

Women's experience of posttraumatic growth following a traumatic birth

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Submitted in accordance with the requirements for the degree of
Doctor of Clinical Psychology (D. Clin. Psychol.)

The University of Leeds

School of Medicine

Academic Unit of Psychiatry and Behavioural Sciences

August 2019

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Acknowledgements

It is with great gratitude that I thank and dedicate this thesis to the women who supported this study: in particular the eight women who shared their stories of adversity and growth with me, but also all of the other women who wanted but were unable to participate in this research and have their stories heard.

Secondly, thank you to my supervisors Zoe Darwin, Ciara Masterson and Linda McGowan for your invaluable guidance and wisdom throughout this research. I greatly appreciate the essential support and energy you all provided.

Thank you to my family, particularly Mum, Ella and Alice for your unwavering support and your belief in me. Thank you to my friends, housemates and cohort. Your patience, encouragement, entertainment and nourishment have pulled me through it.

I would like to thank the Max Hamilton Fund for its helpful financial contribution to this study. I am also grateful to the Birth Trauma Association and the National Childbirth Trust for their support with recruitment and promotion. Thank you to Rebecca Dickinson for generously giving up your time and passing on your insights.

Abstract

Introduction: Research demonstrates that some people experience positive benefits through struggling to cope with traumatic life events, leading to the development of theories of 'posttraumatic growth'. More recently this has included an acknowledgment that common difficult experiences such as childbirth can also generate both traumatic stress and traumatic growth responses. Research on posttraumatic growth following a traumatic birth is still limited. This research project aimed to contribute to the emerging knowledge base by conducting an in-depth study with women who have experienced posttraumatic growth following a traumatic birth.

Method: A qualitative approach using Interpretative Phenomenological Analysis was used to explore in-depth the experiences of women who self-identified as having found positive benefits through coping with a traumatic birth. Eight women who had given birth in the past five years were interviewed.

Results: Three superordinate themes were identified with two, four and five subordinate themes respectively. The three superordinate themes were "*The total opposite to what I'd expected*", "*I see it a bit differently now*" and "*A much better place*".

Discussion: The themes provide an insight into both the journey to growth experienced by the participants and the experience of growth 'outcomes' following a traumatic birth. Societal and cultural influences on participants' pre-conceptions of birth led to a difference between their expectation and the reality of their experience that challenged their sense of identity as women and mothers. In overcoming these challenging experiences, participants described a process of actively striving to cope and make sense of their experience. A variety of factors facilitated this, notably partner support, the opportunity to tell their story, acknowledging the impact of the birth and developing a compassionate narrative. Growth was experienced in ways that are commonly reported by survivors of challenging life events, with some aspects of growth appearing more specific to birth trauma.

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1. Introduction

This chapter begins with an overview of relevant issues in perinatal and maternal mental health, including the impact of birth trauma. This is followed by a summary of the posttraumatic growth literature and the available research on posttraumatic growth as it relates to birth. The chapter ends with the rationale for this study. A glossary of terms relating to pregnancy and birth can be found in Appendix A.

1.1 Maternal mental health

Good maternal mental health has been defined as “a state of well-being in which a mother realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community” (Herrman et al., 2006). The term ‘perinatal mental health’ covers mental health during pregnancy and in the first year after birth (NICE, 2014). The NHS ‘Long Term Plan’ (NHS England, 2019) commits to extending support from specialist perinatal mental health services to two years after birth.

Although women benefit from a decreased risk in what is termed ‘Severe Mental Illness’ (e.g. psychosis) during pregnancy, in the postnatal period the risk of developing mental health problems, from mild through to severe, increases (Confidential Enquiry into Maternal and Child Health, 2007). A significant number of women are affected by perinatal mental health problems. Recent research suggests that 27% of women experience mental health problems of some description during pregnancy (Howard et al., 2018). Around 10% of pregnant women and 13% of women in the postnatal period are believed to experience mental health problems, most commonly in the form of postnatal depression and anxiety (Fisher et al., 2012). This includes ‘diagnosable’ anxiety disorders such as Panic Disorder, Specific Phobia, Obsessive Compulsive Disorder (OCD) and Generalised Anxiety Disorder (GAD) with higher levels of OCD and GAD found in the postnatal population than the general population (Ross & Mclean, 2006).

There is a known impact of poor maternal mental health on child development and the mother-baby relationship (Ayers, McKenzie-McHarg, & Slade, 2015). Antenatal mental health problems are associated with poorer child behavioural outcomes (O'Donnell et al., 2014). Postnatal anxiety and depression have been linked to disruptions in mother-baby bonding and attachment, increasing the subsequent risk of poor mental health for the child. A 2010 systematic review of the impact of postnatal anxiety on the child found somatic, developmental and psychological consequences (Glashen, Richardson & Fabio, 2010). There is also an economic cost. A 2014 report into the economic cost of poor perinatal mental health calculated that the financial burden to the NHS is £1.2 billion per one-year cohort of births, rising to a long term cost to society of £8.1 billion per cohort (Bauer et al, 2014). Almost three quarters (72%) of this related to adverse impacts on the child.

Table 1
Summary of DSM-V criteria for PTSD (American Psychiatric Association, 2013)

DSM-V Criteria	Ways in which the criteria can be demonstrated
<p>Criterion A: stressor The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (one required)</p>	<ul style="list-style-type: none"> • Direct exposure. • Witnessing the trauma, in person. • Indirectly, by learning that a close relative or close friend was exposed to trauma. • Indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders).
<p>Criterion B: intrusion symptoms The traumatic event is persistently re-experienced (one required)</p>	<ul style="list-style-type: none"> • Intrusive thoughts: Recurrent, involuntary, and intrusive memories. • Nightmares. • Dissociative reactions (e.g., flashbacks) • Intense or prolonged distress after exposure to traumatic reminders. • Marked physiologic reactivity after exposure to trauma-related stimuli.
<p>Criterion C: avoidance Avoidance of trauma-related stimuli after the trauma (one required)</p>	<ul style="list-style-type: none"> • Trauma-related thoughts or feelings. • Trauma-related external reminders (e.g., people, places, conversations or situations).

<p>Criterion D: negative alterations in cognitions and mood Negative thoughts or feelings that began or worsened after the trauma (two required)</p>	<ul style="list-style-type: none"> • Inability to recall key features of the trauma • Overly (and often distorted) negative thoughts and assumptions about oneself or the world • Exaggerated blame of self or others for causing the trauma event or for resulting consequences. • Negative affect / trauma-related emotions (e.g., fear, horror, anger, guilt, or shame). • Decreased interest in (pre-traumatic) activities. • Feeling isolated (e.g., detachment or estrangement). • Difficulty experiencing positive affect / persistent inability to experience positive emotions.
<p>Criterion E: alterations in arousal and reactivity Trauma-related alterations in arousal and reactivity that began or worsened after the trauma (two required)</p>	<ul style="list-style-type: none"> • Irritability or aggression • Risky or destructive behaviour • Hypervigilance • Heightened startle reaction • Difficulty concentrating • Difficulty sleeping

1.1.1 Posttraumatic stress following birth

Although research has historically focused on postnatal depression, there is increasing recognition that maternal mental health problems are much broader than this and include a range of traumatic stress responses. To be given a diagnosis of Posttraumatic Stress Disorder (PTSD), a person must meet the criteria laid out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V, American Psychiatric Association, 2013). These criteria are summarised in Table 1. Symptoms must have been present for at least one month and cause distress or functional impairment.

Early diagnostic criteria for PTSD required that the triggering traumatic event be “outside the normal range of experience” (American Psychiatric Association, 1987). Much early work on PTSD focused on the experiences of war veterans, and so for some time the triggering traumatic events associated with PTSD were on the scale of war, rape and natural disasters. Over time it has become

increasingly acknowledged that PTSD can result from events that are not inherently unusual or severe, with an increased recognition of the subjective nature of trauma (Ayers & Pickering, 2001). The most recent, 5th, edition of the DSM allows for PTSD following any event where the person was “exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence” (American Psychiatric Association, 2013). This relaxation of the diagnostic criteria acknowledges research into the development of PTSD following more everyday experiences such as a difficult experience of childbirth.

Not everyone who experiences a traumatic event will go on to develop PTSD. Kessler et al. (1995) estimate the risk of developing PTSD after a traumatic event at 8.1% for men and 20.4% for women. Prevalence can be difficult to accurately determine due to social and cultural differences and differences in methods used to identify PTSD (Shaban et al., 2013). Prevalence estimates of clinically significant PTSD in the general population of perinatal women typically range from 1.7% to 3.17%, increasing to between 15% and 18% for women in high-risk groups such as those experiencing stillbirth (Wijma, Soderquist, & Wijma, 1997; Grekin & O’Hara, 2014; Yildiz, Ayers & Phillips, 2017).

There is increasing evidence that birth-specific events can contribute directly to maternal mental health problems. Alcorn et al. (2010) recruited 933 women in their third trimester of pregnancy and interviewed them at several time points to determine the presence of PTSD, depression and anxiety. Participants were interviewed during the last trimester of pregnancy, 4–6 weeks postpartum, 12 weeks postpartum and 24 weeks postpartum. After controlling for symptoms of anxiety and depression during pregnancy and pre-existing PTSD, Alcorn et al. found that PTSD rates were 1.2% at 4–6 weeks, 3.1% at 12 weeks and 3.1% at 24 weeks postpartum. All women in their study who went on to develop PTSD experienced at least one of the following events: an episiotomy, a perineal tear, use of forceps or vacuum instruments to assist vaginal birth, general anaesthetic, emergency Caesarean, baby being placed in a neonatal intensive care unit, baby being born with a medical illness or disability, premature birth, mother or baby experiencing an injury during labour or birth, mother experiencing a medical

complication and other obstetric complications during birth. However, 80.1% of their sample of women attending an antenatal clinic reported experiencing at least one of these events, suggesting that these birth-specific events do not lead to PTSD in all cases.

Other risk factors have also been identified. In Ayers et al.'s (2016) meta-analysis of 50 studies into the aetiology of PTSD following birth, negative subjective birth experiences (which includes overall ratings of the birth experience, negative emotions and distress, and control and agency), lack of support and dissociation were among the 'in-birth' experiences most strongly associated with PTSD. Such findings are reflected in guidance from the National Institute for Health and Care Excellence on perinatal mental health which states that the term 'traumatic birth' should include "*births, whether preterm or full term, which are physically traumatic (for example, instrumental or assisted deliveries or emergency caesarean sections, severe perineal tears, postpartum haemorrhage)*" and "*births that are experienced as traumatic, even when the delivery is obstetrically straightforward*" (NICE, 2014).

Research shows that up to a third of women rate their experience of birth in a way that meets the perceived threat requirement in the DSM-IV diagnostic criteria for PTSD (Olde, Kleber, Hart, & Pop, 2006). However, White et al. (2006) demonstrated that many women in the perinatal period do not meet the threshold for PTSD but nonetheless experience significant trauma symptoms. They recruited 400 women who had recently given birth from a postnatal ward and administered a range of questionnaires including the Post-traumatic Stress Symptom Scale (PSS-SR, Foa et al., 1993) at six weeks, six months and 12 months post-partum. At six weeks post-partum, 2% of women met the criteria for PTSD and a further 10.5% did not meet full diagnostic criteria, but were classed as experiencing 'subclinical posttraumatic stress' as they met DSM-V criteria B, C and D (as summarised in Table 1). At six months post-partum 2.6% of women met full PTSD criteria and 5.9% were in the subclinical category. At 12 month follow up 2.4% met full PTSD criteria and 5.5% were in the subclinical category. With this in mind, White et al. suggest that traumatic responses following birth are better understood as a continuum, rather than in categories of presence or

absence of PTSD, as the boundaries of such categories can be arbitrary and do not fully capture women's experience of trauma following a difficult birth. White et al. also highlight that the currently available self-report measures of PTSD have not been validated with women in the post-partum period and often lack specificity meaning that such tools may not be capturing symptoms specific to birth trauma. There have been recent attempts to remedy this, for example the development of the City Birth Trauma Scale (Ayers, Wright & Thornton, 2018). This is a 29-item questionnaire designed to measure birth-related PTSD using DSM-V criteria that has been found to have high reliability (Cronbach's $\alpha = 0.92$) (Ayers, Wright & Thornton, 2018). The authors of the scale found that removing the item measuring an inability to remember details of the traumatic event (from DSM-V Criterion D) increased internal reliability. They suggest this item might not be as relevant to postpartum women as other trauma populations, possibly because birth experiences are subject to more attention, discussion and repetition.

Tokophobia is the extreme fear of birth, and can be categorised as either 'primary' in women who have never experienced birth or 'secondary' in women who have experienced birth (Bhatia & Jhanjee, 2012). In most studies women who are pregnant for the first time score higher on measures of fear of birth, such as the Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ, Wijma et al., 1998), than women who have previously experienced birth (Nieminen, Stephansson & Ryding, 2009). However, women who have experienced a traumatic birth are more likely to experience 'intense fear of birth' as indicated by a score ≥ 85 on the W-DEQ (Nieminen, Stephansson & Ryding, 2009).

Traumatic stress responses following a difficult birth can also impact on future reproductive choices. Secondary tokophobia is associated with a maternal preference for elective caesareans (Nieminen, Stephansson & Ryding, 2009). There is also evidence to suggest that some women avoid future pregnancy following a traumatic birth, despite the desire to have more children (Ayers et al., 2006).

1.1.2 Defining Birth Trauma

It is clear from the research that women who experience a difficult birth can suffer from a range of traumatic stress responses. This can take the form of secondary tokophobia, diagnosable PTSD or sub-threshold PTSD symptoms. Elmir et al. (2010) point out that there is no consensus on how to define birth trauma or as yet a systematic way to measure and assess it. Beck and Watson (2008) define birth trauma as “an event that occurs during any phase of the childbearing process that involves actual or threatened serious injury or death to the mother or her infant” (p.229). Both Beck (2004) and Thompson and Downe (2008) conducted qualitative studies exploring the experiences of women who had experienced a self-defined traumatic birth. Beck found that women can experience their birth as traumatic in circumstances where clinicians would not define it as such, and Thompson and Downe found that births that would likely be considered ‘normal’ could be perceived as traumatic by the women experiencing them. Such findings led Beck to suggest that birth trauma is “in the eye of the beholder” (Beck, 2004). This is also in line with the guidance from NICE (2014) quoted above that states that a traumatic birth should be taken to include births that are experienced by the individual as traumatic, even if the delivery would be perceived as straightforward obstetrically.

1.1.3 Intervention following a traumatic birth

Following a traumatic birth most women who experience PTSD-type symptoms will recover ‘spontaneously’ within three months of the traumatic event, as is seen with traumatic stress responses in other populations (Ayers, 2004). This natural recovery raises a dilemma for healthcare providers as to when to offer trauma-based interventions.

Psychological debriefing, sometimes referred to as ‘critical incident debriefing’ is a one off structured session, often conducted as a group session, in which facts, thoughts and feelings about the traumatic event are discussed (Rose et al., 2002). Its aim is to prevent mental health problems arising from the trauma by

encouraging emotional processing of the event. This type of psychological debriefing has been criticised due to the lack of evidence of its effectiveness and some research linking it to an increased risk of PTSD (Rose et al., 2002). Postnatal debriefing is a vaguely defined intervention used to describe a variety of post-birth discussions with women who have experienced a difficult or traumatic birth (Bastos et al., 2015). A 2015 Cochrane review (Bastos et al., 2015) looked at the effectiveness of debriefing interventions for women following traumatic birth. A range of debriefing methods were covered in the studies they found, including critical incident debriefing and less formal or structured discussions. They concluded that the currently available evidence was too low quality to make any conclusions about debriefing's positive or negative effects. A survey by Ayers, Claypool and Eagle (2006) established that 94% of UK hospitals were providing some type of postnatal service for women who had experienced a difficult birth with 78% of these being debriefing services delivered by midwives, midwife-counsellors, or doctors. Although psychological debriefing is no longer recommended as a routine treatment (NICE, 2005), it is unclear if this is still offered in perinatal services.

In its guidance on interventions for PTSD, NICE recommends offering trauma-focused Cognitive Behavioural Therapy or Eye Movement Desensitisation and Reprocessing (EMDR) to everyone presenting with PTSD one month after the traumatic event, with allowances for beginning treatment within one month if symptoms are severe (NICE, 2014). The guidance highlights there is currently no convincing evidence base for any other form of psychological therapy for PTSD. Unfortunately, perinatal health provision following a traumatic birth is often inconsistently delivered and favours interventions for physical rather than psychological needs (Peeler et al., 2013). Peeler et al. (2013) also point out that many women who have experienced a traumatic birth will no longer be under the care of a midwife when the full impact of the experience is felt, and might not present to their GP because of societal expectations that they should be happy in their new role. They also highlight that measures of postnatal depression are typically used to assess mental health in perinatal healthcare appointments, which might not capture symptoms related to PTSD.

1.2 Posttraumatic Growth (PTG)

Evidence increasingly shows that positive outcomes can result from traumatic experiences (Linley, 2003). These positive outcomes have been given various labels in the psychological literature, including benefit finding, stress-related growth, perceived benefits, thriving, blessings, positive by-products, positive adjustment, positive adaptation and adversarial growth (Linley & Joseph, 2004). The term 'Posttraumatic Growth', or PTG, was coined by Tedeschi and Calhoun (1995) and has become the most commonly used name for this phenomenon.

1.2.1 Tedeschi and Calhoun's model

Tedeschi and Calhoun's model of PTG uses the following definition: "a positive change in one's beliefs or functioning resulting from a struggle with highly challenging life circumstances" (Tedeschi, Park, & Calhoun, 1998). It involves cognitive, emotional and behavioural transformations. They theorise that the path to PTG begins with a traumatic event significant enough to disrupt a person's worldview, resulting in emotional distress and rumination. When this experience is met with either successful emotional regulation or self-disclosure leading to increased support, PTG is facilitated through the construction of a narrative including new and positive meanings from the trauma (Tedeschi & Calhoun, 2004). In this model, PTG arises specifically from the struggle to cope with the effects of the trauma.

Tedeschi and Calhoun developed the Posttraumatic Growth Inventory (PTGI, Tedeschi & Calhoun, 1996) to measure PTG. It was originally developed using a thorough review of the PTG literature available at the time and using interviews with individuals who had lost a spouse and people who had become disabled in adulthood, and achieved strong internal consistency (Cronbach's $\alpha = .90$) (Tedeschi & Calhoun, 1996). It has since been validated with a wide variety of samples, for example breast cancer survivors (Brunet et al., 2010) and active duty soldiers (Lee, Luxton, Reger & Gahm, 2010).

The PTGI has five domains: Relating to Others, New Possibilities, Personal Strength, Spiritual and Existential Change and Appreciation of Life. Tedeschi and

Calhoun (2018) suggest that change in even just one domain, if it is significant and important to the individual, can be considered PTG. In their 2018 book, Tedeschi and Calhoun describe these domains as follows:

Relating to Others – the experience of positive changes in relationships, and one's attitudes or behaviours in relationships (e.g. 'I have more compassion for others').

New Possibilities – the individual's identification of new possibilities for one's life or of the possibility of taking a new and different path in life (e.g. 'I am able to do better things with my life').

Personal Strength – an increased sense of self-reliance, a sense of strength and confidence, and a perception of self as a survivor or victor (e.g. 'I discovered that I am stronger than I thought I was')

Spiritual and Existential Change – an engagement with matters related to religious beliefs, spiritual matter and existential philosophical questions (e.g. 'I have a stronger religious faith')

Appreciation of Life – a greater appreciation for all the things life has to offer, whether small things previously taken for granted or a greater appreciation for things that people still have in their lives (e.g. 'I can better appreciate each day').

Tedeschi and Calhoun have revised their model several times. A diagrammatic representation of their most recent version is presented in figure 1 (Tedeschi & Calhoun, 2018).

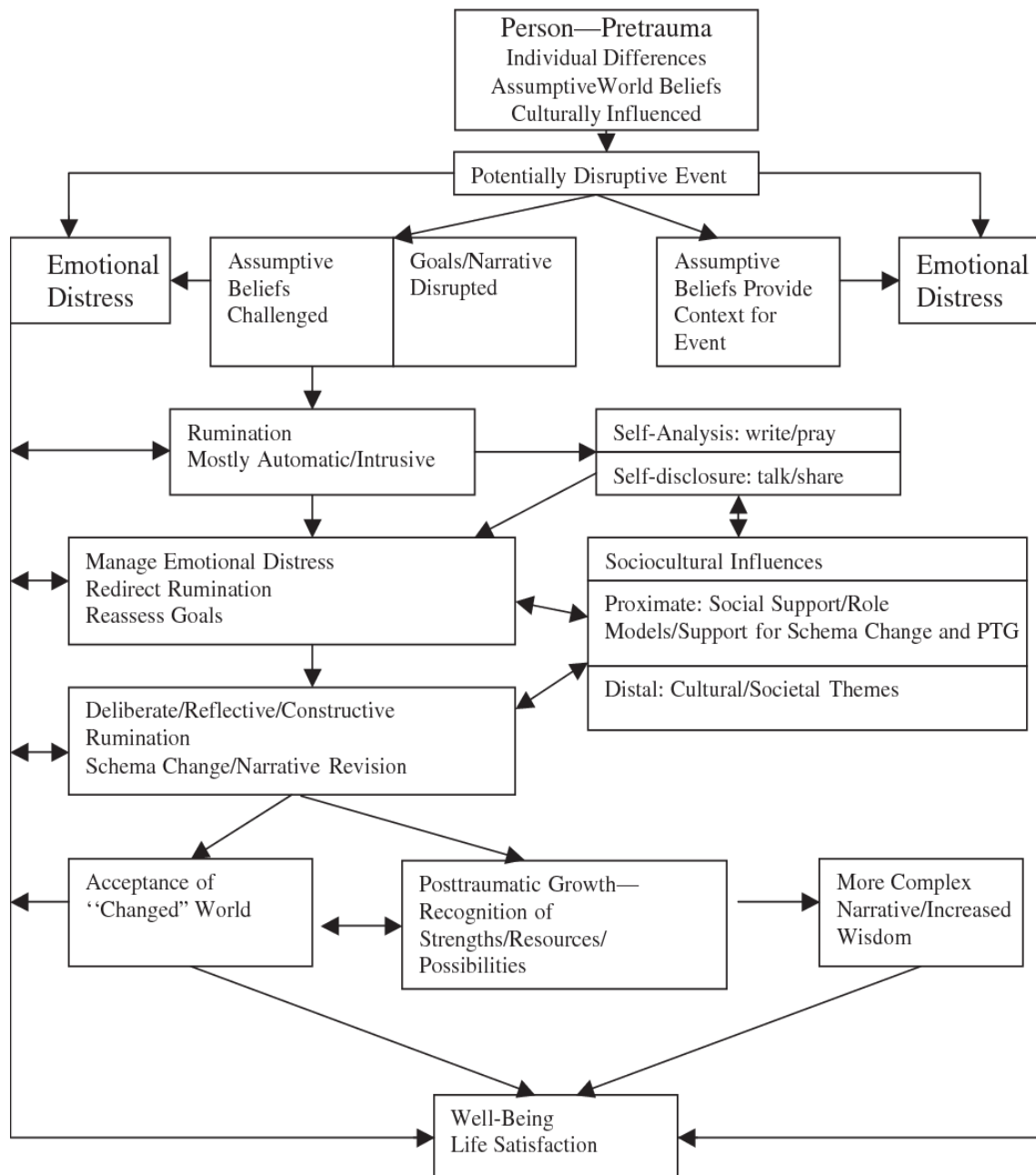


Figure 1: Tedeschi and Calhoun's (2018) revised model of posttraumatic growth

1.2.2 Alternative models and critiques

Joseph and Linley (2005) have also proposed a less widely cited theory of PTG drawing on the person-centred model. It is based on the idea that humans are intrinsically growth-orientated and is called Organismic Valuing Theory. Through a natural human tendency towards self-actualisation, the traumatic experience is accommodated to develop the person's worldview (Joseph & Linley, 2008). PTG

is therefore seen as a normal part of human development as opposed to an experience separate and distinct from typical human development. In their 2004 review of 39 studies looking at the prevalence of PTG, Linley & Joseph (2004) found wide variation in rates of growth. These ranged from 3% for people who had been bereaved to 98% for women with breast cancer. Tedeschi and Calhoun (2018) suggest that this variation is at least partly owing to differing cut off criteria for growth.

PTG can be considered distinguishable from resilience, which typically refers to the ability to return to levels of functioning achieved prior to the traumatic event, because PTG involves positive change beyond pre-trauma functioning (McGrath & Linley, 2006). Tedeschi and Calhoun (2013) state that PTG is distinct from phenomena such as personal development and maturity because PTG is brought about specifically through struggle, initially the struggle to survive or cope. They acknowledge that PTG outcomes can look similar to growth arising from other causes, but stress that PTG specifically relates to outcomes caused by the struggle to cope with highly challenging life events. They also separate PTG from the more general concept of 'benefits', giving the example of stopping smoking. Stopping smoking is a beneficial behavioural change that might arise following a significant life event; however they argue it is not personally transformative as PTG is.

