – 2020 shows that women from Black ethnic backgrounds were 3.7 times more likely to die and women from Asian ethnic backgrounds were 1.8 times more likely to die compared to white women (The Maternal, Newborn and Infant Clinical Outcome Review Programme [MBRACE-UK], 2022). Furthermore, an ongoing increase in deaths was observed for women from socially deprived areas.

The Safety of Maternity Systems in England report made recommendations to move towards closing the gap in care, including prioritising developing better understandings of wider social determinants of health and creating a specific strategy for maternal and neonatal outcomes for birthing people from racially minoritised backgrounds (House of Commons, 2021a). For these recommendations, and other recommendations, to be successful attention will need to be paid to the unique socio-political context of the NHS and the UK; for example, the unprecedented strike action by healthcare professionals, ongoing NHS-wide workforce shortages, and a ‘cost of living crisis’ exacerbating vulnerabilities related to poverty.

1.4. Birth Trauma

1.4.1. Childbirth as a Traumatic Event

Trauma is widely understood as an emotional response to a psychologically distressing event (i.e. a ‘traumatic event’). There is some variation in understandings of what is considered a traumatic event. In diagnostic classification systems traumatic events are conceptualised as extreme experiences where life is threatened or there are serious violations of a person’s bodily integrity. The DSM-5 defines a traumatic event as ‘actual or threatened death, serious injury or sexual violence’ (APA, 2013), whereas the ICD-10 describes an event which is ‘exceptionally threatening or catastrophic nature’ (WHO, 2019). Although these definitions suggest that the traumatic event needs to be experienced directly, it is widely recognised that people can experience trauma vicariously; for example, by healthcare providers involved in traumatic childbirth (Shorey et al., 2021).

Dominant discourses of childbirth position birth as a natural or medically routine event with positive connotations often attached. However, many birthing people describe birth experiences that are in keeping with trauma as defined by diagnostic classification systems. For example, nearly half of women in a recent cohort study thought that their baby or themselves would die or be injured during childbirth (Kjerulff et al., 2021). Furthermore, the language of sexual assault has been used in descriptions of birth experiences (Beck, 2004; Morris et al., 2021). Understandably, birth trauma research often draws upon medical models of trauma and conceptualises birth trauma within the context of post-traumatic stress disorder (PTSD, see section 1.4.1.1. for a description). For example, one definition of birth trauma given in a literature review described birth trauma ‘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’ (Beck, 2004).

However, using a medical lens to understand birth trauma can be challenging. Birth experiences perceived to be traumatic by the birthing person may be considered to be non-exceptional or medically routine by others such as healthcare providers (Beck, 2004). Furthermore, PTSD is only one response to experiencing a traumatic event and not everyone with a traumatic birth goes on to develop PTSD. This is highlighted in the difference between statistics describing the prevalence of experiences of traumatic birth and birth-related PTSD. Nearly one-third of births are experienced as psychologically traumatic (Alcorn et al., 2010; Soet et al., 2003) whereas 3 - 4% of people who have given birth reach clinical thresholds for a PTSD diagnosis postnatally (Ayers et al., 2016; Yildiz et al., 2017).

Leinweber et al., (2020) highlight how the reliance on PTSD-based definitions of trauma result in an unhelpful use of ‘birth-related PTSD’ and ‘traumatic birth experience’ interchangeably in the literature. Through consultation with experts and women with birth trauma they proposed a refined definition of birth trauma: ‘a woman’s experience of interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions; leading to short and/or long-term negative impacts on a woman’s health and wellbeing’ (Leinweber et al., 2020, p. 691). This is a helpful conceptualisation of birth trauma in that it is inclusive of non-PTSD responses to birth trauma and incorporates the relational aspect of birth trauma. Although there is a strong emphasis on centring the lived experiences of birth trauma, the authors adopted a binary ‘woman-centred’ approach. Focusing solely on the experiences of cis-women limits the application of this definition, particularly when considering the consistently worse perinatal care given to trans and non-binary people (LGBT Foundation, 2022).

Similarly to Leinweber et al (2022), the current study has opted to move away from definitions of trauma that are theoretically driven and allow space for subjectivity. Instead, birth trauma will be defined by the perceptions of the birthing person; i.e. ‘birth trauma lies in the eye of the beholder’ (Beck, 2004).

1.4.1.1. *Development of PTSD following a traumatic birth:* Although there are some conceptual challenges of using the PTSD construct to understand birth trauma, much of the birth trauma literature is presented through a PTSD lens. As such, it is helpful to further discuss the development of PTSD following a traumatic birth.

PTSD refers to a set of symptoms that persist following the experience of a traumatic event. Re-experiencing symptoms such as flashbacks and nightmares, avoidance and hyperarousal are central to the experience of PTSD (APA, 2013; WHO, 2019). Initially these symptoms are to be expected after experiencing a traumatic event as part of the natural processing of the event. However, if these symptoms persist and result in distress for the individual a diagnosis of PTSD may be given. PTSD symptoms following a traumatic birth are qualitatively similar to PTSD following any other traumatic event (James, 2015; Thiel et al., 2021). James’ (2015) review describes re-experiencing symptoms as the most commonly experienced symptoms in birth-related PTSD and the related avoidance of triggers was often specific to reproduction and infants, for example, the avoidance of sex and future pregnancy.

In line with the broader PTSD literature, a diathesis-stress model has been used to understand why some people go on to develop PTSD following a traumatic birth. Ayers et al’s (2016) describe how vulnerability factors during pregnancy such as a history of mental health difficulties or tokophobia, interact with birth risk factors, such as, lack of support or dissociation. This interaction between these factors influences the appraisal of the birth experience as traumatic; these appraisals and the subsequent trauma-related symptoms alongside other postnatal factors work to maintain PTSD. The attention paid to the maintaining role of appraisals and trauma responses are in keeping with cognitive models of PTSD (e.g. Ehlers & Clark, 2000).

Cognitive models are widely used to understand PTSD in both academic and therapeutic arenas; this is reflected in the funding and availability of cognitive behavioural (CBT) interventions for PTSD relative to other therapeutic modalities.

There is evidence that birthing peoples' lived experience of birth related PTSD is in keeping with cognitive models of PTSD (James, 2015). Although PTSD is not observed in all people who have experienced a traumatic birth, understanding the mechanisms of PTSD may be helpful in understanding traumatic birth experiences more broadly. For example, comparisons of narratives of women with and without PTSD following a traumatic birth experience found that although women with PTSD experienced more re-experiencing symptoms, narratives were not dissimilar in terms of perceptual processing and coherence (Ayers et al., 2015).

However, the authors acknowledged that this finding does not necessarily fit with the suggestion in cognitive models of PTSD that trauma memories in PTSD are fragmented and less cohesive than other non-PTSD memories. Bernsten et al's landmark hypothesis (2003, cited in Ayers et al., 2015) was put forward as one possible explanation; this hypothesis suggests that incoherent narratives can be a product of any psychologically distressing experience and is not exclusive to PTSD.

Cognitive models have clearly provided a helpful framework to understand birth related PTSD. However, it is also important to consider the limitations of such models. The inquiries and reviews of NHS maternity services in recent years have highlighted how pervasive systemic issues within services create environments which lend themselves to potentially traumatic birth experiences. Cognitive models of PTSD have been criticised for locating difficulties within the individual and their lack of capacity to address the harm caused at a systems level. Additionally, such models are lacking in their ability to acknowledge sociocultural factors that may make someone more vulnerable to experiencing a traumatic event; for example, using maternity services as someone from a socially deprived background or belonging to a minioritised ethnic group (Turienzo et al., 2021; MacLellan et al., 2022; MBRACE-UK, 2022).

1.4.2. Impact of Birth Trauma

Birth trauma has been found to have a wide-reaching psychosocial impact, with birthing people reporting difficulties in multiple areas of their lives. Earlier sections of this chapter have discussed the relationship between birth trauma and developing PTSD (e.g. Yildiz et al, 2017). PTSD and birth trauma have been linked to tokophobia, an extreme fear of childbirth, which in turn can impact future reproductive and childbirth decision making (Jomeen et al., 2020; Olsen et al, 2022). Other responses to experiencing a traumatic birth include postnatal depression, anxiety and stress (Fenech et al., 2014; Türkmen et al., 2020; Barut et al., 2022). For example, Bay et al., (2020) found that birthing people with high levels of 'traumatic childbirth perception' were up to five times more likely to experience postnatal depression. Some birthing people experience a sense of loss, or grief, for how the birth trauma altered their birth experience, engagement with parenthood and sense of self (Fenech et al., 2014).

The impact of birth trauma is not confined to individual distress of the birthing person. For example, postnatal mental health difficulties have been found to have a negative impact on an infant's development (Slomian et al., 2019; Oyetunji & Chandra, 2020; HM Government, 2021). Additionally, birth trauma and the associated psychological impact has been found to impact upon attachment and bonding with the new baby (Nicholls & Ayers, 2007; Simpsom et al., 2018; Mayapoulos et al., 2021; Sieleghem et al., 2022). This includes mothers feeling disconnected from their baby and experiencing a 'lower level of attachment' (Molloy et al., 2021). When birth trauma involves the dismissal of a bodily experiences, some birthing people found that they doubted their abilities as a parent and became anxious about their baby's health (Molloy et al., 2021).

The experience of birth trauma also places strain on other important relationships in the birthing person's life (Simpsom et al., 2018). With partners this included tension arising from lack of support, lack of intimacy and poor communication. Similarly, birthing people reported being more distant and isolated in social and familial relationships as a result of the emotional toll of birth trauma and the lack of shared understanding and experience. The focus of the current study is on the experiences of the birthing person, however, it is important to note that birth-related trauma can be experienced by those witnessing the birth. A recent study exploring the experiences of fathers, found that witnessing birth trauma had a detrimental impact on the father's psychological wellbeing postnatally and altered their ability to bond with their new child (Daniels et al., 2020). Similarly, witnessing birth trauma can leave healthcare professionals vulnerable to experiencing PTSD and challenge their understanding of their professional identity (Uddin et al., 2022).

1.4.2.1. *NHS support for birth trauma:* Specialist perinatal mental health services. (SPMHS) are well established (Cantwell, 2022). These services are designed to offer specialist mental health support during pregnancy and postpartum. The NHS Long Term Plan (NHS, 2019) acknowledges the psychological support needs of people with birth trauma and highlighted a gap in service provision. Often people with birth trauma do not meet thresholds for referral to a SPMHS but would benefit from the perinatal specific knowledge held within these teams. As such, the Long Term Plan (NHS, 2019) set out plans to roll out Maternal Mental Health Services (MMHS). MMHS's bridge SPMHS and maternity services, and offer specialist, NICE recommended support to individuals who have experienced birth trauma, as well as individuals who have experienced baby loss (NHS, 2019; Crook et al.,2022). Early data from MMHS's have reported success in the service model; for example, a pilot MMHS in East Kent found that 100% of patients showed significant improvements to their symptoms of PTSD as measured by the PTSD checklist (PCL-5, Crook et al., 2022).

1.4.3. Risk Factors of Birth Trauma

To understand what factors may make someone vulnerable to experiencing birth trauma and identify preventative measures there has been a large amount of research exploring the risk factors of birth trauma. Similarly, to the wider trauma literature, exploration of risk factors has predominately been within the context of PTSD. As such, many risk factors are considered at an individual level and there is a lack of exploration around wider systemic factors that contribute to the experience of birth trauma.

Reviews of birth-trauma and birth related PTSD have identified several psychological vulnerability factors during pregnancy. These include depression or anxiety during pregnancy, tokophobia (which can be a consequence of previous birth-related trauma), history of mental health difficulties, trauma history (particularly when there is previous experience of sexual violence) and feelings of fear or apprehension about what is to come (Ayers et al., 2016; Simpson & Caitling., 2016; Simpson et al., 2019; Watson et al., 2021; Khsim et al., 2022). Khsim et al., (2022) also describe demographic factors, 'belonging to a non-European status' and being single, as vulnerability factors. Given the inequalities of care arising from structural racism and discrimination (Turienzo et al., 2021; MacLellan et al., 2022) it is reasonable to assume that individuals belonging to a minioritised group would be at greater risk of receiving care which lends itself to a traumatic experience.

In the intrapartum, operative birth (i.e. instrumental intervention and/or caesarean) and infant complications including preterm delivery have been found to be risk factors for birth trauma (Ayers et al., 2016; Simpson & Caitling., 2016; Simpson et al., 2018; Khsim et al., 2022). Psychological risk factors centred around the nature of the subjective birth experience, for example, experiencing distressing emotions such as fear and powerlessness, dissociation and having unmet expectations (Ayers et al., 2016; Simpson et al., 2019; Watson et al., 2021; Khsim et al., 2022). Birthing people desire 'safe, supportive, kind, respectful and responsive care' during their birthing experience (p.12, Downe et al., 2018). In line with this, healthcare providers have a role in managing distress during childbirth. Lack of support and collaboration from healthcare providers has been listed as a risk factor for birth trauma in multiple reviews (Elmir et al., 2010; Ayers et al., 2016; Simpson & Caitling., 2016; Simpson et al., 2019; Watson et al., 2021; Khsim et al., 2022).

Negative interactions with healthcare providers has been robustly identified as a risk factor for birth trauma. A recent scoping review examining women's experiences of birth trauma describes how negative interactions with healthcare providers can give rise to negative emotions and impact on perceptions of birth (Watson et al., 2021). Experiences of feeling forced or threatened into consent (i.e. coercive consent) and dismissed bodily experiences gave rise to feelings of powerlessness which left women feeling abused, vulnerable and distressed. The role of healthcare interactions in birth trauma is supported by findings that a third of the peak moments of distress during childbirth, or 'hotspots', related to interpersonal experiences such as 'being ignored' or 'poor communication' (Ayers & Harris, 2012). Ayers and Harris (2012) also found negative interpersonal experiences to be the strongest predictors of developing birth related PTSD. Furthermore, a review attempting to define birth trauma found interactions with healthcare professionals so integral to the experience of birth trauma that it was included within their final definition ('a woman's experience of interactions and/or events directly related to childbirth', Leinweber et al., 2020). Such findings illustrate how negative interactions during childbirth can play a role in birth trauma, irrespective of the physical events of birth.

1.5. Scoping Review

As highlighted above, aetiological birth trauma research has consistently found the nature of interactions with healthcare providers to be a risk factor for experiencing a birth as traumatic. To better understand the relationship between birth trauma and negative healthcare provider interactions, a scoping review was conducted. The scoping review aimed to answer the following question: what is already known about birthing peoples' experiences of negative healthcare provider interactions during a traumatic birth? The search was carried out across several databases and materials were reviewed from multiple fields, including medical, midwifery and psychology journals. The final search was conducted on 30th April 2023.

1.5.1. Search Strategy and Outcome

A search was conducted using terms that pertain to childbirth ("childbirth", "birth"), trauma ("trauma", "birth trauma", "PTSD", "posttraumatic stress" "post traumatic stress") and healthcare providers ("healthcare provider", "care provider", "healthcare professional", "staff", "caregiver", "professionals", "midwives"). Searches were carried out across several electronic databases including, EBSCO (APA PsycInfo, CINHAL, Academic Search Ultimate) and Scopus. Human only and English filters were applied to help promote the return of relevant and accessible papers.

The search returned 2023 papers, of these ten were selected for inclusion in the scoping review. Selection was made by initially screening titles for relevance, followed by the abstract and then full paper. Suitability for the scoping review was assessed using the following inclusion criteria: 1) studies were available in English; 2) participants had experienced a psychologically traumatic birth; 3) the study explored negative interactions with healthcare providers during birth; and 4) includes discussion of the nature of negative interactions with healthcare providers beyond simply stating their aetiological role in birth trauma development.

A summary of the papers identified for the scoping review have been summarised in Table 1 below. Full details of the search strategy and a PRISMA diagram (Moher et al., 2015) can be found in Appendix A and B respectively.

Table 1

Description of Relevant Articles Identified from Literature Search

Author & Date	**Country**	**Aims**	**Study Design**	**Participants**	**Conceptualisation of Birth Trauma**
Beck (2004)	New Zealand	To understand birth trauma from the woman's experience	Qualitative: Written accounts of birth trauma experience Descriptive phemomenology	38 Mothers who had experienced a traumatic birth	Participant-led, focus on subjective experience of birth trauma
Byrne et al., (2017)	Ireland	To explore subjective birth experience of birth trauma in first-time mothers	Mixed methods: Screening questionnaire & semi-structured interviews	7 First-time mothers who gave birth in the last 12 months	Used Ayers at el., (2008) definition: 'women who experience symptoms of PTSD following the experience of childbirth, but do not necessarily meet the diagnostic criteria for PTSD' Subjective birth experience

			Interpretative Phenomenological Analysis		explored alongside symptoms of PTSD (distinct from postnatal depression)
Elmir et al., (2010)	Studies included from New Zeland, US, UK & Australia	To understand commonalities and differences in findings of studies with women who experienced a traumatic birth	Meta-ethnography	10 studies included Combined sample of 398 women	Reviewed definitions available in the literature but did not align study with one
Forssén et al., (2012)	Sweden	To explore negative experiences of medical care during childbearing and birthing and their significance for women's wellbeing over a lifetime	Qualitative Interviews through form of unstructured conversations. Phenomenological approach	20 Women who had given birth between 1934 and 1966 (older women selected for ability to provide a lifetime perspective)	Not supplied
Murphy & Strong, (2018)	England	To focus on events during and after birth in their medical context	Qualitative Semi-structured interviews	4 First-time mothers	Discussion of theoretical frameworks concludes that more research is needed

			Narrative analysis		Participant-led – participants asked if they thought they had birth trauma
Patterson et al., (2019)	Scotland	To understand how women who have developed PTSD experienced their interactions with healthcare providers during labour, birth and early postnatal period. To understand how midwives experiences interactions with women whilst providing care.	Qualitative Semi-structured interview Interpretative Phenomenological Analysis	12 total 6 women who had developed PTSD related to childbirth 6 midwives	Focus on PTSD
Reed et al., (2017)	Australia and Oceania, North America & Europe	To understand women's experiences of birth trauma	Qualitative Survey (part of a larger mixed methods study)	748 women (943 participants in larger study)	Participant-led – focus on subjective experience of birth trauma

			Thematic analysis		
Rodríguez-Almagro et al., (2019)	Spain	To investigate women's perceptions of living a traumatic birth experience and related factors	Qualitative Semi-structured interview Thematic Analysis	32 women	Not explicitly stated
Thomson & Downe (2008)	England	To gain a deeper understanding of women's lived experiences of traumatic and positive birth.	Qualitative Interpretive interview Interpretative Phenomenological Analysis	14 women	Participant led – self-defined birth trauma
Van der Pijl et al., (2019)	Netherlands	To understand types of disrespect and abuse women reported in #genoeggzwegen campaign (a social media campaign – translates to #breakthesilence).	Qualitative Content analysis of #genoeggzwegen campaign stories	438 #genoeggzwegen stories	Participant led – self-defined birth trauma

The selected papers all focus on the experiences of people who have experienced birth trauma and negative healthcare provider interactions. These ten papers will be discussed within two themes: 1) the nature and experience of negative interactions, and 2) the impact of negative interactions.

1.5.2. The Nature and Experience of Negative Healthcare Provider Interactions

Byrne et al., (2017) described negative interactions in a traumatic birth as arising from impersonal maternity systems that were incompatible in with individuals with individual needs and hopes. Similarly, some studies described the hospital's agenda being prioritised above the needs of the birthing person (Reed et al., 2017; van der Pijl et al., 2019) and birthing people being problematised by healthcare providers for expressing needs (Byrne et al., 2017; Murphy & Strong, 2018; Patterson et al., 2019). Reed et al., (2017) highlight how these tensions contradict global standards for personalised and individualised care in maternity services. Within this conflict birthing people felt that there was no space to for their emotions and distressing thoughts to be acknowledged (Beck et al., 2004; Thomson & Downe, 2008; Murphy & Strong, 2008; Byrne et al., 2017).

Negative interactions can also be understood in the context of the significant power healthcare professions hold when a birthing person is in their care. All studies reviewed described misuse of the power inherent to the healthcare providers role. Particularly concerning, were the descriptions of interventions and observations being carried out without consent (Elmir et al., 2010; Reed et al., 2017; Patterson et al., 2019; Rodríguez-Almagro et al., 2019; van der Pijl et al., 2019), coercive compliance (Thomson and Downe., 2008; Byrne et al., 2017; Reed et al., 2017; van der Pijl et al., 2019) and healthcare professionals ignoring requests to stop distressing examinations (Reed et al., 2017; Murphy & Strong., 2018; van der Pijl et al., 2019). In one study, participants described healthcare providers using the 'dead baby threat' to coerce them into comply (Reed et al., 2017).

