

Parents' Perspectives of Birth Trauma During COVID-19

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**A thesis submitted in partial fulfilment of the requirements of the University of
East London for the degree of Professional Doctorate in Clinical Psychology**

May 2023

ACKNOWLEDGEMENTS

I would firstly like to thank all those who bravely and courageously participated in this project, who shared their personal stories with me so openly, and without whom this project would not be possible. I would like to thank Dr Kenneth Gannon for his invaluable support, guidance, time and encouragement throughout this project. I would like to thank my family and friends who have supported me so compassionately through this process.

ABSTRACT

Aim: The COVID-19 pandemic, and related restrictions in maternity settings, elevated the risk factors for traumatic birth experiences. Indeed, quantitative research has found higher levels of acute stress responses following birth during the pandemic. The present research aimed to qualitatively examine and describe traumatic birth experiences during the pandemic from the perspective of birthing people. The study sought to understand the contributing factors, impacts, support birthing people received and service improvements that could be made.

Methods: Semi-structured interviews were conducted with fifteen participants who self-identified as having experienced a traumatic birth during the COVID-19 pandemic in NHS maternity services (March 2020 – August 2021). Recruitment was supported by a charity and through snowballing techniques. Thematic analysis was employed to analyse the data and interpret the findings.

Results: The analysis resulted in the development of three themes. The first theme, 'Vulnerability and Disempowerment', spoke to participants' lack of control over their experiences, dehumanising treatment during labour, and being alone with a lack of an advocate. The second, 'Emotional Magnitude and Lasting Impacts', referred to the significant emotional toll of participants' experiences, and the impact on their key relationships and trust in the wider healthcare system. The final theme, 'Isolation and Loss', described participants' feelings of isolation and loss of experiences, due to the pandemic.

Conclusions: Overall, participants spoke to experiences during pregnancy, labour and postpartum that contributed to childbirth trauma during the pandemic. Factors that exacerbated experiences of distress, and the wide-ranging and extensive impact of their experiences, were also reported. Service recommendations included a need for greater support, more compassionate care, and a move towards a trauma-informed framework in care delivery within maternity services. Birth-reflections and adequate, timely emotional support were suggested as factors to help mitigate experiences of distress. Implications for prevention policy and future research have also been presented.

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1. CHAPTER ONE: INTRODUCTION

1.1 Defining Birth Trauma

Childbirth has been shown to evoke significant distress and is described as 'traumatic' by over a third of women (Alcorn et al., 2010; Boorman et al., 2014; Mollard, 2014). There are many different ways of conceptualising and understanding birth trauma, but generally it is recognised as significant emotional distress resulting from negative experiences that occur during the birthing process (Shaban et al., 2013). Furthermore, birth trauma tends to be the manifestation of a cumulation of distressing experiences during the birthing process, as opposed to the result of a single incident (Moran Vozar et al., 2021). These experiences are then psychologically interpreted and perceived as traumatic (Beck, 2004; Moran Vozar et al., 2021). Psychological interpretation and embodied experience are subjective and influenced by a range of psychosocial factors occurring at the individual, social and structural level (Beck, 2004; Moran Vozar et al., 2021). This highlights the complexity and nuanced nature of birth trauma, and currently there is no standardised, universally recognised definition.

1.1.1 Diagnostic Manuals

Studies vary in their criteria for capturing experiences of birth trauma. Typically, within quantitative studies, trauma is often defined according to the Posttraumatic-Stress-Disorder (PTSD) criteria (e.g. Dekel et al., 2019), which includes cognitive and behavioural changes following a traumatic event(s). The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) states that for a diagnosis of PTSD, difficulties must include one or two of the following associated with a stressor(s): intrusive symptoms, persistent avoidance, negative changes in cognitions, mood and levels of arousal (American Psychiatric Association, 2013). The International Classification of Diseases, 10th revision (ICD-10) shares similar criteria including "flashbacks", emotional blunting, detachment, avoidance and hyperarousal, all in response to an event(s) that was threatening in nature (World Health Organisation, 2019). In relation to birth trauma, such symptoms may include flashbacks of the birth or related experiences, avoidance of hospitals or future

pregnancy, detachment from key relationships, or feelings of shame (American Psychiatric Association, 2013) and may be defined as postpartum-PTSD (PP-PTSD) within the literature (e.g. Dekel et al., 2019).

1.1.2 Critique of PTSD Diagnosis

Critiques argue that the conflation of birth trauma with a diagnosis of PTSD places emphasis on individual dysfunction and pathology, reinforcing dominant medical understandings of distress (Burstow, 2005; Lafrance & McKenzie-Mohr, 2013), ignoring the social structures that may contribute to such childbirth trauma (MacDougall, 2020).

Furthermore, current diagnostic manuals do not distinguish between PTSD and PP-PTSD, and so clinicians must evaluate and apply the criteria to the context of the perinatal experience (Cirino & Knapp, 2019). In addition, studies incorporate different time periods when reporting on PTSD (e.g. postpartum-PTSD, perinatal-PTSD etc), resulting in inconsistencies between findings (Moran Vozar et al., 2021). A further complicating factor is that PP-PTSD may not solely be related to experiences during childbirth, as high-risk perinatal experiences may increase the likelihood of experiencing PTSD postpartum, such as pregnancy complications or premature births (Christiansen, 2017; Farren et al., 2016).

Moreover, given that 3 – 4 % of women are diagnosed with PP-PTSD after childbirth (Alcorn et al., 2010; Ayers et al., 2016; Yildiz et al., 2017) but approximately 20 – 45% of women experience childbirth as traumatic (Ayers et al., 2006; Ayers & Pickering, 2003; Soet et al., 2003), the use of such criteria may result in a large number of traumatic childbirth experiences being unaccounted for in the literature. In addition, such criteria tend to exclude partners' experiences of traumatic births from research, despite the evident emotional distress they can experience as a result of being witness to the traumatic birth and subsequent impact (e.g. Etheridge & Slade, 2017; Iles et al., 2011).

Instead, qualitative studies tend to include individuals who self-identity as having experienced a traumatic birth, as opposed to administering a quantifiable measure of

trauma (e.g. Murphy & Strong, 2018); the former approach would help to ensure a greater representation of birth trauma within the findings.

1.1.3 Choice of Terminology

Given that most quantitative studies use PP-PTSD as a measure to examine postpartum experiences of trauma following childbirth, this construct will be referred to in the following chapter when discussing such studies. Though due to the limitations of this construct, as discussed above, studies which use other criteria to capture birth trauma will also be incorporated.

Moreover, the overwhelming majority of studies reporting on childbearing experiences are comprised of a sample of individuals who self-identify as women (e.g. Breman et al., 2021; Moran Vozar et al., 2021). For these studies, the term 'mothers' or 'women' will be used when referring to the participants or findings. However, the term 'birthing person' will also be retained throughout this manuscript, to highlight that not all those who give birth self-identify as being a woman. The term 'birthing person' refers to an individual who has gone through the embodied process of pregnancy and giving birth, and 'non-birthing partner' refers to the partner of that birthing person.

1.2 Birth Trauma Prevalence and Demographics

Birth trauma is an international public health concern which has been reported across the world including countries in Asia (e.g. Takegata et al., 2017), Europe (e.g. Turkey, İsbir et al., 2016) and the UK (e.g. Thomson & Downe, 2016).

Research has documented that childbirth is experienced as traumatic by approximately a third of birthing people, resulting in an acute stress response (Ayers & Ford, 2016; Dekel et al., 2017) that may then develop into a more chronic manifestation of trauma in approximately 6 to 19% of individuals (Dekel et al., 2017). Meta-analyses have found that approximately 3 - 4% of women are affected by PP-PTSD following childbirth (e.g. Ayers et al., 2016; Beck, 2004; Grekin & O'Hara, 2014; Moran Vozar et al., 2021; Yildiz et al., 2017), but many individuals likely go

undetected (Ayers & Ford, 2016). Prevalence rates for PP-PTSD can be difficult to deduce due to the subjectivity of diagnosis, limited screening tools and variance in the time periods incorporated as previously discussed (Ayers & Ford, 2016; Cirino & Knapp, 2019; Moran Vozar et al., 2021).

Far less is known about the prevalence of trauma amongst partners who witnessed a traumatic birth. Of the few studies which do exist, PTSD is reported to occur in 0 – 5% of partners at 6 – 9 weeks postpartum (Andersen et al., 2012; Ayers et al., 2007), though such studies use questionnaire measures that may be reductionist in approach (Bradley et al., 2008), and therefore the figure may be longer.

1.2.1 Intersectionality

It is well documented that racialised birthing people experience poorer birth outcomes, an increased risk of birth complications and a higher rate of maternal and neonatal mortality than white birthing people (e.g. Creanga et al., 2014; Leonard et al., 2019). Alarming, the most recent MBRRACE-UK report found that black women are over three times more likely to die than white women during, or up to six weeks after, giving birth in the UK (Knight et al., 2022). The reasons for such disparities are complex, but in part may be attributable to discriminatory practices within healthcare settings, resulting in experiences of low-quality care, contributing to poorer health outcomes (Alhusen et al., 2016; Giurgescu, 2021; Howell et al., 2016; Mayne et al., 2018). Moreover, birthing people from more deprived areas and of lower socio-economic backgrounds are also more likely to experience poorer childbirth outcomes (Knight et al., 2022). In addition, those facing multiple disadvantages are increasingly more likely to die during the perinatal period (Knight et al., 2022). Therefore, it is plausible to deduce that these groups of individuals facing such inequalities may have higher rates of traumatic births than other populations, as poor birth outcomes and quality of care are associated with experiences of trauma (Ayers et al., 2008).

1.3 Childbirth Policies, Frameworks and Context

1.3.1 Global Guidance on Childbirth

The World Health Organisation (WHO) recognises the importance of positive childbirth experiences in influencing both the short-term and long-term wellbeing of birthing people and their children (WHO, 2018). The WHO Framework for improving the quality of care for women during childbirth highlights the importance of a person-centred, holistic approach, adopting a human rights-based framework, with emphasis on respect, understanding and tailored individualised care (Renfrew et al., 2014).

1.3.2 The Context and Current Guidance for Maternity Services in the UK

An independent review, published in 2015, highlighted significant failings in UK maternity services (Kirkup, 2015), following an investigation into a number of serious maternity incidents that occurred within an NHS Foundation Trust. Since then, there has been a government focus on improving the safety of care provided by maternity services in the UK. This has resulted in the development of the Better Births vision by the National Maternity Review, which set a series of targets for maternity services to halve the rates of stillbirths, neonatal and maternal deaths and brain injury by 2025 (Department of Health, 2017; NHS England, 2016c). Furthermore, the Maternity Transformation Programme (MTP) was developed to enrol the vision and achieve the key goals of providing compassionate, personalised and professional care nationally (NHS England, 2016b). Moreover, the NHS Five Year Forward implementation plan focused on increasing specialist perinatal community support, backed by £365million (NHS England, 2016a). In addition, the NHS Long Term Plan (2019) pledged to ensure that racialized pregnant women would receive care from the same midwife for the entirety of their maternity journey (NHS England, 2019), which was re-emphasised in the 2020 review of Better Births (NHS England & NHS Improvement, 2020).

However, whilst progress has been made, with a 30% reduction in the rates of neonatal mortality rates and stillbirths over the last decade (Health and Social Care Committee, 2021), more needs to be done (NHS England & NHS Improvement, 2020). Moreover, the rate of improvement is not occurring fast enough in comparison

to other countries (Office for National Statistics, 2021). Indeed, the most recent MBBRACE-UK report found that maternal deaths during labour, and up to six weeks post-delivery, was 24% higher in 2018-20 than in 2017-19, and maternal suicide was three times higher in 2020 than in 2017-19 (Knight et al., 2022), indicating a decline in some maternity outcomes.

Furthermore, serious concerns for the safety of mothers and neonates within maternity services in the UK have recently been raised elsewhere (Kirkup, 2022; Independent Maternity Review, 2022). Two independent reviews of maternity services within two NHS Trusts highlighted reoccurring patterns of poor quality of care and repeated failings to properly investigate serious maternity events, such as maternal and neonatal deaths (Independent Maternity Review, 2022). The reviews also highlighted a toxic workforce culture and suboptimal staffing levels, contributing to poor care and unnecessary harmful incidents. The reviews called for adequate funding to employ a safe workforce, the development of escalation and accountability procedures, and enrolment of clinical governance practices, including the routine monitoring of performance and outcomes by relevant bodies, with immediate effect across all NHS Trusts (Kirkup, 2022; Independent Maternity Review, 2022).

As demonstrated, there is a long-standing history of deeply embedded, problematic structures within NHS maternity services in the UK that are resistant to change, jeopardising the safety of patients and likely contributing to traumatic birth experiences.

1.3.3 Current Support Services

For those who may have experienced a more challenging or traumatic birth, maternity hospitals may provide birth reflections or birth debriefs (e.g. see Barking, Havering and Redbridge University Hospitals NHS Trust, 2023 – Birth Reflections service). Birth debriefs and reflections involve maternity staff meeting with families to provide them with a space to talk through their hospital notes and medical records, and for families to ask any questions they may have about what happened during the birth. Currently, these are not offered as part of routine practice or established as a

requirement by NICE Guidance (National Institute for Health and Clinical Excellence, 2015), and the process varies depending on each NHS Trust. Birth reflections may result in the sign-posting of women to other services for support, such as services providing emotional support, if clinically indicated. Perinatal Mental Health Services support women who are pregnant or post-partum presenting with moderate to severe mental-health needs. In 2021, new Maternal Mental Health Support services were established, to support women who were experiencing moderate to high complex needs following experiencing a traumatic birth or loss during the perinatal period, as part of the NHS Long Term Plan (NHS England, 2019). Third-sector organisations also exist to support families during the perinatal period, for example Petals (see Petals Charity, 2023) is a charity providing counselling-services to parents who have lost their baby, Sands (see Sands, 2023) also provides bereavement support for baby loss, and the Birth Trauma Association (see Birth Trauma Association, 2023) provides information and support to those who have experienced a birth trauma.

1.4 Birth Trauma Risk Factors

Factors that may contribute to, and increase the risk of, birth trauma are multifaceted and interactional, existing at the intrapersonal, interpersonal and societal levels. Additionally, these factors are influenced by experiences that occur prior to conception, during pregnancy, birth, and postnatally (Ayers et al., 2016).

1.4.1 Intrapersonal

At the individual level, research has found that fear of childbirth (Anderson & Gill, 2014), limited preparation (Hinic, 2017; Miron-Shatz & Konheim-Kalkstein, 2019) and perceived difficulties coping (Berentson-Shaw et al., 2009) may contribute to distress during childbirth. Individual fear of birth tends to centre around labour pain, fear for the infant's health and anxiety about the general birthing experience (Korukcu et al., 2016; Murphy & Strong, 2018). Indeed, neonatal complications are also a strong predictor of postpartum distress (Ayers et al., 2008), as are medical complications during pregnancy (Maggioni et al., 2006), as these exacerbate fear. Perceptions of childbirth and subsequent fear are, therefore, complex and influenced by a number of psychosocial factors, such as past birthing experiences (Freedman et al., 2020),

socioeconomic status (Fottrell et al., 2010) and prenatal mental health difficulties (Wijma et al., 1997). Furthermore, a history of trauma has been found to significantly predict childbirth anxiety and experiences of PP-PTSD (Onoye et al., 2009), with a history of sexual trauma particularly likely to increase the risk of childbirth being experienced as traumatic (Ayers et al., 2009).

1.4.2 Interpersonal

Research has found that birth experiences are significantly influenced by social interactions that occur during the birthing process (Murphy & Strong, 2018). Negative interactions with healthcare staff, such as being spoken 'at' not 'with', feeling excluded, undermined or ignored during the birthing process, are reported by women who experienced a traumatic birth (Reed et al., 2017; Watson et al., 2021).

Furthermore, a lack of information sharing during the birthing process contributes to experiences of fear, helplessness and powerlessness (Murphy & Strong, 2018).

Whereas shared knowledge can help mitigate experiences of trauma (Byrne et al., 2017; Iles & Pote, 2015) by increasing the likelihood of informed choice, which has a long-term positive impact on birth satisfaction (Maznin & Creedy, 2012).

Furthermore, a lack of humanity or compassion from staff is reported to exacerbate the distress experienced (Byrne et al., 2017; Iles & Pote, 2015). Moreover, social expectations and narratives about how one should feel post-birth have been found to compound negative feelings and self-blame following a traumatic birth experience (Iles & Pote, 2015).

The literature consistently documents that medical complications and interventions are associated with birth dissatisfaction and trauma (Falk et al., 2019). As well as contributing to fear, as discussed above, interventions may result in medical agendas being seemingly prioritised over embodied experience and individual choice, contributing to a sense of being out of control (Reed et al., 2017). Indeed, women often report feeling coerced or deceived into complying with medical interventions, which is experienced as violating or abusive (Peeler et al., 2018; Reed et al., 2017).

Moreover, support, particularly during and immediately post-birth, is consistently found to be hugely important in contributing to experiences of birth satisfaction (Iles & Pote, 2015). Indeed globally, the presence of a birthing partner of choice is recognised as a key component of a positive childbirth experience (Bohren et al., 2019; Shakibazadeh et al., 2018). In fact, the presence of a birthing partner is associated with a number of clinically beneficial outcomes (Bohren et al., 2017, 2019), buffering against psychological distress during labour, in particular experiences of trauma (Simpson et al., 2018).

1.4.3 Partners

Research on partners' experience of birth trauma, and subsequent risk factors, alludes to similar findings to that of birthing people. Not feeling adequately prepared for the birth, with a lack of information from healthcare staff, is associated with experiences of trauma (Daniels et al., 2020). Moreover, unsatisfactory communication with healthcare professionals, including experiences of insensitivity and exclusion during the birth and across the perinatal journey (Poh et al., 2014; Wells, 2016), has been reported to result in increased experiences of distress, inadequacy and birth dissatisfaction (Daniels et al., 2020; Etheridge & Slade, 2017; Nicholls & Ayers, 2010). Indeed, many partners report feeling 'isolated and abandoned' following the birth (Iles et al., 2011), which negatively impacts a partner's perceptions of being able to cope and support their family postnatally (Nicholls & Ayers, 2010).

1.4.4 Race

As previously mentioned, racialised communities are significantly more likely to experience poorer birth outcomes than white communities (Knight et al., 2022; Creanga et al., 2014; Leonard et al., 2019). The reasons for such disparities are multifactorial and may be attributable to higher rates of chronic health conditions (Howell et al., 2018; Leonard et al., 2019), less access to primary care and being more at risk of experiencing structural and social determinants of poor health (e.g. food poverty) (Gadson et al., 2017). Furthermore, racialised communities are more likely to face prejudice and discrimination within healthcare settings (Alhusen et al., 2016; Giurgescu, 2021; Howell et al., 2016; Mayne et al., 2018) and are twice as

likely to receive mistreatment within maternity services (Vedam et al., 2019). Indeed, racism and discrimination have long been recognised as barriers to accessing perinatal care in hospital settings (Alhusen et al., 2016; Altman et al., 2019; D.-A. Davis, 2019; McLemore et al., 2018). Moreover, the historic exclusion of racialised populations from research means few culturally appropriate practices have been developed, further contributing to poorer birth outcomes for these populations (Delahoy, 2020). Such factors suggest that racialised communities are at the greatest risk of experiencing a traumatic birth, by being disproportionately more affected by such factors of inequality.

1.4.5 Structural Factors

As mentioned previously, problematic, deeply-embedded structures within maternity services contribute to an inadequate workforce and unsafe environment nationally (Independent Maternity Review, 2022). Insufficient staffing levels, a toxic workforce culture, including reports of bullying or staff avoiding escalating concerns in fear of being shut down or blamed, and hierarchical structures resulting in abuses of power, have resulted in the practice of suboptimal care, with significant implications for birthing experiences (Kirkup, 2022; Independent Maternity Review, 2022). Additionally, a lack of accountability from staff and services, resulting in a failure to properly investigate and learn from serious events and, in some cases, cover-up negligence, perpetuates the risk of poor childbirth outcomes and birth trauma (Kirkup, 2022; Independent Maternity Review, 2022).

It is widely recognised that the imbalance of power between healthcare professionals and service-users are important (e.g. Corless et al., 2016) and that this can be particularly acute in maternity services (e.g. Schaaf et al., 2023). Such power dynamics within maternity care may occur at the intrapersonal level, for example patients lacking knowledge or understanding about their own rights, at the interpersonal level, such as the patient-professional hierarchy, and at the organisational level, such as particular outcome drivers (Schaaf et al., 2023). Trauma-informed frameworks, such as the Power Threat Meaning Framework (PTMF) (Johnson et al., 2018), may be used to consider how such structural oppressions of power can result in experiences of emotional distress. This particular

framework seeks to identify the role and misuse of power that has occurred in an individual's experiences and examine emotional distress within this context. The multiple layers of potential abuses of power within maternity services, as mentioned above, could be examined within this framework, with the consequent emotional distress being seen as an understandable threat response to such abuses of power, as opposed to distress being viewed as symptomatic of pathology and psychiatric diagnosis (Johnson et al., 2018).

1.4.6 The Medicalisation of Childbirth

The medicalisation of birth in Western culture has long been criticised as turning the human experience into a form of “engineering obstetrics”, contributing to greater childbirth distress (Murphy & Strong, 2018). Over the past thirty years, childbirth experiences have transformed, and out of the approximately 600,000 births per year, less than half go without medical interventions, with the majority of people giving birth in a hospital and experiencing a cascade of medical interventions (Earle, 2019). Medical interventions typically employed during childbirth include inductions of labour, ultrasounds, caesareans, episiotomy and others, which have all sharply arisen over the past decades (Kessler et al., 2006; McDougall et al., 2016; Wagner, 2008). Whilst obstetricians play a key role in preserving life during complicated pregnancies and deliveries, in developed countries, however, their involvement has become routine, often without evident effectiveness (Johanson et al., 2022). There is research to suggest that the large numbers of interventions often used are, for some cases, not necessary or warranted and are actually harmful to the birthing person (McDougall et al., 2016).

There are many explanations for the medicalisation of birth. Firstly, medical narratives, and the medical model, construct birth as a ‘high-risk’ medical experience, therefore legitimising the use of intrusive interventions that then become standard procedure, privileging the medical system and ‘knowledge’ above embodied experience and individual choice (Cahill, 2001; Murphy & Strong, 2018; Zadoroznyj, 2001). The medical philosophy of birth focuses on the pathology of pregnancy and childbirth, and the potential adverse events that could occur (Davison, 2020). Feminist sociologists note the discourse that exists in obstetrics

which asserts the body as a machine, and the hospital being the workshop that has the 'right tools' to 'correct broken parts' (Oakley, 1989; Davison, 2020), best dealt with by 'skilled operators', usually being male doctors (Davison, 2020). Many women chose to birth in hospitals, as this is assumed to be the safest option, however research suggests that for normal, low-risk pregnancies, birthing at home is as safe and results in less interventions (e.g. Brocklehurst et al., 2011; Zielinski et al., 2015).

Secondly, defensive medical practice has been identified as another explanation behind the increased medical interventions used in childbirth (Earle, 2019). In society, serious maternal events, such as neonatal deaths, results in the assumption that someone must be blamed. This leads to defensive practice, which is the favouring of practices that serve to protect medical professionals, over and above the needs of women and their infants (Earle, 2019).

Thirdly, the concept of 'choice' in childbirth has been debated, and whilst the increase in medical interventions during childbirth has been attributed to the kinds of choices women are making, many argue that 'choice' in childbirth is an illusion (Earle, 2019). For instance, if in hospital birthing people are presented with interventions deemed as 'routine', and told are preferable for the safety of themselves and their infant, one can see how their choices exist within the context and parameters of the medical model. Indeed, feminist movements argue that the medical domination of childbirth denies birthing people the right to make choices about and to control their own bodies, and that medical constructs mean that women no longer trust their own bodies or the natural process of birth, and are fearful of the process (Davison, 2020). Furthermore, the biomedical model of birth may result in the 'stigmatising dilemma', which is when women who try to gain authority in the labour room are perceived as irrational and selfish (Ballesteros, 2022). This occurs when childbirth is deemed a risk-inflicting process, when women are viewed as unreliable sources of information, and when medicalised interventions are thought to serve as the safest means for birth, and thus, if birthing people want what was best for them and their child, it is understood that they would just accept the decisions made by medical professionals. In instances during which birthing people challenge this, they are viewed as irrational and selfish, as it is assumed that they therefore clearly do not want what is best for themselves or their child.

Such a medical approach to childbirth has been associated with acute post-traumatic distress postnatally (Ayers, 2014). Hence, hospital de-briefs, psychological screening and interventions are then employed to ameliorate childbirth trauma (Ayers, 2014). However, such interventions are too reductionist in approach and, in fact, perpetuate the problem by detracting from the significant role that services play in contributing to experiences of birth trauma. This then firmly places the responsibility for “psychological adjustment” within the birthing person, exacerbating stigmatising discourse around postnatal distress (McNally, 2009; Peñacoba-Puente et al., 2016).

1.5 Impact of Birth Trauma

The impact of birth trauma is extensive and wide-reaching, with implications not only for the individual birthing person but their key relationships, with both short and long-term effects on wider society too.

1.5.1 Impact on the Birthing Person

Traumatic births are associated with an increased risk of postnatal distress and adverse psychological effects, such as experiences of depression, anxiety, psychosis, suicidality and posttraumatic stress (Bell & Andersson, 2016; Chabbert et al., 2021; Dunkel Schetter & Tanner, 2012). Traumatic stress responses to the birth may include anger, dissociation, apathy or rumination about the event and detachment (Nilsson et al., 2010), which may develop into a more chronic manifestation of trauma, including reexperiencing symptoms, such as intrusive memories, flashbacks and nightmares about the birth (Ayers et al., 2016; Beck et al., 2011; Chan et al., 2020; Dekel et al., 2017).