There remains some debate around the validity of PTG as a concept. McFarland and Alvaro (2000) suggest that reporting positive changes in the wake of stressful life events can be a maladaptive coping strategy to avoid confronting the new reality and to reduce distress, and represents illusions of growth rather than actual transformative changes. This idea of PTG as a self-deceptive coping strategy is echoed by Maecker and Zoellner (2004), who differentiate between the avoidant coping described by McFarland and Alvaro and actual PTG, which represents successful coping. It is difficult to differentiate between these two experiences through self-report measures. Sumalla et al. (2009) suggest the difference between 'real' PTG and illusory PTG lies in whether assimilation or accommodation is used to integrate the traumatic experience. They argue that authentic PTG leads to positive identity change through an accommodation

process, whereas in illusory PTG an assimilation strategy is used in which the traumatic experience is integrated in a positively biased way that preserves an individual's existing identity as their coherence, sense and self-esteem are threatened. Affleck and Tennen (1996) write of a distinction between benefit-finding (an "adaptive conclusion") and benefit-reminding (an active coping strategy for managing distress). However, Tedeschi and Calhoun (2013) argue this is not inconsistent with their theory of PTG, which allows for PTG as both a process and an outcome: "Whether it is considered one or the other may simply depend on where a person is standing in time" (Tedeschi & Calhoun, 2013, p.25).

In addition to critiques around the nature and validity of growth, the model has also been criticised for its roots in an individualistic Western-centred perspective (Splevins et al., 2010). For example, although the concept of individuals holding core beliefs and assumptions might transfer across cultures, the nature of these beliefs and assumptions could differ. Relevant examples of assumptions that have been suggested to be located in Western and individualistic cultures include the belief in a 'just world' (Carboon et al., 2005) and the assumption of having control and agency in the world (Laungani, 1997b). Splevins et al. (2010) also point to evidence that responses to trauma differ across cultures, with Western cultural scripts allowing for the social identity of trauma survivor- victim with a focus on unique personal experience in a way that collectivistic cultures, with their greater emphasis on interdependent social roles, might not. Nonetheless, evidence of PTG has been found in a range of cultural settings (Tedeschi & Calhoun, 2018). The model could benefit from further research looking at the relationship between PTG and wellbeing/ mental health outcomes, and research looking further at the timing of growth.

1.2.3 The temporal nature of growth

Linley and Joseph (2004) reviewed the PTG literature (n = 39) and concluded that the evidence is mixed as to whether time since the traumatic event influences presence and degree of reported PTG. Some studies suggest that the longer the time since the traumatic event the greater the likelihood of PTG, whereas other studies have not found this to be evident. Linley and Joseph's (2004) examination of longitudinal studies of sexual assault survivors concludes

that signs of PTG can be detected as little as two weeks following the event, with most PTG occurring in the first two months remaining fairly stable over a year period. Black and Sandelowski (2010) conducted an ethnographic study of women who had a diagnosis of severe fetal defect, and their male partners. They found evidence of growth at four months after pregnancy. In their 2018 book on Posttraumatic Growth, Tedeschi and Calhoun (Tedeschi and Calhoun, 2018) review more up to date literature and draw the same conclusion as Linley and Joseph: that the research on the relation between time since the traumatic event and PTG is inconsistent. They suggest this could be because there might be a high degree of individual variability in growth trajectories.

1.2.4 Event type and PTG

There is relatively little research focusing on the influence of event type on PTG (Tedeschi & Calhoun, 2018). Shakespeare-Finch and Armstrong (2010) looked at levels of PTG (measured by the PTGI) in 94 survivors of sexual abuse, motor vehicle accidents and bereavement. They found that those who had experienced bereavement reported higher levels of growth than survivors of sexual abuse and motor vehicle accidents, with different event types also leading to differing levels of growth on the PTGI domains. For example, those in the bereavement group scored higher on the Appreciation of Life and Relating to Others domains than sexual abuse survivors, with no significant differences between scores on the other three domains across the three event types. Using a sample of 132 Palestinian adults who had experienced trauma, Kira et al. (2013) categorised traumas into four types: one-off traumatic events (e.g., car accident); traumatic events that happened several times in the past and stopped (e.g., physical and sexual abuse); traumatic events that happened, continued to happen, and did not stop (e.g., discrimination and racism); and cumulative traumas that consist of the effects of different types of victimisation and trauma. One-off and cumulative traumas were positively related to PTG. In this study, events that happened several times in the past and stopped were unrelated to PTG, and events that happened, continued to happen, and did not stop were negatively related to PTG. They also found variation in the specific type of traumatic event and PTG, for example refugee experiences were positively related to the Appreciation of Life

and New Possibilities domains of the PTGI but not others.

Overall, the research suggests that event type does influence PTG, but these differences are likely due to factors such as the severity of the event or causal attributions as opposed to the event type per se (Tedeschi & Calhoun, 2018). Linley and Joseph (2004) state in their review of the PTG literature that the type of traumatic event is less relevant to the presence and degree of growth than the subjective experience of such events (such as degree of control and helplessness experienced during the event).

Following a similar trajectory to the PTSD literature, early research focused on PTG following less common events such as sexual assault (e.g. Frazier, Conlon & Glaser, 2001) and war (e.g. Angel, 2016). Aldwin and Levenson (2004) argue that positive events, such as childbirth, marriage and profound religious experiences, can also engender the same outcomes as highly stressful/ traumatic events. They point to research by Cowan and Cowan (2000) demonstrating that childbirth can have fundamental and profound effects including identity change, increased emotional ties, changes in priority and opening up new paths in life.

1.3 The relationship between PTG and PTSD

Research so far has uncovered a complex and multifaceted relationship between PTSD and PTG. For example, Dekel, Mandl and Solomon (2011) summarise three possible relationships in the literature. The first is a negative relationship whereby high levels of PTSD predicts less PTG, suggesting that the two outcomes are at different ends of a continuum (e.g. Frazier, Conlon, & Glaser, 2001). The second comes from research suggesting that PTG and PTSD can co-occur in both linear (e.g. Hall et al., 2010) and curvilinear (e.g. Solomon & Dekel, 2007) relationships. And still other research has found no significant relationship at all between PTG and PTSD (e.g. Salsman, 2009). Taken in sum, the literature to date leaves us unclear as to whether PTSD and PTG are independent of one another, overlap or are even part of the same construct. It might be that PTSD acts as a catalyst for PTG.

Looking at the factors predicting PTSD and PTG, Dekel, Mandl and Solomon's

(2011) own study found that amongst prisoners of war, loss of control and active coping during captivity were predictive of both PTSD (measured using the PTSD Inventory, Solomon et al., 1994) and PTG (measured using the PTGI), suggesting that negative experiences during trauma can lead to both outcomes. When PTG was controlled for, loss of control ceased to predict PTSD suggesting at least a partially separate relationship. They hypothesise that loss of control during a traumatic event can lead to two paths, both beginning with a shattering of assumptions around self-controllability. If a sense of control is then regained through coping and adjustment, growth is facilitated. If the shattered assumption is maintained through lack of coping, PTSD is fostered.

In Sawyer and Ayers' (2009) study looking at PTSD and PTG with women who had given birth in the previous 36 months, birth variables (in this case normal birth, instrumental birth or C-section) were related to PTSD symptoms as measured using the Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997) but unrelated to levels of growth (measured using the PTGI). As with research into PTSD and PTG relating to other kinds of traumatic events, their findings leave us unclear about the relationship between PTSD and PTG. They found no significant association between PTG and PTSD symptoms, and replicated this finding in their 2012 study, suggesting that PTG can be experienced regardless of PTSD following birth. However, in their 2012 prospective study Sawyer and Ayers did find that higher PTSD levels during pregnancy predicted greater growth following birth, suggesting that pre-event mental health plays a significant role in later growth.

1.3.1 Event centrality

Event centrality can be defined as “the extent to which a memory for a stressful event forms a reference point for personal identity and for the attribution of meaning to other experiences in a person’s life” (Bernsten & Rubin, 2006). Such events can be seen as a “turning point” in a person’s life story. Event centrality is typically measured using the 20 item Centrality of Event Scale (Bernsten & Rubin, 2006), which asks respondents to indicate their level of agreement with statements such as ‘This event can be seen as a symbol or mark of important

themes in my life' and 'This event tells a lot about who I am'. Event centrality has been found to be predictive of both PTSD (Bernsten & Rubin, 2006) and PTG (Boals & Schuettler, 2011). Groleau et al. (2013) further explored the role of event centrality in the development of PTSD and PTG. A range of measures was given to 187 undergraduates who had experienced a highly stressful or traumatic life event in the previous two years. They found that event centrality predicts PTG and PTSD even after controlling for the role of a challenge to core beliefs, deliberate rumination and the presence of meaning in the event. They also found no correlation between PTSD and PTG, suggesting that event centrality contributes to both PTSD and PTG but that the two can occur independently.

1.4 The Relationship between PTG and wellbeing

The research into the relationship between PTG and general mental health or wellbeing is limited (Schneider et al., 2019). The studies conducted have yielded mixed results, which is similar to those examining the relationship between PTG and PTSD discussed above. Studies can be found showing that higher rates of mental health diagnoses such as anxiety and depression are associated with less growth (e.g. Holtmatt et al., 2016) or more growth (e.g. Schneider et al, 2019), or that the two are unrelated (e.g. Feder et al., 2008). This has led some researchers to consider that a curvilinear relationship best explains the relationship between mental health and PTG, in which too little or too much distress inhibits growth, but moderate amounts of distress foster it (Schneider et al., 2019). This could explain the mixed results in the research.

The clinical relevance of PTG has been considered by researchers. A two year longitudinal study by Husson et al. (2017) of adolescents with cancer found that higher levels of PTG (as measured by the PTGI) predicted greater wellbeing, as measured by higher scores on the mental health component of the Medical Outcomes Study Short Form-36 Health Survey (SF-36, WARE et al., 1993). In their review of the literature, (Zoellner & Maercker, 2006) found that longitudinal studies show a weak positive relationship between growth and adjustment. They suggest that the adaptive benefits of PTG could manifest over time, and so recommended that PTG needs to be studied longitudinally to understand this

better. In a qualitative study looking at personal experiences of mental health recovery in 77 individuals, Slade et al. (2019) found that 83% of their sample experienced components of posttraumatic growth when talking about the recovery journey. The authors conclude that encouraging posttraumatic growth is an important part of recovery promotion, however they also caution that “The relationship between mental health recovery and post-traumatic growth is unclear, as is the extent to which they are the same or overlapping but distinct phenomena” (Slade et al, 2019, pp. 8). Tedeschi and Calhoun (2018) reviewed the literature into PTG and positive emotions. They conclude that PTG does not always lead to an increase in positive emotions, but that experiencing positive emotions can support people to recognise growth and vice versa (Tedeschi & Calhoun, 2018, pp. 75).

1.5 Posttraumatic Growth, birth and the perinatal period

There is currently little research focusing on PTG following birth specifically. A systematic search of Ovid (including PubMed and PsycINFO) and Web of Knowledge was conducted, with Google Scholar used as an additional resource for sourcing relevant articles. Details of the search strategy and terms used can be found in Appendix B. A summary of the available literature will now follow and is represented in Table 2. Most research has focused on the factors associated with PTG. All quantitative studies in this section used the Posttraumatic Growth Inventory to measure growth.

Growth has been detected in women and their partners following potentially traumatic perinatal events such as fetal loss and abnormality. Winograd (2017) looked at the factors influencing PTG in 103 women who have experienced pregnancy loss (from early stage miscarriage to late stage stillbirth). It was found that perinatal grief, family processes, hope, and coping styles all predicted PTG in this population. Similarly, Black and Wright (2012) reviewed the literature on PTG following perinatal loss and showed that PTG has been detected in these women across a range of studies. In a qualitative study, Black and Sandelowski (2010) found evidence of PTG in women and their male partners in the aftermath of a diagnosis of severe fetal abnormality. Participants were recruited as close as

possible to the time of diagnosis, and interviewed following recruitment, and then again around the time of the due date (regardless of whether the pregnancy was terminated or not), at approximately the half way point between the due date and the one-year anniversary of the diagnosis and finally one year after diagnosis. Interviews were analysed using 'directive content analysis', using the PTGI domains to guide coding of the interview data. Lafarge et al. (2017) found moderate levels of growth (the overall sample growth score was 46.6 out of a maximum score of 105 as measured using the PTGI) in women who had ended a pregnancy because of fetal abnormality. This study did not report any inclusion or exclusion criteria relating to the timing of the traumatic event. Several coping strategies were also positively associated with PTG: emotional support, positive reframing, use of religion, acceptance and instrumental support.

Little research has been conducted into PTG following childbirth. A key piece of research has been the Sawyer and Ayers (2009) study, which involved a sample of 219 women who had given birth in the previous 36 months. No specific eligibility criteria relating to the birth was used, and so their sample would have included women whose birth was objectively 'normal' as well as difficult or traumatic. Sawyer and Ayers use the term 'growth' rather than posttraumatic growth, as PTG has been found to result from challenging but not *necessarily* traumatic events such as a childbirth. They found moderate degrees of growth following birth in around 50% of their sample, measured by achieving a score of at least 62 on the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996). This demonstrated growth at similar levels to those found in people who have experienced accidents and assaults (Snape, 1997). They found a positive association between growth and women's approach to coping but no relation between growth and levels of support and control during the birth. Age was the main predictor of growth in this study, with older women reporting less growth. This is consistent with previous research investigating PTG following other events. The authors speculate that this might be because developmental change is slower in later life, or because other life events are interfering with the growth process in some way.

A prospective study by Sawyer et al. (2012) of 125 women examined the

variables associated with PTG. Again this was a community sample and so included women regardless of the nature of their birth experience. As with the Sawyer and Ayers (2009) study, they also refer to 'growth' rather than PTG, and growth was measured using the PTGI at approximately eight weeks after childbirth. The only birth variable to predict growth was experiencing an unplanned caesarean section rather than a normal vaginal delivery. Subjective elements of the birth experience were not related to growth e.g. pain during labour or rating the birth as traumatic. As with the Sawyer and Ayers (2009) study age was also related to growth, with older women reporting less growth. Levels of social support following the birth were also unrelated to growth. The evidence on the importance of social support for growth is mixed, and the authors point out that further research is needed to understand the types of social support that are most relevant for growth. Sawyer et al. also measured posttraumatic stress symptoms during pregnancy, and found that higher symptom levels predicted greater growth after childbirth. They offer two possible explanations for this: that women who are already distressed pre-birth would be more likely to view the birth event as a crisis (which is necessary for growth to occur according to Tedeschi and Calhoun's model), and that individuals who have experienced previous distressing events might have greater coping resources which could foster growth.

Sawyer et al. (2015) examined correlates for growth in 203 women from the UK and 117 women from Croatia who had given birth within the last two years. Approximately 44% of the UK sample and 35% of the Croatian sample reported at least a moderate level of growth. In Croatian women, avoidant coping strategies were predictive of growth, whereas in UK women active and emotion-focused coping strategies were predictive of growth. They suggest this could be owing to cultural differences, but also point to the fact that research findings have been inconsistent regarding the types of coping strategies that are related to growth. In this study, the women had given birth between one month and two years previously. Time since birth was not related to growth in this study.

In Nishi and Usuda's (2017) follow up study, women in Japan were recruited at between 12 and 24 weeks' gestation and interviewed one month after birth.

There were 117 women who completed the study, in which growth was assessed four weeks' post-birth. They found higher levels of PTG in women who had experienced their first birth, reported greater resilience in pregnancy and less fear during childbirth. The strongest predictor of PTG was this being the woman's first birth experience. The authors speculate that giving birth for the first time is likely to be an event of significant enough challenge to disrupt the woman's assumptive world, compared with subsequent birth experiences.

One quantitative study was conducted with women who had experienced a traumatic birth. Beck and Watson (2018) conducted a recent pilot study with 30 women who had experienced a traumatic birth (self-defined) to determine levels of posttraumatic stress, core beliefs disruption, and posttraumatic growth. Their findings revealed a small degree of posttraumatic stress symptoms and PTG, and a moderate level of disruption to core beliefs. As found in previous studies, women who had a C-section experienced significantly more PTG than women who gave birth vaginally. Interestingly they found that there was no significant relationship between the degree of core belief disruption and the degree of PTG, which challenges Tedeschi and Calhoun's (2004) model of growth. Contrary to the Sawyer et al. (2015) study, time since birth was related to growth levels, with greater growth found the longer the time since the birth.

Two qualitative studies have been conducted on PTG with women following a traumatic birth. Souza et al (2009) conducted a qualitative study in Brazil with 30 women who had almost died during pregnancy or childbirth (defined as women who admitted to an Intensive Care Unit during pregnancy or in the six week after childbirth). Women were interviewed shortly after the birth. On average this was on the fifth day while the women were still in hospital. Results were analysed using Thematic Analysis. One of their findings was that most of the women interviewed were able to find some positives from their experience, depicted in their theme entitled *severe maternal morbidity as an opportunity for inner growth*. Women who were represented in this theme talked of the following 'values': the need to give more value to the simple things in life; importance of giving value to loved ones and/or God; giving less value to material things; and abandoning risky behaviour. These findings could be interpreted as showing very early growth in

women following a traumatic birth experience. However, the study authors note that a limitation of the study is that a fuller and perhaps more realistic sense of 'inner growth' would likely be better explored at a later time point after the women had returned to their normal lives. Interviews at later dates would also indicate if the growth was stable. It could be argued that the 'inner growth' detected in this study might not constitute 'posttraumatic growth' per se, as PTG (by Tedeschi and Calhoun's 1995 definition) comes from the struggle to cope with a traumatic event. Such struggle is perhaps unlikely to have occurred in a matter of days. Nonetheless, the 'values' identified by Souza et al. (2009) are comparable to some of the domains of the PTGI, for example "the need to give more value to the simple things in life" seems similar to the Appreciation of Life domain, and the value around "God and giving less value to material things" links with Spiritual and Existential Change.

Beck and Watson (2016) conducted a descriptive phenomenological analysis study into posttraumatic growth following a traumatic birth. To be considered for the study, women had to perceive that their birth was traumatic and have experienced some aspect of personal growth following this. The authors did not provide further information on how this was phrased to participants in their article. Women self-defined whether they met these criteria. Length of time since the traumatic birth experience ranged from five months to 19 years. They recruited fifteen women online via the Trauma and Birth Stress website (a charity supporting women who have experienced a traumatic birth in New Zealand). Participants wrote narratives responding to the statement "Please describe for us in as much detail as you can remember your experiences of any positive changes in your beliefs or life as a result of your traumatic birth". The analysis identified four themes: Opening Oneself Up to a New Present (involving experiences such as becoming stronger, more empathic and more assertive), Achieving a New Level of Relationship Nakedness (being open with friends, family and partners about the details of the birth experience, leading to closer relationships), Fortifying Spiritual-Mindedness (developing a stronger sense of their faith) and Forging New Paths (pursuing new professional and personal goals). The authors relate these findings to the 2009 and 2012 studies by Sawyer and Ayers

discussed above. In those studies, Appreciation of Life was the highest scored domain on the PTGI. Beck and Watson state that “The voices of the mothers in this current phenomenological study did express appreciation of life but it was not the strongest essential component of their posttraumatic growth.” (Beck & Watson, p. 269). In the Beck and Watson study, Personal Strength and Relating to others were more salient (as evidence by the themes ‘Opening Oneself up to New Present’ and ‘Achieving a New Level of Relationship Nakedness’ respectively). Beck and Watson suggest that the difference could be accounted for by the different samples in the study, in that Sawyer and Ayers use community samples of women who have given birth (but not necessarily experienced a traumatic birth) whereas Beck and Watson required women to self-describe their births as traumatic, though they do not elaborate on this explanation.

In summary, although studies have been conducted into PTG following childbirth this area of research is still in its infancy. Most studies have focused on the factors influencing growth. Several of the studies have used community samples with no inclusion criteria related to whether the birth was traumatic or not. These studies can draw conclusions around PTG-type growth, but not necessarily PTG per se. At the same time, these studies are valuable in demonstrating that even normative events can promote growth and that the subjective experience of the event rather than the event itself is key for growth, as suggested by Linley and Joseph (2004).

Table 2

Summary of literature on posttraumatic growth, birth and the perinatal period

Study	Study design	Sample	Measure of growth	Summary of findings
Winograd (2017)	Quantitative, cross-sectional	Women who had experienced pregnancy loss	PTGI	Perinatal grief, family processes, hope, and coping styles all predicted PTG.
Black & Sandelowski (2010)	Qualitative, longitudinal	Women who had experienced a diagnosis of a severe fetal anomaly and their partners	Directed qualitative content analysis using the PTGI	Eighteen of 25 participants experienced positive change across the PTGI domains. The most consistent and prolonged change was found in the “Relating to others” domain. Negative change was evident in four participants.

Lafarge, Mitchell & Fox (2017)	Quantitative, cross-sectional	Women who had undergone a termination for fetal abnormality	PTGI	Moderate levels of PTG were found on the PTGI domains "relating to others," "personal strengths" and "appreciation of life." Positive reframing was a significant predictor of PTG.
Sawyer & Ayers (2009)	Quantitative, cross-sectional	Women who had given birth in the previous 36 months	PTGI	At least moderate degrees of growth were reported by around half of the sample. Growth was positively related to approach coping and the avoidant strategy of seeking alternative rewards, but was unrelated to support and control during birth, other avoidant coping strategies after birth, and PTSD symptoms. Age was the main predictor of growth in this study, with older women reporting less growth.
Sawyer et al. (2012)	Quantitative, prospective	Women who were at least 28 weeks pregnant	PTGI	Almost half of the sample reported at least a small degree of positive change. Average levels of growth were lower than generally reported in other studies. The strongest predictors of growth were operative delivery and posttraumatic stress symptoms in pregnancy. Older women reported less growth.
Sawyer et al. (2015)	Quantitative, cross-sectional	Women who had given birth between one month and two years prior to recruitment in Croatia or the UK	PTGI	Around 44% of the UK sample and 35% of the Croatian sample reported a moderate level of growth. Older women reported less growth. In the UK sample, coping strategies were related to higher growth. In the Croatian sample, higher posttraumatic stress symptoms and the avoidant coping strategy of denial were associated with higher levels of growth.
Nishi and Usuda (2017)	Quantitative, follow up study (at one month after birth)	Women at between 12 and 24 weeks gestation	PTGI	Higher levels of PTG were reported in women who had experienced their first birth, reported greater resilience in pregnancy and less fear during childbirth. The strongest predictor of PTG was this being the woman's first birth experience. High resilience and less fear at childbirth were also

				associated with the “personal strength” domain of the PTGI. This being the first experience of birth and high depressive symptoms were associated with greater appreciation of life. No variables were associated with spiritual change.
Beck and Watson (2018)	Quantitative, cross-sectional	Women who perceived they had experienced a traumatic birth (self-defined)	PTGI	The study found a small degree of PTG and a moderate disruption to core beliefs. Women who had a C-section experienced significantly more PTG than women who gave birth vaginally. They found no significant relationship between the degree of core belief disruption and the degree of PTG. Time since birth was related growth levels, with greater growth found the longer the time since the birth.
Souza et al (2009)	Qualitative, cross-sectional	Women admitted to an intensive care unit following birth	Self-reported growth during interviews	Two major themes were identified relating to the experience of a critical illness and the experience of care. Most of the women interviewed were able to find some positives from their experience
Beck and Watson (2016)	Qualitative, cross-sectional	Women who perceived their childbirth had been traumatic and experienced some aspect of personal growth after the birth trauma (both self-defined)	Self-reported growth in written accounts of their experience	Four themes of posttraumatic growth were identified: Opening oneself up to a new present, Achieving a new level of relationship nakedness, Fortifying spiritual-mindedness, and Forging new paths.

1.6 Rationale and aims for this study

Research on PTG following a difficult birth is still limited. As summarised above, poor maternal mental health generally and birth trauma specifically can have a significant negative impact on both the mother and child. It is important that research in this area continues so that clinicians understand that range of

possible responses to birth trauma and to develop ways of promoting and facilitating growth where appropriate and possible.

The little research that has been conducted on PTG, in general as well as on birth specifically, leaves many questions unanswered around how PTG is experienced by women following childbirth in general and traumatic birth more specifically (Sawyer and Ayers, 2009). A difficult birth is different to other kinds of potentially traumatic events in ways that might influence PTG. For example, there are often societal expectations that pregnancy and birth are 'positive' events, whereas other kinds of traumatic events (e.g. assaults, accidents, significant illnesses) are generally assumed to be negative. Furthermore, the outcome of a successful birth is commonly a wanted child and, for those who are first time mothers, a desired new role of motherhood. At present we do not know whether these aspects of the pregnancy, birth and parenting experience affect PTG. It is plausible that the birth of a healthy, wanted child and the expectations on women to find new meaning in their lives might encourage PTG. Further research is needed that investigates issues specific to the aftermath of birth trauma to develop interventions that are specific to birth trauma survivors.

The need for more qualitative research to provide deeper insights into the nature of positive outcomes following a traumatic birth has been identified by McKenzie-McHarg et al. (2015) who state that "research on growth following childbirth is limited and important gaps remain around conceptualisation, measurement, predictors and how growth can be incorporated into clinical interventions." An in-depth, qualitative study looking at women's experiences of PTG could aid our understanding of the mechanisms that foster PTG, influence the practice of clinicians working with women who have experienced a traumatic birth, and direct future research in this area.

