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**THE IMPACT OF BIRTH TRAUMA ON THE COUPLE RELATIONSHIP  
AND ASSOCIATED REQUIREMENTS FOR SUPPORT**

Thesis submitted for the degree of Doctorate of Philosophy

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2022

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## Declaration

Chapter 1 presents an overview of the current literature regarding birth trauma, the impact this can have on the couple relationship, and associated requirements for support. Chapters 2 to 6 of this thesis are distinct articles published in peer-reviewed journals. Chapter 7 presents an over-arching discussion of the findings presented in the previous chapters. The references for all chapters in this thesis can be found in Chapter 8.

The articles in Chapters 2 to 6 are presented as the final accepted manuscripts. These articles are my own work under the guiding supervision of Professor Susan Ayers and Dr Sarah McMullen. For all articles I wrote the first draft of the manuscript and was responsible for subsequent revisions including those pertaining to the peer review process. Full authorship and description of contributions follows:

Chapter 2 is published in the *Journal of Reproductive and Infant Psychology* as:

Delicate, A., Ayers, S., Easter, A., & McMullen, S. (2018). The impact of childbirth-related post-traumatic stress on a couple's relationship: a systematic review and meta-synthesis. *Journal of Reproductive and Infant Psychology*, 36(1), 102-115. <https://doi.org/10.1080/02646838.2017.1397270>

Amy Delicate wrote the protocol and undertook the literature search, quality appraisal, data extraction, and primary data analysis and interpretation. Abigail Easter completed independent analysis and interpretation of the collected data and assisted in defining the presented findings. Susan Ayers and Sarah McMullen

contributed to the design of the study and reporting of the data, as well as guiding revisions to the articles through various iterations.

Chapter 3 is published in *Midwifery* as:

Delicate, A., Ayers, S., & McMullen, S. (2018). A systematic review and meta-synthesis of the impact of becoming parents on the couple relationship. *Midwifery*, 61, 88-96. <https://doi.org/10.1016/j.midw.2018.02.022>

Amy Delicate wrote the protocol and undertook the literature search, quality appraisal, data extraction, data analysis, and interpretation. Susan Ayers and Sarah McMullen contributed to the design of the study and reporting of the data, as well as guiding revisions to the articles through various iterations.

Chapter 4 is published in the *Journal of Reproductive and Infant Psychology* as:

Delicate, A., Ayers, S., & McMullen, S. (2020a). Health-care practitioners' assessment and observations of birth trauma in mothers and partners. *Journal of Reproductive and Infant Psychology*, 40(1), 34-46. <https://doi.org/10.1080/02646838.2020.1788210>

Amy Delicate wrote the study protocol and survey and undertook the process of gaining ethical approval. Amy Delicate was responsible for participant recruitment and engagement. Data analysis and interpretation was conducted by Amy Delicate with supervisory support from Susan Ayers. Both Susan Ayers and Sarah McMullen contributed to the design of the study including the survey and had guiding involvement as the article was revised through various iterations.

Chapter 5 is published in the *Journal of Primary Health Care Research & Development* as:

Delicate, A., Ayers, S., & McMullen, S. (2020b). Healthcare practitioners' views of the support women, partners, and the couple relationship require for birth trauma: current practice and potential improvements. *Primary Health Care Research & Development*, 21(e40), 1-10. <https://doi.org/10.1017/S1463423620000407>

Amy Delicate wrote the study protocol and survey and undertook the process of gaining ethical approval. Amy Delicate was responsible for participant recruitment and engagement. Data analysis and interpretation was conducted by Amy Delicate with supervisory support from Susan Ayers. Both Susan Ayers and Sarah McMullen contributed to the design of the study including the survey and had guiding involvement as the article was revised through various iterations.

Chapter 6 is currently submitted to the journal of *Midwifery* as:

Delicate, A., & Ayers, S. (2022). The impact of birth trauma on the couple relationship and related support requirements: a framework analysis of parents' perspectives.

Amy Delicate, with contribution and supervision from Susan Ayers, wrote the study protocol and undertook the process of gaining ethical approval. Amy Delicate was responsible for participant recruitment and engagement. Amy Delicate conducted all the research interviews, transcription, data analysis, and interpretation with supervisory support from Susan Ayers. The article was drafted by Amy Delicate with input from Susan Ayers at all stages of development and editing for publication.

I hereby declare that this thesis has not been, and will not be, submitted in whole or in part to another university for the award of any other degree.

Amy Delicate

March 2022

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## Abbreviations

|               |                                                                   |
|---------------|-------------------------------------------------------------------|
| <b>ASD</b>    | Acute Stress Disorder                                             |
| <b>CASP</b>   | Critical Appraisal Skills Programme                               |
| <b>COREQ</b>  | Consolidated Criteria for Reporting Qualitative Research          |
| <b>CBT</b>    | Cognitive Behavioural Therapy                                     |
| <b>CI</b>     | Confidence Interval                                               |
| <b>DSM-IV</b> | Diagnostic and Statistical Manual of Mental Disorders - version 4 |
| <b>DSM-5</b>  | Diagnostic and Statistical Manual of Mental Disorders - version 5 |
| <b>EMDR</b>   | Eye Moment Desensitisation and Reprocessing                       |
| <b>EPDS</b>   | Edinburgh Postnatal Depression Scale                              |
| <b>GP</b>     | General Practitioner                                              |
| <b>MIDIRS</b> | Midwives Information and Resources Service                        |
| <b>NCT</b>    | National Childbirth Trust                                         |
| <b>NHS</b>    | National Health Service                                           |
| <b>NICE</b>   | National Institute for Health and Care Excellence                 |
| <b>PDS</b>    | PTSD Diagnosis Scale                                              |
| <b>PTSD</b>   | Post-traumatic Stress Disorder                                    |
| <b>PTSS</b>   | Post-traumatic Stress Symptoms                                    |
| <b>SD</b>     | Standard Deviation                                                |
| <b>TTP</b>    | Transition to Parenthood                                          |
| <b>UK</b>     | United Kingdom                                                    |

## **Abstract**

**Background:** Traumatic childbirth can cause ongoing distress, often called birth trauma. Such distress can affect women, their partners, and the couple relationship. Good quality couple relationships are important to the well-being of individuals and the wider family.

**Aims:** This thesis aimed to investigate the impact of birth trauma on the couple relationship and associated requirements for birth trauma support.

**Methods & Results:** The thesis aims were addressed through four pieces of research. Two systematic reviews and meta-syntheses to investigate: (1) the impact of childbirth related PTSD or PTSS on the couple relationship (n=7); and (2) the impact of becoming parents on the couple relationship (n=12). These reviews reported a range of impacts on the couple relationship with some similarity in themes across reviews. However, the impact of birth trauma was perceived more negatively. Two empirical studies were conducted: (1) a survey of UK healthcare practitioners (n=202) investigated assessment and observation of birth trauma and related support; and (2) interviews with UK parents investigated their experiences of the impact of birth trauma on the couple relationship and associated support needs (n=18).

Empirical studies reported that barriers exist to accessing birth trauma support for the couple relationship, that current support is limited in effectiveness, and enhancement of dyadic support is required. Thesis findings were synthesised into two proposed models: (1) the impact of birth trauma on the couple relationship; and (2) the birth trauma support required by the couple relationship.

**Discussion & Conclusions:** Thesis findings suggest that birth trauma can have a negative impact on the couple relationship. However, some report that birth trauma

can strengthened the relationship. Current support for birth trauma is limited with little evidence of effectiveness. Thesis findings indicate how birth trauma support for the couple relationship could be enhanced. Implications for research and practice are considered.

# **1 Background**

This thesis presents a programme of research which investigated the impact of birth trauma on the couple relationship and associated requirements for birth trauma support. This chapter details the background literature pertaining to this research topic and states the research aims and objectives. Chapters 2 to 6 present distinct, yet connected, articles from the doctorate research. Finally, Chapter 7 provides an overarching discussion of the findings from the studies presented in Chapters 2 to 6, enabling conclusions to be drawn.

## **1.1 Introduction**

This chapter gives an overview of the current literature and research pertaining to the doctorate topic presented in this thesis. Section 1.2 looks at definitions of birth trauma, to understand the concept as used in existing research and healthcare services. Section 1.3 outlines the impact of birth trauma on women, their partners, and family. Section 1.4 explores the treatment and support available for birth trauma, both evidence-based and anecdotal. Section 1.5 introduces the importance of the couple relationship, and section 1.6 presents the evidence relating to the impact of birth trauma on the couple relationship. Finally, section 1.7 gives an overview of the research aims, objectives, and methodology.

## **1.2 Defining Birth Trauma**

Birth trauma has been defined and measured in various ways. Reactions of those who experience trauma are complex, and it is important to acknowledge that not all those who experience childbirth as traumatic will have continuing distress. Whilst initial reactions following a traumatic birth may be challenging and have a negative effect on well-being and day-to-day functioning, for many people

symptoms will resolve without treatment or intervention (Center for Substance Abuse Treatment, 2014; Elmir et al., 2010).

### ***1.2.1 Traumatic Childbirth***

In the UK, the National Institute for Health and Care Excellence (NICE) define traumatic childbirth as “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, p14).

Trauma responses can be about psychological distress not just physical pain and complications (Taghizadeh et al., 2013). So, whilst obstetric events are a risk factor for experiencing extreme distress during birth, studies have found interpersonal difficulties with healthcare practitioners are also a trauma risk (Harris & Ayers, 2012; Reed et al., 2017). Experiencing birth as traumatic is about personal perception (Beck, 2004a) with an individual’s negative appraisal of the birth experience being a strong indicator for birth trauma (Garthus-Niegel et al., 2013).

There is evidence to suggest that some women are more vulnerable to experiencing birth as traumatic. Such risks can be predisposing and apparent antenatally such as current or prior mental health problems, a history of traumatic or sexual abuse, and poor physical health in pregnancy. Intrapartum vulnerability to experiencing birth as traumatic includes medical interventions, lack of support and sense of loss of control. In the postnatal phase, factors such as poor social support and coping skills are risk factors for maintaining or intensifying the trauma response (Ayers et al., 2016; Dekel et al., 2017; Grekin & O’Hara., 2014; Simpson et al., 2018; Slade, 2006).

Research shows 20-40% of women report their birth to be traumatic (Alcorn et al., 2010; Creedy et al., 2000; Dikmen-Yildiz et al., 2017b; Soet et al., 2003).

Whilst smaller in scale, research into partners has shown that those attending birth can also experience the birth as traumatic (Daniels et al., 2020), which may cause ongoing distress (Etheridge & Slade, 2017) and affect mental well-being (Elmir & Schmied, 2016; Hinton et al., 2014).

### ***1.2.2 Birth Trauma***

Within research, the measurement of birth trauma ranges from asking women whether they perceived their birth to be traumatic (Beck, 2004b), through to using diagnostic criteria for post-traumatic stress disorder (PTSD) (Taghizadeh et al., 2013). The terms traumatic childbirth, birth trauma, post-traumatic stress symptoms (PTSS), and PTSD are used interchangeably in research, policy, and practice guidance (Anderson, 2017). This lack of universal diagnostic criteria makes establishing prevalence of birth trauma problematic.

Parent information sources in the UK define birth trauma as an alternative term for childbirth-related PTSD (Birth Trauma Association, 2018; Mind, 2020). However, ongoing distress related to traumatic childbirth does not always result in women having symptoms that meet PTSD diagnostic criteria (Dikmen-Yildiz et al., 2017b). Yet the distress can persist for many years affecting the individual's day-to-day well-being (Moore, 2019). Defining birth trauma as a clinical PTSD diagnosis may exclude many from having their trauma symptoms and distress acknowledged, and consequently prevent access to appropriate support.

Adapted from PTSD stressor criterion, birth trauma has been defined as “an event occurring during the labour and delivery that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences

intense fear, helplessness, loss of control, and horror” or an event where the birthing “woman perceived she is stripped of her dignity” (Beck et al., 2013, p8). This definition is useful as it highlights that trauma can stem from both objective and subjective elements of the birth experience. However, it is focused on defining the traumatic childbirth experience and does not describe longer term response or impact.

As research in this field has grown and understanding of the phenomenon has developed the proposed definitions of birth trauma have begun to share common features that refer to impact and length of trauma response. Highlighting traumatic childbirth to be “...events or care that cause deep distress or psychological disturbance...resulting in psychological distress of an enduring nature” (Greenfield et al., 2016, p265), and “...childbirth that caused overwhelming distressing emotions and reactions; leading to short and/or long-term negative impacts on a woman’s health and well-being” (Leinweber et al., 2021).

Within an enduring trauma response there will be a spectrum of distress experienced by individuals, which can include a range of PTSS or diagnosis of PTSD (Ayers et al., 2008). The range of birth trauma symptoms means that the affect and impact of birth trauma can also be broad (Fenech & Thomson, 2014; Thomson et al., 2017). Therefore, it is important to understand how support and treatment can resolve birth trauma to curtail any impact (Cirino & Knapp, 2019; Peeler et al., 2013).

Birth trauma can also be co-morbid with postnatal depression (Dikmen-Yildiz et al., 2017a) and secondary tokophobia (Hofberg & Brockington, 2000). Co-morbidity can create difficulties in identifying birth trauma due to routine screening in the UK being focused on detecting depression and anxiety (NICE, 2015).

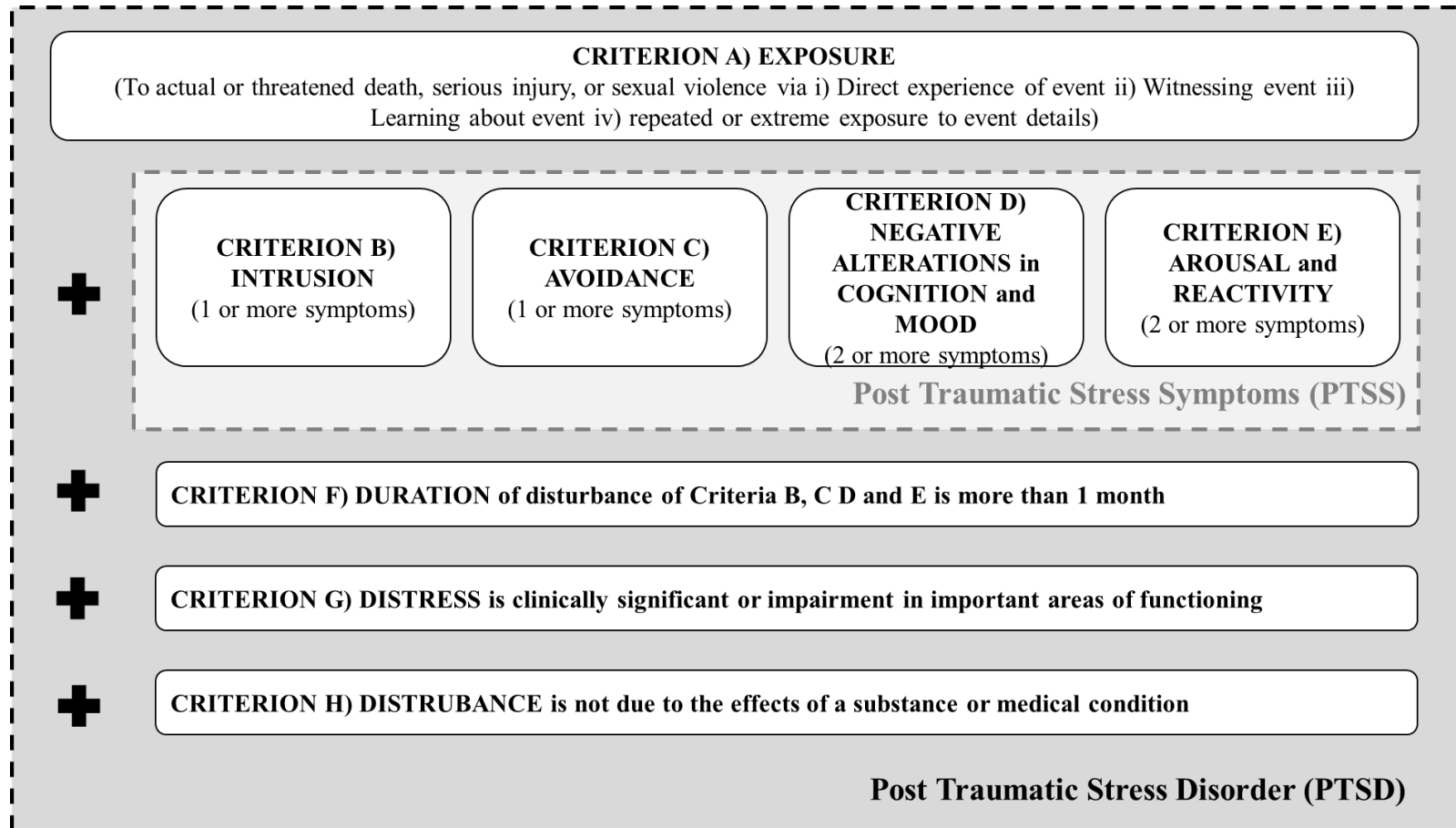
Treatment can also be affected as there is a lack of integrated interventions that deal with co-morbidity (Howard & Khalifeh, 2020).

### ***1.2.3 Post-traumatic Stress Symptoms (PTSS)***

PTSS have been found in 14-17% of postnatal women (Boorman et al., 2014; Dekel et al., 2017) and there is emerging evidence that partners witnessing a traumatic birth can experience PTSS (Bradley et al., 2008). Childbirth factors such as satisfaction with healthcare professionals (Dikmen-Yildiz et al., 2017b), objective birth experience (Grekin et al., 2020), and subjective experiences of birth (Garthus-Niegel et al., 2013) are also associated with postnatal PTSS. Postnatal factors such as stress, poor coping (Ayers et al., 2016), and low social support (Dikmen-Yildiz et al., 2017b) are associated with maintenance of PTSS.

Following a traumatic event, PTSS are usually defined within the categories of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5, American Psychiatric Association, 2013). These are intrusion, avoidance, negative alterations in mood and thinking, and arousal and reactivity. These PTSS categories are criterion B to E of the DSM-5 diagnostic criteria for PTSD as depicted in Figure 1.1.

**Figure 1.1** *Diagnostic Criteria for PTSD - Developed from DSM-5 (American Psychiatric Association, 2013)*



Intrusion symptoms (criterion B) include involuntary reoccurring distressing trauma memories; recurrent distressing dreams relating to the trauma; and dissociative reactions, such as flashbacks. Avoidance symptoms (criterion C) relate to efforts taken to avoid distressing thoughts and feelings and/or avoidance of external reminders related to the trauma. Negative alterations in cognition and mood symptoms (criterion D) include being unable to remember important aspects of the traumatic event; persistent negative emotional state such as fear, guilt, or shame; and feeling detached or estranged from others. Hyperarousal symptoms (criterion E), alterations in arousal and reactivity symptoms include irritability and angry outbursts; heightened startle response; and sleep disturbance (American Psychiatric Association, 2013).