Examples of epistemic privileging of healthcare professionals and testimonial injustice (Carel & Kidd, 2014) were seen across studies in participants' descriptions of the dehumanising impact of non-consensual and forceful interactions (Thomson & Downe, 2007; Elmir et al., 2010; Byrne et al., 2017; Reed et al., 2017; Murphy & Strong, 2019; van der Pijl et al., 2019). The dehumanising effect of these interactions and actions were captured by the use of metaphors such as ‘lump of meat’, ‘slab on a table’ and ‘production line’ (Thomson & Downe., 2007; Elmir et al., 2010; Byrne et al., 2017) and comparisons made to sexual assault (Beck, 2004; Elmir et al., 2010; Reed et al., 2017). Understandably, participants spoke of feeling violated, betrayed, degraded, ashamed and humiliated in response (Beck, 2004; Byrne et al., 2017; Elmir et al., 2010; Patterson et al., 2010; Reed et al., 2017; van der Pijl et al., 2019). These findings are in keeping with the wider trauma literature which acknowledges the role of dehumanisation in interpersonal traumatic experiences. Thomson and Downe (2008) draw parallels between dehumanising experiences reported in their study and torture; the authors highlight how during birth agency can be restricted psychically, psychologically and cognitively through the interactions with healthcare providers.

In addition to non-consensual actions and coercive interactions, birth trauma narratives frequently described interactions, or lack of interactions, which result in the birthing person feeling dismissed and excluded from the birth. Byrne et al., (2017) described how for birthing people communication and information from healthcare professionals was used as a way of establishing a sense of safety in an otherwise vulnerable situation. However, across studies participants described being ignored, dismissed and excluded from decisions through lack of information sharing (Thomson & Downe, 2009; Elmir et al., 2010; Byrne et al., 2017; Reed et al., 2017; Murphy & Strong, 2018; Patterson et al, 2019; Rodríguez-Almagro et al., 2019; van der Pijl et al., 2019). The failure of healthcare providers to appropriately collaborate with birthing people resulted in them feeling alienated and isolated from the birth experience (Beck, 2004; Byrne et al., 2017; Murphy & Strong, 2018; Patterson et al., 2019) and ultimately out of control (Beck, 2004; Thomson & Downe, 2009; Elmir et al., 2010; Byrne et al., 2017; Reed et al., 2017; Murphy & Strong, 2018; Patterson et al, 2019; Rodríguez-Almagro et al., 2019; van der Pijl et al., 2019).

In line with the wider trauma literature, feeling out of control during childbirth gave rise to distressing emotions and cognitions. Some participants internalised experiences of being ignored or dismissed and blamed themselves for seeking that information (Byrne et al., 2017). Others described a resulting power struggle, where their unsuccessful attempts to regain control gave rise to a sense of powerlessness (Beck, 2004; Patterson et al., 2019; van der Pijl et al., 2019). Within all the interactions described, a feeling of powerlessness was a predominant theme. Across the studies, participants shared how feelings of powerlessness emphasised their vulnerability and resulted in feeling unsafe and fearful. These feelings were perpetuated by an erosion of trust in the healthcare providers ability to care for them in a way that was in their best interests (Beck, 2004; Thomson and Downe, 2008; Patterson et al., 2019).

Feeling powerless and the associated sense of vulnerability appears to be a key factor in perceiving childbirth as traumatic; for example, unsuccessful attempts to recover power featured in highly distressing moments, or ‘hotspots’, within the birth memory (Patterson et al., 2010). In another study, authors linked powerlessness to dissociation, a coping mechanism commonly described during traumatic events (Byrne et al., 2017). Powerlessness was experienced as a need to surrender to healthcare providers and a maternity system that had proven itself to be a threat (Thomson & Downe, 2008; Elmir et al., 2010; Byrne et al., 2017; Reed et al., 2017; Patterson et al., 2019; van der Pijl et al., 2019).

1.5.3. The Impact of Negative Healthcare Provider Interactions

Feeling powerless was a central theme in the experience of negative healthcare provider interactions during a traumatic birth. However, feelings of powerlessness are not limited to the birth experience and a sense of powerlessness or stuckness featured in narratives of the impact of birth trauma (Elmir et al., 2010; Forssén et al., 2012; Byrne et al., 2017; van der Pijl et al., 2019). Trauma-related symptoms, such as flashbacks, nightmares and infant-focussed hypervigilance, were described after experiencing birth trauma, sometimes years after the birth took place (Elmir et al., 2010; Forssén et al., 2012; Byrne et al., 2017; Rodríguez-Almagro et al., 2019; van der Pijl et al., 2019). In addition to trauma-related symptoms, birth trauma and experience of negative interactions with healthcare providers had a detrimental impact on birthing peoples’ mental health and their daily functioning. This includes anxiety, loss of coping skills, depression and suicidal thoughts (Elmir et al., 2010; Forssén et al., 2012; Byrne et al., 2017; Rodríguez-Almagro et al., 2019).

Negative interactions with healthcare providers stayed with the women in the studies long after they happened. For example, in one study women who gave birth between 1934 and 1966 described how healthcare professionals ‘exerted power in a way that caused profound and life-long self-reproach' (Forssén et al., 2012). One participant in this study described being blamed for the death of her baby which occurred shortly after birth; she shared thinking about this and blaming herself every day since. Similarly, Elmir et al (2010) described mothers feeling anger towards themselves for being unable to advocate for themselves during the birth.

The internalisation of messages received during birth about being a failure was reflected in birthing people's relationship to breastfeeding. Multiple papers described a redemptive quality to breast feeding with birthing people viewing it as an opportunity to regain control and 'prove' themselves as a mother (Elmir et al, 2010; Forssén et al., 2012; Byrne et al., 2017). However, for some this came at the cost of pushing through pain and triggering trauma-related symptoms (Elmir et al., 2010; Forssén et al., 2012). Tokophobia has been linked to previous experiences of birth trauma; this is reflected in several of the reviewed studies whose participants described feeling fearful of conceiving again or having more children (Elmir et al., 2010; Forssén et al., 2012; van der Pijl et al., 2019). However, for some women this resulted in feelings of remorse later in life for not having more children (Forssén et al., 2012).

Avoidance of future pregnancy contributed to some birthing people's experiences of difficulty in their relationships with their partners as they avoided sex and intimacy (Elmir et al., 2010). Additionally, feelings of disappointment and frustration towards partners were shared in the context of there being a lack of emotional support (Elmir et al., 2010; Rodríguez-Almagro et al., 2019). Lack of emotional support was also mirrored in birthing peoples' social networks, with people feeling isolated, different and unable to share their experiences with others (Forssén et al., 2012). It is possible that the lack of support experienced postnatally following birth trauma reflects both social and cultural narratives of childbirth as positive and a lack of understanding of birth trauma.

In keeping with the wider birth trauma literature, difficulties in the parent-infant relationship were reported. Initial moments to bond were not given to some women; for example, Rodríguez-Almagro et al (2019) highlight how mothers felt that skin-to-skin contact post birth was important for initial bonding, but this choice wasn't always given. Some mothers describe struggling to feel an emotional connection or bond with their baby for several months after it was born and difficulties in bonding further perpetuated feelings of failure (Elmir et al; 2010).

1.5.4. Conclusions and Critique

In total ten papers describing negative interactions during birth trauma and their impact were reviewed as part of this scoping review. These papers described care of birthing people that goes against recommended global recommendations for personalised care in maternity services (WHO, 2007). The interactions and care described result in birthing people feeling without control and powerless in their birthing experience. The subsequent birth trauma had a profound and lasting impact on their mental and emotional wellbeing, relationships and sense of self and coping.

1.5.4.1. *Description of research:* of the ten publications included in this review (see Table 1), eight were qualitative in design, one was mixed methods (Byrne et al., 2017) and one was a meta-ethnography (Elmir et al.,2010). The paper using mixed methods had a focus on qualitative methodology, quantitative measures of postnatal depression and PTSD were used as part of the screening process. Three were carried in the UK within an NHS context (two in England, one in Scotland), whereas Ireland, Netherlands, New Zealand, Spain, and Sweden each had one paper conducted in that country. Reed et al., (2017) conducted their study in Australia but included participants internationally from Australia and Oceania, North America and Europe. Whereas Elmir et al's (2010) meta-ethnography included publications from New Zealand, US, UK and Australia.

The studies presented in this scoping review provide insight into the nature of healthcare provider interaction involved in birth trauma. However, it is important to note that two thirds of the studies took place outside of the UK. The current study is interested in exploring birth trauma within NHS maternity systems; although global standards of maternity services exist (WHO, 2007), there is likely to be differences between studies in terms of the provisions of care based on the socio-political contexts the maternity services exist within. However, despite likely differences in models of care, participants across studies reported comparable events and were distressed by similar types of interactions. This was true even when births that happened decades earlier were explored (Forssén et al., 2012). This suggests that birthing people valued similar things in their care, such as information sharing, compassion, and respect.

Healthcare systems, including maternity services, are ever developing and changing. Over half (six) of the papers included in this review were published in the last five years and are likely to capture experiences that are representative of maternity systems today. However, it is important to note that all the studies were carried out prior to the COVID-19 pandemic. To prevent spread of the virus, the pandemic resulted in sudden and drastic shifts to the delivery of care in maternity systems worldwide which impacted upon the care birthing people received (Townsend et al., 2021). Research looking at the healthcare provider interactions during and post-COVID would be of value to help understand the current context and systems these interactions take place in.

1.5.4.2. *Sample and Methodology:* a range of approaches were used for data analysis, including: Interpretative Phenomenological Analysis (three studies); Thematic Analysis (two studies); a phenomenological approach (two studies); Narrative Analysis (one study); social media Content Analysis (one study). The majority of the studies gathered data through the use of individual semi-structured interviews, including the studies included in the meta-ethnography (Elmir et al., 2010). Sample sizes for studies using semi-structured interviews ranged from 4 participants to 32 participants, and the meta-ethnography had a combined total of 398 participants. Studies using social media content analysis (van der Pijl et al., 2019) and surveys (Reed et al., 2017) had much larger sample sizes (438 and 748 respectively).

To recruit participants the main methods of sampling used were self-selection and purposive sampling. The use of self-selecting sampling methods supports efforts made by authors to honour subjective experiences of birth. However, it is important to note that a self-selection bias may be operating within these participant groups (Heckman, 1990). Participants who self-select need to both be willing to share emotionally distressing experiences and feel comfortable identifying their birth as traumatic when there are prevailing social and cultural discourse around birth being a positive event. Purposive sampling allowed for a homogeneity of samples, but presents an ethical consideration when participants were recruited by maternity professionals. The research summarised in this scoping review highlights a significant power difference between maternity professionals and birthing people that resulted in experiences of coercion. As such, it is important to consider how being approached by a professional to take part in research may have been experienced by the birthing person and how that may have contributed to participants acquiescing.

All of the studies focussed exclusively on the experiences of cis-women. Therefore, to the authors knowledge, there is no research which explores the experiences birth trauma in the context of negative healthcare provider interactions for trans and nonbinary people, despite trans and non-binary people routinely receiving poor care in maternity services (LGBT Foundation, 2022). Understanding how interactions with healthcare professionals relate to birth trauma, ultimately allows for improvements to be made to best practice, thus it is important for research to reflect the diversity of people that access maternity services.

1.5.4.3. *Conceptualisation of birth trauma:* There was a general acknowledgement in the literature of the importance of recognising subjective experiences of birth trauma. This is a helpful stance given the potential for conflict between birthing people's experiences and what is considered routine or normal by healthcare professionals (Beck, 2004). However, it is difficult to evaluate if the participants of the study are describing comparable experiences and if conclusions can be generalised outside of the study. Furthermore, most studies lacked reflexivity regarding the authors positioning to the research topic. This is particularly important in qualitative research as research will be interpreted through the lens of the authors own professional and personal knowledge and experience.

Some studies used measures of PTSD as a screening tool to identify individuals with PTSD type symptoms to include in the study (Byrne et al.,2017; Patterson et al., 2019). Although this helps to ensure a shared understanding of birth trauma, it is vulnerable to excluding participants with relevant experiences that are not experiencing symptoms of PTSD. Furthermore, focusing on symptoms experienced by an individual limits the opportunity to explore the systemic factors which enable negative interactions and cause iatrogenic harm.

1.6. The Current Study: Rationale and Aims

The experience of birth trauma has a lasting impact on the birthing person, their infant and their relationships. The literature presented in the previous sections of this report illustrates the iatrogenic harm caused by negative interactions with healthcare providers in maternity systems and how such interactions contribute to the experience of birth trauma. Many of the descriptions of these interactions describe care which is unacceptable and undermines global standards of care.

The relationship between healthcare provider interactions and birth trauma has predominately been established through research exploring aetiological factors of birth trauma more broadly. Of the studies that directly explore negative healthcare provider interaction, there is a limited number within a recent NHS context (Thomson & Downe, 2008; Murphy & Strong., 2018; Patterson et al., 2019). As such, the current study aims to gain a deeper understanding of the nature of negative interactions with healthcare providers in the NHS and explore how negative interactions contribute to the experience of birth trauma.

1.6.1. Research Questions

The current study aims to address the following research questions:

1. How do birthing people describe their negative interactions with healthcare providers?
2. How did negative interactions with healthcare providers contribute to the experience of birth trauma?

2. METHOD

2.1. Overview

This section will summarise the methodology and processes used to address the research questions '*how do birthing people describe their negative interactions with healthcare providers?'* and '*how did negative interactions contribute to the experience of birth trauma?'.* This includes commentary on the epistemological and ontological position taken, rationale for chosen design and description of participants.

2.2. Epistemological and Ontological Position

Epistemology refers to the philosophical theory of knowledge and is concerned with how knowledge is acquired and what constitutes knowledge (Harper & Thompson, 2011). Ontology refers to the related but separate study of 'being and existence' and explores questions relating to what exists and can be considered 'real' (Harper & Thompson, 2011). Epistemology influences the choice and implementation of methodology, as well as how findings are communicated to the research audience (Carter & Little, 2007). Thus, explicit acknowledgement of epistemological positioning, and assumptions being made about the knowledge being created, is important to promote trustworthiness in research (Nowell et al., 2017).

Epistemological and ontological positioning can be thought about on a realism-relativism continuum. Realism is a position which believes that it is possible to gain knowledge which reflects reality in a way that is independent of culture, perspectives, and experiences. Whereas relativism describes a position which argues that there are multiple valid ways to understand the world and these understandings are shaped by the context in which the observer exists.

The research questions of the current study (as described in section 1.6) are centred around the experiences of birth trauma. As such, they assume that birth trauma is something which can be understood empirically and objectively. However, the study defines birth trauma in a way that acknowledges the role of subjective experience in determining if a birth was traumatic or not. As such, the study has adopted a critical realist position. A critical realist approach is ontologically realist as it assumes that there is a 'real' observable reality but is epistemologically relativist in that it acknowledges that there are many factors which can shape a person's experience of that reality (Harper & Thompson, 2011; Willis, 2022).

A person's childbirth experience is influenced by multiple different factors that operate at individual, relational and sociocultural levels (e.g. Tabaghdehi et al., 2020; Chabbert et al., 2021; McKelvin et al., 2021). Critical realism has been proposed as an appropriate epistemological and ontological position to capture the complexity of childbirth; critical realism 'encourages a holistic exploration of phenomena' and acknowledges the role of individual and societal interpretative lenses in understanding birth experiences (Walsh & Evans, 2014). The acknowledgment of different interpretive lenses is in keeping with the current study's decision to focus on subjective experiences of birth trauma and explains how the events of birth may be understood differently by different people (e.g. birthing person describing their birth as traumatic when their healthcare providers describe it as medically routine).

2.2.1. Researcher's Positioning

Researchers bring their own personal and professional experiences, beliefs and biases to the research. In a thematic analysis authors have an active role in constructing data into meaningful themes (Braun & Clarke 2006; Byrne, 2021). Therefore, attention and reflexivity of the researchers position in relation to the population being studied is important in building the quality, credibility, and trustworthiness of the research (Berger, 2013).

I am a 30-year-old white British cis-woman, who has not experienced pregnancy or childbirth. I bring to the research my own experiences of accessing and interacting with healthcare providers, both as a patient and a carer, as well as professional experience interacting with service users as an NHS mental health professional. Professionally, I have a special interest in the perinatal period and have experience working therapeutically in primary and secondary care mental health services with people during pregnancy and postnatally. Consideration and reflection of how my positioning may have influenced my relationship with participants and understanding of the data collected will be explored in the later discussion chapter of this thesis (section 4.3.3.).

2.3. Methodology

The aims and research questions of this study are concerned with birthing people's experiences of negative interactions and birth trauma. As such, the qualitative approach of thematic analysis was chosen as the most appropriate methodology to conduct the current study.

2.3.1. Rationale and Approach to Thematic Analysis

Thematic analysis is an approach to data analysis which identifies patterns of meaning, or themes, in the data (Braun & Clarke, 2006). It is suited to research questions that look to understand subjective experiences as it allows for the collection of ‘rich and detailed, yet comprehensive’ data (Braun & Clarke, 2006). As a methodology, thematic analysis is non-specific and not bound to any one epistemological position (Braun & Clarke, 2006; Braun & Clarke, 2014; Byrne, 2021). Thematic analysis is considered compatible with a critical realist position as it describes patterns in the data which could be considered to reflect reality, whilst acknowledging the researcher’s subjectivity in data interpretation and individual differences in experiences of reality (Braun & Clarke, 2006; Braun & Clarke, 2013; Byrne, 2021).

Interpretative phenomenological analysis (IPA) was also identified as a potential methodological approach due to its focus on exploring the meaning making of lived experience (Larkin et al, 2006; Pietkiewicz & Smith, 2017). To examine an individual’s experiences IPA utilises phenomenological, hermeneutic and idiographic frameworks (Pietkiewicz & Smith, 2017). The research questions of the current study are interested in how negative interactions contribute to the experience of birth trauma. However, the research questions frame ‘experiences’ in the vernacular sense, and therefore approach experiences from an atheorectical standpoint. As such, thematic analysis was deemed more appropriate than IPA to answer the research questions.

There are a limited numbers of studies exploring the experience of negative healthcare provider interactions in people with birth trauma within a NHS context, therefore the research questions of this study are exploratory in nature. In line with this, the thematic analysis was conducted inductively; the generation of themes was driven by the data itself rather than existing theoretical frameworks (Braun & Clarke, 2006; Byrne, 2021). However, Braun & Clarke (2006) offer an important reflection on how a thematic analysis cannot be wholly inductive as ‘researchers cannot free themselves of their theoretical and epistemological commitments, and data are not coded in an epistemological vacuum’. The impact of my position will be considered in later chapters of this thesis (section: 4.3.3.).

Data coding can be done at semantic or latent levels. Semantic coding takes the data at its ‘surface meaning’ whereas latent coding looks under the surface at implicit meanings in the data (Braun & Clarke, 2006; Braun & Clarke, 2013; Byrne, 2021).

The current study primarily used latent coding to connect participants' experiences with assumptions, ideologies, and frameworks in a meaningful way. However, as described in Braun & Clarke (2013), in practice semantic and latent coding are not always mutually exclusive and at times it would be appropriate to utilise both forms of coding.

2.4. Research Procedure

2.4.1. Ethical Approval

Ethical approval was obtained from the University of East London School of Psychology Research Ethics Committee (see Appendies C and D for ethical application and approval). Additional ethical considerations are discussed in section 2.6.

2.4.2. Participant Recruitment

Self-selection sampling was used to recruit participants to the study. Participants responded to a study advert (Appendix E) which contained a brief description of the study aims and the participant inclusion criteria. To ensure the study advert reached the relevant populations the advert was kindly shared on the social media group of a UK birth charity that supports birthing people and their families. Anyone who was interested in participating was invited to contact the researcher via their university email.

Prospective participants were then provided with a participant information sheet (Appendix F) via email and a screening call was arranged. The screening call served the dual purpose of ensuring that prospective participants were eligible to take part in the study and establishing if there were concerns relating to safety if this person were to participate. In line with the wider birth trauma literature, it was anticipated that postnatal mental health difficulties (such as depression, PTSD and suicidal ideation) would be likely within this population. Therefore, participants were not excluded if these symptoms were present. Decisions to exclude would be based on severity of symptoms or disclosure of risk or safeguarding concerns (e.g. suicidal ideation with intent). Table 2 below lists the inclusion and exclusion criteria used for participant recruitment.

Table 2

Description of Inclusion and Exclusion Criteria for Participant Recruitment

Inclusion Criteria	**Exclusion Criteria**
• Gave birth using NHS maternity services within the last 5 years (to ensure that experiences are relevant to current NHS context) • Aged 18 and over • Perceived their childbirth experience as traumatic • Experienced negative interactions with healthcare providers during the birth experience	• Gave birth using non-NHS/private service • Gave birth over 5 years ago • Under 18 years of age • Disclosure of severe mental health difficulties and/or risk or safeguarding concerns at screening call

Note: Decision to limit birth experiences to the last 5 years is supported by evidence that recall of childbirth is good at five years postpartum (Takehara et al., 2014)

During the screening call prospective participants were given the opportunity to ask any questions they had about the study. Interview times were arranged with participants either at the end of the screening call or in follow up emails. All participants received and returned consent forms (Appendix G) digitally via email. Participants did not receive payment or compensation for their participation in the study.