With this in mind, the aim of this study is to explore how women make sense of the experience of posttraumatic growth following a traumatic birth.

2. Methodology

This chapter provides an overview of the methodological approach used in this study, followed by a detailed account of the study design, conduction of data collection and analysis, ethical considerations and reflexivity.

2.1 Methodological approach

Elliott (1995) states that the value of a research method lies in “its ability to provide meaningful and useful answers to the questions that motivated the research”. Qualitative approaches are “concerned with the exploration of lived experience and participant-defined meanings” (Willig, 2008, pp. 9). They aim to “understand and represent the experiences and actions of people as they encounter, engage, and live through situations” (Elliot, Fischer & Rennie, 1999), whereas quantitative methods are more concerned with hypothesis testing, looking for causal relationships and measuring generalisability (Elliott, 1995). For these reasons, a qualitative design was chosen over a quantitative design as the most appropriate approach for meeting the research aims.

A variety of qualitative approaches were considered for their suitability in answering the research question. Interpretive Phenomenological Analysis was selected as the most appropriate choice. The reasons for this and a brief discussion of other approaches considered will now be presented.

2.1.1 Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) was the most appropriate qualitative approach for this study as it is concerned with the study of existence and experience (Larkin & Thompson, 2012). This focus is consistent with the research aims to gain an in-depth exploration of individual experiences. IPA is also compatible with my assumptions about what the data generated from this

study can tell us: that it will provide an insight into participants' experience of the world and how they make sense of it (Smith, Flowers & Larkin, 2009).

IPA is a qualitative approach with philosophical underpinnings in phenomenology, hermeneutics and idiography.

Phenomenology is the philosophical study of existence and experience (Larkin & Thompson, 2012). The phenomenological origins of IPA are in the work of Husserl, who highlighted the relevance of focusing on experience and its perception as the primary source of all knowledge. Husserl placed importance on 'bracketing' – the segmenting off of the assumptions hold so that we might transcend these in order to get closer to the essence of human experience (Smith, Flowers & Larkin, 2009). IPA was developed more directly from the later work of philosophers such as Heidegger and Merleau-Ponty. Heidegger suggested that total bracketing of our assumptions is not possible. Humans are 'beings-in-the-world' in that we are constantly and inherently related to the world and in relationship with others (Smith, Flowers & Larkin, 2009).

Hermeneutics refers to the interpretive aspect of IPA. IPA draws on ideas from Schleiermacher, Heidegger and Gadamer around the examination of what is latent or disguised as well as what is manifest, and that humans project meaning onto our experiences in a dynamic process. Interpretation introduces a new perspective that adds value (Smith, Flowers & Larkin, 2009). Conducting IPA research involves a 'double hermeneutic', in that participants engage in the first level of interpretation through their own attempts to make sense of their experiences which is followed by the researcher adding a second level of interpretation as they hear and try to understand the participant's account. Researchers bring their own assumptions and experiences to this process, so reflexivity is required (Smith & Osborn, 2003).

Finally, the idiographic aspect of IPA relates to its focus on the particular and idiosyncratic experience of particular people in their particular context, examining this with detail and depth (Smith, Flowers & Larkin, 2009).

2.1.2 Alternative approaches considered

2.1.2.1 Descriptive Phenomenological Analysis

The Descriptive Phenomenological method stays closer to the idea of Husserl than Interpretive Phenomenological Analysis, in that the researcher attempts to set aside all pre-existing knowledge – both expert knowledge and personal biases – in order to focus on the experience that is being presented (Lopez & Willis, 2004)

The premise of this approach, that full ‘bracketing’ of assumptions can occur, does not fit with my own standpoint as a researcher, which is that to fully understand an experience is an interpretative process in which full bracketing is “neither possible nor desirable” (Tufford & Newman, 2010). Furthermore, this research is grounded in an applied psychology framework which seeks to contribute to clinical practice. Descriptive Phenomenological Analysis does not attend to the contextual factors that have influenced an experience, which can be relevant to clinical practice.

2.1.2.2 Thematic Analysis

Thematic Analysis is a qualitative method developed by Braun and Clarke (2006) for identifying, analysing and reporting patterns in data, and interpreting aspects of the research topic. This approach can be of benefit when looking for a theoretically flexible method. However, considering the lack of focus on interpretation and phenomenology, it was decided that this was a weaker fit for this research than IPA given the research question.

2.2 Design

2.2.1 Sampling:

The sample for this study was adult women living in England who had experienced a self-defined traumatic birth in the five years preceding recruitment. Participants also needed to self-define as having experienced positive benefits through coping with their difficult birth experience, in line with Tedeschi and Calhoun's (1996) definition of PTG.

Smith, Flowers and Larkin (2009) state that a sample of between six and ten participants is common and sufficient when using IPA. With this in mind, a sample size of 8-10 participants was aimed for.

2.2.2 Inclusion and exclusion criteria:

A summary of the following inclusion and exclusion criteria for this study is presented in Table 3.

There was no upper age limit for this study, but participants were required to be at least 18 years old, so as to be able to consent independently to taking part in the study. Participants had to be living in England and have had experienced a self-defined traumatic birth in the five years preceding recruitment. This timeframe was initially set at 12 months, however feedback from women and organisations supporting recruitment was that PTG was unlikely to occur or be identified in the first 12 months after birth (see the 'Ethical Considerations' section in this chapter). Women also needed to self-define as having experienced PTG through struggling with their difficult birth experience.

There were no requirements as to the type of birth experienced (e.g. C-section, instrumental/ assisted e.g. forceps, vaginal delivery) or specific birth events (e.g. experiencing an episiotomy or a perineal tear) for inclusion in the study.

Women whose baby died before, during or shortly after birth (stillbirths and neonatal death) were excluded from the study, as the birth experience is likely to have been significantly different in this group and involve differences in trauma responses i.e. grief reactions (Gravensteen et al., 2013). To ensure that the

experience related to the birth itself (and not traumas/ difficulties in the postnatal period) inclusion criteria were birth at 'full term' (37 weeks or more for the purpose of this study) and no Neonatal Intensive Care Unit or Special Care Babies Unit admissions. For the same reason women who were admitted to a High Dependency Unit or Intensive Care Unit following their birth were also excluded.

Participants were required to be fluent in English. This was to ensure they had the language skills to fully engage in in-depth interviews with an English speaking interviewer, as the research budget did not allow for the use of interpreters.

2.2.2.1 Mental health

Women were not eligible for the study if they were experiencing significant trauma symptoms at the time of recruitment, to avoid exacerbating distress through talking about unprocessed traumatic events. This was determined during a telephone screening appointment during which the Primary Care Post-traumatic Stress Disorder Screen was administered. This is a five item questionnaire which is used to identify respondents with probable Post-traumatic Stress Disorder (see Appendix C). Answering 'yes' to three or more of the items is considered a 'positive result' on the screen and excluded women from eligibility for the study. No women were excluded due to significant trauma symptoms as none answered yes to three or more items.

Women were not eligible if they were under the care of a psychiatric team at any time in the perinatal period (i.e. during pregnancy and the first year after birth), as they were likely to have had a fundamentally different experience of care around the birth and during pregnancy.

Table 3
Summary of inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Age 18 or over	Stillbirths and neonatal deaths
Living in England	Baby admitted to a Special Care Baby Unit/ Neonatal Intensive Care Unit
Experienced a difficult or traumatic birth in the past five years (self-defined)	Baby born before 37 weeks' gestation
Experienced positive benefits through coping with the birth (self-defined)	Admitted to a High Dependency Unit or Intensive Care Unit
	Not fluent in English
	Experiencing significant trauma symptoms at time of recruitment
	Under the care of a psychiatric team during the perinatal period

2.2.3 Recruitment:

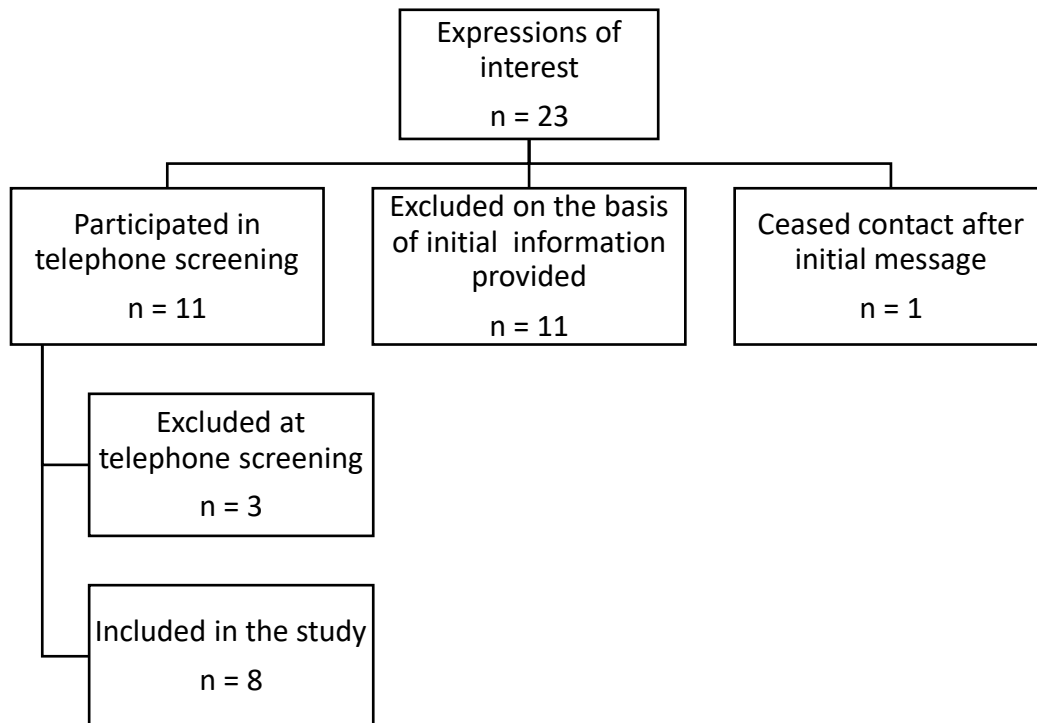
Participants were recruited through online advertisement and promotion of the study (see Appendix D). Recruitment was supported by two national charities: The Birth Trauma Association (which supports women who have had a traumatic birth experience) and the National Childbirth Trust (which provides practical and emotional support to parents) who promoted the study on their websites and social media platforms. The study was also promoted the study via the researcher's professional Twitter account.

Potential participants were invited to read about the study by following a link to an online version of the Participant Information Sheet (PIS) (see Appendix E) on the Online Surveys website. Women then made contact by telephone or email if they believed they met the eligibility criteria and were interested in taking part.

Potential participants then had a telephone screening to administer the Primary Care Post-traumatic Stress Disorder Screen and determine whether they met the study criteria. This was also an opportunity for them to ask any questions and for me to explain in more detail what participation would involve. If women were still interested in taking part at the end of this call and they met all eligibility criteria an interview was arranged.

Twenty-three potential participants made contact to express interest in taking part in the study. One of these women ceased contact after sending her initial message. Eleven were excluded on the basis of information provided in their initial email or telephone call and did not progress to the telephone screening phase. Eleven women participated in a telephone screening, of which three were excluded. The remaining eight women were eligible and opted to take part in the study and therefore made up the sample. The recruitment flowchart in figure 2 depicts this process.

Figure 2: Recruitment flowchart



All fourteen women who were excluded from the study made contact before the amendment to extend the timeframe criterion (see 'Ethical Considerations' section below). Table 4 shows the reasons that these fourteen potential participants were excluded from the study. Several of these women had consented to being re-contacted in the future if the eligibility criteria changed in a way that brought them into eligibility, however none of them responded when re-contacted after the amendment was approved. The eight women who were included in the study made contact after the amendment.

Table 4
Information on participants not included in the study

Respondent number	Birth was outside of one year timeframe	Baby admitted to Special Care Unit	Trauma/ growth not birth related	Premature birth	Stopped contact after initial message
1	✓				
2	✓				
3	✓		✓		
4	✓				
5	✓				
6		✓			
7		✓		✓	
8	✓				✓
9	✓				
10	✓				
11	✓				
12	✓				
13	✓				
14	✓				
Total	12	2	1	1	1

2.2.4 Semi structured interviews:

Participation in the study involved a one to one interview lasting around an hour. There was the option of a second interview if it was felt to be required, but none of the participants requested this.

Participants were given the option of having the interview at their home or in a meeting room at the University of Leeds to ensure a safe, private and comfortable environment. If participants lived outside of the local area they were also given the option of a Skype or telephone interview. All participants opted for a face to face interview. One of these was conducted at the University of Leeds, six were conducted in participants' homes and one was carried out in a private room at the participant's place of work (at her request). The interviews followed a semi-structured format. Semi-structured interviews are the usual way of carrying out data collection in IPA as they allow a flexible approach to the interview process giving participants an important role in what is discussed and providing space for them to tell their stories (Smith, Flowers & Larkin, 2009, pp4).

A topic guide was developed to assist the interview process (see Appendix F). This was informally piloted by conducting a practice interview with a friend who had given birth to better anticipate the kind of data that the questions might generate. Following this I thought the topic guide was suitable for the study and no changes were made. In keeping with the orientation of IPA the questions in the topic guide were used flexibly and did not comprise an exhaustive list, as I adapted questions in a way that was responsive to the participant's answers and behaviour (Smith, Flowers & Larkin, 2009, pp58). Reflections on some of the interviews are included in the pen portraits (see 'Results' chapter).

2.2.5 Service User Consultation

I met with a Service User Consultant (SUC) who had first-hand experience of a traumatic birth and had experience of supporting research and the work of the Birth Trauma Association. This contact was made through a supervisor of the thesis. The SUC advised on the content of the topic guide and the recruitment and participant materials for the research.

2.3 Ethical considerations

2.3.1 Consent:

Participants completed a consent form for the study (see Appendix G) before their interview began, following the opportunity to read through the PIS and ask the researcher any questions they might have, as described above.

2.3.2 Ethical approval:

Ethical approval for this study was granted by the University of Leeds School of Medicine Research and Ethics Committee (SoMREC) (see Appendix H). The organisations supporting recruitment followed their relevant internal research governance processes.

Following initial problems recruiting sufficient participant numbers, an amendment was submitted to SoMREC requesting permission to advertise on social media

platforms other than Twitter (e.g. Instagram) and to contact relevant organisations beyond the Birth Trauma Association and National Childbirth Trust and individuals to invite them to promote the study. This amendment was approved, although not enacted as sufficient participants were recruited through the originally approved channels.

A second amendment increasing the timeframe post-birth was approved by SoMREC following feedback from women who wanted to take part in the study but did not meet the original timeframe criteria (that the traumatic birth needed to have occurred in the preceding 12 months). This feedback was that PTG would be unlikely to occur in the first 12 months following a traumatic birth. This opinion was shared by the recruitment contact at the BTA who had received similar comments online in response to the study.

2.3.3 Participant Distress:

As mentioned, to avoid exacerbating distress through talking about unprocessed traumatic events, women experiencing 'active trauma symptoms' were not included the study.

Participants were reminded of the potential for distress arising from the subject matter of the interviews in advance of data collection. This was during the telephone screening and via the Participant Information Sheet (PIS). Participants had the opportunity to discuss any concerns about this during the telephone screening. Participants were informed that they could pause or withdraw from the interview at any point and were under no obligation to answer questions they did not want to answer. In the event, no participants became significantly distressed and none of the interviews were paused or ended early.

As a Psychologist in Clinical Training, I am a practicing mental health clinician with experience of discussing sensitive topics and managing distress. All participants were provided with resources and contact details of organisations who can provide further support (see Appendix I).

2.3.4 Confidentiality:

Interview data was anonymised during transcription. Participants were allocated a pseudonym for any written reports produced using their data. Participants were informed via the PIS that in the unlikely event that I was concerned that there is an immediate risk of harm to the participant or someone else I would have a duty of care to pass this information on and so confidentiality may need to be broken. This was not necessary in the event.

2.3.5 Withdrawal from the study:

Participants were informed that they were free to withdraw from the study at any time, but that if they withdrew from the study longer than two weeks after data collection it would not be possible to withdraw the data already collected as the analysis will have started. No participants chose to withdraw from the study.

2.3.6 Data storage:

Interview data was recorded using an encrypted portable recording device and then transferred onto a secure computer drive managed by the University of Leeds to which only the research team had access and deleted from the device. Any hardcopies of data (e.g. transcripts) were anonymised. Following the completion of the research, the audio files and any other data related to the study will be held on the secure drive for three years, with the study supervisor as custodian of the data, before being destroyed.

2.4 Transcription

The eight completed interviews were recorded and then transcribed. I transcribed the first three interviews myself to gain an understanding of the process, and the remaining five interviews were transcribed by a professional transcriber. Table 5 shows the writing conventions used during transcription.

Table 5
Writing conventions

[merge]	Lines of transcript omitted for coherence
(laughs)	Explains the participant's non-verbal communication
...	Denotes a pause

2.5 Analysis

Interviews were analysed as the data became available. To conduct the analysis I followed the guidelines for using IPA given by Smith, Flowers & Larkin (2009), which includes the following steps.

Step 1 – 'Reading and re-reading'

In this initial stage, I read through the transcript twice at different time points, without making any notations on the transcript, to re-familiarise myself with the data. I then read through the transcript again while listening to the audio recording of the interview, using cues such as the pace of the interview and the participant's tone of voice to add to my understanding of their words. During this stage I noted my thoughts and feelings about the interview and the participant's responses in my reflective diary.

Step 2 – 'Initial noting'

I began this stage by making notes on the transcript of any interpretative observations that arose from my reading of the data. At this point in the analysis I included all initial thoughts on the transcript without being concerned with categorising the notations. Following this, I organised and added to the notations using the categorisation of linguistic, conceptual and descriptive comments as suggested by Smith, Flowers & Larkin (2009) on an electronic version of the

transcript, reading through the transcript several more times while refining these comments. Examples of the initial noting on transcripts and the electronic categorisation of notations can be found in Appendix J and Appendix K.

Steps 3 and 4 – ‘Developing emergent themes’ and ‘Searching for connections across emergent themes’

At this stage, I developed emergent themes for the transcript by mapping connections between the notes generated during Step 2. These emergent themes were recorded in an additional column on the electronic version of the transcript used in Step 2. As noted by Smith, Flowers & Larkin (2009) not all emergent themes are retained during the process of looking for connections and grouping the themes. As they advise, I was guided by the research question and focusing on the most interesting and important aspects of the participant’s account. I used a list of the emergent themes as they had appeared in chronological order throughout the transcript, moving these around into groupings using the following processes described by Smith, Flowers & Larkin (2009): Abstraction, Subsumption, Polarization, Contextualisation, and Numeration. These groupings were then named.

Step 5 – ‘Moving to the next case’

The process described in Steps 1 to 4 was repeated for each transcript.

Step 6 – ‘Looking for patterns across cases’

During this ‘group analysis’ stage, the subthemes for all participants were clustered and re-clustered to make sense of the data on a group level. Each cluster was assigned a name to represent the experience of the participants. Through this process, it became apparent that several of the subthemes matched very closely onto the four domains of Posttraumatic Growth described in Tedeschi and Calhoun’s (1996) Posttraumatic Growth Inventory (PTGI). The PTGI is a 21 item questionnaire designed to measure PTG. Its five domains are named New Possibilities, Relating to Others, Personal Strength, Spiritual Change and Appreciation of Life. Table 8 in the Results chapter of this thesis depicts

these similarities. The relevance of these similarities to the analysis is discussed further in the 'Reflexivity' section below and the Discussion chapter.

2.6 Quality Assurance

It is essential that quality checks are included throughout the process of conducting qualitative research in order to give readers confidence in the high standard of the work. Both Elliott et al. (2009) and Yardley (2000) have produced guidance on this with suggestions for researchers looking to produce robust research.

Elliott et al. suggest the following measures for ensuring quality: owning one's own perspective as a researcher, providing contextual information about the sample, grounding the analysis and results in examples from the data, providing credibility checks, coherence, writing in a way that resonates with readers and accomplishing general versus specific research tasks. Elliott and Timulak (2005, p.157) define this final measure as follows: "For a general understanding of a phenomenon, use an appropriate sampling strategy and range of instances (informants or situations). For understanding a specific instance, make sure it has been studied and described systematically and comprehensively."

Yardley's (2000) focus is on sensitivity to context (acknowledging the theoretical and socio-cultural contexts of the study and the researcher-participant relationship), commitment (prolonged engagement with and immersion in the research topic and data), rigour (completeness of data collection and analysis), transparency (disclosing as much of the research protocol as possible) and coherence (constructing a meaningful narrative and ensuring a good fit between the research question, philosophical perspective and research methods), and impact and importance (conducting research that, for example, has practical use, has sociocultural/ political impact or has theoretical worth) .

Table 6 outlines the quality measures implemented during this study and the corresponding guideline(s) from Elliott et al. (2009) and/ or Yardley (2000).

Table 6
Quality measures

Quality measures implemented	Corresponding guideline
Monthly supervision with supervisors experienced in researching birth trauma and in supervising these using the IPA method	Providing credibility checks (Elliott)
Obtaining supervisor feedback and quality checks at each stage of the analysis	Providing credibility checks (Elliott)
Attending a peer group with other Psychologists in Clinical Training using IPA to reflect on our experiences of interviewing, discuss the analysis process and read extracts from each other's transcripts to consider alternative readings of the data.	Providing credibility checks (Elliott) Owning one's own perspective as a researcher (Elliott)
Maintaining a reflective diary throughout the research process, paying particular attention to record reflection after each interview and during the analysis process. Material from the diary was taken to supervision when I felt an alternative lens on the reflections would be beneficial.	Owning one's own perspective as a researcher (Elliott)
Providing extracts in the Results chapter to support the analysis	Grounding the analysis and results in examples from the data (Elliott)
Practicing reflexivity throughout the research process. A reflexive statement is included in this chapter.	Owning one's own perspective as a researcher (Elliott) Sensitivity to context (Yardley)
Inclusion of pen portraits and the context of the birth trauma in the Results chapter	Providing contextual information about the sample (Elliott)
An extensive and thorough process of analysis was carried out and has been detailed in this chapter with examples provided in appendices.	Rigour (Yardley) Transparency (Yardley) Commitment (Yardley)
Care has been taken to present the analysis in a coherent and authentic narrative that is accessible and meaningful to readers	Coherence (Elliott and Yardley) Writing in a way that resonates (Elliott)
The findings are discussed in relation to the existing knowledge base with recommendations for further research and clinical practice in the Discussion chapter	Impact and Importance (Yardley)
An appropriate design and sampling method was chosen to answer the research question	General vs Specific (Elliott)

2.7 Reflexivity

Practicing reflexivity involves considering the effect of the researcher as a 'whole person' on the research, which can include the researcher's personal experiences and their assumptions, influences and beliefs (Attia & Edge, 2017).

As a method, IPA acknowledges the integral role the researcher plays in the

whole research process and the importance of exploring this (Biggerstaff & Thompson, 2008). The following reflexive statement is included to assist the reader in locating and understanding my position as a 'whole person' researcher. It also includes my reflections on the overall process of data collection and analysis.

2.7.1 Reflexive statement

I have a longstanding interest in psychological trauma stemming from my clinical work in mental health. During my Doctorate in Clinical Psychology training I have felt increasingly drawn to 'Positive Psychology' and approaches to distress that focus on an individual's strengths and not only their problems. I also have a particular interest in health issues primarily affecting women, which has its origins in my engagement in feminism. I was interested in the societal pressures and narratives women must contend with around birth and motherhood, and how this might interact with their experience of a traumatic birth and subsequent growth. For example, I perceived birth trauma to often involve a positive outcome in the form of a wanted child, unlike most other traumatic experiences. There are also contradictory narratives around what makes a "good birth" in terms of the growing popularity of natural births involving minimal medical interventions on one hand, and the judgement that can come with advocating for this at the perceived expense of the baby's safety. Combined with the potential pressure on women to be happy after birth and be seen to be "good mothers" I was interested in how this might affect the experience of struggling with the impact of birth trauma. Throughout the interview and analysis process I was mindful of these areas of interest and how they might affect the research.

I do not have personal experience of pregnancy or parenting. A few of the women asked me about this directly, or referred to it in a less direct way. At the telephone screening stage several women asked me what drew me to the research and whether I had any personal experience of the topic. I was conscious that these are experiences that are difficult to compare with experiences I might have had

myself, and I wondered whether the participants would be less likely to trust me with their stories knowing this. My sense from conducting the interviews was that this was not the case, and at times it seemed the women took care to explain things to me more vividly or in greater detail because of my lack of first-hand knowledge.

While interviewing, I found it could be difficult to balance the time spent discussing the traumatic birth experience and the time spent discussing the growth experience. Giving space and time to the trauma felt important for several reasons: to understand the genesis of the growth, to ensure the women felt heard in the entirety of their experience and to assist in building rapport. As a clinician I am more used to discussing difficult experiences with people over several meetings and perhaps at times it was difficult to switch off my clinical approach. Moving the conversation along felt as though it was “shutting down” the distressing part of the participant’s story. I also reflected that participants seemed much more used to discussing the difficult parts of their experience, and in some ways this might have felt more in their comfort zone and easier to recall than their growth experience, having shared their birth stories several times before. I also imagined that the trauma experience was easier to locate in time, as it is linked with the relatively short experience of labour, birth and the immediate aftermath, whereas the timing of growth was harder to pinpoint and in some cases might have felt ongoing.