#### ***1.2.4 Acute Stress Disorder (ASD)***

Whilst research on ASD following traumatic childbirth is limited, ASD is a relevant issue. ASD can be diagnosed after exposure to trauma resulting in nine or more trauma symptoms that impair function and persist for two days or up to one month. Whereas PTSD diagnosis requires distress to be present for one month or more (Bryant, 2017). Studies with women traumatised by premature childbirth or having an infant in neonatal intensive care report ASD rates of 28% and 54% respectively (Jubenville et al., 2012; Shaw et al., 2009). ASD has been reported to affect women and partners after childbirth, with ASD predicting subsequent PTSD diagnosis (Schobinger et al., 2020).

Becoming a parent is an inherently stressful time (Ayers et al., 2019), that can be significantly challenging (St John et al., 2005). It requires adaptation to new responsibilities, roles, and tasks (Deater-Deckard, 2008). Parents affected by birth trauma may need additional support during their early transition to parenthood (TTP)

(Etheridge & Slade, 2017; Molloy et al., 2021) due to distress falling within ASD criteria.

### ***1.2.5 Post-traumatic Stress Disorder (PTSD)***

As depicted in Figure 1.1 if PTSS are extensive with at least one symptom from criterion B and C, and at least two symptoms from criterion D and E, which persist for more than one month (criterion F), then a diagnosis of PTSD can be made. Further requirements are that symptoms cause clinically significant distress or impairment of an individual's functioning (criterion G) and cannot be attributed to anything else such as alcohol or another medical condition (criterion H) (American Psychiatric Association, 2013).

Meta-analysis indicates that 4% of women are affected by childbirth-related PTSD (Yildiz et al., 2017). Antenatal mental health problems such as anxiety, PTSS (Dikmen-Yildiz et al., 2017b), and fear of childbirth (Grekin et al., 2020) are reported to be associated with experiencing postnatal PTSD. Whilst research into PTSD in partners is limited, there is evidence that some partners experience severe PTSD symptoms following childbirth (Ayers et al., 2007; Bradley et al., 2008). It is pertinent to recognise that there are gender differences in PTSD diagnosis, with women reporting higher PTSD rates in general population studies (Frans et al., 2005; Lukaschek et al., 2013).

## **1.3 Defining the Importance of the Couple Relationship**

The work presented in this thesis takes a dyadic perspective, investigating the impact of birth trauma on the couple relationship. For the purposes of these studies, couple relationships were defined as a romantic partnership between two people, regardless of gender, habitation, or marital status. For consistency, the label mother

or woman is used to refer to the parent who gave birth, and partner or man for the other person in the relationship.

The couple relationship is important for health and well-being. In general, good quality relationships are associated with positive personal outcomes (Reynolds et al., 2014) comprising of higher well-being (Proulx et al., 2007), better physical health (Robles et al., 2014), and increased life achievements (Marjoribanks, 2016a). Distress and depression appear inter-linked between partners and also health behaviours such as sleep, exercise and diet (Kiecolt-Glaser & Wilson, 2017).

### ***1.3.1 Transition to Parenthood (TTP) - from Partners to Parents***

There is a robust body of evidence that shows becoming parents is associated with a decline in relationship satisfaction (Belsky & Rovine, 1990; Doss & Rhoades, 2017; Lawrence et al., 2008; Mitnick et al., 2009; Mortensen et al., 2012).

Relationship vulnerabilities present prior to becoming parents have been shown to impact on how the relationship adapts in the TTP (Kluwer, 2010), with the quality of a relationship before childbirth being an indicator of the quality after the TTP (O'Reilly Treter et al., 2020).

New parents report relationship problems relating to increased sexual concerns (Schlagintweit et al., 2016), reduced freedom for personal activities (Twenge et al., 2003), lack of perceived fairness in division of work in the home (Chong & Mickelson, 2013), and increased negative communication (O'Reilly Treter et al., 2020). These relationship changes observed in new parents have been found to hinder personal resilience of both parents in the first year of parenthood (Young et al., 2020). Whilst the effect of becoming parents can be detrimental, there is evidence that it can also bring personal benefits (Nomaguchi, 2012) and strengthen the couple relationship (Doss et al., 2009).

The phenomenon of relationship change in new parents is examined in this thesis through two systematic reviews and meta-syntheses of the qualitative literature. One systematic review examines the impact of becoming parents on the couple relationship (chapter 3, article 2). The other considers the evidence of the impact of childbirth-related PTSD or PTSS on the couple relationship (chapter 2, article 1). The aim of conducting two systematic reviews was to understand if the impact of birth trauma on a couple relationship is different to the general impact of the TTP on the couple relationship.

### ***1.3.2 The Couple Relationship and Parenting***

The couple relationship also impacts on parenting and infant well-being. Relationship quality is linked to greater parental engagement with the infant (Carlson et al., 2011), which is related to positive development and well-being of the child (Sunderland, 2006). Where parents have high relationship satisfaction and low conflict, it is reported that children are less likely to display symptoms associated with stress and depression (Hughes et al., 2020). Furthermore, there is some evidence of an association between parental conflict and security of infant attachment (Finger et al., 2009; Wong et al., 2009; Tan et al., 2018).

Breakdown of parental relationship is associated with short-term distress for most children, with a minority of children experiencing longer-term adverse outcomes such as lower education achievement, behavioural issues, and health problems (Coleman & Glenn, 2010). When parental relationships have ended, children are more likely to experience circumstances that raise the risk of negative outcomes such as poverty, poor parenting practices, and violence (Mooney et al., 2009).

### ***1.3.3 The Couple Relationship and Parental Mental Health***

The mental health responses of partners following childbirth appear to be inter-linked (Atkinson et al., 2020; Iles et al., 2011), highlighting the need for a dyadic perspective to distress in the TTP (Gillis et al., 2019). Likewise, understanding how couples impact upon one another's mental health is important when developing health promotion and interventions (Lee et al., 2020).

Dyadic coping commonly reduces in the TTP and is associated with decreased personal quality of life and increased symptoms of anxiety and depression (Alves et al., 2020; Figueiredo et al., 2018). Increased negative interactions between partners in the TTP such as irritability, arguments, and criticisms are associated with higher levels of depression in men and women. Decreased positive interactions between partners such as reduced affection, closeness, and sense of support is associated with increased anxiety for women. (Figueiredo et al., 2018).

## **1.4 Impact of Birth Trauma**

If birth trauma is to be considered a spectrum of distress from ASD, to PTSS, or a PTSD diagnosis, then it stands that the impact of birth trauma can also be wide ranging in terms of experience and duration. Whilst the body of literature on the affect and impact of birth trauma is still emerging, the available evidence is presented below.

### ***1.4.1 Impact of Birth Trauma on Women***

For women birth trauma can affect their self-image and emotions (McKenzie-McHarg et al., 2015). Childbirth-related PTSD is associated with not breastfeeding (Garthus-Niegel, Horsch & Ayers et al., 2018), and women perceiving a poorer quality bond with their infant (Dekel et al., 2018). Qualitative research suggests that birth trauma can leave some women feeling disconnected from their baby and result

in lower confidence in their parenting ability (Molloy et al., 2021). Furthermore, some women highlight that birth trauma impacted on the relationship with their partner (Beck, 2004b; Iles & Pote, 2015), having a negative effect on the emotional (Taghizadeh et al., 2013), and sexual (Elmir et al., 2010) elements of their relationship.

#### ***1.4.2 Impact of Birth Trauma on Partners***

Research exploring the impact of birth trauma on partners is limited and predominately focused on fathers. Partners can be affected by birth trauma due to witnessing traumatic childbirth, or as a consequence of being the partner of someone with perinatal mental health problems (Bradley & Slade, 2011). There is evidence that partners experience PTSS related to childbirth (Hambidge et al., 2021) and that postnatal depression is highly associated with PTSS (Ertan et al., 2021). For fathers, rates of ASD of 4.4% at one week postnatal, and PTSD of 7.2% at one month postnatal, have been reported (Schobinger et al., 2020).

For partners, literature highlights an adverse effect of birth trauma on work productivity (Etheridge & Slade, 2017), the ability to cope with day-to-day tasks, and capacity to be happy (Daniels et al., 2020). As seen for women, partners also report that birth trauma can create relationship difficulties (Elmir & Schmied, 2022; Inglis et al., 2016) and reduce sexual functioning (White, 2007). Men have reported there are limited outlets for them to talk about their experience of birth trauma and its impact on them (Elmir & Schmied, 2022). Likewise, a lack of suitable birth trauma support or treatment is reported for partners (Kothari et al., 2022), with current services being focused on women (Hodkinson & Das, 2021).

### ***1.4.3 Impact of Birth Trauma on the Couple Relationship***

Negative perceptions of the birth experience have been associated with parental stress (Holopainen et al., 2020). Synthesis of qualitative birth trauma research found that when traumatic childbirth affects a woman, it can damage the relationships with her child and partner and leave the whole family susceptible to impairment (Beck & Casavant, 2019).

This family vulnerability is supported by general trauma research which reports that trauma should be regarded as something that can affect the whole family, with the ability to impact the couple relationship in diverse ways (Marshall & Kuijer, 2017). There is evidence that trauma symptoms can be transmitted between partners and that trauma responses can affect couple functioning (Goff & Smith, 2005) leading to relationship distress (Campbell & Renshaw, 2018). Indeed, the quality of the couple relationship has been shown to either exacerbate trauma or assist recovery (López-Zerón & Blow, 2017).

However, there is limited quantitative research on the impact of birth trauma on the couple relationship with just three studies published. The first reported no association between postnatal PTSS and changes to the couple relationship (Ayers et al., 2007). The second and third studies found postnatal PTSS was related to symptoms of depression which were associated with poorer relationship satisfaction (Garthus-Niegel, Horsch & Handtke et al., 2018; Parfitt & Ayers, 2009).

Whilst still limited, there is comparatively more qualitative data on this issue. Qualitative evidence largely contradicts the quantitative findings as many negative impacts of birth trauma on the couple relationship are reported. Impacts such as reduced sexual relations (Kendall-Tackett, 2014; Taghizadeh et al. 2013);

negative interactions including anger and disagreements (Beck, 2004b; Nicholls & Ayers, 2007); and absence of support between partners (Allen, 1998; Ayers, Eagle & Waring, 2006). This body of qualitative evidence is the subject of systematic review and meta-synthesis presented in Chapter 2, article 1.

## **1.5 Treatment and Support for Birth Trauma**

Although there is evidence that PTSS related to childbirth may manifest differently to PTSS related to other events (Harrison et al., 2020), research into viable support and treatment specifically for birth trauma is limited (Lapp et al., 2010). Most recommendations for birth trauma treatments are based on the evidence from general PTSD research even though it is still largely unclear if general PTSD treatments are as effective for trauma relating to childbirth (Ayers et al., 2008). It is acknowledged that childbirth-related PTSD may have unique characteristics compared to general PTSD (Horesh et al., 2021) which may affect how the disorder is experienced and diagnosed.

In the UK, NICE clinical guidelines recommend that healthcare professionals offer advice and support to women who report their birth as traumatic. Additionally, NICE highlight that practitioners should consider that the woman's partner may also have been affected by the traumatic experience and require their own support (NICE, 2020).

### **1.5.1 PTSD Treatment**

When PTSD is suspected, the evidence-based system of care advocated by NICE is initially watchful waiting, not immediately offering treatment but reassessing at relevant intervals. Once treatment is indicated, NICE endorse trauma-focused cognitive behaviour therapy (CBT) or eye movement desensitisation and

reprocessing (EMDR), although this guidance is not specific to childbirth-related PTSD (NICE, 2018b).

There is limited evidence for effective psychological intervention for PTSD relating to childbirth (Slade et al., 2021). There are preliminary findings that EMDR (Chiorino et al., 2020) and other trauma-focused psychological therapies (Shorey et al., 2021) may be effective at reducing PTSS in the early postnatal phase for women. However, more research is required to explore long term outcomes and effectiveness for PTSD (Furuta et al., 2018) and treatment of men (Chiorino et al., 2020). No research has been identified that looked at birth trauma interventions targeting partners or the couple relationship.

### ***1.5.2 Birth Trauma Support***

For those not gaining a diagnosis of PTSD but experiencing ongoing distress from birth trauma the treatment pathway is unclear and lacks an evidence-base. An intervention commonly offered for birth trauma in the UK is midwifery-led debriefing, also referred to as birth listening or reflection (Ayers, Claypool & Eagle, 2006). Whilst women appear to value such debriefing services (Baxter, 2019; Meades et al., 2011) there is no robust evidence for effectiveness in preventing or reducing PTSS (Bastos et al., 2015; de Graaff et al., 2018).

From the literature it is evident that a range of other support strategies are used by those impacted by birth trauma, such as writing about their trauma (Di Blasio et al., 2015) and sharing their birth experience online (Blainey & Slade, 2015). Also, gaining social support (Vesel & Nickasch, 2015), obtaining information from website and helplines (Thomson et al., 2017), and engaging in complementary therapies like art therapy (Hogan, 2015) and hypnosis (Slater, 2015).

Parents indicate that they want support for birth trauma (Ayers, Eagle & Waring, 2006; Etheridge & Slade, 2017). Women report it is helpful to be made aware of support options, to have an opportunity to discuss their birth experience with a healthcare professional, and to receive information about birth trauma (Thomson & Downe, 2016). There is evidence that some women are only seeking help for PTSS relating to childbirth when the impact has pushed them to “breaking point” (Slade et al., 2021, p.691) and that partners are often coping alone with the impact of birth trauma (White, 2007).

There are no known interventions that offer dyadic, or relationship support specifically for birth trauma. In general, couple counselling has been shown to result in positive changes in relationship quality and communication (Spielhofer et al., 2014). However, meta-analysis of relationship interventions in the TTP found only a small effect on couple communication and well-being (Pinquart & Teubert, 2010). There is emerging evidence from the wider PTSD literature, that couple-based trauma therapy can simultaneously reduce trauma symptoms and improve relationship satisfaction (Greenman & Johnson, 2012; Monson et al., 2015).

### ***1.5.3 Barriers to Support and Treatment***

Although awareness of the importance of perinatal mental health is rising (Ayers & Shakespeare, 2015) and recommendations for perinatal mental health pathways exist (NICE, 2020; Oates, 2015) barriers remain to gaining support for birth trauma.

In the UK, clinical guidelines suggest postnatal healthcare services only routinely assess women for depression and anxiety (NICE, 2015). Research on assessing partner’s perinatal mental health is scarce (Darwin et al., 2020) and there is a lack of standard assessment for birth trauma for either parent (Nilvér et al., 2017).

These assessment issues create barriers to identifying those in need of birth trauma support.

Barriers to seeking assistance with birth trauma may stem from the parents themselves due to factors such as lack of awareness of mental health symptoms (Russell et al., 2017), mental health stigma (NCT, 2017), and feeling a sense of guilt for being unhappy at a perceived time of great joy (Smith et al., 2019). Such issues could be compounded by misconceptions surrounding childbirth even being a potential trauma, with a perpetuating myth that the only important outcome from birth is a healthy baby (Moore, 2019).

Even when parents wish to obtain support for birth trauma, healthcare practitioners can create barriers to treatment through their own lack of awareness of birth trauma and limited training in how to provide effective support (de Vries et al., 2018). Lack of continuity of care (Bayrampour, et al., 2018) and practitioners having insufficient time to spend with parents (Noonan et al., 2018) are further limitations to providing support.

Funding deficits for perinatal mental health services (Bauer et al., 2014), especially for birth trauma mean there are limited services to refer parents to and long waiting times to be seen (Thomson & Garrett, 2019). Despite growing evidence of the impact of trauma in the perinatal phase, mental health services continue to be focused on providing treatment for depression (Higgins et al., 2018) or for individuals who are severely affected by their mental health disorder (Russell et al., 2017). Even though acknowledgement of the importance of paternal perinatal mental health pathways is increasing (NHS, 2019), partners continue to be overlooked in maternity healthcare provision (Baldwin et al., 2018) and in perinatal mental health services (Daniels et al., 2020; NHS, 2021).

## **1.6 Summary, Research Aims, and Objectives**

In summary, research has shown that birth trauma can affect women, partners, and the relationship between them. The quality of the couple relationship can influence the TTP and affect personal health and well-being. Whilst data on the impact of birth trauma on the couple relationship is limited, the affect has been shown to be wide ranging and enduring. Parents indicate that they want support for birth trauma which can take many forms such as information and advice, help from healthcare practitioners, and psychological treatment. However, there is a limited evidence-base for what constitutes acceptable or effective support for birth trauma, with no research about the support needed for the couple relationship following birth trauma.

To address these gaps in the literature the aim of this thesis was to investigate the impact of birth trauma on the couple relationship and associated requirements for birth trauma support.

### ***1.6.1 Research Objectives***

(1) To explore existing evidence of the impact of birth trauma on the couple relationship.

(2) To investigate UK healthcare professional's observations of the impact of birth trauma on the couple relationship and associated requirements for birth trauma support.

(3) To investigate UK parents lived experience of the impact of birth trauma on the couple relationship and associated requirements for birth trauma support.

(4) To consider potential enhancement of birth trauma support in relation to the impact of birth trauma on the couple relationship.

Table 1.1 presents an overview of the studies in this thesis including aims, methods, and the chapter where findings are presented.

**Table 1.1** *Overview of Studies*

| <b>Study/Article Title</b>                                                                                                            | <b>Research Aims</b>                                                                                                                                                                                        | <b>Method</b>                                        | <b>Sample</b>                 | <b>Chapter</b> |
|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------|----------------|
| <b>1</b> - The Impact of Childbirth-Related Post-Traumatic Stress on a Couple's Relationship: A Systematic Review and Meta-Synthesis. | To identify the impact of childbirth-related PTSD or PTSS on a couple's relationship.                                                                                                                       | Systematic Review.<br>Meta-ethnography.              | 7 papers.                     | Chapter 2.     |
| <b>2</b> - A Systematic Review and Meta-Synthesis of the Impact of Becoming Parents on the Couple Relationship.                       | To synthesise qualitative research of the perceived impact of the TTP on a couple's relationship in contemporary western society.                                                                           | Systematic Review.<br>Meta-ethnography.              | 12 papers.                    | Chapter 3.     |
| <b>3</b> - Healthcare Practitioners' Assessment and Observations of Birth Trauma in Mothers and Partners.                             | To investigate the experiences of healthcare practitioners from the UK in the assessment of birth trauma, perceived occurrence of birth trauma, and observed impact on parents and the couple relationship. | Online Survey.<br>Quantitative Statistical Analyses. | 202 healthcare practitioners. | Chapter 4.     |

|                                                                                                                                                                    |                                                                                                                                                                                                                |                                                 |             |            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------|------------|
| Healthcare Practitioners' Views of the Support Women, Partners, and the Couple Relationship Require for Birth Trauma: Current Practice and Potential Improvements. | To examine UK healthcare practitioners' views of the support women, partners, and the couple relationship require when affected by birth trauma, barriers to gaining such support, and potential improvements. | Qualitative. Content Analysis.                  |             | Chapter 5. |
| <b>4 - The Impact of Birth Trauma on the Couple Relationship and Related Support Requirements: a Framework Analysis of Parents' Perspectives.</b>                  | To explore the lived experience of the impact of birth trauma on the couple relationship and related support requirements.                                                                                     | Semi-structured Interviews. Framework Analysis. | 18 parents. | Chapter 6. |

### **1.6.2 COVID-19 Pandemic**

In late 2019 China saw the first cases of the infectious coronavirus disease, COVID-19, which would go on to become a global pandemic. From early 2020, the UK began to be impacted by rising COVID-19 infections which increased pressure on acute and routine health services. In response to the threat to life that COVID-19 posed, the UK government, like many across the world imposed various restrictions to limit personal contact and spread of disease (Johnson, 2020).