2.4.3. Interview Procedure

2.4.3.1. *Interview schedule and structure:* Review of related research within the scoping review helped shape the development of questions within the interview schedule (see Appendix H for interview schedule). The schedule contained six broad, open-ended questions related to relevant themes from the existing literature (e.g. '*What was your childbirth experience like?'*) in order to elicit in-depth information about participants' experiences of negative healthcare provider interactions during a traumatic birth.

The schedule was applied as a guide, in the format of a semi-structured interview with a view of creating the feel of an in-depth but informal conversation. The rationale for using a semi-structured interview was two-fold. Firstly, semi-structured interviews are suited to discovery and gathering exploratory data about individual experience (DeJonckheere & Vaughn, 2019). Secondly, consideration was given to the relational aspects of an interview and how power held by the interviewer may be experienced by participants who have had negative and/or traumatic interactions with healthcare providers previously. Taking a semi-structured approach to interviewing creates capacity for curiosity and 'unfolding, iterative interactions' (DeJonckheere & Vaughn, 2019), as such it is hoped that there was space for the participant to share what was meaningful to them and to feel heard.

Interviews began with introductions and information about the study such as consent and interview structure. The sensitive nature of the interview was acknowledged and participants were reminded that they were welcome to pause or end the interview at any point. Before starting the main part of the interview, questions were asked to contextualise the birth experience (e.g. '*were any interventions used during your birth?'*). The interview ended with a debrief where the interviewer checked in with the participant's experience of the interview. Full details of the interview process can be seen in the interview schedule in Appendix H. Upon completion of the interview participants were sent a debrief form (Appendix I) via email which contained information about further support, withdrawing from the study and data management.

2.4.3.2. *Interview setting:* All interviews took place virtually over MS Teams at a time that was convenient for the participant. When arranging an interview time, participants were encouraged to join the interview from a place where they were able to speak freely and confidentially. All participants chose to join from their home. The interviewer conducted the interviews from their home in a private office space.

2.4.3.3. *Recording interview data:* Thematic analyses require data used to be 'true' to its original nature (Braun & Clarke, 2006). As such, the interviews were recorded verbatim using the MS Teams software for auto-transcription. Transcripts were manually reviewed and edited for accuracy. During this process all identifying information, such as names, were removed to maintain confidentiality and anonymity.

2.4.4. Materials and equipment

Interviews were conducted and recorded using MS Teams software. Initial editing of transcripts was done using Microsoft Word. Both MS Teams and Microsoft Word were accessed using a personal, password protected laptop.

2.5. Data Collection and Analysis

Eleven interviews took place between October 2022 to January 2023. Data collected in these interviews were analysed using the six phases of thematic analysis described by Braun and Clarke (2006)

2.5.1. Participants

There is no well-defined guidance on sample size for thematic analysis and a priori calculations of sample size have been argued to be inappropriate for use with inductive approaches to analysis (Sim et al., 2018). In total, interviews were held with eleven participants who all identified as having experienced birth trauma and experienced negative interactions with healthcare providers. This sample size is comparable to other qualitative studies in the birth trauma literature. Demographic information of participants has been summarised in Table 3 below.

The participant sample was homogenous; with all participants identifying as female and all expect one identifying as white British. Participants gave birth between 2018 and 2022 and were between the ages of 26 and 40 at the time of giving birth (M = 31.18, SD = 4.31). There was an even mix of women giving birth vaginally (six women) and via caesarean (five women), however, nearly all births involved some form of operative intervention.

Table 3

Description of participant demographic information and birth type

	Age	Ethnicity	Gender	Relationship Status	Year of Childbirth Experience (Participant Age)	Birth Type
P1	36	White British	Female	Married	2019 (age 32)	Crash caesarean under general anaesthetic
P2	29	White British	Female	Cohabiting	2022 (age 28)	Vaginal birth with intervention
P3	29	White British	Female	Married	2020 (age 26)	Vaginal birth with intervention
P4	31	Hispanic	Female	Married	2021 (age 30)	Emergency caesarean
P5	38	White British	Female	Married	2021 (age 37)	Vaginal birth with intervention

P6	36	White British	Female	Married	2018 (age 31)	Vaginal birth (however was being prepped for caesarean)
P7	28	White British	Female	Cohabiting	2022 (age 27)	Vaginal birth with intervention
P8	35	White British	Female	Married	2021 (age 34)	Emergency caesarean
P9	41	White British	Female	Married	2021 (age 40)	Planned caesarean
P10	34	White British	Female	Separated	2018 (age 29)	Caesarean
P11	30	White Welsh	Female	Married	2021 (age 29)	Vaginal birth with intervention

2.5.2. Conducting the Thematic Analysis

2.5.2.1. *Phase one, familiarising self with the data:* This initial phase of data analysis involves reading and re-reading data collected in order to become acquainted to the content of the data (Braun & Clarke, 2006; Byrne, 2017). In this study this process began during the editing of transcripts as this was the first time the researcher read through the content of each transcript. Following this, transcripts were re-read multiple times.

2.5.2.2. *Phase two, generating initial codes:* Phase two is the start of meaningfully organising data, this is done by labelling pieces of the data that appear relevant or important with codes (Braun & Clarke, 2006; Byrne, 2017). Microsoft Excel was used in the current study for coding; codes were generated by systematically reading through the transcript, these were then recorded in an Excel spreadsheet along with the corresponding data extract. Throughout phase two, handwritten notes were kept of the process. Once coding was complete for all transcripts, the initial codes across the data were collated into one Excel sheet. An example extract of this can be seen in Appendix J.

2.5.2.3. *Phase three, searching for themes:* Codes are organised and collapsed into themes that represent a pattern of meaning in the data (Braun & Clarke, 2006; Byrne, 2017). In phase three, the researcher searched for candidate themes in the data; this process involved multiple iterations and amendments as themes were shaped. The researcher continued to keep handwritten notes of the process, including mind maps of initial themes. A mind-map of initial candidate themes and subthemes can be seen in Appendix K.

2.5.2.4. *Phase four, reviewing themes:* In this phase the candidate themes are reviewed and consolidated. Braun and Clarke (2006) break this process down into two levels: 1) ensuring the codes within each theme form a ‘coherent pattern’ and, 2) evaluating if the themes provide a valid and accurate interpretation of the overall dataset. To guide this process the researcher used prompt questions suggested by Braun and Clarke (2012, cited in Byrne, 2017) e.g. ‘are the data too diverse and wide ranging (does the theme lack coherence)?’.

2.5.2.5. *Phase five, defining and naming themes:* Once final themes were identified, they were named and defined. Definitions of themes aimed to capture the ‘essence’ of what is contained within that theme (Braun & Clarke, 2006).

2.5.2.6. *Phase six, producing the report:* Writing up the final themes and analysis within a report, or in this case thesis, is the final stage of the analysis. In line with Braun and Clarke’s (2006) guidance, attention was paid to selecting data extracts which were able to vividly illustrate the nature of the theme. The researcher aimed to present the themes analytically, within the context of the research questions.

2.5.3. Quality

Spencer et al (2003) describe four guiding principles for assessing research quality: contribution, defensibility, rigour and credibility. Descriptions of these four principles and discussion of issues relating to quality will be discussed in the discussion chapter of this thesis (section 4.3.1).

To help ensure that these four principles were evident in the current study, researchers held in mind Braun and Clarke’s (2020) twenty critical questions for evaluating thematic analysis (see Appendix L for the question list).

2.6. Ethical Considerations

It is paramount that all research prioritises patient safety and is conducted ethically.

2.6.1. Distress and Risk

Revisiting and sharing traumatic experience has the potential to cause distress for participants both during and after the interviews. Although there is some evidence that taking part in trauma research is experienced positively by participants and does not result in harm (Griffin et al, 2003; Jaffe et al, 2015), active efforts were made to minimise the potential for distress.

The interviews were facilitated by a Trainee Clinical Psychologist with experience of working therapeutically with mental health difficulties in the perinatal period. For each interview a compassionate and flexible approach was adopted, and participants were given the opportunity for break, rescheduling and withdrawal if needed. During the interviews several participants became tearful or upset when retelling difficult parts of their birth experience, however none of the participants wanted to break or stop the interview. Participants were invited to only answer and share what they felt comfortable to and to ask any questions they may have. During the debrief section of the interview participants were given a ‘check in’ and asked how they found the experience. Post interview, all participants were provided with a debrief form (Appendix I) that contained signposting information to relevant sources of support.

As all participants received a screening call prior to the interview, it was expected that disclosure of risk or safeguarding concerns would be unlikely. If any concerns were disclosed a plan was made for the researcher to seek supervision from an experienced clinician. The next steps and any actions would be communicated transparently with the participant. However, as anticipated, there were no concerns relating to risk or safeguarding during the course of the interviews.

2.6.2. Informed Consent

Informed consent is a key feature of ethical research. Prior to participating, all prospective participants were provided with a participant information sheet (Appendix F). This information sheet contained information about the research aims, what participation involves, potential disadvantages to taking part, confidentiality and data management. The researcher’s contact details were provided for prospective participants to ask questions. Participants confirmed that they read and understood the information by signing a digital consent form (Appendix G) prior to participation. Additional opportunities to ask questions were given during the screening call and the interview itself as well as reminders of the right to withdraw.

2.6.3. Confidentiality and Anonymity

The participant information sheet (Appendix F) provided participants with information about confidentiality and its limits. To maintain anonymity and confidentiality all identifying information was removed, this included details relating to healthcare providers such as hospital name. For all activities post-data collection participants will be referred to by a participant number (e.g. P3).

2.6.4. Data Management

All data was collected and stored in line with General Data Protection Regulation (GDPR) as set out in the Data Protection Act (2018). To manage this a detailed data management plan was developed and approved by the UEL Data Management Officer (Appendix M).

Contact numbers were deleted for all participants upon completion of the screening call. All participants were asked if they would like to receive a summary of the research via email. For the participants who agreed, their email addresses will be deleted after they have received the summary. For participants who declined, their email addresses were deleted once the interview had been completed and the debrief form had been sent.

Final edited and anonymised transcripts were stored digitally using the secure and encrypted OneDrive for Business (UEL account). Transcripts saved within MS Teams and laptop downloads were deleted once transcripts were edited and uploaded to OneDrive. Transcripts will be held by the Director of Research for a maximum of 3 years, after which all data will be deleted. Full description of the data management process can be found in the data management plan in Appendix M.

3. RESULTS

3.1. Overview

To answer the research questions of this study, a thematic analysis of interview transcripts from eleven participants who had experienced birth trauma and negative interactions with healthcare providers was conducted. The results chapter of this thesis presents the themes and subthemes developed through the thematic analysis. These will be discussed within the context of the research question and situated within the existing literature and relevant theoretical frameworks in the upcoming discussion chapter.

Themes and subthemes will be defined and illustrated with use of extracts from the interview transcripts.

3.2. Use of Interview Extracts

In a thematic analysis data extracts are used to illustrate themes and ‘make an argument in relation to your research question’ (Braun & Clarke, 2006). Some extracts presented within this thesis have received edits for the purposes of clarity. Any edits were to enhance readability and the meaning and content of the extract was retained. For example, sometimes words were added to provide context to the reader. When this happened, the word was placed within square brackets (e.g. P9: ‘I didn’t know when he [the baby] was taken out’). Similarly, the removal of words is indicated by ‘[…]’. As described in the results section, participant numbers will be used to maintain anonymity and confidentiality. All extracts presented will be attributed to a participant number (e.g. extracts from participant three would be labelled ‘P3’).

3.3. Introducing and Defining Themes

The thematic analysis resulted in three main themes and eight subthemes. Table 4 below provides an overview of these themes.

Table 4

Themes and subthemes developed through thematic analysis of data

Main theme	Subthemes
Hospital centred care	
	Consent, choice, and informed decision making
	Confusing, conflicting, and frightening communication
	Centring the birthing person
Power and the maternity system	
	Power and acknowledging harm
	Unseen and unheard
The Lasting impact	
	Difficult emotions and processing the birth
	An altered reproductive journey
	Trusting the system

3.3.1. Theme One: Hospital Centred Care

This theme describes participants' experiences of care which stood in contrast to the national commitments to person-centred care in NHS maternity systems (National Maternity Review, 2016; NHS Long Term Plan, 2019). Within this theme participants shared experiences where their needs were secondary to those of the hospital. Participants described feeling excluded from discussions about their care and unable to make informed decisions due to lack of or inconsistent information sharing. Consent to interventions and examination was often lacking and many participants felt coerced into consenting to procedures. The experiences of the care diminished participants' feelings of control and their sense of safety.

Participants shared hopes for maternity systems to be able to deliver compassionate and person-centred care where information was readily available.

3.3.1.1. *Consent, choice and informed decision making:* ten out of the eleven participants shared difficult experiences with consent, lack of choice and lack of information. Participants described feeling pressured to make choices based on the way in which healthcare providers presented options to them. For example, participant one recalled being presented with a choice where there was a sense of implied threat. Whereas participant two described being presented with a 'it's this or nothing' style choice.

> P11: The doctor came in and she went to do an [internal] examination on me […] I was like 'ohh no thank you' and she was like 'no I have to do it otherwise it's a c-section'. And I was like 'I don't want a c-section' and she was like 'so I need to do the examination'. I was like 'I don't want you to do the examination' and she was like 'then you are having a c-section'. There was no room for me to have a different option.

> P2: I'm not taking morphine as she's [P2's baby] premature and already at risk of respiratory distress. I'm not going to give her something that's going to make her potentially be on a ventilator. And she [the midwife] left the room. Come back in with the morphine. Was like 'you can't get an epidural, take the morphine, it'll help'. Waving it in my face. That was the only thing I was getting.

Participant six, described how her healthcare providers encouraged her to choose their favoured birth plan by emphasising the risk to her infant.

> P6: I got played the dead baby card a lot, like probably about five occasions whilst I was sort of fighting for this VBAC [vaginal birth after caesarean]. Where people, consultants particularly, would say, there's a risk if what you're doing is going to mean your baby dies. That language is not helpful. That language isn't particularly true. They don't frame it in a way that's healthy and reasonable. Like saying 'this is your risk of rupture, here's the evidence for that. And to make you aware if you do rupture in this many cases the outcome of the baby dies' […] So I was very much pushed towards their method that they felt was safest, which was a caesarean for me. Caesarean wasn't a safe first option, it wasn't best for me […] I had a ten-month-old baby when I gave birth and had to carry him everywhere. Couldn't do that with a c-section.

Participants also described feeling violated by invasive examinations and procedures being conducted without any form of consent being obtained.

> P4: I just got violated basically left, right and centre. When they took the plug off of her [P4's baby] hair the midwife was like I can't reach it because she is so high up. The doctor just came, said 'oh I'll get it' and just shoved his entire arm and pulled it off. And I'm like, you're not going to ask me if that's ok?

> P2: I was listening and one of the doctors come in and they said oh we only have, I don't know if it was 1% lidocaine or whatever […] And the doctor, he was sat at the foot of the bed was like 'it's fine, draw it off'. Like, right they're going to cut me. So, they did an episiotomy without saying. I only knew it was happening because I heard them talking about the lidocaine.

Other participants shared examples of interactions which suggested a 'tick box' approach to the consenting process.

> P8: I'm at 37 weeks and I saw a consultant I had never seen in my life who just went 'here's a piece of paper, sign here'. And I was like, 'what the hell is this for? Oh, the consent form, for what?'. There was no discussion, no plan, no forewarning. Nothing. I was terrified.

> P10: It seemed that yeah, I'd signed a document when I'd gone to have my caesarean. I don't have a clue what I signed, what was in that? But I definitely know that, yeah, there was a lot that was just action without my consent.

Issues relating to consent also related to participants' inability to make informed decisions due to being provided with limited information to support decision making. This contributed to some participants feeling out of control and struggling to make sense of the events which took place.

> P11: I was like I don't understand, and no one was telling me what was going on or why. I feel like the minute I went onto the labour ward I didn't have any control over my labour. At that point it was just people making decisions and I wasn't involved at all.

> P3: You're stuck in a trauma cycle, you're still looking at the same thing, trying to make sense of it. Whereas if that information is given to you, you're not having to google it at three o'clock in the morning.

In addition, the lack of choice and consent resulted in participants feeling excluded and alienated from their birth experience.

> P10: I just had the sense I wasn't involved in any kind of decision. Like I can remember very clearly that I was asked what radio station I would like on during the procedure. But anything personal […] there was just no options for me, like there was no discussion. It was very much like, this is what is happening, that's the end of it.

> P8: They weren't letting me be me. I felt very much like a child, like someone else was in charge […] to the day I die, I will never say the words that I gave birth to him because I didn't. And that, the whole experience has been stolen from me. I feel like it's just been taken away.

3.3.1.2. *Confusing, conflicting and frightening communication:* This subtheme captures participants' experiences of unhelpful, or lacking, communication with their healthcare providers. Conflicting advice from different healthcare professionals fostered feelings of fear and confusion.

> P1: The worst bit I think was when the consultant left that room and said stop pushing, and the midwife said keep pushing, and the registrar said I don't know. And that is when I felt utterly terrified, like, what the hell are you all doing? You're meant to be professionals. I've got three different answers here. I think that was the worst, scariest point in terms of how they work. So I thought, like no one knows what they are doing. And you feel like you've got no choice, I couldn't go home.

> P5: His [doctor] manner was so lackadaisical. He told me that I'd never had an infection, that I didn't need antibiotics […] I said 'can you please explain to me then why I've been on intravenous antibiotics for five days, why have I been told that I have a course of antibiotics to take home and now you're completely contradicting them'.

At other times, there was a complete lack of communication about the events that had taken place.

> P9: I had this overwhelming feeling I was going to die. I think they refer to it as impending doom. And the anaesthetist was talking to me very calmly. Took my other arm that didn't already have injection things in and started putting things in that arm. But no one explained what was going on.

> P10: Within the first few minutes they had to stop the procedure because they informed me that they'd found something, which terrified me […]. Is there another baby? I don't understand […] They said they'd found something and when the consultant came, he was like 'no, no it's fine carry on'. And that was it, it was kind of really brushed over. So, like in my head, I'd already gone through was it a child that's a twin that hadn't progressed? Was it cancer? My head was in a complete spiral.

Feelings of confusion and fear were also a product of unclear plans resulting from staff not communicating with each other.

> P9: Every single shift that came on I would ask the same questions, when would I get my blood thinners? […] Can I get some painkillers? […] and I was always met with blank looks or 'I'll go check' or 'we've not had an update'. There was no communication.

Participants reflected on how inappropriate and lacking communication was a by-product of the routineness of childbirth for maternity professionals.

> P8: It might be routine for someone who does it every day. It's not routine to me.
>
> P9: The registrar stood in front of me and he said we will be coming to your room to do a debrief shortly. As he stood there, he's holding his Crocs in his hand covered in blood, cleaning them. I didn't know I'd haemorrhaged at this point. I had no idea what had happened and I turned around and went 'is that my blood?'. He looked at me and went 'yes' and I laughed because you know I didn't know what was happening. But that image of him holding his Crocs covered in my blood is actually probably the lasting image of my birth.

3.3.1.3. *Centring the birthing person:* Participants expressed the importance of centring the birthing person and their individual needs during childbirth. Healthcare providers paying attention to birthing people's needs during the intrapartum and postnatally was seen as having the potential to mitigate the birth trauma experienced by participants. For many participants, this could have been achieved by healthcare providers simply being more empathetic and compassionate in their interactions with them.

> P9: I didn't need someone to come and give me a cuddle and tell me everything was going to be alright. I just needed someone to understand how I was feeling.
>
> P1: I think I could have got over the trauma of the birth […] it would be hard still because mistakes had been made and so I'd already been let down, and it was, you know, really basic stuff that didn't have to happen. But I think I could have got over that if immediately afterwards there was care and compassion and understanding, whereas I felt like I was in a parallel universe. I remember sitting and thinking 'what? What? Everything I've been through. Why is no one saying anything? Like why is no one looking after me?'.

Many participants had created birth plans to communicate their individual needs and preferences. However, participants described birth plans being ignored or dismissed, even when there were no apparent barriers to delivering the plan. For some participants this meant they were denied experiences that were important to them.

> P5: They didn't respect anything that was in my birthing plan. I didn't have skin-to-skin contact. My baby was born a ten out of ten on the APGAR score so it was not like they needed to check on her. They didn't put her on my breast. I was denied the golden hour and I wasn't even asked about it.

> P10: In my birth plan it was highlighted that having skin-to-skin was really important to me and also that as long as she [P10's baby] was medically ok, that she didin't have to go to NICU, the baby and my husband stay with me until I come out of theatre. And straight away they said we're going to take her through with your husband to your bedroom and I just thought, like where?