During interviewing I was mindful of the influence of the reading I had done around PTG on my questioning. As mentioned, during the later stages of the analysis process it emerged that some of the themes bore a close resemblance to the five domains of the PTGI. Much of the data that led to this theme development was offered spontaneously by participants over the natural course of the interview. However, listening back over the interviews there were times when I might have prompted some of the data that contributed to these themes, for example by asking questions around whether the participant had experienced any positive changes in their relationships with others (which would connect with the PTGI domain ‘Relating to Others’). An assumption of the underlying philosophy of IPA is that our pre-existing knowledge of a topic area cannot be

entirely bracketed, but through the process of reflexivity we can ensure that analysis remains true to the data. When finalising the themes their similarity to the PTGI domains was discussed at length during supervision. I felt confident that the clustering of the data in this way was a useful and justified reflection of the essence of the experiences described.

3. Results

In this chapter I will present the research findings, beginning with some context around the births to help the reader locate the 'post traumatic' experience of growth. This is followed by individual pen portraits for each participant, including my reflections on their interviews. The overall group analysis is then presented, with additional context provided for some themes. Quotes from interviews are indicated with italics.

3.1 Context: the nature of the birth trauma

Before introducing the participants in their pen portraits, I will provide an overview of the difficult and traumatic events and experiences described by the women in their interviews. Eight women participated in the study. They are referred to by the following pseudonyms throughout this thesis to protect their anonymity: Heather, Sally, Amy, Alison, Tracey, Angela, Helen and Sarah. Although the experience of birth trauma was not the focus of this project, the women's birth experiences are an important part of understanding their overall experience of growth.

The wider and sometimes 'pre-existing' context in which the births were experienced was a clear part of the story, though sometimes this context was offered later in the interviews. Examples of this are a history of abuse, strong fear of hospitals and medical interventions, a history of perinatal loss (own or familial) or a partner being severely ill during the labour. Some of the women entered their birth experience with strong pre-existing fears and apprehensions ("*[I] spent the whole of the pregnancy fearing that [a miscarriage] was going to happen*" - Tracey). Others anticipated things going well and 'according to plan' ("*I'd done all*

the possible preparation: my home was really ready, I was mentally ready, physically ready.” - Helen).

All participants gave birth in hospital, and the hospital environment was also a factor in the negative experiences. For some participants this involved unsanitary conditions (*“When I went to the loo it was not clean and somebody else’s blood was all on the floor.” - Helen*). A common experience was feeling a lack of privacy and dignity (*“I’d never looked that colour before, erm...with my bum hanging out and just all these people you know, it was just the most...I felt quite erm, I dunno, I felt like I wanted a bit more privacy” – Sally*; *“I didn’t want all of the people in with my legs splayed. I thought oh god please just let it be over really quick.” - Heather*).

As might be expected the births involved several ‘specific birth events’ that contributed to the difficult experience. These included episiotomies, emergency and unplanned C-sections and severe perineal tears. Several women also experienced health complications increasing the risks associated with pregnancy and labour such as gestational diabetes and pre-eclampsia. Participants often reported that there were several moments of threat, fear and worry – felt by them, their partners and sometimes the hospital staff – around the safety of both the women themselves and their babies. Induced labour was a prevalent experience and extreme pain was also common, to the extent that one participant, Tracey, stated *“I felt like my spine was pulling down like I was on one of them stretching machines. Um, and I felt like I was being tortured. I felt like...I, I could understand why people being tortured want to die and beg to die.”*

Alongside these difficult specific birth events, many of the women reported that they did not feel ‘in good hands’ with the maternity staff. Sometimes this was because mistakes were perceived or the staff appeared anxious. Participants often felt dismissed or patronised (*“I think the whole thing had been done with a sort of we’re doing this to you, it’s going to happen, live with it kind of thing.” - Amy*) or that they were treated without care or compassion (*“I just wanted somebody to hold my hand cause I was in so much pain, ‘Please!’ you know quite scared by then as well not knowing what was going on with [baby] or even*

me. And I just remember the midwife being quite like hard and just talking with the paramedic and I'm, 'Please help me!' Feeling a bit ignored, I suppose." - Sarah). A recurring sentiment was feeling that medical staff were not keeping them informed - a sense of not understanding what was happening or why, which felt confusing, frustrating and concerning for the women. Others experienced long periods of time in pain and distress without any contact from the hospital staff. Although the women did not state this explicitly, it seems intuitive that this compounded the fear and anxiety they felt during the birth. They were going through a terrifying experience, and felt abandoned and ignored by those around them. These experiences left them feeling afraid and out of control (*"I think I felt out of control. I think I felt very out-like it was all completely out of my control. Umm, and that I just didn't have, I was a little bit trapped and I didn't, I just didn't have the right to say anything at this point, you know"* - Angela).

The early postnatal period was also a significant part of the experience. For some this involved having to return to hospital to receive care. One participant's husband was diagnosed with cancer shortly after the birth. Another participant suffered the death of a much loved dog just afterwards. One woman had a painful skin condition that could not be treated while breastfeeding. Taken with the events and experiences surrounding and preceding the birth, it is important to note that the 'difficult or traumatic birth experience' cannot be isolated to just one experience or moment for all the women. Although many of these circumstances taken in isolation would not have been experienced as unusually difficult or traumatic the cumulative and overall effect of them was.

3.2 Pen portraits

This section provides an introduction to each of the participants, with some information about their birth and their growth experiences along with some reflections on the interview. All participants were living with their male partner.

Heather

Heather was a White British woman in her mid 30s from the north of England. Her interview was conducted around five months after her difficult birth experience. This was her only experience of birth.

Heather's birth experience

Heather described a difficult birth experience involving a lengthy labour and an unanticipated degree of physical pain. She arrived at her birth experience with a strong pre-existing fear of episiotomies; a procedure which she required during the birth. Heather also felt a high degree of distress during labour around the welfare of her baby, in the context of losing her niece who died shortly after birth. Heather disclosed later in the interview that she had a history of abuse which had left her with challenging feelings around being naked in front of strangers. Her birth experience involved many different professionals, including male students, observing her in a vulnerable, unclothed state which she described as "*horrible*" and "*the worst possible scenario*" for her. The care she received left her feeling dismissed and out of control at times and there were moments that felt undignified and intrusive.

Heather's growth experience

Heather noted that she began to feel positive about the birth around a couple of weeks after, once most of the physical pain had subsided. This coincided with a sense of relief and surprise that she did not experience the "*big emotional dip*" she was anticipating after the experience: "*I've survived that, and that wasn't that bad now*".

Through facing her worst fears and coping better than expected with this, Heather experienced a significant change in her temperament which she described as "*like a personality change, more confidence which is huge for me*".

One manifestation of this was her liberation from social anxiety and a newfound sense of confidence in her body: *“I feel really content in myself. I kind of feel like I don’t care about things anymore, like I used to worry that people would judge me and look at me and now I don’t care”*. This confidence had also led to greater independence and confidence in her relationship with her partner. Whereas previously she would feel anxious when they were apart and rely on her partner for reassurance and practical support, now she says *“But I can see that he cares, I don’t worry about that now, and I think he appreciates that – I’m not as needy!”*. She was also considering taking on a role with more responsibility at work for which she *“wouldn’t have the confidence to do before”* and explains that before the birth she was *“never a leader, always just follow”*.

For Heather there was a clear sense that these positive benefits were a result of the birth being so difficult for her, as opposed to changes that she might expect to see after any birth: *“as horrible as a normal birth would be, as painful, I think because it was everything, it ticked all my big anxiety boxes, that’s kind of what made me feel well yeah, that was alright.”*

Reflections on the interview

As this was the first interview I felt a little nervous and was unsure what to expect. However I soon felt at ease in conversation with her, and felt the interview flowed well. I found Heather to be very open and articulate about her experience, which was all the more notable when she explained later in the interview that before the birth she would not have had the confidence to volunteer for a study like this one.

Sally

Sally was a White British woman in her early 30s living in the south of England. Her difficult birth experience was approximately seven months prior to the interview, and was her only experience of birth.

Sally's birth experience

Sally's birth experience involved a relatively fast labour, with some initial stress due to the snowy weather and her concerns around who would look after her dogs while she and her partner were at the hospital. The birth became more difficult towards the very end of labour, at which point she experienced severe pain and there was a sense of panic in the room as she was rushed to surgery. The birth left her with "*quite a lot of damage*" physically. Some significant context for understanding Sally's experience is that she had a pre-existing fear around hospitals and needles, which had caused her a great degree of anxiety both in the lead up to and during the birth. There were moments where she felt out of control during the birth and a lack of dignity.

Sally's growth experience

Sally noticed some positive changes just a couple of weeks after the birth, but it was around two months after that she "*started to feel really invincible*", because she "*was always really terrified of giving birth and I never thought I would want to or be able to do it, and I did it*". This change in how she felt about her own abilities boosted her motivation to live life to the fullest and seize the day. She explained that she felt she and her husband "*need to up our game*" and work on their "*bucket list*" and that "*being forced to face something so terrifying*" as a medicalised birth and coping with this led her to think "*what else have you not been doing?*". This manifested in making plans to live abroad, challenging herself with social situations she would have previously avoided and pushing herself physically through running. Her perspective on life had changed, with a refocusing on "*what matters to me and, you know, erm, what do I feel I'm capable of*".

The experience also helped with her needle phobia. Whereas previously she avoided exposure to needles and required support from others for blood tests etc. she now feels she could do this alone and without "*freaking out*" explaining that for her this is a "*massive mind set change*".

Sally was unsure how much to attribute her growth experiences specifically to the birth being difficult (as opposed to the changes anyone might expect to see after giving birth), saying *“Some people run a marathon and for them that is their Everest...but yeah for me, something as medically involved as giving birth...I think if it had just been that I gave birth and nothing had happened afterwards or it was a bit more routine then I don’t know if I would feel differently because I still would have given birth”*.

Reflections on the interview

This was the first interview I conducted in a participant’s home and on reflection I felt a slight unease around not wanting to overstay my welcome. Sally spoke quite quickly during the interview, and was often quite matter of fact in her responses. I noticed that I felt rushed at times, perhaps because of these factors, and did not follow up or probe for more depth in Sally’s responses as much as I would have liked. Sally described herself as “very independent”. I wondered whether this, combined with a squeamishness at discussing medical procedures, led her to be vague in some of her responses, or minimise the impact of the birth.

Amy

Amy was a White British woman in her early 30s living in the North of England. Her difficult birth experience was approximately eleven months prior to the interview, and was her only experience of birth.

Amy’s birth experience

Amy’s birth experience was the *“exact opposite”* of what she had expected: *“I’m a preparer; I like to read and I google everything.”* After going into hospital following her waters breaking, she discovered she had severe pre-eclampsia and had to be induced. She explained that *“The one thing I really didn’t want was an induction, because a lot of this [hypnobirthing] course had been about how horrific inductions were.”* This caused a sense of panic for her, suddenly she *“felt*

totally out of control of the whole thing.” She had entered the birth experience feeling empowered and prepared, but in the event she *“completely froze”* and felt *“totally helpless”* and *“vulnerable”*. This response seemed to be a shock to her, as she sees herself as usually very assertive. Though she and her baby were ultimately unharmed, she was worried about the baby’s safety throughout the labour and the staff expressed concerns about Amy’s own wellbeing. For a period of time was fearful that a forceps delivery would be needed. Though she was able to have the vaginal birth she wanted, she did receive an unwanted epidural that only partially worked, which meant that her suturing was very painful.

Amy’s growth experience

Amy noticed that she began to feel some positive from the birth experience just a few days afterwards. Though talking to others about what happened, she was able to focus on the fact that her son was healthy. She also felt a strong sense of respect for her partner, who *“really stepped up”*. She felt this had *“changed [their] relationship massively”*. She experienced a shift in her priorities, focusing more on family and her own wellbeing and realising *“I don’t want to run myself into the ground anymore, I was to be able to enjoy myself”*. She also had to deal with confronting an increased sense of her own vulnerability, which was challenging but led to her being more able to accept support from others.

Amy seemed confident that the positive changes she had experienced – her changes in perspective and around vulnerability – came from the birth experience being so difficult. She joked that *“Part of me wonders if it had gone how we had planned, would I have come out feeling a bit smug about the whole thing”*. She did wonder about how much of her experience was more widely shared by people who have any birth experience (*“I think it would be interesting to know how much people who don’t find their birth traumatic feel that vulnerability”*) and expressed her sense that this was *“exacerbated”* in her case by the intense feelings of being out of control and not being told what was happening.

Reflections on the interview

As Amy works in a similar profession to me, I found I was more aware of my interview technique than I had been previously with a little concern that she might be evaluating me on my performance in some way. I do not feel this significantly affected the interview however, and it seemed to be that we developed a good rapport and she was open and articulate about her experiences.

Alison

Alison was a White British woman in her late 30s living in the North of England. Her difficult birth experience was around 22 months prior to the interview. She has two children, and the focus of the interview was her second birth experience.

Alison's birth experience

Alison had suspected pre-eclampsia with both of her pregnancies, with oedema and high blood pressure. Her first birth experience (with her son) took five days, but felt *"well managed and well organised"* and so was a fairly positive experience, though she had post-natal depression afterwards.

With her daughter, she was induced and was initially pleased that this stimulated labour right away. However, she soon began to experience extreme pain that *"stopped me in my tracks"* and continued to the point that she thought she was going to die and felt *"paralysed in pain"*. She was left without staff support or pain relief for long stretches of time, despite repeatedly asking for help. Right until the last minute, the staff seemed unaware that the baby was about to arrive, and there was a sense that Alison felt dismissed and uncared for by the midwives. She suffered a fourth degree tear. She found the high level of medical intervention in the aftermath upsetting and it was distressing to be taken off for surgery and be unable to spend the time she wanted with her new daughter. After leaving hospital she experienced panic attacks and other anxiety symptoms such as reliving the trauma, and there were ongoing worries such as concerns that she might have an infection.

Alison's growth experience

Alison had subsequent positive experiences with professionals that supported her growth. A community midwife left her feeling *"Yes! Someone finally gets me!"* and signposted her to counselling which was helpful. She also complained to the hospital and met with the Director of Midwifery who gave her acknowledgement that she should have had a better experience. They put her in touch with a Patient Experience Midwife who helped Alison use her experience to improve training for midwives. She felt this was *"cathartic"* and that *"some good's gonna come of this"*. She went on to deliver several talks to large audiences of NHS staff and feed-in to ongoing improvement initiatives at the hospital. She felt that the growth began around eight or nine months after the birth, when she began this work. She spoke of the increased confidence and sense of empowerment this had given her, which she had taken into her professional life too. She was also able to create a strong bond with her daughter by coming to a sense of partnership around what they experienced together during the birth.

Reflections on the interview

I went into the interview feeling a little unsettled, as I'd had some trouble finding Alison's workplace (where the interview was conducted) and was also concerned I might have caused difficulty for Alison at work by revealing who I was to the receptionist. I was also aware that we were on a tighter time schedule than some of the other interviews. Perhaps because of these factors I felt less 'in control' of this interview, and I spoke less and asked fewer questions than in most of the other interviews. Although I felt I provided less structure, Alison appeared very confident in telling her story to me and conveyed a huge amount to me in our time together.

Tracey

Tracey was a White British woman living in her mid-30s in the North of England. Her difficult birth experience was around four years prior to the interview. She has two children, and the focus of the interview was her first birth experience.

Tracey's birth experience

Tracey explained at the start of the interview that she had experienced a miscarriage before her traumatic birth experience, and was fearful throughout her pregnancy that the same thing would happen again. She had a strong emotional reaction to not going into labour when she'd expected to, saying that she felt "*devastated*" and that it "*reflected on [her] as [her] failure*". This self-criticism and self-blame was a strong theme throughout her experience. Tracey explained that the most traumatic part of the experience for her was the extreme pain (perhaps because of the baby's unusual position) which felt "like torture" and left her thinking "*I just wanna die, I just wanna die*". She felt unable to express what was happening to her, and that no one was helping which left her feeling panicky. She was later diagnosed with PTSD. The aftermath of the birth was very difficult for Tracey. Her miscarriage experience left her feeling terrified that she would be responsible for her baby's death, and to protect herself emotionally from this she felt unable to tell him that she loved him until he was three years old.

Tracey's growth experience

After the birth Tracey initially struggled to name her experience as traumatic, feeling that at least she had a healthy baby and did not "deserve" to be traumatised by what happened. With time she was able to acknowledge what she had been through, using therapy and peer support. This was very important in helping her see that her response did not mean she was "*just weak*". She met with the supervising midwife but unfortunately did not receive the acknowledgement she felt she needed, though she later received this from the Head of Midwifery. Her second birth experience was carefully supported and managed with the Head of Midwifery, and was a positive experience that was an important part of her working through what had happened "*I really needed it as*

part of my healing process; that I needed to do it again. I needed proof that it didn't have to be the way it was the first time". She had used her experience to help others, through blogging, peer support and this had helped her recognise how much she cares about other people.

Reflections on the interview

By this stage in the data collection process I was feeling more confident and familiar with interviewing. I felt a lot of empathy for Tracey's story, which she told powerfully with a lot of emotion, becoming upset at several points. I was struck by a sense that some of the negative impact of the birth was still very much with Tracey, and it felt harder to draw out the growth experience. With hindsight, a second interview could have helped facilitate this.

Angela

Angela was a White British woman in her mid 30s living in the South of England. Her difficult birth experience was around 16 months prior to the interview. This was her only experience of birth.

Angela's birth experience

Angela had gestational diabetes leading to concerns that the baby might be very large and an induced labour was required, which ultimately ended with an emergency C-section. There was a prolonged period of time waiting for her own labour to start where she was on a small ward with other women in labour who were experiencing a lot of pain: *"I think that was horrible because you sit there and you feel you're getting an insight into what's going to happen to you"*. Her baby's heart rate was too high and there was a sense of *"panic, panic, panic"* as they tried to return it to normal levels. Angela explained that the part of the birth that *"haunts [her] dreams"* is the moment where the staff decided to proceed with the emergency C-section, and though she felt very strongly she did not want this she did not feel she could speak up and say so. She was shocked by this response in herself, that she did not speak up. At various points there was a

sense that there was a lack of dignity and compassion about the experience. She described the experience as “*disempowering*” and she felt “*very much at the mercy of these people*”. She also had a painful skin condition which she was unable to take medication for while breastfeeding.

Angela’s growth experience

A couple of days after the birth, Angela had an “*epiphany*” in which the full reality of her own mortality and that of her child and everyone else she loved came to her in a strong “*sudden realisation*”. This left her with an “*overwhelming*” sense that “*life is a tragedy*” and “*you just lose everything*”. After around a month of struggling with this, she decided that the only option open to her was “*to be stupidly grateful for everything all the time, and to kind of not give a shit about stuff that doesn’t matter*”. She became active in her local Buddhist Centre and also decided to address some long-standing issues around food with a 12 step program for eating disorders. She explained that now she was “*just not being quite as hard on myself*” and shifting her priorities towards the things that really matter to her. She had also let go of much of the guilt and self-blame she felt around the birth being so difficult.

For Angela there was a clear sense that her post-birth epiphany and subsequent growth experiences were linked to the birth being so difficult. The epiphany seemed to be “*an answer*” to the self-blame she felt around not speaking up about the C-section, which had left her feeling like “*the worst mum in the world*”. She had spoken to other women about their reactions to birth and feels that her experience is different: “*I’d left the birth with a big, big question and it needed a big, big answer*”.

Reflections on the interview

My impression was that before these events religion or spirituality had not been a big part of her life, and that it was something of a shock to her to find herself with a new perspective on life. At times she seemed to be struggling with wanting to describe her experiences without relying on overtly religious language (such as

'epiphany'). I had a real sense in this interview that Angela's epiphany and subsequent engagement in Buddhism and a life of gratitude had enabled her to be compassionate to herself not just about the birth, but in other aspects of her life too leading to a wide ranging positive impact.

Helen

Helen was a White British woman in her 30s living in the South of England. Her difficult birth experience was approximately five years prior to the interview. Helen had two children. The focus of the interview was her first birth experience.

Helen's birth experience

Helen had very carefully planned for a home birth: *"And I just felt if anyone's gonna manage a home birth it's gonna be me. Like I've had all the thoughts about it, I'd done all the possible preparation."* She'd attended a hypnobirthing course and had a strong desire for a birth with minimal medical intervention. She was overdue, and though her waters seemed to have broken she did not go into labour. To increase her chances of a homebirth her waters had to be fully broken artificially, as there was a concern about infection. Her husband started to become very unwell. Eventually she had to go into hospital where she discovered her membranes had not been properly broken. She described many different midwives coming in and out, and a *"horrible"* room with a toilet that had *"somebody else's blood all over the floor"*. She recalls being told by a doctor that she was *"irresponsible"* for attempting to have a home birth. She was in a lot of pain and accepted an epidural. Her daughter's heart rate became very high and she had to have an emergency C-section. She was later diagnosed with PTSD. She had to remain in hospital overnight but her husband felt unable to stay leaving her feeling very alone. They discovered shortly after the birth that he had blood cancer. In the months after the birth he had to undergo intensive treatment for this including stays in intensive care.

Helen's growth experience

Helen attended a debrief appointment at the hospital with a consultant, at which she received an apology for how she was cared for and for the room she was given during labour. She felt *"a real sense of pride"* that she had expressed to them so clearly what an impact the birth had had on her, and this led to changes that would improve the experience of other women. She saw a psychologist who helped her realise *"how deeply this hypnobirthing had affected [her]"* – she was carrying a lot of self-blame about the birth not going to plan. She subsequently had a second, much more positive experience that *"couldn't have been more different"*, in which she planned for different eventualities and felt much more supported.

Helen felt positive changes around a year after the birth. She explained that she felt *"like a different person"* but found it hard to tell whether this was because of the difficult birth experience or generally becoming a parent. She felt she was more empathic as a result of the experience and had *"basically tried to clear a lot of unnecessary stress out from my life"*. Breastfeeding had been an important way for her to look after her daughter after being unable to have a vaginal birth, and she trained as a breastfeeding supporter and became involved in the Positive Birth Movement to help other women.

Reflections on the interview

Helen was very insightful and reflective in her telling of her experience. She struck me as very proactive in her desire to cope with the effects of her difficult birth and have a better experience with her second child.

Sarah

Sarah was a White British woman in her late 30s living in the South of England. Her difficult birth experience was around one year prior to the interview. Sarah

had two children and though both birth experiences were difficult the second was the focus of the interview.

Sarah's birth experience

Sarah went into her first birth with "*high expectations*" which she puts down to societal messages about birth and media influences such as 'Call the Midwife'. She found that she often did not understand what was happening and why, and despite being in severe pain feeling "*a bit ignored*" by the midwives, who seemed "*hard*" and lacking in compassion. She therefore went into her second birth experience wanting things to be different, and had planned with her midwife to have an epidural.

After going into labour she went to hospital where she was placed on a busy, open ward with no privacy. Despite asking for pain relief on multiple occasions she was left for hours without any medication. She reported thinking that the midwife was "quite nervous" and struggling to get the baby's heart monitor working. At some point during the labour she began experiencing a voice in her head and her "*mind was going like a thousand miles an hour*". The voice told her that she was dead which left her feeling "*freaked out*" and "*trapped*". She was in extreme pain and feared that she might not survive the experience and could hear the staff saying that her heart rate was low. She also had an episiotomy.

Sarah's growth experience

Sarah was encouraged to meet with a team of professionals at the hospital to discuss her birth experience which she found really helpful. She also praised the aftercare she received from the 'follow up midwife' and health care visitor. She felt her marriage was stronger for coming through the experience together. The other main area of growth or positive benefit was Sarah was her Christian faith. She had questions for God around where he was in that room, "*and I suppose it's that, you know, why did you let that happen question*". Through a dialogue with God she came to see that she had a choice trust in him or not, and decided to trust him. This allowed her to "*let go of the whole experience*" and it

“strengthened [her] faith.” She felt a newfound sense of courage and strength. She also saw a therapist who combined her training with a religious perspective which *“really helped look at things differently”*. Sarah began experiencing these positive changes around a month after her difficult birth.

Reflections on the interview

As this was the final interview I was feeling confident and comfortable with it. Although I had arrived late due to severe snow and had some concern about the journey home due to public transport disruption, Sarah was very accommodating and I do not think this negatively affected the interview. I was struck by Sarah’s calm and considered account of her experience, which as a listener would have made it easy to overlook the full impact the birth had on her.

3.3 Group analysis

As described in the Methodology chapter, I then carried out a group analysis to synthesise into themes the experiences shared by some or all participants. This section presents and briefly discusses each superordinate and subordinate theme, with supporting quotes and extracts from interviews. Three superordinate themes were identified: ***“The total opposite to what I’d expected”***, ***“I see it a bit differently now”*** and ***“A much better place”***. These are comprised of two, four and five subordinate themes respectively. A thematic map is provided in figure 3 below to help the reader conceptualise the data. Table 7 depicts the representation of each participant within the themes.