The COVID-19 pandemic resulted in a range of changes to UK maternity services in 2020 and 2021. The most reported changes included reduced antenatal and postnatal appointments and removal of some birthing settings such as homebirth and midwifery led units (Jardine et al., 2020). Whilst policies differed by geographical area, there is evidence of restrictions on birth partners attending antenatal appointments, being present during the latent phase or induction of labour, and visiting on postnatal wards (Iacobucci, 2020). Similarly, parents faced restrictions on visiting infants being cared for on neonatal units (McKinnell, 2020).

Postnatal support once discharged from hospital also declined due in part to health visitor redeployment to pandemic duties and the replacement of face-to-face services with telephone contact (McKinnell, 2020). Likewise, peer and social support was disrupted by COVID-19 restrictions, leaving many parents feeling isolated and lonely (Saunders & Hogg, 2020).

Research on the impact of the pandemic on parents, reported lower levels of well-being and higher anxiety symptoms (Cusinato et al., 2020). In a pandemic survey of UK parents, 61% of parents shared considerable concern about their mental health, yet only 32% felt confident they could get mental health support if needed (Saunders & Hogg, 2020). There is emerging evidence of higher prevalence

of postnatal depression symptoms and PTSS compared to pre-pandemic (Ostacoli et al., 2020).

Due to the pandemic having a range of effects on families two clarifying questions were added to the interview schedule of the study with parents (chapter 6), to enable understanding of any impact of COVID-19 on the lived experience of birth trauma. Firstly asking, do you feel that the COVID-19 pandemic had any effect on the couple relationship experiences you have shared? Then secondly, has the COVID-19 pandemic had any impact on support for birth trauma?

The COVID-19 pandemic also had an impact on the progression of doctorate work. The initial plan had been for the semi-structured interviews with parents to be conducted face to face but this was not permitted due to COVID-19 restrictions. Therefore, gaining ethical approval for the interview study was delayed due to seeking necessary amendments to enable remote data collection. From a personal perspective, living through the pandemic and associated restrictions also resulted in delays in progression of doctorate work. Due to these delays, it was not possible to take thesis findings back to healthcare practitioners and parents for evaluation and refinement as initially planned.

## **1.7 Methodology Overview**

From the literature it is clear there is no universally accepted definition of birth trauma, with the terms birth trauma, PTSS and PTSD being used interchangeably in research and practice. The empirical studies presented in this thesis used a simplified version of the birth trauma definitions given in section 1.2, “emotionally traumatic childbirth causing ongoing distress”. This definition was felt to encompass the complex phenomenon of birth trauma in a way that was easy to comprehend by research participants. As research on birth trauma treatment

and support is so limited, in this thesis the term birth trauma support is used in the widest sense. It is acknowledged that birth trauma support could take many forms such as information and advice, care or advocacy from healthcare practitioners, and psychological treatment.

The doctorate was matched funded and supervised by City, University of London, and the National Childbirth Trust (NCT). As a charity the NCT is focused on supporting parents in the first 1000 days of parenthood in the UK. Due to NCT scope and the inimitable National Health Service (NHS) in England, Scotland, Wales and Northern Ireland, empirical doctorate work was limited to UK data.

Table 1.1 gives an overview of the four studies in this thesis with general method information. Study 1 and 2 were systematic reviews and therefore did not require ethical approval as this was secondary data analysis. Ethical approval for study 3 (appendix 4) and 4 (appendix 6) was granted by the School of Health Sciences at City, University of London.

### ***1.7.1 Researcher Background***

I came to the topic of birth trauma from personal experience. In 2005 my husband and I experienced the birth of our first child as traumatic, from which I went on to be diagnosed with PTSD and later in my second pregnancy, secondary tokophobia. It was our journey through birth trauma and recovery which led me to qualify as an antenatal teacher in 2010. Both my own lived experience of birth trauma and involvement in supporting parents as an antenatal teacher, led me to embark on this doctorate in 2015.

Whilst my personal experiences helped shape my doctorate focus and research questions, I was mindful throughout my research to ensure that findings were not influenced by my lived experience and were grounded in the data. This was

achieved through reflective journaling, robust discussion of data findings with my supervisors, and underpinned by my ontological view as a researcher.

My approach is one of interpretive pragmatism, that there is no single truth and reality is created by individuals based on their lived experience. Furthermore, it is more important to choose the appropriate research method to address the research question, than align with a single epistemology (Goldkuhl, 2012). As a qualitative health sciences researcher, I am emic in approach, interacting with people as the expert by experience, to find out what a phenomenon means for them (Ormston et al., 2014). I aim to conduct research that can contribute to improving the perinatal experiences and associated outcomes for families.

#### ***1.7.2 Study 1 & 2 – Systematic Reviews and Meta-Syntheses***

The initial approach to the doctorate program was to investigate what evidence already existed pertaining to the impact of birth trauma on the couple relationship. To ensure that all relevant work was found, a systematic review was conducted. Due to a scoping search highlighting limited literature in this field, date of publication and country of study population was not limited. Likewise, the scoping review identified that the language of prior work was more in line with childbirth-related PTSD than birth trauma. Therefore, this language was reflected in the study, and the systematic review aimed to identify the impact of childbirth-related PTSD or PTSS on a couple's relationship.

The systematic review identified only two quantitative studies but seven qualitative studies. Consequently, meta-synthesis was conducted on the seven qualitative studies which resulted in five themes of the impact of childbirth-related PTSD or PTSS on a couple's relationship (chapter 2, article 1).

A second systematic review of the impact of the TTP on the couple relationship was conducted to assess if the findings from the first meta-synthesis of the impact of childbirth-related PTSD or PTSS on a couple's relationship were novel. A scoping search for this second systematic review yielded much higher levels of evidence for the impact of the TTP on the couple relationship. Therefore, the review aimed to synthesise the available body of qualitative work on the perceived impact of the TTP on a couple's relationship in contemporary, western society. The systematic review resulted in twelve studies which were subject to meta-synthesis which resulted in six themes of the impact of the TTP on the couple relationship (chapter 3, article 2).

### ***1.7.3 Study 3 – Healthcare Practitioner Survey***

The third study aimed to investigate the experiences of healthcare practitioners from the UK in the assessment of birth trauma, perceived occurrence of birth trauma, and observed impact on parents and the couple relationship. Furthermore, the study aimed to examine healthcare practitioners' views of the support women, partners, and the couple relationship require when affected by birth trauma, barrier to gaining such support, and potential improvements.

The study was designed to achieve a comprehensive practitioner view of the phenomenon. To understand the extent of the problem, the current support that is offered to couples, and if further support was thought necessary. To address the broad scope of the study a survey was developed to address the study research questions (appendix 4). The survey was hosted online to aid ease of participation, reduce burden on the sample, and facilitate data collection.

Inclusion criteria for participants was those working in the UK supporting parents in the first postnatal year. Initial recruitment of the study was focused on

clinical healthcare professionals such as general practitioners (GP), midwives, health visitors, and counsellors who support parents in the first postnatal year. As preliminary recruitment numbers were low, the recruitment period was extended, and the sample population extended to include non-clinical healthcare practitioners who were supporting new parents and could provide insight to the research questions. This included practitioners such as parent educators, doulas, and breastfeeding specialists.

Ultimately the data collection for the study was successful and along with quantitative data it also yielded qualitative findings from open questions. Therefore, the findings from this study were presented in two separate articles to enable the breadth of study results to be disseminated. The first article (chapter 4, article 3) reported birth trauma assessment practices, perceived incidence, observed symptoms, and impact on the couple relationship. The second article (chapter 5, article 4) reported data about birth trauma support. Namely, what support is currently offered, perceived barriers to gaining support, and views on potential improvements to birth trauma support.

#### ***1.7.4 Study 4 – Parent Interviews***

The fourth study aimed to explore the lived experience of the impact of birth trauma on the couple relationship and related support requirements. This study therefore used qualitative methodology, which acknowledges and supports data collection of the wide range of personal circumstances surrounding birth trauma and family arrangements.

One-to-one interviews were selected to enable consideration of each unique narrative and to capture the experience each participant had following a traumatic birth. The interviews were semi-structured using a topic guide (appendix 6) to enable

all research questions to be explored. However, participants were encouraged to talk about anything they felt was relevant, to support collection of data on the entirety of their experience and understanding.

Data were analysed using framework analysis as this provided a systematic way of managing the large qualitative data set and to ensure effective analysis of all data and acknowledgement of the breadth of experiences represented in the sample. Analysis reported 27 themes, which detailed both positive and negative aspects of the impact of birth trauma on the couple relationship and associated requirements for birth trauma support (chapter 6, article 5).

## **2      The Impact of Childbirth-Related Post-Traumatic Stress on a Couple's Relationship: a Systematic Review and Meta-Synthesis**

### **(Article 1)**

- Delicate, A., Ayers, S., Easter, A., & McMullen, S. (2018). The impact of childbirth-related post-traumatic stress on a couple's relationship: a systematic review and meta-synthesis. *Journal of Reproductive and Infant Psychology*, 36(1), 102-115. <https://doi.org/10.1080/02646838.2017.1397270>
- Delicate, A. (2016, September 13-14). A review and meta-synthesis of the impact of traumatic childbirth on couples' relationships [Poster]. *36th Annual Society for Reproductive and Infant Psychology Conference*, Leeds, UK.
- Delicate, A. (2016, April 12). A review and meta-synthesis of the impact of traumatic childbirth on couples' relationships [Oral Presentation]. *4th Annual School of Health Sciences Doctoral Research Conference*, City, University of London, UK.

## **2.1 Abstract**

**Objective:** This review aimed to identify the impact of childbirth-related PTSD or PTSS on a couple's relationship. **Background:** Childbirth can be psychologically traumatic and can lead to PTSD. There is emerging evidence that experiencing a traumatic birth can affect the quality of the couple's relationship. This is an important issue as poor-quality relationships can impact on the well-being of partners, their parenting, and the welfare of the infant.

**Methods:** A systematic search was conducted of Amed, CENTRAL, Cinahl, Embase, Maternity and Infant Care, Medline, MITCognet, POPLINE, PsycARTICLES, PsycBITE, PsycINFO, Pubmed, and Science Direct. Additionally, grey literature, citation, and reference searches were conducted.

Papers were eligible for inclusion if they reported qualitative data about parents who had experienced childbirth and measures of PTSD or PTSS and the relationship were taken. Analysis was conducted using meta-ethnography.

**Results:** Seven studies were included in the meta-synthesis. Results showed that childbirth-related PTSD or PTSS can have a perceived impact on the couple's relationship and five themes were identified: negative emotions, lack of understanding and support, loss of intimacy, strain on the relationship, and strengthened relationship. A model of proposed interaction between these themes is presented. **Conclusions:** The impact of childbirth-related PTSD or PTSS on couple's relationships is complex. As the quality of the couple relationship is important to family well-being, it is important that healthcare professionals are aware of the impact of experiencing psychologically traumatic childbirth as impetus for prevention and support.

## **2.2 Introduction**

For some women childbirth can be psychologically traumatic due to a perceived threat of injury or death to the woman, infant or both, and this can lead to PTSD. The prevalence of childbirth-related PTSD in women is 3 to 4% (Dikmen-Yildiz et al., 2016) but more may suffer from symptoms of PTSS despite not meeting diagnostic criteria. PTSD presents with symptoms such as re-experiencing the traumatic event, increased arousal, avoidance of trauma triggers and numbing of emotions. The impact of PTSD or PTSS can be wide ranging affecting for example, the parent-infant bond, relationships, self-image, and emotions (McKenzie-McHarg et al., 2015).

Partners of women can also be affected. Witnessing traumatic childbirth has the potential to affect partner's mental health (Hinton et al., 2014) leading to anxiety (Bradley et al., 2008) or PTSS (Elmir & Schmied, 2016). The mental health responses of partners following childbirth appear to be interlinked (Iles et al., 2011) and postnatal mental health has been shown to affect the quality of the relationship between partners (Burgess, 2011).

Good quality relationships are associated with positive personal outcomes (Reynolds et al., 2014), increased achievement (Marjoribanks, 2016a), higher personal well-being (Proulx et al., 2007) and better health (Robles et al., 2014). Relationships also influence parenting and a child's attachment to its parents (DCSF, 2010). A child's future psychological well-being is associated with the type of the attachment it forms with its parents (Sroufe, 2005), and parental relationship breakdown is associated with poverty, poorer health, lower educational attainment, and behavioural problems for the child (Coleman, 2010).

The impact of childbirth-related PTSD or PTSS on the couple's relationship has been examined by a few studies. Most of the research is qualitative and reports a range of impacts of traumatic childbirth on the couple's relationship. Only two quantitative studies have been published. The first was a study of 64 couples which found that childbirth-related PTSS was not associated with changes in the couple's relationship (Ayers et al., 2007). The second was an online survey of 152 women and men that found that childbirth-related PTSS was associated with a worse relationship, but that this was fully mediated by symptoms of depression (Parfitt & Ayers, 2009).

This systematic review aimed to investigate the body of qualitative work of the impact of childbirth-related PTSD or PTSS on the couple's relationship, as qualitative research allows greater understanding of the phenomenon to be gained through description of the lived experience (Al-Busaidi, 2008).

## **2.3 Method**

### **2.3.1 Design**

A systematic review was conducted according to PRISMA guidelines to facilitate completeness of information gathering and strengthen the validity of review findings (Liberati et al., 2009). Results of papers included were then synthesised using meta-ethnography (Noblit & Hare, 1988a).

### **2.3.2 Inclusion Criteria**

All types of couple relationships (e.g., married, cohabitating, heterosexual, and homosexual) were eligible for the systematic review. Papers were included if they presented first order qualitative couple relationship data and measures of PTSD or PTSS (whether formal scales or self-reported) of parents aged over eighteen who had experienced childbirth of a live infant after 24 weeks of gestation. Miscarriage

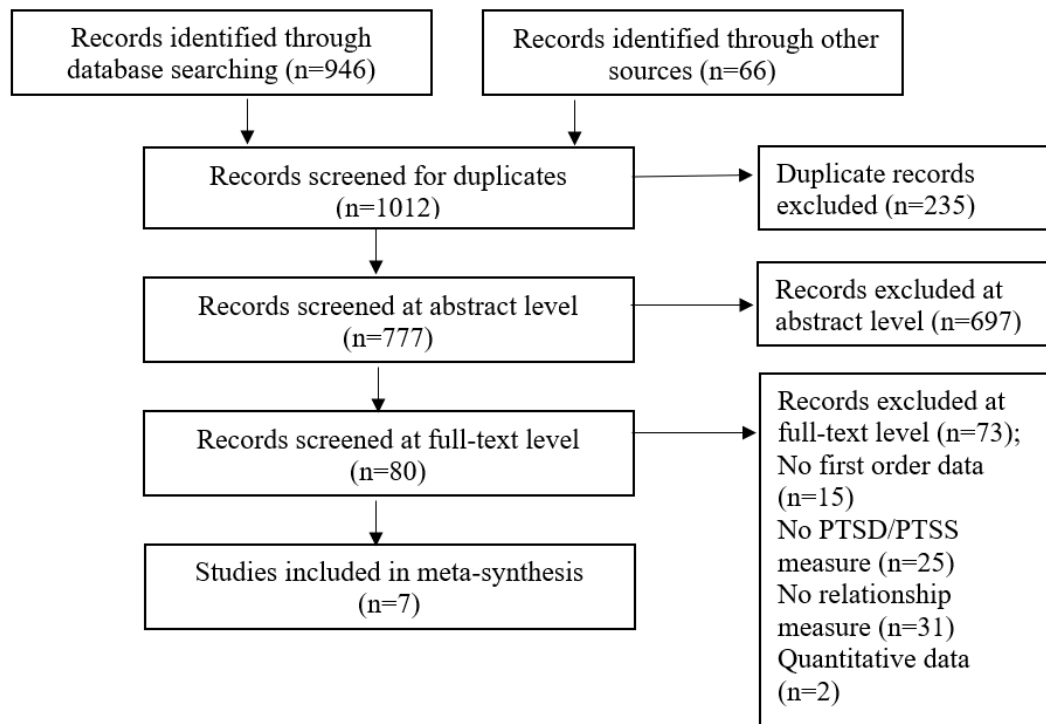
and stillbirth were excluded as grief reaction is a complex psychological issue, arguably requiring separate consideration (Badenhorst & Hughes, 2007). Only studies reported in English were eligible for inclusion. There were no restrictions made by clinical or normative population, publication dates, or country of origin due to limited research in this topic.

### **2.3.3 Search Strategy**

Thirteen databases were searched in November 2015 (Amed, CENTRAL, Cinahl, Embase, Maternity and Infant Care, Medline, MITCognet, POPLINE, PsycARTICLES, PsycBITE, PsycINFO, Pubmed, and Science Direct). Search terms within the following concepts were crossed using Boolean syntax AND: (1) Parental (e.g., Parent\* OR Couple); (2) Pregnancy and Childbirth (e.g., \*birth OR pregnanc\*); (3) Psychological (e.g., trauma\* OR distress); and (4) Relationship (e.g., partner\* OR spouse\*). Full details of search terms can be found in appendix 1.

Searches were also conducted of grey literature (e.g., Open Grey and EthOS) and websites of relevant organisations (e.g., Birth Trauma Association). Citation and reference searches were conducted of eligible papers and ten key authors contacted to enquire about relevant work for the review, eight of these responded but did not provide any additional eligible research. One thousand and twelve records were initially identified and after applying the inclusion criteria seven studies were retained. Figure 2.1 depicts the evidence identified at each stage of the search.

**Figure 2.1** *PRISMA Flowchart*



#### 2.3.4 *Quality Appraisal*

A two-stage process was used to critically appraise the validity of the studies in the systematic review. Firstly, papers were screened against the consolidated criteria for reporting qualitative research (COREQ) checklist (Tong et al., 2007) which was designed to improve the quality of qualitative research by assuring comprehensive reporting. Then content was assessed against the Critical Appraisal Skills Program (CASP) checklist for qualitative work to ascertain the validity and value of results (CASP, 2014).

Validity was considered. Six of the seven included papers met a high proportion of the COREQ and CASP checklist items and were considered reliable. Reporting of the final study (Kendall-Tackett, 2014) made it difficult to ascertain the study design to complete the appraisal checklists, however, this paper was retained as its themes were consistent with other included papers.

### **2.3.5 Analysis**

Results of the identified studies were synthesised using meta-ethnography techniques (Noblit & Hare, 1988a) to systematically compare and examine the results of included studies and enable a deep understanding of the research (Toye et al., 2014). This technique was selected as interpretations from meta-ethnography can more readily generate new awareness of a subject (Paterson et al., 2001), adding to the body of evidence and informing the development of theories of experiences and behaviours (Atkins et al., 2008).

All papers were read, and data extracted verbatim into a spreadsheet as first order (participant's voice) and second order (author's voice) data. Each data item was assigned a concept based on the message of the data and concepts were compared across studies, analysed, and refined into emerging overarching themes (Walsh & Downe, 2005). This process was completed independently by two researchers who then discussed the themes identified. Once finalised, themes were developed into a proposed model of the interaction between themes.