Other participants described how lack of acknowledgment of the birth plan prevented necessary accommodations and adjustments being made.

> P8: I went over and above in the explanation of what reasonable adjustments I was asking for. I asked for less than I thought I needed so that I wasn't asking for too much, but we never once even got acknowledgement.

Participants described how a focus on monitoring created a barrier to receiving care which supported their individual needs and preferences.

> P6: I needed my birth to be active and be able to move around. I didn't want to be restricted in any way. And there's a lot of evidence to say that routine monitoring isn't always useful. And they could just not get their heads around that fact.

> P4: I'm like they were restraining me to the bed to keep monitoring the baby. I couldn't move around. I couldn't shower. I couldn't do anything.

3.3.2. Theme Two: Power and the Maternity System

This theme encapsulates participants' experiences of the maternity system and how that system contributed to their traumatic birth experiences. Participants described a power imbalance within the healthcare provider–birthing person relationship and how it operated in a way that resulted in harm. Within this dynamic, participants felt unsafe and struggled to get themselves seen or heard by their healthcare providers. This theme also speaks to participants' experiences of maternity systems being poorly equipped to acknowledge harm.

3.3.2.1. *Power and acknowledging harm:* Participants were aware of an inherent power imbalance between themselves and healthcare providers during their childbirth experience.

> P11: I think what was really hard is sometimes interactions were kind of like there was an external layer of 'we're doing this to help you'. It wasn't a really overt 'I'm going to be really aggressive' […] it was almost like insidious. I think it made it harder to understand what was going on. But looking back, actually, the word I would use to describe it is abusive. It's an abuse of power. It's an abuse of knowledge and it's an abuse of someone being in a vulnerable situation.

> P5: I was less than, so I was not an equal party in the interaction. And as a professionally registered person, I was really shocked I couldn't articulate myself in a way to get myself out of being less than. […] And that was awful. Like really, really awful. It was like being in a nightmare.

Participants described working hard to diffuse the power imbalance to regain some control in their birth experience.

> P6: I had to basically write a paper on my research that I'd done myself and write my conclusions in black and white. And staple it to my notes that I had done research. I had made an informed decision.

> P2: I felt like I argued with staff the whole time, my whole labour.

The stress and fear created by the experience of the healthcare provider-birthing person relationship had a direct impact on how able some participants felt to give birth.

> P4: The thing that it seems like they don't understand is that what they are creating is your adrenaline levels to rise. And if your adrenaline level is rising so much, you're not going to have a birth, that's going to stop it […] Because they make you feel anxious and in there, I said to my husband I think I would

> only be able to have a natural birth where I feel safe. I don’t feel safe in hospital. I would never relax in hospital and completely get in the moment. I was constantly on guard. Like, what they going to do now, what they going to come for now, what type of rubbish they going to tell me.

Experiences of harm were perpetuated by maternity systems failing to appropriately acknowledge the harm caused. Participants described being met with defensiveness when they tried to understand what had happened to them and why.

> P1: The postnatal interactions are just as traumatising as the birth […] it was like gaslighting to it’s highest proportion. It was like no one acknowledged what had happened and the language feels so defensive, it feels like they’re waiting for you to sue them. And so, they sweep everything under the carpet and it’s like ‘well, at least you’ve got a healthy baby’. I got told that so many times and it’s like yeah, I know that. But also, why do I feel so awful?

> P5: I was in a t-shirt and knickers, I hadn’t had any sleep, my husband wasn’t present. He [the doctor who delivered P7s baby] came into the cubicle and sat on my bed and he said ‘I’m really sorry. I think that I may have removed the placenta too soon and that’s what caused the problem’. Now that doesn’t seem to be anywhere in my records. He refutes saying it in the complaint. […] I know that conversation happened and I can remember thinking to myself ‘remember this, remember this, this is significant’. But nobody would acknowledge he’d said it. […] So I was left with this interaction that I claimed happened, but I could tell no one wanted to acknowledge it. And that’s had a much more profound effect on my mental wellbeing that probably anything else.

Failure to appropriately respond to harm undermined opportunities to address traumatic births, such as birth debriefs and formal complaints.

> P11: In my debrief that matron said to me ‘you and I both know what happened to you in terms of consent, and some of the things that happened were illegal. But you and I know if you stood up in a court and a doctor stood up in court who’s going to be believed?’ […] it’s a shame the complaints process is so combative. It feels harmful when it should be a healing process

> for people. I think how professionals and systems are responding to that really need to change.

Some participants felt let down by the lack of meaningful follow up or investigation of mistakes made in their care. For example, Participant 7 experienced seizures during and after giving birth due to a retained pessary and felt that errors made in her care were not adequately addressed:

> P7: The retained pessary meant that they were forced to trigger an investigation anyway. But yeah, it's lots of bureaucratic nonsense. No one can be held responsible. It's a procedural issue. But is it a procedural issue when I told your midwife that it was still there and she ignored me, is that a procedural issue?

Whereas Participant 3, who needed a colostomy bag fitting soon after giving birth, described a lack of transparency and conflicting information given regarding what had happened to her.

> P3: So someone that's never met me, someone that had never seen my vagina, for someone that had never saw that tear, had made the decision to downgrade my tear. I was then stitched at his classification of what I was originally told was a fourth degree tear. So again, it was all these other questions covered up and it felt a lot like covering tracks. Just felt fishy.

3.3.2.2. *Unseen and unheard:* This subtheme describes how participants felt like they were not seen or heard within the maternity system. There were multiple descriptions of how healthcare providers dismissed or ignored participants' embodied experiences.

> P5: I kept saying I am in a lot of pain, I feel as though I am giving birth again. And they were like 'oh it's just your uterus contracting'. This is one of the main bugbears, not being listened to. And I said I wanted to ask for gas and air because I was in so much pain and I couldn't hold the baby. And I kept looking at him going 'please don't wake up, please don't cry because I can't help you'. That's something that really upsets me. And later that day, I was moved […] when they changed the bed, more birth product came out and more placenta on the bed. I was absolutely horrified because that's why I was in pain, my

> body expelling both these products. And then I was given some really brush off explanation […] when I think now about my mental state at that time, I was 100% in shock. Just absolutely in shock.
>
> P2: Even when the doctor and everything came in, like I was having back-to-back contractions. Intense contractions. Like an hour and half before she was born and the midwife has said to the doctor 'she's not really contracting' […] just completely dismissing everything I had said.

This dismissal was not limited to maternity services and participants described being dismissed when seeking help for ongoing physical issues related to the birth.

> P7: [sought medical support for seizures and sensation changes in arm postpartum] Someone told me I was just tired and that was the reason. Someone told me and another obstetrician told me that I was a medical anomaly and there was nothing physically wrong with me. I'd like her to eat her words because it turns out on day twelve they found the retained pessary.
>
> P3: [describing seeking help for passing gas vaginally following a serious tear during childbirth] I think the whole thing was really frustrating. Like obviously telling the health professional like there's something wrong with me, why you not helping me? But I don't think in my head I had any idea that I was going to end up with a colostomy bag at 26 years old. Like that was huge.

Additionally, participants described how their psychological needs and distress during childbirth went unnoticed or unacknowledged by their healthcare providers.

> P10: My first words were that's [P10's baby] not mine. For me to say that was like a cry for help, like what's going on, like why have you given me a child that's not mine? […] There was just no communication about what was happening. And when nobody questioned when I first said that she's not mine, I though that there isn't anyone I feel I can trust around me.
>
> P11: My brain won't compute that I gave birth because I couldn't feel anything and I couldn't see anything. There was nothing to kind of make that make sense and no one cared. They just wanted to know whether it was a boy or a girl and I was just trying to be with my baby.

Healthcare providers' reactions to participants trying to get themselves heard left participants feeling further dismissed and infantilised.

> P9: Every time I asked for something I felt as if I was being a nuisance. I felt like I was being a naughty schoolgirl.

> P5: One of the things they kept repeating and they repeated it to me from being out of theatre. I just had this terrible experience. I've just lost 2.5 litres of blood. And they say this phrase, they say 'you've just given birth, you're really emotional and you hormones are all over the place'. And at one point I said you are going to have to stop saying that to me because I am completely in control of my emotions. I was in shock, but I was in control of my emotions. I was like my feelings are 100% valid and you are not recognising them because of this. It doesn't matter what's wrong with you, they say that to you for everything and everyone […] It's blaming you. You are not a person. You are just a slave to those hormones that you have no control over. And it's like just because I've had a baby doesn't mean I don't know my own thoughts and my own feelings about things. I was like, how could you possibly strip me of that.

Participants also shared the dehumanising nature of interactions where they were not acknowledging or listened to.

> P8: I said to somebody at one point, I felt that I was like a taxi. Like the passengers important and I'm just nothing, I don't matter and that's the feeling I got from every single person in that hospital.

> P5: I felt like a vessel. In terms of being a human being with cognitive thoughts, it wasn't a factor. I was a vessel for the baby and that was really very, very hard to come to terms with.

For some participants, they understood their negative interactions as being connected to their identity as a woman using healthcare services.

> P7: It was derogatory to read the woman, the woman, the woman, the woman, the woman, because it was like I'm only having this experience because I am a woman. […] but it goes into care is poorer for women […] I

> could be totally wrong, but in any other medical circumstances, if something is retained in your body, it's negligence.

3.3.3. Theme Three: The Lasting Impact

The significant and lasting impact of birth trauma and negative interactions with healthcare providers is captured within this theme. Participants reflected on the psychological impact of the trauma and how they feel changed as people following their experiences. For some participants, the impact of their experiences in the maternity system left them questioning whether they would be able to have more children in the future, despite wanting to grow their family.

3.3.3.1. *Difficult emotions and processing the birth:* The emotional impact of the birth trauma was substantial, and many participants described struggling with difficult emotions long after their baby was born. Some participants internalised their experiences of being dismissed and felt a sense of failure for being unable to get themselves heard.

> P8: For a long time I felt like I failed him [P8's baby]. I failed him before he was even born. So many things I know that I didn't fail with, but I feel like I did. And there's this weird disconnect between if I look at it as an outsider and if I look at it as me […] I should have pushed and said 'no, he's not right. I want the paediatrician up here'. But they were just to dismiss me as some looney first time mummy who worries about everything.

> P7: I felt a lot, and I still do, feel like it's my fault because if I had been like 'there is definitely something wrong' actively, (*pause*) but then saying that, I don't think it would have made any difference because I think they just thought it was in my head.

Feelings of self-blame and guilt led some participants to question their worth as a parent.

> P10: My worthlessness kind of increased, like I don't deserve to be a mum. Like my body let me down and was it a sign that I shouldn't have even had this baby?

> P5: I felt like I was going to be a completely inadequate parent. I don't understand how I am going to look after this baby? I don't know what I am doing? I'm actively harming him. That was the feeling. I've waited all this time, I'm an older parent and actually I'm not fit for purpose, you know. That was a really horrible, horrible feeling.

Questioning of worth also extended to participants' confidence within themselves more generally.

> P10: It's really knocked my confidence in all areas of like being me, let alone being Mum as well.

> P7: I feel like all my confidence has gone because I don't have any faith in myself whatsoever, even though I know I was right.

Healthcare providers failure to acknowledge participants' experiences made it hard for participants to accept that their difficult feelings about their birth experience were valid.

> P1: There was no sorry. There was no, just, acknowledgment of what you experienced. Just minimised it and making you feel not valid. And it was only when I started seeing the Clinical Psychologist for PTSD treatment that she validated it. And that's when I really thought actually it's okay to feel this bad about this.

Many participants described trauma-related symptoms which impacted on their day-to-day lives. This included reliving symptoms such as nightmares and flashbacks.

> P8: I had flashbacks for a long time afterwards, like, I was just reliving it over and over.

> P2: Even bringing the breast pump to the hospital, I was freaking out. Like at night when I'm freaking out, everything's going through my head, and I end up like rocking in my bed in my hips. And then it triggers me mor because I was rocking in labour. When I was struggling to get pregnant, I would have done deep breathing exercises, to kind of help with the stress and stuff. But even breathing exercises now triggers me because of breathing in labour.

The adjustment to being a parent to a newborn, meant that for some participants the emotional impact of the trauma was not fully realised until some time after they gave birth.

> P11: To begin with I think you are just in kind of survival mode because you have a newborn and you have a job to do and it's 24/7. You can't stop and pause and take a breath […] I really started to realise that I wasn't ok when I started to go to mum and baby groups a few months down the line and everyone starts talking about their birthing experiences […] tears would pour out of me every time, there was so much emotion there that didn't have anywhere to go because I had to be mum all the time.
>
> P3: I had a bit of a mental breakdown about all of it, like a month ago. I coped with it so well for like the last two years and I've just sort of kept my head above water, but all of a sudden it just imploded and I was like fuck I need help, I actually need some help with this.

Some participants also spoke of how the birth trauma also had a significant impact on their partners.

> P5: My husband had seven months off work because he could take six months paid paternity. We knew it was going to be difficult as first-time parents, older parents especially. But still, it was going to be seven months together and we were going to have this amazing opportunity so many fathers don't get […] It was just awful a lot of the time, it was just really terrible. It was very sad, but I had to not be sad because I had to look after the baby. And he changed completely. He wasn't and still isn't the person that I knew before.
>
> P11: He [P11's partner] carries an awful lot of guilt because I'll say 'I didn't want that and I tried to make people listen and no one listened' and he kind of say's 'it was my job to get them to listen to you. And if you failed, I failed'.

3.3.3.2. *An altered reproductive journey:* Over half the participants commented on how the harm caused by negative interactions and resulting loss of trust in maternity systems altered the course of their reproductive journeys. For some this was changing their mind on, or questioning, if they wanted children in the future.

> P3: For the first year, I didn’t want to have anymore. I was like absolutely no way. But I don’t want my daughter to be an only child.

> P8: I said ‘I’m never having another child again. It cannot and will not happen and it’s not up for discussion’. He [the GP] told me I’m strong, told me I didn’t know what I was talking about.

Whereas others considered alternative routes to deliver future children, such as free birthing.

> P7: I do want more but we’ve already like decided that if we had another baby we just wouldn’t go to a hospital.

> P11: [who is currently pregnant with her second child] I really really considered free birthing because of my experience. Like there’s no way I’m ever engaging with our system again […] obviously if it’s like life or death situation or I absolutely have to I will reengage with that system, but if there’s any possible way that I can avoid doing so I will. I don’t trust it at all.

3.3.3.3. *Trusting the system:* Participants’ experiences of traumatic interactions whilst giving birth had a profound impact on their trust of maternity systems, and healthcare systems more broadly. This lack of trust was exacerbated by an awareness of systemic issues such as staffing, culture and application of policy.

The majority of participants described an altered relationship with accessing healthcare and felt that they could no longer trust that they would be treated well when receiving care.

> P5: I have zero trust now. And that’s very strange for me to think because my feeling used to be that if there is something wrong with you, a medical professional will help you find the problem and put it right. I don’t believe that now […] that’s something I’ve had to come to terms with, the fact that I will trust my own judgement and fact finding over that of the doctor. And that’s not a very nice feeling because now I think gosh, if I get a terrible illness, how can I trust them to treat me correctly? That’s the horrible feeling.

> P4: Basically they just made me concern for my life. If I'm in hospital and if I'm awake and they don't ask for my consent, imagine if I get into a coma or something, what they going to do to me?

For some participants, accessing medical support serves as a reminder to the birth trauma and gives rise to feelings of fear and anxiety.

> P7: A big thing is we decided to move because I will never, ever, ever return to that hospital and I am now terrified of returning to any doctor or whatever because I have no trust.

> P1: I won't phone the GP, my husband will because I'm triggered by having to phone the GP. Now I take anti-anxiety medication and I'm always running out because I can't face phoning to sort out a repeat prescription. And like last month […] I run out, was getting really woozy like withdrawal effects. And in the end I just spent £40 on a private GP online consultation who could prescribe it. And I just thought this £40 for me is well spent because I don't have to phone the GP.

Participants shared understanding their traumatic birth experiences in the context of organisational and systemic issues. This contributed to a lack of trust more broadly in healthcare settings.

> P1: it felt like a system was falling around me and I was in the middle.

> P9: I mean sometimes you have rogue doctors or rogue nurses and things like that, but you can't go blaming individuals. It's a whole culture within an organisation. But unfortunately, the organisation is nationwide.

There were particular concerns about how the hierarchical cultures within the NHS contribute to traumatic interactions and harm.

> P6: Consultants just ruled the roost. They were not challenged […] There was this culture of trying to avoid risk, which actually caused more risk because they were just absolutely mad decisions, and my case is just one of them [P6 nearly underwent an unnecessary caesarean].

> P11: My midwife didn’t stand up for me or advocate for me at all and I wonder about the power dynamics there in terms of registrars, consultants, midwives and the hierarchy within the NHS

Navigating a new relationship with healthcare systems was especially challenging for participants whose professional identities were related to healthcare.

> P11: I found it really hard to go back to work because I work for the same overall organisation. And you know, I just really struggled with this organisation has done harm to me and to other people, I’ve met other people who have very similar kind of stories. How can I work for an organisation that is doing this harm? How can I justify that? What does that mean? […] I had to do a lot of kind of thinking really seriously about what that meant and what my options were, my choices were. But also, in terms of healthcare has just totally broken my trust. I don’t trust that a professional will be honest with me anymore. I don’t trust that they’ll empower me. I don’t trust that even their decisions are the right decisions.

> P2: I don’t know what I am going to do about work because I work in the same kind of hospital. Thankfully, I work in ICU, so a lot of my patients are sedated. But, I mean, they’re not always. And I don’t know how I will cope with seeing them, seeing the interventions. I don’t know. I’ve considered maybe changing.

4. DISCUSSION AND CONCLUSIONS

4.1. Overview

This study explored negative interactions with healthcare providers and their contribution to experiences of birth trauma. Themes developed from the thematic analysis will be discussed in this chapter in relation to the research questions and in the context of existing birth trauma literature. Strengths, limitations and reflexivity are considered within the critical review. Additionally, the chapter outlines recommendations for practice and suggestions future research based on the study findings.

4.2. Research Questions, Existing Literature and Study Findings

The study sought to answer two research questions: 1) how do birthing people describe their negative interactions with healthcare providers; 2) how did negative interactions with healthcare providers contribute to the experience of birth trauma. To answer these questions three main themes were identified: 1) hospital centred care; 2) power and the maternity system; and 3) the lasting impact.

4.2.1. The Nature and Experience of Negative Interactions

Negative interactions with healthcare providers are an established risk factor for birth trauma (Elmir et al., 2010; Ayers et al., 2016; Simpson & Caitling., 2016; Simpson et al., 2019; Watson et al., 2021; Khsim et al., 2022). The participants in the current study provided descriptions and examples of negative interactions which were in keeping with descriptions in the previous literature (Thomson & Downe, 2008; Elmir et al., 2010; Byrne et al., 2017; Reed et al., 2017; Murphy & Strong, 2018; Patterson et al., 2019; Rodríguez-Almagro et al., 2019; van der Pijl et al., 2019). However, the experiences shared in the current study are situated specifically within a recent NHS context.

4.2.1.1. *Lack of personalised care:* The findings of the current study suggest a conflict between the agenda of the maternity systems and the individual needs of the birthing person. This incompatibility has also been reported in several previous studies (Byrne et al., 2017; Reed et al., 2017; Murphy & Strong, 2018; Patterson et al., 2019; van der Pijl et al., 2019). Theme one, hospital centred care, describes how participants in the current study experienced this conflict as the maternity system's needs being prioritised over their own. Examples provided ranged from maternity systems failing to recognise the magnitude of childbirth as a life event to forceful non-consensual care.

Beck (2004) highlighted how perceptions of birth may differ between birthing people and the healthcare providers caring for them. For maternity professionals' childbirth becomes a routine event, however for birthing people childbirth is an important and transformative life event (Downe et al., 2018). Healthcare providers' failure to recognise this difference in perspective resulted in interactions which felt task-orientated and unattuned to the individual needs of the birthing person. This misattunement was particularly distressing when there had been complications during the birth; for example, participant nine described the horror of learning that she had a major haemorrhage by seeing her doctor clean his blood-covered shoes in front of her.

Participants viewed the maternity system’s agenda as being accorded a greater priority than their individual needs. In line with previous findings, this appeared to be a consequence of maternity systems failing to offer true choice (Thomson & Downe, 2009; Elmir et al., 2010; Byrne et al., 2017; Reed et al., 2017; Murphy & Strong, 2018; Patterson et al, 2019; Rodríguez-Almagro et al., 2019; van der Pijl et al., 2019). Informed choice is identified as a key component of delivering high quality, personalised maternity care (WHO, 2007; National Maternity Review, 2016; NHS, 2019) and a cornerstone of ethical practice in healthcare (GMC, 2020). However, participants described receiving inadequate information sharing to make an informed choice and shared experiences of coercion through threat or being presented with ‘choices’ where there was only one real option available. For example, participant eleven, declined an internal examination and was told she either had to go ahead with it or she would have to have a caesarean. Concerningly, there were instances where choice was removed entirely, and interventions and examinations were carried out without any consent. The psychological impact of the lack of personalised care and non-consensual interactions will be discussed later in this chapter in section 4.2.2.2.