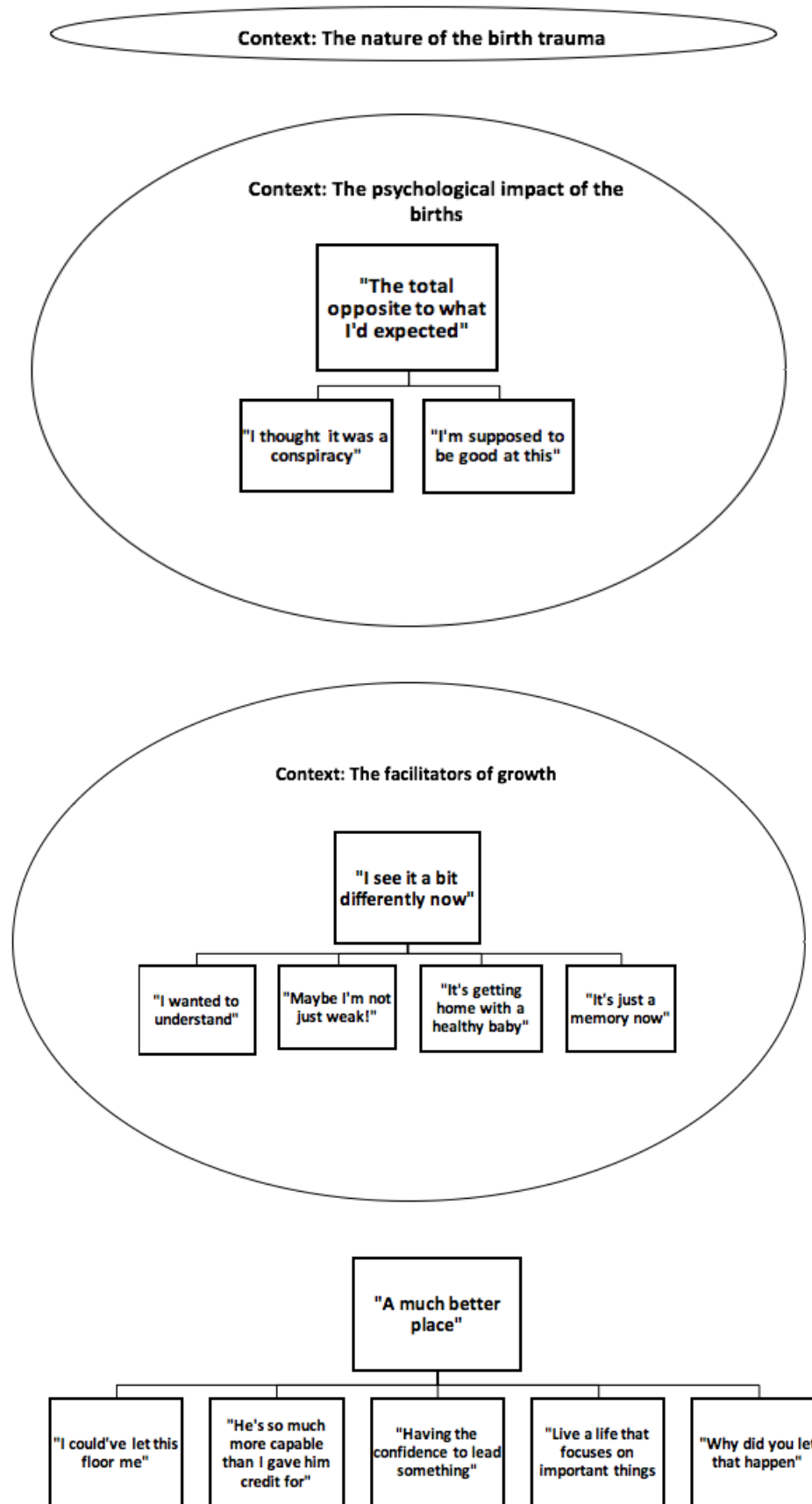


Figure 3: Thematic Map

Table 7
Representation of each participant within the themes

Super-ordinate theme	Sub-ordinate theme	Heather	Sally	Amy	Alison	Tracey	Angela	Helen	Sarah
The total opposite to what I'd expected	<i>I thought it was a conspiracy</i>	✓	✓	✓	✓	✓	✓	✓	✓
	<i>I'm supposed to be good at this</i>			✓		✓	✓		
I see it a bit differently now	<i>I wanted to understand</i>			✓	✓	✓	✓		✓
	<i>Maybe I'm not just weak!</i>			✓	✓	✓	✓	✓	
	<i>It's getting home with a healthy baby</i>			✓	✓			✓	✓
	<i>It's just a memory now</i>		✓	✓		✓	✓		
A much better place	<i>I could've let this floor me</i>	✓	✓	✓	✓	✓	✓	✓	✓
	<i>He's so much more capable than I gave him credit for</i>	✓	✓	✓	✓	✓		✓	✓
	<i>Having the confidence to lead something</i>	✓	✓	✓	✓	✓		✓	✓
	<i>Live a life that focuses on important things</i>	✓	✓	✓			✓		✓
	<i>Why did you let that happen</i>						✓		✓

3.3.1 Context: the psychological impact of the births

This section provides some additional information on the emotional impact of the birth experience on the participants. As with the nature of the birth trauma, the psychological impact of the birth was not the focus of this study. However, some of the data generated on this is provided to help set the scene for the first theme (***“The total opposite to what I expected”***).

As might be expected, several of the women described trauma type symptoms and manifestations of stress and anxiety in the aftermath of their birth experience. Heather described experiencing intrusive images of the birth: *“...again like just had the flashbacks just yeah horrible images in my head. And then I think it was a couple of days after in the bath, because I had salt baths just for the stitches, and whenever I got in there it was like being back in the birthing pool and thinking about the birth again.”* Similarly, Alison recalled “re-living” the experience: *“I started talking about things with my husband and we were just re-living it; and er, as I was re-living it I started to get a migraine.”* As did Sarah: *“There were times when it would, you get intrusive thoughts and you flu-you know you kind of flush back to it.”* Amy commented: *“I can still hear that beeping machine, you know the heart beat monitor”*. Some of the women also experienced hypervigilance after the birth: *“...when I got home I didn’t sleep for the first two nights. I stayed awake because I was worried that she’d, that she’d die.”* (Heather). Two of the women, Helen and Tracey, disclosed that they had been diagnosed with PTSD following the births.

Anger was also part of the emotional aftermath for some of the women: *“Since he was born anger has been the predominant emotion for me and in the early weeks I would get explosively angry.”* (Amy) and *“Quite a lot of sort of anger [pauses] because I just felt like they’d kept me in the dark about it all.”* (Angela).

Feelings of shame and guilt around the trauma were expressed by several of the women, who often blamed themselves for things that had been difficult about the birth: *“I was a little bit almost embarrassed of what had happened. Umm, cause I*

just felt like I'd let him down" (Angela) and "I just blame myself for everything . . . everything that went wrong." (Tracey).

For Amy, there were feelings of envy that other women had much more positive birth experiences, which then brought on feelings of guilt. She discussed this in the context of another woman sharing that she had similar feelings: *" 'Do you sometimes feel a bit jealous when you see that it's gone, like, well?' erm and she said 'Yeah, definitely'. So that made me feel a bit better because I was like oh I'm a horrible person [for feeling jealous]" (Amy).* The sense of loss around the birth not going as hoped for was shared by several of the women, e.g. Sarah: *"I suppose I look back on it now and I, I'm sad that my experience was like that".*

Helen described being *"in survival mode"* after the birth, explaining that she *"just became manic and busy and slightly obsessive about things so that my brain was full."* as a way of coping with what had happened.

In summary, the women described a variety of distressing emotional and psychological responses to their birth experiences that are not uncommon in the aftermath of a traumatic event. This context can assist the reader in understanding the emotional environment in which the struggle to cope and subsequent growth occurred.

3.4 "The total opposite to what I'd expected"

This superordinate theme depicts the struggle to accommodate the birth experience in the post-natal period. It is comprised of two subordinate themes: *"I thought it was a conspiracy"* and *"I'm supposed to be good at this"*.

3.4.1 "I thought it was a conspiracy"

This theme relates to the ways in which participants' expectations and assumptions about the birth and how they would cope with it differed to the reality of their experience. Needing to work through these differences and assimilate

what had happened was part of the impact of the difficult birth experience for the participants.

Several of the women had idealised the birth experience, and there was a strong sense of anger and loss at being deprived of the hoped for 'perfect birth experience'. For example Helen, who had planned for a home birth but was admitted to hospital and had an unplanned C-section, said:

"I remember feeling so angry like I'm here and everyone's been horrible to me and it is horrible and I can't even get my own baby without ringing the bell. And I had this image of this perfect birth and I was gonna be the one to do it! I was gonna wake up- have my baby and then have my tea and toast and in my own bed and it was all going to be a dream. And actually it was a nightmare."

Some of the women talked about specific aspects of the post-birth experience that they had been told about and looked forward to. Amy referred to the "golden hour" after birth, involving uninterrupted 'skin-to-skin' contact with her new born baby. In the event this period of time was painful, "awful" and "horrific" and Amy expressed a sense of loss that that she had been unable to spend this time with her baby as she had imagined: *"I'd read all the stuff about how important that first hour was and I basically spent it crying and shouting."* Similarly, Tracey spoke about the anticipated "tears of joy" she expected to have post-birth. When the midwife saw her crying immediately after her baby was born, she asked Tracey if she was having her tears of joy. Tracey commented *"No. these aren't tears of joy. They're tears of, of pain and relief and a bit more pain and terror and horror; and just this kind of sense of 'Why, why me; why did this happen-happen to me?'"*

Often the sense of anger and loss was felt on behalf of their baby as well as themselves, and several women expressed concern and disappointment that they had not been able to provide them with the start in life that they had hoped to:

"And just, I think because it wasn't the way we should have done it there was that about it as well but that I think because I'd read all the stuff about how

important that first hour was and I basically spent it crying and, and he was there he was right next to me I think unfortunately doing [the job I do] you're very aware of how really sort of early experiences impact and I- I'm sure he will never remember that but you sort of think we missed that. I felt I'd lost that time and it should have been really special." (Amy)

Among some of the participants there was a sense of shock or betrayal that other women had not warned them about what was to come. There was a feeling among some women that had they had a better idea of what to expect, the birth might have had less of a negative impact, or they might have been able to make sense of their experience sooner. As Tracey put it: *"I thought it was a conspiracy. I thought everyone did feel that way and that just no one had told me and I felt completely cheated. Um, cause, because everyone, everyone had told me all my life this was wonderful and joyous experience [merge] it felt so dramatic to be talking about the word trauma in the same sentence as childbirth because I'd never heard of birth trauma."* Angela also found the lack of warning about the realities of having an emergency C-section had a negative effect on her: *"What I found really hard about that was that they don't sort of warn you what it's gonna be like; and it's actually really nasty."*

Several participants mused on whether it would have been better to know more about what could have gone wrong or not, seeing that both could potentially have a negative impact. The women talked of seeing both sides of the dilemma and experiencing this themselves in considering how much to reveal about their own birth experiences. Alison summed this up: *"You don't want to scare women to tell them that this is-could happen; but equally you're not prepared in the slightest for anything like that."*

Some of the women provided clues as to how their expectations of birth had been formed. Sarah spoke of the *"high expectations"* she had developed through watching television programs about birth such as 'One born every minute' and 'Call the midwife': *"Actually looking back now, they gave me a false impression of, of what midwives are there for"*. Sarah found that she *"had a complete different experience [to what was portrayed] and...their role was in some ways*

different to what I expected.” She felt that she had entered her birth experience “quite naïve and blind”, saying: *“it feels like society sets you up for it, for childbirth, in a certain way and, you know the media culture umm, unless you speak to some really honest friends or family who tell you different experiences.”*

Helen spoke of the effects of hypnobirthing on her expectations of birth, saying: *“I hadn’t realised how deeply this hypnobirthing had affected me”*. She experienced *“disappointment, self-blame, these feelings of loss of control”* after the birth, and concluded that *“a lot of people, from what I can gather from my readings, who have done hypnobirthing then don’t have a perfect birth have these feelings.”* Amy also found that her hypnobirthing experience had left her with unrealistic expectations of birth. The message she had been left with was that her body would know what to do, but in reality she found that: *“Erm so that was the total opposite of what I’d expected and my I guess my belief system really. I’d gone in thinking so this is a really natural thing, it’s gonna happen how it’s gonna happen. I can’t influence it.”*

Amy fell pregnant easily, and noted that she thought: *“a lot of my friends and family haven’t had that experience so a bit of me was like this is great, this is obviously meant to be.”* It seemed that family narratives around birth could have played a role in Amy’s pre-birth expectations. Her own mother had had positive birth experiences: *“My mum always, she had, she’s had three children and she said ‘You know I never had more than gas and air, always had sort of natural births’ and I thought oh I’ll be the same.”*

3.4.2 “I’m supposed to be good at this”

This describes the struggle of participants to integrate their birth experiences, their responses during and after the birth and how they coped with it all into how they see themselves as a person, a woman and a mother.

For many of the women, the fact that their birth experience did not go according to plan or as hoped for was taken as a reflection on their ability to ‘do birth well’, and for some it left them with a sense they had failed as a mother. Tracey

experienced this self-criticism and blame acutely, explaining: *“And then I didn’t go into labour. And then I somehow reflected that on me as my failure”* and *“And then I only blamed myself afterwards for needing stitches, because obviously that meant I was a failure as well. If I’d just been able to cope better then they might not have ended up with stitches in.”* She summed up these feelings with the following statement: *“If something happened when I was giving birth that would be my fault cause that’s my body and it means I didn’t do it right.”* This was echoed by Angela, who described thinking *“I’m terrible and I feel so guilty [merge] I should’ve stood up for him [merge] I’d let him down. This little thing that couldn’t speak for itself and the first thing I’d done, as his mum, was to let him down”*.

Amy had carried a strong sense of being in some way destined for motherhood, and a strong belief that she was *“supposed to be good at this”*. The complicated birth experience threw this belief into doubt for her, causing significant emotional distress:

“You know people say I’ve always been maternal I’ve always wanted to have children [merge] but the sort of conflict with that I’m somebody who loves children so much and would love to have more children versus my body just doesn’t seem to like this. [merge] I think that’s probably been quite...probably emotionally that’s one of the hardest bits actually. That that’s not that’s not how it was supposed to be. That’s not me. I’m supposed to be good at this [merge] thinking about it maybe I feel like it reflects on my ability to be a mum that I can’t...because that’s all part of it isn’t it.”

Many of the women expressed a strong desire for as ‘natural’ a birth as possible with minimal medical intervention. Having a more medically involved birth gave rise to feelings of failure, a sense of not having done birth ‘properly’. Angela expressed this as follows:

“I think for a while I didn’t really feel like [pauses] er-ugh, I remember having a conversation with my sister. My sister’s had three kids and she was like umm, ‘Oh, well done! You’ve earned your stripes.’ And I sort of went, ‘well not really cause I had a C-section so it wasn’t.’ [merge] you know there’s-there’s a kind of

idea of it's the easy way out, d'you know what I mean [merge] I think it just stayed with me for a long time that like I was a little bit almost embarrassed of what had happened."

Amy's experience had led her to doubt her own body and its abilities. She explained that her hypnobirthing course had taught her *"You know your baby knows best and you know best"* and then went on to say *"but I was thinking well that can't be right because my body isn't doing what it's supposed to do. And there was an element of, well you know you told me the whole way through my body will do what it's supposed to do and it isn't! It isn't doing what it's supposed to do. Erm, I can't rely on it to just do what it meant to, it's not safe."*

Some of the women expressed shock or disappointment at their responses during the birth. For example, Alison said: *"I'm being one of them women I never wanted to be that you see on TV, you know wailing down um, down the corridor."* For some there was a sense that they did not recognise themselves during the birth, and their reaction was very different to what they would expect given how they see themselves. Amy described herself as usually very *"opinionated"*, but found herself feeling out of control and disempowered during the birth: *"The only way I can put it is it was complete rabbit in headlights. I just of went 'Yep you do what you need to do. Erm, I'll just go along with it, sit there and just, just take it really."* This was the opposite of how she had anticipated herself being going into the birth, where she felt *"That I knew my options, I knew my choices and I wouldn't mind saying what I wanted."*

For Angela, the part of the birth experience that she described as *"the bit that, like, haunts my dreams"* was when the doctors suggested a C-section, and despite having a very strong preference not to have this she felt paralysed and unable to speak up. She explained her feelings about it as follows: *"Who am I to tell them not to, you know. But actually I wish that had been drilled in to me a little bit more cause I would've argued a little bit. I just didn't think really I had the right to argue with them, do you know what I mean?"* Her behaviour in that moment had a significant effect on her, as she reacted so differently to how she would have wanted and expected to: *"That is the moment that really hurts my heart"*

bigtime you know because I just, I'm not a very quiet person [chuckles a little] and I tend to . . . there's not been many occasions that I've not, if I really feel strongly about something, that I've not said something."

3.5 "I see it a bit differently now"

This theme relates to the processes the women experienced on their journey in coming to a place of growth. There are four sub themes: ***"I wanted to understand"***, ***"Maybe I'm not just weak!"***, ***"It's getting home with a healthy baby"*** and ***"It's just a memory now"***

3.5.1 "I wanted to understand"

This theme describes the questioning and striving to understand that the women went through – their struggle to assimilate what had happened. Several women described an active process of meaning making, in which they were striving to make sense of what they had experienced, as described by Tracey: *"I wanted to make a sense of it; I wanted to understand why I felt the way I did."* Alison also spoke to a proactive approach to coping with the impact of the difficult birth, which led her to seek professional help: *"I wanted to recognise the things that were affecting me and get 'em dealt with and nip 'em in the bud. And this is where the positivity comes in because [the therapist], so she helped me deal with that."* Sarah experienced a similar process, through the lens of trying to understand what the role of God had been in allowing her experience to happen:

"So after that experience I was processing that in terms of my Christian faith [merge] And I suppose it's that, you know, why did you let that happen question. I mean all of us, whether you believe in God or not I guess, ask why things happen sometimes [merge] Why did we, why wasn't it how we expected. All those kind of questions."

Several of the women, including Amy, questioned their own role in the birth: *“I thought why has this happened, like I am I just not supposed to have baby? There was that kind of thought process as well.”*

3.5.2 “Maybe I’m not just weak!”

This theme relates to the reconceptualising of the experience that many of the women engaged in.

Some of the women needed to go through a process of accepting that their responses to the birth were valid, and that they could name their experiences as traumatic. Several engaged in a kind of trauma-comparison, initially feeling that their experience was not ‘bad enough’:

“You know for a long time afterwards I used to worry about talking about it because I used to think, ‘Well, my trauma’s not that great compared to some people who have these huge injuries after birth; or their babies are terribly sick or worse-case-scenario they don’t end up with a child or, you know their child dies. Like what right have I got to be this . . . upset, but I feel the whole proce-coming through the whole process and getting to where I am now I realise it’s all subjective, isn’t it and you’re feeling it. And I didn’t let myself feel that until this last couple of years.” - Helen

This was echoed by Tracey, for whom reconceptualising the birth as traumatic allowed her to begin being more compassionate to herself and feel deserving of support:

“I think when were first talking about trauma and it felt so dramatic to be talking about the word trauma in the same sentence as childbirth because I’d never heard of birth trauma [merge] it was a slow process but little by little I was finding bits of information here and there and I found the Birth Trauma Association . . . website. And I read a story on there that, you know was completely different to my story but with things that were exactly the same. And I started to recognise that, ‘Oh actually, yeah, you know I might not have had a haemorrhage or a C-

section but I did feel this lack of control. I felt like I wasn't being listened to, you know just-and-and I, you know every time I found a story that was, that had something in there, I just cried cause I was like maybe this is real. Maybe, maybe I'm not just weak!"

Being able to acknowledge and recognise what she had endured was for Amy "one of the hardest bits." As time passed the reality of what happened to her during the birth became more salient: *"I started to put bits of conversations that people had had around me together and then oh shit that was really scary (laughs) and its I think thinking back on it actually that the fear comes a bit yet I don't remember feeling scared at the time."* Processing and fully acknowledging what had happened was in some ways more difficult than the birth itself: *"So yeah I think the following weeks were probably more difficult weirdly, cos I was thinking back and you know thinking that wasn't very nice, that was horrific."*

Professional validation and support played a significant role in this process for several of the women. Alison explained that her community midwife was "fantastic": *"I told her the whole-the whole tale and she went, 'You must've felt,' you know, 'You must have felt like this. You must have felt like that.' and she just nailed the feelings out I was having and I was like, 'Yes! Somebody finally gets me!' and she gave me the card of a counsellor at the hospital". Alison went on to have an appointment with hospital staff to discuss her birth experience. She explained: "They were very apologetic and it was like, 'Okay. I'm done. I can feel okay with things now. I can draw, I can draw a line under it because they've acknowledged I'm not losing it. I'm not imagining this is worse than it is. It really is that bad and yeah, I'm happy with the response.'"*

3.5.3 "It's getting home with a healthy baby"

This subordinate theme relates to the ways in which participants were able to put their experience into perspective without minimising what had happened to them, and to find some good in what had happened to them.

For Alison, this meant finding solace in her relationship with her new daughter, who she had associated with the difficult birth experience: *“The upshot was of-of the time in hospital that I had to find a way to view [daughter] in a positive way. And, and I’ve thought about it and I thought she’s the only person who’s gone through this with me. She’s my little . . . partner; she’s been there with me. And she came, she came through it with me. So we’re a team and that was my way of coping and connecting with, connecting it all.”*

Many of the women talked of wanting to recognise that, as difficult as the birth was, it could have been worse and that others have birth experiences with worse consequences. In the early days after the birth, for some women these thoughts were connected with shame and a sense that they didn’t deserve to feel so upset by the experience. However, after time had passed they were able to put the birth into perspective in a more helpful way, more connected to gratitude than shame. This was expressed by Amy, who said *“You know, we’ve got a healthy boy here that, you know we might, we might not have in any other situation.”* and *“at the end of the day the ins and outs of how you’re going to get there aren’t important, it’s getting home with a healthy baby.”* Amy mentioned that talking to others about the birth and also reading a blog written by a women whose birth Amy perceived to be worse than her own helped her reconceptualise her experience in this way: *“Yeah it’s that comparison actually of yeah that was awful but we’ve been lucky in so many ways”*. Similarly Sally said: *“I have just read some real horror stories and it’s just like Christ almighty, you know, I got off lightly, really lightly in comparison.*

For Helen, finding good from the experience came from her work as a breastfeeding supporter, through which she was able to use her experience directly to support other mothers who might be struggling: *“I really think the breastfeeding thing did come from the birth because I think it was a way, I remember feeling like ‘I couldn’t give birth to you and I really failed with that and I really want to succeed with this’. This is, it was really important to me because of . . . how she was born. And umm . . . I know I guess I’d this ideal of optimal birth, which I didn’t achieve; but this, I could achieve optimal breastfeeding, I suppose.*

Umm, and then I became to really deeply understand breastfeeding because of that so I can help other people”

3.5.4 “It’s just a memory now”

In coming to a place of growth it seemed significant for several of the women to put the birth behind them in some way. For some this meant holding a more compassionate narrative for what happened, that released them from self-blame and questioning whether they could or should have done something differently. Angela expressed this as follows: *“I think what has struck me is that I did the best, I did do the best that I could in that situation, at that time.”* and *“I can relieve my own guilt a little bit d’you know what I mean. Now. But that’s come from a lot of work.”* This sentiment was shared by Amy, who said: *“...because to be fair you know none of us could have done more than we did. I know, I think I’ve sort of got my head around that.”*

A sense that the birth experience had been processed and belonged to their past also came through. This was done in a way that meant the experience was not minimised or avoided – the challenge and impact of it was still acknowledged. But perhaps it was less ‘live’ for the participants now and there was a sense of being having moved on from it. Heather said: *“I survived that and that wasn’t that bad now. It was horrible at the time but yeah it’s just a memory now.”* A similar feeling was expressed by Tracey: *“I suppose I see it a bit differently now; it feels a bit like it happened to someone else. So . . . and that’s good; it’s good cause it makes me think I’m not there when I’m talking about it.”* Sally echoed this, adding that putting it in the past meant she was able to refocus onto positive things: *“Everything’s fine and therefore it’s alright now because it’s in the past but I don’t have to think about it now I’ve done it I’ve given birth...I think because I’ve not had to dwell on it doesn’t take any energy talking about things that have happened, so what I can focus on is the better things of how I feel.”*

3.6 Context: the facilitators of growth

The experiences and processes that allowed the women to come to a place of growth in the theme above (*“I see it a bit differently now”*) were facilitated by a variety of factors. This data is descriptive and so has not been included as a theme in its own right, but nonetheless provides useful context for understanding how it was that the women believe they were able to experience growth.