## **2.4 Findings**

### **2.4.1 Identified Studies**

Seven studies met inclusion criteria and are presented in Table 2.1. All studies used a clinical population of parents who reported childbirth-related PTSD or PTSS and sample sizes varied widely from 2 (Kendall-Tackett, 2014) to 145 participants (Allen, 1998). None of the studies used relationship type as inclusion criteria and only two studies reported the relationship status of the sample (Ayers, Eagle & Waring, 2006; Nicholls & Ayers, 2007).

**Table 2.1** *Studies and Characteristics*

| <b>Author (Year)</b>         | <b>Title (Location)</b>                                                                                                      | <b>Methodology/<br/>Methods</b>                                               | <b>Aim</b>                                                                                                                                                                               | <b>Sample</b>                                       | <b>Inclusion Criteria</b>                                                                         |
|------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Allen (1998)                 | A qualitative analysis of the process, mediating variables, and impact of traumatic childbirth (UK).                         | Grounded Theory. Self-reported questionnaire then semi structured interviews. | To identify whether women do experience significant PTSD symptoms following childbirth and provide data to facilitate prevention of PTSD symptoms and guide psychological interventions. | First stage – 145 women<br>Second stage – 20 women. | Women presenting their baby for an 8 week check and rating their labour as extremely distressing. |
| Ayers, Eagle & Waring (2006) | The effects of childbirth-related post-traumatic stress disorder on women and their relationships: a qualitative study (UK). | Thematic Analysis. Semi-structured interviews.                                | To carry out an investigation of the long-term impact of a traumatic birth and postnatal PTSD on women.                                                                                  | 6 women.                                            | Women who reported having psychological problems after a traumatic birth.                         |
| Beck (2004b)                 | Post-traumatic stress disorder due to childbirth. (New Zealand, UK, US, and Australia).                                      | Phenomenology. Women's written accounts of experience.                        | To describe the woman's experience of PTSD after childbirth.                                                                                                                             | 38 women.                                           | Woman who had experienced PTSD attributed to birth.                                               |

|                                                                                                                            |                                                         |                                                                                                                                     |                                                             |                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| Kendall-Tackett (2014)<br>Childbirth-related posttraumatic stress disorder (US).                                           | Qualitative.<br>Women's<br>accounts in own<br>words.    | To describe the prevalence of<br>PTSD after childbirth and<br>symptoms so Lactation Consultants<br>can recognise and refer mothers. | 2 Women.                                                    | Unclear.                                                                                                                                                  |
| Nicholls & Ayers (2007)<br>Childbirth-related post-traumatic stress disorder in couples: a qualitative study (UK).         | Thematic<br>Analysis. Semi-<br>structure<br>interviews. | To look at the experience and<br>impact of childbirth-related PTSD<br>in women and their partners.                                  | 6 couples.                                                  | A traumatic birth over 3 months<br>ago, one member of the couple<br>had to fulfil DSM-IV PTSD<br>criteria and both partners be<br>willing to participate. |
| Taghizadeh, Irajpour & Arbabi<br>(2013) Mothers' response to<br>psychological birth trauma: a<br>qualitative study (Iran). | Content<br>Analysis.<br>Interviews.                     | To describe a woman's response to<br>psychological birth trauma.                                                                    | 94 Women<br>screened -<br>23 Women<br>included in<br>study. | No previous post-trauma stress<br>or psychotic disorders prior to<br>experiencing psychological<br>birth trauma as assessed by<br>DSM-IV.                 |
| White (2007) You cope by<br>breaking down in private: fathers<br>and PTSD following childbirth<br>(New Zealand).           | Descriptive<br>Phenomenology.<br>Narrative.             | To explore the phenomenon of<br>PTSD following childbirth from the<br>fathers' perspective.                                         | 21 Men.                                                     | Men that had experienced their<br>partners giving birth as<br>traumatic.                                                                                  |

Five studies were based on women: two in the UK (Allen, 1998; Ayers, Eagle & Waring, 2006), one in the US (Kendall-Tackett, 2014), one in Iran (Taghizadeh et al., 2013), and one across Australia, New Zealand, and the UK (Beck, 2004b). One study was based on couples in the UK (Nicholls & Ayers, 2007) and the final study was of men in New Zealand (White, 2007). Three studies included participants based on self-identified PTSS (Kendall-Tackett, 2014; White, 2007) or disclosure of an earlier diagnosis (Beck, 2004b). Remaining studies used a variety of PTSD measures: the PTSD Diagnosis Scale (PDS) (Ayers, Eagle & Waring, 2006; Nicholls & Ayers, 2007), the revised Impact of Event Scale (Allen, 1998), and assessment using the DSM-IV criteria however, it is unclear if this was done by interview or questionnaire (Taghizadeh et al., 2013).

#### **2.4.2 Themes**

Five themes were identified: (1) Relationship strain, (2) Strengthened relationship, (3) Negative emotions, (4) Lack of understanding and support, and (5) Loss of intimacy. Table 2.2 shows which studies themes were drawn from. Themes are outlined below and illustrated with quotations which state whether the quote is from the author or a male/female participant.

##### **2.4.2.1 Relationship Strain.**

All seven studies found a perceived negative impact of childbirth-related PTSD or PTSS on the couple's relationship. This was expressed as strain (Ayers, Eagle & Waring, 2006), demanding relationships (Taghizadeh et al., 2013), barriers in the relationship (Nicholls & Ayers, 2007), and frustration between partners leading to treating one another badly (Allen, 1998).

**Table 2.2** *Identified Themes*

|                                      | Themes              |                           |                   |                                   |                  |
|--------------------------------------|---------------------|---------------------------|-------------------|-----------------------------------|------------------|
|                                      | Relationship Strain | Strengthened Relationship | Negative Emotions | Lack of Understanding and Support | Loss of Intimacy |
| <b>Papers</b>                        |                     |                           |                   |                                   |                  |
| Allen (1998)                         | X                   |                           | X                 | X                                 | X                |
| Ayers, Eagle & Waring (2006)         | X                   |                           | X                 | X                                 | X                |
| Beck (2004b)                         | X                   |                           | X                 | X                                 | X                |
| Kendall-Tackett (2014)               | X                   | X                         | X                 | X                                 | X                |
| Nicholls & Ayers (2007)              | X                   | X                         | X                 | X                                 | X                |
| Taghizadeh, Irajpour & Arbabi (2013) | X                   |                           | X                 | X                                 | X                |
| White (2007)                         | X                   |                           | X                 |                                   | X                |

*I always used to be patient, but now I fly off the handle. I just need to get rid of the frustration, but the next day I think 'God. I was so unreasonable' and then I'd feel bad and that it has put even more strain on my relationship with [husband] (female). (Allen, 1998, p. 120)*

*She's a lot more standoffish now of me. At times when as a couple you want to be kind of closer, and then that closeness seems to have something stopping it, there's a barrier to being closer that shouldn't be there (male). (Nicholls & Ayers, 2007, p 500)*

It is important to highlight that there were examples when relationships were strained to the limit (Beck, 2004b) leading to relationship breakdown (Ayers, Eagle & Waring, 2006; White, 2007). However, there was no information about how individuals felt about the end of their relationship.

*One woman had separated from her partner, and a further two women said their difficulties nearly caused them to separate (author). (Ayers, Eagle & Waring, 2006, p. 394)*

*His wife and baby survived but his marriage did not (author). (White, 2007, p. 43)*

#### **2.4.2.2 Strengthened Relationship.**

In contrast, two studies (Kendall-Tackett, 2014; Nicholls & Ayers, 2007) showed that although there was relationship strain there were also examples of couples working together and the experience ultimately strengthening their relationship.

*By the grace of God, my husband and I made it. We are best friends, and war buddies, and love each other more every day (female). (Kendall-Tackett, 2014, p. 55)*

*But, you know, what did it do to our relationship, it strengthened it if anything, not that it needed it, it was like we came through this thing (male). (Nicholls & Ayers, 2007, p.502)*

#### **2.4.2.3 Negative Emotions.**

Experiencing negative emotions was reported in all the studies. The most mentioned emotion was anger, which was reported in six of the seven papers.

*He went to a job where he was treated like crap and came home to a wife who hated him. We were both miserable (female). (Kendall-Tackett, 2014, p. 54)*

*I do tend to be very angry towards him, which he does find very difficult (female). (Ayers, Eagle & Waring, 2006, pp. 394-5)*

Other emotions highlighted were guilt (Allen, 1998), blame (Ayers, Eagle & Waring, 2006), and disagreements (Nicholls & Ayers, 2007).

*When it didn't get any better we just started to take it out on each other really, and blaming each other for it (male). (Nicholls & Ayers, 2007, p. 501)*

*I think with [my wife] I was a lot more careful of what I might say and what I might do. It was a bit like walking on eggshells all the time. You put on foot wrong and you're likely to cop a serve. Yes I guess I avoided the position which could lead into an argument for a long time (male). (Nicholls & Ayers, 2007, p. 501)*

Depressive mood was also apparent with symptoms such as emotional numbness and detachment (Ayers, Eagle & Waring, 2006; Taghizadeh et al., 2013), feeling empty or soulless (Beck, 2004b), and suicidal thoughts (Ayers, Eagle & Waring, 2006). These depressive symptoms affected personal well-being and had an impact on the couple relationship.

*Negative changes in mood and cognition overlap considerably with depression and can directly impact how a woman feels about her baby and partner (author) (Kendall-Tackett, 2014, p. 53).*

*We lost a lot of the light-hearted stuff like we used to have, we got a lot more serious with the responsibility and when [my baby] was crying it really*

*pulled us down...I think it was a very dark period in our lives really (male).*

*(Nicholls & Ayers, 2007, p. 502)*

#### **2.4.2.4 Lack of Understanding and Support.**

A lack of understanding and support between partners was reported in six of the seven papers. This was described in terms of apathy (Taghizadeh et al., 2013), partners not understanding what women were going through (Ayers, Eagle & Waring, 2006), partners showing irritation that women's distress was prolonged (Allen, 1998), and women feeling neglected by their partners (Kendall-Tackett, 2014).

*When [the baby] was born he didn't see anything wrong with it, he didn't really; couldn't really empathize and didn't really notice the mess I'd gotten into or tried not to notice it (female). (Ayers, Eagle & Waring, 2006, p. 394)*

*...women...reported that the closeness of their relationship had been negatively affected and that their partners showed irritation with them because their distress was so prolonged (author). (Allen, 1998, p.121).*

A mismatch of support was highlighted in terms of partners trying to help women through their difficulties but offering support that was ineffective (Ayers, Eagle & Waring, 2006) or not accepted by the women (Nicholls & Ayers, 2007).

*He loves me more than ever, he just wants to try and make it better, and no matter what he does he just doesn't make it better (female). (Ayers, Eagle & Waring, 2006, p. 394)*

*...we had arguments in which she says that she has a problem, I try to say, well, let's talk about it right now, and [my wife] refusing...and therefore, for me, frustration because I cannot solve the problem, I cannot help (male).*

*(Nicholls & Ayers, 2007, p. 501)*

Women identified that their partners also required support, but they were unable to personally provide this due to a lack of personal resources (Allen, 1998; Ayers, Eagle & Waring, 2006).

*Two [women] stated that their own emotional resources were so depleted that they could no longer provide any support for their partner (author). (Allen, 1998, p. 121)*

*There have been times when I felt I want to leave and just take [the baby] and not be with him anymore, and it's not because I don't love him, it's because I don't feel that I can give to him anymore (female). (Ayers, Eagle & Waring, 2006, p. 394)*

A reduction in communication between couples was reported due to a lack of understanding (Kendall-Tackett, 2014) or due to the process being too painful (Nicholls & Ayers, 2007).

*My husband was completely confused. I wanted a baby. I had a baby. Why was I mad at him? And why was I so sad? We weren't talking at all (female). (Kendall-Tackett, 2014, p. 54)*

*I would get desperately upset if we tried to talk about it, talking about it was painful and awful (female). (Nicholls & Ayers, 2007, p. 500)*

#### **2.4.2.5 Loss of Intimacy.**

All seven papers reported that sexual relationships were affected with a reduction in sexual relations (White, 2007) and loss of intimacy (Taghizadeh et al., 2013). Some women and their partners reported having flashbacks when initiating sex (Beck, 2004b) or avoiding sexual intercourse due to fears about becoming pregnant (Nicholls & Ayers, 2007).

*Our emotional relationship decreased after childbirth. I lost my sex drive. I don't know what is my problem. I was damaged (female). (Taghizadeh et al., 2013, p. 4)*

*After about 6 months, my husband and I still hadn't had sex since before the birth. When we began to try, I had flashbacks to the birth (female). (Beck, 2004b, p. 219)*

Closeness (Nicholls & Ayers, 2007), love (Taghizadeh et al., 2013) and romance also reduced between partners with some women saying the dynamics of their relationship had changed to one of friendship (Ayers, Eagle & Waring, 2006).

*My anxiety affected my marital relationship. We became apart; our love decreased, it affected our life directly (female). (Taghizadeh et al., 2013, p. 4)*

*There was no romantic inclination, we were friends (female). (Ayers, Eagle & Waring, 2006, p. 394)*

#### **2.4.3 Proposed Model of the Impact of Childbirth-Related PTSD or PTSS on the Couple's Relationship**

The meta-synthesis identified five themes of the perceived impact of childbirth-related PTSD or PTSS on a couple's relationship. Negative impact themes: relationship strain, negative emotions, lack of understanding and support, and loss of intimacy, and a fifth positive theme of strengthened relationship. These themes are presented in a proposed model in Figure 2.2. The lower level of the model shows the symptoms a couple may experience, filtering up to middle level, which shows the themes of relationship issues. The top layer of the model shows the overall perceived impact on the couple's relationship where symptoms and problems

combine to lead to relationship strain (and potential breakdown) or conversely to a strengthened relationship.

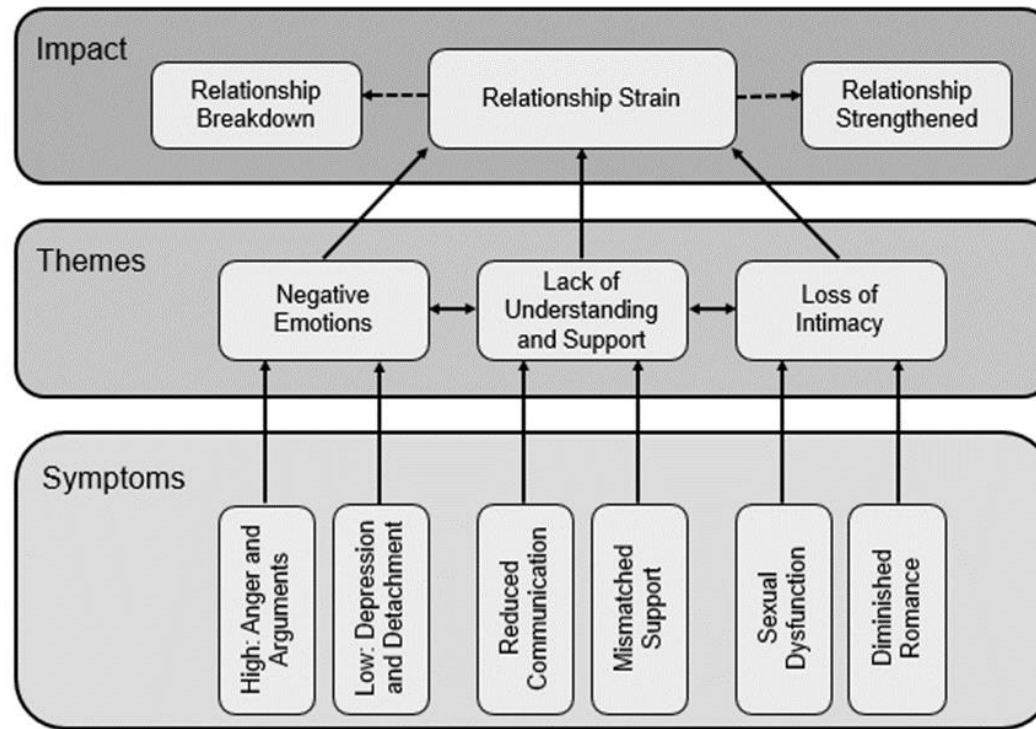
## **2.5 Discussion**

From the limited qualitative literature, this review with the use of meta-ethnography has demonstrated the perceived impact of childbirth-related PTSD or PTSS on the couple's relationship. Five themes being identified: relationship strain, strengthened relationship, negative emotions, lack of understanding and support, and loss of intimacy.

These findings are consistent with previous qualitative literature. A previous meta-ethnography of psychosocial implications for women (Fenech & Thomson, 2014), and a study of paternal mental health after traumatic childbirth (Inglis et al., 2016) both reported a detrimental impact on the couple relationship. Relationship strain is a broad theme reported by the review. This has various indicators and the ability for strain to contribute to the end of the relationship which is consistent with previous case studies (Beck, 2015; Joseph, 2011).

The theme of negative emotions found in the present review is consistent with previous studies. A meta-synthesis of fathers' experiences of complicated childbirth reported feelings of guilt and blame (Elmir & Schmied, 2016) and seething anger was a theme found in a meta-synthesis of the consequences of traumatic childbirth (Beck, 2015). The identification of depressive symptoms within this theme is consistent with the high co-morbidity of postnatal PTSD and depression (White et al., 2006). Previous studies also support the themes of lack of understanding and support (Elmir et al., 2010) and loss of intimacy (Olde et al., 2006) found in this review.

**Figure 2.2** *Proposed Model of the Impact of Childbirth-Related PTSD or PTSS on the Couple's Relationships*



There is less evidence for childbirth-related PTSD or PTSS resulting in a strengthened relationship with only two papers in the review supporting this theme. However, it has been observed in other studies looking at the impact of potentially life-threatening events during pregnancy and childbirth (Hinton et al., 2015; Engström & Lindberg, 2012), these studies were not eligible for the review as they did not include relationship first order data (Hinton et al., 2015) or PTSD/PTSS measures (Engström & Lindberg, 2012). Unfortunately, there was no information in the included studies to enable understanding of the mechanisms by which some relationships strengthen after experiencing traumatic birth, but it is speculated that this could be due to post-traumatic growth (Beck & Watson, 2016; Joseph, 2011).

In contrast, previous quantitative research in this area found that childbirth-related PTSD or PTSS is not associated with the quality of a couple's relationship (Ayers et al., 2007) or that the association is fully mediated by symptoms of depression (Parfitt & Ayers, 2009). In the present review, included studies did not control for depression so it is possible that the reported perceived impact on the couple relationship is not entirely attributed to childbirth-related PTSD or PTSS and that depression is a contributing factor. Further quantitative research is needed in more representative samples as the existing quantitative studies are limited methodologically. For example, being restricted to couples who were still together so potentially had a stronger relationship (Ayers et al., 2007), and a self-selected sample recruited from the internet (Parfitt & Ayers, 2009).