Personalised care is recognised both nationally and globally as being essential for positive childbirth experiences (WHO, 2007; National Maternity Review, 2016; NHS, 2019), yet the findings of this study and the prior birth trauma literature highlight that it can be difficult for maternity systems to deliver it. Villarmea and Kelly (2020) describe how elements of personalised care, such as shared decision making, are conceptualised at an individual level, rather than an organisational one. As such, the feasibility of delivering personalised care within pressurised and understaffed maternity systems has been questioned. In a study exploring healthcare provider interactions during childbirth and PTSD, midwives described the challenges of balancing personalised care and organisational demands as being ‘torn in two’ (Patterson et al., 2019). The idea of being ‘torn in two’ is consistent with the findings of the current study which suggests conflict between organisational needs of maternity systems and the individual needs of birthing people.

4.2.1.2. *Ethical practice:* All registered healthcare professionals, such as midwives or obstetricians, have professional codes of conducts and professional standards they must adhere to. For example, the Nursing and Midwifery Council's 'The Code' for nurses, midwives and nursing associates (NMC, 2018). Such codes of conduct aim to provide a clear set of professional standards to ensure the safe and ethical treatment of the people in their care. However, findings of the current study illustrate multiple examples of practice and care which violates such codes of practice.

The consent, choice and informed decision-making subtheme captures how nearly all participants shared difficult experiences with consent and decision making. The General Medical Council (GMC) position shared decision making and consent as fundamental to safe patient care (GMC, 2020). As such, the GMC have outlined seven principles to support good practice in processes of consent and shared decision making (described in Appendix N: GMC, 2020). However, participants; experiences of inadequate information sharing, exclusion from decision making, coercive consent, and non-consensual interventions are not in keeping with these principles.

Central to the seven principles of decision making and consent is the concept of autonomy. In biomedical ethics, the principle of autonomy describes 'the obligation to respect the decision-making capacities of autonomous persons' (Beauchamp, 2003, p. 269). The next section in this chapter, section 4.2.1.3., will discuss the lack of autonomy afforded to participants in the context of the assumptions underlying the maternity system.

4.2.1.3. *Assumptions of the maternity system, testimonial injustice and symbolic violence:* The findings of the current study support previous literature which has found that the experience of negative interactions is related to a lack of personalised care and non-adherence to decision-making processes. Theme two, power and the maternity system, captures how participants worked hard to get their individual needs met but felt powerless within their interactions with the healthcare providers. The participants' experience of this power imbalance was intrinsically linked to interactions that left participants feeling dismissed and dehumanised, with a diminished sense of safety. This was illustrated by several participants using metaphors of being a 'vessel' or a 'taxi'. These metaphors can be likened to

Villarmea and Kelly's (2020) 'container' metaphor, which described birthing people as being positioned as a 'container' whose 'contents' are best cared for by the healthcare providers.

These metaphors speak to the assumptions underlying the biomedical model of childbirth. The biomedical model views the role of healthcare services as to 'repair physiological mechanisms'; to achieve this they rely on the knowledge of trained professionals and medical technology (David-Floyd, 2001; Carel & Kidd, 2014). In maternity systems, the biomedical model lends itself to assumptions about high levels of infant risk and medical knowledge being paramount to ensure safety (Ballesteros, 2022). As such, birthing people are expected to passively receive care offered to them to ensure the safe delivery of their baby (Reed 2017; Ballesteros, 2022). Ballesteros (2022) suggest that such ideas intersect with societal ideals of motherhood as selfless and self-sacrificing, i.e. birthing people should sacrifice their needs and preferences to allow for the safe delivery of their child.

The endorsements of such assumptions in maternity services gives rise to paternalistic care. Assumptions about infant risk and the importance of medical knowledge results in the bioethical principle of beneficence (the 'obligations to provide benefits and balance risk against harm', Beauchamp, 2003, p.269), being positioned as of greater importance than the principle of autonomy (Iserson, 1999). As such, knowledge held by healthcare professionals and medical technologies is privileged over the knowledge and embodied experiences of birthing people (David-Floyd, 2001; Carel & Kidd, 2014; Reed et al., 2017; Ballesteros, 2022). The problem with privileging medical knowledge in this way is two-fold. Firstly, as illustrated in the previous section, it creates a barrier to delivering personalised care and accommodating individual needs and preferences. Secondly, it creates a power imbalance which leaves birthing people vulnerable to being unheard and dismissed (as illustrated in theme two, power and the maternity system).

Stereotypes attached to birthing people, such as 'unreliable patients' (Carel & Kidd, 2014), 'irrational women' and 'selfish mothers' (Ballesteros, 2022) can work to maintain power imbalances. For example, the 'stigmatising dilemma' described by Ballesteros (2022) was present in the accounts shared by the participants of the current study. Participants' experiences were attributed to irrationality in the way healthcare providers understood them in the context of hormones being ‘all over the place’, sleep deprivation, being a confused or overly-worried first-time parent. Interactions where participants were scolded or questioned about wanting to risk their infant’s life spoke to healthcare providers assumptions of selfish motives.

Participants’ experiences of being dismissed and ignored due to being characterised as irrational, selfish and/or unreliable due to their status as a pregnant person can be considered an example of testimonial injustice (Carel & Kidd, 2014; Ballesteros, 2022).The experience of testimonial injustice was not limited to maternity services and participants shared examples in other healthcare settings (e.g. GP surgeries and A&E) both antenatally and postnatally. It is possible that this reflects the position of pregnancy and childbirth as a ‘women’s health’ issue and the longstanding history of women being deemed irrational within medical settings (Villarmea & Kelly, 2020; Ballesteros, 2022).

In addition, the current study found that harm caused by the interactions and actions of healthcare providers, were poorly acknowledged by maternity systems. For example, participant one described how maternity professionals framed her childbirth experience as positive by focusing on the fact she now has a ‘healthy baby’, which invalidated her feelings about the birth. The failure to appropriately acknowledge harm caused could be considered a form of symbolic violence as it works to normalise and legitimise negative and harmful experiences, whilst undermining the experiences of the birthing person (Wijma et al., 2007; Thomson & Downe, 2008).

It is important to note that testimonial injustice and symbolic violence are not presented as issues with individual behaviour or personalities of the professionals working in NHS maternity services. Rather, it is considered as a systemic issue rising from the underlying assumptions of the system and the challenges created by the current socio-political context.

4.2.1.4. *Systemic issues:* Participants described interactions with individual healthcare providers which were problematic and concerning. However, most participants understood their experience of negative interactions as relating to systemic issues such as culture, staffing and policy. Detailed exploration of how organisational and systemic factors contribute to negative interactions with healthcare providers is outside the scope of this study. However, it is helpful to contextualise the participants’ experiences of interactions within the context of the current challenges faced by NHS maternity systems.

The current staffing shortages in NHS maternity services are an ongoing national issue (RCM, 2016; The Health Foundation, 2019; The Kings Fund, 2022), therefore it is reasonable to assume that staffing would have been a challenge experienced to some degree by the maternity services accessed by the participants. To manage the increased pressures of short staffing, maternity services have been found to prioritise efficiency and clinical outcomes over the relational aspects of care (APPG on Baby Loss and APPG on Maternity, 2022). The detrimental impact of short staffing is well documented (Kirkup, 2015; Ockenden, 2020; House of Commons, 2021a; APPG on Baby Loss and APPG on Maternity, 2022). Evidence provided by maternity professionals in the ‘Safe Staffing’ report (APPG on Baby Loss and APPG on Maternity, 2022) describes a burnt-out workforce which feels ‘exhausted’, ‘demoralised’, and ‘frustrated’. Burnout has been recognised as a consequence of the excessive workload created by short staffing in the NHS (House of Commons 2021b) and has a detrimental impact on the quality of patient care and safety (Salyers et al., 2017; Garcia et al., 2019; House of Commons, 2021b; Doherty & O’Brien, 2022).

4.2.2. Negative Interactions and the Experience of Birth Trauma

Participants provided powerful and emotive accounts of their birth experiences and described interactions with healthcare professionals which continue to impact their lives today. The birth stories shared featured physical trauma and unexpected serious complications, however participants described feeling as if they could had coped with these had they received kind, compassionate and personalised care.

4.2.2.1. *Connecting the experience of birth trauma to the experience of negative healthcare provider interactions:* The narratives shared by the participants of the current study all described unexpected physically challenging and frightening birth experiences. These included medical complications requiring emergency intervention and physical trauma which seriously impacted recovery in the postnatal period and beyond. Complications and physical interventions in the intrapartum have previously been identified in the literature as risk factors for developing birth trauma (Ayers et al., 2016; Simpson & Caitling., 2016; Simpson et al., 2018; Khsim et al., 2022). However, participants in the current study connected their experience of birth trauma to the negative interactions they experienced during their childbirth, rather than the physical events that took place or the need for emergency procedures. Several participants commented on how they felt that they would have been able to cope with the physicality of their childbirth had they received kind and compassionate care. This is in keeping with the existing birth trauma literature. For example, Ayers and Harris (2012) finding that one-third of the most highly distressing moments during a traumatic birth were interpersonal in nature (e.g., being ignored by staff) and negative interpersonal experiences were the strongest predictors of PTSD following birth.

Theme one, hospital centred care, and theme two, power and the maternity system, illustrate interactions with healthcare providers which were dismissive, dehumanising and disempowering. In line with previous studies (Thomson & Downe, 2000; Elmir et al., 2010; Byrne et al., 2017; Reed et al., 2017; Murphy & Strong, 2018; Patterson et al., 2019; Rodríguez-Almagro et al., 2019; van der Pijl et al., 2019), participants described how such interactions left them feeling alienated from the events of their birth and out of control. Furthermore, experiences of coercive and non-consensual care understandably eroded participants' trust in the maternity system's ability to care for them.

Lack of control and lack or trust diminished participants' sense of safety and left them feeling vulnerable in the hands of the professionals. Previous birth trauma research has drawn parallels between birth trauma, sexual assault, and torture (Beck, 2004; Thomson & Downe, 2008; Elmir et al., 2010; Reed et al., 2017; Morris et al, 2021). Both sexual assault and torture are interpersonal traumas which are typically sustained over long periods of time. Similarly, labour can last many hours during which birthing people are exposed and often physically restricted in what they can do (e.g. pain, epidural, attached to monitoring equipment). As such, birthing people have limited avenues to regain control and increase their sense of safety during a traumatic birth. The participants' experience of feeling trapped in a traumatising situation was summarised by participant one, 'you've got no choice, I couldn't go home'.

Being trapped within a system which left participants feeling vulnerable and unsafe understandably caused considerable distress. This was evidenced by participants' descriptions of ongoing trauma-related symptoms such as flashbacks of events that occur and strong emotional reactions to reminders of their birth experience. This is in keeping with previous birth trauma research that identified trauma 'hotspots' as being most commonly related to interpersonal events such as being ignored or struggling to regain power (Patterson et al., 2010; Ayers & Harris, 2012). Although this study was not exploring birth trauma within a PTSD context, the majority of participants shared either receiving a PTSD diagnosis or suspecting themselves that they may have PTSD.

The experience of birth trauma for participants was further perpetuated by a lack of opportunities for sense-making and processing of their birth experiences. A lack of information sharing from healthcare providers was present in all the accounts shared by participants. The absence of information resulted in participants struggling to make sense of the events that were taking place during their birth and exacerbated feelings of being out of control. Without the relevant information to understand the events that were taking place participants feared multiple different worst-case scenarios. For example, participant ten's caesarean was interrupted because doctors found 'something' and she was then told it was 'fine', the lack of follow up information left her wondering if she had cancer or if her baby had a twin that had died. Some participants felt that inadequate information sharing reflected a difference in perceptions of childbirth between themselves and the healthcare providers.

Postnatally, the lack of information made it hard to create a cohesive narrative of their birth experiences which impacted their ability to process events. This was worsened by the maternity system's failure to appropriately acknowledge the harm experienced by participants, as illustrated by theme two, power and the maternity system. Earlier in the discussion chapter, the failure to acknowledge harm was conceptualised as a form of symbolic violence. Symbolic violence is often subtle and is most noticeable in the way in which it impacts the individuals affected (Wijma et al., 2007). In the current study, opportunities to make sense of events (such as post-birth debriefs and complaints) were often invalidating experiences as healthcare providers approached them from a position of defensiveness or denial. This lack of acknowledgement legitimised the harmful interactions and care received. Participants described being emotionally disenfranchised, which subsequently gave rise to feelings of guilt and self-blame (as captured on theme three, the lasting impact).

4.2.2.2. *The lasting impact:* Theme three, the lasting impact, captures participants' reflections on the profound and lasting impact their experiences of birth trauma have had on their lives. Previous research has highlighted how the implicit messages in negative interactions with healthcare providers are internalised by birthing people (Elmir et al., 2020; Byrne et al., 2017). In the current study, the internalisation of experiences was linked to participants' experiences of being invalidated and not being provided with adequate information to make sense of their experiences. This resulted in feelings of guilt, self-blame and diminished confidence in self. Interestingly, there were parallels between participants' descriptions of feeling guilt and self-blame and the implicit messages of the 'stigmatising dilemma' (Ballesteros, 2022). For example, participants experienced interactions where their embodied experiences were dismissed as unreliable and also described no longer trusting themselves following their birth experience. Similarly, participants had experiences of their preferences being framed by healthcare professionals as needlessly risky to their baby and also described blaming themselves for the events of their birth and feeling like an unworthy parent.

In keeping with the literature, experiences of negative interactions during birth eroded participants' trust in the ability of healthcare providers to provide care (Thomson & Downe, 2008; Patterson et al., 2019). This erosion of trust has been previously described in the context of 'shattered expectations' (Patterson et al., 2019). Birthing people enter the maternity system expecting to receive respectful and compassionate care; however, the experience of negative interactions undermines these assumptions. The shattering of worldviews (such as '*healthcare providers will keep me safe*') during a traumatic experience has been found to change the way in which the world is viewed moving forward (Schuler & Boals, 2016). This was evident in the current study, where participants reported a complete loss of trust in healthcare systems and doubted that services were able to keep them safe or treat them humanely. This was particularly complicated to navigate for participants whose own profession involved providing care as it left them questioning how they could consolidate their experiences with their own professional identity.

Participants widely reported a changed relationship with help-seeking and avoiding accessing healthcare services when possible. Accessing healthcare services was described as highly anxiety inducing, and for some triggered trauma-related symptoms such as flashbacks. Alongside a changed relationship with healthcare, participants shared questioning, or no longer wanting, more children (see the subtheme, an altered reproductive journey). Fear of childbirth, or tokophobia, has been linked to previous experiences of a traumatic birth (secondary tokophobia; Jomeen et al., 2020; Olsen et al., 2022). Participants shared dilemmas concerning future children in the context of not wanting to re-enter the maternity system. This resonates with findings in tokophobia research which highlight childbirth fears related to the experience of care, such as fear of being ‘done to’ (Slade et al., 2019). However, caution needs to applied when using tokophobia as a framework to understand birthing peoples’ concerns and fears about re-entering maternity systems that have previously harmed them. Conceptualising the experiences as a phobia individualises the experiences and may work to further invalidate or trivialise experiences of harm.

4.3. Critical Review

4.3.1. Quality and Methodological Strengths

The four guiding principles of quality assessment described by Spencer et al (2003) were held in mind throughout the research process to maintain quality. This was supported through the use of Braun and Clarke’s (2020) twenty critical questions for evaluating thematic analysis (see Appendix L). The principles of contribution, defensibility, rigour and credibility will each be discussed individually in relation to the current study.

4.3.1.1. *Contribution:* This principle suggests that new research should contribute to the existing literature by developing what is already know (Spencer et al., 2003). A scoping review was conducted to understand what was already known about the experiences of birth trauma relating to negative healthcare provider interactions. The scoping review identified nine papers in total, with only two conducted within an NHS context (Thomson & Downe, 2008 and Patterson et al., 2019). The current study was able to build upon research by placing it within the current socio-political NHS context and consider findings within the current challenges experienced within NHS maternity care.

The broader birth trauma literature often conceptualises birth trauma through a PTSD framework. The use of a non-theoretical, participant-led definition of birth trauma was a methodological strength of the current study. Defining birth trauma in this way allowed for exploration of experiences that were of importance and meaning to the population being studied, rather than just experiences that are clinically significant. Furthermore, the current study is able to discuss recommendations for practice and policy that concern the current priorities of NHS maternity systems, such as personalised care.

4.3.1.2. *Defensibility:* It is imperative that a study's design is appropriate to answer the research question (Spencer et al., 2003). Thematic analysis was chosen is suitability to answer the exploratory research questions of this study. The rationale for thematic analysis alongside relevant epistemological and ontological considerations are discussed in detail in the methods chapter of this thesis (see sections 2.2. and 2.3.1.).

4.3.1.3. *Rigour*: The guiding principle of rigour focuses on the transparency of research through employment of systematic research processes (Spencer et al., 2003). Use of Braun and Clarke's (2006) six phases of thematic analysis provided the researcher with a framework to systematically analyse the data and pull-out themes which meaningfully represented the dataset. The initial phases of the data analysis were recorded using Microsoft Excel, this allowed for each stage of the data to be recorded (an extract example of the collated final codes can be seen in Appendix J).

The study acknowledged how they researcher plays an active role In constructing themes (Braun & Clarke, 2006; Byrne, 2021). As such, detailed description of the epistemological and ontological lenses applied to the data was provided (see section 2.2.). The findings are further contextualised through discussion of author reflexivity during the research process (section 4.3.3.). Handwritten notes were kept throughout the process to record thoughts, decisions and aid the meaning-making process.

4.3.1.4. *Credibility:* Credibility is concerned with the extent to which the study's conclusions are accurate and well-founded (Spencer et al., 2003). The systematic approach of Braun and Clarke's (2006) six phases of thematic analysis promoted reliability in the study. Patterns of meaning contained within each theme were illustrated through the use of extracts from participant data to demonstrate the credibility of each theme.

Findings of the current study were considered in the context of the existing birth trauma literature. Participants accounts of birth trauma and negative interactions with healthcare providers were largely consistent with descriptions in the previous literature. Theoretical and conceptual frameworks used to discuss themes had been previously applied within healthcare contexts.

4.3.2. Study Limitations

The study has a number of limitations which may have impacted on the data collected and the generalisability of findings. Firstly, the participants interviewed were largely homogenous in terms of demographics. All participants were cis-women, in male-female relationships at the time they gave birth, ten out of the eleven participants identified as white British (or white Welsh). A homogenous sample of participants can be desirable in qualitative research as it allows for an in-depth exploration of a particular group. However, the demographic homogeneity of the current study limits the exploration of experiences of birth trauma in the context of negative healthcare provider interactions. It is well documented that structural racism and discrimination in NHS maternity care creates poorer outcomes for people belonging to minoritised groups (House of Commons, 2021a; Turienzo et al., 2021; LGBT Foundation, 2022; MacLellan et al., 2022; MBRACE, 2022). This inequality of care is reflected in all levels of the maternity system but is experienced by individuals at the relational level; for example, in 'poorer and less respectful treatment' (Turienzo et al., 2021; MacLellan et al., 2022). To answer the research questions more fully, the study would have benefitted from hearing the voices of a more diverse sample of birthing people.

The participant-led approach to defining birth trauma was considered a methodological strength of the study, as it didn't limit experiences to just those considered to be of clinical relevance. However, most participants in the study had either received a diagnosis of PTSD or had understood their experiences in the context of PTSD. Understanding experiences through a PTSD lens will likely have influenced the way in which participants engaged with and answered the interview questions.

There are several possible explanations as to why people who experienced birth trauma without PTSD-type symptoms may not have volunteered for the study. Socio-cultural narratives of childbirth as a positive, joyous event can work to dismiss and invalidate experiences of birth trauma, subsequently impacting the meaning making of birth experiences. As PTSD is widely used to understand traumatic experiences, birthing people with PTSD-type responses to birth trauma may have a greater opportunity to connect their experiences to birth trauma. Additionally, the word trauma has become synonymous with PTSD, and the two are often used interchangeably. To recruit participants the study used an advert (Appendix E) which used the terms ‘birth-related trauma’ and ‘birth trauma’. It is possible that some prospective participant believed they did not meet the inclusion criteria as they did not have PTSD. The use of broader language such as ‘distressing birth experiences’ in recruitment materials may have connected with a wider range of participants.