One global qualitative study found that following a traumatic birth, mothers reported feeling numb, detached, distressed and isolated, which indirectly impacted their relationship with their infant (Beck & Watson, 2019). A scoping review of five qualitative studies (Watson et al., 2021) found that women reacted by avoiding people close to them (Peeler et al., 2018) and efforts to deflect from thinking about what happened were associated with intrusive memories and flashbacks of the

experience (Iles & Pote, 2015; Peeler et al., 2018). Participants reported experiencing gaps in their memory from the event (Iles & Pote, 2015; Peeler et al., 2018) and an altered sense of self following the birth trauma (Byrne et al., 2017; Peeler et al., 2018), such as feelings of isolation and self-doubt (Iles & Pote, 2015; Peeler et al., 2018). Such experiences can impact key relationships (e.g Beck & Watson, 2019; Garthus-Niegel et al., 2018); indeed, many couples report experiencing difficulties following a traumatic birth, such as conflict in communication and difficulties with intimacy (Nicholls & Ayers, 2010).

1.5.2 Impact on the Infant

As mentioned, traumatic birth experiences can have a negative impact on the parental-infant relationship (e.g. Beck & Watson, 2019; Bell & Andersson, 2016; Chabbert et al., 2021). Some qualitative studies have found that birthing people report feeling violated post-birth, which can affect their perceptions of their infant (Ayers et al., 2006) or result in a need to avoid physical contact, which can impact breastfeeding (Chan et al., 2020; Dekel et al., 2019). This may all indirectly impact infant development, and one meta-analysis found that maternal PP-PTSD is associated with delays in socioemotional development (Garthus-Niegel et al., 2017). However, research in this area is limited and so findings should be interpreted with caution (Cook et al., 2018).

Psychological distress following traumatic birth experiences can impact parenting practices (Ayers et al., 2006) and qualitative studies have found that some women report feeling extremely anxious and overprotective of their child (Nicholls & Ayers, 2010) or in other cases struggling to bond entirely (Ayers et al., 2006). Indeed, experiences of trauma have been found to increase the likelihood of avoidant, hostile, intrusive, controlling and/or overprotective parenting styles (Cook et al., 2018; Erickson et al., 2019). Furthermore, trauma can be continued intergenerationally through its impact on parenting styles (Erickson et al., 2019). Crucially, traumatic birth experiences can negatively affect a parent's capacity to emotionally and physically care for their infant during the postnatal period (Borg Cunen et al., 2014).

1.5.3 Impact on the Partners

Much less is known about the impact of traumatic births on partners. One study found that partners mirrored the birthing persons' responses to the birth, particularly traumatic stress responses, which were associated with impaired well-being, functioning and relationships postpartum (Iles et al., 2011). A qualitative study found that the birth negatively impacted partners' mental health and functioning, with many reporting symptoms of depression, OCD, anxiety and trauma symptoms, such as flashbacks and nightmares (Daniels et al., 2020). The study found that the partners had to assume the role of primary carer for the infant and their partner, which subsequently impacted work, relationships and their expectations of parenthood (Daniels et al., 2020), with many reporting difficulties in bonding with their infant. Another UK qualitative study derived similar findings and found that partners reported feelings of hopelessness, disconnection, fear and preoccupation with the birth, resulting in difficulties functioning at work and in relationships (Etheridge & Slade, 2017).

1.5.4 Wider Social Impact

Traumatic birth experiences can impact perceptions of, and engagement with, healthcare systems (Ayers et al., 2006; Hofberg & Brockington, 2000), with implications for the health and safety of the parent and infant. Moreover, traumatic birth experiences can affect decisions to have another child in the future (Ayers et al., 2006; Hofberg & Brockington, 2000) due to fear of the birthing process (Iles & Pote, 2015), further highlighting the longstanding and life-altering impact birth trauma can have.

The economic cost of traumatic birth experiences is likely to be considerable. Perinatal mental health difficulties, which may be caused and exacerbated by traumatic births, are estimated to cost the NHS approximately £1.2 billion for each annual cohort of births (Bauer et al., 2014). Furthermore, the cost to society is approximately £8.1 billion annually (Bauer et al., 2014), due to the impact on employment, reliance on services, and adverse effects on the infant. Additionally, 20-30% of maternal deaths in the postpartum period result from suicide and substance overdose (Lindahl et al., 2005), which cause more deaths than postpartum medical

complications, thus highlighting the current inadequacies in detecting and treating postpartum distress (Chin et al., 2022). Improvements to maternity services to prevent harm being caused (Independent Maternity Review, 2022), and effective early intervention, are therefore imperative to reduce the long-term human and financial costs of perinatal mental health difficulties (Bauer et al., 2014).

1.6 Childbirth and COVID-19

The first case of Coronavirus Disease (2019) (COVID-19) in the UK was identified in January 2020. By the 23rd March 2020 a national lockdown was enforced (Aspinall, 2020), which involved non-essential businesses closing, and people only being permitted to leave their home for essential purposes (e.g. to buy provisions, key healthcare workers etc.). Over the next year and a half, the UK succumbed to a continual cycle of lockdowns being introduced and lifted to varying degrees, until July 2021 (Brown & Kirk-Wade, 2021). This had significant implications for the economy, services, people's livelihoods and mental health (Xu & Banks, 2020) and negatively impacted the population's physical health, exacerbating health inequalities (Mehlmann-Wicks, 2022).

1.6.1 Pandemic-Related Service Reconfigurations

In response to the pandemic, maternity services imposed restrictions, which resulted in the suspension of home and water-births, exclusion of partners from perinatal appointments, visitor restrictions in hospitals and a move to remote postnatal care (Aydin et al., 2022). Generally, birthing partners were only permitted to join the birthing person once they were 4cm dilated; they were not permitted during the early stages of labour, nor at the beginning of an induction or for the preparation of a C-Section, and they were forced to leave shortly after their partner had given birth (Regan, 2020). Many of the restrictions were a result of a shortage in the workforce and a diversion of resources to pandemic-related needs (Aydin et al., 2022). In fact, The Royal College of Midwives reported a doubling in the shortage of midwives since before the pandemic in 2019 (Royal College of Midwives, 2020; Sherwood, 2020).

NHS Trusts were expected to develop their own guidance during the pandemic, resulting in inconsistencies between maternity services (Aydin et al., 2022; Topping & Duncan, 2020). Whilst the government advised Trusts to reintroduce support persons for pregnant people in services in early September 2020 (NHS England, 2020a), and then again more explicitly in December 2020 (NHS England, 2020b), only 23% of maternity services allowed partners to be present for the duration of childbirth during this time (Topping & Duncan, 2020). Indeed, restrictions in maternity services are continuing to this day (e.g see East and North Hertfordshire NHS Trust, 2022 - current maternity and neonatal guidance).

As such, the pandemic resulted in the provision of suboptimal care within NHS maternity services. Adherence to WHO guidance for quality maternity care and best practice (Renfrew et al., 2014) was suspended, as demonstrated by accounts of individuals giving birth alone (Betteley, 2020; San Francisco: Human Rights in Childbirth, 2020; Walsh et al., 2020), restrictions placed on birth plans and individual choice (N. Davis, 2020; Greenfield et al., 2021; Hodson, 2020; Summers, 2020), and recovering in hospital alone with restrictions on visitation rights (Aydin et al., 2022).

1.6.2 Impact of COVID-19 and Restrictions on Birthing People

It is well documented that levels of anxiety around pregnancy and childbirth increased during the pandemic as a result of strict public health guidelines, increased demands on healthcare services and associated restrictions, and the potential unknown risk of the COVID-19 virus on the birthing person and unborn infant (Ahlers-Schmidt et al., 2020; Davenport et al., 2020; Lebel et al., 2020; Liu, Erdei, et al., 2021b; Moyer et al., 2020). All these factors exacerbated the stress that normally occurs during the perinatal period (Iyengar et al., 2021; Matvienko-Sikar et al., 2021).

During the pandemic, the number of expectant parents accessing NHS services decreased, and there was an increase in the number of families accessing private support (Davis, 2020) and exploring 'free birth' options (Greenfield et al., 2021; Hodson, 2020). Moreover, 90% of maternity choices were impacted by restrictions and access to specialist mental health support was halved (Baptie et al., 2020).

Furthermore, maternity-restrictions elevated levels of negative birthing experiences and distress (Aydin et al., 2022).

1.6.3 Birth Trauma During COVID-19

Research has demonstrated that the pandemic contributed to an increase in traumatic birth experiences and greater levels of mental health disturbances perinatally (Hessami et al., 2020; Mayopoulos et al., 2021). Indeed, one quantitative study, comparing 637 American women who gave birth during COVID-19 with 637 matched controls who gave birth before COVID-19, found that those who gave birth during the pandemic reported more clinically acute stress responses to birth than the controls ($Z= 2.65$, $p= .008$). This stress response was found to be associated with posttraumatic symptoms ($\beta= .42$, $p< 0.001$), difficulties in bonding with the new born ($\beta= .26$, $p< .001$) and difficulties in breastfeeding ($\beta= .10$, $p< .01$) (Mayopoulos et al., 2021). Additionally, higher levels of posttraumatic stress following birth during the pandemic have consistently been found in studies conducted worldwide (e.g. Diamond & Colaianni, 2022; Mariño-Narvaez et al., 2021; Oddo-Sommerfeld, Sommerlad, et al., 2022).

Furthermore, quantitative studies have found that pandemic-related perinatal healthcare changes were significant predictors of trauma symptoms following birth (e.g. Diamond & Colaianni, 2022). Fluctuating guidance and difficulty navigating the healthcare system have been found to contribute to symptoms of trauma postnatally (Liu, Erdei, et al., 2021a; Spatz & Froh, 2021; Liu, Koire, et al., 2021), as have pandemic-related anxiety in pregnancy (Liu, Koire, et al., 2021), limited social support and ineffective online appointments (Spatz & Froh, 2021). Pandemic-related restrictions on the presence of a birthing partner and visitation rights post-birth have consistently been found to be associated with greater psychological distress, anxiety and posttraumatic stress symptoms (Liu et al., 2021; Oddo-Sommerfeld, Schermelleh-Engel, et al., 2022), as have changes to birth plans and the requirement to wear masks (Diamond & Colaianni, 2022).

In summary, research has demonstrated that the pandemic was associated with increased reports of trauma following birth and perinatal distress, which may result

from pandemic-related restrictions, increased experiences of anxiety, and limited support. What remains unclear are the individual experiences of those who gave birth during the pandemic. This is important to examine in order to truly understand the conditions that contributed to such distress and to explore the likely significant and wide-ranging impact of such experiences, from the voice of those with direct experience. This would enable the consideration of preventative measures, adequate solutions and interventions to effectively help support those in distress and mitigate the related impacts.

1.7 Scoping Review

1.7.1 Objectives

A scoping review was conducted to examine birth experiences in the context of the COVID-19 pandemic and subsequent emotional impact. The aim was to understand the unique accounts of birthing experiences, and how the context of the pandemic may have contributed to traumatic experiences, as quantitative research suggests. Due to the interest in full, rich accounts of individual, subjective experiences, entirely quantitative studies that captured limited parameters of birth to examine “birth experiences” (e.g. vaginal vs caesarean birth, accompanied vs unaccompanied births) and standardised measures to investigate subsequent “emotional impact”, were excluded from the scoping review. Using standardised measures to examine birth or emotional experiences risks being reductionist and presumptive in approach, reinforcing the researcher’s academic understanding of the concepts as opposed to seeking to understand such experiences from the perspective of those with direct, lived experience. Such an approach risks privileging researcher knowledge and academic definitions of concepts over and above the understanding of those with lived embodied experience, resulting in an imbalance of power between the researcher and participants. This imbalance of power risks reflecting the imbalance of power between service-users and healthcare professionals during childbirth, as discussed above. Furthermore, qualitative research enables the examination of the phenomenon, in this instance being childbirth, situated within a particular context, the COVID-19 pandemic, and therefore facilitating an understanding of the contextual relationship. Due to the fairly limited existing research on this topic, particularly from

the UK, studies were sourced from a global context to ensure important findings were not missed.

1.7.2 Search Strategy

The following databases were searched: EBSCO HOST (APA PsychInfo, Academic Search Ultimate, CINAHL), SCOPUS and Google Scholar. The databases were searched for articles relating to COVID-19, Birth and Trauma, using 'OR' and 'AND' Boolean operators:

1. Birth terms ("childbirth" OR "birth trauma" OR "birth" OR "birth injuries" OR "traumatic birth" OR "birth" OR "postnatal")
2. COVID-19 terms ("COVID-19" OR "coronavirus" OR "pandemic")
3. Trauma terms ("trauma" OR "traum*" OR "birth trauma" OR "traumatic birth" OR "distress" OR "PTSD" OR "psychological stress" OR "mental health" OR "anxiety" OR "posttraumatic stress" OR "distress" OR "psychological distress")

1.7.3 Databases and Findings

The process of extracting the relevant studies from the database searches can be referred to in Figure 1.

Inclusion criteria:

- Studies that examine and speak to the nature of childbirth experiences during the COVID-19 pandemic, from parents' perspectives.
- AND studies that focus on the psychosocial impact of such experiences, such as the impact on emotional wellbeing, parenting and psychosocial functioning.

Exclusion criteria:

- Studies that do not examine birth experiences during the pandemic or speak to the nature of such experiences.
- Studies that do not examine the psychosocial impact of such experiences (i.e. no exploration of the emotional impact of such experiences).
- Studies that are not relevant to the COVID-19 pandemic.
- Studies that are not published in English.

Figure 1

Process of Extraction

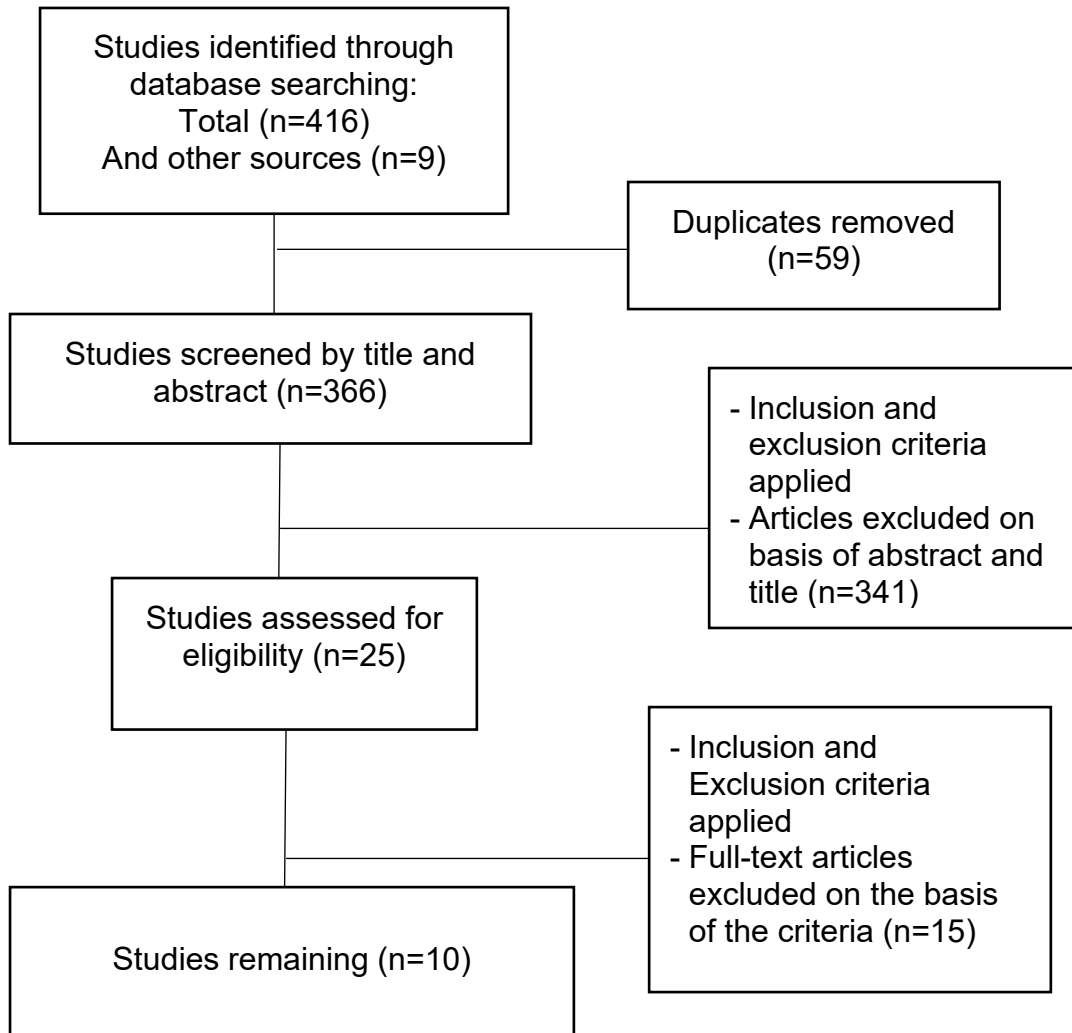


Table 1: Overview of Studies Included in the Scoping Review

Title	Authors/ Year	Country	Participants	Methodology, Design, Analysis
Narrative Analysis of Childbearing Experiences During the Covid-19 Pandemic	Ajayi et al. (2021)	Worldwide – participants included from 8 countries (3 pps unknown country), including US, UK, Philippines, Jamaica.	N = 83 Ages: N/A	Qualitative study Birth accounts on YouTube Narrative Analysis Framework
Giving Birth During the COVID-19 Pandemic, Perspectives from a Sample of the United States Birthing Persons During the First Wave: March-June 2020	Breman et al. (2021)	US	N = 388 Mean: 31.5 years	Mixed-methods Survey Content analysis
Mothers' Experiences of Pregnancy, Labour and Birth, and Postpartum during COVID-19 in the United States: Preliminary Results of a Mixed-Methods Study	Saleh et al. (2022)	US	N = 32 24 – 40 years	Mixed-methods Surveys and interviews Descriptive statistics and TA

Title	Authors/ Year	Country	Participants	Methodology, Design, Analysis
"Mourning the Experience of What Should Have Been": Experiences of Peripartum Women During the COVID-19 Pandemic	Shuman et al. (2022)	US	N = 371 18 – 45-years	Qualitative study Survey TA
Birthing Experiences of Spanish Speakers During the COVID-19 Pandemic in NYC	Granada et al. (2022)	US (NYC)	N = 30 >18 years	Qualitative Semi-structured interviews TA
"COVID Affected us All:" The Birth and Postnatal Health Experiences of Resettled Syrian Refugee Women During COVID-19 in Canada	Cameron et al. (2021)	Canada	N = 8 Ages: N/A	Qualitative Semi-structured interviews Constructivist grounded theory
Lockdown Babies: Birth and New Parenting Experiences During the 2020 COVID-19 Lockdown in South Africa, a Cross-sectional Study	Farley et al. (2022)	South Africa	N = 520 18 ≥ 35 years	Mixed-methods Survey Descriptive statistics, multivariate analysis and thematic content analysis

Title	Authors/ Year	Country	Participants	Methodology, Design, Analysis
Giving Birth and Becoming a Parent During the COVID-19 Pandemic: A Qualitative Analysis of 806 Women's Responses to Three Open-Ended Questions in an Online Survey	Eri et al. (2022)	Norway	N = 806 18 - ≥ 40 years	Qualitative study Survey TA
Welcoming New Life Under Lockdown: Exploring the Experiences of First-Time Mothers who Gave Birth During the COVID-19 Pandemic	Gray and Barnett (2022)	UK	N = 10 21 – 35 years	Qualitative Semi-structured interviews Reflexive TA
Giving Birth in a Pandemic: Women's Birth Experiences in England During COVID-19	Aydin et al. (2022)	UK	N = 477 Ages: N/A	Mixed-methods Survey TA and Descriptive statistics

1.7.4 Scoping Review Studies

A global study of participants from eight different countries analysed 83 first-person, birth-story accounts extracted from YouTube, recorded in English (Ajayi et al., 2021). Narratives were included if the narrator had recently given birth or in their second or third pregnancy trimester during the pandemic. A narrative analysis framework, applied to the accounts, derived a number of key themes, including an overall sense of loss of pregnancy and birthing experiences, changes in hospital experiences and support from healthcare staff determining birth satisfaction. A number of subthemes were also identified, including opting for home births to avoid hospitals; increased valuable time with their partner; having a healthy new-born helped to negate the negative feelings in relation to the pandemic; testing positive for COVID-19 resulting in unsatisfactory care from staff; and the importance of timely and effective communication with staff.

A US study examined 388 people's experiences of giving birth during the first wave of the pandemic (March 2020 to June 2020) (Breman et al., 2021). The sample was predominately White (89.7%), female-identifying (99.7%), and the majority had private health insurance (85.3%). The study employed a mixed-methods approach, analysed using descriptive statistics and content analysis. Black respondents reported receiving lower levels of respectful care than white respondents and increased rates of pre-term births. Themes relating to participants' experiences of pandemic-related birth changes included institutional policies, such as visitor restrictions in hospitals, and restrictions on the care they received (e.g. no water birth, pressures to have induction, early discharge). Respondents reported receiving sub-par care as a result of COVID-19 hospital restrictions, feeling unsupported by healthcare staff, receiving minimal emotional and physical support, and reported on sentiments of loneliness, anxiety, isolation and overwhelm.

Another US study examined the experiences of pregnancy, birth and postpartum during the pandemic through the use of online surveys and interviews. In total, responses of 32 women were included (78.1% White) (Saleh et al., 2022). A mixed-methods approach was adopted; descriptive statistics and thematic analysis (TA) were used to analyse the data. Respondents reported experiencing mental health distress, including anxiety and depression, and that the pandemic had negatively

impacted the support they received from services and their social networks throughout their maternity journeys. Themes from the qualitative findings included a difference in expectations versus reality, as a result of pandemic-related hospital changes. Differences in early versus late pandemic experiences were also found, with those giving birth earlier in the pandemic experiencing less disruption to their care but greater levels of anxiety regarding the impact of COVID-19. In addition, women recognised their strengths in the face of adversity, whilst simultaneously experiencing mental distress, such as guilt, shame and depersonalisation.

Another US cross-sectional study reported on the findings of two free-text items from a survey completed by 371 postpartum mothers on their experiences of giving birth and the postpartum period during the COVID-19 pandemic (Shuman et al., 2022). Five key themes were derived, which included heightened levels of emotional distress in relation to lockdown restrictions; adverse breastfeeding experiences, resulting from a lack of support; and unanticipated hospital policy changes, impacting on birth and postnatal experiences. Mothers reflected on their expectations versus the reality of their experiences, reporting a sense of loss and isolation as a result, but also some positive experiences in having more time with their partner and infant. The study concluded that the pandemic exposed peripartum mothers to new stressors and exacerbated existing ones.

A US study examined differences in the birth experiences of 15 monolingual Spanish and 15 bilingual Spanish / English-speaking patients who delivered at one tertiary care facility in NYC in April or May 2020 (Granada et al., 2022). Remote semi-structured interviews were conducted with the 30 participants, and the qualitative data were organised into themes. Participants spoke of their births and associated positive experiences with having a healthy baby, high-quality care and supportive staff. Participants who reported negative experiences did so because of fears around going to hospital, differences between their expectations and reality of birth, a lack of information from staff and inter-relational difficulties, such as experiencing a lack of respect or compassion from professionals. Respondents reported language-related difficulties, such as not being offered an interpreter, and pandemic-related restrictions on visitors, doulas and support persons during and post-birth, resulting in

isolation, distress and loneliness. Nearly all respondents felt that COVID-19 negatively impacted their emotional wellbeing.

A qualitative study, conducted in Canada, examined the experiences of a marginalised and minoritized group of Syrian refugees on their birth and postnatal experiences during the pandemic (Cameron et al., 2021). In total, eight Syrian women were included, who had given birth from March 2020 to August 2020. Constructivist grounded theory identified three key themes. The first theme reported on the impact of the pandemic on the accessibility of services, due to limitations on childcare, support people and moving to remote care. This was reported to have resulted in isolating birthing experiences, such as women giving birth alone, recovering postnatally in hospital alone and there being a lack of interpreter provision. The second theme related to a loss of informal support postnatally as a result of lockdowns, closures of schools and day-care facilities. The third theme related to the impact of the pandemic on emotional well-being, such as increased anxiety, fear and a sense of loss for what their birth experience should have been.

A cross-sectional study, conducted in South Africa, surveyed 520 parents (95% were female) on their experiences of childbirth and becoming new parents during the pandemic (Farley et al., 2022). A mixed-methods approach was used to examine responses: descriptive statistics, multivariate analysis and thematic content analysis. The findings demonstrated that during the pandemic, women were less likely to have their delivery of choice, less likely to have skin-to-skin with their new-born immediately post-birth and were more likely to report negative experiences than those who gave birth outside of the pandemic. Moreover, negative feelings about the birth were found to increase the likelihood of depression and were associated with traumatic experiences, feeling disconnected from the birth and not having a partner present during labour. Themes included feelings of social exclusion and isolation; hospital restrictions negatively impacting the quality and extent of maternity support; restrictions causing more stress and increasing the “mental-load” of parenting; and that positive birthing experiences helped to mitigate the negative impact of COVID-19 on new parents.