When looking at literature more broadly, the results of the review correspond with general trauma literature which points to a potential association between trauma-related symptoms and marital satisfaction (Weinberg et al., 2017) with a qualitative study reporting a range of perceived relationship effects including sexual

intimacy problems (Goff et al., 2006). Similarly, relationship satisfaction commonly declines in the TTP (Shaprio et al., 2000) and research looking at the impact of becoming a parent on a couple's relationship also reports strain (Luhmann et al., 2012), negative emotions (Parfitt & Ayers, 2014), lack of understanding (Chong & Mickelson, 2013), and loss of intimacy (Yeniel & Petri, 2014). Studies included in the review did not provide comparison of relationship changes following traumatic and non-traumatic childbirth, so it was not possible to examine whether the themes identified in the meta-synthesis are unique to traumatic childbirth.

### ***2.5.1 Limitations and Strengths***

This is the first systematic review with meta-synthesis of the impact of childbirth-related PTSD or PTSS on the couple's relationship. The search strategy was comprehensive and the study conclusions more robust due to the synthesis being conducted independently by two researchers.

However, the review has limitations which need to be considered. The meta-synthesis was based on a small sample of seven papers and some studies were not focused primarily on measuring the couple relationship. The quantity of data extracted from each study varied, and studies used a variety of measures for defining PTSD or PTSS in their samples. No studies compared the couple's relationships before and after childbirth to assess for changes over time, and no comparisons were made between experiencing psychologically traumatic childbirth versus non-traumatic childbirth.

## **2.6 Conclusions**

This systematic review with meta-ethnography suggests the impact of childbirth-related PTSD or PTSS on the couple's relationship is complex. Experiencing psychologically traumatic childbirth can lead to relationship strain and

associated symptoms of negative emotions, lack of understanding and support, loss of intimacy, and in some cases relationship breakdown. Conversely, the synthesis showed evidence of strengthened relationships but there was no data to allow understanding why or how this growth occurs.

As the quality of the couple relationship is important for personal well-being and is associated with the parent-infant bond and infant welfare, it is important that healthcare professionals are aware of the potential impact and presentation of childbirth-related PTSD or PTSS on a couple's relationship, and the need for support for couples.

More research is required to understand this phenomenon as impetus for prevention of childbirth-related PTSD or PTSS and the development of interventions to support couples following such an experience. Future research would benefit from being dyadic in focus, ascertaining how the impact of childbirth-related PTSD or PTSS on the couple's relationship differs from typical changes for couples in the TTP. Similarly, research looking at the mechanisms by which some relationships breakdown or develop following childbirth-related PTSD or PTSS may increase understanding of the support and interventions such couples require.

### **3      A Systematic Review and Meta-Synthesis of the Impact of Becoming Parents on the Couple Relationship (Article 3)**

Delicate, A., Ayers, S., & McMullen, S. (2018). A systematic review and meta-synthesis of the impact of becoming parents on the couple relationship. *Midwifery*, 61, 88-96.

<https://doi.org/10.1016/j.midw.2018.02.022>

Delicate, A. (2017, September 12-13). The impact of traumatic and non-traumatic childbirth on a couple's relationship: two systematic reviews and meta-syntheses [Oral Presentation]. *37th Annual Society for Reproductive and Infant Psychology Conference*, York, UK.

Delicate, A. (2017, June 8). A systematic review and meta-synthesis of the impact of becoming parents on the couple relationship [Poster]. *5th Annual School of Health Sciences Doctoral Research Conference*, City, University of London, UK.

### **3.1 Abstract**

Background: The TTP is associated with changes to a couple's relationship.

Quantitative evidence shows the TTP is associated with reduced satisfaction and quality of a couples' relationship. Qualitative research provides information on the lived experience of couples in the TTP so can provide a more in-depth understanding of the impact. This review therefore aimed to synthesise qualitative research of the perceived impact of the TTP on a couple's relationship in contemporary western society. Design: A systematic search was conducted of nine databases and grey literature. Key author, citation and reference searches were also undertaken. Papers were included if they presented qualitative data of romantic partner relationships during the TTP with parents aged 18 or over. Studies were restricted to those conducted from 1996 in western societies. Analysis was conducted using meta-ethnography. Findings: Searches identified 5256 papers. After applying inclusion criteria 12 papers were included in the meta-synthesis. Six main themes were identified: (1) Adjustment Phase (a period of change in the relationship), (2) Focus on the Baby (with a sub-theme of feeling unprepared for the relationship impact), (3) Communication (shifts in communication patterns and importance), (4) Intimacy (changes to sexual relations, romance, and closeness), (5) Strain on the Relationship (short-term or prolonged), and (6) Strengthened Relationship (deepening of connection and new affinity). Except for the themes of Strain on the Relationship and Strengthened Relationship, the findings showed the TTP had positive and negative impacts on couples' relationships. Key Conclusions and Implications for Practice: The review highlights a range of TTP relationship issues that couples experience and may require help with. Healthcare professionals working with parents in the TTP may be able to provide support through antenatal education that

includes preparation for relationship changes, and provision of postnatal support to identify and overcome problems.

### **3.2 Introduction**

Understanding the TTP, the effects of pregnancy and early parenting, on a couple's relationship is essential as good quality relationships are important for personal well-being (Proulx et al., 2007). For individuals, the quality of relationships has been shown to be associated with positive personal outcomes (Reynolds et al., 2014), increased achievement (Marjoribanks, 2016a), and improved physical (Robles et al., 2014) and emotional health (Figueriedo et al., 2008).

From the perspective of the child, the quality of their parent's relationship is important as it can influence parenting and the parent-child attachment (DCSF, 2010). Low quality relationships and high rates of conflict between parents are associated with an insecure infant-parent attachment (Finger et al., 2009; Wong et al., 2009) which can affect a child's psychological well-being (Sroufe, 2005). Economic analysis estimates the cost to UK society of family breakdown to be £48 billion per annum (The Relationships Foundation, 2016) and for the child, parental relationship breakdown is associated with poverty, ill health, lower educational attainment, and behavioural problems (Coleman, 2010).

The TTP creates changes in a couple's relationship and has been shown to have a significant impact on marital functioning (Doss et al., 2009), resulting in strain (Nelson et al., 2014), reduced marital quality (Ahlborg et al., 2009) and decline in relationship satisfaction (Mortensen et al., 2012). However, it is argued that research has largely focused on the costs of parenting with the benefits being largely ignored (Nomaguchi & Milkie, 2003). There is growing research suggesting parenthood is associated with greater marital stability (Roy et al., 2014), with first-

time parents generally being more satisfied with their relationship than childless couples (Guttmann & Lazar, 2004).

The TTP seems to magnify existing difficulties in a couple's relationship (Belsky & Rovine, 1990; Doss et al., 2009) however, this experience can differ by gender and the impact can be transient in nature (Cowan & Cowan, 2000). The strength of the relationship prior to becoming parents (Lawrence et al., 2008), marital status (Howard & Brooks-Gunn, 2009), and if the pregnancy was planned (Schwerdtfeger et al., 2013) can influence the impact of the TTP on the couple's relationship.

Relationship disharmony in the TTP may be due to several factors. For example, tension has been associated with the shift in roles (Twenge et al., 2003), perceived fairness of labour division (Chong & Mickelson, 2013), and increased opportunities for conflict (Roy et al., 2014). Patterns of parenting develop after childbirth with co-parenting alliance (Van Egeren, 2004), parenting self-efficacy, and parenting stress having been associated with relationship satisfaction (Kwan et al., 2015).

The strength of partner relationships can affect the psychological adjustment of parents (Figueiredo et al., 2008) and be a predictor of postnatal depressed mood (Matthey et al., 2000). There is emerging evidence that experiencing psychologically traumatic childbirth can affect the couple relationship (Delicate, Ayers, Easter & McMullen, 2018), that there is concordance of mental health problems between partners (Roberts et al., 2006), and that those with mental health problems more commonly report poor partner relationship (Parfitt & Ayers, 2014).

Conflict concerning finances is a common theme seen in all types of partner relationship research and becoming parents brings its own financial pressures

(Marjoribanks, 2016b). As well as increased expenditure relating to caring for the baby, parents often have loss of income due to changes in employment to enable parental leave. The length of maternity and paternity leave (Feldman et al., 2004), the woman's return to work (Spiteri & Xuereb, 2012), or ceasing work to be a full-time parent (Keizer et al., 2010) are also associated with a negative impact on a couple's relationship.

Pregnancy and childbirth can also affect a couple's physical relationship (Yeniel & Petri, 2014) with sexual relationship concerns appearing widespread (Schlagintweit et al., 2016) and for some long-term (Hansson & Ahlborg, 2012). Changes in sexual relationships have been shown to be affected by altered body image (Olsson et al., 2005), mismatch of desire, and less time due to parenting (Houlston et al., 2013).

The social and cultural context within which relationships and families develop has altered in the last two decades due to changing attitudes to relationships (Duncan & Phillips, 2008), increasing personal self-sufficiency, and the fragmentation of community, family, and friend networks (Gabb et al., 2013). Whilst the structure and practices of family life continue to change, the importance of good quality relationships is still paramount (Marjoribanks, 2016b). Therefore, it is important to comprehend the impact of the TTP on relationships in contemporary society to develop appropriate information and support services.

There is an extensive body of quantitative research on the TTP and relationship changes. Much of this research focuses on changes in factors such as relationship satisfaction (Mortensen et al., 2012; Shapiro et al., 2000), relationship quality (Doss et al., 2009; Kluwer & Johnson, 2007), and patterns of interaction within couples (Belsky & Rovine, 1990; Cox et al., 1999). In contrast, qualitative

research provides an understanding of the lived experience of the TTP (Al-Busaidi, 2008). Much of the qualitative research focuses on particular aspects of the relationship during the TTP such as intimacy (Olsson et al., 2005), gender (Sevón, 2012) and fatherhood (Deave & Johnson, 2008). This qualitative literature provides a rich account of couples' experiences during the TTP and therefore helps develop a more in-depth understanding of this complex phenomenon (Walsh & Downe, 2005).

This review therefore aimed to synthesise the available body of qualitative work on the perceived impact of the TTP on a couple's relationship in contemporary, western society. The results of the synthesis can help inform midwives and allied professionals of the current relationship issues parents may require preparation and support with.

### **3.3 Method**

#### **3.3.1 Inclusion Criteria**

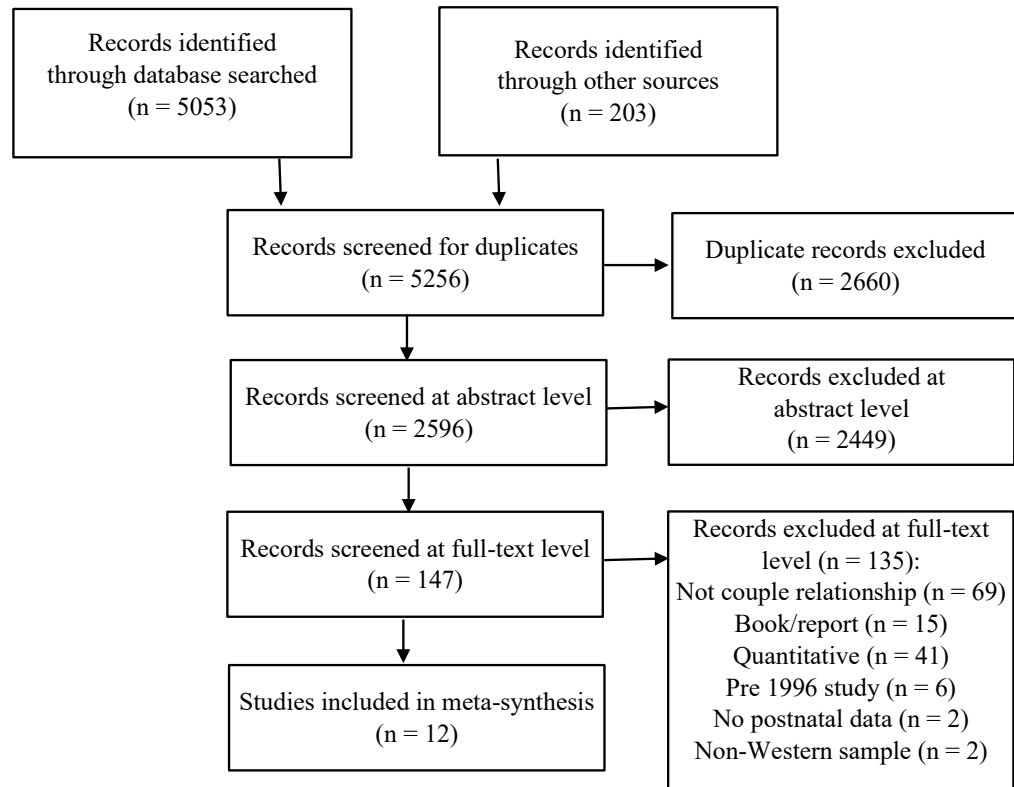
Papers were included if they presented qualitative data of romantic partner relationship changes experienced by parents aged eighteen or over. Inclusion was restricted to studies conducted from 1996 in a western society.

#### **3.3.2 Search Strategy**

Nine databases were searched in October 2016 (Amed, Cinahl, Maternity and Infant Care, Medline, POPLINE, PsycARTICLES, PsycINFO, Pubmed, Science Direct). Search terms within the following concepts were crossed using Boolean syntax AND: Couple (e.g., Couple\* OR Relation\*); Parenthood (e.g., Child\* OR Parent\*); Relationship (Change OR Quality). Full details of search terms can be found in appendix 2. Searches were also conducted of grey literature (e.g., Open Grey and EthOS) and relevant organisations (e.g., Fatherhood Institute and Relate). Citation and reference searches were conducted of eligible papers and associated authors

checked for further relevant research. Searches identified 5,256 records and after applying inclusion criteria, 12 studies were retained. Figure 3.1 shows the PRISMA flowchart of records at each stage of the search (Liberati et al., 2009).

**Figure 3.1** *PRISMA Flowchart*



### 3.3.3 *Quality Appraisal*

A two-stage process was used to critically appraise the validity of studies in the systematic review. Papers were screened against the COREQ checklist (Tong et al., 2007) to assess the quality of study reporting. Then content was assessed against the CASP checklist to ascertain the validity and value of results (CASP, 2014). All studies met a substantial proportion of the COREQ and CASP checklist items and were considered reliable and retained for synthesis.

### **3.3.4 Data Analysis**

Papers were synthesised using meta-ethnography techniques to examine and compare the results of the included studies (Noblit & Hare, 1988b), rationalising findings across papers (Campbell et al., 2012) to generate new subject understanding (Paterson et al., 2001). Data was extracted verbatim, as first order (participant) and second order (author). Each data item was given a concept based upon its message. These concepts were compared across studies and refined into common themes.

## **3.4 Results**

Twelve studies met inclusion criteria and an overview of these studies is given in Table 3.1. Sample sizes varied from five couples (Ahlborg & Strandmark, 2001) to 128 men in a mixed methods study (Williamson et al., 2008). Six studies were based on men: four in Sweden (Fägerskiöld, 2008; MacAdam et al., 2011; Olsson et al., 2010; Premberg et al., 2008), one in the UK (Deave & Johnson, 2008) and one in Australia (Williamson et al., 2008). Three studies had women as participants: one in Australia (Woolhouse et al., 2012), one in Finland (Sevón, 2012) and one in Sweden (Olsson et al., 2005). The final three studies had couples as participants: two studies in the UK (Deave et al., 2008; Faircloth, 2015) and one in Sweden (Ahlborg & Strandmark, 2001).

**Table 3.1** *Paper Characteristics*

| <b>Authors (Year) Title<br/>(Location)</b>                                                                                                    | <b>Methodology/Methods</b>                                                                                                              | <b>Aim</b>                                                                                                                                                                                                                                                                        | <b>Sample</b>             | <b>Inclusion Criteria</b>                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------|
| Ahlborg & Strandmark (2001)<br>The baby was the focus of attention - first time parents' experiences of their intimate relationship (Sweden). | Descriptive phenomenology.<br>Qualitative interviews when child was 6 and 18 months old.                                                | The purpose of this study was to describe the way first-time parents experience their intimate relationship and to identify the essence of this phenomenon and its meaning for the parents.                                                                                       | 5 couples.                | Parents willing to be interviewed.                                                              |
| Deave & Johnson (2008)<br>The transition to parenthood: what does it mean for fathers (UK).                                                   | A cross-sectional study using semi-structured interviews in the last trimester of pregnancy and for a second time 3-4 months postnatal. | The aim of the study was to explore the needs of first-time fathers in relation to the care, support and education provided by healthcare professionals during the antenatal period, particularly in relation to preparing for the transition to fatherhood and parenting skills. | 20 men.                   | Partners who were supporting women with uncomplicated first pregnancies who understood English. |
| Deave, Johnson & Ingram (2008)                                                                                                                | Semi-structured interviews in the last trimester of pregnancy and for a second time 3-4 months postnatal.                               | The aim of this study was to explore the needs of first-time parents in relation to the care, support, and education during the antenatal period, particularly in relation to                                                                                                     | 24 women and 20 partners. | Women with uncomplicated pregnancy who had not had a previous live baby                         |

|                                                                                                         |                                                                                                          |                                                                                                                                                                                                                                          |             |                                                                                       |
|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|---------------------------------------------------------------------------------------|
| Transition to parenthood: the needs of parents in pregnancy and early parenthood (UK).                  |                                                                                                          | preparing for the transition to parenthood and their parenting skills.                                                                                                                                                                   |             | and who understood English.                                                           |
| Fägerskiöld (2008)<br>A change in life as experienced by first-time fathers (Sweden).                   | Ground Theory. Semi-structured interviews of parents with infants 5-9 months of age.                     | The aim of this study was to explore first-time fathers' experiences during early infancy. This study is a part of a larger research project focusing on fathers' experiences and interaction with the child healthcare services.        | 20 men.     | Men with children that were willing to participate in the study.                      |
| Faircloth (2015)<br>Negotiating intimacy, equality, and sexuality in the transition to parenthood (UK). | Longitudinal study of mixed methods including interviews with parents of infants under 12 months of age. | The intention of the study was to explore the relationship between gender, equality and intimacy as couples make the transition to parenthood. This paper focuses on couples' accounts of sex as they make the transition to parenthood. | 15 couples. | First time parents in heterosexual dual earner couple.                                |
| MacAdam, Huuva & Bertero (2011)<br>Fathers' experiences after having a child: sexuality                 | Interpretive phenomenological approach. Narrative in-depth interviews of parents                         | The aim of this study was to identify and describe men's experiences of sexuality, 6 to 13 months after having a child.                                                                                                                  | 10 men.     | 18 years of over, in an ongoing relationship with the mother of their infant, able to |

|                                                                                                                                                                     |                                                                                                                                       |                                                                                                                                                                                                                       |           |                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------------------------------------------------------------------------------------------------------------------|
| becomes tailored according to circumstances (Sweden).                                                                                                               | with infants 6-12 months of age.                                                                                                      |                                                                                                                                                                                                                       |           | communicate fluently in Swedish or English, have a child between 6 and 18 months and not be known to the interviewer. |
| Olsson, Robertson, Björklund & Nissen (2010)<br>Fatherhood in focus, sexual activity can wait: new fathers' experience about sexual life after childbirth (Sweden). | Descriptive design using content analysis from focus group discussions or semi-structured interviews conducted 3-6 months postpartum. | The aim is to describe fathers' experiences of sexual life 3-6 months after the birth of their child.                                                                                                                 | 10 men.   | Partners of women that had normal term pregnancies.                                                                   |
| Olsson, Lundgvist, Faxelid & Nissen (2005)<br>Women's thoughts about sexual life after childbirth: focus group discussions with women after childbirth (Sweden).    | Focus group discussions conducted 3-24 months postpartum.                                                                             | The purpose of the present study was to elucidate women's experience of their sexual life after childbirth in order to get a better understanding of women's thoughts about this issue and their need for counselling | 27 women. | Swedish speakers who had given birth at least 3 months before the focus group.                                        |

|                                                                                                                                                      |                                                                                                                          |                                                                                                                                                                                 |           |                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------------------------------------------------------------------------------------------------|
| Premberg, Hellstrom & Berg (2008)<br>Experiences of the first year as a father (Sweden).                                                             | Interviews conducted 12-14 months postpartum.                                                                            | The aim of this study was to explore experiences of the first year as a father.                                                                                                 | 10 men.   | Purposive sample.                                                                                 |
| Sevón (2012)<br>My life has changed, but his life hasn't: making sense of the gendering of parenthood during the transition to motherhood (Finland). | Longitudinal approach with narrative interviews at four time points within the first year postpartum.                    | This narrative longitudinal study aims to understand how first-time mothers make sense of the couple relationship, mothering and fathering at the beginning of their motherhood | 7 women.  | Convenient sample.                                                                                |
| Williamson (2008)<br>An Australian perspective of fatherhood and sexuality (Australia).                                                              | A descriptive correlation study with mixed methods.<br>Time point was 6 weeks post-partum.                               | The aim of the study was to develop an understanding of fathers' functional status after the birth of a baby.                                                                   | 128 men.  | Had fathered a healthy, singleton baby at term and could read and write English.                  |
| Woolhouse, McDonald & Brown (2012)<br>Women's experiences of sex and intimacy after childbirth: making the adjustment to motherhood (Australia)      | Interviews with sub-sample from a prospective longitudinal pregnancy cohort study conducted 2.5 – 3.5 years post-partum. | The aim of the study was to bring to life women's own voices around their experiences of changes to sex, sexuality and intimacy following childbirth.                           | 18 women. | Selective sampling to gain variety of experiences. Women living within 20km of central Melbourne. |

### 3.4.1 Themes

Six themes were identified: Adjustment Phase, Focus on the Baby, Communication, Intimacy, Strain on the Relationship and Strengthened Relationship, Table 3.2 shows which studies themes were drawn from. Figure 3.2 illustrates the themes, highlighting that within most themes there are examples of positive and negative experiences, except for Strain and Strength. Themes are presented with quotations from the original studies, indicating whether the participant quote is taken from a man or woman.