To ensure that experiences were reflective of a current NHS context, participants had to have given birth within the last 5 years. Although recall of childbirth at 5 years has been found to be good (Takehara et al., 2014), it is important to recognise the potential limitations of a retrospective design. There are multiple factors which can impact recall of life events and how memories are constructed. Participant interviews coincided with the publishing of the East Kent investigation report (Kirkup, 2022). During this time there was a lot of media shared relating to harm within maternity services, including personal stories of experiences with maternity services. It is likely that some of the media shared would have resonated with participants of the current study. Emotional responses to the media may have connected, or disconnected, participants to certain aspects of their birth experiences.

It is important to distinguish the recalling of a life event from the retelling of a life event (Marsh, 2007). When participants share experiences in a research interview, they are retelling events in a way that feels most appropriate, and safe, to answer the questions asked by the interviewer. As such, data collected from interviews may be impacted by a social desirability bias; an inclination to respond in ways perceived to be socially desirable (Bergen and Labonté, 2019). In the current study participants were aware of the researcher position as a Trainee Clinical Psychologist in the NHS as well as the aims of the study. Transparency was essential from an ethical perspective but may have increased social desirability bias. Firstly, awareness of the aims of the study may have primed participants to provide answers which were in keeping with the aims. Whereas knowledge of the researcher's relationship to the NHS may have shaped what information participants felt able to share, particularly given the context of their previous negative experiences with NHS healthcare providers.

The study focused on birth trauma experienced in the last five years to make findings generalisable to the current NHS context. However, the five years cover a highly unusual time for the NHS due to the COVID-19 pandemic. The unprecedented pressures placed on the NHS created considerable barriers to the delivery of quality care in maternity services which impacted the experiences of birthing people (West Yorkshire & Harrogate Maternity Voices, 2021; Sanders & Baylock, 2021; Turienzo et al., 2021; Flaherty et al., 2022). The majority (eight out eleven) participants gave birth between 2020 – 2022 and will have been impacted by COVID-19 measures to varying degrees. Although it is known that COVID-19 exacerbated challenges experiences by maternity systems in delivering quality care, it was not possible to distinguish whether some experiences with negative interactions arose specifically from the COVID-19 context. This needs to be considered when generalising findings to a post-covid maternity context.

Advertisement of the study resulted in a high volume of interest from prospective participants, as such interviews were offered on a 'first come first served' basis; i.e. the participants who responded first were the first to be offered an interview time. It is possible that this approach may have resulted in privileging a particular group of participants. Participant occupation was not collected as part of the data, however, during the interviews nearly one-third of participants (three out of the eleven) disclosed being healthcare professionals themselves. Research exploring healthcare professional's experiences of being a patient has found that medical knowledge and understanding of health systems can impact upon the way in which care is experienced (Kay et al., 2008; Stoliar et al., 2022). In the current study, participants who were healthcare professionals spoke about their understanding of the evidence-base for different interventions, as well as their own professional expectations for providing care. As such, it is likely that these participants will have understood their birth experience differently to non-healthcare professional participants. This potential difference in meaning making may have impacted upon the development of themes in the study.

4.3.3. Reflexivity

In a thematic analysis, the analysis of data and development of themes is influenced by the subjectivity of the researcher (Braun & Clarke, 2006; Byrne, 2021). As such, reflexivity of personal, methodological, and contextual issues is essential at all stages of the research process to evaluate the impact and influence of the researcher's subjectivity (Olmos-Vega et al., 2023).

4.3.3.1. *Influence of the researcher's position on the research:* The conceptualisation of birth trauma in this thesis was influenced by my professional background and training. Through my psychology training and experiences of working therapeutically with birth trauma, I have adopted a critical position of diagnostic models of trauma. From my clinical experience, I have observed how conceptualising birth trauma as a mental health problem can further perpetuate birthing people's experiences of being invalidated and problematised. This positioning is reflected in the decision to use participant-led definition of trauma and approach.

Clinical experience and theoretical training likely also influenced the approach taken to data collection. Emphasis was placed on relational aspects of the interview process and ensuring that participants were able to share their birth trauma in a way that was meaningful to them. As such, a semi-structured approach to interview was chosen for its capacity to curiously gather exploratory information about a person's experiences (DeJonckheere & Vaughn, 2019). Similarly, questions contained in the interview were open-ended and were not linked to specific models of trauma. For example, the interview asked about the impact of birth trauma, rather than the symptoms.

Alongside completion of this thesis, I worked clinically in a Maternal Mental Health Service (MMHS) where there was a close proximity to maternity systems. This provided insight into the ways of working in maternity care and illustrated how quality of care is intrinsically linked to wider systemic issues. This insight reinforced the decision to approach the research from a critical realist perspective. A critical realist position recognises that birth experiences will be viewed differently by different people based on the different interpretive lenses they hold (Walsh & Evans, 2004). This allows the experience of birthing people to honoured whilst acknowledging the challenges faced by maternity systems and their staff, as opposed to searching for a single 'truth'.

Throughout the data collection and data analysis, I was mindful of not having any personal experience of carrying a child or giving birth. It is likely that my engagement with the data would have been different had I come to the research with my own embodied experiences of pregnancy and childbirth. As such, it is reasonable to assume that my lack of personal experience may have prevented me from recognising certain patterns within the data. My personal experience of not having children was not disclosed to participants. In my clinical work in the MMHS, I have had several experiences where service users assumed I had children. I attributed these assumptions to service users' observations of me as a female of average childbearing age who is professionally interested in working in the perinatal period. It is possible that participants made similar assumptions about my child status in the current study, and this may have influenced what they felt safe to share with me as an interviewer.

4.3.3.2. *Influence of the research on the researcher:* During the interviews and data analysis I was particularly struck by participants' accounts of the profound and lasting impact of being dismissed and invalidated. This led me to reflect on my own responses and reactions to birth trauma, and trauma more broadly. In particular, I reflected upon how psychological training can lead psychology professionals to normalise emotional reactions to trauma without ever explicitly acknowledging the harm done. I wondered if, this inadvertently further legitimises harmful interactions and poor care.

Participants were passionate about preventing future birthing people from having similar birth experiences to themselves. Many participants shared examples of how they have used their birth experience to make changes in their local maternity system. This included consulting on care pathways, joining feedback groups and delivering training. The dedication and passion of participants to make change, motivated me to disseminate findings and recommendations in a way that they can be practically applied.

The nature of the research topic led me to evaluation my own personal beliefs relating to childbirth and consider how they might have been constructed. I was surprised at how automatically I endorse wider socio-cultural narratives of childbirth as joyous and positive, despite having an understanding how emotionally challenging and complicated it can be for many people. This was something I tried to remain mindful of through writing the thesis to ensure that my stance remained neutral.

4.4. Implications and Recommendations

The current study highlights the types of negative interactions experienced by birthing people in NHS maternity systems and illustrates how they can lead to experiences of birth trauma. This section will consider the implications these findings may have for maternity systems and will propose recommendations for policy, practice, and future research.

4.4.1. Maternity Systems and Policy

The relationship between personalised care and positive birth experiences is well established and NHS guidance positions personalised care as national priority (National Maternity Review, 2016; NHS, 2019). The findings of the current study highlight how valued personalised care is to birthing people. However, the findings also highlight that maternity systems can fail to offer it. The study discusses some of the potential barriers to personalised care, but audit of processes relating to personalised care (e.g. consenting process, offering informed choice) in individual maternity services may offer insights into areas for development. It is important that for personalised care to be delivered it is operationalised in policy in a way which makes it feasible to deliver at an organisational level (Villarmea and Kelly, 2020). Drawing upon the experiences of frontline staff would likely offer key insights into the barriers to delivering personalised care.

It is recognised that the ongoing staffing issues in NHS maternity systems can undermine attempts to deliver personalised care (House of Commons, 2021a; APPG on Baby Loss & APPG on Maternity, 2022). The resolution of staffing issues will likely require a long-term solution. Whilst staffing remains an ongoing issue, attention should be given to how best to effectively support the remaining workforce and minimise the risk of burnout (House of Commons, 2021b; APPG on Baby Loss & APPG on Maternity, 2022). Effective staff support would need to go beyond self-care ideas and directly address the excessive workload experienced by maternity staff (House of Commons, 2021b).

Additionally, the current study found that maternity systems can struggle in to appropriately recognise and respond to instances of harm. Failure to acknowledge harm impeded participants' ability to make sense of and process their experiences. It is important that maternity policies pertaining to acknowledging harm, such as the complaints process, are beneficial for the birthing person and their family as well as the maternity system. To achieve this a co-production approach would be beneficial to shape the process in line with the needs of birthing people. Furthermore, it is important that maternity systems recognise the relative lack of power held by the birthing person and how that may impact upon their ability to share concerns. As such, it is recommended that maternity systems and their leaders foster a culture that empowers individual staff members to advocate for the needs of the birthing person. Dedicated pathways for anonymously escalating harmful care (e.g. carrying out an intervention without consent), may help to navigate barriers created by the hierarchal culture of NHS services.

4.4.2. Training and Supporting Reflective Practice

Ongoing training is essential for healthcare professionals to maintain skills and continue their professional development. The study recommends that birth trauma awareness becomes a part of mandatory training for all staff in maternity systems. It is essential that this incorporates an understanding of how professionals contribute to birth trauma through their interactions. This recommendation is supported by suggestions from several participants who felt that it would be beneficial for healthcare providers to hear experiences of birthing people who have experienced birth trauma. A trauma-informed approach to training which utilises principles of trauma informed care (e.g. Blackpool Better Start, 2021) would help provide a framework for healthcare professionals to make changes to their own practice.

The current study discussed negative interactions in the context of the assumptions underlying the biomedical model of childbirth. Maternity staff may benefit from reflective spaces that allow them to reflect on their own assumptions, values and beliefs and consider how they may influence the work that they do. For such spaces to be beneficial to staff careful planning is required to ensure that it doesn't place any additional burden on an already overstretched workforce.

4.4.3. Practice

The findings of the current study detail some concerning and unacceptable practice in maternity systems which undermines the ethos of NHS maternity care. The negative interactions described in the current study resulted in participants feeling out of control, scared and ultimately traumatised. These findings support previous findings that birthing people want compassionate, supportive, and respectful care to feel safe during childbirth (Downe et al., 2018). Care that deviates from this should be viewed by all staff as unacceptable. Frameworks to support good practice such as 'The Code' (NMC, 2018) and the GMC's seven principles of decision making, and consent (2020) should be used to guide practice.

Healthcare providers should strive to work in accordance with the principles of personalised care and trauma informed care to promote a positive childbirth experience for the people accessing their service (National Maternity Review, 2016; SAMHSA, 2018; NHS, 2019). In line with this, true choice and consent should be considered non-negotiable in all aspects of a birthing person's care. To support this, it would be helpful for healthcare providers to explore ways in which they can assess that they have effectively shared information with participants. Villarmea and Kelly (2002) have previously made helpful recommendations for improving shared decision making in maternity services, including recommendations for questions to invite the birthing person into the decision making.

Understandably, situations requiring unexpected or emergency intervention can provide some of the most challenging situations for healthcare professionals to maintain standards of personalised care. There is some evidence that perceptions of personalised care as being inefficient and slowing down care create a barrier to its delivery (Joseph-Williams et al., 2017; Villarmea & Kelly, 2020). However, personalised care can actually work to support efficient care at it allows for birthing people’s individual needs to be met and supports positive outcomes. As such, it is important that such perceptions are challenged.

4.4.4. Future Research

Negative interactions with healthcare providers are an established risk factor for birth trauma. However, there are limited number of studies exploring how birthing people experience these negative interactions and how they contribute to birth trauma. Furthermore, only three previous studies have explored this within an NHS context. Therefore, more research is still needed in this area.

The sample of participants in the current study were largely similar to each other in terms of demographics. Hearing the voices of birthing people who belong to minoritised groups is particularly important for developing recommendations for practice and policy given the current inequalities of care. As such, replication of the study with recruitment from specific groups (for example, birthing people belonging to racialised minority group or birthing people in same-sex relationships), would help develop the understanding of the nature and impact of negative interactions from healthcare providers.

Negative interactions in the current study reflected a lack of personalised care. As such, replications of the current study would be complemented by research exploring the barriers to maternity healthcare professions in delivering personalised care. Developing an understanding of these barriers would potentially uncover ways for maternity systems to be more successful in their implementation of personalised care and in turn improve the experiences for birthing people.

The current study focused solely on the experiences of birthing people. However, participants shared important reflections on how the experience of birth trauma had a profound impact on partners who attended the birth. The impact of birth trauma for partners has been explored previously (e.g. Daniels et al, 2020), however, further research focusing specifically on birth trauma related to negative healthcare provider interactions may provide useful insights into how to better care for partners. Moreover, this would help support the ‘family friendly’ goal in of the Maternity Transformation Programme (National Maternity Review, 2016

4.5. Conclusions

This research study aimed to explore how birthing people described their negative interactions with healthcare providers and how these interactions then contributed to the experience of birth trauma. The findings of this study describe experiences of interactions where there was a lack of personalised care and inadequate attention to birthing people's individual needs. This was reflected participants' experiences of being denied true choice and true consent. It was argued that birthing peoples' experiences of being unseen and unheard by healthcare providers were examples of testimonial injustice and symbolic violence.

Negative interactions with healthcare providers were central to participants' experience of birth trauma. The findings of this study were in keeping with the previous birth trauma literature and suggested that the nature of negative interactions left participants feeling out of control and unable to trust their healthcare providers, which subsequently diminished their sense of safety. Lack of information and invalidating experiences during labour and postnatally make it difficult for birthing people to make sense of their experiences and process the events of their birth. Symbolic violence legitimised experiences of negative interactions and gave rise to feelings of guilt and self-blame. Overall, birth trauma was found to have a detrimental and lasting impact on birthing people's psychological wellbeing.

These findings were in keeping with the previous birth trauma literature and offer implications for best practice. Findings illustrate that personalised care is essential to promote positive birth experiences and any barriers to delivering personalised care should be addressed at an organisational level. Further research exploring negative interactions and their contribution to birth trauma, will help build upon the recommendations made by the current study for best practice.

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APPENDICIES

Appendix A: Scoping Review Search Strategy

Aims of the Scoping Review

The scoping review aimed to answer the following questions: what is already known about birthing peoples experiences of negative healthcare provider interactions during a traumatic birth?

Search Terms Used

Key search terms related to childbirth, trauma, and healthcare provider:

(“childbirth”, “birth”)

AND

(“trauma”, “birth trauma”, “PTSD”, “posttraumatic stress” “post traumatic stress”)

AND

(“healthcare provider”, “care provider”, “healthcare professional”, “staff”, “caregiver”, “professionals”, “midwives”)

Databases Searched

- EBSCO:

    - APA PsycInfo
    - CINHAL
    - Academic Search Ultimate
- Scopus

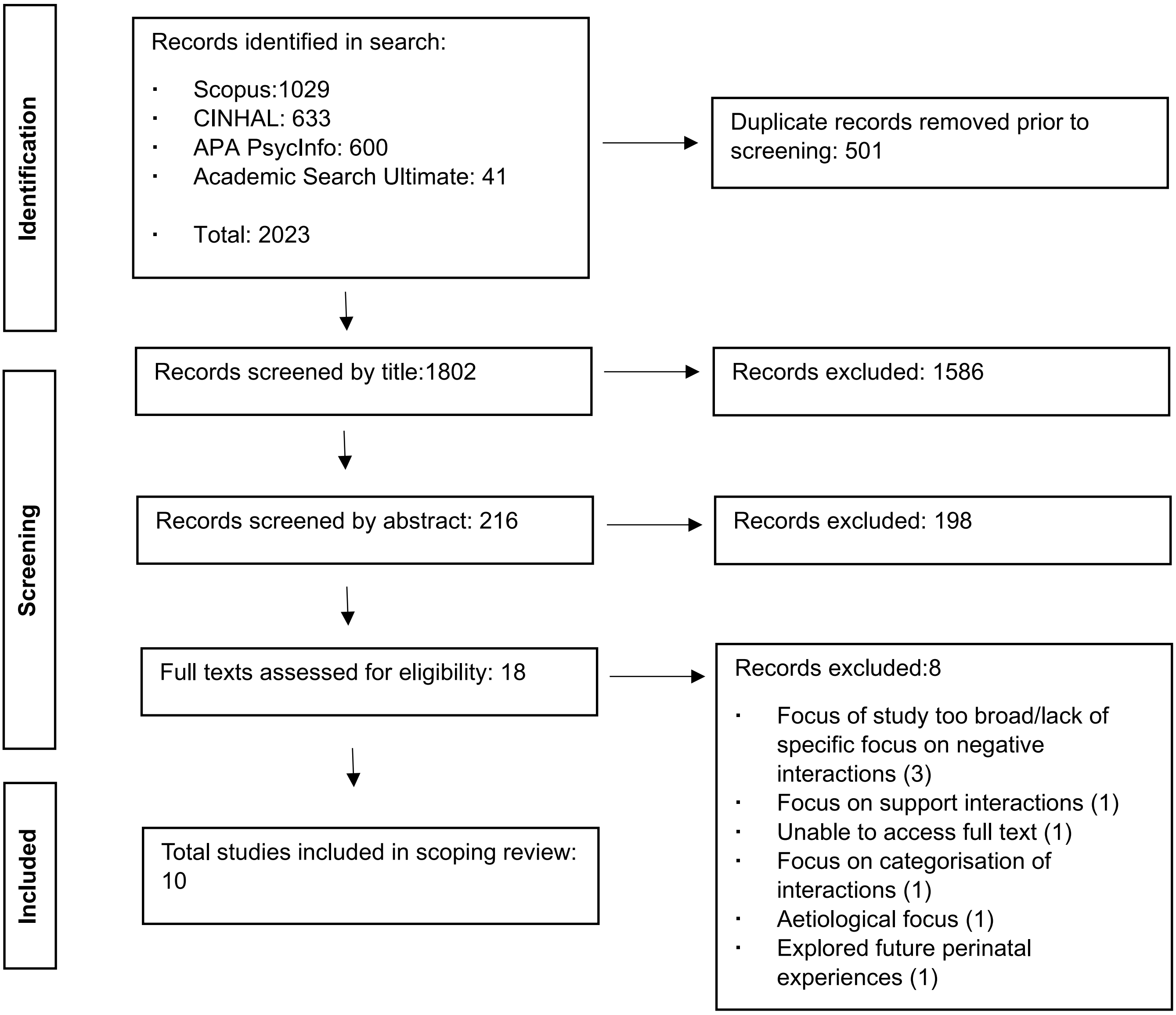
Scoping Review Inclusion Criteria

1) The study is available in English.
2) Participants had experienced a psychologically traumatic birth.
3) The study explored negative interactions with healthcare providers during birth.
4) The study includes discussion of the nature of negative interactions with healthcare providers beyond simply stating their aetiological role in birth trauma.

Scoping Review Exclusion Criteria

1) The study is not accessible (e.g. not available in English)
2) The study focuses on negative interactions with healthcare providers outside of the birthing or maternity context.
3) The study explores negative interactions with healthcare providers not in relation to the experience of birth trauma.
4) The purpose of the study is to develop or validate a measure of birth trauma or negative interactions.
5) The study focuses on physical birth trauma rather than psychological.

Appendix B: PRISMA Diagram for Scoping Review



Appendix C: UEL Ethics Application

Appendices in the application which are duplicated in the Appendices of this thesis have been removed for clarity (i.e. participant information sheet, interview schedule, debrief form, consent form and study advert).

Any identifying information has been edited for confidentiality purposes.

UNIVERSITY OF EAST LONDON School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form

(please read carefully)

1.1	Before completing this application, please familiarise yourself with: • British Psychological Society's Code of Ethics and Conduct • UEL's Code of Practice for Research Ethics • UEL's Research Data Management Policy • UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: • If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. • Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hraapproval/ • If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. • HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. • The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.