Having outlets through which to share their story was important and provided validation, a space to process what had happened and sometimes opportunities to find positives from the experience through influencing the health system or directly speaking to other pregnant women or new mothers. These outlets came in a variety of forms including family and friends (*“[It was a huge thing] to share the stories and to talk through things and to have somebody else say of god yeah that sounds awful but he’s here and you’re both ok” - Amy*) professional support (*“[the midwife] just nailed the feelings out I was having and I was like, ‘Yes! Somebody finally gets me!’ - Alison*) and wider audiences of professionals (*“having a patient speaker at one of these events [for midwives] and talk about themselves, their experience, puts things into a lot of context for them so they can actually bring back the reason why they were midwives in the first place.” - Alison*). Four of the participants met with hospital staff to discuss their experiences of the birth, and three had a course of therapy as a result of their experience.

Some participants also pointed to pre-existing personality traits (*“I have always been a glass half full kind of person” - Amy*) or strategies to manage distress (*“I think that again I guess I’m quite anal, again tick box, getting through little hurdles. That might have been part of my personality.” – Heather*) that were useful to them in this process. Sarah had met with a psychologist some time before her pregnancy and was able to use some of the strategies she had learned there to help her manage post-birth: *“a lot of the stuff that [the psychologist] did with me was, was really helpful.”*

Putting boundaries in place was also helpful for some participants. This took the form of distancing from negative influences (*“And actually not seeing, my mum saw her twice, but she can be quite overbearing. [merge] The distance between me and that negative influence was really good - Heather*) but also positive stories of birth, as in Alison’s case: *“I’m not ready yet to let my story, [my]self be the advocate for all these women um, sharing these positives stories and get their voices heard when I really feel like I want my voice heard.”*

Healing relatively quickly from the physical impact of the birth facilitated growth for some women. This gave them space to focus on other aspects of their wellbeing as they did not have constant reminders of the birth trauma: *“If you had erm problems as a result of a birth and you took years to get over it then every time you have that problem you’re reminded of perhaps why you have that problem in the first place so I think, yeah, but I think the fact that by about three months everything was pretty much ok [was useful]” – Sally.* This sentiment was echoed by Amy, who struggled while still in the process of healing: *“...I’d had a lot of problems healing as well so it was only sort of three months after he was born that everything sort of resolved and physically I was still struggling with that and it was sort of a constant reminder really of everything that had happened.”*

Other factors also gave the women the time they needed to reflect. For example, not seeing any visitors (*“the first few days or so after the birth I mean I locked myself in the bedroom pretty much cause I didn’t want any visitors. I just wanted to be left alone. Um, and I was kinda tryin’ to work through what was going on.” – Tracey*) or a partner taking care of practical matters (*“So I think getting home and just having that time to unwind a little bit and relax and sleep that made a huge difference because I really there was a huge difference in just sleeping, I would wake up and feel a lot better. So I think his support with the sleep was really important.” - Heather* and *“[partner] had quite a long time, I think he had about three weeks off work in total because I needed I couldn’t cope on my own really before then” - Amy*). Similarly, for Helen, some parts of the healing process felt more accessible to her once she created more space for herself: *“I cleared out a lot, I basically tried to clear out a lot of stress from my life, unnecessary stress. Umm . . . and then umm, I was able to do a bit more stuff myself.”*

3.7 “A much better place”

This theme relates to how the participants experienced growth itself, how they described what ‘growth’ or ‘positive benefits’ meant to them in the context of their birth trauma, what the “better place” of growth looks like in their lives. There are five subordinate themes: ***“I could’ve let this floor me”***, ***“He’s so much more capable than I gave him credit for”***, ***“Having the confidence to lead something”***, ***“Live a life that focuses on important things”*** and ***“Why did you let that happen?”***

3.7.1 *“I could’ve let this floor me”*

This theme describes the positive changes in how participants understand themselves. For some there was a real sense of pride in how they had overcome such a challenging experience: *“I think I probably have more confidence in myself and um, pride in myself . . . thinking, you know I, I could’ve let this floor me. I could’ve let this completely consume me; many people do and I’m not taking anything away from them, you know everybody’s different. But I, I was, you know proud of how I got through things and I think that pride and confidence has come out in, in me.”* (Alison). For Heather, facing her worst fears and emerging from that happy was a significant achievement: *“I think because it was everything - it ticked all of my big anxiety boxes, that’s kind of what made me feel well yeah that was alright. As horrible, as anxious, as sick as I felt, my heart was pounding and I thought I’m just going to close my eyes and disappear now, this is horrible, I think well, you didn’t disappear and yeah I’m alright. I’ve come through, happy.”*

Participants were proud of their strength in overcoming and surviving.

An increased sense of one’s own confidence and courage was a common occurrence in the women’s growth stories. Often this meant recognising that these qualities were already there, but previously overlooked or yet to be revealed, as for Sarah: *“This has made me a better person, actually. It’s, you know it’s bringing me out things in me that I didn’t know were there. so, yeah*

[merge] umm, well courage, I suppose. Um, strength, you know strength of character I didn't know umm, was there." There was a sense that these changes were profound and enduring: *"I'm not sure what erm the positive experience was but for me that's just been like a personality change, more confidence which is huge for me."* (Heather)

Heather spoke of the increased body-confidence she experienced as a result of enduring such a physically exposing birth: *"It's had a huge difference to me. Like for years I'd been thinking 'oh if only I could be happy, I wish I could have the confidence to wear a bikini, I wish that I had the confidence to wear a dress that's above the knee' and things and I thought well yeah, I do that now without thinking."* There was a sense that she has reclaimed her body for herself and could take pride in its usefulness in nourishing her baby: *"...it makes me happy when I realise that I'm feeding in public and I haven't thought about it I haven't thought about oh there are people here and I haven't even thought that I should cover up."*

Amy described an increased sense of her own vulnerability. She explained that seeing herself as vulnerable was *"a horrible and uncomfortable feeling and not one I sit well with"* but acknowledged that following the birth *"I do feel more vulnerable. I don't necessarily think that's a bad thing. It sounds bizarre I know but I'm not sure that's a bad thing."* Having to rely on her partner for support was a very valuable experience in recognising that *"I'm not infallible"* and *"...it has taught me that's it's ok to be a bit more that way."*

For Sally, who had a fear of needles and medical procedures, coming through such a medicalised birth experience led to a new independence and ability to manage her fears: *"I'm pretty sure I would be able to go [to have an injection or blood test] by myself even and have it done and not be really freaked out about it and you know it sounds really trivial but for me that a massive mind-set change to be able to do that."*

3.7.2 “He’s so much more capable than I gave him credit for”

This theme is concerned with the positive changes in relationships experienced by participants due to their difficult birth experience.

Several participants spoke to a newfound admiration for their partner, or a sense they now knew they could rely on their partner, having witnessed them ‘step up’ during the labour or aftermath of the birth. There was a greater sense of partnership for having enduring such a difficult and frightening experience together. Amy summarised this in relation to her own relationship: *“I think it’s given me a new respect for him really, because you know whatever happens now I sort of think you know what, he can handle this...we’ve never really faced anything that difficult between us ...actually he’s so much more capable than I gave him credit for.”* Sarah felt a similar appreciation for her partner’s support during the birth: *“You know he was the constant and he was, he was just fantastic. He was like having my own midwife, I suppose really, you know he was trying to sort all that out, sort me out, you know. And so actually it’s made our, our marriage stronger.”* There was a sense that his support had made a real difference to her coming through the trauma, as she said *“he got me through that actually.”*

Alison initially found she associated her baby with her traumatic experience, but found a way to reconsider how they uniquely shared the birth experience, leading to a close bond: *“She’s the only person who’s gone through this with me. She’s my little . . . partner; she’s been there with me. And she came, she came through it with me. So we’re a team and that was my way of coping and connecting with, connecting it all.”*

Heather found that she was released from a kind of social anxiety or lack of confidence that had previously held her back from really being open to new or deeper connections with others: *“I was quite closed off. But I’m a little better now at speaking to be people I don’t know, and people I do!...Now I think because I’m more confident and now I don’t care. I used to sit back and think ‘Oh now I’m saying something and that sounds really stupid’ and I think ‘what do they think of*

me' and now I just have a conversation, it's not as anxiety producing seeing, seeing people that I don't know, speaking to them and just saying hello and just 'go on, have a chat' now".

Other participants reflected that before the birth they were less tolerant or understanding of others, but that their experience had softened this, and they were more able to relate to others with less judgement and more empathy. Sally said *"I used to be quite judgy...I'm more outwardly tolerant now"* and Helen expressed this as follows:

"It's made me far more empathetic umm, I think it's made me appreciate that you never know someone's back story now like I think before perhaps I was a bit arrogant. Umm . . . and a bit intolerant; not, not majorly; I don't think I was an unkind person. I just don't think I realised . . . you know that people can have gone through really awful things and you don't know. Umm ... so I try and, I think I'm a lot more understanding than I used to be. Umm, I look at them a lot more deeply."

3.7.3 "Having the confidence to lead something"

This theme speaks to the ways in which participants have forged different paths for themselves, including taking on new challenges and in particular using the experience to help others.

Several of the women had felt moved to use their experience 'for the greater good', which in turn left themselves feeling positive. Some of the women became active in online forums, such as the Birth Trauma Association Forum. For example, Helen said: *"I found that I just knew a lot of facts that could be useful to other people, and spent time sharing them. And how that was... I felt good about that."* Helen also sought out training to support other women:

"So I trained as a breastfeeding supporter . . . and then . . . and I . . . don't do it as much now but I supported a lot of women with breastfeeding, especially through IVF. And I felt that that was something really was [pauses] umm [pauses]"

yeah, I feel really good about that [merge] I really think, I really think the breastfeeding thing did come from the birth because I think it was a way, I remember feeling like I couldn't give birth to you and I really failed with that and I really want to succeed with this. This is, it was really important to me because of . . . how she was born. And umm . . . I know I guess I'd this ideal of optimal birth, which I didn't achieve; but this, I could achieve optimal breastfeeding, I suppose. Umm, and then I became to really deeply understand breastfeeding because of that, so I can help other people."

Often these acts of public service had a dual benefit for the women, of allowing them to make a difference to others but also bringing growth to their professional lives in some way. For example Alison took on a public speaking role, sharing her experience with hundreds of healthcare professionals to improve practice.: *"But I think the positive, the main positives being the public speaking. Um, speaking to all those people, and the fact that I would never have imagined being able to do that. Um, I'm not, I was not that kind of person really. Um, but having done it I was like 'Mm, this is good, I can do this'. And it made me realise that actually if you know the subject as much as you know something like that, you can deliver it really powerfully and it's really influencing."* This gave her increased confidence and skills that she was then able to take into her professional working life, opening up new opportunities to grow in her career: *"So when I came back to work, there was an opportunity to start this new role which was taking on a training role in terms of rolling out our vision and values. And it involved public speaking which I would have 100% shied away from before this experience, before public speaking."*

Heather similarly found herself exploring more of a leadership role at work (*"it's a big difference for me, having the confidence to lead something even if it's just with one person."*) Before the birth she did not see herself as the kind of person who could do this sort of work, saying *"I was never a leader, always just follow."*

For Helen, it was important to speak up and fight for changes in the system and hospital she gave birth in, to reduce the likelihood of other having to endure what she had. She met with hospital staff to feedback on her experience: *"It's not just*

about me. It's about everyone else that goes after me. So I think that's something positive that came out of it." Again this meeting served a dual purpose – it was also a real turning point in her own recovery and journey to growth from what had happened: *"If we hadn't gone to that meeting at six months I think it would've all been probably swept under the carpet and I don't know where we'd have ended up. I mean in terms of my own feelings. I don't know how it would've all come out in the end."*

Other women found new challenge away from their professional life or helping others. Sally talked of a new sense of drive and desire to push herself through running: *"So I was doing park run before I got pregnant but I was only sort of half-arsed doing it, whereas now I started doing again in the last couple of months and it's become a bit of an obsession [merge] I wanna run faster, I wanna, you know, I wanna erm do better and erm and to do 10k's and stuff. Whereas before I would have been like I just run because I feel like I'm supposed to."*

Amy summed up the sentiment expressed by several women that the birth experience and jolted them somehow out of the old life, and awakened in them a strong desire for change: *"It's almost I imagine a little bit like what you must feel if you've had that near death experience sort of thinking yeah you know I really need to change my life."*

3.7.4 "Live a life that focuses on important things"

This theme speaks to the changes in perspective and priorities that the women experienced as part of their growth.

For Heather, this is seen in her shifting focus away from broader world events, focusing in on a smaller world but one that is more full of joy: *"I used to be really worried about the news, about things happening in the wider world and think well this is a really horrible, horrible world to live in and now my world is a lot smaller because it involves my daughter most of the time and that has been really good*

because watching her smile is a lot better than listening to news about Trump". This sentiment was echoed by other participants, for whom priorities seemed clearer after the birth: *"I think that's when the whole determination to to, to I guess live a life that focuses on important things feels more worthwhile, for me anyway."* (Amy).

For Amy, this change in perspective was clearly linked to her understanding of the birth experience, integrating what happened into her approach to life going forward :*"I do wonder whether that has erm been one of the positive things, is that at the end of the day the ins and outs of how you're going to get there aren't important, it's getting home with a healthy baby, it's having a happy baby, it's you know whether they sleep through or not but it's er...keeping what's important in your mind I guess."*

Angela spoke of her new attitude to life (*"I want to say lowering expectations but it's not lowering expectations. It's just maybe shifting my expectations of actually umm [pauses] of what my priorities are"*) and how it changed her relationship with eating and her weight, which she has struggled with, resulting in a move away from worrying about how she looks and focusing more on her health: *"It's just maybe shifting my expectations of...of what my priorities are, you know and . . . it doesn't, it sort of stops mattering to me umm, what I might look like and it's more about...the focus is more on just having a healthy mental attitude towards food."*

For Sarah, shedding worry and anxiety and being able to "just go with what's happening now" was a real positive change following the birth. She experienced this as a choice in which she could *"think about things that have not or might not ever happen; or I can choose to live here every day"* and a realisation that she had the option to not *"let anxiety steal stuff"*.

Sally found herself compelled to consider what was on her *"bucket list"* and an increased sense of wanting to 'seize the day', leading her to consider with her husband what their future plans should be: *"I kept saying why can't we bring things forward let's not look where we'll be in 20 years let's look where we'll be in five years."* She summed up this change in her priorities as focusing on *"what*

are my perspectives on things and what matters to me and and you know and erm what do I feel I'm capable of".

3.7.5 "Why did you let this happen"

This final theme was present in two participants, and relates to their engagement with issues of spirituality, religion and mortality.

For Angela, this began with a sudden "*epiphany*" a few days after the birth, where facts of life that she was previously, of course, aware of became more salient to her and were felt on a level beyond intellectually knowing them to be true: "*I had all these very sudden realisations that this little baby that I've got here one day is gonna be an old man and he's going to die [pauses] how is that . . . how is that possible.*" Although there was a sense that Angela felt uncomfortable making sense of this in a religious framework, it was clearly a profound spiritual moment for her of some kind: "*It was just this sudden feeling of nothing actually really matters, you know but in a really umm, again, I don't really know how to describe the feeling but it, you know how they talk about God being terrific, like terrifyingly great. It was like a moment of terror...and then it's gone.*" Angela described a process of struggling to process these realisations about mortality and where they left her, before coming to answer that changed her approach to life and led her to explore and engage in Buddhism: "*Umm . . . like there's no answer to it: you are gonna lose everything and you are gonna die. There's no answer to that. There's nothing you can do. You can't beat the system. So the only kind of antidote to get through everything is to be like stupidly grateful for everything all the time and [pauses] to kind of not give a shit about stuff that doesn't matter.*" Although the birth and subsequent epiphany were distressing experiences, Angela felt that overall they had brought her to an important place of growth: "*I mean I suppose in a way as much as I still have a lot of like residual feelings about it, I am now kind of quite grateful, you know if you look at it from a holistic sort of point of view, it's led me to a much better place*".

Unlike Angela, Sarah already had a strong sense of faith through Christianity. For her, the birth threw up questions and dilemmas that left her wanting answers from God about his role in her trauma experience: *“I was like, ‘Okay God, you say you’ll be with me all the time and never leave me or forsake me. Where were you? You know where were you in the room? What were you doing?’ And I suppose it’s that, you know, ‘why did you let that happen’ question.”* Through this struggle, Sarah came to a place of deeper trust in God and a stronger sense of her own faith:

“So I was in this umm, dilemma: do I trust you God or do I just do things in my own way and work things out. And actually, I’m just gonna trust you God. I know what you’re doing. I know you’ve got a plan for my life. I know you love me umm and since then it, it’s . . . it’s been amazing cause it’s like I’ve just let go of like the whole experience. [merge] So I’ve experienced amazing joy actually out of it, which is completely weird. Umm, so yeah, that, that has been incredible. So it has strengthened my faith and enabled me to umm . . . in some ways bring my faith, I would say bring it to, to, to make it applicable, to bring it to life in a way that it may have not done before.”

4. Discussion

In this chapter I will revisit the rationale and aim for this research and then discuss the study’s findings in relation to this aim. The study’s strengths and limitations are considered. This is followed by suggestions for future research and clinical practice.

4.1 Revisiting the research aims

The rationale for this research was grounded in the observation that research on PTG following a difficult birth is still in its infancy and leaves many questions unanswered around how PTG is experienced by women following a traumatic birth. Traumatic childbirth has some differences to many other types of trauma, and research is ongoing into whether these differences affect PTG. It was

concluded that an in-depth, qualitative study could contribute to our understanding of how women experience PTG following a traumatic birth, and potentially support future research and clinical practice.

The aim of this study was to explore how women make sense of the experience of posttraumatic growth following a traumatic birth. This research project sought to meet this aim through interviewing women who identified themselves as having experienced positive benefits through coping with a traumatic birth. IPA was used to analyse these interviews, producing three superordinate themes and 11 subordinate themes. These themes will now be summarised and discussed. To organise this discussion, I will address two questions relating to the research aim that have been explored through this study: *how do women experience PTG after a traumatic birth?* and *how do women experience the journey to growth?*

4.2 Summary and discussion of findings

4.2.1 How do women experience PTG after a traumatic birth?

There were clear examples of growth across the sample in several areas of each woman's life. These were organised into the superordinate theme ***"A much better place"*** with five subordinate themes: ***"I could've let this floor me"***, ***"He's so much more capable than I gave him credit for"***, ***"Having the confidence to lead something"***, ***"Live a life that focuses on important things"*** and ***"Why did you let that happen?"***.

Across these subordinate themes was a real sense of transformational positive change. Sally commented that for her, personal growth meant *"being the person that people were telling me I would turn into"*. She said *"I feel a lot more certain of who I am now I think."* Heather echoed this sentiment, saying *"I'm not sure what erm the positive experience was but for me that's just been like a personality change, more confidence which is huge for me."*

As a group, the women described growth experiences and outcomes that mapped closely to the five domains of the PTGI, as previously discussed. Table 8 shows how each of the subordinate themes within the ***“A much better place”*** superordinate theme connects to the PTGI.

Table 8
Summary of themes and corresponding PTGI domains

Theme	PTGI Domain
<i>“I could’ve let this floor me”</i>	Personal Strength
<i>“He’s so much more capable than I gave him credit for”</i>	Relating to Others
<i>“Having the confidence to lead something”</i>	New Possibilities
<i>“Live a life that focuses on important things”</i>	Appreciation of Life
<i>“Why did you let that happen?”</i>	Spiritual and Existential Change

Through a rigorous and thorough analysis process, exercising reflexivity and discussion in supervision, I was left confident that clustering the interview data in this way was a good representation of the women’s growth experience. Similarities to the PTGI domains have been found in several other qualitative studies of PTG (Tedeschi & Calhoun, p.85) across a range of traumatic events (e.g. Kampman et al. 2015; Morris, Wilson, & Chambers, 2013). Beck and Watson’s (2009) theme ‘Opening oneself up to a new present’ bears close resemblance to ‘Personal Strength, and ‘Achieving a new level of relationship nakedness’ connects to the PTGI domain ‘Relating to Others’. These findings can give confidence to researchers and practitioners who wish to use the PTGI in their work with women who have experienced birth trauma, as it appears the PTGI domains are relevant to the experience of PTG after birth.

Tedeschi and Calhoun (2013, p.85) point out that qualitative research can help to capture aspects of PTG that are specific to a particular sample or traumatic event in ways the quantitative approaches using self-report questionnaires such as the PTGI cannot. For example, Kampman et al. (2015) conducted a qualitative study exploring PTG in people with life-threatening illnesses. Most themes mapped

onto the five domains of the PTGI, but within this there were 'event specific' manifestations of growth that related to the corporeal aspects of the trauma, for example having a greater awareness of their physical potential. Although overall the growth experiences were clustered in this way, within some of the subordinate themes there were signs of idiosyncratic manifestations of growth that appeared more particular to birth.

In terms of growth under the ***"I could've let this floor me"*** theme, Heather talked of a new relationship with her body following her birth experience: *"Yeah I was pretty amazed that er it could go through that and yeah its fine."* This led to real changes in how comfortable she felt with her body in public, which before the birth had sometimes been a struggle for her. She expressed this through her confidence breastfeeding, but also more broadly in ways less directly related to motherhood:

"...it's probably one of the best things that's happened, having that horrible thing happen and yeah, cos it's had a huge difference to me. Like for years I'd been thinking oh if only I could be happy, I wish I could have the confidence to wear a bikini, I wish that I had the confidence to wear a dress that's above the knee and things and I thought well yeah I do that now without thinking."

Sally talked of her changed relationship with running. Since the birth she has felt driven to challenge herself, to *"run faster"* and *"do better"* and now thinks *"what can I achieve doing this?"*. Both Sally and Heather entered their birth experience with a significant degree of anxiety about how they would cope, and were pleasantly surprised at how well they coped during the birth while facing their fears. This was in contrast to the other women in the sample, who either went into the birth feeling positive and in control and/ or coped differently to how they imagined they would in a more negative way. It could be that having the sense of overcoming a very intense, physical ordeal led to these particular positive changes for Sally and Heather relating to their body, what it is capable of and what it can achieve or be used for.

Within the theme ***“Having the confidence to lead something”***, it emerged that both volunteering and undergoing training in areas related to birth and birth trauma were important aspects of growth for several of the women. Although connecting with other mothers and other women who had experience traumatic birth was key, there was a sense that going beyond this to actively help other women who had had a similar experience or to try and prevent others from going through the same ordeal. This took a range of forms including blogging, being active in online forums, training to support women with breastfeeding, sharing their birth experience at events for professionals and participating in projects aimed at improving care provided to women during childbirth. Several women also commented that this was their motivation for taking part in this research study. This kind of engagement is not unique to PTG following birth trauma, however it did seem to feature particularly prominently in this sample. Prevention might seem more tangible for birth trauma than some other traumatic events, as birth is a predictably occurring event (although of course it often cannot be predicted that a birth will be unusually difficult). There is a ready audience for online information in pregnant women, many of whom are likely to feel nervous about or fearful of birth. It is estimated that between 6 and 10% of pregnant women have a strong fear of birth (Rouhe et al., 2009). Overall women who have previous experience of a traumatic birth report the highest levels of fear of birth, though among those who have not experienced birth trauma it is women experiencing their first pregnancy who report higher levels of fear (Nieminen, Stephansson & Ryding, 2009). Seven of the eight women in this study were interviewed about their first birth. Research with women who have a severe fear of birth has found that women who have no previous birth experience tend to fear the unknown, pain and loss of control whereas women who have given birth previously tend to have fears related to their previous birth experiences (Rouhe et al, 2009).

Speculatively, helping other women could also have felt so important because women who have experienced birth trauma might identify with several interrelated communities or identities: those around being mothers, of being women who have experienced a traumatic birth and also being women more generally. This could enhance the sense of responsibility to help other women.

Several women ended their interviews with comments on the gendered nature of childbirth and the societal narratives around this that they felt were unjust. Sarah said: *“...if men had to have babies the world would be a different experience [chuckles] it would be so different...”*. Tracey expressed strong feeling around the lack of support for women around birth:

“Um, and then obviously combining that with kind of women’s rights and um, equality and how unfair it is. And I feel really oh, indignant about it because I went back to work in full, I went back to work full time after both of my maternity leaves in the full expectation that I would be supported to do that because that’s what the law says.”

She continued:

“And my guess would be that there’s a high percentage of women dropping out [of work] than men because women have this responsibility – not only physically but mentally and emotionally as well – for pregnancy, childbirth, breastfeeding and nurturing our young and it’s not fair. It’s just not fair. And society is gonna crumble at some point down the line if we haven’t got female role models in professions like teaching showing children that you can do this. Because the, the myth that we can have it all is just that; because we can’t. we can only have it all at the expense of ourselves, and that’s not fair.”

Heather also expressed frustration at how the experience of childbirth can be minimised:

“I’ve felt that since having my daughter, hearing a lot of people say that ‘You’ve just given birth’ makes me want to defend people’s experiences. The friend that I told you about she cried every day for two weeks. She was really, really depressed after giving birth. Then when one of our male friends said ‘You’ve just given birth, it’s something that everybody, every woman should do’ he’s a bit sexist, but I got really annoyed and I thought how would you know, you haven’t given birth and you won’t give birth.”