#### 3.4.1.1 Adjustment Phase.

As partners became parents there appeared to be a period of change in their relationship as they adjusted to their new parenting roles (Sevón, 2012). Changes in the relationship were common but not always seen as negative (Fägerskiöld, 2008). On welcoming a baby to the relationship there is a period of “survival” (MacAdam et al., 2011, p.151) as life becomes driven by the needs of the baby (Premberg et al., 2008).

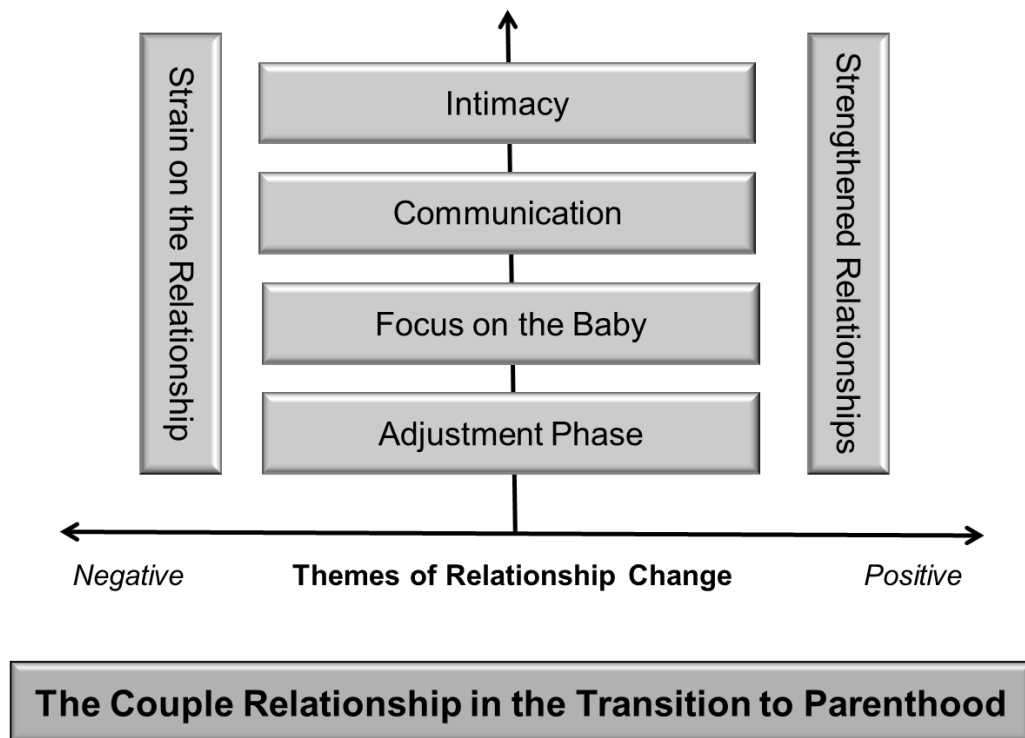
*We've become adults I guess, I don't know; we say that we should be together more and that we should find time to take care of our relationship, but it has just remained in the background. We are first of all parents and then [partners]. Woman (Sevón, 2012, p.75)*

*...we felt that our relationship changed. I wouldn't call it deteriorating, but we just didn't feel as close to each other in a way, which we missed. Maybe we felt too much like a 'team' and a little less like lovers!.. Man (Faircloth, 2015, p.9)*

**Table 3.2** *Identified Themes*

|                                            | Themes           |                   |               |          |                            |                           |
|--------------------------------------------|------------------|-------------------|---------------|----------|----------------------------|---------------------------|
|                                            | Adjustment Phase | Focus on the Baby | Communication | Intimacy | Strain on the Relationship | Strengthened Relationship |
| <b>Papers</b>                              |                  |                   |               |          |                            |                           |
| Ahlborg & Strandmark (2001)                |                  | X                 | X             | X        | X                          | X                         |
| Deave & Johnson (2008)                     | X                | X                 | X             |          | X                          |                           |
| Deave, Johnson & Ingram (2008)             | X                |                   | X             |          | X                          | X                         |
| Fägerskiöld (2008)                         | X                | X                 | X             |          |                            | X                         |
| Fairecloth (2015)                          | X                | X                 | X             | X        | X                          | X                         |
| MacAdam, Huuva & Bertero (2011)            | X                | X                 | X             | X        |                            | X                         |
| Olsson, Lundgvist, Faxelid & Nissen (2005) |                  | X                 |               | X        |                            |                           |
| Olsson, Robertson & Nissen (2010)          | X                | X                 | X             | X        |                            | X                         |
| Premberg, Hellstrom & Berg (2008)          |                  |                   | X             |          |                            | X                         |
| Sevón (2012)                               | X                | X                 | X             |          | X                          | X                         |
| Williamson (2008)                          | X                |                   |               | X        |                            |                           |
| Woolhouse, McDonald & Brown (2012)         | X                | X                 | X             | X        |                            | X                         |

**Figure 3.2** *Diagram of Identified Themes*



Immediately after childbirth there was a natural halt to sexual relations due to lack of time and energy (Williamson et al., 2008) and due to the physical effects of childbirth and breastfeeding (Faircloth, 2015).

*Well your sex-life doesn't really bloom after having a child. It creates a situation, you know the woman cannot have sex under a certain time...and maybe I did not feel the need for it either. Man (MacAdam et al., 2011, p.151).*

*...my wife...during labour suffered a tear, and for the moment it has not healed sufficiently to resume sexual intercourse. Obviously, I'm not satisfied with not being able to resume sexual intercourse, but if my wife needs time to recover, then so be it. Man (Williamson et al., 2008, pp.103-4)*

Changing roles within the couple created some tension (Sevón, 2012) with a tendency for gender stereotypes in the division of chores and childcare (Woolhouse et al., 2012).

*It's kind of like a bit of a conflicting role to be a mother and a nurturer on one side, and a whore in the bedroom on the other side [laughs]. And I don't actually think my husband sees me differently...Whereas I'm a completely different person... Woman (Woolhouse et al., 2012)*

*We've already had quarrels about housework...when you hear the other person playing a computer game...then you need to count to ten many times. Like, it can't be true that he has time for something like that. I don't have time [emphasised, delayed speech] ...Sometimes I get the feeling, like damn, I do everything... Woman (Sevón, 2012, p.71)*

However, there were positive examples of partner support during the adjustment phase of welcoming a baby (Premberg et al., 2008; Sevón, 2012).

*I've noticed that when I feel really bad, [T] supports me. . .I know there are men that don't do housework or care for the baby . . .if I'd had a bad partner, he'd have left us, because I wouldn't have been able to care for both the man and the baby' Woman (Sevón, 2012, p.74)*

*My wife felt she needed to do something else to get new energy, so I have taken care of the child every evening this week. I think it's worth it, to get a cheerful wife. Man (Premberg et al., 2008, p.20)*

#### **3.4.1.2 Focus on the Baby.**

Relationship adjustment and changes can stem from the parents physically being focused on the baby (Ahlborg & Strandmark, 2001), leaving them too tired

(Fägerskiöld, 2008) or with a lack of time (Williamson et al., 2008) for themselves or the relationship.

*Life has become somewhat divided, we don't have as much time for each other...our little girl is in the centre of things until nine at night, then it's our turn and when you've been busy all day...it's not the same, the love is still there but it's not the same as before...we talk about this a lot. Man*  
(Fägerskiöld, 2008, p.67)

*I'm very tired at night. At half past eight, I say goodnight, go to bed and fall asleep. And there he is sitting alone. Sometimes I can only stay up late...But I'm so tired, that I don't care. Being a mother is enough for me. Woman*  
(Ahlborg & Strandmark, 2001, p. 322)

Similarly, some parents are so emotionally focused on their baby, that they report their need for intimacy being met by their baby (Olsson et al., 2005) with no emotional energy left for their partner (Ahlborg & Strandmark, 2001). Mothers being emotionally focused on the baby led some partners to feel left out or that they were competing with the baby for affection (Olsson et al., 2010).

*I think another part of it is that, sometimes I feel as though I'm more in love with my children... Isn't that madness? But that kind of love that...being madly in love the way I was with Michael, it's become more of a stable kind of love, and my children have almost replaced that breath-taking, head-over-heels kind of in love. Woman* (Woolhouse et al., 2012, p.187)

*It's hard. Maybe not so much physically as the fact that she is emotionally absent. All her love is directed towards O, our son. But it is not enough for me then, so to speak. We don't even hug. She hugs O instead. I also hug him.*

*But I can't get from O what I lack from her...There is a kind of black hole right now. Man (Ahlborg & Strandmark, 2001, p.322)*

Conversely, some parents highlighted that this focus on the baby had a positive impact on their relationship (Ahlborg & Strandmark, 2001). Couples reported a sense of completeness, new affinity (Premberg et al., 2008), and the creation of new ways of closeness (MacAdam et al., 2011).

*I have only seen others before. Now it's me who is a mother, I have the responsibility and it's very positive. All three of us could lie in bed talking while breastfeeding, it was very cosy. Woman (Ahlborg & Strandmark, 2001, p321).*

*It's the best that's ever happened in my life it's hard to tell. This that we are a family, a wholeness, we belong together much more now. Man (Premberg et al., 2008, p.60)*

Some parents reported feeling unprepared for the impact the TTP would have on their relationship (Fägerskiöld, 2008) and sex life (Olsson et al., 2010); feeling antenatal preparation was only focused on pregnancy and childbirth (Deave & Johnson, 2008).

*You are both tired, niggling at each other, and it was probably slightly worse from what we thought. I mean, if the awareness could have been made a lot more, because no one ever really spoke to us about that other side...the relationship with us and the baby. Man (Deave & Johnson, 2008, p.631)*  
*They [midwives] said; try to keep the relationship together, half of all relationships go to pot when the first child arrives...that's all I remember. Man (Fägerskiöld, 2008, p.67)*

### 3.4.1.3 Communication.

Instances of negative communication were evident with examples of insufficient communication (Ahlborg & Strandmark, 2001), tension and irritability (Fägerskiöld, 2008), arguments (Sevón, 2012) or communication being centred around the baby (Faircloth, 2015).

*We don't argue, we don't snap at one another. and....knowing I was doing it [snapping]...for no good reason and was upsetting her... If you got any, any stress in your marriage, and a kid, they would struggle I think. Man (Deave et al., 2008, p.7)*

*And yeah it does just feel like you don't get any time together. You're just talking about what you going to have to do now. 'Do you want to cook dinner?' 'I'll wash up.' That's it really. 'Do you want to change the baby's nappy?' 'Do you want to hold the baby?.' Woman (Faircloth, 2015, p.8).*

However, not all parents saw disagreements as negative, but as necessary for the development of their relationship (Premberg et al., 2008). There were also examples of effective communication being the tool couples used to successfully navigate the adjustment to parenthood (Ahlborg & Strandmark, 2001)

*We talk a lot, as we always have; we did it before we had a child so I don't think we have changed our relation. We talk a lot and discuss problems at an early stage. Man (Premberg et al., 2008, p.60)*

*We start with good food. We think that is important. Then, we have the time to sit down and talk with each other, see each other. Man (MacAdam et al., 2011, p.153)*

#### 3.4.1.4 Intimacy.

The TTP was reported to have a negative effect on sexual relationships due to tiredness (Williamson et al., 2008), the distraction of physically having the baby present (Faircloth, 2015), mismatch of desire between partners (MacAdam, 2011), and sex now being a lower priority (Olsson et al., 2010).

*...baby feeding at night, getting up to other child and bringing work home to do after the family is asleep; both of us are too tired for sex. Man (Williamson et al., 2008, p.104)*

*I guess I went from having a very healthy sex-drive and a very healthy libido and interest in sex, to being completely disinterested, completely.... And doing it out of obligation, because I felt that Michael really enjoys it - as most men do (chuckles). So, I felt as though I was kind of letting him down, so I pressured myself into it. Woman (Woolhouse et al., 2012, p.188)*

Some women also expressed an impact on their sexual relationship due to a reduction in body confidence (Olsson et al., 2005) and a loss of sensuality due to the impact of childbirth and breastfeeding on their body (Faircloth, 2015).

*There's the whole weight loss thing, and you've got a flabby tummy and your boobs are a different shape and you don't see yourself in the mirror the way you did before you had kids and go "Oh, not too bad", now it's like "Oh. Can you turn the light out if we're going to have sex"? ... I am actually horrified by the thought of having sex in broad daylight. Woman (Woolhouse et al., 2012, p.187)*

*I have asked him if my vagina felt outsized and he said no. I don't believe him, but it is nice of him to say that. Woman (Olsson et al., 2005, p.385)*

As well as a reduction in sexual relations, studies also reported a loss of intimacy, affection (Woolhouse et al., 2012), and tenderness (Ahlborg & Strandmark, 2001).

*Because we don't have sex very often now at all, a lot of the intimacy has gone as well. And I think that if we had more intimacy, we'd have more sex...*

*Woman (Woolhouse et al., 2012, p.188)*

*Every ounce of my energy, my affection, my love, it was all focused on him [the baby]. And I think that there wasn't room for anything or anybody else.*

*Woman (Woolhouse et al., 2012, p.187)*

In contrast, there were also examples of improvements to intimacy (Olsson et al., 2005), increased sexual activity (Williamson et al., 2008), a greater importance of tenderness (MacAdam et al., 2011), and improved body confidence (Woolhouse et al., 2012).

*We don't have sex as often now, the quality is more important: that special feeling, the look in his eyes. It is not so very often, but it is quality not quantity. Woman (Olsson et al., 2005, p.384)*

*Of course, sex is important, but closeness and touch is much more important than sex as it usually is. So, therefore it is not the same drive. You have to be aware of this, to keep the conversation about it [sex] going. Man (Olsson et al., 2010, p.720)*

#### **3.4.1.5 Strain on the Relationship.**

In the TTP some parents experienced strain in their relationship (Sevón, 2012) which ranged from mild to severe (Ahlborg & Strandmark, 2001).

*If this [tension] carried on we would not have been together for this meeting.*

*We sort of sat down and we tried about two or three different ways and*

*thought about it... now we've got just back to the way we were before. The only difference is we've got a little girl. Man (Deave et al., 2008, p.7)*

*...I think I knew that it would put a strain on the relationship but you can't really imagine it happening until it has happened. And my sister just kept saying everything that's wrong with the relationship is magnified when you have children... Woman (Faircloth, 2015, p.6)*

Strain was potentially a short-term negative effect (Sevón, 2012) whilst the couple adjusted and found a new balance with their relationship and the baby (Deave & Johnson, 2008)

*...especially at the beginning, we're snapping at each other and I wondered at that phase whether our relationship was really as bad as everybody else's (laughs), when we were tired and snappish, but luckily it passed over, so now I'm not afraid of that anymore, we'll manage, and with a good relationship too" Woman (Sevón, 2012, p.74).*

*And it was trying to find the right balance. Things like to find enough energy. Trying to find the right balance between the relationship and the baby...Man (Deave & Johnson, 2008, p.631)*

#### **3.4.1.6 Strengthened Relationship.**

In contrast to relationship strain, some couples reported that becoming parents had strengthened (Deave et al., 2008) and deepened their relationship (Ahlborg & Strandmark, 2001). Parenthood bringing a new affinity to the couple (Premberg et al., 2008) and positivity about becoming a family (Deave and Johnson, 2008).

*I think that we're probably closer if anything because we sort of feel like a complete package. Woman (Deave et al., 2008, p.7)*

*You have a greater understanding for each other why you are tired or sad, and can provide each other with support in different ways, so in that way it has strengthened the relationship. Man (MacAdam et al., 2011, p.151)*

*It's just nice to feel like a family. I didn't think I'd enjoy the baby part as much as I did. It surprised me because of how much they actually do. I enjoyed that a lot more than I thought I would. Man (Deave & Johnson, 2008, p.631)*

### **3.5 Discussion**

This review synthesised the qualitative evidence of the impact of the TTP on couples' lived experience of their relationships in contemporary western societies. From 12 included papers, the review identified six themes of: Adjustment Phase, Focus on the Baby, Communication, Intimacy, Strain on the Relationship and Strengthened Relationship, which is largely consistent with previous literature. The review illustrates both positive and negative effects of the TTP on relationships within the first four themes.

Previous studies suggest a period of relationship adjustment following the birth of a child. A literature review of parents' experiences of the first postnatal year found a theme of "living in a new and over-whelming world" (Nyström & Öhring, 2004, p. 324) with a quantitative study finding that the TTP had a significant impact on marital functioning (Doss et al., 2009). In a previous meta-synthesis of the experience of women in the transition to motherhood, changing relationships with partners was evident, with a shift in roles aligning to gender stereotypes (Nelson, 2003). The theme of adjustment phase reported in the present review relates to previous research that reported a couple's priority in the initial postnatal stage is their baby (Fox, 2009) as they develop their co-parenting relationship (Van Egeren,

2004). The meta-synthesis showed that this focus on the baby can have a positive impact on the couple relationship (Ahlborg & Strandmark, 2001), creating a sense of completeness and new affinity (Premberg et al., 2008).