1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ☐ Study advertisement ☐ Participant Information Sheet (PIS) ☐ Participant Consent Form ☐ Participant Debrief Sheet ☐ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ☐ Permission from an external organisation (see section 7) ☐ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ☐ Interview guide for qualitative studies ☐ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	**Jodie Canning**
2.2	**Your supervisor's name:**	**Dr Kenneth Gannon**
2.3	**Name(s) of additional UEL supervisors:**	**Prof Nimisha Patel**
		3rd supervisor (if applicable)
2.4	**Title of your programme:**	**Professional Doctorate in Clinical Psychology**
2.5	**UEL assignment submission date:**	**22/05/2023**
		Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	**A qualitative investigation of the experiences and impact of negative healthcare provider interactions during a traumatic birth**

3.2	**Summary of study background and aims (using lay language):**	**The DSM-5 defines trauma as “actual or threatened death, serious injury or sexual violence” (APA, 2013). Birth-related trauma is a common experience, with around 30% of births each year being experienced as psychologically traumatic (Yildiz et al, 2017). The psychosocial impact of birth-related trauma is wide reaching with parents reporting difficulties with attachment, bonding, relationships, mental health and adjustment. The birth-trauma literature has consistently found that negative interactions with healthcare providers (HCP), such as midwives and doctors, contribute to the experience of trauma. However, little is known about precisely how negative interactions with HCP contribute to the experience of a traumatic childbirth nor the longer-term impact of these interactions. The existing literature suggests that improving the interactions between people giving birth and healthcare providers could mediate experiences of birth-related trauma (e.g. Patterson et al., 2017). The proposed study aims to build on existing birth-related trauma literature by gaining a deeper understanding of how interactions with HCP contribute to birth trauma and explore the impact of negative interactions with HCP postnatally. In addition, the proposed study aims to identify what people who have given birth would have liked to have been done differently in relation to the quality of the interactions they had with their HPCs. It is hoped that findings from the proposed study can inform best practice within perinatal services.**
3.3	**Research question(s):**	**1) How do interactions with HCPs contribute to the experience of birth-related trauma? 2)What is the impact of negative interactions with HCP postnatally? 3) What do people that have experienced birthrelated trauma think could be done differently by HCPs to improve the quality of their interactions?**

3.4	**Research design:**	**The proposed study will adopt a qualitative design involving individual interviews. Thematic analysis (Braun & Clarke, 2006) will be used to analyse data collected from semi-structured interviews.**
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	**The proposed study looks to recruit individuals who have experienced negative interactions with HCP and perceive their experience of giving birth as traumatic. Defining birth trauma is challenging as the experience of trauma is highly personal and subjective. Therefore, in line with previous research, the proposed study will take a participant-led approach to defining trauma.** **INCLUSION CRITERIA:** **-Given birth in the last 5 years (to ensure experiences are relevant to the current NHS context) -** **Aged 18 years or older** **-Perceived childbirth as traumatic** **-Had experiences of negative interactions with HCP during the childbirth experience** **EXCLUSION CRITERIA:** **-Gave birth over 5 years ago** **-Gave birth in a non-NHS/private service** **-Under 18 years of age**
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	**The [name of charity removed for confidentiality purposes] have kindly agreed to advertise the study on their website and identified that many of their users fit the inclusion criteria (appendix F). The proposed study will also utilise social media to advertise the study by asking those with access to perinatal networks to share the study advert on their social media accounts.**
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	**No specialist equipment or materials are required for this study. All interviews will be carried out on MS Teams using a UEL account. MS Teams will be accessed by a password protected laptop.**
3.8	**Data collection:**	**Consent will be recorded via a consent form (appendix B); if participants are willing to provide**

	Provide information on how data will be collected from the point of consent to debrief	**consent, they will tick to show their agreement with statements relating to their understanding of the study and both the participant and the researcher will sign their names. As interviews are online, consent forms will be signed digitally. The MS Teams auto-transcribe function will be used to transcribe the interview verbatim. These will be edited post-interview to remove any identifying information such as name. The interview schedule includes a debrief. The debrief involves checking in on how the participant is feeling, seeing if there is anything they would like removed from the transcript and offer signposting information. All the participants will be also emailed a debrief form.**	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	**Will participants be reimbursed?**	**YES** ☐	**NO** ☒
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	Please state the value of vouchers	
3.11	**Data analysis:**	**Data will be analysed using thematic analysis (Braun & Clarke, 2006). Coding and identification of themes will be carried out by the researcher.**	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.		

4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	**Transcripts produced will be edited to remove any identifying information. Participants will be referred to by participant number (e.g. "P1") at all stages post interview, including for any direct quotations used in the final report. Any names of services or HCPs will be redacted from the transcript.**	
4.3	**How will you ensure participant details will be kept confidential?**	**Only the researcher will have access to any identifying/confidential information. Upon completion of the interview, transcripts will be edited to remove any identifying information. From this point onwards all participants and their transcripts will be allocated a participant number. Any quotes used in the final report/future dissemination will be attributed to the anonymous participant number.**	

4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	**UEL's OneDrive for business will be used to securely store all data collected in this study. Transcripts will be recorded using a secure UEL MS Teams account that only the researcher has access to. Final edited and anonymised transcripts will be password protected and saved on the UEL OneDrive. MS Teams automatically saves transcriptions to the UEL Microsoft Stream Library, however this will be deleted once the final edited transcript has been uploaded to OneDrive.** **For purposes of supervision, anonymised data may be shared with the research supervisor. This will be done securely by sharing the data file on UEL OneDrive for business.** **Any identifiable information, such as participant contact details and demographics, will only be accessible to the researcher.** **Data collected in this study will form part of a UEL Professional Doctorate in Clinical Psychology Thesis and therefore will be available on UEL's research repository. This thesis, and any subsequent dissemination, will use anonymised quotes taken from the transcript to illustrate key themes in the data.**
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	**The researcher: will have access to all data, in all forms through the course of this study.** **Research supervisor/examiners: will have access to anonymised transcripts.**
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	**Upon completion and examination of the project, it is expected that participant demographics, anonymised transcripts and any related data analysis documents will be retained to support further dissemination (e.g. publication).**

4.7	**What is the long-term retention plan for this data?**	**Any data that does not have long-term value will be deleted upon completion and examination of the proposed research.** **Data which holds long-term value will be saved on the UEL OneDrive for business of the Director of Studies, and will be deleted after three years postcompletion.** **The final write-up for the thesis will be uploaded to the UEL research repository where it can be accessed publicly.**	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐

	If yes, what are these, and how will they be minimised?	**The participants will be asked to share their experiences of birth trauma. Talking about traumatic experiences has the potential to be distressing both during and following the research interviews. A compassionate and flexible stance will be adopted during the interviews, where participants will be offered the opportunity for breaks, rescheduling and withdrawal should they feel distressed. Interviews will conclude with a debrief that provides the opportunity to check in with how participants are feeling post-interview (see appendix G for interview schedule). All participants will be given signposting information for relevant sources of support (appendix C).**		
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐	
	If yes, what are these, and how will they be minimised?	**Hearing participants experiences of trauma has the potential to be distressing for the researcher. To minimise risk of this the researcher will schedule interviews with participants in a way that allows for breaks and time to reflect between interviews. Supervision will be utilised regularly throughout the course of the research.**		
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	

	If yes, where?	**Interviews will be conducted via MS Teams. The researcher will be conducting the research from their home address. All participants will be encouraged to join the call from somewhere where they can speak freely and confidentially.**	
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒
	If yes, where?	Please state the country and other relevant details	
	If yes, in addition to the General Risk Assessment form, a CountrySpecific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has beenz attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	**YES** ☐	

5.7	**Additional guidance:** - For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on ‘sign in’ and then ‘register here’ using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. - For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). - For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). - Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☐	**NO** ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) ‘Vulnerable’ people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		

6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** X	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** X	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	**001703104257**	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▯ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▯ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions

7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☒	**NO** ☐
	If yes, please provide their details.	**[removed for confidentiality purposes]**	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	**YES** ☒	

7.2	**Additional guidance:** Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as ‘my’ or ‘I’ with ‘our organisation’ or with the title of the organisation. This organisational consent form must be signed before the research can commence. If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.

Section 8 – Declarations

8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Jodie Canning**
8.3	**Student's number:**	**U2075199**
8.4	**Date:**	**24/06/2022**

Supervisor’s declaration of support is given upon their electronic submission of the application

Student checklist for appendices – *for student use only*

Documents attached to ethics application	**YES**	**N/A**
Study advertisement	☒	☐
Participant Information Sheet (PIS)	☒	☐
Consent Form	☒	☐
Participant Debrief Sheet	☒	☐
Risk Assessment Form	☒	☐
Country-Specific Risk Assessment Form	☐	☒

Permission(s) from an external organisation(s)	☒	☐
Pre-existing questionnaires that will be administered	☐	☒
Researcher developed questionnaires/questions that will be administered	☐	☒
Pre-existing tests that will be administered	☐	☒
Researcher developed tests that will be administered	☐	☒
Interview guide for qualitative studies	☒	☐
Any other visual material(s) that will be administered	☐	☒
All suggested text in RED has been removed from the appendices	☒	☐
All guidance boxes have been removed from the appendices	☒	☐

Appendix D: General Risk Assessment Form template

UEL Risk Assessment Form

Name of Assessor:	**Jodie Canning**	**Date of Assessment:**	**23/06/20202**
Activity title:	**Professional Doctorate in Clinical Psychology thesis: A Qualitative investigation of the experiences and impact of negative healthcare provider interactions during a traumatic birth**	**Location of activity:**	**Online via MS Teams**
Signed off by Manager: (Print Name)	**Dr Kenneth Gannon**	**Date and time: (if applicable)**	

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc.). If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

The thesis will interview 12 – 15 participants who have experienced birth trauma on their experiences of interactions with healthcare providers. These interviews will take place over MS Teams and be recorded for transcription. It is anticipated that interviews will last 45 – 60 minutes. Questions asked will explore the participants experiences of interactions of healthcare providers during childbirth, how these interactions impacted them and recommendations for improving practice.

Overview of FIELD TRIP or EVENT:
NA

Guide to risk ratings:

a) Likelihood of Risk	**b) Hazard Severity**	**c) Risk Rating (a x b = c)**
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	**Who is at risk?**	**Existing Controls**	**Likelihood**	**Severity**	**Residual Risk Rating (Likelihood x Severity)**	**Additional control measures required (if any)**	**Final risk rating**

Participants will be discussing their experiences of a traumatic event which has the potential to be distressing.	Participants	Researcher will take a compassionate and flexible approach to interviews. Participants will be offered opportunities to take a break, reschedule and cancel interviews if needed. All participants will be provided with information of where to access support specific to birth trauma.	1	1	1		Minor
Listening to trauma during interviews may be distressing for the researcher.	Researcher	Researcher has previous clinical experience of working with difficulties related to the perinatal period. Will seek supervision from research supervisor if needed.	1	1	1		Minor

Review Date 23/06/2022

Appendix D: UEL School of Psychology Ethics Committee Ethics Application Decision Letter

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details	
Reviewer:	**Jeeda Alhakim**
Supervisor:	**Kenneth Gannon**
Student:	**Jodie Canning**
Course:	**Prof Doc Clinical Psychology**
Title of proposed study:	A Qualitative Investigation of the Experiences and Impact of Negative Healthcare Provider Interactions During a Traumatic Birth

Checklist
(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☒	☐
Detailed account of participants, including inclusion and exclusion criteria	☒	☐	☐

Concerns regarding participants/target sample	☒	☐	☐
Detailed account of recruitment strategy	☒	☐	☐
Concerns regarding recruitment strategy	☐	☒	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☒	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☒	☐	☐
Clear and detailed outline of data collection	☒	☐	☐
Data collection appropriate for target sample	☒	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☒
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☒	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☒	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☒	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☒	☐
If required, General Risk Assessment form attached	☒	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☒	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☒	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☒
If required, a DBS or equivalent certificate number/information provided	☐	☐	☒
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☒	☐	☐
All relevant information included in the participant information sheet (PIS)	☒	☐	☐
Information in the PIS is study specific	☒	☐	☐
Language used in the PIS is appropriate for the target audience	☒	☐	☐
All issues specific to the study are covered in the consent form	☒	☐	☐
Language used in the consent form is appropriate for the target audience	☒	☐	☐
All necessary information included in the participant debrief sheet	☒	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☒	☐	☐
Study advertisement included	☒	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☒	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments
Please clearly detail the amendments the student is required to make
The student could consider adding an additional exclusion criterion concerning the participants' current mental health status and current level of risk – for example, current postpartum depression, ongoing PTSD related symptoms and suicidal ideation **I ask the student to consider introducing a screening call with participants concerning the above in order to ensure participants safety during the interview process.** Following discussion with research supervisor, the following steps will be

taken:
- All prospective participants will be given a screening call before being asked to participate in the study.
– The presence of symptoms of PND, PTSD or suicidal ideation alone would not result in an exclusion as it is anticipated that these symptoms will be likely in the population being studied. Decisions to exclude will be based on severity of symptoms/ serious concerns raised (e.g. suicidal ideation with intent).
- For any serious concerns raised supervision will be sought from the research supervisor or an experienced clinician.

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	

If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:

HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒

Reviewer recommendations in relation to risk (if any):	I would ask that if the above amendments are made then for this to be added to the risk assessment form. I would also ask the student to consider raising the risk level to 2 rather than 1, when it comes to Participants levels of distress when discussing their experiences of a traumatic event

Reviewer's signature

Reviewer: (Typed name to act as signature)	**D**r Jeeda Alhakim
Date:	**21/09/2022**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	**Jodie Canning**
Student number:	**U2075199**
Date:	**27/09/2022**

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required

Appendix E: Study Advert

Do you have birth trauma?

University of East London

We are looking to interview people who have experienced birth-related trauma about the interactions they had with their healthcare providers.

This research aims to better understand how interactions with healthcare providers may contribute to the experience of birth trauma, as well as exploring the impact of negative interactions.

Who can take part?

We are looking for people who...

- have given birth in the last 5 years using NHS services
- consider their childbirth experience to be traumatic
- had a negative experience of interactions with healthcare providers
- are 18 and over

How to take part

If you would like to take part, or find out more information please email me, Jodie Canning (Trainee Clinical Psychologist): **U2075199@uel.ac.uk**

Appendix F: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

A Qualitative investigation of the experiences and impact of negative healthcare provider interactions during a traumatic birth

Contact person: Jodie Canning (Trainee Clinical Psychologist)
Email: U2075199@uel.ac.uk

Thank you for your interest in participating in this research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?
My name is Jodie Canning. I am a Trainee Clinical Psychologist on UEL's Professional Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?
Research has shown that approximately 30% of people giving birth view their experience as traumatic. There are many factors that contribute to a birth being experienced as traumatic; this includes negative experiences of interactions with healthcare providers (e.g. midwives and doctors).

This research aims to develop our understanding of the impact of how interactions with healthcare providers may contribute to the experience of birth trauma and the impact they may have following birth. We are also interested in learning more about what people would like to be done differently in terms of healthcare provider interactions.

Why have I been invited to take part?

To address the study aims, I am inviting people who have experience of birth trauma to take part in my research. If you have given birth in the last five years and consider that experience to be traumatic, you are eligible to take part in the study.

It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be invited to an individual interview taking place on MS Teams. These interviews will take the form of an informal conversation, where I will ask you more about your experiences of childbirth and the interactions you had with your healthcare providers. It is anticipated that interviews will take 45 – 60 minutes. However, it is likely that this may vary from person to person depending on what they would like to share. As these interviews will take place virtually, we encourage you to find a place where you feel comfortable to speak freely without interruption.

During the interview the MS Teams auto-transcription function will be used to produce transcripts of our conversation. These transcripts will allow me to look at all participants responses to the interview questions and analyse them for any themes or patterns.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview, you can do so by contacting myself on the above email address. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

Participating in the research will not involve any danger or harm caused to you. However, it is possible that recalling and talking about the events around your childbirth experience may be upsetting or distressing for you.

If you do become upset during the interview you would be supported to take a break, reschedule, or cancel the interview. All participants will be provided with information about where they can access resources and support specific to birth-related trauma.

How will the information I provide be kept secure and confidential?

All transcripts will be edited following the interview to remove any information that may identify you, this includes things like your name and the details of the services you used. These transcripts will be stored securely on UEL's OneDrive that only I [Jodie Canning] have access to. As this research forms part of an academic submission, it is possible that my research supervisor (Dr Kenneth Gannon) and UEL examiners may review anonymised transcripts. This would be done via sharing a file secure on UELs OneDrive.

The thesis, and any additional dissemination, of this research will use direct quotes from the interview to illustrate key themes and patterns in the data. To ensure anonymity and confidentiality all quotes will be attributed to a participant number (e.g. “P1”).

The only situation where I may need to break confidentiality is if I had serious concerns relating to your, or someone else’s safety. Any decisions around needing to pass on concerns relating to safety will be made in consultation with the research supervisor and we would keep you informed of this.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the ‘public task’ condition contained in the General Data

Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as ‘special category data’ in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/dataprotection

What will happen to the results of the research?
The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL’s online Repository. It is hoped that any findings will also be disseminated to wider audiences through journal publication. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. You will be given the option to receive a summary of the research findings once the study has been completed.

Anonymised research data will be securely stored by Dr Kenneth Gannon for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?
My research has been approved by the School of Psychology Ethics Committee. This means that the Committee’s evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Jodie Canning

U2075199@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor, Dr Kenneth Gannon, School of Psychology, University of
East London, Water Lane, London E15 4LZ,
Email: K.N.Gannon@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London,
Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix G: Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

A Qualitative investigation of the experiences and impact of negative healthcare provider interactions during a traumatic birth

Contact person: Jodie Canning (Trainee Clinical Psychologist)

Email: U2075199@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that a transcript of the interview will be recorded using MS Teams.	
I understand that my personal information and data from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	

I agree to take part in the above study.	

Participant’s Name (BLOCK CAPITALS)

………

Participant’s Signature

………

Researcher’s Name (BLOCK CAPITALS)

………

Researcher’s Signature

………

Date

………

Appendix H: Semi-Structured Interview Schedule

Section A – introductions, setting up & establishing

- Introduce self to one another and general rapport building (e.g. ask how they are, thank the participant for joining)
- Opportunity to check call quality and fix and technical difficulties
    - Can we hear each other?
    - Any connection issues?
    - Is the participant in a place where they can speak freely and confidentially?
    - Agree on what will happen should the call encounter technical difficulties later on
    - If there is young children at home agree on plan for if they need attending to (e.g. pause the interview)
- Remind the participants of information relating to consent, withdrawing and confidentiality and provide an opportunity to ask questions.
- Explain process (i.e.. "I have 6 questions to think about today, I may ask follow up questions to find out more").
- Establish an estimated time frame for the interview and remind participant that they can take breaks if needed.

Section B – Details of Birth

- Details of the birth to be collected
    - How long ago did the participant give birth?
    - What kind of birth was it? (e.g. vaginal, c-section, emergency c-section)
    - Were there any interventions? (e.g. forceps)
    - What setting did the birth take place in?
    - Who was present?
    - Any other details the participant thinks is relevant to understanding the birth
- Collection of demographic information

Section C - Interview

1. What was your childbirth experience like?
2. How would you describe the interactions you had with the healthcare providers?
3. How did those interactions with healthcare providers impact upon your experience of birth?
4. Did these experiences of healthcare provider interactions during birth impact you postnatally?
5. Did your experiences of healthcare providers impact you seeking support later for either yourself or your baby?
6. What would you have like to have been different about your interactions with healthcare providers during your birth?

*This interview is semi-structured, therefore there may be additional questions asked where relevant. Prompting may be used to gain more information and clarity on a particular topic (e.g. "would you be able to tell me more about X", "do you have an example?").

Section D – Debrief

- Check in with how participant is feeling post interview
- Ask how they found the interview
- Is there anything that they would like to be removed from the transcript
- Opportunity for participants to ask questions
- Offering of signposting information on relevant support and resources
- Reorientation to the researchers details on the participant information sheet should they have any questions once the interview has ended.
- Thank participant for their time.