Another cross-sectional, survey-based study, conducted in Norway, also examined the experiences of becoming a parent during the first year of the COVID-19 pandemic (Eri et al., 2022). A total of 806 women were included and completed an online survey. TA was employed to analyse the responses and found that pregnancy was perceived as a stressful waiting period due to uncertainty over hospital restrictions, anxiety around catching the virus and its impact on the infant, and a fear of being alone during labour. Respondents reported feeling isolated and disempowered without the presence of their partner and feeling alone at their most vulnerable, particularly during labour and on the postnatal wards. Participants also reported a sense of loss, grief and tragedy in not being able to share moments across their maternity journeys, and immediate postnatal experiences as a family. The final theme related to the lack of compassion respondents received during their postnatal care due to understaffing, which created a cold and tense atmosphere, resulting in patients feeling overlooked, dismissed and abandoned.

A UK-based study conducted semi-structured interviews with mothers on their experiences of birth and becoming first-time mothers during the COVID-19 pandemic (Gray & Barnett, 2022). Ten participants were included, and TA derived two key themes. The first theme encapsulated the mothers' exacerbated sense of responsibility for their infant during the pandemic, heightened by societal expectations around doing the 'right' thing and uncertainty around COVID-19 guidance. The second theme reported on the harmful impact of the pandemic on the transition into motherhood as a result of disrupted birthing experiences due to service-restrictions, lack of contact with social networks, and limited support from services postnatally. Furthermore, the study described exacerbated levels of stress, anxiety and emotional distress experienced by first-time mothers as a result of disrupted hospital experiences and the pandemic. In contrast, some positive experiences, as a result of the pandemic, were also reported, such as an increase in the presence of partners in lockdown and time with the infant.

Another study examined 436 parents' experiences of giving birth during the pandemic in England, via a survey (Aydin et al., 2022). A mixed-methods approach was adopted, using descriptive statistics and TA. Quantitative analysis revealed that participants reported a largely negative sentiment in relation to their experiences

(46.9% negative, 33.2% positive, 19.9% neutral), particularly during the first lockdown (56.9%) compared with the second (34.2%) and third lockdown (50% negative). TA of the qualitative data revealed that some parents reported that their birth went according to plan, whilst others expressed not having made a birth plan due to the hospital restrictions. Pandemic-related changes were reported to include the suspension of home births and birthing pools, being alone during inductions, difficulties accessing pain relief, feeling rushed and out of control, and being alone for the majority of their experience, resulting in distress and anxiety. Respondents reported that when non-pandemic related changes to their birth occurred, a lack of support and poor communication from hospitals exacerbated distress. Many parents also spoke of the fluctuating pandemic-related guidance as causing anxiety.

1.7.5 Key Findings and Limitations

The studies included in the scoping review highlight several ways in which the pandemic impacted birthing experiences, such as disrupting and limiting birth plans, the support and aftercare received from staff, and the presence of partners and visitors in hospital, which generally resulted in negative sentiments and birth dissatisfaction. Furthermore, most studies reported experiences of isolation and exacerbated anxiety as a result of the pandemic, and an overall sense of loss of experiences during pregnancy, birth and postnatally.

The studies present some important limitations. Firstly, most of the studies consist of large sample sizes, focusing on the quantity of data as opposed to gathering fewer but richer accounts of birth experiences and related impacts. Secondly, for the majority of the studies descriptive birth experiences formed only a small component of the data derived, with many being of mixed methodology, further limiting the extent of detail provided. Thirdly, many of the studies recruited participants who gave birth at specific time-points during the pandemic, questioning the generalisability of the findings outside of that timeframe. Finally, only two of the studies were conducted in the UK, relating to birthing experiences during the pandemic within NHS maternity services. This is significant, as findings from an international context may have limited utility within the UK, due to differences in the structure of services, pandemic-related restrictions and lockdown rules.

1.8 Rationale

As discussed, the scoping review presents a number of important findings on birth experiences during the pandemic and related impacts on birthing people and their families. However, it also highlighted several limitations and gaps in the literature. Crucially, the scoping review has identified a lack of research into experiences of traumatic births during the pandemic. Whilst many of the studies indicate that the risk factors for traumatic birth experiences may have been elevated during the pandemic, such as changes to birth plans, limited support and poorer interactions with staff, none of the studies directly examine experiences of traumatic births, contributing factors and subsequent impacts. Moreover, some studies even excluded participants with a postpartum mental health diagnosis (e.g. Gray & Barnett, 2022), a cohort more likely to have had a difficult birthing experience. Therefore, it is likely that those who experienced trauma may have faced a unique set of experiences and exacerbated distress not yet represented in the literature, warranting further investigation. Furthermore, conducting the research in the UK, within the context of the NHS system and national pandemic-related restrictions, will help to further our understanding of how wider-systemic factors may have contributed to traumatic birth experiences, with implications for service recommendations.

1.9 Clinical Relevance

Birth trauma has a wide-ranging impact on not only the birthing person, but their infant, partner and other key relationships, and has both short-term and long-term implications for society. This suggests that professionals and services have not only a moral but also an economic obligation to investigate such experiences and intervene. Psychologists and other Psychological Practitioners, which may include Psychotherapists, Clinical Psychologists, Counselling Psychologists, Specialist Midwives and Perinatal Cognitive Behavioural Therapists, for example, may be best placed for this, drawing on their skills in research and clinical practice. Psychological practitioners can critically formulate experiences of birth trauma, investigating the contributing and perpetuating factors at the micro, meso and macro-levels, and examine the range of psychosocial harms caused, offering a psychologically

informed perspective. Given that previous research clearly highlights the role of healthcare professionals, services, and structural factors that may contribute to experiences of birth trauma, findings from a psychologically-informed examination of traumatic birth experiences may help to guide policy and shape services, to help prevent such incidents from reoccurring, and inform interventions.

Furthermore, psychological practitioners, as duty-bound healthcare professionals, have a legal obligation to investigate reports of harm and to prevent and intervene effectively. The Human Right's Based Approach (HBRA) is a framework for health, based on international standards, aimed to "address and rectify inequalities, discriminatory practices and unjust power relations, which are often at the heart of inequitable health outcomes" (WHO, 2015). "The right to the highest attainable standard of health" (WHO, 2015) indicates an internationally agreed, legal obligation on states to ensure all persons have access to appropriate conditions and health as a human rights-standard. Mistreatment, abuses and violence against birthing people in reproductive and birthing healthcare settings violates human rights, as described in internationally recognised human rights standards (United Nations, 1948) and such abuses occur in countries across the world (Bohren et al., 2015; WHO, 2015). The UK Equality Act (2010) exists to prevent discrimination and to place an obligation on all public bodies to consider all individuals when developing and delivering services and shaping policy, which includes the prevention of discriminatory practices on birthing people within NHS maternity services (Bowser & Hill, 2010).

The context of the pandemic and related maternity restrictions likely exacerbated such violations in human rights, as previously mentioned, with accounts of women giving birth alone without an advocate or support person, restricted visitation rights, minimal support from services and restricted choice (Aydin et al., 2022; Renfrew et al., 2014; WHO, 2018). Within this context, the medical model and maternity restrictions took precedent over individual choice and embodied experience, likely contributing to experiences of trauma, as documented by studies demonstrating elevated levels of postnatal posttraumatic distress during this time (Mayopoulos et al., 2021). However, a detailed investigation into the factors contributing to birth trauma during the pandemic, potential violations in human rights

within maternity services, and subsequent impact of the trauma, from the perspective of those with lived embodied experience, is lacking. Such an investigation could help identify recommendations and policies to prevent repeat occurrences in the future.

1.10 Research Aims

This research will seek to understand the experiences of birth trauma during the COVID-19 pandemic from the perspective of parents. This will be achieved by asking birthing persons, with lived embodied experience of a traumatic birth during the pandemic, a series of questions to answer the following research questions:

1. How do parents describe and understand birth trauma that occurred during COVID-19?
2. What is the impact of birth trauma, from parents' perspectives?
3. What support did they receive from services, and/ or what do they think could have been helpful?

2. CHAPTER TWO: METHOD

2.1 Ontology and Epistemology

Epistemology and ontology refer to philosophical standpoints that underpin the acquisition and interpretation of knowledge and truth, within research (Braun & Clarke, 2021b). Both are philosophical commitments, concerned with understanding the fundamental nature and existence of a topic of interest (Dilts & DeLozier, 2000) and how we come to acquire and gain knowledge about that topic (Willig, 2019a). Therefore, they act as the foundation of the researcher's approach to a research topic and will guide the choice of methodology. Understanding the researcher's epistemological and ontological positions enables an appreciation of their values and aims, which can influence their pursuit of knowledge, the methodology employed, and shape the process of data analysis and interpretation (Greenwood & Terry, 2012; Mauthner & Doucet, 2003; Snape & Spencer, 2003).

The present research was conducted from a critical realist position. Critical realism is ontologically realist, yet simultaneously recognises that the acquisition and interpretation of knowledge is shaped by subjective experience and subsequent unavoidable bias (Willig, 2012; Bhaskar, 1979); whilst proposing the existence of an absolute truth, this can never truly be ascertained due to the mediation of knowledge acquired via a sociocultural lens (Greenwood, 1994; Pilgrim & Bentall, 1999). Furthermore, critical realism seeks to identify both the observable and unobservable underlying structures at play that influence meaning, in order to provide a deeper understanding of an individual's account that goes beyond what is reported at the surface-level (Willig, 2012). This study was informed by critical realism, as it assumes the concepts of "childbirth" and "trauma" exist and are informative of reality, with material consequences for those with lived experiences of childbirth trauma. In addition, the study simultaneously recognises that such experiences are contextualised within wider sociocultural influences, and therefore there may be many dimensions of this reality (Willig, 2013). Indeed, such an approach acknowledges that data acquisition is dependent on the methodological and analytical processes, the researcher's interpretation and participant accounts, which

are influenced by sociocultural experiences, pre-existing knowledge and subsequent assumptions (Bhaskar, 1979; Willig, 2019; Bisman, 2010).

2.2 Design

A qualitative approach has been used to enable exploration of the nature, quality and meaning of individual experiences (Willig, 2019b). Qualitative research seeks to further understanding and increase knowledge of a particular phenomenon, in this instance being experiences of birth trauma during the COVID-19 pandemic.

2.2.1 Rational for Thematic Analysis

Thematic Analysis (TA) is a method of analysis used to identify patterns within data, known as themes. Furthermore, this approach offers an interpretation on the meaning and significance of the patterns identified (Braun & Clarke, 2006). TA is a method used to both reflect reality, as well as dissect the surface of 'reality', characterised by a critical realist position (e.g. Willig, 1999). The analytic process involves a progression from being merely descriptive, through the organisation of data to demonstrate patterns in semantic content, to interpretative, during which the significance, broader meaning and implications of such themes are theorised (Patton, 1990).

The present research aimed to adopt an inductive, data-driven approach to analysis. This approach assumes that meaning is grounded in the data, the explicit things that are said, and their interpretative framework, without being made to fit pre-existing assumptions or a coding framework (Braun and Clarke, 2006). In reality, analysis is likely to be both inductive and deductive, as the analysis does not occur within an epistemological vacuum (Braun & Clarke, 2012; Braun & Clarke, 2006).

Furthermore, analysis involves the active engagement of the researcher in order to make sense of the data and interpret meaning, which impacts how analysis is generated (Braun & Clarke, 2006). Therefore, it is imperative that the researcher demonstrates reflexivity, to consider their position, disciplinary commitments and sociocultural background, as these might influence analysis (Braun & Clarke, 2006).

2.3 Participants

Fifteen individuals with experiences of birth trauma during the COVID-19 pandemic (March 2020 – August 2021) were recruited through purposive sampling. This sample size is greater than the size that has been found to provide data saturation when conducting interviews (Guest et al, 2006), however, is small enough to produce rich, thick data (Braun & Clarke, 2021a). Participants were from England (twelve participants), Wales (two participants) and Scotland (one participant), accessing maternity services from across the UK.

Participants were included if they self-identified as having experienced a traumatic birth during the pandemic. This was decided over applying a standardised, quantifiable measure of 'birth trauma', to avoid privileging researcher or academic concepts of trauma over individual experience. It was felt this was more in line with the epistemological and philosophical stance of the research and reflexive TA.

Furthermore, only birthing persons were recruited to participate in the study; partners, or those who witnessed the birth, were not included. This allowed for the exploration of all aspects that may have contributed to birth trauma, in particular embodied experience. Whilst it is recognised that partners experience distress following being witness to a traumatic birth, considering the limited research into the topic at present, it was decided that focusing on birthing persons in this instance is important and most in line with the epistemological position chosen.

2.3.1 Summary of Criteria

Inclusion Criteria

- Birthing persons who self-identify as having experienced a traumatic birth during COVID-19 (March 2020 – August 2021) in NHS maternity services in the UK.
- 18+ years.

Exclusion Criteria

- Birthing persons who lost/ are no longer with their baby following the traumatic birth.

2.3.2 Participant Demographics

The mean age of participants was 31-years-old, ranging from 24 to 41-years-old. Participant demographics are presented in Table 2 below. For the majority of participants, this was their first pregnancy; only two of the women had given birth prior to their traumatic birth experience during the pandemic.

Table 2: Participant Demographics

N	Gender	Sexual Orientation	Age	Ethnicity	Birth Date	Pregnancy number
P1	Female	Heterosexual	33	White British	May 2021	First
P2	Female	Heterosexual	25	White British	November 2020	First
P3	Female	Heterosexual	30	White British	March 2021	First
P4	Female	Heterosexual	27	White British	July 2021	First
P5	Female	Heterosexual	32	White British	July 2021	First
P6	Female	Heterosexual	33	White British	July 2020	First
P7	Female	Heterosexual	41	White British	May 2020	Third
P8	Female	Heterosexual	28	White British	March 2021	First
P9	Female	Heterosexual	31	White British	June 2020	First
P10	Female	Heterosexual	34	White Other	March 2021	First
P11	Female	Heterosexual	27	White British	November 2020	First
P12	Female	Heterosexual	38	White British	August 2020	First
P13	Female	Heterosexual	27	White British	July 2020	First
P14	Female	Heterosexual	24	White British	March 2021	Second
P15	Female	Heterosexual	33	Mixed Other	May 2020	First

2.4 Procedure

2.4.1 Development of the Research Project

The Birth Trauma Association (BTA), a relevant charity, was consulted during the project's development and agreed to share the study's advert on their social media platforms, once ethical approval was obtained, as they felt this was an important topic to research. The charity provided written confirmation, to support with recruitment, which was included in the ethics application.

Due to the sensitive nature of the interview content, the charity was consulted regarding mitigating distress and supporting participants effectively throughout the process. The charity stated that in their experience, people welcome the opportunity to talk through their experiences, particularly if they have volunteered to participate and agreed to offer feedback to support with the development of the interview schedule.

A draft interview schedule was presented to the BTA via email. The charity provided feedback regarding the phrasing and sensitivity of questions, the ordering and structure of the schedule and additional questions that might help to shed light on the entirety of the birth trauma experience. Specifically, it was advised that questions about their pregnancy and postnatal experiences during the pandemic should be asked, as the charity reported that often these experiences contribute to the overall trauma.

2.4.2 Development of the Interview Schedule

The interview schedule incorporated 19 questions, designed to address the three research questions (Appendix A). The first set of questions aimed to examine the context of the birth, birth experiences, postpartum experiences and factors contributing to the trauma. The second set aimed to investigate the impact of the birth trauma. Finally, the third set related to the support received from services, and what they feel could have helped them through their experiences. A semi-structured approach was adopted, in order to ensure experiences were asked about in a standardised manner, helping to guide participants through potentially emotive and

distressing discussions. This approach also allows for individual flexibility, to enable participants to expand or discuss topics not raised by the schedule (Braun & Clarke, 2021b). A final copy was sent to the BTA and discussed with the research supervisor.

2.4.3 Recruitment

The BTA advertised the study via their social media platforms (Twitter and Instagram) and through their mailing group (Appendix B). Snowballing techniques were also employed as participants shared the study with others. Due to the charity's large following, there was an influx of interest to participate in the study, and it did not need to be advertised via other means.

Those interested in participating in the research registered their interest and availability with the researcher via email. A follow-up email was then sent with further information about the study. Interviews were offered with a flexible schedule to ensure participation. A total of 45 potential participants registered their interest across the recruitment period. Twenty-four did not respond to the email with further information about the study or a final follow-up email sent two weeks later to prompt engagement. Four did not respond to email correspondence during the stage of scheduling the interviews, and two declined to participate.

2.4.4 Consent and Confidentiality

One week before the interview, participants were sent an information sheet (Appendix C) and consent form (Appendix D) via email, to be completed and returned to the researcher prior to the meeting. All participants consented to participate in the study, for the interview to be recorded and transcribed, and for anonymised extracts and quotes to be included in the write-up of the research and any future reports or publications. Data were stored in password-protected files on a password-protected computer, and transcripts were pseudonymised, which involved names being changed or removed, and identifiable information removed or replaced.

2.4.5 Interviews

Semi-structured interviews were conducted, recorded and transcribed via Microsoft Teams video-conferencing platform. Interviews aimed to last 1-hour and ranged from 58 to 87 minutes. Before starting the interview, the research rationale was presented, consent was confirmed, and data management and confidentiality were recapped. Participants were reminded that the interviews would be recorded and transcribed and that they had the right to withdraw at any point during the interview, and up to three weeks following completion of the interview. They were also informed that they could stop or pause the interview at any point. Demographic questions were asked before the main interview schedule. Following the completion of the interview, participants were offered a space to debrief and ask any follow-up questions. This was a particularly important component of participation, considering the sensitive nature of the interview content. A debrief form (Appendix E) was then sent via email, to thank participants for their time and participation, and included information regarding relevant organisations and support services, and contact information should they have any questions or concerns regarding the research.

2.4.6 Transcription

Interviews were automatically transcribed via Microsoft Teams programming. These were then checked against the interview recordings for accuracy and edited accordingly to ensure the content directly reflected participant responses. The recordings were then deleted immediately, and the transcripts were stored in separate files to the consent forms to protect anonymity. The extracts included in the following manuscript were improved in clarity, removing non-linguistic features but true to the content of participant responses (Willig, 2019b).

2.5 Ethics

Ethical approval for the research was granted by the School of Psychology Ethics Committee, at the University of East London (Appendix F). The ethics application outlined the project, confidentiality and data retention plans and a risk assessment plan, to help minimise potential psychological distress through participation. Due to the focus on experiences of traumatic births, it was recognised that the interviews

have the potential to be triggering or distressing. Therefore, a few proposals were made to help support participants through the interviews, including reiterating the right to withdraw, request for breaks and to pause or stop the interview at any point, as well as drawing on clinical judgement to monitor the participants' emotional states. Furthermore, participants were provided with a list of resources and support groups in the post-interview debrief form.

2.6 Approach to Analysis

2.6.1 Process

The process of TA was informed by the six phases of thematic analysis developed by Braun and Clarke (2006). The process was recursive, going back and forth between each phase as the analysis progressed (Braun & Clarke, 2006).

The first phase involved familiarization with the data set, which involved transcribing then re-reading the transcripts to become fully immersed within the data-set. Initial notes were taken during this phase regarding possible meanings and patterns in the dataset (Braun & Clarke, 2006), what assumptions existed and researcher reflexivity (Braun & Clarke, 2021b).

The second phase comprised of generating initial codes. This involved assigning codes to particularly important features of the transcripts, that captured meaning within the text. The meaning was explored from a semantic, overt level, to a more latent, implicit level (Braun & Clarke, 2021). In the third phase of analysis, themes were then developed to demonstrate shared patterns of meaning across the data as relevant codes were collated. Themes were then reviewed several times during the fourth phase of TA, to check them against the codes and the entire data-set. A 'map' of analysis was generated to identify any connections between the themes and to determine a hierarchy within themes by creating sub-themes. In the fifth phase of analysis, the themes and subthemes were defined, labelled and then redefined through an evolving process of refinement, to ensure they accurately and concisely represented key patterns of meaning across the data-set.

The final phase of analysis involved reviewing the validity and utility of each theme and subtheme. The research supervisor was consulted throughout the process. A thematic map was developed once the names and definitions of each theme and sub-theme were confirmed.

2.7 Evaluating Quality

Evaluating the quality of research is important due to potential researcher bias, the influence of the epistemological position, and the researcher's relationship to the project (Madill et al., 2000). Quality criteria have been applied, regarding analytical rigour, researcher transparency, the study's contribution to the research field, credibility and transferability (Spencer & Ritchie, 2011; Braun & Clark, 2021), and such principles will be explored in full in the discussion. Research claims will be evaluated against existing knowledge to determine the plausibility of such claims, the degree of useful insight and how future research should progress.

2.8 Reflexivity

The rationale for coding and theme development was made clear and applied consistently throughout the analysis, to ensure reflexive TA was conducted well (Braun & Clarke, 2021b). Personal reflections have been shared to demonstrate transparency and recognition that the researcher's position and relationship to the research topic can influence all stages of the study and analysis (Willig 2013; Braun & Clarke, 2021b); this will be explored further in the discussion.

2.8.1 Statement of Researcher's Position

I have always been interested in the topic of birth and have often reflected on the confusing and contradictory social narratives of birth in Western culture. Birth is viewed as a natural process that should be led by the instinctive drives of the birthing person; however, this is juxtaposed with birth predominantly being treated as a high-risk, medical process or procedure, within hospitals.

I am aware my mother had one particularly traumatic birth, and other more positive experiences, and I became interested in what contributed to such contrasting

experiences. Driven by my interest, I began to listen to accounts of people's births on podcasts and found that their perceptions of their experiences varied greatly depending on the type of birth, the setting the birth took place and the support they received.

With the publication of number of independent reviews (e.g. Kirkup, 2015; Independent Maternity Review, 2022) and, as such, maternity services coming under scrutiny in mainstream media, I became aware of some of the failings in maternity settings and repeated patterns of poor care, putting mothers and infants at risk. I heard countless stories of pregnant people who gave birth during the pandemic, through friends and acquaintances, and heard first-hand the distress and anxiety the pandemic and related hospital restrictions caused, impacting birth choices and birthing experiences. I felt compelled to research this topic further, to shed light on such experiences.

The interviews I conducted with the participants for this research were emotively powerful, shocking, and distressing, furthering my desire to document and reflect their stories accurately, to support change and to ensure that their experiences did not go forgotten. Furthermore, clinically I am currently working in a maternity service, with women who have experienced birth trauma, loss or tokophobia (fear of giving birth). Whilst the data collection, analysis and much of the thesis were written and conducted prior to starting this placement, these experiences are likely to have influenced the interpretation of findings as I feel strongly aligned with the women I support.

I believe that the pandemic may have exacerbated some of the pre-existing, deeply embedded, problematic structures within maternity services. These include the voice of the birthing person being secondary to medical knowledge and professional decision-making, with little thought given to the fact that medical interventions and examinations deemed 'high-risk' are being implemented on birthing people who, for the most part, are conscious during the whole process. Restrictions on visitors and birthing partners in hospitals highlighted these points further, as the needs of women and birthing people were treated as secondary to hospital policy and restrictions. Although I have hypotheses about what might contribute to traumatic birth

experiences, I have worked hard to remain reflexive throughout the research process in interviews and data interpretation, by remaining curious about the factors that may be influencing my decision-making, supported through a reflective log and discussions with the research supervisor. However, due to the role of the researcher in the process of TA, it is likely that these influences would have still impacted the research process.

3. CHAPTER THREE: RESULTS

Thematic analysis of the interview data derived three overarching themes, with four sub-themes (see Table 3). Each theme and sub-theme incorporated data from each participant, and a selection of participant quotes have been presented to support the description of each theme. A thematic map has been included (Appendix G) and the process of developing and refining the themes and sub-themes has been incorporated (Appendix H).

Table 3: Themes and Subthemes

Themes	Sub-themes
Vulnerability and Disempowerment	Lack of Control and Dehumanising Treatment Being Alone and Lack of Advocate
Emotional Magnitude and Lasting Impacts	Emotional Toll Impact on Key Relationships and Wider System
Isolation and Loss	

3.1 Theme One: Vulnerability and Disempowerment

All participants spoke to feelings of vulnerability and disempowerment, contributing to experiences of birth trauma and distress.

3.1.1 Subtheme One: Lack of Control and Dehumanising Treatment

All participants reported experiencing an overall lack of control and dehumanising treatment across their maternity journeys, particularly during labour, which seemed to significantly contribute to their experiences of trauma.

All of the women spoke of their fears of the unknown and having to relinquish some degree of control over their circumstances due to COVID-19 and related restrictions. For many, this was reported to have increased anxiety during pregnancy about their upcoming birth, as a result of the uncertain and evolving hospital restrictions, as mentioned by the participants below.

When I saw those restrictions change [in the maternity hospital], a month from birth...that's the point in my pregnancy where I started feeling really anxious, like now he can't come to the scan, and what if he can't come to the birth...I was really anxious that I would give birth alone.

Participant 15

I elected for a home birth as I wanted my husband there the whole time, and in hospital he would only be allowed in at a certain point of dilation [due to pandemic-related restrictions]... but there was a lot of talk around services being pulled due to staff shortages in COVID including the running the home birth service... there was much more uncertainty than you'd usually have in a pregnancy.

Participant 3

Many participants spoke of their birth plans being ignored during labour, and feeling robbed of experiences as a result, which perpetuated a sense of despair and lack of control. Many alluded to the importance of these small requests, outlined in their birth plans, in order to regain some sense of control during the pandemic, as described by Participant 4.

You know, I think for the partner to cut the cord and to tell you the gender. They're not wild requests... because obviously with COVID you're already surrendering a level of control. You can't have your visitors, you can only have one birth partner...It's the little things that matter a lot, and then to just have those taken too, it is not okay.