The theme ***“He’s so much more capable than I gave him credit for”*** revealed the ways in which the some of the women’s relationships with their partners had changed for the better. Of course, the support of a partner is always likely to be valuable in a difficult time. But in this sample, there seemed to be a particular focus on how the partner behaved during the traumatic event. There was a sense that partners had gone beyond what the women might have expected from them. It is possible that this can be explained by the nature of the traumatic event, in that partners are more likely to be present during birth trauma than other traumatic events and therefore witness the woman’s experience first-hand. In this sample all of the women had their partners present during the labour and birth, and lived with their partners in the post-natal period with a new shared identity as parents. Although partners are not present for all births, according to the National Childbirth trust around 90% of fathers are now present at the birth of their child (NCT, 2019). Perhaps this engenders a greater feeling that the couple has been through something together than with traumas where the partner is not present, which could in turn foster growth in the relationship.

In the theme entitled: ***“Live a life that focuses on important things”*** a new focus on family life and in particular the baby was perhaps unsurprisingly common. As Amy put it: *“it’s getting home with a healthy baby, it’s having a happy baby, it’s you know whether they sleep through or not but it’s er...keeping what’s important in your mind I guess.”* Heather echoed this: *“now my world is a lot smaller because it involves my daughter most of the time...”* We might expect such change following any birth experience, or indeed upon becoming a parent. Although it is worth noting that not all of the women found this a helpful way to view their experience. For example, Alison commented that other people can be “very quick’ to point out that she has a healthy baby, *“but that doesn’t help me. It doesn’t help me feel any better about what happened.”*

Taubman-Ben-Ari et al. (2009) looked at PTG and the transition to motherhood by administering the PTGI at two time points with first-time mothers: during the third trimester of pregnancy and again at two months after the birth. They found that growth was significantly higher at the second time point, and that appraising motherhood as a challenge was related to greater growth. They concluded that

although growth can result from childbirth, the appraisal of the experience of motherhood as challenging was an important aspect of growth. It is not possible to say conclusively that the changes experienced by the women in this study can be attributed specifically to the birth being traumatic. Several women gave their own opinion on what caused their growth, with mixed opinions. Some felt clear that their growth, or aspects of it, would not have happened if the birth had not been traumatic. Sally said of her growth experience: *“I don’t think just naturally getting older might have done it but I think going through something like a) having a baby but b) facing some fears like I did I think [mmm] that definitely sort of accelerates that kind of attitude change.”* Angela also attributed her PTG to the difficult aspects of the birth: *“I’d left the birth with a question; a big, big question, and it needed a big, big answer.”* Others either felt too unsure to say or felt aspects of their growth might have happened anyway.

Tedeschi and Calhoun’s (1995, 2013) model of PTG uses an earthquake analogy, explaining that PTG requires a seismic event stressful enough to disrupt a person’s assumptions and core beliefs about themselves, the world or others and causing emotional distress. It is these shaken assumptions and distress that initiate rumination, triggering the processes leading to growth. In this sample, the women self-defined their birth experience as traumatic, which is in keeping with Tedeschi and Calhoun’s (2013, p.42) view that “what is traumatic varies in individual circumstances”. There were also many details in the women’s stories that fit with a more objective definition of trauma (for example in the ‘Context: the nature of the birth trauma’ section in the Results chapter) and indeed some of the women were given a diagnosis of PTSD resulting from the birth. Despite this, some of the women expressed uncertainty or discomfort around labelling their birth as traumatic. This appeared to be rooted in a sense that others have more difficult experiences and a fear that they were somehow exaggerating the impact of their experience or claiming a hardship that was not justified, and so a kind of trauma comparison was being employed: *“I thought, well I was thinking was mine really that traumatic? Because loads of people have episiotomies and things and I think for me it was because I was really worried about it from finding out I was pregnant and I was kind of scared of giving birth...”* (Heather) and *“I certainly feel that some people for example if some people have absolutely horrendous erm*

things so whilst I do feel it was traumatic I just don't feel that...actually when I put it in perspective you know we're both healthy" (Sally). It is also possible that the growth process involves a kind of reappraisal of events that for some women makes it more difficult to see the event as traumatic. There is perhaps a cultural discourse around trauma that fails to hold the existence of PTG without seeing a paradox – an idea that if such positives come out of an event perhaps it was not really that bad.

Ultimately, being able to characterise events as traumatic or not, and characterising growth as the 'posttraumatic' kind or not, might be of little real importance to the individuals living through these experiences, as the impact on their lives is the key issue. Models of growth such as Linley and Joseph's (2004) Organismic Valuing Theory do not rely on categorising experiences in this way. They use the term 'adversarial growth' to acknowledge that although stressful and traumatic event are often the ones triggering growth, they are not necessary for growth to take place (Joseph & Linley, 2006). They suggest that any experience that causes conflict with our assumptions and core beliefs can lead to growth, including more every day occurrences such as a "sharp or truthful word from a friend" or even positive experiences. This view of growth is situated within the person-centred framework of Carl Rogers (1959), who used the term 'fully functioning' to describe individuals who "value all aspects of themselves - their strengths and weaknesses; is able to live fully in the present; experiences life as a process; finds purpose and meaning in life; desires authenticity in themselves, others and societal organisations; values deep, trusting relationships; is compassionate towards others; and is acceptant that change is necessary and inevitable." (Joseph & Linley, 2004). Rogers' person centred theory (1959) suggests that humans have an innate tendency to move towards this 'self-actualisation'.

4.2.2 How do women experience the journey to growth?

The journey to growth in this sample was organised into two superordinate themes: ***“The total opposite of what I’d expected”*** and ***“I see it a bit differently now”***, with two and four subordinate themes respectively.

“The total opposite of what I’d expected”

“The total opposite of what I’d expected” encompasses the sub-themes ***“I thought it was a conspiracy”*** and ***“I’m supposed to be good at this”***. ***“I thought it was a conspiracy”*** describes a part of the experience that for some began during the birth itself, in which the women felt shock and disappointment that the birth was so different to what they expected. Their expectations came into direct conflict with the reality of the situation, and this struggle to understand how this had happened to them seemed to be the start of their journey to growth. The subordinate theme ***“I’m supposed to be good at this”*** relates to the sense of failure and shaken identity experienced by the women as they struggled to integrate their responses during and after the birth into how they saw themselves. Across these two subordinate themes were ideas around natural versus medicalised births and how one ‘should’ behave during childbirth. These ideas will now be discussed.

On the whole, the women in the sample expressed a desire to have a ‘natural birth’ – one with minimal medical intervention. Angela spoke of the moment her waters broke and she thought ***“It’s all finally starting and we can have a natural birth and everything will be lovely”*** and Amy said ***“It was going to be a very lovely natural relaxed birth”***. Helen had hoped to have a home birth, and described researching the ***“optimal conditions”*** for this and planning in details how things would be: ***“I was gonna wake up- have my baby and then have my tea and toast and in my own bed and it was all going to be a dream.”*** Alison described her disappointment as she was being treated for her 4th degree tear: ***“Just not, not meant to be, all this intervention.”*** When the births did not go as planned, and medical interventions were necessary, some of the women experienced strong feelings of anger, guilt and disappointment. There was a sense of failure at not

being able to control the conditions of the birth, and for some a feeling that they had been let down somehow by not being better prepared for what could happen.

Five of the eight women had engaged with hypnobirthing, and some attributed their birth expectations and subsequent unpreparedness to this. Helen said *“I think hypnobirthing had made me have quite a closed mind actually”* and Tracey commented: *“And a lot of people out there who are teaching hypnobirthing they’re doing it because they’ve only had good experiences. And I think that really only paints half of the picture cause that’s great but then when people come back and say they had a traumatic experience then it’s like, ‘Oh, we don’t know why that happened.’”*

Helen also attended NCT classes, and relayed a conversation she had with the class leader: *“she told me not to listen to anyone’s negative birth stories and I hadn’t; I hadn’t listen to one. I’d shut everyone down.”*

Debates continue around the extent of medical intervention in childbirth, for example Wagner (1998) provides a critique of the over-use of technology in childbirth under the guise of safety. However, women often find themselves in a double bind whereby they might feel criticised for having a medicalised birth on one hand, but also on the other for pursuing a ‘natural birth’ and potentially opening up themselves and their child to unnecessary risk. Wackerhausen (1999, p.1110) sums this debate up concisely: *“The uses of ‘natural’ and ‘normal’ in debates about technology and medicine, health care and childbirth are more a burden than a blessing, more a source of confusion than a source of clarification. In the name of nature, unbearable sufferings and misery might potentially be tolerated or even promoted. Yet inappropriate highly technological treatments and interventions can also be argued for by reference to the natural.”*

Wackerhausen (1999) suggest that it might be more helpful for women to aim for a ‘good birth’ rather than one which is labelled ‘natural’ or ‘normal’, taking into account the woman’s personal opinion of what a good birth would look like for her. Dara (2009) draws parallels with Winnicott’s (1953) theory of the ‘good-enough’ mother, that is, taking a pragmatic approach to childbirth that balances a

woman's wish to plan and prepare for her birth experience while also holding in mind the unpredictable aspects of birth. Dara (2009, p.302) points out that "Winnicott's theory refers to new mothers being capable of adapting and coping with the challenges of losing control in early motherhood" and relates this to labour.

Feeling out of control, kept in the dark and disempowered during the birth was an experience described across the sample, and several women found that they did not react as they would have expected themselves to in these situations. For example, for Angela, this was the most significant moment of her birth experience, describing the moment she agreed to a C-section as the part that "haunts my dreams".

Martin (2003) writes of the internalised gender expectations that women carry with them into their birth experience that come from societal idea that women should be nice and polite, stating that "Gender is in us, and we bring its power to discipline our bodies, selves, and lives to even the most natural events". Davis-Floyd (2001) also contributes to this narrative, pointing out that the hierarchical and technocratic ethos of the Western healthcare system gives medical professionals (particularly doctors) and institutions supreme authority, taking responsibility and autonomy away from patients, in this case women giving birth. She writes: "Many doctors are able to present an option as the answer quite easily, by simply refusing to discuss non-paradigm alternatives. In this scenario, a patient's most comfortable role is abdication of personal preference in favor of the doctor's choice." (Davis-Floyd, 2001, p.4). Martin (2003) suggests that these factors prevent women from being assertive during their birth experience and from putting themselves at the centre of what is happening. One example of this came from Alison, who described that after several hours in painful labour she was unable to find a comfortable position to lie in and doing what felt intuitive she knelt on the floor next to the bed. A midwife arrived and said "*What are you doing down there?*". There was a sense of dismissiveness or perhaps even something shaming about this comment, with Alison left feeling frustrated at this question as she felt that positioning her body this way was her only option. Wagner (2001) advocates 'humanising' childbirth, which he defines as acknowledging that the

woman is a human being and not a “container for making babies”. He describes as essential the need to empower women in childbirth and ensure they are respected and feel fulfilled in the experience.

“I see it a bit differently now”

The second theme in this study that speaks to the journey to growth is entitled ***“I see it a bit differently now”*** comprising four subordinate themes: ***“I wanted to understand”***, ***“Maybe I’m not just weak!”***, ***“It’s getting home with a healthy baby”*** and ***“It’s just a memory now”***. This theme describes how the women moved through the struggles documented in the theme discussed above (***“The total opposite to what I’d expected”***) in a process that involved an active quest to make sense of the birth trauma, developing a compassionate narrative that acknowledged the extent of what they had endured and refocusing on the positives that had come from the situation, before coming to a place where the birth trauma was at least mostly ‘in the past’ or processed in some way. This final subordinate theme around processing the trauma (***“It’s just a memory now”***.) reflects cognitive models of trauma that suggest that traumatic stress responses are maintained by appraisals of the traumatic event that leave the individual with a sense of current threat (e.g. Ehlers & Clark, 2000). Reconceptualising the trauma as a time-limited event, now in the past, is important for recovery.

In ***“I wanted to understand”*** some of the women describe a process aligned to Tedeschi and Calhoun’s (2013) essential components of PTG. They describe how initial, often automatic and more negative rumination about the traumatic event moves on to become a more deliberate rumination leading to narrative change, opening up the potential for growth. Positive associations between this process and PTG have been documented in the literature (e.g. Cann et al., 2011; Morris & Shakespeare-Finch, 2011). Typically, research has found a gender difference in PTG in that women are more likely to report PTG than men (Vishnevsky et al., 2010). Sawyer and Ayers (2009) found that women’s coping style was a predictor of growth following childbirth. Women are more likely than men to use ‘emotion-focused’ coping strategies, which involves thinking about the event, attempting to make sense of what happened and cognitively work through

it (Vishnevsky et al., 2010). This is in line with what Tedeschi and Calhoun (2013) suggest facilitates growth, although they also state that more research is needed to fully understand these gender differences (Tedeschi & Calhoun, 2018).

The themes ***“Maybe I’m not just weak!”*** and ***“It’s getting home with a healthy baby”*** could be seen as the later stages of this process, in which the narrative change is underway. This study allowed women to self-define whether they experienced their birth as ‘difficult or traumatic’. This is in line with the focus in IPA on the individual meaning a person gives to their experience, and also fits with the perspective of birth trauma researchers such as Beck (2004) who suggest that birth trauma is “in the eye of the beholder”. Acknowledging the birth event as traumatic was an important part of the process for some women, after an initial period for some of minimising their experience or feeling guilty for using the word trauma to describe their experience. Smith (2013) highlights that minimisation is commonly seen in survivors of traumatic events. Smith explains this as a short term coping strategy that can help with daily functioning in the aftermath of a seismic event, but in the long-term “often produces symptomatic behaviours which can manifest as physical or psychological distress”. Amy described employing this so as not to alarm or burden other people:

“I am somebody who will tend to look on the bright side of things anyway erm, so I think that fits a bit more. And in the early days I think I did that to soften it for other people. So when other people asked how it’d gone I’d sort of say well this happened and this happened and he was fine and this is ok and we’re all fine. And I think I didn’t believe it as much back then.”

Some of the women in this study demonstrated initial self-criticism for what happened during the birth, experiencing feelings of guilt and shame. On their journey to growth developing a more compassionate narrative seemed to be an important part of accepting the events of the birth, moving on from them and being open to the potential of growth. The importance of self-compassion in the aftermath of trauma has been demonstrated in the literature, with self-compassion being associated with less posttraumatic stress symptoms in a survivors of a range of traumatic events (Dahm et al., 2015). Wong and Yeung

(2017) looked more specifically at the relationship between self-compassion and PTG in a sample of 651 university students. Higher levels of self-compassion were positively associated with PTG. They also found evidence that cognitive processes might explain this relationship, as the association was mediated by levels of acceptance, positive reframing and presence of meaning.

The sub-theme ***“It’s getting home with a healthy baby”*** documents how some of the women were able to take positives from the birth and put in into perspective, without minimising what they had overcome. Alison spoke of the necessity of this for her recovery: *“The upshot was of-of the time in hospital that I had to find a way to view [daughter] in a positive way.”* She explained how being able to see her daughter as her *“little partner”* who had shared the difficult experience with her in a unique way was her way of *“coping and connecting”* with the experience. Amy’s representation in this theme comes from her focus on the fact that the birth gave her a healthy son: *“You know, we’ve got a healthy boy here that, you know we might, we might not have in any other situation.”* Ayers (2007) conducted a qualitative study on the thoughts and emotions of women during a traumatic birth and found a similar theme entitled ‘focusing on the present’. Focusing on the present, and in particular focusing on the baby, was a coping strategy used by women in her study. This provided a sense that the birth experience had been worth it because of the outcome of a healthy, wanted child.

4.3 Strengths and Limitations

At both the telephone screening stage and during the interviews, several of the women commented that this research study felt important to them and that it was needed. There were expressions of gratitude that researchers are looking into recovery from birth trauma and are interested in these stories. Some expressed their hopes that such research could contribute to efforts to improve things for other women in the future.

I was fortunate to have input from a Service User Consultant in the early stages of this study. She provided valuable advice, particularly around wording of study

recruitment materials, that helped to shape and improve the research. This gave me greater confidence that the study materials and interviews would resonate with the target population.

The study was successfully designed to meet the research aims. The use of IPA for the analysis, and following a rigorous and thorough process for this, has generated rich and detailed phenomenological data that can make a real contribution to our understanding of women's experience of PTG following a traumatic birth. I transcribed over a third of the interviews myself as part of the analysis process. I was able to meet all of the participants face to face, which enabled me to build a good rapport and respond to non-verbal cues sensitively during the interviews, leading to high quality data. Achieving a sample size of eight can also be seen as a strength of this study. Hale, Treharne and Kitas (2007) state that "data saturation is not generally a goal of the IPA approach" as the focus is more on obtaining rich and in-depth data from the sample used. They argue that a person's individual experience is so particular to them that true saturation might not be possible. The sample size of eight in this study is within the recommended sample size from Smith and Flowers (2009) and contributed a large amount of rich data to the analysis.

With hindsight, I think this study could have been improved by conducting two interviews with each participant: one focusing on the birth itself and a second focusing on the growth experience. This was considered during the study design, however I was concerned that this would put an unnecessary burden on participants in terms of their time and need to arrange childcare for the interviews. There were also study constraints in terms of the relative short timeframe of the Doctorate in Clinical Psychology and the research budget – both impacted by the fact I was travelling to interview women living across England.

A homogenous sample is aimed for in IPA with the aim of capturing a detailed account of a group of people who have shared a specific and similar experience, and generalisability is not a goal of IPA studies (Smith & Flowers, 2009). Nonetheless, it is possible that aspects of this sample's homogeneity could have influenced the findings in ways that are worth highlighting. Overwhelmingly the

participants in this research were white women in their 30's with professional jobs (or who had professional jobs before their pregnancies). Several had accessed hypnobirthing, which is not routinely offered in NHS antenatal classes. It could be that this demographic of women is more likely to feel aligned to the natural birth movement and to have the motivation or means to access hypnobirthing. Communities of women who enter their pregnancies and birth experience with different hopes and expectations might experience PTG differently.

4.4 Further Research

As examined earlier in this chapter, partners played a significant role in several of the women's journey to growth. A future study could focus on the partners of women who have experienced a traumatic birth, both to capture their perspective on the women's growth experience but also to look at the potential for 'vicarious' growth. Tedeschi and Calhoun (2013, p165-167) summarised the research into PTG in partners of people affected by cancer and found there was a kind of 'transmission' of PTG to partners. Research has also suggested that intimate relationships can be strengthened through struggling together to overcome adversity (e.g. Berger, 2015; Cohan et al. 2009). Furthermore, partners of people who have experienced PTG report increased relationship quality even if they have not experienced PTG themselves (Canevello et al., 2016). Buchi et al. (2009) studied PTG in couples who have experienced the death of a premature baby and found that when grief scores between the couples were concordant the couple also shared PTG processes whereas if their grief scores were discordant their PTG experience was less likely to be connected. This suggests that a shared experience of distress or grief from the trauma is important for PTG between couples. Interviewing couples with a focus on relationship changes following traumatic birth could increase our understanding of how birth trauma and growth might impact and be impacted by the partner relationship, and in turn lead to joint interventions to support growth within a family.

A prospective qualitative study interviewing women over several time points could also enhance the findings of this research. Interviewing women before birth could

provide a rich sense of their pre-birth assumptions and expectations. This could be followed by a second interview in the first few months after the birth, when women are likely to be struggling to accommodate their birth experience could also help to capture in 'real time' what the journey to growth looks like. A final interview could capture women further along this journey. A prospective qualitative study of PTG following birth trauma would be difficult to achieve logistically, as most traumatic births cannot be predicted as such in advance. Those women who do know in advance that their birth is likely to be difficult could carry different assumptions and expectations into the experience.

4.5 Clinical Implications

As discussed in the introduction of this thesis, the relationship between PTG, psychological distress and wellbeing requires further research. We know that distress and PTG can co-occur. For many individuals fostering PTG will not necessarily eliminate distress. Therefore, services that focus only on 'symptom reduction' as a clinical outcome might question the relevance of PTG in their work. However, there is evidence to suggest that PTG might lead to increased wellbeing for some people (Husson et al, 2017), which should act as an incentive for clinicians to incorporate PTG into their understanding of the range of possible trauma-responses. Regardless of whether PTG reduces distress, it can be conceptualised as a positive wellbeing outcome in itself that more holistic clinicians can support and encourage (Tedeschi & Calhoun, 2018). Giving voice to birth stories that include both trauma and PTG can also contribute to the development more varied and positive narratives around birth at a societal level. This adds to the current dominant stories that either there are births that 'go well' or births that 'go badly'.

Clinicians working with women who have experienced a difficult birth can share the findings of this study with these women where appropriate, to demonstrate that growth is possible for some women and provide real example of how this has happened. Interventions specifically designed to foster PTG are still in their infancy and little researched, and so caution is still required until more is known

about how clinicians can facilitate growth effectively and safely. Tedeschi, Calhoun and Groleau (2015) offer guidance to those who seek to support others in fostering growth. They point out that heavy-handed or premature attempts to promote growth and move trauma survivors towards understandings they have not experienced for themselves is likely to inhibit growth. The clinician's role is to be a facilitator and supporter for the individual, who ultimately need to come to growth experientially. This involves the clinician having the ability to attune to where the individual might be in the process of PTG. They put forward several guidelines for working in this way. For example, they highlight the necessity of working within the client's own framework for the traumatic event, understanding their way of thinking about it and being patient as the individual tells their story. Clinicians can also listen for and label PTG as and when it does reveal itself. Being mindful of timing is an important part of facilitating growth, avoiding the imposition of potentially insensitive or non-relatable positivity, particularly early in the post-trauma process. They suggest an appropriate way to open a conversation about the potential for growth could be: "You may have heard people say that they have found some benefit in their struggle with trauma. Given what has happened to you, do you think that is possible?" Finally, they advocate a "little push towards growth" when appropriate, which could involve engaging the client in written activities to encourage narrative development around the trauma and the struggle to cope. Importantly, they offer the following reminder to those working with trauma survivors: "Posttraumatic growth occurs in the context of suffering and significant psychological struggle, and a focus on growth should not come at the expense of empathy for the pain and suffering of trauma survivors."

4.6 Conclusion

This study explored the experiences of women who had experienced positive benefits through coping with a traumatic birth, adding an in-depth account of PTG following traumatic birth to the existing literature. Three superordinate themes emerged from the IPA analysis that provide insight into both the journey to PTG and the participants experience of the manifestations of growth. Overall, the women in this study described a process to growth beginning with shattered

assumptions about what their birth experience would be like and how they would cope. They spoke to the societal and cultural influences on their pre-conceptions of birth, and described how this difference between their expectation and the reality of their experience challenged their sense of identity as women and as mothers. In overcoming these highly challenging experiences, the women described a process of actively striving to cope with and make sense of their experience, facilitated by a variety of factors. The importance of partner support and the opportunity to tell their story was essential in many of the women's stories. Being able to acknowledge the impact of the birth and in some cases claim the word 'traumatic' was a significant part of this journey, allowing some of the women to move towards a narrative for their birth experience that was compassionate and included ways in which they saw themselves as fortunate. This allowed the experience to be processed and become a thing of the past. The women reported experiencing growth in ways that are commonly reported in survivors of a range of challenging life events, as reflected in the themes' similarities to the domains of the PTGI. Some aspects of growth appeared more specific to survivors of traumatic birth through a changed relationship with their bodies, a focus on preventing other women from enduring what they had to, an improved relationship with their partners and an ability to appreciate that the ultimate outcome of the birth was a healthy, wanted child.

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Appendix A: Glossary of terms relating to pregnancy and birth

Caesarean section/ C-section: an operation to deliver a baby via an incision made in the mother's abdomen and womb.

Episiotomy: a surgical cut made at the opening of the vagina during childbirth, to aid a difficult delivery and prevent rupture of tissues.

Forceps delivery: a type of assisted vaginal delivery in which a clinician uses forceps to guide the baby's head out of the birth canal.

Full term: a pregnancy or birth at at least 37 weeks gestation.

Gestational diabetes: high blood sugar levels in the mother that develops during pregnancy.

High dependency unit: an area in a hospital where patients can be cared for more extensively than on a normal ward, but not to the point of intensive care.

Hypnobirthing: a childbirth education course that emphasises natural childbirth and teaches self-hypnosis techniques to combat fear and pain during labour.

Induction: the stimulation of uterine contractions during pregnancy before labour begins on its own to achieve a vaginal birth.

Instrumental delivery: an assisted vaginal delivery using forceps or a vacuum cup.

Intensive care unit: a hospital ward that provides intensive treatment and monitoring for people who are seriously ill.

Neonatal intensive care unit: a hospital ward specialising in the care of ill or premature newborn infants who require the highest levels of support.

Perinatal: the time period during pregnancy and the first year after birth.

Perineal tear: a laceration of the skin and other soft tissue structures which separate the vagina from the anus.

Post-partum: following childbirth.

Pre-eclampsia: a potentially life-threatening condition that develops in pregnancy involving high blood pressure and often a significant amount of protein in the urine.

Pre-term: a pregnancy or birth prior to 37 weeks gestation.

Special care baby unit: an area in a hospital where newborn infants can be cared for more extensively than on a normal ward, but not to the point of intensive care.

Tokophobia - primary: severe fear of pregnancy/ childbirth in a woman who has no previous experience of pregnancy.