The meta-synthesis theme of intimacy is consistent with previous quantitative research findings that there can be longer term impairment of the frequency (Houlston et al., 2013) and quality of sexual relations (Hansson & Ahlborg, 2012), and that sexual concerns appear widespread (Schlagintweit et al., 2016). The meta-synthesis allows increased understanding of why there can be loss of intimacy due to factors such as: loss of body confidence (Olsson et al., 2005), the effects of breastfeeding (Faircloth, 2015), and tiredness (Williamson et al., 2008). Conversely, the meta-synthesis also shows that some parents report improvements in their sexual relationships (Olsson et al., 2005) and an increased importance of tenderness (MacAdam et al., 2011).

The concept of reduced communication and increased disagreements found in the present review is important as previous research has found that good couple communication can act as a buffer to relationship decline (Bateman & Bharj, 2009), and is related to the quality of the intimate relationship and relationship satisfaction (Kluwer & Johnson, 2007). Within the present review there were examples of effective communication being cited as a tool to navigate adjustments to parenthood (Ahlborg & Strandmark, 2001) and the notion that disagreements are not always negative and can be part of the development of partners becoming parents (Premberg et al., 2008).

Relationship changes after the birth of the baby have been shown to create relationship strain (Nelson et al., 2014) which is supported by the meta-synthesis. However, the present review highlights that this sense of strain can be short-term

(Sevón, 2012) as a couple adjust to being parents and caring for their child (Deave & Johnson, 2008). The meta-synthesis presents a theme of strengthened relationship, where through navigating the adjustment to parenthood, the relationship feels stronger (Deave et al., 2008) with parenting bringing a new affinity to the couple (Premberg et al., 2008). This supports the findings of previous quantitative work showing stable, or increased relationship satisfaction for one third of women (Shapiro et al., 2000); as well as a meta-synthesis of fathers' TTP experiences which found fathers reporting a more united team with a deeper, stronger relationship (Chin et al., 2011).

The effect of becoming parents on the couple relationship may be experienced differently whether it is a first or a subsequent child (Krieg, 2007). Whilst still at risk of relationship stress and decline, partners becoming parents for a second or subsequent time show a different pattern of adjustment and co-parenting to first-time parents (Volling, et al., 2015). Any differential effect on relationships between first and subsequent parents is difficult to ascertain from the studies included in the present review. Some had mixed samples of parents having first and second children that were not considered separately and some studies samples only looked at first time parents.

When examining the impact of the TTP it is important to look at the wider household issues that can contribute to how a couple relationship adjusts. Financial pressures of becoming parents (Marjoribanks, 2016b) as well as changes to employment status (Keizer et al., 2010) can impact on relationship changes. The meta-synthesis did not provide adequate results to explore the notion of financial concerns or employment changes having an impact on the couple relationship. This

could have been due to the questions used in the included studies and are potential relationship factors to be noted for future TTP research.

There is a large body of evidence that becoming a parent can have an impact on maternal and paternal mental health (Mckenzie & Carter, 2012; Parfitt & Ayers, 2014) and emerging research that this is associated with the couple relationship (Figueiredo et al., 2008; Letourneau et al., 2012). Whilst assumptions can be made that the relationship themes within the present review may be associated with psychological health, no personal well-being or mental health measures were collected within the included studies to enable stronger conclusions.

Within the focus on the baby theme, the meta-synthesis highlighted that some parents felt unprepared for changes to their relationship. This adds to the evidence that parents require more awareness of potential relationship stresses (Entsieh & Hallström, 2016) and preparation for problem management to reduce conflict and distress (Kluwer & Johnson, 2007). Prior research has shown that without interventions new parents are vulnerable to relationship strain (Schulz et al., 2006) and attending antenatal classes can mitigate the decline in relationship satisfaction. (Mitnick et al., 2009). Whilst some TTP relationship interventions have been shown to be effective (Shapiro et al., 2015) and beneficial to parents (Linville et al., 2017), more research is required to improve TTP relationship interventions (Pinquart & Teubert, 2010).

### ***3.5.1 Limitations and Strengths***

The review adds to the body of evidence by systematically reviewing and analysing the lived experience of couples' TTP in contemporary western society. This combined with the comprehensive search strategy means the review offers a good indication of the current situation for parents in western societies. The review

findings are novel in documenting a range of impacts the TTP has on couples' lived experiences of their relationship, with a balance of negative and positive experiences.

However, the review has limitations in that the primary searches and analysis were only conducted by one researcher. There were limitations with some of the papers included in the review such as: small sample size, convenience sampling, and short-term measurement. Whilst some of the studies were longitudinal, none of the studies measured relationships from before pregnancy (i.e., pre-conception). Furthermore, there could have been wide ranging relevant family circumstances and history that were not measured, such as pre-existing relationship or parenting problems.

### ***3.5.2 Conclusion and Recommendations***

This review and meta-synthesis suggested that the TTP has a notable impact on a couple's relationship. Six themes were identified of: Adjustment Phase, Focus on the Baby, Communication, Intimacy, Strain on the Relationship, and Strengthened Relationship. Within the first four themes, there were examples of both positive and negative effects of the TTP on relationships.

The quality of couple relationships are important for the well-being of partners and their children. This review highlights complex relationship issues that couples experience and may require help with. Healthcare professionals working with parents in the TTP may be able to provide support through antenatal education that prepares them for relationship changes, and provision of postnatal support to help identify and overcome problems.

To further understand how to support couples effectively in the TTP, future research would benefit from being dyadic in focus to understand the impact on both

partners and the corresponding support required. Similarly, research that differentiates between the TTP for first or subsequent children would determine whether there are differences in the impact on the relationship and support needs of couples following a first or subsequent child. Longitudinal relationship research from pre-conception to after childbirth may enable understanding of why some relationships experience strain or conversely growth in the TTP, which can inform effective support strategies.

#### **4      Healthcare Practitioners' Assessment and Observations of Birth Trauma in Mothers and Partners (Article 3)**

Delicate, A., Ayers, S., & McMullen, S. (2020a). Health-care practitioners' assessment and observations of birth trauma in mothers and partners. *Journal of Reproductive and Infant Psychology*, 40(1), 34-46.

<https://doi.org/10.1080/02646838.2020.1788210>

Delicate A. (2019, September 5-6). Healthcare practitioners' perspectives of birth trauma: prevalence, impact, and support [Oral Presentation]. *39th Annual Society for Reproductive and Infant Psychology Conference*, London, UK.

#### **4.1 Abstract**

Background: Evidence shows that traumatic childbirth can cause ongoing distress, often referred to as birth trauma. This can have an impact on parents and the couple relationship, and consequently identifying and supporting parents with birth trauma is important to practice. Practitioners working with parents in the postnatal period may hold a key role in helping to identify birth trauma, but currently there is limited literature on how this occurs in practice. Aim: To investigate the experiences of healthcare practitioners from the United Kingdom (UK) in the assessment of birth trauma, perceived occurrence of birth trauma, and observed impact on parents and the couple relationship. Methods: An online survey of UK practitioners working with parents in the first postnatal year. The survey measured assessment practice for birth trauma, perceptions of the incidence of parents affected by birth trauma, observed symptoms, and impact. Results: A sample of 202 practitioners reported identifying birth trauma in 34.4% of mothers and 25.0% of partners. Assessment for birth trauma was only conducted for 50.3% of mothers and 25.9% of partners. The most observed symptoms were re-experiencing among mothers (87.1%) and avoidance among partners (50.9%). Birth trauma was perceived as impacting on the couple relationship for 29.8% of mothers and 26.9% of partners. Written responses provided more detailed observations of the impact of birth trauma. Conclusion: Understanding how birth trauma may present differently in mothers and partners could support effective assessment. Once birth trauma is identified, parents require personalised support to help them cope with the impact.

## **4.2 Introduction**

There is evidence that 20 to 40% of women report their birth as traumatic (Alcorn et al., 2010; Ayers et al., 2018; Creedy et al., 2000; Soet et al., 2003). Experiencing emotionally traumatic childbirth that causes ongoing distress is often referred to as birth trauma (Elmir et al., 2010). Currently there is no agreed definition for birth trauma, and likewise measurement differs, ranging from asking women whether they perceived their birth to be traumatic to using diagnostic criteria for a traumatic event (e.g., women have to think they or their baby would die or be severely injured; American Psychiatric Association, 2013). The lack of universal diagnostic criteria for birth trauma makes establishing the prevalence of birth trauma difficult.

Similarly, birth trauma is often used interchangeably with the terms PTSS and PTSD. However, the perception of childbirth being traumatic does not necessarily mean women will experience PTSS or PTSD. Symptoms of PTSS include re-experiencing, avoidance, hyperarousal, and negative alterations in mood and thinking. PTSS is evident in 14 to 17% of postnatal women (Boorman et al., 2014; Dekel et al., 2017).

If PTSS are severe and meet diagnostic criteria, a clinical diagnosis of PTSD may be made (Dekel et al., 2017; Simpson et al., 2018). Meta-analysis suggest PTSD affects 3 to 4% of women following childbirth (Yildiz et al., 2017). There is emerging evidence that witnessing traumatic childbirth may affect a partner's mental health (Hinton et al., 2014), leading to anxiety (Elmir & Schmied, 2016), or PTSS (Bradley et al., 2008).

Research on the impact of birth trauma on the couple relationship is limited, but is an important issue because the quality of this relationship may affect personal

well-being (Proulx et al., 2007). For example, a longitudinal cohort study found PTSS at 8 weeks postnatal were associated with poor couple relationship at two years postnatal, and this effect was mediated by depression (Garthus-Niegel, Horsch & Handtke et al., 2018). A meta-synthesis of literature on the perceived impact of birth trauma on the couple relationship found five themes. Four negative themes: strain on relationship, negative emotions, lack of understanding and support, loss of intimacy, and a fifth but positive theme of strengthened relationship (Delicate, Ayers, Easter & McMullen, 2018). These are similar to themes observed in the impact of the TTP generally (Delicate, Ayers & McMullen, 2018). However, the effect of birth trauma appears to affect the relationship more negatively.

A good quality couple relationship is associated with improved personal physical (Robles et al., 2014), and emotional health (Figueiredo et al., 2008). During the perinatal period, poor relationship interactions between parents are associated with symptoms of depression and anxiety (Figueiredo et al., 2018). High levels of conflict in the couple relationship is associated with an insecure infant-parent attachment (Finger et al., 2009; Wong et al., 2009), which can affect infant well-being (Sroufe, 2005). Breakdown of the couple relationship is associated with child poverty, ill health, lower educational achievement, and behavioural problems (Coleman & Glenn, 2009).

The UK has a publicly funded NHS, which offers universal maternity care. Most UK mothers are in contact with a variety of healthcare practitioners in the perinatal period. In particular midwives and health visitors (public health nurses), who are well placed for the prevention, recognition, and support of perinatal mental health (Bayliss-Pratt, 2015; Noonan & Galvin et al., 2017). A GP can be accessed by parents at any time for physical and mental health support. The final formal postnatal

check for a mother and her baby is usually conducted by a GP six to eight weeks postnatally (NCT, 2017). Third sector organisations (non-profit and non-government organisations, e.g., charities) also have an important role in helping support parents in the perinatal period (NHS, 2014).

Third sector organisations offer support to parents through various practitioners such as parent educators who facilitate parenting information and support (Ayers & Delicate, 2016), doulas who provide non-clinical childbirth and postnatal care (Simkin, 2011), peer supporters who are parents trained to help other parents (McLeish & Redshaw, 2017), and lactation specialists who assist parents with infant feeding (Thurman & Allen, 2008).

Whilst most perinatal women have increased contact with numerous healthcare practitioners, detection of mental health problems remains inadequate (Viveiros & Darling, 2019). Women with postnatal distress report positive and negative experiences of healthcare services. Negative perceptions include feeling unheard or uncared for (Coates et al., 2014). Some women report that postnatal care is focused on infant health and physical recovery with limited attention on emotional needs (Byrne et al., 2017; McCarter & MacLeod, 2019). Furthermore, mental health assessment and support for partners is lacking (Baldwin et al., 2018). Service developments are needed to effectively engage partners and meet their needs in maternity services (Burgess & Goldman, 2018).

Despite growing evidence of the prevalence of birth trauma and emerging understanding of the impact, it is not routinely assessed. Current UK clinical guidelines from NICE, only recommend assessing for anxiety and depression in pregnancy and after childbirth (NICE, 2015). Although practitioners working with parents in the postnatal period could play a key role in helping to identify birth

trauma and its impact, there is very little evidence on how this occurs in practice. Therefore, the present study aimed to examine healthcare practitioners' experiences of assessing birth trauma, and the perceived occurrence of birth trauma in parents. In addition, the present study aimed to investigate practitioners' observations of the impact of birth trauma on mothers, partners, and the couple relationship. Results on the support needed by parents with birth trauma are reported in Chapter 5 (Delicate et al., 2020b).

### **4.3 Method**

The study used an online survey to maximise response rates and ensure a range of practitioners were represented in the sample.

#### **4.3.1 Sample**

The study used a convenience sample of UK healthcare practitioners. Practitioners were eligible to participate if they were working in clinical and non-clinical care roles, within the NHS or third sector. Sample size was not predetermined as the survey was exploratory.

#### **4.3.2 Measurement**

A survey was developed to address the study aims, drawing on previous literature. Questions about observed birth trauma symptoms were based on the symptoms listed in the DSM-5 criteria for PTSD (American Psychiatric Association, 2013). Questions about observed impact on the couple relationship were based on themes from a meta-synthesis of the impact of birth trauma on couples (Delicate, Ayers, Easter & McMullen, 2018). The survey also included open text boxes for practitioners to note how birth trauma assessment was conducted, symptoms in mothers and partners, and the impact on couple relationships. The survey questions

were piloted with a small number of healthcare practitioners and adapted following feedback.

At the beginning of the survey birth trauma was defined to practitioners as “emotionally traumatic childbirth causing ongoing distress”. Practitioners were asked to respond to the survey based on their experience of working with parents in the first postnatal year. Survey questions can be found in appendix 4. The survey also included questions about the support needed by parents for birth trauma, which are reported in Chapter 5 (Delicate et al., 2020b).

#### ***4.3.3 Procedure and Recruitment***

Ethical approval for the study was obtained from the School of Health Sciences at City, University of London. The survey was hosted online via Qualtrics. Recruitment took place between May and September 2018 through social media (e.g., Twitter and Facebook) and relevant organisations such as the Institute of Health Visiting, NCT, Midwives Information and Resources Service (MIDIRS), and the Royal College of General Practitioners.

Recruitment information included a link to Qualtrics where potential participants could access and download the participant information sheet. If practitioners decided to participate, they were required to give consent electronically in Qualtrics before being able to access the survey. Responses were recorded anonymously but participants could provide their contact email address if they wished to receive a summary of the results. Survey data were recorded electronically in Qualtrics.

#### ***4.3.4 Data Analysis***

Data were exported from Qualtrics into SPSS Statistics 25 for analysis and screened to check distributions so parametric or nonparametric tests were used

appropriately. Descriptive statistics were used to examine the sample characteristics including the number of participants per practitioner role, and time since qualification.

Whether practitioners assessed birth trauma or not was examined using frequencies. Chi-square was used to examine difference in whether practitioners assessed mothers or partners. Written responses for how practitioners assessed birth trauma were labelled as (1) well-being scale or questionnaire; or (2) general questions and observation, and frequencies then calculated.

The perceived occurrence of birth trauma in mothers and partners, and the impact on the couple relationship, were examined using means with 95% confidence intervals (CI). A paired sample t-test assessed difference between the perceived rate in mothers and partners. A Pearson's correlation test examined the association between the observed occurrence in mothers and partners.

Frequencies were calculated of whether personal symptoms of birth trauma were observed or not, with chi-square applied to assess for any significant differences between mothers and partners. Likert scale responses to the observed couple relationship symptoms were examined using means and standard deviations (SD). Practitioners written responses regarding the impact of birth trauma on the couple relationship were analysed using content analysis.

#### **4.4 Results**

Results report practitioners' practice of assessing for birth trauma, perceptions of how frequently birth trauma occurred, the symptoms observed in parents, and impact on the couple relationship. Sample (N = 202) characteristics are shown in Table 4.1. The largest groups of practitioners in the sample were midwives (n = 66), health visitors (n = 44), and parent educators (n = 41). The most frequent

length since qualification for participants was 0 to 4 years (n = 56, 27.7%), then 5 to 9 years (n = 49, 24.3%).

**Table 4.1** *Survey Sample (N = 202)*

| <b>Practitioner Role</b>           | <b>n (%)</b> |
|------------------------------------|--------------|
| Breastfeeding Counsellor           | 2 (1.0)      |
| Community Midwife                  | 66 (32.7)    |
| Community Nurse                    | 4 (2.0)      |
| Doula                              | 24 (11.9)    |
| Family Support Worker              | 2 (1.0)      |
| General Practitioner               | 7 (3.5)      |
| Health Visitor                     | 44 (21.8)    |
| Maternity Care Assistant           | 2 (1.0)      |
| Parent Educator                    | 41 (20.3)    |
| Peer Supporter                     | 1 (0.5)      |
| Psychological Counsellor/Therapist | 9 (4.5)      |
| <b>Length of Qualification</b>     | <b>n (%)</b> |
| Student                            | 20 (9.9)     |
| 0-4 Years                          | 56 (27.7)    |
| 5-9 Years                          | 49 (24.3)    |
| 10-14 Years                        | 31 (15.3)    |
| 15-19 Years                        | 20 (9.9)     |
| 20 + Years                         | 26 (12.9)    |

#### **4.4.1 Assessing Birth Trauma**

Half of practitioners indicated they assessed mothers for birth trauma (n = 86, 50.3%) but significantly fewer assessed partners (n = 44, 25.9%;  $\chi^2$  (1, n = 169) = 49.81,  $p < .001$ ). Some practitioners (n = 54) gave written information about how they assessed birth trauma with 18.5% (n = 10) reporting using a questionnaire such

as the “*PHQ9 and GAD7*” (health visitor) or “*maternal mood assessment*” (health visitor). However, none of the questionnaires listed were specific to birth trauma. The remaining 81.5% (n = 44) reported using general questions and observations to assess birth trauma, for example “*if the language they use or the body language or facial expressions they exhibit seem to suggest some level of distress*” (doula) and “*opportunities given to ask questions relating to birth, if we highlight a particular traumatic delivery then we ask deeper*” (midwife).

#### **4.4.2 Perceived Occurrence of Birth Trauma**

The mean proportion of parents that practitioners observed to have experienced birth trauma was 34.4% (n = 169, CI 95% 31.5-37.3) for mothers, and 25.0% (n = 162, CI 95% 22.1-27.8) for partners. The difference in the observed birth trauma rate in mothers and partners was significant ( $t_{161} = 8.27$ ,  $p < .001$ ). However, the proportion of mothers and partners reported by practitioners to have birth trauma was strongly correlated ( $r = .69$ ,  $p < .001$ ).