Participant 4

I felt like I was robbed of everything that I'd planned, like the skin-to-skin as soon as he was born... I would have liked to have had the curtain lowered so that I could actually see him being taken out of me, like I never got to see him all gunky...like all those little things that are really little, but they're important.

Participant 8

All of the participants spoke of a lack of informed choice and consent during their labour experiences, with many women speaking to a sense of 'things being done to me, not with me', contributing to trauma and reinforcing this sense of not being in control.

This is part of my PTSD, because I was attached to this drip and I was in so much pain... and I just felt trapped, like there was no way out. And they kept turning it up, and I was saying, "please stop it, I'm in too much pain and can't manage". And they said "no, no" and kept tuning it up ... like they don't listen to you... they just see you as this machine to produce a baby. You're not a woman. You're not a person that matters...

Participant 6

I had had about five different conversations with people about how I did not consent to an episiotomy... and I just remember her turning casually to the person next to her and going "Ohh, I've cut her. Can I have swabs because she's bleeding?" And that's how I found out she had done an episiotomy on me.

Participant 3

All of the women reported 'being spoken about, not to' during labour, by not being properly addressed by the medical staff, as though they were invisible and their opinion irrelevant. Some reported that these experiences felt dehumanising and degrading, as vividly described by Participant 3, who reported "not having a clue to what I was consenting to", which reflects not only a lack of informed consent, but a lack of any understanding as to what she was consenting to.

I got to the hospital and then the midwives did a changeover with the hospital team and they had an argument in front of me over who is gonna take over my care...in this time, they were shoving the IV drip into me or whatever making me sign these forms...but this was all whilst I was pushing and in extreme pain and not I having a clue to what I was consenting to.

Participant 12

The registrar, who I had been assigned to me, I experienced him as extremely degrading, extremely derogatory. He came in and said this is what is happening, giving orders and completely ignoring me and didn't bother to read my birth plan. It was like I wasn't even there.

Participant 3

Most of the women spoke of professionals prioritising their medical knowledge over the women's voiced embodied experiences, resulting in coercive and violating treatment, with invasive examinations and medical interventions. This further reinforced a lack of control over their experiences and contributed to a greater sense of overall fear.

He asked for my consent to do the vaginal examination. He said let me know if it gets too much ... because he was trying to turn the baby because he was back-to-back... but it was really, really painful. So I did ask him to stop... I was literally like begging and crying and begging him to stop doing it... but he just continued to do it... that was the worst part because that was the point where I just felt I've lost all control here...

Participant 4

And then they broke the waters and I said “can I have a couple of hours, see if the contractions start spontaneously”, and they said “no, you've been waiting long enough...” ... this was pre husband arriving, there were about six or eight medical staff in the room, like they were all ganged against me, you just feel pushed into it...

Participant 6

Moreover, many of the women reported a lacked sense of compassion, empathy and human dignity in the treatment they received from medical professionals in hospital. This further contributed to experiences of dehumanising and degrading treatment.

At 3am she said you need to get up and walk around because if you don't, you're gonna get blood clots [following an emergency C-Section]. And I was like well how do you suppose I do that because nobody's here to help me get up and I am in immense pain and my epidural hasn't worn off yet, so I'm a bit paralyzed still. And she just sort of scoffed and then just walked out and left ...

Participant 14

I think the main thing was that there was a lack of compassion [when postnatal in hospital]... they didn't seem to see you as a person... There was no conversation, there was no “how you feeling?”, “Do you need anything?”, “Can I do anything to help?”. They just prescribed medicines and said see you again in the morning...

Participant 11

In addition, communication was highlighted as a key issue by all participants, with either there being a lack of communication or miscommunication of information shared or problems in how information was conveyed from professionals. This further contributed to a sense of vulnerability and disempowerment.

I just had an emergency C-Section, I am in so much pain, and then you get put back in your room [in hospital] and nobody comes. The doctor doesn't come and explain what happened. Like nobody actually talks about it after it's just done, and then that's it.

Participant 8

Services still use this language of we will allow you to have a home birth or we will allow you to do this [regarding choices during labour], when actually, legally, it's the family's choice anyway... You might not be advised to do something, but actually it's always your decision and I think the language used throughout is so disempowering it. Yeah, it sets up this power dynamic that then perpetuates and plays out during the labour...

Participant 3

Moreover, pain-relief was often reported as being withheld for extended periods of time by professionals during labour without explanation, perpetuating this sense of disempowerment and lack of control over their experiences.

I was obviously exhausted [from being in labour]... at that point I was slightly panicking. Because the pain was so much and I had no relief, they kept refusing it, and I kept saying to her, like, should this be like this because I'm not feeling well... I was kind of in and out of wanting to sleep.

Participant 9

I asked if I could have some pain relief [during labour in hospital]... and she laughed and she said is this your first and then she walked off... I didn't get assessed for a couple of hours...she didn't want to give me any gas and air... when she finally came back, she assessed me and turns out I was like 6 centimetres dilated...

Participant 13

As a result of such experiences in hospital and the problematic interactions with healthcare professionals, in which participants were left feeling dehumanised by the

treatment they received, this sentiment of feeling like a patient number on a production line was often alluded to in the interviews.

They [healthcare professionals in hospital] just saw me as a patient, like patient X. They didn't bother to learn my name, or consider that I am a first time mum that is scared and is missing her partner and is in a lot of pain...They just basically saw me as a patient number and didn't ask me at all at any point how I felt about any of it.

Participant 13

The thing is, nobody cares. You don't matter to them [the professionals in hospital]. You're just on a production line. You know, you're not a woman that they care about. You're just another one with a baby. You know, the next one in the in the line. That is how you are treated.

Participant 6

Following such experiences, many of the women sought out ways to try and make sense of their experiences, regain some sense of control, seek closure and recognition for what they went through from the maternity hospital. Some women found birth reflections helpful, which involved meeting with maternity staff to talk through their birth and their hospital records. Other women considered seeking medical negligence claims and making complaints.

I did find that [birth reflections] quite helpful, from like a medical point of view, to talk about what happened, cos there were all these missing pieces in my head [regarding labour]...And it was like it was a good way of helping explain what had happened [during labour] and for it to make more sense...

Participant 15

I did actually try recently to pursue a medical negligence claim [following experiences in the maternity hospital]. I really wasn't going to... And then about a couple of months ago, like loads of these feelings of trauma came up again [regarding labour]... I thought in terms of closure, if I can at least get a

solicitor to look into it and say, yes, there was four counts of medical negligence.

Participant 12

3.1.2 Subtheme Two: Being Alone and Lack of Advocate

All women mentioned that the lack of partner support during labour and postpartum, due to pandemic-related hospital restrictions, contributed to experiences of vulnerability, disempowerment and suffering. There was a sense that this felt inhumane and barbaric, as women were left without an advocate or adequate support.

I was induced and I was in hospital for three days on my own. He wasn't allowed to visit me. I remember, I was just crying on the phone to him because I couldn't manage... you know, deprived of contact with your loved ones at your most vulnerable and therefore you can be manipulated more easily because you're on your own.

Participant 6

There were certain things that I could have said to them and pushed back on and said no [during labour]... But it's so hard to do when you don't have someone advocating for you, your partner is not allowed in, and you're in the middle of contractions.

Participant 13

Furthermore, all women reported a lack of support from staff in hospitals, particularly on the postnatal wards, and without the support of visitors or partners, this meant predominantly recovering in hospital, with a new-born, alone. This perpetuated suffering and a sense of vulnerability, and likely impacted the women's recovery, as often women were left to look after themselves and their new-born when they weren't physically able to do so.

I would go down to see her [baby] in the NICU...walking across the hospital up and down the stairs and stuff, pulling myself along by the railings as I was in so much pain, no one helped... Yeah, it was absolutely awful... I don't know what they were doing all day because they weren't looking after us.

Participant 11

And she said right here are some bed wipes and I'll leave you to it [following an emergency C-Section in hospital]... I didn't really know what bandage was on my wound from surgery, I didn't know if I could bend, it was difficult just standing... so I got back on the bed but bled... I pressed the buzzer and she just said well there are sheets at the bottom of the wards. You just help yourself and you can put on your sheets, because we're not doing bed changes...

Participant 10

I was on my own in a side room, feeling like I was gonna die [postnatally in hospital]...My baby was crying and I was so out of it with whatever they'd given me and all the blood loss [during labour], that I was literally laying there in a room on my own with a screaming baby and nobody was there, nobody came and it was terrifying.

Participant 14

Each participant reported an evident lack of staff in maternity units, which they felt contributed to their experiences of poor care. This was deemed particularly problematic, and potentially dangerous, without the support of partners or visitors. Participants recognised staff were burnt-out and over-worked, as reported by Participant 14.

I suppose in normal times my partner would have been there [whilst recovering postnatally in hospital], so he could have helped me with things...whereas in the hospital they didn't have extra staff to make up for the extra work they were getting left with...

Participant 10

And because of the staffing issues, they didn't have time to come and sit with me and hold him so I could do stuff like shower [postnatally in hospital]... and just the general morale in the NHS, I've never seen it so low... They were all, like worked to the bone.

Participant 14

As a result of the lack of support the participants received whilst recovering postnatally in hospital, all of the women spoke of their physical struggles looking after a new-born alone, whilst also trying to recover themselves from a traumatic childbirth.

With him [baby] having the infection I would have to wheel him down to NICU and get his antibiotics and then wheel him back [postnatally in hospital]... I mean, there was no sleep for days... I mean it just doesn't happen [sleep] with a new-born and there are complications and you are all on your own.

Participant 15

So after my c-section I was just put in this room with this baby, and my partner then had to go... I couldn't put him in the cot because I couldn't get up... nobody came to me when I buzzed them... So, I ended up just holding him for this whole night, laying in this bed with the baby in pain, not able to sleep...

Participant 8

Many of the participants reported that the COVID-19 hospital rules appeared to be nonsensical, by not seeming to serve their purpose of preventing the spread of the virus. Participants reported that their partners were only allowed to visit the hospital during restricted times in order to control infection, yet this meant they were coming and going from the hospital each day, posing a greater risk of transmission than if they were allowed to stay in the hospital for the entire duration of their birthing partner's stay.

I could see my partner [following the birth]... he was allowed in the hospital up to the postnatal wards but only outside the doors. So I could go out, see him for a cuddle, collect supplies he brought and come back in... so if he or any

other partner had COVID, they are spreading it anyway, going home and back... Would it not have been safer to have them in and stay in?

Participant 15

I haven't slept after two days of labour...I couldn't even speak to my partner face-to-face about the fact that we've just had a son. It was just crap, it was awful. I just didn't understand why there was just an hour allowed for visiting [on the postnatal wards in hospital]. Why is that hour less risk of transmission? If he was to bring COVID in, then he would in that hour...

Participant 13

Furthermore, many of the women reported on the injustice of the hospital rules, which seemed to contradict the lapsing of restrictions in broader society. They felt this to be inhumane, causing unnecessary physical and psychological harm.

You know, it was at a time where people were eating out, for half price, eat out to help out, and you know everyone was out at football matches and stuff. And my partner wasn't allowed to come in and bond with his son [in hospital following the birth]. It just got me really angry.

Participant 13

I think being left alone when you're like at your most vulnerable, physically and mentally [in the maternity hospital]. I don't think it's fair... it is inhumane. Also, at that time people could go to the pub. And the football was on and people were gathering in crowds, it was disgusting really.

Participant 15

Overall, all participants reported that the presence of a birthing partner at all stages of labour and postpartum should be a non-negotiable for women at their most vulnerable and that their experiences would have been different if they'd had their support.

Partners should be allowed in for the entirety of the birth and also with the aftercare, because don't forget the women's recovering themselves, if they

have had a caesarean or any birth they're gonna need help with their baby, you know they can't do it all alone...

Participant 6

I don't think partners, or at least one birth partner being there, is like an optional thing...I know guaranteed that if he was around, yes it would have still probably been the same birth...but it felt like if he was there, it wouldn't have been as bad because then it's just the normal stresses of you have a poorly baby and you have to spend more time in hospital, but I don't think that I would have gone through what I did mentally on my own... that should never have happened and that should never happen again [being left alone in maternity hospital postnatally]...

Participant 15

3.2 Theme Two: Emotional Magnitude and Lasting Impacts

It was evident across all interviews that the participants' birth experiences had a significant impact on their emotional well-being, as well as on their relationships and wider system at large.

3.2.1 Subtheme One: Emotional Toll

All participants reported experiencing anxiety and fear following their traumatic birth, particularly when reminded of their experiences in hospital. Some of the participants mentioned difficulties in being honest about what they were feeling, due to fears of being judged or deemed as unsafe and having their child removed, as mentioned by Participant 6.

I still really don't like being in a hospital or a medical situation... medical staff make me feel very uncomfortable and watching anything on the telly about birth or characters giving birth or even just people kind of talking about it. I have two friends who've given birth since me in the same hospital and both times I was absolutely fraught with anxiety...

Participant 4

Intrusive thoughts as well, I had a lot of them... but that was quite scary because nobody told me about them, so I thought I was some weird baby killer...I felt really frightened and really like scared people would take the baby off me or you know.

Participant 6

Each woman reported obsessive rumination about the birth in an attempt to make sense of their experiences, with some reporting to have re-experienced the birth in the form of flashbacks and nightmares.

I just played the birth over and over and over... it was almost like I thought if I played through it enough times, I might understand it, I just kept looking for it to make sense ... And the emotional toll and the fatigue that sets in from that constant mental activity.

Participant 3

And I mean the birth itself was maybe the thing that was on my mind most. I had a lot of nightmares about hands pulling me in different ways just because of how everything happened ...

Participant 10

The distress of their birth experiences and related impacts resulted in emotional detachment for some, and an overall sense of unhappiness. Many of the participants reported having to put on a mask and disguise their distress from others. Participant 1, for example, described only giving way to emotion when alone and covering up their distress when around others.

And the emotional numbing as well. You just feel nothing for months and that's really tough to deal with... I thought there was something sort of terribly wrong with me.

Participant 6

But those first, like six months, I wasn't happy, but I would pretend I was.... I would get tearful, but I would only do that like if I was in the shower, not around everyone... Yeah, I just covered it up.

Participant 1

Some women felt so low and desperate that they even experienced suicidal ideation, and resorted to other means of coping, to be free of their pain, such as considering leaving their baby. Participant 4, for example, seems to have believed that her presence negatively impacted her baby and felt she was a bad mother, and he would be better off without her.

And in the first few weeks, genuinely I was talking about having him [baby] adopted... I just didn't want this reminder of what I'd gone through, and he was a reminder... I would say to my husband why don't we just split up? Because then you could meet someone who would be a better mother for him and I can be out of his life and everything will be better...

Participant 4

I would say to my husband, just like as clear as day, I don't wanna be here anymore... I just wanna die. Like I don't wanna be a mum... I'd say to him, I'll just go and you do it or just give him to someone who can do it. I didn't wanna live anymore....

Participant 9

Every mother reported experiencing self-blame, self-criticism and guilt for their traumatic experiences and related repercussions. This was perpetuated by a lack of explanation from hospitals regarding what happened during the birth, resulting in the mothers blaming themselves, exacerbating postnatal distress.

I think you try to find a reason for why it's happened [negative birth experience], and then you feel like you are the reason for a lot of it when you don't really know any of the other answers... I thought if I was able to give birth to him quicker then maybe we wouldn't have had the infection and

maybe we wouldn't have had to stay in hospital and then none of that would have happened...

Participant 15

Umm, the forceps did cause a neck injury. It really affected his ability to breastfeed and his ability just to turn his head... and I felt like it was my fault because I had known in my guts that we did not need an assisted delivery or a C-section? ... I feel like I didn't protect him.

Participant 3

Many of the mothers reported feeling a sense of resentment for what their experiences ended up being, and jealousy of other people's more positive birth experiences, particularly when hospital restrictions eased.

And then you feel this, kind of, jealous feeling of women now who are giving birth or are pregnant and you just think... they'll never have it like we had it. Because it's different now and people forget, but we don't forget, it's not something that ever really leaves you.

Participant 9

Weirdly, when restrictions started easing... I felt quite jealous of the woman when I would read that partners were allowed back in. That would make me feel like why do they get that and I didn't get it?

Participant 15

3.2.2 Subtheme Two: Impact on Key Relationships and Wider System

Most of the mothers spoke to the impact of the experience on their relationship with their new-born and their new-born's attachment style. For some their experiences resulted in difficulties with bonding initially or feeling insecurely attached and/or hypervigilant in the relationship with their baby. Some mothers reported that their infant developed an insecure attachment to them, and could not be soothed by others, as mentioned by Participant 11 who described her child as "a terrified little baby". Many of the mothers reported that their difficulty to bond with their baby

initially then developed into difficulties being apart from their baby, as reported by Participant 9.

Because I was so traumatized and with everything that happened [during the birth], I didn't get that rush of love straight away for my daughter... Like how can I feel love and happiness after everything that's just happened...

Participant 2

I remember holding him [baby] going like I don't know if I can do this [being a mother]... I need to think about giving him away...But now I'm obsessed with him. And it's the other end of the scale...I have serious like attachment issues and I can't detach from him yet...

Participant 9

And she [baby] wouldn't be put down... She's only ever contact-napped or napped next to me...for the first eight months of her life, she would not tolerate anybody else. She was a terrified little baby.

Participant 11

Many of the mothers reported that their experience impacted their relationship with their partner, partly due to the challenges of having been separated during such a pivotal time in hospital and, therefore, lack of shared experience. This led to a sense of being disbelieved or dismissed by their partner for what they went through, creating a barrier and disconnect between them as a result. Participant 4, for example, described this disconnect as leading to a near separation.

It's driven a massive wedge between us [relationship with partner]. We separated for a while because it was just completely unmanageable. You know I was just obsessed with it [the birth]. He [partner] was completely sick of hearing about it...I'm definitely a different person than I was before that experience, and it made us question whether we should stay together.

Participant 4

It put a massive rift between us [relationship with partner] ... And I think because he hadn't been there for all of it [the birth and postpartum] and I hadn't been able to explain what was going on and what happened... I just felt disconnected from everybody and everything.

Participant 14

When you're being violated to some level, just having someone there to hold your hand helps [during labour in hospital]. And also I think it's quite hard for him [partner] to understand when he wasn't physically seeing it...I mean there in the room they can see someone putting their hand up you every like six hours, and the panic and the hurt and the pain and the anxiety and apprehensiveness of it...it helps with empathy.

Participant 5

All mothers noted that their partners felt excluded and shut out of the process by services, resulting in the loss of shared experiences. This exclusion of partners during the vital early postnatal stages in hospital was reported to have impacted their capacity to bond with their infant, with implications for the family unit as mentioned by Participant 9.

But my husband was obviously suffering as well mentally, like the first week of the child's life is the most important week. But he wasn't there. I brought a baby home to him and he did not know what to do with him...

Participant 9

I know the hardest part was not being able to come in [to hospital] when he wanted to, not being able to be there to ask questions, and I was sending voice notes back to him with what I was getting told by the Doctor... I think he felt very helpless and that he had been shut out of it.

Participant 10

Some of the mothers reported difficulties with physical intimacy following childbirth, having felt so violated during labour. This was reported to have impacted not only the

mother's relationship with their partner, but also with their infant, due to difficulties with bodily touch.

When he [baby] got strong enough to push off me whilst I was holding him, I found that really triggering because I felt like I was in hospital, being pushed down on the bed...it would give me a panic attack.

Participant 10

I didn't wanna be intimate with my husband for ages after giving birth because I was like that lack of control over your own body, having anyone just stick needles in you or, you know, do things to you and you just having to lay there and just take it...

Participant 9

The mothers spoke about the impact of their experience on their relationships with family and friends in their wider social network, with many reported to have socially withdrawn as a result of their emotional distress and difficulties leaving the house, or as a form of self-protection from other people's more positive experiences.

I didn't want to do anything at all. I was just I was in this awful cycle hating being a mother, hating being around this child, but not wanting to be away from him either... I wouldn't want to go out. I still struggle now...it's difficult maintaining friendships when you don't want to go out and do anything.

Participant 4

Most of my friends had a very different experience because they had antenatal classes, they had family come straight after the birth, their partner was allowed for the whole birth... so I didn't want to discuss it with them because it just made me feel sad... so I was very isolated. I spent a lot of time on my own.

Participant 13

As a result of their experiences and consequent difficulties, all participants alluded to feeling disregarded and subsequently let down by the wider healthcare system.

Many reported a lack of aftercare or mental health support once they were discharged from hospital, further perpetuating this sense of being overlooked and their distress dismissed by maternity hospitals/ further perpetuating this sense of hospitals absolving all responsibility for the harm caused.

I said I really don't feel great [to the maternity staff during a birth de-brief], is there anyone who can help, like the perinatal mental health team? No, perinatal mental health can't help because they only see people with psychosis, bipolar, self-harming or suicidal. So, it is nothing to do with the experience, just your diagnosis or whatever. And so no one would see me.

Participant 7

And I did birth afterthoughts, we went through the birth and she said "I can see some of this is upsetting... maybe you should just go to your GP and get some help. I don't do perinatal mental health." ... it felt like they just want to bounce you off, you've got the baby so now they just want to kick you out... they didn't care about the mother at all... As long as the baby was alright vaguely, then off you go out the door..

Participant 6

Moreover, many of the participants reported experiencing medical complications due to negligence, inadequate care in hospital and aftercare, further perpetuating this sense of distrust with healthcare providers and services.

It got quite dangerous towards the end because the doctor said I can't go home until my blood pressure is below 140 [from the postnatal hospital ward]...so an HCA [healthcare assistant] came in at the end of the week and said we're gonna give you a bigger cuff that we use for bigger patients and that will show a lower reading. And it did. So they discharged me. The community midwife came to see me in the morning when I was at home and did my blood pressure and it was 170. So they sent me back in to hospital to get on some extra medication...you could tell they were just trying to kind of empty the ward and discharge us.

Participant 11

In hospital, I pulled something on my wound and I'd ask them to come and check and they said it looked fine [the hospital maternity staff]...but the midwives who came to the home visit noticed that it had burst and clotted... it ended up getting infected, and I think I had three courses of antibiotics and it took about six months to fully close... I couldn't walk for months because of it... but I know that if it had just been looked after in hospital, that probably wouldn't have happened.

Participant 10

For many, this broken trust was reported to impact future decision-making with healthcare services, in terms of seeking support from services and future birth-plans.

My trust and my faith in clinicians was really, really shaken by what I had experienced. I didn't want to seek support through the NHS service... I didn't want to go back into that same system.

Participant 3

I've gone on to have a successful pregnancy. I mean, I'm being monitored because of my mental health and under specific team of midwives too...I'm actually having an elective caesarean this time, to ensure it is as least traumatic as possible...I did say at my first appointment with the midwife that if you don't advocate for me to have the birth I want and I'm not listened to, I will walk out here now and book a termination ...

Participant 2

3.3 Theme Three: Isolation and Loss

All respondents spoke to this overall sense of isolation in their experiences and loss for what their experiences should have been, perpetuated by social narratives and responses, exacerbating distress.

Each woman spoke to this sentiment of feeling forgotten about once having given birth, by services, family and friends, with all the focus solely directed towards the new-born.

You are kind of treated as a vessel when you're pregnant, so everyone looks after you. Then once the baby's out, the baby gets all the treatment, which is great, but then you don't get anything.

Participant 11

I remember saying to my husband, I feel like I've been the surrogate for like everybody else in my life, like all my friends and family just doted on this baby that I just had absolutely no connection to. My pain was almost irrelevant.

Participant 4

All mothers reported feeling isolated in their experiences and this sense that others will never truly understand what they went through, and the horror of hospital experiences during the pandemic, as described by Participant 9. This isolation was even described reported to exist within the parental relationship, in part as the mother's embodied experience was different to that of their partners, and due to being separated at pivotal moments.

And you try and explain it to people, but no one will ever really understand how bad it was to sit and listen to a room of women cry all on their own and no one comes to them [in the postnatal ward]. No one does anything. It's almost a bit like, did that really even happen? Because of how awful it was.

Participant 9

I think what was interesting was we [birthing person and partner] found different bits traumatic... and the fact that our experiences were different...It's not quite a shared experience in the same way, and that can sometimes make you feel like you are alone... That niggle of will anybody else ever really understand what it was like to experience that...

Participant 3

For some, this sense of isolation was perpetuated by the invalidation they experienced from others when sharing their experiences, which served to silence them further. Many reported on the negative impact of 'toxic positivity' in dismissing the severity of their distress.

People don't know what to say, they try and make you feel better by saying things like "but at least you're OK", or "at least you and the baby are healthy" which can feel quite invalidating and dismissive. And it adds to that sense that other people don't understand.

Participant 3

They meant well, but especially his mother-in-law is quite into that like toxic positivity. You know saying "as long as you know he's alive and it is birth. It's never going to be good is it?"... they just really couldn't understand... everyone kept saying, "oh, you forget the pain", but with birth trauma, it's quite the opposite, because you are thinking about it all the time.

Participant 4

In addition, many participants were met with invalidating and unhelpful hospital responses, and a lack of accountability from services, when making complaints about their experiences and treatment, with some even reporting that their medical records were wrong, which perpetuated suffering, frustration and feelings of isolation. For many, validation, recognition and a space to be heard were sought to help mitigate distress.

We requested another debrief for some answers or at least recognition that this shouldn't have happened... but it was just one dismissal after another... I asked "why did I suddenly develop pre-eclampsia?" And she said, "Ohh, it's because you and your husband are incompatible". Like, that's just factually incorrect.

Participant 11

They said “it is very unlikely that the drip caused the haemorrhage and fetal distress” [during the birth de-brief]. And I was “if you say that you need to give me another explanation”. And they said “you were induced for reduced fetal movement”. Well no I wasn’t, that was a lie... it just frustrates me, the lack of informed consent, lack of accountability...it is dangerous.