Tokophobia - secondary: severe fear of pregnancy/ childbirth in a woman who has previous experience of pregnancy.

Vacuum delivery: a type of assisted vaginal delivery in which a clinician uses a ventouse suction cup applied to the baby's head to assist it out of the birth canal.

Appendix B: Literature search strategy and terms

A comprehensive search of the PTG literature was conducted using Web of Knowledge and Ovid (inclusive of PubMed and PsycINFO). All journal articles published within the past 20 years that included at least one search term from each of the categories below (for PTG and for birth) were identified and then refined for relevance.

Search terms for PTG

Post-traumatic growth
Posttraumatic growth
Post Traumatic Growth
Benefit Finding
Adversarial Growth
Perceived Benefits
Stress-related growth
Positive changes

Search terms for birth

Traumatic birth
Birth-trauma
Difficult birth
Perinatal
Post-birth
Mother
New mother

Appendix C: The Primary Care PTSD Screen

Answering 'yes' to three or more of the items is considered a 'positive result' on the screen and will exclude women from eligibility from the study.

In the past month, have you...

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?
YES / NO

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
YES / NO

3. Been constantly on guard, watchful, or easily startled?
YES / NO

4. Felt numb or detached from people, activities, or your surroundings?
YES / NO

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
YES / NO

Appendix D: Online recruitment leaflet



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VOLUNTEERS NEEDED FOR EXPERIENCES OF BIRTH STUDY

Have you experienced a difficult or traumatic birth in the past five years?

For example, did your birth experience leave you feeling distressed, frightened or out of control?

Have you experienced any positive changes in your life through coping with the difficult or traumatic birth?

Many women may not feel that their traumatic experience has itself led to any positive changes. For others, they may have experienced, for example, a greater appreciation of life, a changed sense of priorities, warmer and more intimate relationships, a greater sense of personal strength, recognition of new possibilities, or spiritual development.

About the study:

Some people feel that through coping with a traumatic event they experience some positive changes or personal growth. In psychology, these experiences are sometimes called 'posttraumatic growth'. Little is known about posttraumatic growth relating to birth experiences. This research aims to develop our understanding about women's experiences relating to this.

Participants will be asked to take part in an interview lasting around an hour to discuss their experiences.

If you answered yes to the questions above and are willing to be interviewed about your experiences, please contact:

Rhianna Ketley Psychologist in Clinical Training

Faculty of Medicine and Health, University of Leeds
umrmk@leeds.ac.uk Telephone: 07585340963

This study form part of the research requirements for a Doctorate in Clinical Psychology. The research is supervised by Dr Zoe Darwin (Lecturer in Maternal Health), Dr Ciara Masterson (Lecturer in Clinical Psychology) and Professor Linda McGowan (Professor of Applied Health Research), School of Healthcare, University of Leeds.

Appendix E: Participant Information Sheet

PROJECT TITLE

Women's experiences of posttraumatic growth following a traumatic birth

INVITATION

You are being asked to take part in a research study looking at the experiences of women who have had a difficult or traumatic childbirth, and then gone on to experience positive changes in their life through coping with this. Many women may not feel that their traumatic experience has itself led to any positive changes. For others, they may have experienced, for example, a greater appreciation of life, a changed sense of priorities, warmer and more intimate relationships, a greater sense of personal strength, recognition of new possibilities, or spiritual development. In psychology, these experiences are sometimes called 'post traumatic growth'. Little is known about post traumatic growth relating to birth experiences. This research aims to develop our understanding about women's experiences relating to this.

The main researcher is Rhianna Ketley, Trainee Clinical Psychologist at the University of Leeds, studying for a Doctorate in Clinical Psychology. The research forms part of this doctoral training research. The study is supervised by Dr Zoe Darwin (Lecturer in Maternal Health), Dr Ciara Masterson (Lecturer in Clinical Psychology) and Professor Linda McGowan (Professor of Applied Health Research) School of Healthcare, University of Leeds.

This project has been approved by the Research Ethics Committee at the Faculty of Medicine and Health, University of Leeds (Ref no: MREC17-085).

WHO CAN TAKE PART?

The study is open to women over 18 who have experienced a difficult or traumatic birth in the past five years, and who also feel they have experienced some positive life changes through coping with this experience. If you would answer 'yes' to the two questions below then you might decide that you meet these criteria.

Have you experienced a difficult or traumatic birth in the past five years?

For example, did your birth experience leave you feeling distressed, frightened or out of control?

Have you experienced any positive changes in your life through coping with the difficult or traumatic birth?

Many women may not feel that their traumatic experience has itself led to any positive changes. For others, they may have experienced, for example, a greater appreciation of life, a changed sense of priorities, warmer and more intimate relationships, a greater sense of personal strength, recognition of new possibilities, or spiritual development

Participants will need to be fluent in English and live in England.

Every woman's birth experience is different. Some kinds of traumatic or difficult birth are likely to lead to significantly different experiences and distress. For this reason, women whose baby died or was admitted to a Neonatal Intensive Care Unit will not be interviewed for this study. For the same reason women will not be interviewed if they were admitted to a High Dependency Unit or Intensive Care Unit following their birth.

WHAT WILL HAPPEN?

If you are interested in taking part in this study then the next step is to contact the researcher (Rhianna Ketley) to arrange a telephone call. During this call the researcher will make sure you understand the information in this sheet and meet the study's eligibility criteria. You will have the chance to ask any questions you might have about the study before agreeing to take part.

Women who are currently experiencing significant trauma symptoms will not be invited to take part in the study to avoid increasing distress by talking about their difficult birth experience. During the telephone call the researcher will go through a brief questionnaire with you to help determine this.

In this study, you will be asked to meet the researcher for an individual face to face interview. The focus of this interview will be to discuss the positive or 'growth' experiences you have had following your difficult birth. These interviews can take place in your home, or the researcher can book a quiet, private room at the University of Leeds – whichever you prefer. If you live outside of the West Yorkshire area then your interview can take place by telephone or online via Skype. At the end of the interview, if you and the researcher agree that there is more to capture about your experience you will be invited to take part in a second, optional interview at your convenience.

It is important that you feel as comfortable as possible talking about your experiences openly during the interview. For this reason we suggest that only you and the researcher are in the room during the interview. Of course we appreciate that it can be difficult to arrange childcare and do not want this to be a barrier to taking part. If you feel you can take part in the interview with your baby in the room then you are welcome to have them there.

WHAT ARE THE RISKS AND BENEFITS OF TAKING PART?

Whilst there are no immediate benefits for those participating in this study, it is hoped that the results will improve our understanding of how women experience post-traumatic growth following a difficult birth.

You will not be made to talk about anything you do not want to and you have the right to stop the interview at any time or decline to answer a question. However, participants should feel prepared to discuss some elements of their difficult birth experience and how it has affected them. Please only volunteer to take part if you are comfortable to have these discussions. It is possible that you might find these

discussions upsetting. All participants will be provided with information on where to access help and support after the interview if they feel this is needed.

Unfortunately, it is not possible to pay you for your time, so if you choose to take part in the study it will be on a voluntary basis. If you travel to the University of Leeds to be interviewed it might be possible to reimburse your travel expenses. The researcher will discuss this with you during the initial telephone call.

PARTICIPANTS' RIGHTS

Participation in this study is entirely voluntary and you do not have to take part. If you do decide to participate you will be able to keep a copy of this information sheet and will need to sign the consent form.

You may decide to stop being a part of the research study at any time without giving a reason, and ask that your data be destroyed. If you decide to withdraw more than two weeks after your interview then it will not be possible to withdraw your data because analysis will have started.

You have the right to not answer or respond to any question that is asked of you.

You have the right to have your questions about the procedures answered. If you have any questions as a result of reading this information sheet, you should ask the researcher before the study begins.

CONFIDENTIALITY/ANONYMITY

Any personally identifiable information you provide (e.g. your name, date of birth, address) will be stored separately to your interview data. The interviews will be recorded (audio only) using an encrypted portable recording device and then transferred onto a secure computer drive managed by the University of Leeds to which only the research team will have access and which will be password protected. These recordings will be transcribed either by the researcher or a professional transcription service. These transcripts will be anonymised, meaning that they will not contain any information that could be used to identify you.

Although the interviews are for research and not therapy, the researcher still has a duty of care if she feels there is a risk of harm to you or someone else. In this situation, she would share her concerns with you and might need to share these concerns with other professionals on a need to know basis. Please feel free to discuss this with the researcher before signing the consent form if you have any questions.

WHAT WILL HAPPEN WITH THE RESULTS?

After the data has been analysed, the results will be written up as part of the researcher's doctoral thesis. This will be available online through 'White Rose Etheses Online', which holds electronic copies of theses from the University of Leeds. The results of the study will also be shared at conferences and be written up into articles for publication in journals. You will not be identified in any

documents published from this study. If you would like to receive a summary of the study's findings, there is a section on the consent form to indicate this.

FOR FURTHER INFORMATION

Rhianna Ketley will be glad to answer your questions about this study. You may contact her at birthexperiences@leeds.ac.uk or on 07585340963.

If you have questions about your rights in this research, or you have any other questions, concerns, suggestions, or complaints that you do not feel can be addressed by the researcher, please contact the Committee Chairs of the Faculty of Medicine Research Ethics committee (Dr Naomi Quinton and Dr Anthony Howard). You can also contact the study supervisors Dr Zoe Darwin (Lecturer in Maternal Health), Dr Ciara Masterson (Lecturer in Clinical Psychology) and Professor Linda McGowan (Professor of Applied Health Research) at the School of Healthcare, University of Leeds.

Appendix F: Topic Guide

Could you tell me a bit about what happened during the difficult/ traumatic birth?

Prompts: What was it about the experience that you found difficult/ traumatic? What were your expectations about how the birth would be? Was your experience different to this?

What were the negative impacts of the birth for you?

Prompts: Did the experience lead to any changes in how you see yourself/ the world/ those around you?

How would you describe the positive changes or benefits you experienced as a result of coping with the difficult birth?

Prompts: When did you start to notice these changes? Do you have any thoughts on why you started to experience these positive changes/ benefits? What do you think your partner/ friends/ family would say about how the difficult birth affected you – the positives and the negatives? Do you think there is anything that would have made it easier or more difficult for you to experience these positive changes? What was it about how you coped that led to the positive changes/ benefits?

How do you think your life would be different if you had experienced your difficult/ traumatic birth, but not been able to experience these positive changes/ benefits?

Appendix G: Consent Form

Consent to take part in: Women's experiences of posttraumatic growth following a traumatic birth.	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet dated 08/04/2018 explaining the above research project and I have had the opportunity to ask questions about the project.	
<p>I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. I also understand that if I withdraw from the study more than two weeks after a research interview my data will still be used in the study.</p> <p>Main researcher: Rhianna Ketley Tel: 07585340963 Email: umrmk@leeds.ac.uk Main research supervisor: Dr Zoe Darwin Tel: 0113 343 0549 Email: z.j.darwin@leeds.ac.uk</p>	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	
I understand that my responses will be kept strictly confidential unless the researcher feels there is a risk of harm to me or someone else. In this situation, the researcher will share her concerns with me and might need to share these concerns with other professionals on a need to know basis.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change during the project.	
I would like to receive a summary of the research and its findings.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	
Signature	
Date*	

Appendix H: School of Medicine Research and Ethics Committee confirmation of ethical approval



UNIVERSITY OF LEEDS

Faculty of Medicine and Health Research Office School of Medicine Research Ethics Committee (SoMREC)

Room 9.29, level 9
Worsley Building
Clarendon Way Leeds, LS2 9NL
United Kingdom
+44 (0) 113 343 1642 20

July 2018

Rhianna Ketley
Psychologist in Clinical Training
Leeds Institute of Health Sciences
Faculty of Medicine and Health
Clinical Psychology, Level 10, Worsley Building
University of Leeds
Clarendon Way
LEEDS LS2 9NL

Dear Rhianna Ref no: **MREC17-085**

Title: **Women's experiences of posttraumatic growth following a traumatic birth**

Your research application has been reviewed by the School of Medicine Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the following documentation received from you and subject to the following conditions *which must be fulfilled prior to the study commencing*:

- **C5 The dates provided for the fieldwork have already past. Please confirm that no work will be carried out until approval has been granted and provide suitable alternative dates.**
- **C20 Please clarify where signed consent forms will be stored. These must be stored either in a locked cabinet on University/NHS premises (e.g. supervisor's office) or preferably scanned and saved on to the University M drive (with paper copies shredded).**

Please amend the documentation as required above and submit for file. Once you have done this the study may commence as further confirmation of approval is not required.

<i>Document</i>	<i>Version</i>	<i>Date Submitted</i>
Ethics Form	1.0	16/04/2018
Correspondance with NCT	1.0	16/04/2018
Fieldwork Risk Assessment	1.0	16/04/2018
Research Protocol v1.0 08 04 2018	1.0	16/04/2018

Please notify the committee if you intend to make any amendments to the original research ethics application or documentation. All changes must receive ethics approval prior to implementation. Please contact the Faculty Research Ethics Administrator for further information (fmhuniethics@leeds.ac.uk)

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and all other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

We wish you every success with the project.

Yours sincerely

Dr Anthony Howard, Co-Chair, SoMREC, University of Leeds

(Approval granted by Co-Chair Dr Anthony Howard on behalf of the committee).

Appendix I: Sources of help and support

You might have found taking part in this study and speaking about your birth experience upsetting. This is an understandable reaction to discussing a sensitive topic and usually these feelings will not last long. If you need support to manage how you are feeling, here are some options for you:

- ***The National Childbirth Trust Helpline*** – The National Childbirth Trust run a helpline for practical and emotional support in all areas of pregnancy, birth and early parenthood. Calls cost the same as a local call from a landline: (0300 330 0700).
- ***The Birth Trauma Association*** – The Birth Trauma Association supports all women who have had a traumatic birth experience. Their website has lots of information and advice, as well as a directory of birth trauma related support groups: <http://www.birthtraumaassociation.org.uk/>.
- ***Connect Helpline*** – The Connect Helpline is a telephone support service based in Leeds. It is open 6pm-2am every night of the year. You can call on 0808 800 1212.
- ***The Samaritans Helpline*** – The Samaritans offer free, confidential listening support to anyone who needs it 24 hours a day. You can call them on 116 123.

Another option is to speak to a healthcare professional, such as your GP or health visitor, who can help you think about your support needs.

If you wish to contact me again about any aspect of the study, please feel free to do so. I can be contacted by email at: umrmk@leeds.ac.uk or by telephone on: 07585340963.

A very sincere thank you for making this research possible.

Appendix J: Example of initial noting on transcripts from transcript 1

INTERVIEW ONE TRANSCRIPT
69 minutes

1 I: So we can just start, if it's ok with you by...if you want to tell me a
2 little bit in your own words about your difficult birth experience.

fear of episiotomy
specific birth event

3 P: Yes, yeah. I think the thing that I found most traumatic was I
4 guess you could say I was really worried about having an episiotomy.

antepartum - worried in advance

5 I: OK.

identified as the 'worst' thing

6 P: From the beginning I was really worried about that, and just
7 because it was so long.

long labour

8 I: OK, Mhmm

9 P: I went into labour, I had contractions, I felt like twinges through
10 the day on the Friday, she was born on the Monday, the next
11 Monday and erm yeah through the night and I was woken by pains
12 about 2am, well 1 or 2 am, and tried to sleep through that and then
13 obviously the next day trying to go for long walks and get things
14 going and that didn't seem to work that well...and bounced a huge
15 ball, they say bounce on that, bouncing away...and that night I called
16 the midwife who said when you have contractions three minutes
17 apart for two hours then call. I was really worried about that
18 thinking I might give birth, stupidly, I might give birth three minutes
19 apart but yeah so called her when that'd happened...just really
20 painful [laughs].

long, tired, relaxing walking
twinges every 3 mins

lots of, what if, worries?!

a dilemma? what should I do?
will I be left without help?

not fully trusting of the advice?

not believed? PAIN

harsh! but reflecting - was just a fear, not likely in reality, sees that now

21 I: Yeah.

22 P: But erm yeah then I popped into the hospital and she said oh
23 you're just two or three centimetres - ugh it's been 24 hours. And
24 erm, stayed there. She said oh do you want to have a little walk
25 round - walk for two hours and then come back and we'll see how
26 far you are, so did that, and I was again about three centimetres, so
27 she said oh go into the mac ward because you'll probably get to four
28 centimetres fairly soon because it was erm about midnight/ one
29 o'clock in the morning then.

Time
feeling patronised? dismissed?

30 I: Is this on the Sunday?

31 P: Er no er Saturday. And then I stayed there in labour getting really
32 painful, well I thought they were painful, [both laugh] contractions,
33 well they'd slowed down, about every four/five minutes by that
34 point and one of the midwives came in and said would you like
35 paracetamol? and I thought I really want to hit you but just in case it
36 works a tiny bit I'll have them. It didn't make a difference but...yeah
37 and again they're walking round, it was about 3 o'clock in the
38 afternoon and I kept asking if I could be examined because they

as above - not being taken seriously

What's the feeling there? Anger, annoyance, Frustration. How dare you?!

accepting / needing their help - accepting in spite of herself.

having to repeat self
not feeling listened to?

wanting reassurance, worrying

INTERVIEW ONE TRANSCRIPT
69 minutes

PAIN

39 were getting really really painful and they didn't seem to believe me
40 because I'm quite a quiet person.

dismissed not believed - makes me curious about her abuse experience

41 I: OK.

→ explanation is blame attributed here?
her fault?

as though they think she's nagging? too much?

42 P: Quite shy, so they said oh you'd be in more pain if you were you
43 know further along and I don't want to examine you all the time

so vulnerable!

mismatch? sound like being assertive, keeps asking, asks directly for what she wants/BUT not getting it w/c too quiet?

44 because you could get infections and things so I thought Ok, I'll trust
45 them and again I said can you see how far along I am because I think,

lots of pain over a long period of time, not feeling believed, having to convince self to trust them

46 I'm in quite a bit of pain I'd like some more pain relief rather than
47 just paracetamol which doesn't work. And I had a TENS machine

48 that again didn't really work. And so erm she said Oh we'll come
49 back, we'll come back and eventually about 30'clock they came and

50 said oh you're about 7/8 cm. I thought oh thank god for that I can
51 have some more pain relief. So they whizzed me round to the er

52 delivery ward. I thought oh fantastic I can have some Entonox.

such relief things are moving

nothing working for pain, nothing working to speed up labour. They = useless? or she feeling powerless? In God's hands.

53 I: Mhmm

54 P: So I tried that and that didn't come out of the wall and she said
55 oh you need to suck really hard, so I was [makes sucking noise]

56 trying to suck on that but with the contractions I don't know if
57 you've erm given birth or anything?

couldn't detect what she thought of this. not much I think. perhaps already assumed didn't seem to be a -ve reaction.

58 I: No.

Implication is I'd know this if I'd given birth } it's integral

59 P: But you can't really think when you're in that much pain so I was
60 just [three quick sucking noises] and she said no you need to have a

feeling judged? failing?

61 long slow breath and I thought ok, which is fine in between
62 contractions but as soon as you start feeling that pain it was [quick

63 sharp sucking noises] and she said oh no you're doing it wrong so I
64 was getting really anxious and frustrated. I'm in agony and you're

very direct.

65 telling me I'm doing things wrong and this isn't working. And so erm,
66 a few hours doing that, trying to get some pain relief and said "Is

having to ask again.

67 there any other kind of pain relief that I can have?" and she said well
68 you can have oh what is it its not pethadine, there's another

not listened to or understood. dismissed again. "you're not helping"

69 injection which she said I could have and I thought well I didn't
70 really want that because it can affect the baby's breathing.

another fear A dilemma

71 I: Right.

72 P: So I thought erm, my sister erm had a stillborn baby and they said
73 that it could have been that her lungs just didn't develop or she

just the back I wonder?

74 didn't breathe properly so that was in the back of my mind as well. I
75 thought just carry on with this. And the midwife then said would you

76 like to have erm a water birth. Because at 8cm you could be quite
77 close. So I thought right then, I'll have a water birth that sounds

sense of just going along with things feeling powerless?

no choice will have to bare the pain.

Appendix K: Example of electronic categorisation of notations from transcript 2

Emergent Themes	Transcript	Exploratory comments Normal text = descriptive <i>Italics = linguistic</i> Bold = conceptual
<p>Comparing own experience to others'</p> <p>What makes a birth traumatic?</p> <p>Comparing own experience to others'</p>	<p>P: I think in some ways it's difficult...every birth is traumatic to some extent. I refuse to believe that no one has any pain and you know ok maybe some people have a home birth and its everyone's there and it's all you know everything's beautiful and maybe it is for some people but I kind of feel that to some extent everybody probably has some kind of...even if it's just a tiny bit or erm relating to the birth so I don't...I certainly feel that some people for example if some people have absolutely horrendous erm things so whilst I do feel it was traumatic I just don't feel that...actually when I put it in perspective you know we're both healthy and you know it's happened now whereas some people you know I just really feel for some of them. I wasn't in pain for that long really. Some people have horrendous erm you know birth injuries or you know they're really haunted by what happened and and er I don't feel like I am so...</p>	<p>What makes something traumatic? Does she feel it is shameful in some way to have found the birth traumatic? That if everyone finds birth difficult, it means she is not weak? 'refuse to believe' - indicates that she thinks some people claim this – that their birth is pain free? But they are lying. Also wonder if here there is some resentment of those that have an easier birth – 'everything's beautiful' feels scornful in some way.</p> <p>'I'm not haunted by it'</p> <p>Wish I'd asked more here – so why was the birth traumatic for you? Is she minimising here again?</p>
<p>Loss of independence. Impact of birth experience</p> <p>Coping alone</p> <p>Minimising of experience</p>	<p>I: Yeah, yeah, it makes sense (good) erm and how about in the kind of in the days or first few weeks afterwards. How were you feeling in yourself?</p> <p>P: Erm so the things that...to start with so so when I had erm quite a lot of stitches they said they would dissolve and that was fine but there was one stitch that was kind of sticking out and it didn't dissolve. And every time I was walking I could just feel it catching. And it was really frustrating because I just wanted to get up and move and get out I like...I'm very independent and I really hate it when I can't do something erm I hate asking for help so I really wanted to even just get out and go for a walk and it was like it really hurts and I went, I went to the GP and erm she said she wouldn't, she said she could see that the stitch was poking out and she said I'm not gonna touch it, you wait until you see your gynaecologist but that wasn't until three months that I would see her so I was a bit like erm I kind of just wanted, wanted it all to heal really quickly so it could be over. I think erm as I say once the kind of wave of adrenaline and erm once the reality, ah ok, it's hard enough looking after a baby as it is but when you're trying to heal or when you're trying to</p>	<p>Physical impact/ legacy of the birth. Complications.</p> <p>Struggling to cope with loss of independence. <i>Repetition of hate.</i></p> <p>Left without help. (so at the same time as seeing self as strongly independent, feels left alone when help isn't offered. Perhaps it took quite a lot for her to go to the GP with this)</p> <p>Impatient to heal.</p> <p>Par for the course – it was normal? Again I wonder if she is minimising here, it sounds like she really found it quite hard. Often does this – makes everything ok. 'It was fine really. It's all ok now though.'</p>

<p>Negative impact of birth experience</p> <p>Support of others</p> <p>Expectation vs reality</p> <p>What makes an experience normal?</p>	<p>deal with something else I just...it was quite difficult initially to just get over that in terms of its not going to heal in a week it is going to take a bit longer erm but then, but then it did heal and everything was is fine now so actually it was par for the course really.</p> <p>I: So although things are ok now there was this period of time when you felt erm when is this going to end? When is it going to heal? Or felt impatient for that to happen?</p> <p>P: Yeah and I think erm I think I just felt like...so I went to an NCT class and all the other girls obviously had their own different births and stuff but they were all sort of going out and doing all these classes and doing all this stuff and I was like oh I kind of want to do that but I was like I felt like ooo I'm not sure if I can or I'm worried it'll...I'm not ready to do that or whatever. But actually I ended up...my husband sort of said well why don't you just try doing one thing and see how you get on. So I tried to do one thing and actually it was fine. It sounds really stupid but the thing I was most worried about was sitting on the floor because sitting down was really hurting, but I took a cushion and we were all good (laughs) but erm I think erm I've lost my train of thought (laughs) that happens sometimes, sorry (laughs) no I can't remember where I was.</p> <p>I: We were talking about wanting things to heal quickly and then –</p> <p>P: Yes that right, I was getting very impatient because I wanted things to be...you see you see mums on telly and you know they gave birth two weeks ago and they're out running and all this and I'm like you, what difference, you know I'm not exactly looking to have a celeb body but you know what I mean I wanted to, wanted things to be normal but there is no normal. Your perception of what is normal when you have a child is just (laughs) [yeah] you know I don't know what my normal is now.</p>	<p>Decrease in confidence at this stage? Worried, fearful. Felt restricted, can't participate in typical post-birth activities.</p> <p>Encouraged by husband – he believed in her. Fear of pain.</p> <p>Expectation vs reality. Feeling pressure particularly to be fit, change her body? What is normal after birth? Desire for normality. Realising normal doesn't exist, or has changed. If there is no normal, can't categorise self or others into normal or abnormal. Have to just take things as they are.</p>
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