Appendix I: Participant Debrief Form

PARTICIPANT DEBRIEF SHEET

A Qualitative investigation of the experiences and impact of negative healthcare provider interactions during a traumatic birth

Contact person: Jodie Canning (Trainee Clinical Psychologist)
Email: U2075199@uel.ac.uk

Thank you for participating in my research study looking at the relationship between birth trauma and healthcare provider interactions. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. It is hoped that findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. Any quotes used in from your transcript will be attributed to an anonymous participant number.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Kenneth Gannon for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?
It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

Name	**Details**
Birth Trauma Association	The Birth Trauma Association are a charity that support women who have experienced birth trauma. They offer support through peer supporters who can talk with you via email and closed social media groups for parents with birth trauma. The organisations websites contains lots of useful information and resources related to birth trauma. Website: https://www.birthtraumaassocaition.org.uk Email contact: support@birthtraumaassociation.org.uk
PANDAS (PND awareness and support)	PANDAS offer peer support for parents affected by perinatal mental illness. They offer a helpline, email support, text support, and social media groups. Full details of each can be found on their website. Website: https://www.pandasfoundation.org.uk Helpline (11 am – 10 pm): 0808 1961 776
Samaritans	Samaritans are a provide telephone support for anyone who is struggle to cope or needs someone to listen without judgement or pressure. Telephone number (24/7): 116 123
GP & midwife	If you are worried about your mental health or the impact of the traumatic birth your GP and/or midwife will have a good knowledge of local services and make a referral on your behalf. You may want to explore the possibility of a birth debrief (availability varies depending on location/services used). A birth debrief is an

	opportunity to discuss what happened during your birth and why with a specially trained health professional. The aim of a debrief is to help you feel empowered and reassured.
Improving Access to Psychological Therapies (IAPT)	IAPT services provide evidence-based psychological therapies to people experiencing mental health difficulties such as anxiety and depression. https://www.nhs.uk/service-search/mentalhealth/find-a-psychological-therapies-service/

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Jodie Canning
U2075199@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor, Dr Kenneth Gannon. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: K.N.Gannon@uel.ac.uk

or

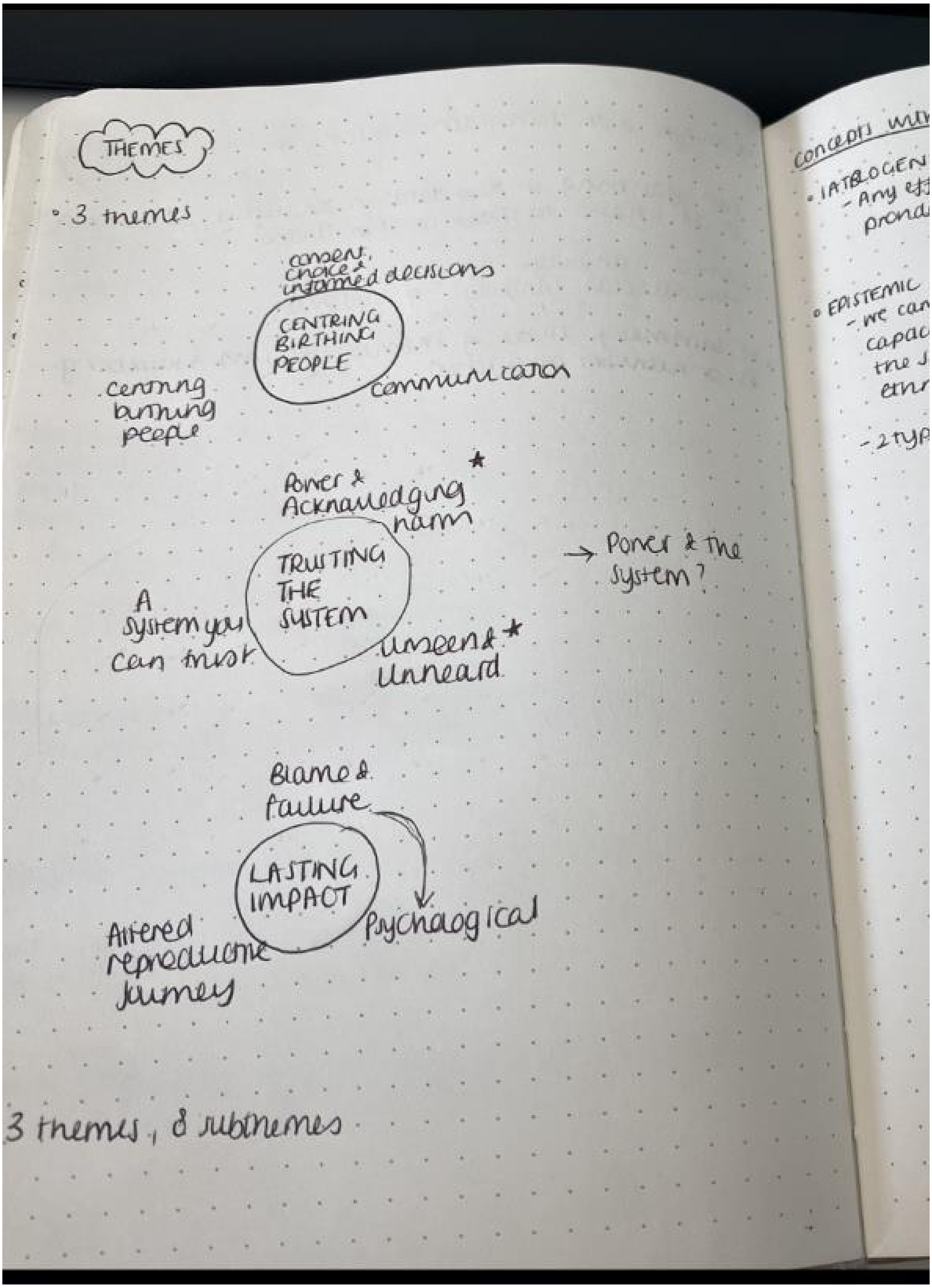
Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix J: Example of Collated Codes

ATTUNEMENT	INFANTALISATION	POWER	DETATCHED /COLD/DISMISSIVE	HOSPITAL AGENDA = PRIORITY	BABY AS SOLE FOCUS	UNHEARD
P11: My brain won't compute that I gave birth because I couldn't feel anything and I couldn't see anything. There was nothing to kind of make that make sense to me and no one cared. They just wanted to know whether it was a boy or a girl and I was just trying to be with my baby.	P11: It was demeaning, at one point the doctor kept calling me girl	P11: You know your're hugely hugely vulnerable and I just felt so taken advantage of and so like theres an inherent power difference isn't there? But I just felt like that was used to massive advantage to just get me to comply. So I didn't even feel like a person in those interactions.	P10: They were getting on with their job and that's what they were focused on, but in hindsight, like I'm fully aware of what's going on and just some acknowledgement that I'm there like. There was a complete kind of detachment of me as a person.	P8:Everything was so hospital centred it was what works best for them. What's most efficient for them, you know, will give you an appointment time, but you can sit and wait	P10: I know their job was to deliver the baby, but like I'm as important in this as the rest of my body.	P10: I've never been an angry person and I've found that there was like this switch of just pure anger and rage within me that I was like, why are none of these people like seeing me there or hearing what I am saying?
P9: The registrar stood in front of me and went and he said we will be coming to your room to do a debrief shortly. As he stood there, he's holiding his Crocs in his hand covered in blood, cleaning them. I didn't know I'd haemorrhaged at this point. I had no idea what had happened and I turned around and went is that my blood? And he looked at me and went yes and I went and laughed because you know I didn't know what was happening. But that image of him holding his Crocs covered in my blood is actually probably the lasting image i've got of my birth.	P9: Every time I asked for something I felt as if I was being a nuisance. I felt like I was being a naughty little school girl.	P11: I think what was really hard is sometimes interactions were kind of like there was an external layer of like we're doing this to help you. It wasn't like a really overt I'm going to be really aggressive ... it was almost like insidious and that I think made it much harder to kind of really understand what was going on. But looking back actaully the word I would use to described it is abusive. It's an abuse of power. It's an abuse of knowledge and it's abuse of someone being in a vulnerable situation.	P9: The registrar came in and they spoke to us probably for about 2 and half minutes and she said expecte you'll need a blood transfusion and you did lose a little bit of blood. That is fine, you are fine. That's it. No explanation to anything.	P8: there was a lot of a lot of feeling that I was being made to feel guilty like guilt tripping. Was constantly implied that I wasn't doing what was right.	P10: It's like I didn't matter in any of the factors. And that it was solely focised on my daughter. I'm torn beucase obviously her safety was really important, but also my physical and mental wellbeing should have been factored in.	P9: I have large teams of people ... how could I not communicate with these people? How were they not listening to me?
P5:He said [the doctor] you know, if when you have another baby, which you will want one, it'' be so much easier next time compared to this time. At the time, the part of me that was remaining in my psyche that was my usual self was going this is ridiculous, but my overriding state was just like ok. Because I could not beleive what had transpired in what I was feeling. It was just horrendous. (prior to quote spoke about being in shock)	P8: The mental health midwife called me childish for being scared.	P7: People look down at you because they don't know, they think you don't know whats going on	P10: I felt that there was this knid of screen between myself and those carrying out the procedure and there was no communication from them at all.	P4: The think that it seems like they don't understand is that what they are creating is your adrenaline level risk. And if your adreneline level is rising so much, you're not gonna have abirth, that''s gonna stop it. ... Because they make you anxious and in there I said to my husband I think I would only be able to have a natural birth wehre I feel safe. I dont feel safe in hospital, I would never relax and completely get in that moment. I was constantly on guard. Like, what they going to do	P9: All of the doctors who ever came round. Nobody wanted to look at me, even though I had extra incisions in my belly. I was absolutely in agony. They just wanted to look at my baby. Nobody wanted to look at me.	P8: I think for me it's a big thing was I didn't feel like anybody ever listened to me. I saw a different person every single time I went near the hospital.

Appendix K: Extract from Handwritten Notes Illustrating Initial Organisation of Themes



Appendix L: Braun and Clarke (2020) Twenty Critical Questions for Evaluating Thematic Analysis

1. Do the authors explain why they are using TA, even if only briefly?

2. Do the authors clearly specify and justify which type of TA they are using?

3. Is the use and justification of the specific type of TA consistent with the research questions or aims? 4. Is there a good ‘fit’ between the theoretical and conceptual underpinnings of the research and the specific type of TA (i.e. is there conceptual coherence)?

5. Is there a good ‘fit’ between the methods of data collection and the specific type of TA?

6. Is the specified type of TA consistently enacted throughout the paper?

7. Is there evidence of problematic assumptions about, and practices around, TA? These commonly include:

- Treating TA as one, homogenous, entity, with one set of – widely agreed on – procedures.
- Combining philosophically and procedurally incompatible approaches to TA without any acknowledgement or explanation.
- Confusing summaries of data topics with thematic patterns of shared meaning, underpinned by a core concept.
- Assuming grounded theory concepts and procedures (e.g. saturation, constant comparative analysis, line-by -line coding) apply to TA without any explanation or justification.
- Assuming TA is essentialist or realist, or atheoretical.
- Assuming TA is only a data reduction or descriptive approach and therefore must be supplemented with other methods and procedures to achieve other ends.

8. Are any supplementary procedures or methods justified, and necessary, or could the same results have been achieved simply by using TA more effectively?

9. Are the theoretical underpinnings of the use of TA clearly specified (e.g. ontological, epistemological assumptions, guiding theoretical framework(s)), even when using TA inductively (inductive TA does not equate to analysis in a theoretical vacuum)?

10. Do the researchers strive to 'own their perspectives' (even if only very briefly), their personal and social standpoint and positioning?

11. Are the analytic procedures used clearly outlined, and described in terms of what the authors actually did, rather than generic procedures?

12. Is there evidence of conceptual and procedural confusion?

13. Do the authors demonstrate full and coherent understanding of their claimed approach to TA? A well-developed and justified analysis

14. Is it clear what and where the themes are in the report? Would the manuscript benefit from some kind of overview of the analysis: listing of themes, narrative overview, table of themes, thematic map?

15. Are the reported themes topic summaries, rather than 'fully realised themes' – patterns of shared meaning underpinned by a central organising concept?

- If so, are topic summaries appropriate to the purpose of the research??
- Have the data collection questions been used as themes?
- Would the manuscript benefit from further analysis being undertaken, with the reporting of fully realised themes?
- Or, if the authors are claiming to use reflexive TA, would the manuscript benefit from claiming to use a different type of TA (e.g. coding reliability or codebook)?

16. Is non-thematic contextualising information presented as a theme? (e.g. the first 'theme' is a topic summary providing contextualising information, but the rest of the themes reported are fully realised themes). If so, would the manuscript benefit from this being presented as non-thematic contextualising information?

17. In applied research, do the reported themes have the potential to give rise to actionable outcomes?

18. Are there conceptual clashes and confusion in the paper? (e.g. claiming a social constructionist approach while also expressing concern for positivist notions of coding reliability, or claiming a constructionist approach while treating participants' language as a transparent reflection of their experiences and behaviours)

19. Is there evidence of weak or unconvincing analysis, such as:

- Too many or two few themes? Too many theme levels? Confusion between codes and themes? Mismatch between data extracts and analytic claims? Too few or too many data extracts? Overlap between themes?

20. Do authors make problematic statements about the lack of generalisability of their results, and or implicitly conceptualise generalisability as statistical probabilistic generalisability (see Smith 2017)?

Appendix M: Data Management Plan

UEL Data Management Plan

Completed plans must be sent to researchdata@uel.ac.uk for review

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	Jodie Canning
PI/Researcher ID (e.g. ORCiD)	U2075199 ORCiD: 0000-0002-9827-563X
PI/Researcher email	U2075199@uel.ac.uk
Research Title	A qualitative investigation of the experiences and impact of negative healthcare provider interactions during a traumatic birth.
Project ID	N/A
Research start date and duration	7 months, August 2022 – May 2023

Research Description	Negative interactions with healthcare providers during birth is a common experience in people with birth-related trauma. The proposed study seeks to qualitatively explore the impact of negative healthcare provider interactions during a traumatic birth. Specifically, the study aims to address the following research questions: 1) How do interactions with healthcare professionals contribute to the experience of birth-related trauma? 2) What is the impact of negative interactions with healthcare providers postnatally? 3) What do people that have experienced birth-related trauma think could be done differently by healthcare professionals to improve the quality of their interactions? The study hopes to recruit 12 – 15 participants who have experienced birth-related trauma and negative interactions with healthcare providers to take part in a semi-structured interview. The Birth Trauma Association has agreed to advertise the study via their website and social media accounts. Interviews will be conducted remotely over MS Teams using a UEL account. All interviews will be transcribed using the MS Teams auto-transcription function; these will manually reviewed and edited post interview. Data collected will be analysed using Thematic Analysis.
Funder	N/A – study forms part of a professional doctorate
Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	23/08/2022
Date of last update (of DMP)	
Related Policies	e.g. Research Data Management Policy
Does this research follow on from previous research? If so, provide details	No
Data Collection	

What data will you collect or create?	MS Teams auto-transcription function automatically saves transcripts to the UEL Microsoft Stream Library. Post-interview this will be downloaded in a .docx file, where it will be edited to pseudonymise and remove any personally identifiable information. Edited and pseudonymised transcripts will be password protected and saved on the UEL OneDrive. Transcripts automatically saved to the UEL Microsoft Stream will be deleted upon upload of the final transcript to OneDrive. After a three-week-withdrawal period, any information linking data to participants will be deleted; at this point data will be fully anonymised. It is hoped that 12 – 15 participants will be recruited to take part in the study. Therefore, 12 – 15 transcripts will be produced: • File format: .docx • Estimated individual file size: 25 kb • Estimated total size of all transcript files: maximum 375 kb Participants will be given the option to share demographic information (e.g. age, ethnicity, gender, marital status). This will be removed from the transcript and saved into a single, password protected .docx file that will be saved on the UEL OneDrive. It is estimated that this file will be a maximum of 25 kb in size. Consent forms will be collected for all participants and will be saved on the UEL OneDrive: • File format: .docx • Estimated individual file size: 20 kb • Estimated total size of all consent form files: 300 kb
How will the data be collected or created?	To take part in the study, participants have been asked to contact the researcher via their UEL email address. Consent forms will be sent/returned via this email thread. Semi-structured interviews will take place remotely using MS Teams and will be transcribed using the auto-transcription function. All interviews will use the same interview schedule. It is anticipated that interviews will last 45 – 60 minutes. Post-interview, transcripts will be downloaded as a .docx file to the researcher's personal laptop and edited by the researcher to anonymise and remove personally identifiable information (this includes names of healthcare professionals/services). All transcripts will be stored on the UEL OneDrive, all copies on the researcher's personal laptop will be deleted. To distinguish between participants, each participant will be assigned a participant number (e.g. 'P1'). This will be allocated based on chronological interview order.

	Documents saved on the OneDrive will be organised into the following folders: • ‘Consent Forms’: This folder will contain signed consent forms (.docx file). Each .docx file will use the following naming convention ConsentForm_[date signed] (e.g. ‘ConsentForm_16.08.2022’) • ‘Transcripts’: Each individual transcript .docx file will be saved separately in its own sub-folder. Participant numbers will be used to name subfolders e.g. ‘P1’, ‘P2’, ‘P3’. The following naming convention will be used for each transcript .docx file [participant number]_Transcript_[date of interview] (e.g. ‘P1_Transcript_16.08.2022). After a 3-week-withdrawal-period the name will be changed to [participant number]_Transcript (e.g. ‘P1_Transcript’) to ensure that data cannot be linked to participants. • Demographic Information: If a participant has opted to respond to demographic questions, these will be removed from the transcript and saved in a separate, single .docx file named ‘birth trauma study demographic information’. This will be saved within the ‘Demographic Information’ folder on the OneDrive.
Documentation and Metadata	
What documentation and metadata will accompany the data?	All participants will receive the following documents: • Blank Consent form • Participant information sheet • Debrief sheet Other: • Study advertisement flyer • Interview schedule
Ethics and Intellectual Property	

Identify any ethical issues and how these will be managed	Participant confidentiality For purposed of anonymity and confidentiality, all transcripts will be anonymised with any identifiable information removed. Post-interview, each participant will be assigned a participant number. In any subsequent write up, any quotes used from the data will be attributed to the participant number. The only time confidentiality may be broken is if serious safeguarding concerns relating to the participant or their child were identified during the interview. Participants are made aware of this via the participant information sheet prior to consenting. If such concerns were identified, supervision would be sought as a matter of urgency. The participant would be kept informed of any decisions made/steps taken. The study is compliant with DPA 2018 and GDPR as steps have been taken to minimise the amount of data collected, storage of data is within the EU and there is robust anonymisation of data. Healthcare professionals' anonymity Transcripts will be edited post-interview to remove any identifying information about healthcare professionals or specific services. Data protection/storage Consent forms will be sent via a secure UEL email address, using password protected files. All data collected will be stored on UEL OneDrive; all files stored on OneDrive are encrypted. Only the researcher will have access to consent forms and demographic information, and these will be stored in separate folders. Right to withdraw Participants are informed of their right to withdraw via the participant information sheet. To ensure that it is feasible to remove data, participants are asked to contact the researcher within 3 weeks of completing the study. If a participant wishes to withdraw, any data relating to them will be deleted. To support the right to withdraw ____. After the 3-week-withdrawal period, any information held to link participants to their data will be deleted. At this point data will become fully anonymised. Emotional distress Discussing trauma has the potential to be distressing both during and after the interview. A compassionate, flexible stance will be adopted during the interviews, where participants will be offered the opportunity for breaks, rescheduling, and withdrawal should they feel distressed. Interviews will conclude with a debrief which provides the opportunity to check in with how the participants are

	feeling post-interview. All participants will receive a debrief sheet with signposting information for relevant sources of support.
Identify any copyright and Intellectual Property Rights issues and how these will be managed	N/A – none identified
Storage and Backup	
How will the data be stored and backed up during the research?	Interviews will be transcribed using the MS Teams auto-transcription function. Post-interview a copy of the transcription will be automatically saved to the Microsoft Stream Library. This will be downloaded and edited. The final version of the transcript will be password protected and saved on UEL OneDrive. Once saved on the OneDrive the transcript will be deleted from the Microsoft Stream Library. To ensure anonymity demographic information will be removed from the transcript and saved into a separate, password protected file. Password protected consent forms will be sent by and returned to a secure UEL email address. Signed consent forms will be stored on the UEL OneDrive. To maintain anonymity and confidentiality, separate folders will be used to store transcripts, demographic information and consent forms.
How will you manage access and security?	Only the researcher will have access to the transcripts and consent forms. These files will all be password protected. These files will be accessed via the researcher's personal laptop; this laptop is password protected and only the researcher has access to it. Anonymised transcripts may be shared with the researcher's supervisor and examiners for purposes of supervision and examination. Sharing of this data will be done securely via sharing the data file on UEL OneDrive using Secure Links. This data will not be accessed or shared with anyone else.
Data Sharing	

How will you share the data?	Anonymised transcripts may be shared with the researcher supervisor and examiners for purposes of supervision and examination. Sharing of this data will be done securely via sharing the data file on UEL OneDrive using Secure Links. This data will not be accessed or shared with anyone else. The final thesis write up will be uploaded to the UEL Repository, where it can be access publicly. The thesis, and any other subsequent dissemination, will use direct quotes to illustrate key themes. These quotes will be attributed to a participant number (e.g. P1) and will not contain any identifiable information.
Are any restrictions on data sharing required?	Only the researcher will have access to identifiable information (consent forms, demographic information). The researcher, supervisor and examiners will have access to anonymised transcripts. No other researcher/organisation will have access to this data. Any participants used in the study will have provided informed consent for their data to be written up as a thesis and for any subsequent publication
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	Upon completion and examination of the project, the participant demographics, anonymised transcripts and any related data analysis documents will be retained to support further dissemination (e.g. publication).
What is the long-term preservation plan for the data?	Any data that does not have long-term value will be deleted upon completion and examination of the proposed research. Data which holds long-term value will be securely stored on the UEL OneDrive for business of the Director of Studies and will be deleted three years post-completion. The final write-up for the thesis will be uploaded to the UEL research repository where it can be access publicly.
Responsibilities and Resources	
Who will be responsible for data management?	Researcher: Jodie Canning Supervisor: Dr Kenneth Gannon

What resources will you require to deliver your plan?	A laptop and UEL account to access MS Teams, UEL OneDrive, UEL email.
Review	
	Please send your plan to researchdata@uel.ac.uk **We will review within 5 working days and request further information or amendments as required before signing**
Date: 23/08/2022	Reviewer name: Leo Watkinson Assistant Librarian (Open Access)

Appendix N: General Medical Council Seven Principles of Decision Making and Consent (GMC, 2020)

Principle one	All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able.
Principle two	Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.
Principle three	All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.
Principle four	Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.
Principle five	Doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements.
Principle six	The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them.
Principle seven	Patients whose right to consent is affected by the law should be supported to be involved in the decision-making process, and to exercise choice if possible.