Participant 6

Many spoke about unhelpful media and cultural narratives around birth, in silencing negative birth experiences. Such narratives were reported to perpetuate isolation for those who had difficult births, and exacerbate this sense of shame and hopelessness around traumatic birth experiences.

I think there's a lot of things in the media and online that actually trigger women and like, you know, the positive birth company... I mean, that's amazing for women who are pregnant and want to have a positive birth, but it's never really talked about how you can still turn the negative into the positive if it doesn't go your way.

Participant 9

There's a real sense of, oh you should never talk about a negative birth experience... I think this can actually help to traumatise people, because there is this picture-perfect reality that is not a reality... And there is this sense of shame...I do think in our society, we judge people for how they give birth. And I think that is silencing as well, and I think it's incredibly damaging.

Participant 3

Some women noted the harmful effects of antenatal courses or information shared by medical professionals that don't accurately depict all the realities of birth, which left them feeling unprepared. Furthermore, they felt such inadequate resources perpetuates the blame culture on women when birth doesn't go to plan.

I think a lot of the antenatal or hypnobirthing courses are not open enough about the limitations of these types of things... there's this idea that if you educate yourself and advocate for yourself, professionals will respect your

choices. ... I think there's this undertone that if things go wrong then it's your fault.

Participant 3

I think NCT is a pile of shit...I mean, I was beyond naive to what induction was. Like no one talks about it... I think it's worth offering something like a class that's just a midwife that can tell you what the room will look like, that this is what can happen, sometimes if they pull or use forceps it isn't always bad...so you're just not scared, so you're prepared.

Participant 5

All mothers reported missing out on shared experiences with family and friends, and support from their communities and wider networks, due to pandemic-related restrictions, contributing to a sense of longer-term isolation and loss.

I don't think my partner's mum held [baby] till he was maybe three months old. Maybe longer... My parents couldn't come as planned. I couldn't see my family... But it's just accepting the fact that you've missed all those moments that you can't get back... It was just sad.

Participant 15

We live in little village...so I am used to walking to the shops, but no, I wasn't even walking to the local shop... the aqua-natal stopped and the swimming stopped. And that is what was keeping me going.

Participant 7

4. CHAPTER FOUR: DISCUSSION

4.1 Research Aims

This research sought to understand traumatic birth experiences during the COVID-19 pandemic by examining how parents described and understood their birth trauma experiences, the related impacts, the support they received from services and what they feel could have been helpful.

4.2 Overview of Results

Overall, respondents spoke to experiences that occurred during pregnancy, labour and postpartum that contributed to their traumatic childbirth during the pandemic, and subsequent impacts. Participants reported sentiments of vulnerability and disempowerment, as their choices were limited or removed entirely during pregnancy and labour. The limitation in choice reinforced a lack of control over their experiences and exacerbated the inherent power-imbalance that exists between service-users and services, in which medical agendas and service policies are privileged over embodied-voiced experiences and individual needs. All of the women spoke of dehumanising treatment during labour and postpartum, with a lack of informed consent, experiences of violating medical interventions, a lack of compassion and being ignored or disregarded by professionals during the labour process. Such sentiments of vulnerability and disempowerment were likely amplified during the pandemic, as women's rights were taken away, being left without a support person and advocate at crucial stages during their pregnancy, labour and postnatal recovery in maternity hospitals. Given that the women described not being listened to, heard and ultimately discriminated against within services, I propose drawing on epistemic injustice and related concepts to illuminate the present findings further. Epistemic injustice occurs when a person is wronged "in their capacity as the knower" (Fricker, 2007), as reported by the women when their embodied experiences were consistently dismissed and treated as secondary to medical knowledge or agendas (Carel & Kidd, 2017). Indeed, responses indicate the need for services to recognise women's embodied experiences during labour, which could be considered through a

phenomenological framework that focuses on first-person accounts of overall, lived and embodied experience (Carel, 2021), and will be discussed further in this chapter.

Respondents spoke to the emotional magnitude and wide-ranging and lasting impact of their experiences, resulting in significant distress, such as feelings of anxiety, panic, trauma, low mood, detachment, and even suicidality. This subsequently impacted their relationships with those around them, such as their partner and their new-born, with implications for the family unit and potential socioemotional development of the infant. The women spoke to this sense of isolation in what they went through, perpetuated by social narratives and hospital responses that serve to silence negative birth experiences, minimise or dismiss experiences of distress following labour, and ultimately blame and ostracise women for the trauma they experienced. Overall sentiments of loss were reported as a result of the pandemic and traumatic birth experiences, particularly a loss of shared experiences right across the women's maternity journeys. Following their traumatic births, the mothers reported a resultant mistrust of the healthcare system, with implications on their decisions to expand their family and on future interactions with the NHS healthcare system. Ultimately, participants speak to experiences of psychological trauma that occurred within healthcare settings, as a result of their interactions with healthcare professionals and experiences of violation. Fortunately, there is an increasing recognition that services should practice from a trauma-informed framework, recognising the signs and impact of trauma, and the need to actively prevent re-traumatisation (Office for Health Improvement & Disparities, 2022). As such, trauma-informed practice (TIP) will be considered as a means to prevent such accounts of avoidable harm within maternity services.

4.3 Research Questions and Summary of Findings

4.3.1 How do Parents Describe and Understand Birth Trauma That Occurred During COVID-19?

The theme '*Vulnerability and Disempowerment*' describes how participants had to relinquish a large degree of control over their maternity experiences during the pandemic as a result of service restrictions, impacting their birth plans and limiting

their choices. The mothers reported experiencing anxiety during pregnancy in relation to the confusing and ever-evolving pandemic-related hospital restrictions, and fear of catching the COVID-19 virus and its potential impact on their infant. Other studies, conducted in the UK, have reported similar findings on the impact of the pandemic on limiting birth plans and adherence to birth plans (Gray & Barnett, 2022; Aydin et al., 2022), with a largely negative sentiment in relation to these experiences (Aydin et al., 2022), which negatively impacted the transition into motherhood (Gray & Barnett, 2022). Studies across the world have also reported on the impact of the pandemic on birth and postnatal experiences due to hospital restrictions resulting in heightened levels of distress (Shuman et al., 2022; Farley et al., 2022; Eri et al., 2022). Indeed, pandemic-related perinatal healthcare changes and fluctuating guidance have been found to be significant predictors of trauma-symptoms postnatally (e.g. Diamond & Colaianni, 2022; Liu, Erdei, et al., 2021a; Spatz & Froh, 2021; Liu, Koire, et al., 2021). Furthermore, elevated levels of anxiety during pregnancy in the pandemic have been reported in other studies from across the world, including the UK, in relation to uncertainty over hospital restrictions, fears of giving birth alone and fear of catching the virus and potential consequences (e.g. Eri et al., 2022; Ayin et al., 2022).

Moreover, the mothers reported experiences of dehumanising treatment and problematic communication with staff in hospital during the pandemic, with reports of an evident lack of compassion, empathy and dignity in the treatment they received, which furthered this sense of vulnerability and disempowerment. They spoke of a lack of informed choice over decisions being done ‘to them’ during labour and being ‘spoken about not to’ by medical professionals, resulting, at times, in experiences of coercive and violating treatment. Many reported pain relief being withheld for extended periods, further contributing to a sense of disempowerment and vulnerability. Reports of medical agendas being privileged over the birthing person’s voiced-embodied experience and individual choice, resulting in violating, abusive or coercive treatment, have appeared in the literature on birth dissatisfaction and trauma prior to the pandemic (Peeler et al., 2018; Reed et al., 2017). The influence of interactions that occur during the birthing process on the subjective experience and perceptions of birth is strongly supported by existing literature (Murphy & Strong, 2018), with negative interactions, including feeling excluded, undermined and

ignored by professionals, associated with traumatic births (Reed et al., 2017; Watson et al., 2021). A perceived lack of compassion from staff has been found to exacerbate distress during childbirth (Byrne et al., 2017; Iles & Pote, 2015) and adequate information sharing during labour has been found to help mitigate experiences of distress (Byrne et al., 2017; Iles & Pote, 2015) and to increase the likelihood of informed choice and birth satisfaction (Maznin & Creedy, 2012). Furthermore, problematic communication with hospital staff has been reported in previous literature on general childbirth experiences during the pandemic (Ajayi et al., 2021), and a lack of compassion in maternity settings during the pandemic has been reported in other countries outside of the UK (e.g. Eri et al., 2022).

Such experiences of vulnerability and disempowerment were amplified during the pandemic, with restrictions in place on the presence of a support person and subsequent lack of advocacy during labour and postnatally in maternity services. It is well documented that having a support person present during labour, and in the postpartum period in hospital, contributes to birth satisfaction (Iles & Pote, 2015), and that a birthing partner is a key factor in contributing to positive birthing experiences (Bohren et al., 2019; Shakibazadeh et al., 2018), helping to mitigate distress and, in particular, experiences of trauma (Simpson et al., 2018). Indeed, pandemic-related restrictions on the presence of partners and visitors in maternity hospitals has consistently been found to be associated with greater psychological distress and posttraumatic-stress in birthing people (Liu et al., 2021; Oddo-Sommerfeld, Schermelleh-Engel, et al., 2022). The disregard for the needs of birthing people during the pandemic, by withholding their right to support and advocacy at their most vulnerable, and placing restrictions on their degree of choice and control, ultimately violates human rights and the standards of quality care outlined by the WHO framework (Aydin et al., 2022; Renfrew et al., 2014; WHO, 2018). Furthermore, the privileging of hospital policy over individual needs is arguably an example of discriminatory practice inflicted on birthing people within NHS services (Bowser & Hill, 2010).

Findings from the present research indicate that birthing people are particularly vulnerable to epistemic injustice within maternity services, as articulated by Fricker (2007), in which a person is wronged “in their capacity as the knower”. The relation

of such to healthcare may arise from epistemic asymmetries; for example, epistemic authority is often denied to service-users within healthcare settings, as knowledge derived from medical training is privileged over and above patient experience (Carel & Kidd 2017), as reported in the interviews. Moreover, power differentials also make epistemic injustice more likely within health settings, for example the power structures within maternity settings may indirectly affect the epistemic confidence of the birthing people, due to feeling vulnerable and fragile in a hostile, uncompassionate or unsupportive setting, which may challenge an individual's agency and capacity to speak their truth or challenge effectively (Carel & Kidd, 2017). This was likely exacerbated during the pandemic when service-users were denied an advocate or support person, further impacting on epistemic capacity and agency.

Reports of being dismissed, invalidated or ignored during the labour process, as voiced-embodied experiences were treated as secondary to medical agendas, constitute testimonial injustice within maternity services. This occurs when the presumptive attribution of gendered stereotypes and prejudice, such as being emotionally unstable, cognitively incapacitated during labour or lacking expert knowledge and understanding, by services and healthcare professionals serve to downgrade the credibility of birthing people's testimonies (Carel & Kidd, 2014; Fricker, 2007). A service-user may be perceived as lacking the characteristics of a credible epistemic agent, such as being detached, objective, collected and calm (Goldie, 2012), which is particularly likely to be the case during labour, when birthing people are at the most vulnerable, physically and emotionally. The credibility of birthing persons' testimonies was put at further risk during the pandemic, due to COVID-19 restrictions on birthing partners and visitors, which left birthing people without an advocate and credible witness to their claim. Whilst birthing people should not need a witness in order for their testimonials to be validated, this may also increase the risk birthing people lacking confidence or trust in the recall of their own experiences. This is likely to occur due to testimonial oppression or silencing by services, in which services fail to recognise, or undervalue, the birthing person as a knower, resulting in birthing people questioning their own competence (Dotson, 2011), as mentioned above. Testimonial injustice was further evidenced during birth reflections and complaints processes, as participants were reportedly met with a lack

of accountability and dismissal from services. Such epistemic injustice, in which medical professionals deflate the credibility of service-users due to prejudice against the group to which they belong, is likely unconscious and structurally embedded (Carel & Kidd, 2017), and speaks to the problematic culture within maternity services in the UK, which was exacerbated during the pandemic.

Furthermore, such testimonial injustice has likely led to overall experiences of hermeneutical injustice within maternity settings. Hermeneutical injustice occurs as a result of gaps in shared hermeneutical resources, which are the culturally shared collective meanings used to understand and communicate experiences. These shared meanings enable individuals to make sense of and articulate their experiences effectively, or to derive an alternative understanding of their experiences that goes against the medical model or other widespread narratives (Carel & Kidd, 2017). This may exist within maternity services as those who experienced a traumatic birth are continually silenced and marginalised, as reported in the interviews. Therefore, their views and experiences are likely underrepresented in the body of knowledge, limiting their capacity to make sense of and even articulate their experiences. Furthermore, service-users may be discouraged from meaning-making practices within a healthcare context that is dominated by medical understanding and knowledge (Blease et al. 2016). This was evidenced by participant reports of being denied the opportunity to make a complaint or have birth reflections with services in the first place, or if provided with such a space, being dismissed during the process – a form of structural testimonial injustice (Carel & Kidd, 2017). This is perpetuated within society, as negative birth experiences are not being widely accepted or spoken of, and indeed are silenced through cultural narratives, expectations and responses, as reported in the participant interviews. This serves to further marginalise those who have been harmed by services due to a lack of conceptual framework for them to make sense of their experiences, and unfairly advantages those whose experiences or beliefs are represented in the larger body of knowledge: “the powerful have an unfair advantage in structuring collective social understandings” (Fricker, 2007, p.147).

4.3.2 What is the Impact of Birth Trauma, From Parents' Perspectives?

All participants spoke of the '*Emotional Magnitude and Lasting Impacts*' of their experience, outlined in theme two, which included the impact of the birth on their emotional wellbeing, relationships, and trust in the healthcare system. All respondents spoke of experiencing anxiety and fear following their childbirth, particularly when reminded of their hospital experiences, and obsessive rumination about the birth in order to try to make sense of their experiences, which would often result in flashbacks and nightmares of their birth. Many reported feeling detached from their experiences and struggling to feel happiness, with some experiencing suicidality and considering other desperate options, such as giving away their child, in order to be rid of such distress. Mothers reported experiencing self-blame and guilt for what happened during their births, and an altered sense of self following their experiences. Reports of anger and resentment were expressed in relation to what they went through, and for what their experiences should have been. Such findings demonstrate the wide-ranging impacts and significant emotional needs of mothers who experienced a traumatic birth during the pandemic.

The current study's findings support existing literature on the adverse psychological effects of traumatic births, outside of the pandemic context, and associated postnatal distress (e.g. Bell & Andersson, 2016; Chabbert et al., 2021; Dunkel Schetter & Tanner, 2012), including detachment, anger, apathy and rumination (Nilsson et al., 2010) and more chronic manifestations of trauma (Ayers et al., 2016; Beck et al., 2011; Chan et al., 2020; Dekel et al., 2017). Sentiments of an altered sense of self and feelings of self-doubt following the trauma have been found in previous qualitative research examining traumatic birth experiences (Iles & Pote, 2015; Peeler et al., 2018). Research conducted on childbirth experiences during the pandemic, not specific to trauma, points to similar findings on the significant emotional impact of giving birth during the pandemic (Saleh et al., 2022), as well as experiences of trauma and feelings of disconnection (Farley et al., 2022). Indeed, the recent MBRRACE-UK report has found that in 2020, women were three times more likely to die by suicide up to six weeks after birth compared to 2017-19 (Knight et al., 2022), which could, in part, be due to the negative impact of the pandemic on birth experiences and consequent distress, including suicidality, as found in the present research. Quantitative research findings consistently report significantly higher-levels

of postnatal posttraumatic stress symptoms in the pandemic compared to prior to the pandemic (Mayopoulos et al., 2021), and this finding has been reported across the world (e.g. Diamond & Colaianni, 2022; Mariño-Narvaez et al., 2021; Oddo-Sommerfeld, Sommerlad, et al., 2022).

All respondents spoke of the impact of their experiences on their immediate relationships and the wider system, including their subsequent degree of trust in the healthcare system. For the majority of participants, their traumatic experiences impacted their attachment style with their new-born, including difficulties with bonding, feeling insecurely attached or hypervigilant in the relationship. Such findings support the extensive literature-base on the impact of birth trauma on the mother to new-born relationship (e.g. Beck & Watson, 2019; Bell & Andersson, 2016; Chabbert et al., 2021; Chan et al., 2020; Dekel et al., 2019), which reports an association between birth trauma and bonding difficulties, or over-protectiveness and hypervigilance (Nicholls & Ayers, 2010; Ayers et al., 2006). Many of the mothers reported difficulties with physical intimacy and bodily touch following their labour experiences, further impacting particular nurturing behaviours with their infant such as breastfeeding and soothing. Indeed, research has found that bonding and breastfeeding difficulties are significantly more likely to occur in women who gave birth during COVID-19 compared to those who gave birth outside of the pandemic, which was associated with acute stress-responses (Mayopoulos et al., 2021). Furthermore, existing literature has found that experiences of violation during childbirth influence perceptions of the infant (Ayers et al., 2006) and the need to avoid physical contact, which can impact breastfeeding and other caregiving behaviours (Chan et al., 2020; Dekel et al., 2019). This can potentially lead to an indirect, negative impact on infant development, particularly socioemotional development (Garthus-Niegel et al., 2017). The mothers in the present study reported a need to prioritise their own physical and emotional healing following their traumatic experiences, impacting their capacity to care for their new-born, which has been supported by previous research (Borg Cunen et al., 2014).

Many of the respondents also reported that their birthing experiences negatively impacted their relationship with their partners, often, in part, due to challenges in having been separated during such a crucial and pivotal time, resulting in a lack of

shared experience and true understanding for what the birthing person went through. Indeed, they reported that their partner's exclusion within services not only impacted the parental relationship but also their partner's bond with their new-born, their role within the family and subsequent family unity. Furthermore, difficulties in physical intimacy with their partner following childbirth were also reported by the mothers, having felt so violated during their childbirth experiences. Previous research, outside of the pandemic, has also found that traumatic birth experiences negatively impact the parental relationship (e.g. Beck & Watson, 2019; Garthus-Niegel et al., 2018; Nicholls & Ayers, 2010). The reported exclusion of partners by healthcare professionals in maternity services has been reported to have occurred outside of the pandemic, and is deeply embedded and longstanding, contributing to distress, a sense of inadequacy and birth dissatisfaction in partners (Daniels et al., 2020; Etheridge & Slade, 2017; Nicholls & Ayers, 2010), in turn negatively impacting their capacity to support the family postnatally (Nicholls & Ayers, 2010). It is likely that the unique context of the pandemic exacerbated these negative outcomes, due to pandemic-related service-restrictions on the presence of partners during labour and postpartum, heightening levels of anxiety and distress.

All participants alluded to this sense of broken trust with a healthcare system that is ultimately there to protect but yet caused such significant harm. The mothers spoke of feeling disregarded and let down by services, with a lack of adequate support in hospital, minimal aftercare provision and no mental health support. Some even reported experiencing medical complications as a result of medical negligence and inadequate care, further exacerbating mistrust with healthcare services. This was reported to impact perceptions of the healthcare system and future decision-making, such as reports of mothers not wanting to have any more children due to such negative birthing experiences or opting to have elective-caesareans in the future to ensure they have a greater degree of control. This broken sense of trust in the NHS healthcare system during the pandemic has been evidenced in existing literature with reports on an increase in the numbers of expectant parents accessing private support (N. Davis, 2020) and even exploring 'free birth' options (Greenfield et al., 2021; Hodson, 2020). The impact of birth trauma on perceptions of, and engagement with, healthcare systems is well documented in the literature (e.g. Ayers et al., 2006; Hofberg & Brockington, 2000), with implications on decisions to have babies in the

future (Ayers et al., 2006; Hofberg & Brockington, 2000; Iles & Pote, 2015), which evidences the life-altering impact of birth trauma on families and indeed society.

All participants spoke to this overall sense of '*Isolation*' in their experiences and '*Loss*' for what their experiences should have been, as described in theme three. Such isolation was perpetuated by invalidating responses from others that dismissed or minimised distress, furthering this sense that others would never truly understand what they went through. Furthermore, unhelpful media and cultural narratives around how birth 'should be' or how one 'should feel' following labour served to silence the mothers who experienced birth trauma, exacerbating experiences of shame, guilt and self-blame, compounding a sense of isolation in their experiences. Mothers reported missing out on shared experiences with their family and friends due to pandemic-related restrictions and a loss of community-based support, contributing to a sense of longer-term isolation. Many reported withdrawing socially from others as a result of the emotional impact of their experiences, to shield themselves from further harm.

The harmful effects of social expectations and narratives around birth, in compounding a sense of self-blame following a traumatic birth, have been reported previously in the literature (Iles & Pote, 2015). It is likely such factors are becoming increasingly more pertinent in society today with a rise in the use of social media (Alan, 2019), and consequent increased accessibility of media messaging. Social media can fuel comparison, compound negativity and increase the permeability of blame culture, negatively impacting psychological wellbeing (e.g. Yoon et al., 2019), due to the prevailing positive self-presentation that occurs online (e.g Waterloo et al., 2018). A loss in informal support postnatally has been reported in other research on childbirth during the pandemic (Stirling Cameron et al., 2021), as has a sense of loss and grief in not being able to share the entirety of the maternity journey with loved ones as a result of lockdown (Eri et al., 2022; Breman et al., 2021; Farley et al., 2022). Differences in the expectation versus reality of experiences and subsequent sense of loss and sense of isolation have even been reported in research on women's experiences of giving birth during the pandemic outside of the context of trauma (e.g. Ajayi et al. 2021; Shuman et al., 2022). The mixed messaging of birth being a natural process juxtaposed with it being treated as a high-risk medical

procedure may further contribute to differences in the expectation and reality of people's experiences, exacerbating distress. Indeed, the medicalisation of birth in Western culture has long been debated as contributing to greater experiences of childbirth distress (Cahill, 2001; Murphy & Strong, 2018; Zadoroznyj, 2001), and the portrayal of birth in the mass media likely perpetuates the medicalisation of childbirth (Luce et al., 2016).

4.3.3 What Support did They Receive from Services, and/ or What do They Think Could Have Been Helpful?

As outlined in theme 1, subtheme 2 '*Being Alone and Lack of Advocate*', all participants consistently reported a lack of support from staff postnatally in hospital, and without the support of partners or visitors, this meant predominantly recovering in hospital, with a new-born, alone. All participants reported an evident lack of staff in maternity units and spoke of their physical struggles recovering and caring for a new-born with such minimal support. Participants spoke to a lack of aftercare following discharge and the absence of mental health support. As previously mentioned, such experiences of inadequate and sub-par care during labour and postnatally amounted to medical negligence and resulted in complications for some, compounding experiences of preventable harm caused by services. Participants reported invalidating and unhelpful hospital responses, incorrect medical records and a lack of accountability from services when raising concerns or making complaints about the care they received, serving to perpetuate suffering and prolong distress, as outlined within theme 3. The subsequent lack of control, disempowerment and vulnerability that participants were subject to meant, for many, birth reflections and medical negligence claims served as a means to seek validation for their experiences, to not be silenced and to break the cycle of hermeneutic injustice (Carel & Kidd, 2017). A lack of support in maternity services during the pandemic has been reported in research on childbirth experiences conducted around the world (e.g. Ajayi et al., 2021; Breman et al., 2021; Eri et al., 2022). Furthermore, accounts of birthing people being pressurised into inductions and early discharge from hospital during the pandemic, as found in the present study, have also been reported in countries outside of the UK (Breman et al., 2021). Problematic cultures within maternity settings, in which there are evident cases of negligence but a lack of accountability

and failure to learn from serious maternity failings, have been documented in major, government-funded reviews on maternity services in the UK (Kirkup, 2022; Independent Maternity Review, 2022).

The interviews with the mothers indicated that a combination of micro and macro-level changes would be required in order to improve services and prevent the infliction of harm in the future. At the individual-level, the interviews indicated that staff should be practicing with a common sense of decency, humanity and compassion, treating all patients as individuals with individual needs, from a trauma-informed stance (Office for Health Improvement & Disparities, 2022). Furthermore, individuals should be held accountable for any instances of harm inflicted on service-users deemed preventable. Relatedly, practitioners should ensure that informed choice is presented, and informed consent is gathered, for all decisions made during labour and that the voice of the birthing person, and their individual needs, remains paramount at every stage of decision-making. Such suggestions are in line with the MTP vision of providing compassionate, personalised and professional care nationally (NHS England, 2016b).

At the systemic-level, participants identified a lack of staffing and a problematic culture within maternity services, as aforementioned, including a lack of accountability following complaints, that would need addressing to prevent harm. All participants reported that mental health support should be more accessible for those who experienced a traumatic birth, and all staff involved in such intimate care of vulnerable people should be enrolled in training on trauma-informed practice (TIP) (Office for Health Improvement & Disparities, 2022), to prevent the infliction of avoidable harm through clinical practice. Furthermore, many of the mothers reported that the information shared by professionals in antenatal appointments and via antenatal courses were problematic, unhelpful and even harmful due to inaccurately depicting the realities of birth, serving to perpetuate this narrative of blame on women when births do not go to plan. They felt that greater information sharing on all realities of birth, and related medical interventions, may help to reduce distress, confusion and anxiety during labour.

At the policy-level, all participants reported that support should never be withheld from birthing people at their most vulnerable. In the future, the needs of birthing people, their partners and new-borns should be paramount in the decision-making process of all policies within maternity settings, in accordance with the Human Rights-Based Approach to health (WHO, 2015) and the WHO framework for improving the quality of care for women during childbirth (Renfrew et al., 2014; WHO, 2016).

4.4 Contribution to the Literature

This was a unique study, qualitatively seeking to explore traumatic birth experiences during the COVID-19 pandemic in the UK from those with embodied, lived experience. The findings are consistent with existing literature on some of the problematic structures in UK maternity settings that contribute to traumatic birth experiences, such as the privileging of medical agendas over embodied experience and individual choice, resulting in experiences of coercive and violating treatment, evidencing the existence of epistemic injustice within healthcare (Carel & Kidd, 2017). The findings also uniquely demonstrate that the context of the pandemic likely exacerbated pre-existing risk factors for traumatic births and produced an additional set of factors of its own, contributing to traumatic births. These additional factors included heightened experiences of anxiety in relation to the virus, restrictions on birth plans and support persons exacerbating a sense of powerlessness, and a burnt-out and understaffed workforce intensifying a problematic culture, reducing compassion, and limiting the provision of support. The findings of the study indicate that the context of the pandemic not only increased the likelihood of traumatic birth experiences but likely amplified the emotional distress experienced following such births, due to lockdown and subsequent isolation, and loss of social and community support.

In addition, the study identified important factors that perpetuated experiences of distress following childbirth trauma in this cohort of women who experienced childbirth trauma during the pandemic. These included widespread, misleading social narratives around birth, including social pressures on how women 'should'

give birth and even feel following labour, a perceived stigma in sharing negative birth experiences, and a blame culture on women whose births did not go as planned.

4.5 Critical Review

4.5.1 Reflexivity

During the interviews, I was acutely aware of my positioning as an NHS employee, interviewing participants on their experiences of trauma and misuse of power that they experienced within NHS services. I was mindful of the potential power-imbalance between interviewer and interviewee and to not replicate such abuses of power that could occur by expecting those who have been subject to oppression to share their personal experiences with the researcher who forms part of that oppressive system. This made selecting quotes for the thesis quite challenging, as I felt strongly that I wanted to give voice to the participants' experiences, and to present extracted quotes in full. In line with my rationale for conducting qualitative research, I did not want to reinforce the power-imbalance between participant and researcher by being too selective over quotes, and so I selected quotes that were representative of the points being made by a number of participants, and summarised these in the text.

The interviews were emotionally moving and powerful and made me reflect on my own clinical practice, in particular the power-imbalance that exists between service-users and services, and how oppressive systems can feel due to their complexity in set-up and the power they hold in making potentially life-altering decisions. The interviews highlighted the importance of adhering to trauma-informed principles of safety, choice, collaboration, trustworthiness and empowerment (Harris & Fallot, 2001; Mental Health Coordinating Council, 2019; Trauma-Informed Oregon, 2018) at all stages of care with service-users, and at all levels of service development and policy, to prevent the traumatisation and re-traumatisation of service-users through replication of oppression and power-imbalance. I considered how this might play out during initial assessments with clients in mental health settings, in what clients are expected to share, what is then shared amongst professionals, and what clients are then offered or not offered by services, and how disempowering this whole process

could feel. The interviews highlighted how the complexity of systems, referral processes and service criteria, may exacerbate distress, reinforce power-imbalances and replicate experiences of oppression.

Finally, I was mindful that the voice of staff members support birthing people during the pandemic in maternity services were not captured within this thesis. Interviewing maternity staff on their experiences during the pandemic may have shone light on some of the stresses that they had to endure and encountered within their roles, from a first-hand perspective. This would not excuse poor practice or the problematic structural problems contributing to traumatic experiences, but it may have helped to illuminate the context in which professionals were working and the stress they were under, which was something that at least some of the participants recognised and acknowledged. Keeping a reflective log throughout the interview process helped me to step-back when I felt myself problematising particular individuals and members of staff, and to focus instead on the problematic systemic structures, such as inadequate staffing levels and a burnt-out workforce, that likely established a context in which poor care was more likely. However, this context does not excuse the preventable acts of harm, inflicted by staff members, that were reported by the participants in the interviews.

4.5.2 Evaluating Quality

The quality of the research has been assessed using common criteria and guiding principles for thematic analysis and qualitative research (Spencer & Ritchie, 2011; Braun & Clark, 2021; Yardely, 2000).

Credibility refers to the plausibility of research findings (Guba & Lincoln, 1994), how well the theory, research project and analysis align (Stenfors et al., 2020) and the representativeness of participant views within the dataset and results (Tobin & Begley, 2004). Credibility was addressed by explaining the methodology in-depth within this manuscript to ensure transparency and through prolonged exposure and familiarisation with the dataset in accordance with the analytical process outlined in detail within the methodology. Furthermore, peer-supervision to discuss preliminary findings, and frequent discussions with the research supervisor during the analytical stage of analysis, helped to achieve 'analytic triangulation' (Grafsky et al., 2018).

Quotes have been provided to demonstrate further transparency of claims made within the findings (Yardley, 2003), and extracts of coded transcripts have been provided in the Appendix (Appendix H), as well as code and theme development (Appendix I).

Transferability refers to the generalisability of claims made to other contexts. The context of the present research and methodology has been outlined to enable an understanding of how the presenting findings can be applied to other contexts (Hadi & Closs, 2015) and the limitations of the research's context have also been considered.

Rigour considers the methodological validity, conduct, thoroughness and dependability of the research (Spencer & Ritchie, 2011). Dependability refers to the research process being clear, traceable and well-documented (Tobin & Begley, 2004) and consistent over time (Guest et al., 2012). Each decision was discussed with the supervisor throughout the process, and clear rationales for each decision made have been incorporated within this thesis. Furthermore, to improve the methodological validity, the BTA, a relevant charity, were consulted. A reflexive log was kept throughout the process (Lincoln & Guba, 1985) and exemplar reflections have been shared in this manuscript.

4.5.3 Limitations

The mode of data collection, via videoconferencing as opposed to in-person interviews, may have felt less personal and intimate for participants, impacting the extent of what was shared during the interviews, particularly due to the distressing nature of the interview content. However, the virtual set-up of the interviews increased accessibility and enabled the participation of individuals from across the UK, who gave birth in a number of different maternity services, increasing the generalisability of the findings.

The sample lacked representativeness, and comprised of predominantly White, heteronormative, cis-gender women. Whilst a homogenous sample has benefits, such as eliminating sociodemographic variation that may contribute to the findings, this does limit the generalisability of claims made to the entire population of people who gave birth in NHS maternity settings during the pandemic. The participants were

recruited via snowballing (participants shared the study with others) and purposive (advertised on the BTA charity's online platforms) techniques, and due to the high levels of response, the study did not need to be advertised elsewhere. However, the lack of representativeness in the sample suggests that perhaps advertising the study via different means or sampling methods may have supported the recruitment of a more diverse sample. Moreover, reports of epistemic injustice in maternity settings may have served to silence and oppress particular groups more greatly than others, such as those from racialised communities who are more likely to experience discriminatory practices, poorer quality of care within maternity settings (Alhusen et al., 2016; Giurgescu, 2021; Howell et al., 2016; Mayne et al., 2018) and higher perinatal death rates (Knight et al., 2022). This may have further impacted the accessibility of the present research to these groups, and individual capacity to participate and articulate their experiences. Furthermore, financial compensation was not offered for participation in the study, which may have further limited the representativeness of the sample; indeed, one participant declined to participate upon finding out there would be no compensation for participation. However, data on participants' socioeconomic status were not gathered, so the variation in this demographic measure across the sample remains unknown.

Furthermore, the mothers' previous history with services was not explicitly examined. Past experiences with the healthcare system are likely to have impacted perceptions of, and relationships with, services, influencing experiences of labour. The mothers were asked about their feelings regarding the upcoming birth to get a sense of their expectations and whether they had given birth before and their related experiences. However, given the evident impact of their birth experiences on feelings of trust with services and future-decision making, historic healthcare experiences, that they or their loved ones have encountered, should have been examined more explicitly. Furthermore, information gathered on past traumatic experiences, or psychological difficulties, would have been useful, as such may have influenced perceptions of the birth and labour, and influenced postpartum experiences (Grekin & O'Hara, 2014).

Participants were from a range of regions across the UK and gave birth during different phases of lockdown, and therefore may have been subjected to varying hospital guidance. This might have impacted participant experiences, contributing to

a variation in the findings. However, all of the participants reported that the visitor restrictions were the most problematic pandemic-related hospital restrictions, causing the most significant distress, and whilst hospitals enforced this rule to varying degrees depending on the stage of lockdown, this was a restriction implemented by all hospitals, impacting all the participants.

4.5.4 Strengths

This is a unique study examining people's traumatic birth experiences during the COVID-19 pandemic, using a qualitative approach from the perspective of those with lived, embodied experience. The study has gathered rich, thick data on what may have contributed to such traumatic experiences, the related impacts and what could be done differently, with implications for services and future practice. The research well documents people's experiences of traumatic births during the pandemic and identifies their unique needs, with implications for clinical practice. Fifteen participants were incorporated within the study, which is greater than the number found for data saturation in qualitative interviews (Guest et al, 2006), but few enough to produce rich, detailed data (Braun & Clarke, 2021a), to enable a thorough insight into people's embodied experiences of traumatic childbirth during the pandemic.

The findings support existing literature on factors contributing to traumatic birth experiences within the context of maternity settings and birth experiences during COVID-19, indicating the credibility and plausibility of claims made. The results suggest that the pandemic exacerbated existing risk factors for traumatic births by amplifying the problematic cultural and structural problems within maternity services, and created a set of additional factors, which contributed to the harm caused. Unique findings on factors that may be exacerbating and prolonging experiences of distress have also been presented.

4.6 Implications of the Research

4.6.1 Clinical Implications

Maternity mental-health settings should be mindful of the experiences of those who gave birth during the unique context of the COVID-19 pandemic, in which distress

was exacerbated and traumatic experiences more likely. This should be considered during assessment, formulation and intervention. Psychological practitioners working clinically with service-users should be curious about any experiences of childbirth and previous encounters with services, being mindful of the impact of trauma and possible experiences of oppression from the NHS system, as this is likely to impact presentation, engagement and trust with services, and subsequent clinical outcomes.

Clinically, the findings indicate that women who have experienced a traumatic birth require adequate and timely mental health support, in line with some of the visions outlined in the NHS five year forward implementation plan (NHS England, 2016a). This would help to prevent the wide-ranging negative impacts of such experiences on the individual, infant, social-network and indeed wider society. There are three key areas in which support is likely to be helpful: parent-infant relationships, support for birthing people, and support for couples. Support groups for women may be particularly helpful for those who have experienced a traumatic birth, due to commonly shared experiences of shame and isolation. These could be run on a peer-support basis, by people with lived experience of a traumatic birth, to help reduce the burden on professionals, and to ensure the groups are appropriate and service-user led. Such groups could be facilitated and supported by a number of different perinatal professionals, including psychological practitioners, midwives and health visitors; involving different professionals would help to reduce the burden on particular members of staff and teams.

Furthermore, considering the impact of traumatic births on the parent-infant relationship, parents should be signposted and referred on to parent-infant services, to support with attachment. Parent-infant services do currently exist within some NHS Trusts, and are often attached to specialist community perinatal teams or children and adolescent mental health services (CAMHS) and may be called a Parent and Infant Psychology Services (e.g. see Whittington Health NHS Trust, 2023 – the Parent Infant Psychology Service) or other similar names. However, their existence and accessibility vary depending on locality and NHS Trust. In addition, couples should also be signposted to services and third-sector organisations for support, given the impact of birth trauma on the parental relationship described by

the participants in this study. NHS maternity services should consider expanding the support they provide to include couples.

Furthermore, similar findings were derived in previous qualitative research examining traumatic birth experiences (e.g. Iles & Pote, 2015; Peeler et al., 2018) that used self-reported, quantifiable PTSD-symptom checklists to identify experiences of birth trauma as medically-recognised concepts of trauma (e.g. Weathers et al., 1993). This not only validates the present findings, but also indicates that if such scales were to be used as a screening tool then qualitative questions should be used in conjunction. This would ensure that clinical cut-offs do not neglect or exclude women from birth trauma research or accessing support within services, who evidently experience similar detrimental impacts.

Finally, all clinicians, and systems, need to be mindful of the actions they take that can ultimately take away an individual's choice and control over their experiences and, as such, cause trauma or replicate experiences of harm. Consequently, adopting a trauma-informed framework within services may help to address some of the issues raised, and prevent instances of avoidable harm perpetrated by services and professionals, by adhering to the principles of safety, trustworthiness, choice, collaboration, empowerment and cultural consideration (Office for Health Improvement & Disparities, 2022). TIP aims to develop a practitioner's awareness of how trauma can affect individuals, increase ability to recognise the signs and symptoms of trauma and subsequent impacts, and increase their capacity to actively prevent re-traumatisation by not replicating experiences of oppression or harm by being culturally sensitive and safe to improve trust, accessibility and engagement (Office for Health Improvement & Disparities, 2022). Professionals need to consider the inherent power-imbalance that exists between service-users and clinicians, particularly with clients at their most vulnerable, such as those during labour, and work to actively address this and prevent experiences of oppression by making birthing people's voices paramount in all decision-making.

Furthermore, consideration should be given to how best to include partners, or a support person, at all stages across a birthing person's maternity journey, to help prevent experiences of distress, ensure adequate advocacy, improve outcomes for

the family unit, and subsequently reduce the burden on services. Participants spoke about the distress caused by enforced separation during the pandemic, as a result of hospital restrictions. Furthermore, the participants felt that the enforced hospital policies and practices were unclear and inconsistent. Given this and the fact that there is a high-risk of future pandemics occurring, similar to COVID-19 (e.g. Joi, 2023; HM Government, 2023), it is important for services to learn lessons from the COVID-19 pandemic. In the early phases of future pandemics, where there may be little information on what might be contributing to the spread of the virus, and thus infection control may need to take precedent, a support person could be offered to birthing people, on the premise that they too cannot come and go from the hospital, and will have to stay on site at all times. This would help to curtail the spread of infection, whilst simultaneously ensuring birthing people have support, to reduce the negative impacts and consequent burden on services. Furthermore, any restrictions should be clear with an explicit rationale, so information is transparently shared to ensure that service-users understand why certain decisions are being made. Given that excluding visitors from hospitals has been proved to be so profoundly harmful, the related negative impacts of doing this should be effectively weighed against the benefits, before such decisions are made in the future. Whilst the COVID-19 pandemic was a unique and challenging scenario, we can learn from what happened and prevent such harm being caused in the future.

4.6.2 Service Implications

Trauma-informed principles of safety, choice, collaboration, trustworthiness and empowerment should inform the development of all services (Harris & Fallot, 2001; Centre for Health Strategies, 2021), particularly maternity settings that care for people at their most vulnerable, physically and emotionally. TIP training should be mandatory for all maternity staff, whose actions greatly risk causing harm and traumatising service-users. Furthermore, the findings highlight how human practices of compassion, empathy, dignity and respect can not only be healing for people recovering from traumatic experiences but may also prevent distress and harm in the first place. This sits in line with the MTP vision of providing compassionate, personalised and professional care nationally (NHS England, 2016b), and should be addressed through further mandatory training, monitoring and accountability

protocols. Though, ultimately, structural problems of inadequate staffing levels on maternity units, particularly during the pandemic, may have contributed to a poor standard of care and practice and may need to be addressed in the first instance before training or other such strategies would have valuable benefits.

Alarming accounts of incorrect record-keeping, a lack of accountability from services and problematic complaint processes were reported by the participants who gave birth within NHS maternity hospitals in the UK. Such results align with findings presented in large-scale reviews conducted on maternity services in the UK (Kirkup, 2022; Independent Maternity Review, 2022). The results indicate that providing a space to be listened to, heard, validated and taken seriously, such as through birth reflections, can provide closure for clients recovering from traumatic birth experiences, enable the processing of such experiences and subsequent healing. Adequate accountability processes within maternity settings need to be established and enforced, including accurate record-keeping, information sharing and accessible complaints processes, in which the voice of service-users are paramount. Furthermore, maternity services need to learn from their mistakes, and implement recommendations in line with the proposals outlined in the Independent Maternity Review report (2022).

4.6.3 Policy and Structural Implications

The individual needs of service-users within maternity settings must remain paramount in all decision making affecting the running of maternity services, in line with the human rights-based approach to healthcare (WHO, 2015). The WHO framework for the care of women during childbirth emphasises a human rights-based approach to care to rectify inequalities and unjust power relations, by providing a person-centred and holistic approach, with emphasis on respect and tailored individualised care (Renfrew et al., 2014; WHO, 2018). This needs to be reinstated after such guidance was clearly violated during the pandemic, with accounts of women giving birth without advocacy, restricted visitation rights, minimal support and limited choice (Aydin et al., 2022; Renfrew et al., 2014; WHO, 2018).

At a policy level, support should be targeted towards those who self-identify as having experienced a traumatic birth, identified through adequate screening, and are in the maternity system pregnant with another baby. Birth reflections should be mandatory across all maternity services, to prevent the prolonging of distress and any confusion or unanswered questions regarding the birth. Materials provided to pregnant women and their families about the birthing process and maternity care should be informative, well-rounded and accurately depict all of the realities of births and possible interventions that may be used.

The existence of epistemic injustice within healthcare is longstanding (Carel & Kidd, 2017) and ultimately evidences that there needs to be a shift in the culture within services and in the communication between professionals and service-users to generate and enable change, and ultimately to prevent harm. To avoid the continual infliction of epistemic injustice within maternity healthcare, birthing people's individual needs, which are explicitly voiced as opposed to being presumed, need to become paramount in all decision-making, understanding that embodied experience is a crucial element of the labour process. This could be considered using phenomenology as a conceptual framework, understanding that distress during and following labour is not linked to physiological dysfunction or individual pathology, but rather a result of an overall, lived and embodied experience (Carel, 2021). This tool is a descriptive method of exploration, that is non-judgemental or pre-assumptive about what an individual's experience might be and instead focuses on the first-person experience, with emphasis on examining the phenomenon in the general context of the person's life (Toombs, 1988; Carel, 2010) and examining the meaning-making of experience. Ultimately, viewed phenomenologically, birth trauma is not an objective entity, but rather is experienced subjectively by the birthing person and may appear differently to each patient, professional or other observer (Carel, 2010).

Birth reflections and debriefs with hospital staff and birthing people may present an opportunity for a phenomenological understanding of birth trauma, deriving a rich and thick account of such embodied experiences, and enabling meaningful change in order to prevent further epistemic injustice. All professionals and services need to work hard to continually consider an individual's needs, expressed wishes and voiced embodied experiences, ensure service-users have choice and control at all

levels of decision-making, to empower them at every stage, and disrupt problematic power-dynamics, ultimately preventing epistemic injustice. This would require the presence of those with direct lived-experience to be consulted in the development of policies and in the structural decision-making of services as valuable service stakeholders.

4.6.4 Implications for Future Research

Future research should focus on recruiting a sample of participants from racialised communities who gave birth during the pandemic, as they are likely to have faced a unique set of experiences that warrants investigating. It is well documented in the literature conducted prior to the pandemic that racialised birthing people experience poorer birth outcomes and increased complications than white birthing people (e.g. Creanga et al., 2014; Leonard et al., 2019), in part due to discriminatory practices within healthcare services and poorer quality of care (Alhusen et al., 2016; Giurgescu, 2021; Howell et al., 2016; Mayne et al., 2018). Indeed, research has found that that black respondents reported receiving lower levels of respectful care than white respondents during the pandemic and increased rates of pre-term birth (Breman et al., 2021; Knight et al., 2022). As such, experiences of traumatic births during the pandemic in racialised communities requires investigating, as the risk factors for experiences of trauma were likely exacerbated.

Additionally, conducting interviews with partners of people who gave birth during the pandemic, whether traumatic or not, would be important to investigate. Historically, partners have felt excluded and undermined by the maternity care system (e.g. Poh et al., 2014; Wells, 2016; Iles et al., 2011), contributing to experiences of distress, inadequacy and birth dissatisfaction (e.g. Daniels et al., 2020; Etheridge & Slade, 2017; Nicholls & Ayers, 2010). This was likely heightened during the pandemic, with restrictions on their presence during pregnancy scans, antenatal appointments, during labour and postpartum in hospital (e.g. Aydin et al., 2022; Regan, 2020). Therefore, the pandemic likely exacerbated experiences of exclusion and distress in partners, with significant implications on the family unit, as alluded to in the present findings.

Given the nature of participant responses and their relation to epistemic injustice, future qualitative research could be conducted in line with a phenomenological approach, to gain access to rich accounts of participants' embodied and 'true experiences' through 'their eyes' (Willig, 2019). Methods such as interpretative phenomenological analysis (IPA) could be used to capture participant experience; analysis would pay attention to the emotional tone as well as the content of interviews, themes and super-ordinate themes would be derived to capture the experiential meaning and combined to reflect the true dimensions of participant experiences (Willig, 2019).

4.7 Conclusion

No previous qualitative research has investigated traumatic birth experiences in the UK during the COVID-19 pandemic, the contributing factors and subsequent impact, and the implications for clinical practice.

Findings indicate that the participants felt vulnerable and disempowered giving birth during the pandemic due to pandemic-related restrictions, a lack of support in hospitals from staff, feeling alone without an advocate, and experiences of dehumanising treatment. The impact of such experiences extended far beyond that of individual distress and mental health disturbance, as attachment behaviours were also impacted, with implications for the infant's socioemotional development, relationships, as were decisions around family planning and future interactions with healthcare systems. Moreover, findings suggest that the mothers' experienced an overall sense of isolation and loss of what their experiences should have been, perpetuated by a lack of accountability from services. More compassionate and empathetic care was highlighted by participants as paramount to improve the quality of care received within maternity settings, as was the need for informed choice and consent in all decisions of care, and adequate accountability from the hospitals. A trauma-informed framework and human rights-based approach to care may help to prevent such harm within maternity services. Future research should focus on traumatic birth experiences within racialised communities during the pandemic, and the maternity and birthing experiences of partners during the pandemic.

Overall the research has enabled a greater understanding of traumatic birth experiences that occurred during the unique context of the COVID-19 pandemic from the perspectives of those with lived, embodied experience. The research highlighted clear contributing and perpetuating factors and the subsequent wide-ranging impact of the experiences and needs of this population group. Subsequently, suggestions have been made regarding clinical practice, service and policy-level reforms, to ultimately reduce and prevent such experiences of birth trauma from being replicated in the future.

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APPENDIX A: Interview Schedule

Demographic Information to be gathered at the beginning of the interview:

- Preferred pronouns (he/him; she/her; they/them; other)
- Gender (male; female; non-binary; other)
- Transgender (yes; no; other)
- Sexual orientation (bi-sexual; gay; lesbian; heterosexual; queer; pan sexual; other)
- Age
- Ethnicity
- Delivery date (month and year)
- First birth (yes/no)

How do parents describe and understand their traumatic birth that occurred during COVID-19?

Context:

1. What were your experiences of pregnancy and how did you feel about the upcoming birth?
2. Is this your first pregnancy and birth? If not, what have been your previous experiences?
3. What specific COVID-19 restrictions impacted you, with regards to maternity services and care?
4. How has the COVID-19 pandemic impacted your experiences of pregnancy, birth and postpartum more generally?

Birth and postpartum:

5. Can you talk me through what happened during the birth?
6. Did you feel prepared for the birth and for what unfolded?
7. How in control did you feel during the birth and did you understand what was happening?
8. Did you feel supported during the birth?
9. What happened immediately after the birth, and did you feel supported?
10. What other factors do you feel contributed to your traumatic experience?

What is the impact of birth trauma, from parents' perspectives?

11. How did you feel after the birth, and how did this compare with how you expected to feel?
12. To what extent has the birth played on your mind, and in what ways has it impacted your mood or mental health?
13. In what ways has the birth impacted your daily life?
14. How has the birth affected your relationship with your partner? (if have one)
15. How has the birth impacted your relationship with others?
16. How has the birth impacted your relationship with your infant?

What support did they receive from services, and/ or what do they think could have supported them through the experience?

17. What support have you received from services (during the pregnancy, labour and postpartum period)?
18. What do you think services could have done differently (at all stages: pregnancy, birth, postpartum) or what would have helped?
19. In what ways do you think services have been impacted by COVID-19?

APPENDIX B: Study Advert

Parents' Perspectives of Birth Trauma During COVID19

PARTICIPANTS:

If you are 18+ years-old, gave birth during the COVID19 pandemic in the UK and experienced this birth as traumatic, you may be eligible to take part in this study and help make a difference to support parents better in the future.

STUDY:

Parents would be interviewed on their experiences of the birth, the impact of such experiences, the support they received from services, and what they think could have been helpful.

CONTACT

If you think you may be interested in taking part and/or would like further information about my research, please do not hesitate to contact me.

Cara James

Trainee Clinical Psychologist

University of East London

Email: u2075209@uel.ac.uk

APPENDIX C: Participant Information Sheet



PARTICIPANT INFORMATION SHEET

Parents' Perspectives of Birth Trauma During COVID19

Contact person: Cara James

Email: u2075209@uel.ac.uk

You are being invited to participate in a 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 Cara James. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a 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?

I am conducting research into parents' experiences of Birth Trauma during the COVID19 pandemic. Restrictions were placed on maternity services during the pandemic, increasing the likelihood of the traumatic birth experiences. Parents would be interviewed on their experiences of the birth and the impact of such experiences. Parents would also be asked about the support they received from services, and what they think could have been helpful. The findings could be used to promote service change and guide how services support parents in these circumstances going forward, particularly in future pandemics.

Why have I been invited to take part?

To address the study aims, I am inviting parents who feel they experienced a traumatic birth during COVID19 to take part in my research. If you are 18+ years-old,

gave birth during the COVID19 pandemic with related service restrictions (from March 2020 to date) in the UK and experienced this birth as traumatic, you are eligible to take part in the study. Parents who lost/ are no longer with their babies following the birth are not eligible to participate 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 asked to participate in a semi-structured interview with me, Cara, the researcher. The interview would take approximately one hour and will ask questions relating to the birth and postpartum experience, the impact of the birth trauma, for example on your daily life and on your relationships etc, and the support you received from services/ what you feel could have been helpful. The interview would be like having an informal chat, that is centred around these broad themes, but will be recorded so that the interview could be typed up for analysis.

The interviews will take place remotely, if possible, via a video-conferencing software called Microsoft Teams (MS Teams), which will also record the interview for transcription purposes (once transcribed, these recordings will be deleted – see below for more information). Instructions and support would be offered to support with this. If it is not possible to conduct the interviews this way, telephone or face to face interviews could potentially be offered as an alternative, and would be recorded using an audio-recording device (again recordings would be deleted once interviews have been transcribed). Face to face interviews would be conducted on the UEL Stratford Campus.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence - your participation in this research is entirely voluntary. If you would like to withdraw from the interview, you can do so by emailing me prior to the interview or stopping the interview at any point. 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 3 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?

As the interview will ask questions related to your birth, the interview has the potential to be distressing or potentially triggering. It is my hope that being provided with the space to talk about your experiences, to potentially better services in the future, will be a valuable experience, however due to the intimate and sensitive

nature of the interview content, this may result in some psychological distress. You can pause the interview at any point, to have a break, or even to resume the interview on another day. You can also stop the interview at any point and withdraw from the study. I will be sensitive and compassionate during the interview, to ensure you feel supported, and use my clinical judgement to pause/ stop the interview if it seems too distressing. You will be provided with information regarding relevant support services after your interview, or if you withdraw from the interview, should you feel these may be helpful.

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

- Participants will not be identified by the data collected, on any material resulting from the data collected, or in any write-up of the research. Pseudonyms (fake names) will be used in the interview transcripts, and recordings will be deleted once the transcripts have been written up.
- Transcripts, demographic information and consent forms will be stored in separate and secure, password protected files, on a secure private password protected laptop and on an encrypted UEL OneDrive.
- The participant consent forms will be sent and received via a secure UEL email address, and then saved in password protected documents.
- Only I, Cara, will have access to the raw data and recordings. I will immediately transcribe the interviews into an anonymised format, using pseudonyms, and delete the recordings. I will save these anonymised transcripts in a secure location (above). Only myself, my supervisor and the examiners will have access to these anonymised transcripts.
- Demographic information will be taken, but such will not be recorded with your name or saved with your transcript or consent forms (all will be saved in separate folders in a secure location), and so the data will not be personally identifiable. Information such as your gender, age and ethnicity will be recorded.
- The consent forms, anonymised transcripts, and demographic information will be kept for examination purposes (up until September 2023). All data will then be deleted/destroyed, except for the anonymised transcripts, which will be kept for 3 years in a secure location after the write-up of the study for potential publication purposes (but only if participants consent to this, if they do not then these too will also be deleted).
- Only the contact details of participants who report they would like to receive a summary of the findings in the consent form will be kept. If they consent to this, their contact information will be stored securely and then destroyed once findings have been sent. I won't be keeping personal contact information otherwise, and participants will not be invited to participate in future studies.
- If participants seem to be at risk to themselves or others, confidentiality may need to be broken, and support from external services may need to be sought.

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/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The final version of the thesis will be publicly available on the UEL Research Repository. The UEL Research Repository preserves and disseminates open access publications, research data, and theses created by members of the University of East London. It exists as an online publication platform that offers free permanent access to anyone. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs, charities, such as The Birth Trauma Association. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally through the data provided (as pseudonyms would be used, and any personally identifiable information will be removed or replaced).

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 Cara James 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 Research 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.

Cara James
Email: u2075209@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 Research 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. Please find relevant supporting organisations below.

Please note relevant supporting organisations have been removed in this document to protect anonymity.

APPENDIX D: Consent Form



CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Parents' Perspectives of Birth Trauma During COVID-19

Contact person: Cara James

Email: u2075209@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 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 the interview will be recorded using MS Teams, or an audio-recording device.	
I understand that my personal information and data, including audio/video recordings 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 data 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 E: Debrief Sheet



PARTICIPANT DEBRIEF SHEET

Parents' Perspectives of Birth Trauma During COVID19

Thank you for participating in my research study on Birth Trauma during the COVID19 pandemic. 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 Research Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs and charities, such as the Birth Trauma Association. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally, as personally identifiable information will either be removed or replaced.

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:

Please note, the relevant organisations have been removed from this document to protect anonymity.

In an emergency:

- Call 999 or go to your local A&E department

If you're in crisis and need to speak to someone:

- Call NHS 111 (for when you need help but are not in immediate danger)
- Contact your GP and ask for an emergency appointment

If you would like professional mental health support, we would advise you attend your GP for a referral to an NHS Mental Health 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.

Cara James
U2075209@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 Research 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 F: Ethical Application and Approval



University of
East London

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: <ul style="list-style-type: none">▪ 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: <ul style="list-style-type: none">▪ 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

	<p>need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance.</p> <ul style="list-style-type: none"> ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ 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	<p>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</p>
1.7	<p>Checklist, the following attachments should be included if appropriate:</p> <ul style="list-style-type: none"> ▪ 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:	Cara Louise James
2.2	Your supervisor's name:	Kenneth Gannon
2.3	Name(s) of additional UEL supervisors:	Maria Qureshi
		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: <u>Please note</u> - If your study requires registration, the title inserted here must be <u>the same</u> as that on PhD Manager	Parents’ Perspectives of Birth Trauma During COVID-19
3.2	Summary of study background and aims (using lay language):	<p>Birth trauma has been found to have a negative effect on parents’ mental health, relationships, infant bonding and infant health (Iles et al, 2011), with implications for services and service provision. Risk factors for experiencing a traumatic birth include perceived lack of support or feeling excluded in maternity choices (Ertan et al., 2021). Restrictions have been placed on maternity services during COVID-19 and include suspension of support services and limitations on partners attending appointments and supporting labour. During COVID-19, 90% of parents experienced a change in their maternity choices and parents’ reported feelings of abandonment, fear and powerlessness in response (Baptie, 2020). It is likely that COVID-19 and related restrictions have amplified factors contributing to birth trauma, increasing the risk and related implications. This study seeks to understand parents’ perspectives of birth trauma during COVID-19. Findings could be used to guide the support provided by services and inform policy.</p> <p>N.B.: ‘trauma’ in the context of this study will refer to any event or experience of birth that people found to be particularly distressing. Anyone with a formal diagnosis of PTSD will be excluded from the study.</p>
3.3	Research question(s):	<p>1. How do parents describe and understand the birth trauma that occurred during COVID-19?</p>

		<p>2. What is the impact of the birth trauma, from parents' perspectives?</p> <p>3. What support did they receive from services, and/or what do they think could have been helpful?</p>
3.4	Research design:	<p>This is a qualitative study. Semi-structured interviews will be conducted with child-bearers who self-identify as having experienced birth trauma during COVID19. Interview questions will relate to the research questions, enquiring about parents' experiences, the impact of the birth trauma and the support they received from services. Interviews will be conducted remotely using a videoconferencing software (MS Teams), or, if this is not possible, via the telephone. In the case that participants cannot access either of these two options, the interviews will be conducted face to face on the UEL Stratford Campus. Qualitative data from the interviews will be gathered, as well as some demographic information.</p>
3.5	Participants: Include all relevant information including inclusion and exclusion criteria	<p>Twelve participants will be recruited through purposive sampling to participate in semi-structured interviews. Participants will be child-bearers, 18+ years old, who self-identify as having experienced birth trauma during the COVID19 pandemic (March 2020 – August 2021). Parents who lost/ are no longer with their baby following the traumatic birth will be excluded from participating. Parents formally diagnosed with PTSD will also be excluded from the study. Participants will be interviewed individually.</p>
3.6	Recruitment strategy: Provide as much detail as possible and include a backup plan if relevant	<p>The Birth Trauma Association have confirmed that they will provide support with recruitment, by advertising the study on their social media platforms and through their marketing emails. Other social media support groups will also be contacted to advertise the project.</p>
3.7	Measures, materials or equipment: Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	<p>An interview schedule has been designed and developed to answer the research questions. The Birth Trauma Association provided feedback on the schedule, and made some suggestions with regards to how questions were phrased and the language used. The schedule was revised accordingly. The videoconferencing software, MS Teams, will be</p>

		<p>accessed via a personal, password protected laptop. Transcripts will also be created on the personal, password protected laptop using Microsoft Word. Access to an audio-recording device, such as a Dictaphone, will be necessary in the case of telephone or face to face interviews. Access to the UEL OneDrive account will be needed, to store the anonymised transcripts, demographic information and consent forms.</p>	
3.8	<p>Data collection: Provide information on how data will be collected from the point of consent to debrief</p>	<p>Participants will be required to provide informed consent in order to participate in the study. Consent forms will be sent electronically and returned via a secure UEL email address using password protected files. The consent forms will be stored securely on the encrypted UEL OneDrive.</p> <p>Interviews will be recorded and transcribed electronically, if using MS Teams. The transcripts will then be anonymised using pseudonyms and personally identifiable information will be altered/ removed. The recordings will then be deleted. The transcripts will be stored on the UEL OneDrive in encrypted files, in a separate folder to the consent forms to protect participant anonymity.</p> <p>Telephone and face to face interviews will be recorded using an audio-recording device, and then transcribed manually. Once transcripts are generated, the recordings will be deleted. The transcripts will be anonymised using pseudonyms, as above, and saved on the UEL OneDrive in encrypted files.</p> <p>Demographic information will also be collected during the interview, and collated into a single document, and stored in encrypted files on the UEL OneDrive, in a separate folder to the consent forms and transcripts to protect participant anonymity.</p> <p>Participants will be sent a debrief sheet post-interviews, with a list of resources and relevant support services to signpost them to.</p>	
3.9	<p>Will you be engaging in deception?</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input checked="" type="checkbox"/></p>
	<p>If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?</p>	<p>If you selected yes, please provide more information here</p>	

3.10	Will participants be reimbursed?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer? <u>Please note</u> - This must be in the form of vouchers, <u>not cash</u> .	Please state the value of vouchers	
3.11	Data analysis:	The anonymised transcripts, from the interviews, will be analysed using Thematic Analysis. This involves the assignment of preliminary codes to the data to describe the content. Next, patterns or themes that emerge across the codes are identified.	

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 <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, please provide details of how the data will be anonymised.	Whilst the researcher will ask the participants for their preferred name during the interview, all transcripts will be anonymised by replacing names with a pseudonym, before being stored in password protected files on the UEL OneDrive. The initial recordings will then be deleted. Demographic information will ask for age, as opposed to DOB, and will not ask for their address/ locality to protect anonymity, and the information will be stored in a separate folder on the UEL OneDrive to the transcripts.	
4.2	Are participants' responses anonymised or are an anonymised sample?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	Pseudonyms will be used in the transcripts to replace names and any personally identifiable information (such as address, locality, name of services) will be altered/removed during transcription. All recordings will be deleted after transcription. The	

		anonymised/pseudonymised data will be kept separate from any identifiable data – the transcripts, consent forms and demographic data will all be kept in separate folders to protect participant anonymity.	
4.3	How will you ensure participant details will be kept confidential?	Pseudonyms will be given in the transcript and write-ups, and any identifiable information will be altered/ removed. Transcripts will be kept in encrypted files on the UEL OneDrive. Consent forms, demographic information and transcripts will all be stored on the UEL One Drive in encrypted files but in different folders to one another (identifiable data will be kept separate to anonymised data). Recordings of the interviews will be deleted immediately following transcription.	
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	Data will be stored on the secure encrypted UEL OneDrive. The files will also be backed up on the researcher’s personal secure OneDrive. The researcher will access such files on a secure, password protected personal laptop. Following examination, transcripts will be stored for three years to allow for the write-up of results and any potential publications – during this time, the anonymised transcripts would be stored on the DoS’s personal encrypted OneDrive. This timeframe will be finalised with the DoS in line with data protection principles.	
4.5	Who will have access to the data and in what form? (e.g., raw data, anonymised data)	The researcher, supervisor and examiners will have access to the anonymised transcripts.	
4.6	Which data are of long-term value and will be retained? (e.g., anonymised interview transcripts, anonymised databases)	Anonymised interview transcripts will be stored securely for three years after examination, to allow for write-ups/ potential publication.	
4.7	What is the long-term retention plan for this data?	The anonymised transcripts will be stored on the supervisor’s personal UEL OneDrive account following examination, in encrypted files. This is so the transcripts can be accessed once the researcher no longer has access to the UEL OneDrive account following course completion.	
4.8	Will anonymised data be made available for use in future research by other researchers?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>

	If yes, have participants been informed of this?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4.9	Will personal contact details be retained to contact participants in the future for other research studies?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, have participants been informed of this?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

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	<p>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.)</p>	<p>YES <input checked="" type="checkbox"/></p>	<p>NO <input type="checkbox"/></p>
	<p>If yes, what are these, and how will they be minimised?</p>	<p>The interviews will be asking participants to talk through their experiences of birth, which has the potential to be triggering and distressing for participants. This will be managed by informing participants of their right to withdraw, reiterating that answering questions is voluntary, reminding participants that they can request breaks, or pause the interview at any point. Interviews can be paused and resumed on another day, or stopped altogether. The researcher will use their clinical skills and clinical judgement to monitor the emotional state of participants, and put measures in place should the participant appear distressed (e.g. regular check-ins throughout interview, pausing interview, stopping interview, etc). Participants will be provided with resources and a list of support groups in the debrief form post-interview.</p> <p>The Birth Trauma Association offered advice on how to manage the sensitive nature of the interviews, and advised that in their experience, individuals welcome the space to talk through their experiences. They said to</p>	

		continuously check-in with participants throughout the interviews, offer breaks and be led by them.		
5.2	Are there any potential physical or psychological risks to you as a researcher?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	
	If yes, what are these, and how will they be minimised?	The researcher will regularly meet with their supervisor, who would provide support should the interviews be emotionally distressing. Adequate time will be had between each interview, to give the interviewer/ researcher a break in between each interview.		
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 <input checked="" type="checkbox"/>		
5.4	If necessary, have appropriate support services been identified in material provided to participants?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
5.5	Does the research take place outside the UEL campus?	YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>
	If yes, where?	Interviews are likely to be conducted remotely, meaning participants will be doing the interviews from their homes or a safe space. The researcher will be conducting the interviews from a safe and confidential space.		
5.6	Does the research take place outside the UK?	YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific 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 been attached as an appendix.	YES <input type="checkbox"/>		

	<p>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.</p>	
5.7	<p>Additional guidance:</p> <ul style="list-style-type: none"> ▪ 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	<p>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</p>	<p>YES</p> <p><input type="checkbox"/></p>	<p>NO</p> <p><input checked="" type="checkbox"/></p>
<p>* 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</p>			

	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 <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
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 <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
6.4	If you have current DBS clearance, please provide your DBS certificate number:	001703546871	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	N/A	
6.5	Additional guidance: <ul style="list-style-type: none"> ▪ 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 <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
	If yes, please provide their details.	The Birth Trauma Association have confirmed that they will help support with recruitment, by advertising the project on their social media platforms/ marketing emails.	
	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	YES <input checked="" type="checkbox"/>	



	institution/organisation). Please confirm that you have attached written permission as an appendix.	
7.2	<p><u>Additional guidance:</u></p> <ul style="list-style-type: none"> ▪ 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 <input checked="" type="checkbox"/>
8.2	Student's name: (Typed name acts as a signature)	Cara Louise James
8.3	Student's number:	U2075209
8.4	Date:	14/02/2022
<i>Supervisor’s declaration of support is given upon their electronic submission of the application</i>		

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:	Anna Stone
Supervisor:	Kenneth Gannon
Student:	Cara James
Course:	Prof Doc in Clinical Psychology
Title of proposed study:	Parents' Perspectives of Birth Trauma During COVID-19

Checklist

(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detailed account of participants, including inclusion and exclusion criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding participants/target sample	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detailed account of recruitment strategy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding recruitment strategy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clear and detailed outline of data collection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Data collection appropriate for target sample	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Concerns regarding data storage (e.g., location, type of data, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding data sharing (e.g., who will have access and how)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, General Risk Assessment form attached	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, Country-Specific Risk Assessment form attached	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, a DBS or equivalent certificate number/information provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All relevant information included in the participant information sheet (PIS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information in the PIS is study specific	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language used in the PIS is appropriate for the target audience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All issues specific to the study are covered in the consent form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language used in the consent form is appropriate for the target audience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All necessary information included in the participant debrief sheet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language used in the debrief sheet is appropriate for the target audience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Study advertisement included	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<p>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.</p> <p>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.</p>
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.
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Decision on the above-named proposed research study

Please indicate the decision:	APPROVED
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Minor amendments

Please clearly detail the amendments the student is required to make

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 <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
	If no, please request resubmission with an <u>adequate risk assessment.</u>	
If the proposed research could expose the <u>researcher</u> 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	<input type="checkbox"/>

	on this basis. If unsure, please refer to the Chair of Ethics.	
MEDIUM	Approve but include appropriate recommendations in the below box.	<input type="checkbox"/>
LOW	Approve and if necessary, include any recommendations in the below box.	<input checked="" type="checkbox"/>
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature

Reviewer: (Typed name to act as signature)	Anna Stone
Date:	01/03/2022

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)	Please type your full name
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Student number:	Please type your student number
Date:	Click or tap to enter a date
<i>Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required</i>	

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught



**University of
East London**

Professional Doctorate students

Please complete this form if

proposed amendment(s) to an ethics application that has been approved by the School of Psychology

you are requesting approval for

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are not to commence until your proposed amendment has been approved.

Required documents

A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	YES <input checked="" type="checkbox"/>
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	YES <input checked="" type="checkbox"/>
A copy of the approval of your initial ethics application.	YES <input checked="" type="checkbox"/>

Details

Name of applicant:	Cara James
Programme of study:	Professional Doctorate in Clinical Psychology
Title of research:	Parents' Perspectives of Birth Trauma During COVID-19
Name of supervisor:	Kenneth Gannon

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Inclusion criterion: Participants will be child-bearers, 18+ years old, who self-identify as having experienced birth trauma during the COVID19 pandemic with related service restrictions (March 2020 to date) in the UK...	Initially, I stated 'from March 2020 until August 2021' to only include those who gave birth during the pandemic with the related maternity restrictions. However, I have since learnt that there are still many COVID19 restrictions remaining in maternity services (including limited support, visitation restrictions etc), and so the end date of 'August 2021' seems somewhat arbitrary and may mean we exclude some people's experiences unnecessarily.
The following exclusion criterion will be removed: 'Parents formally diagnosed with PTSD will also be excluded from the study.'	Initially, participants with a diagnosis of PTSD were to be excluded from the study, to minimise risk of participant distress. However, since conducting the interviews, it has become apparent that most of the participants I have interviewed are experiencing symptoms that may be indicative of PTSD and would probably receive the formal diagnosis if there were to be seen by a psychiatrist. These participants have not been distressed during the interview and instead reported that they valued the space to talk through their experiences and feel they could contribute and make a difference in some way. It therefore feels unreasonable to exclude those who do have the formal diagnosis. I would therefore like to remove this as an exclusion criterion.

Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
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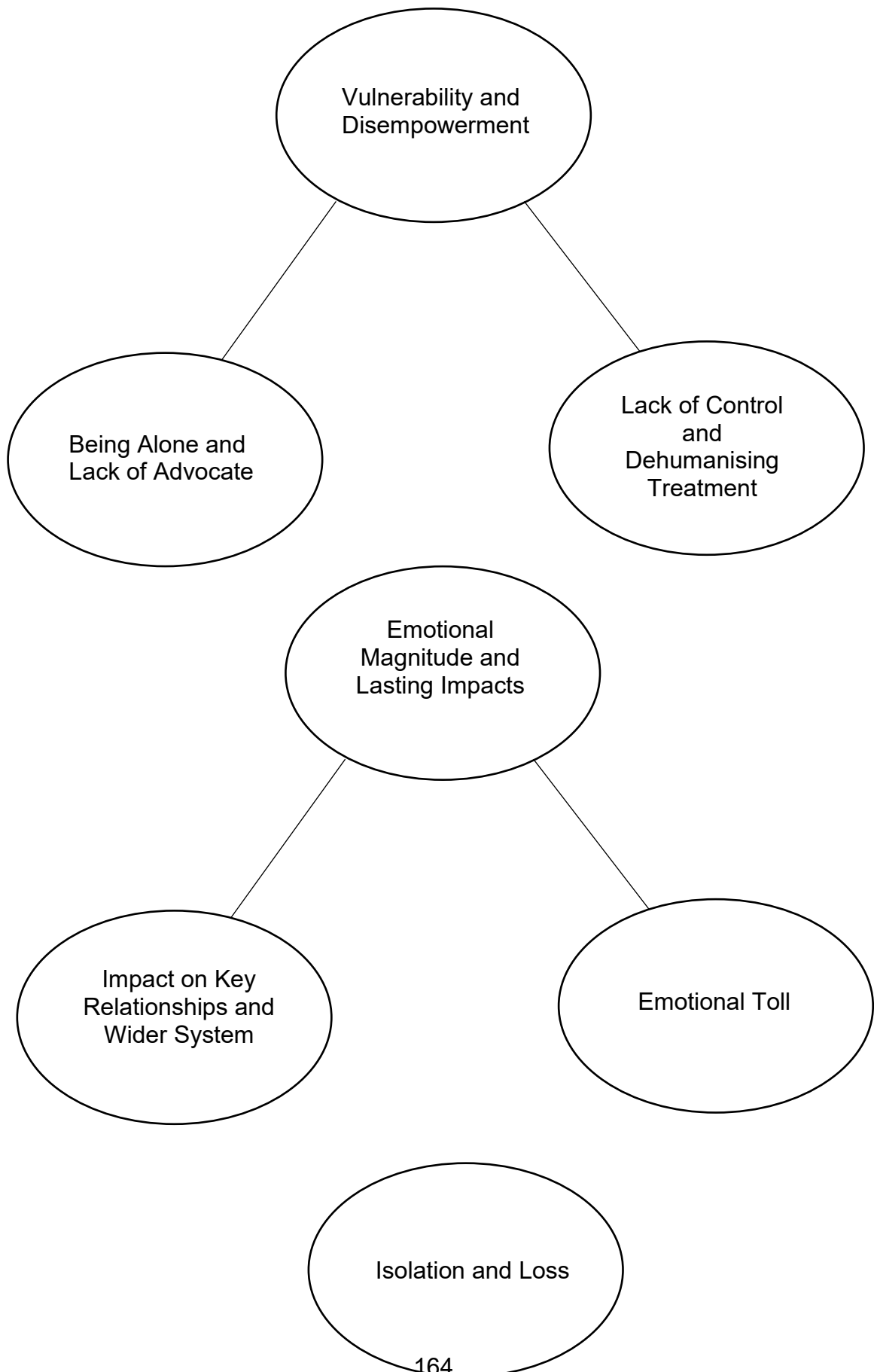
Student's signature

Student: (Typed name to act as signature)	Cara James
Date:	04/05/2022

Reviewer's decision

Amendment(s) approved:	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
Comments:	Please enter any further comments here	
Reviewer: (Typed name to act as signature)	Trishna Patel	
Date:	05/05/2022	

APPENDIX G: Thematic Map



APPENDIX H: Process of Refinement

Please note the codes are summarised and collated - not all codes for each theme are represented

ATTEMPT ONE:

Theme One - Loss

- Subtheme One: Expectation Versus Reality
 - o Loss of what experiences should have been
 - o Painful reminders of what should have been
 - o Birth plans ignored
 - o Feeling detached from experiences
 - o Loss of experiences across all stages
- Subtheme Two: Lost Moments of Shared Experiences
 - o Partners missing out on so much of the maternity journey/ partners exclusion by services
 - o Loss of social support with COVID-19

Theme Two - Injustice

- Subtheme Three: COVID-19 and Medical Negligence/ Harmful Practice
 - o Subpar care due to COVID-19
 - o Incorrect hospital records
 - o Lack of accountability from hospital staff
 - o Harmful/ nonsensical COVID-19 rules, privileged over needs of human beings
 - o Dehumanising treatment / lack of human dignity
 - o Abuse of power and coercive treatment
 - o Support person as a non-negotiable
 - o Broken trust with the healthcare system
- Subtheme Four: Societal Narratives Around Birth
 - o Narrative of blame culture on women for traumatic births
 - o Harmful / problematic media messaging
 - o The forgotten mother
 - o Forced to be silent/ inability to share
 - o Lack of accurate information in mainstream media

Theme Three - Vulnerability and Disempowerment

- Subtheme One: Lack of Control
 - o Choices taken
 - o Lack of informed consent/ choice
 - o Coercive treatment
 - o Things being done to me, not with me
 - o Fear of unknown with COVID-19
- Subtheme Two: Dehumanising Treatment
 - o Violating medical interventions
 - o Being spoken about not to
 - o Poor communication/ kept in the dark
 - o Medical knowledge over embodied experience

- Negative communication with staff (perpetuating fear and blame)
- Barbaric experiences in hospital
- Subtheme Three: Being Alone and Lack of Advocate
 - Alone during labour and postpartum
 - Attending antenatal appointments alone
 - Difficulties making decisions alone / no advocate
 - Minimal communication / kept in the dark

Theme Four - Isolation and Lack of Support

- Subtheme One: Isolation From Family and Friends
 - Feeling let down by family/ friends
 - Invalidation from others / unhelpful responses/ toxic positivity
 - Lack of social support
- Subtheme Two: Lack of Service Support
 - Lack of services across maternity journey – COVID-19 excuse
 - Lack of postnatal support in hospital
 - Lack of aftercare once discharged
 - Lack of antenatal support
 - No mental health support
 - Poor staff support during labour
 - Understaffing in hospital and subsequent minimal support
- Subtheme Three: Isolation
 - Feeling and being alone in hospital during labour and postpartum
 - Being made to feel like a burden
 - Lack of human compassion
 - Isolation of trauma and experiences in hospital – no one will ever understand
 - Stigma in sharing / lack of shared knowledge on birth trauma

Theme Five - Emotional Magnitude and Lasting Impacts

- Subtheme One: Emotional Toll
 - Feelings of anger / resentment for what should have been
 - Anxiety, panic, fear and a sense of uncertainty
 - Experiences of self-blame/ shame and guilt for the birth and related impacts
 - Not feeling happy and having to hide this from others
 - Feeling suicidal/ considering other desperate options
 - Experiences of nightmares, flashbacks, intrusions and other trauma-related symptoms
 - Replaying the birth continuously in mind / obsessive rumination about the birth
 - Experiences of detachment and emotional numbing
 - Not feeling well physically/ sensing something is wrong
 - Emotional labour of trying to find support
- Subtheme Two: Isolation of Trauma
 - No one will ever understand
 - Disconnection from the birth
 - Partners feeling excluded and helpless
 - Impact on future decision making
 - Daily trauma triggers

- Trust – lack of trust in the healthcare system
- Subtheme Three: Impact on Key Relationships
 - Impact on intimacy with partner
 - Impact on parental relationship
 - *Feeling disconnected from partner due to a lack of shared experience*
 - *Emotional connection following adversity*
 - *Changed relationship*
 - Impact on mother and infant relationship / bonding
 - Fiercely protective of infant
 - Difficulties bonding/ detached
 - Needing time to heal, and impact on motherhood
 - Impact on partner and infant relationship
 - Impact of the birth on family
 - Impact on social network – withdrawing and disconnecting

Theme Six - Healing and Empowerment

- Subtheme One: Importance of Validation and Accountability
 - Birth reflections – healing as allow mothers to make sense of experience
 - System providing MH support, for ultimately the harm caused by failures of the system
 - Needing a space to be heard and validated
 - Medical negligence claims / formal complaints, serving to regain a sense of control
- Subtheme Two: Importance of Service Reform
 - Trauma-informed training
 - MH training
 - Staffing issues
 - Injustice of COVID-19 rules, practised over the needs of individuals
- Subtheme Three: Importance of Feeling Valued
 - Importance of proper aftercare
 - Hospitals adequately checking-up on mothers
 - Importance of compassion
 - Importance of communication and accurate information sharing
 - Partner presence as mandatory
 - Human needs prioritised in line with human rights laws

ATTEMPT TWO:

Theme One - Vulnerability and Disempowerment

- Subtheme One: Lack of Control
 - Choices taken
 - Lack of informed consent/ choice
 - Coercive treatment/ abuse of power
 - Medical knowledge privileged over embodied experience (combine with the above)
 - Fear of unknown with COVID-19
 - Poor communication/ kept in the dark

- Medical negligence claims / formal complaints, to regain a sense of control
- Birth reflections as healing, allowing mothers to make sense of experience and regain sense of control
- Subtheme Two: Dehumanising Treatment
 - Violating medical interventions
 - Being spoken about not to
 - Things being done to me, not with me
 - Barbaric experiences in hospital
 - Harmful/ nonsensical COVID19 rules and hospital policies, privileged over the needs of human beings
 - Dehumanising treatment / lack of human dignity
 - Importance of being treated with common sense of humanity
- Subtheme Three: Being Alone and Lack of Advocate
 - Alone during labour and postpartum
 - Attending antenatal appointments alone
 - Difficulties making decisions alone / no advocate
 - Minimal communication / kept in the dark
 - Support person as a non-negotiable
 - Being made to feel like a burden / lack of human compassion
 - Importance of compassion
 - Partner presence as mandatory

Theme Two – Inadequate and Unacceptable Care

- Subtheme One: Lack of Service Support
 - Lack of services across maternity journey – COVID-19 excuse
 - Lack of postnatal support in hospital
 - Lack of aftercare once discharged
 - Lack of antenatal support
 - No mental health support
 - Poor staff support during labour
- Subtheme Two: Lack of Accountability
 - Lack of accountability from hospital staff / complacency
 - Incorrect hospital records / wrong records
 - Accountability - Validation and need to be heard
 - System should provide MH support
- Subtheme Three: Unsafe Services
 - Lack of trust in the healthcare system
 - Medical negligence / cutting corners / medical complications
 - Understaffing in hospital and subsequent minimal support/ subpar care
 - Service reforms suggested by participants that might help
 - Trauma-informed training
 - MH training
 - Staffing issues
 - Individual needs over COVID-19 rules
 - Importance of proper aftercare
 - Hospitals adequately checking-up on mothers
 - Importance of compassion
 - Importance of communication and accurate information sharing

Theme Three - Emotional Magnitude and Lasting Impacts

- Subtheme One: Emotional Toll
 - Feelings of anger / resentment for what should have been
 - Anxiety, panic, fear and a sense of uncertainty
 - Experiences of self-blame/ shame and guilt for the birth and related impacts
 - Not feeling happy and having to hide this from others
 - Feeling suicidal/ considering other desperate options
 - Experiences of nightmares, flashbacks, intrusions and other trauma-related symptoms
 - Replaying the birth continuously in mind / obsessive rumination about the birth
 - Experiences of detachment and emotional numbing
 - Not feeling well physically/ sensing something is wrong
 - Emotional labour of trying to find support
- Subtheme Two: Impact on Relationships and Wider System
 - Impact on intimacy and experiences of bodily safety
 - Impact on parental relationship
 - Feeling disconnected from partner due to a lack of shared experience
 - Emotional connection following adversity
 - Changed relationship
 - Impact on mother and infant relationship / bonding
 - Fiercely protective of infant
 - Difficulties bonding/ detached
 - Needing time to heal, and impact on motherhood
 - Impact on partner and infant relationship
 - Impact of exclusion on partner's emotional wellbeing
 - Impact of the birth on future decision-making (choosing not to have children anymore etc)
 - Impact of the birth on family
 - Impact on social network – withdrawing and disconnecting
 - Broken trust with a system there to protect – feeling let down
- Subtheme Three: Isolation in Experience, Perpetuated by Social Narratives and Responses
 - Negative communication with staff (causing fear and blame)
 - Isolation of the trauma – no one will ever understand
 - Feeling let down by family/ friends
 - Invalidating from others / unhelpful responses/ toxic positivity
 - Lack of social support
 - Blame culture on women
 - Harmful / problematic media narrative
 - The forgotten mother
 - Narrative of blame on mother when things go wrong
 - Be silent / inability to share/ lack of information in mainstream
 - Stigma in sharing / lack of shared knowledge on birth trauma

Theme Four – Loss and Isolation

- Subtheme One: Expectation Versus Reality

- Loss for what experiences should have been
- Painful reminders of what should have been
- Birth plans ignored/ disrupted
- Feeling detached from experiences
- Loss of experiences across all stages
- Anger and resentment for what should have been
- Subtheme Two: Lost Moments of Shared Experiences
 - Though some did recognise the benefits of covid19 - being more time at home with partner
 - Partners missing out on so much of the maternity journey/ partners exclusion
 - Loss of social support with covid19
 - Negative communication with staff (causing fear and blame)
 - Isolation of the trauma – no one will ever understand
 - Feeling let down by family/ friends
 - Invalidation from others / unhelpful responses/ toxic positivity
 - Lack of social support
 - Of the blame culture on women
 - Harmful / problematic media narrative
 - The forgotten mother
 - Narrative of blame on mother when things go wrong
 - Be silent / inability to share/ lack of information in mainstream
 - Stigma in sharing / lack of shared knowledge on birth trauma

ATTEMPT THREE:

Theme One - Vulnerability and Disempowerment

- Subtheme One: Lack of Control
 - Choices being taken
 - Lack of informed consent
 - Coercive treatment/ abuse of power
 - Medical knowledge over embodied experience
 - Fear of unknown with covid19
 - Poor communication/ kept in the dark
 - Complaints and Medical negligence claims / formal complaints - to regain a sense of control
 - Birth reflections – healing as allow mothers to make sense of experience and regain some sense of control
 - Sensing something is wrong
 - Medical complications
 - Birth plans impacted
 - Assisted delivery methods
- Subtheme Two: Dehumanising Treatment
 - Violating medical interventions
 - Being spoken about not to
 - Things being done to me, not with me
 - Barbaric experiences in hospital
 - Nonsensical / Harmful COVID19 rules being, privileged over needs of human beings

- Inhumane treatment (and lack of human dignity)
- Importance of being treated with dignity, compassion and being listened to, like an equal human being
- Importance of mothers' needs being adequately tended to and valued
- Human needs prioritised in line with human rights laws, over and above statutory or service needs
- Subtheme Three: Being Alone and Lack of Advocate
 - Alone during labour and postpartum
 - Attending antenatal appointments alone
 - Partner not being there to advocate/ Difficulties making decisions alone, without an advocate/ partner not there to advocate
 - Support person as a non-negotiable / partner presence as mandatory
 - Being made to feel like a burden / lack of human compassion

Theme Two – Inadequate and Unacceptable Care

- Subtheme One: Lack of Service Support and Sub-par Care
 - Lack of services across maternity journey – COVID-19 excuse
 - Lack of postnatal support and physical health checks
 - Lack of aftercare once discharged
 - Lack of antenatal support
 - Lack of mental health support
 - Lack of staff support
 - Problematic communication/ blaming and shaming
 - Miscommunication of information shared/ lack of information sharing
 - Too little too late
 - System should provide MH support, for ultimately the harm caused by failures of the system
 - Compassion and support as helping to mitigate experiences of trauma
 - Importance of adequate support to aid effective recovery
- Subtheme Two: Lack of Accountability
 - Unhelpful hospital responses / Lack of accountability from hospital staff / complacency
 - Incorrect hospital records / wrong records
 - Need to be heard and experiences not forgotten - birth reflections helping with this.
 - Need for Accountability, validation and to be heard
 - Importance of accountability
- Subtheme Three: Unsafe Services
 - Medical negligence / cutting corners / medical complications
 - Understaffing in hospital and subsequent minimal support/ subpar care
 - Service reforms suggested by participants that might help make services safer:
 - Trauma-informed training
 - MH training
 - Staffing issues
 - Individual needs over covid19 rules
 - Importance of proper aftercare
 - Hospitals adequately checking-up on mothers
 - Importance of compassion
 - Importance of communication and accurate information sharing

- (re-distribute to other headings)
- Failed medical interventions

Theme Three - Emotional Magnitude and Lasting Impacts

- Subtheme One: Emotional and Physical Toll
 - Feelings of anger / resentment for what should have been
 - Anxiety, panic, fear and a sense of uncertainty
 - Experiences of self-blame/ shame and guilt for the birth and related impacts
 - Not feeling happy and having to hide this from others
 - Feeling suicidal/ considering other desperate options or coping strategies
 - Experiences of nightmares, flashbacks, intrusions and other trauma-related symptoms
 - Replaying the birth continuously in mind / obsessive rumination about the birth
 - Experiences of detachment and emotional numbing
 - Not feeling well physically/ sensing something is wrong
 - Emotional labour of trying to find support
 - Feeling changed as a person
- Subtheme Two: Impact on Key Relationships, the Family System and Wider Network
 - Impact on physical intimacy and experiences of bodily safety
 - Impact on parental relationship
 - Feeling disconnected from partner due to a lack of shared experience
 - Emotional connection following adversity
 - Changed relationship
 - Impact on mother and infant relationship / bonding
 - Fiercely protective of infant
 - Difficulties bonding/ detached
 - Needing time to heal, and impact on motherhood
 - Impact of the birth on future decision-making (choosing not to have children anymore etc)
 - Impact on social network – withdrawing and disconnecting, and impact on family
 - Impact on relationship with services - broken trust
 - Impact on partner and family unit
 - Partner's difficulties in bonding with the baby
 - Impact on family unit

Theme Four – Social Narratives, Expectation and Loss

- Subtheme One: Social Narratives and Responses, Perpetuating Isolation/ Distress
 - Isolation of the trauma – no one will ever understand
 - Invalidation from others / unhelpful responses/ toxic positivity
 - Lack of social support
 - Unhelpful / Harmful / problematic media narrative
 - The forgotten mother (vessel during pregnancy, lack of care post-birth, all focus on new-born)

- Stigma in sharing / lack of shared knowledge on birth trauma/ inability to share
- Finding comfort in talking to others who have been through something similar
- Narrative of blame on mother when birth goes 'wrong'
- Negative communication with staff (causing fear and blame)
- Subtheme Two: Expectation Versus Reality
 - Painful reminders of what should have been
 - Birth plans ignored/ disrupted
 - Missing out with COVID-19 / Loss of experiences across all stages
 - Anger and resentment for what should have been
 - Feeling detached from experiences
 - Loss for what experiences should have been
- Subtheme Three: Lost Moments of Shared Experiences
 - Positive pregnancy experiences in COVID-19
 - Partners missing out on so much of the maternity journey/ partners exclusion
 - Isolation and lack of social support with covid19
 - Lost moments of shared experiences

ATTEMPT FOUR (FINALISED VERSION):

Theme One - Vulnerability and Disempowerment

- Subtheme One: Lack of Control
 - Choices being taken away and birth plans ignored
 - Lack of informed consent / choice
 - Coercive treatment/ abuse of power
 - Violating medical interventions – 'things being done to me, not with me'
 - Medical knowledge privileged over embodied experience
 - Fear of unknown with COVID-19
 - Poor communication/ kept in the dark / miscommunication of information shared
 - Blaming or shaming staff responses
 - Being spoken 'about not to' during labour
 - Lack of compassion, empathy and human dignity
 - Dehumanising treatment
 - Pain relief being withheld
 - Complaints and Medical negligence claims / formal complaints, to regain a sense of control
 - Birth reflections as healing as allow mothers to make sense of experience and regain a sense of control
 - Medical complications
- Subtheme Two: Being Alone and Lack of Advocate
 - Alone during labour and postpartum, without partner or support person
 - Attending antenatal appointments alone
 - Lack of staff support in hospital
 - Understaffing / inadequate staffing levels
 - Physical struggles recovering in hospital alone
 - Non-sensical COVID-19 hospital rules

- Injustice of the rules in the context of the restrictions in place in broader society
- Partner not being there to advocate/ Difficulties making decisions alone
- Support person should be non-negotiable / partner presence as mandatory
- Being made to feel like a burden / lack of human compassion

Theme Two: Emotional Magnitude and Lasting Impacts

- Subtheme One: Emotional Toll
 - Feelings of anger / resentment for what should have been
 - Anxiety, panic, fear and a sense of uncertainty
 - Experiences of self-blame/ shame and guilt for the birth and related impacts
 - Not feeling happy and having to hide this from others
 - Feeling suicidal/ considering other desperate options or coping strategies
 - Experiences of nightmares, flashbacks, intrusions and other trauma-related symptoms
 - Replaying the birth continuously in mind / obsessive rumination about the birth
 - Experiences of detachment and emotional numbing
 - Not feeling well physically/ sensing something is wrong
 - Emotional labour of trying to find support
 - Feeling changed as a person
- Subtheme Two: Impact on Key Relationships and Wider System
 - Impact on physical intimacy and experiences of bodily safety
 - Impact on parental relationship
 - Feeling disconnected from partner due to a lack of shared experience
 - Emotional connection following adversity
 - Changed relationship
 - Impact on mother and infant relationship / bonding
 - Fiercely protective of infant
 - Difficulties bonding/ detached
 - Needing time to heal, and impact on motherhood
 - Impact of the birth on future decision-making (choosing not to have children anymore etc)
 - Impact on social network – withdrawing and disconnecting, and impact on family
 - Impact on relationship with services - broken trust with the healthcare system
 - Impact on partner and family unit
 - Partner's difficulties in bonding with the baby
 - Impact on family unit

Theme Three – Isolation and Loss

- Isolation of the trauma – no one will ever understand
- Invalidation from others / unhelpful responses/ toxic positivity
- Loss of social and community support in the pandemic
- Unhelpful and problematic media and cultural narratives around birth

- The forgotten mother
- Stigma in sharing negative birth experiences
- Lack of shared knowledge on birth trauma
- Finding comfort in talking to others who have been through something similar
- Narrative of blame on mother when things go wrong in birth
- Unhelpful / invalidating hospital responses
- Lack of accountability from services
- Harmful effects of antenatal courses or information shared from professionals
- Lost moments of shared experiences with family and friends

APPENDIX I: Extracts of Coded Transcripts

CJ: And did it impact your relationship with other people like family or friends?

P15: It was just a bit sad, wasn't it, that? You know, I don't think my partner's mum held [new-born] till he was maybe three months old. Maybe longer. I can't even remember. We did see them, but it was all, like, spread out in the garden. Umm. I didn't. I don't think it affected our relationships other than it was just a very sad time that people couldn't visit. My parents couldn't come as planned. I couldn't see my family. Yeah. Accepting that you know, my family have still not met him now we're hoping to go back at the end of the year. So yeah. But it's just accepting the fact that you've missed all those moments that you you can't get back. Yeah. It's quite , it was just sad. Yeah, of course. Weirdly, when restrictions started easing, this is not a nice feeling, but I felt quite jealous of the woman when I would read that partners were allowed back in. Umm. That would make me feel like why do they get that and I didn't get it? Like why not me? And that's not at anyone I know. It was like more just generally at other people.

CJ: Yeah, of course. And did the what happened, the birth and the period afterwards, did it impact your relationship with your baby at all?

P15: No, I don't so other than really just struggling to feel like quite joyful about it. Yeah. But the struggles were more within myself.

Codes:

Impact on wider family.

Social isolation during COVID19.

Lost moments of shared experiences.

Resentment and anger at what should have been.

Painful reminders of what could have been.

Struggling to feel happiness.

P15: I think the big thing is I don't think that I don't think partners, or at least one birth partner being there, is like an optional thing. I don't think it should ever be taken away from a woman. I really, really relied on him for support during early labour at home, so I know guaranteed that if he was around, yes it would have still probably been the same birth, maybe I still would have needed forceps, I probably would have still had the epidural, but it felt like if he was there, it wouldn't have been as bad, because then it's just the normal stresses of you have a poorly baby and you have to spend more time in hospital, but I don't think that I would have gone through what I did mentally? I think being left alone when you're like at your most vulnerable, physically and mentally. I just I just don't think it's fair and I, I do understand, not much was known about the pandemic at that time. But it is inhumane. How we were treated.

P15: And also at that time people could go to the pub. Yeah. And the football was on and people were gathering in crowds, it was disgusting really. Like yeah. So I think you know that that should never have happened and that should never happen again. I think ohh another suggestion, but I did a birth reflection like a debrief with the hospital, but I only found out about that from the osteo, I didn't know about it. But I did it in the December, I think I requested it in the June. I think it would be a helpful thing if all women did that, or if it was like offered as part of the end of your like, postnatal care. I think you have to request them, specifically, but I did find

Codes:

Birth support person should be a non-negotiable.

Emotional toll of recovering in hospital alone.

Inhumanity of being left alone at most vulnerable.

Injustice of the hospital restrictions in the context of the COVID-19 rules in general society.

Birth reflections should be mandatory, standard practice and offered to all birthing people.

that quite helpful, from like a medical point of view to talk about what happened, cos there were all the missing pieces in my head, like why we needed to use the forceps and what had happened to him. And it was like it was a good way of helping explain what had happened and for it to make more sense. I don't think that's a standard. I think you do have to ask for one, but it was only a 45 minute like phone call. I just think that something like that would be really good for women, no matter what birth you have had, even out of the pandemic to just like go through what's happened and not so late that you can't undo thoughts because I struggled with even feeling guilty about having the epidural because I thought maybe I was the reason why he needed the forceps or I thought, cause I had the epidural it meant that there were then more complications and I couldn't push as well. I thought that I wasn't pushing good enough like I had all these thoughts go on for those like six months and then when I did have my debrief, the Doctor was able to, like, talk those things through and tell me that of course, that's not my fault. But by then I had a good, you know, six months of me thinking I could have changed the way I gave birth, which isn't very nice, and that's not pandemic related. I suppose that's just giving like birth. Generally, yeah. Umm that really that that would be a good service.

Birth reflections as healing, in helping to make sense of experiences with a medical professional.

Birth reflections should be mandatory, standard practice and offered to all birthing people.

Feelings of guilt for what happened during the birth.

Birth reflections/ debrief as helping with feelings of guilt over birth experiences.

P9: I ended up being there for a week. On my own with my son. Without my husband. I went days without seeing a doctor. Umm, they pumped me with medication and left me on my own. They offered to look after him for me, and when they did, I could hear him screaming down the corridor as they left him alone. And I physically couldn't get out of bed to go get him. And they told me they were gonna bring my husband back in so that I had some support, and then they changed their minds. And so they let me go outside and see him. But [new-born] wasn't allowed to come with. So my husband went a week without seeing him.

CJ: That sounds awful.

P9: Umm and I got to a point where. Like mentally, I was just crashing and I said to. Oh I got told I wasn't bonding with my son because I wasn't well enough to like pick him up or anything. I just got made to feel really awful. I would just be laying there thinking I just need to see someone like 1 member of my family, my husband just for five minutes, someone to hold him so I can go have a shower. Like I haven't had a shower since labour, like, I haven't brushed my teeth for days. Like I can't do anything. Because my son needs me. And I had to like, ask someone to get me milk every time I needed milk, and I was just becoming a hindrance, it felt, to everyone around me. I was taking up space. But no one was doing anything and I said I got to a point where I said to the nurse, listen, if you don't get a doctor here to see me today, I'm gonna send my son out and I'll just stay here on my own. Because if you need me to get to a certain level of health, to go home, I can't do that and look after a baby. I said it's not possible.

Codes:

Recovering in hospital alone without partner support.

Lack of staff support on postnatal wards.

Helplessness, recovering in hospital alone.

Physical toll of recovering in hospital alone.

Problematic communication with staff.

Nonsensical COVID19 rules.

Partner missing out on early bonding experiences with infant.

Emotional toll of recovering in hospital alone.

Blaming / shaming comments from staff, perpetuating self-blame.

Vulnerability, recovering in hospital without a support person.

Lack of human dignity, recovering in hospital alone.

Being made to feel like a hindrance / burden on postnatal wards.

Physical toll of recovering in hospital alone.

P9: And I was so unwell, I was obviously recovering from C-section as well. But three days after my C-section, I was moving bags on my own, heavy bags, lifting my son up, doing all these things that they shouldn't be doing because no one else was there to help me. Nothing. And. And then I. It took me probably about six months to bond with him, like to really bond with him. I loved him, but I didn't feel like he was my son because I wasn't present for the birth and no one really ever helps you with that. I had no support. I went to the doctor and I said, look, I I think I'm really struggling with depression, postnatal depression and he was like the best I can do, because of COVID, is write a letter to say that you need support, but you're gonna have to go out and find it by yourself and I said I I said I'm not well enough to do that. I'm not. And he said that's all I can do.

CJ: So they didn't offer you mental health support?

P9: No, I basically did it all by myself. And after about six months I started to feel human again and I started to really connect with my son. I was having nightmares that he was stuck in a box every single night. Every time I held him, I cried. But after about six months we really started like the turn around because now I'm, like, obsessed with him. And it's like it's the end of the other end of the scale, I am now overly attached, we can't be apart. But my husband was obviously suffering as well mentally, like the first week of the child's life is the most important week. But he wasn't there. I bought a baby home to him and he did not know what to do with him. Actually, the first six months my son had really slow development. And he wasn't making

Codes:

Physical toll of recovering in hospital alone.

No support on postnatal wards.

Impact on mother-to-infant relationship and difficulties with bonding.

Lack of mental health support.

Emotional labour of looking for mental health support.

Impact on bonding between mother and infant.

Experiences of nightmares.

Impact on attachment relationship between mother and infant.

Emotional impact of exclusion from hospital on partners.

Partner missing out on early bonding experiences with infant.

eye contact. He wasn't showing emotion. We had to take him to specialists. Which they think is part of it all with the trauma, because obviously they feed off your energy. But he's absolutely normal, in fact, he excels now. Yeah. Yeah. And from about a year on, I really wanted to do something because I I felt really let down.

CJ: Of course.

P9: And they started saying ohh, you know, you could have partners in the hospital now that you know what? How amazing is that? Like, what a thing to celebrate? And I kept thinking, but what about all those women that didn't? Yeah, yeah. Umm. And I just felt so let down, so I had meetings with the hospital and that bought some form of closure, but not enough really. I appreciate the hospitals did everything they could in those times, but I don't think anyone really understands the magnitude of how it affects you forever. And we've already said we're not having anymore children, because of the health risk on me, but also I would not cope if it didn't go well. You do continue to live with it and it's it's affecting me in like I've never been myself again since before and smallest things remind you of, of how awful it was. And you try and explain it to people, but no one will ever really understand how bad it was to sit and listen to a room of women cry all on their own and no one comes to them. No one does anything. It's almost a bit like, did that really even happen? Because of how awful it was. Umm. You know. It was, it was awful. It was horrendous.

Impact on infant's socioemotional development.

Resentment and anger for what should have been.

Feeling let down by services.

Hospital debriefs enabling closure.

Magnitude of experience, and impact on future decisions to have more children.

Feeling changed as a person.

Daily reminders of traumatic experiences.

No one will ever truly understand.

Disbelief and disconnect from traumatic experiences.

Inhumanity of being left alone at most vulnerable.