#### **4.4.3 Observed Symptoms of Birth Trauma**

The most common birth trauma symptoms (Table 4.2) observed by practitioners in mothers were re-experiencing symptoms (n = 101, 87.1%), followed by negative thoughts and feelings (n = 79, 68.1%). For partners, avoidance was the most common symptom (n = 59, 50.9%), then hyperarousal and reactivity symptoms (n = 51, 44.0%). The frequency of specific symptoms in mothers and partners were not significantly different, except for negative thoughts and feelings, which were observed in significantly more mothers than partners ( $\chi^2 (1, n = 116) = 4.84$ ,  $p = .028$ ). Analysis of practitioners written responses showed other symptoms they attributed to birth trauma. General mental health problems (n = 6) including “*postnatal depression in both [mothers and partners]*” (health visitor) and “*general anxiety and*

*panic*” (health visitor). Fear of pregnancy and birth (n = 5) including “*belief that straightforward birth is dangerous or impossible*” (parent educator) and “*fear of being pregnant again*” (health visitor). Effect on relationship with infant (n = 2) described as “*resentment towards baby*” (counsellor) and “*attachment issues*” (health visitor).

**Table 4.2** *Observed Symptoms of Birth Trauma by Healthcare Practitioners (N = 116)*

|                                           | <b>Mothers</b> | <b>Partners</b> |                            |          |
|-------------------------------------------|----------------|-----------------|----------------------------|----------|
|                                           | <b>n (%)</b>   | <b>n (%)</b>    | <b><math>\chi^2</math></b> | <b>P</b> |
| Reexperiencing Symptoms                   | 101 (87.1)     | 48 (41.4)       | 1.54                       | .215     |
| Avoidance Symptoms                        | 73 (62.9)      | 59 (50.9)       | .19                        | .664     |
| Negative Changes in Thoughts and Feelings | 79 (68.1)      | 31 (26.7)       | 4.84                       | .028     |
| Arousal and Reactivity Symptoms           | 66 (56.9)      | 51 (44.0)       | 3.54                       | .060     |

#### **4.4.4 Observed Effect of Birth Trauma on the Couple Relationship**

Practitioners perceived that the couple relationship was impacted for 29.8% (n = 102, CI 95 % 24.9-34.6) of mothers, and 26.9% (n = 88, CI 95% 21.3-32.4) of partners. The difference in the observed rate of impact of birth trauma on the couple relationship for mothers and partners was significant ( $t_{87} = 2.49$ ,  $p < .05$ ). The perceived rates of impact on the couple relationship reported for mothers and partners were strongly correlated ( $r = .84$ ,  $p < 0.001$ ).

Table 4.3 details the mean and standard deviations for the different ways in which birth trauma was observed to impact on the couple relationship. Lack of intimacy was most common, being observed a moderate amount. Other common

impacts were increased negative emotions, lack of understanding, reduced communication, and strain on relationship. Strengthening of the couple relationship was least common.

**Table 4.3** *Perceived Impact of Birth Trauma on the Couple Relationship (N=111)*

|                               | <b>Mean (SD) <sup>a</sup></b> |
|-------------------------------|-------------------------------|
| Increased Conflict            | 2.46 (0.96)                   |
| Increased Negative Emotions   | 3.12 (1.00)                   |
| Lack of Intimacy              | 3.31 (1.17)                   |
| Lack of Understanding         | 3.18 (0.99)                   |
| Lack of Support               | 2.86 (0.98)                   |
| Reduced Communication         | 3.17 (0.96)                   |
| Relationship Breakdown        | 2.16 (0.85)                   |
| Strain on Relationship        | 3.12 (0.99)                   |
| Strengthening of Relationship | 2.14 (0.86)                   |

<sup>a</sup> Response scale ranged from 1 *not at all* to 5 *a great deal*

#### **4.4.5 Perceived Impact of Birth Trauma on the Couple Relationship**

Content analysis of written comments about the impact of birth trauma on the couple relationship (n = 42) found four themes, presented here with example quotes. Theme one (n = 13) was that the impact on the couple relationship can be profound:

*“It can really test a relationship. Parents will grieve in different ways and this needs to be recognised by each other”* (health visitor);

*“It is something that couples don't imagine happening so it can be a strain very early on in the parenting journey”* (midwife).

Theme two (n=8) was that parents often cope alone (n = 8):

*“I think that parents are expected to get on with parenthood once their baby is born without any thought as to how the birth may have affected them psychologically”* (midwife);

*“So many couples suffer in silence”* (doula).

Theme three (n = 6) was that stigma is a barrier to mothers and partners getting support:

*“I think birth trauma is still a taboo subject and parents feel they should just ‘put up with it as part of childbirth’. Couples can see themselves as failing by disclosing trauma”* (health visitor);

*“Men in particular often feel they need to ‘man up’ seeing themselves as less important as she has done the hard part of birth. Feeling they must be strong and that mental health disorders are a weakness”* (parent educator).

Theme four (n = 12) was that more personalised birth trauma support is required:

*“It affects each person individually. So, although couples may want support together, each may also need one to one support for specific things”* (health visitor);

*“Access to relationship/sex counselling after traumatic birth should be made much easier and one to one birth planning to reduce anxiety around subsequent birth choices”* (doula).

#### **4.5 Discussion**

The present study aimed to explore UK healthcare practitioners’ experiences of assessing for birth trauma, perceived occurrence of birth trauma, and observed impact on parents and the couple relationship. Despite practitioners observing that one third of mothers and one quarter of partners are affected by birth trauma, results

indicate that only half of practitioners assessed mothers, and one quarter assessed partners for birth trauma. This limited assessment for birth trauma is consistent with prior findings (Byrne et al., 2017; Noonan et al., 2018) but contrasts with clinical recommendations for maternity services to have equal emphasis on emotional and physical well-being (Bayliss-Pratt, 2015) to ensure early detection of mental illness (Oates, 2015).

Reported differences in targeted assessment for birth trauma and perceived higher rates in mothers versus partners, highlight a potential bias towards identification of birth trauma in mothers. This could be due to a lack of understanding that partners may also be affected by birth trauma (Burgess & Goldman, 2018), or partners being marginalised in maternity services (Inglis et al., 2016). Alternatively, practitioners could be using their professional judgement to assess only those women and partners they deem at risk of birth trauma. Such an approach could be unreliable if based on obstetric complications, as birth trauma is more strongly related to the subjective experience of childbirth than objective events (Ayers et al., 2016; Slade, 2006).

Limited assessment for birth trauma may lead to underestimating the prevalence of birth trauma and therefore lack of relevant training for practitioners, and absence of support services for affected parents. Whilst a wide range of questionnaires exist for considering the experience of childbirth, no universally accepted birth trauma measurement tool exists, which creates a barrier to effective assessment (Nilvér et al., 2017). Validated assessment measures for birth-related PTSD are available (Ayers et al., 2018; Handelzalts et al., 2018; Stramrood et al., 2010), which may facilitate future standardised assessment and more robust identification of birth trauma.

The perceived rate of birth trauma in mothers reported in the present study is reasonably consistent with other studies of traumatic birth experiences resulting in ongoing distress (Alcorn et al., 2010, Creedy et al., 2000; Soet et al., 2003). Conversely, practitioners perceived one quarter of partners to have birth trauma which is higher than prior studies reporting 5% of fathers with severe PTSD symptoms (Ayers et al., 2007), and 12% with subclinical PTSS (Bradley et al., 2008). The seemingly higher rate of partners with birth trauma in this study could be due to non-clinical practitioners in the sample. Such practitioner roles may have more contact with partners to enable identification of distress (Ayers & Delicate, 2016). Whilst promotion of maternal perinatal mental health is growing in maternity and early years services (Ayers & Shakespeare, 2015), research on effective support for partners' mental health remains limited (Rowe et al., 2013).

Partners may experience birth trauma differently as they experience the traumatic birth vicariously as an observer. However, research exploring partners' lived experience of birth trauma and how their symptoms may vary compared to mothers is limited. The results of the present study suggest differences in birth trauma symptoms for mothers and partners, the most common being re-experiencing in mothers, and avoidance in partners, which is consistent with prior research (Creedy et al., 2000; Etheridge & Slade, 2017). This difference in the presentation of symptoms could distort the perceived prevalence of birth trauma in partners, as avoidance behaviours have less visible distress to identify, compared to re-experiencing symptoms.

Similarly, practitioners observed significantly more mothers with symptoms of negative changes in thoughts and mood compared to partners. This may be due to routine use of the Whooley questions and Edinburgh Postnatal Depression Scale

(EPDS) with mothers in the UK (NICE, 2014), as the questions in these scales coincide with the PTSS category of negative alterations in thoughts and mood. Beyond observations of PTSS, practitioners indicated additional birth trauma symptoms of general mental health problems and fear of pregnancy and childbirth. This is consistent with evidence that birth trauma is often co-morbid with depression (Ayers et al., 2016), anxiety (Dikmen-Yildiz et al., 2017a), and fear of birth (Hofberg & Brockington, 2000). Whilst co-morbidity of mental health problems is commonplace, for some birth trauma may not be acknowledged because healthcare is focused on postnatal depression (Coates et al., 2015).

The postnatal period can already be an inherently stressful phase (Ayers et al., 2019) and the way that birth trauma is experienced by parents may be different to PTSS or PTSD at other times of life (Ayers et al., 2008). The present study indicates that birth trauma has the potential to create further stress on parents due to a negative impact on the couple relationship. Practitioners observed common impacts on the couple relationships of lack of intimacy, reduced communication, lack of understanding, and strain on the relationship. Though it is well documented that the general TTP can affect the couple relationship (Delicate, Ayers & McMullen, 2018), the impact due to birth trauma appears to be more negative and acute (Delicate, Ayers, Easter & McMullen, 2018).

Understanding more about how birth trauma presents in mothers, partners, and affects the couple relationship could lead to better assessment for birth trauma. Furthermore, many healthcare practitioners are well placed to raise awareness of birth trauma in parents and reduce stigma around disclosing mental health problems. Once birth trauma is identified, more needs to be done to ensure that parents have the necessary support to reduce the resulting effect of birth trauma. Healthcare services

need to provide effective referral pathways (NHS, 2018) that enable evidence-based (Lapp et al., 2010), personalised support, for mothers, partners, and the couple relationship.

Limitations of the present study need to be acknowledged, not least the use of a self-selected sample. Likewise, the sample size and demographics are not representative of the range of practitioners supporting postnatal parents. The survey used unvalidated questions which were developed to investigate the study aims. The birth trauma symptoms that practitioners were asked to report on were based on symptoms listed in the diagnostic criteria for PTSD, which may not have fully encompassed birth trauma symptoms. Survey responses are based on practitioners' observations, not clinical diagnoses, and are therefore not indicative of prevalence. Similarly, practitioners were providing generalised responses based on a range of experiences with parents, so results are an approximate benchmark which may have been affected by recall bias.

The present study is unique in combining insight from healthcare professions and third sector practitioners working with parents in the postnatal period. Whilst exploratory, findings add to a limited body of evidence of practitioners' perceptions of birth trauma and impact on parents. The study highlights that both mothers and partners are observed experiencing birth trauma and that their manifestation of symptoms may differ. The main implications of the study are that support for birth trauma could be enhanced through effective assessment, and the development of evidence-based support services to address current disparities in provision.

**5      Healthcare Practitioners' Views of the Support Women,  
Partners, and the Couple Relationship Require for Birth Trauma:  
Current Practice and Potential Improvements (Article 4)**

Delicate, A., Ayers, S., & McMullen, S. (2020b). Healthcare practitioners' views of the support women, partners, and the couple relationship require for birth trauma: current practice and potential improvements. *Primary Health Care Research & Development*, 21(e40), 1-10.  
<https://doi.org/10.1017/S1463423620000407>

Delicate, A. (2021, September 8-10) Healthcare practitioners' practice of identifying birth trauma in women and partners [Oral Presentation]. *The 41st Annual Society for Reproductive and Infant Psychology Conference*, Online.

## 5.1 Abstract

*Aim:* To examine healthcare practitioners' views of the support women, partners, and the couple relationship require when affected by birth trauma, barriers to gaining such support, and potential improvements. *Background:* Ongoing distress following psychologically traumatic childbirth, also known as birth trauma, can affect women, partners, and the couple relationship. Birth trauma can lead to PTSS or PTSD.

Whilst there is a clear system of care for a PTSD diagnosis, support for the more prevalent experience of birth trauma is not well-defined. *Method:* An online survey of healthcare practitioners' views of the support parents require for birth trauma, barriers to accessing support, and potential improvements. Practitioners were recruited in 2018 and the sample for analyses presented in this article ranged from 95-110. *Results:* Practitioners reported differing needs of support for women, partners, and the couple as a unit. There was correlation between practitioners reporting having the skills and knowledge to support couples and feeling confident in giving support. The most offered support was listening to the couple, but practitioners perceived the most effective support for reducing the impact on the couple relationship was referral to a debriefing service. Practitioners observed several barriers to both providing support and parents accessing support, and improvements to birth trauma support were suggested. *Conclusions:* Practitioners indicate that some women, partners, and the couple as a unit require support with birth trauma and that barriers exist to accessing effective support. The support that is currently provided often conflicts with practitioners' perception of what is most effective. Practitioners indicate a need to improve the identification of parents who need support with birth trauma, and more suitable services to support them.

## 5.2 Introduction

If a woman or her partner perceives birth as traumatic it can result in ongoing emotional distress, often referred to as birth trauma. Whilst the term birth trauma lacks universal acceptance or standard definition (Elmir et al., 2010) it is widely used, and recognised that it can lead to PTSS or PTSD (White et al., 2006; Yildiz et al., 2017). The prevalence of birth trauma is difficult to establish as this term is often used interchangeably with PTSS and PTSD. However, evidence suggests approximately 20-40% of women report childbirth as traumatic (Alcorn et al., 2010; Ayers et al., 2018; Creedy et al., 2000; Soet et al., 2003), with healthcare practitioners perceiving thirty percent of women and a quarter of partners to be affected by birth trauma (Delicate et al., 2020a). Systematic reviews find that up to 16.8% of women experience clinically significant PTSS such as: re-experiencing, hyperarousal, avoidance, and negative alterations to cognition (Dekel et al., 2017), and that childbirth-related PTSD affects 3 to 4% of women overall (Yildiz et al., 2017). There is also evidence to suggest that birth trauma can effect partners causing them ongoing distress (Etheridge & Slade, 2017), depression (Hinton et al., 2014), and PTSS (Bradley et al., 2008).

Birth trauma and PTSD are highly co-morbid with anxiety (Dikmen-Yildiz et al., 2017a), depression (Ayers et al., 2016), and secondary tokophobia (Hofberg & Brockington, 2000). For mothers, childbirth-related PTSD is associated with not initiating breastfeeding (Garthus-Niegel, Horsch & Ayers et al., 2018) and perceived reduced bond with their baby (Dekel et al., 2018). There is evidence to suggest that birth trauma can have a negative impact on couple relationships such as strain on the relationship, and loss of intimacy (Delicate, Ayers, Easter & McMullen, 2018). PTSS in the postnatal period being associated with depression symptoms which are

related to poor relationship satisfaction (Garthus-Niegel, Horsch & Handtke et al., 2018). Whilst reduction of couple relationship satisfaction is a common observation in the TTP, the impact of birth trauma appears to be more negative (Delicate, Ayers & McMullen, 2018). The quality of the couple relationship is an important issue as it is associated with individual well-being and child outcomes (Cowan & Cowan, 2019).

Parents affected by birth trauma may require support to address trauma symptoms and overcome any impact these have on their life. It is important that such support addresses the needs of women, partners, and the relationships between them and their infant (NHS, 2015). This support may come from healthcare practitioners such as midwives, health visitors (public health nurses), physicians/GP, or specialist mental healthcare practitioners (Ayers & Shakespeare, 2015). In addition, parents may also access support from third sector (non-profit and non-government) organisations and engage with non-clinical services such as parent education (Ayers & Delicate, 2016).

Whilst awareness of the importance of perinatal mental healthcare is rising, clinical guidelines seldom refer to birth trauma. An exception is seen in the UK which has a public funded NHS guided by NICE. It is recommended by NICE that practitioners offer advice and support to women who report childbirth as traumatic and consider that their partner may also be affected and require help (NICE, 2020). Where childbirth-related PTSD is identified, a stepped system of care is recommended: (1) watchful waiting; and (2) trauma-focused CBT, or EMDR (NICE, 2018b).

When tailored to meet the needs of postnatal women, trauma-focused psychological therapies have been shown to be effective in reducing PTSD

symptoms in the early postnatal period (Furuta et al., 2018). Midwife-led debriefing, whilst routinely provided for birth trauma (Ayers, Claypool & Eagle, 2006) has no robust evidence for effectiveness (Bastos et al., 2015; de Graaff et al., 2018).

However, women appear to value debriefing services, also known as birth listening and reflections, particularly women with high levels of PTSS (Baxter, 2019; Meades et al., 2011). Further birth trauma support strategies reported in the literature include expressive writing (Di Blasio et al., 2015), sharing of birth stories online (Blainey and Slade, 2015), social support (Vesel & Nickasch, 2015), art therapy (Hogan, 2015), hypnosis (Slater, 2015), and information from websites, books, and helplines (Thomson et al., 2017).

Women and partners indicate that they want support for birth trauma (Ayers, Claypool & Eagle, 2006; Etheridge & Slade, 2017), but multi-level barriers exist to accessing perinatal mental health services (Smith et al., 2019). On an individual level parents can lack awareness of perinatal mental health symptoms (Das & Hodgkinson, 2019; Russell et al., 2017), stigma can exist around disclosing mental health concerns (NCT, 2017), and guilt at being emotionally unwell at a perceived time of happiness (Smith et al., 2019). Partners may be particularly reluctant to seek help for their own perinatal mental health (Darwin et al., 2017), and can feel unjustified talking about birth trauma when they witnessed the trauma as oppose to the woman who went through the physical process of childbirth (Etheridge & Slade, 2017).

Barriers to healthcare practitioners supporting parents with birth trauma can exist through lack of knowledge (de Vries et al., 2018) and limited competence in supporting perinatal mental health (Borglin et al., 2015), which could stem from limitations in perinatal mental health training (NHS, 2015). The quality of interpersonal relationships between parents and healthcare practitioners can create

obstacles to identifying parents with mental health problems (NCT, 2017). Barriers can be created due to lack of continuity of care (Bayrampour et al., 2018), parents having limited time with healthcare practitioners, and maternal perception that postnatal healthcare is focused on infant health (Byrne et al., 2017).

The organisation of healthcare can present further problems for accessing services, not least deficits in funding for perinatal mental health services (Bauer et al., 2014) and birth trauma specifically (Thomson & Garrett, 2019). Perinatal mental health services are prone to focus on the treatment of depression (Higgins et al., 2018) and moderate to severe disorders in mothers (Russell et al., 2017). The well-being of partners continues to be overlooked by perinatal services with a general lack of tailored support (Baldwin et al., 2018). Research suggests that perinatal mental health outcomes could be improved by consistent, routine assessment with reliable referral pathways, and specialist support services (Noonan & Galvin et al., 2017; Viveiros & Darling, 2019).

Awareness of perinatal mental health problems is increasing (Ayers & Shakespeare, 2015), and recommendations exist for the identification and support of mental health problems in women and partners (NICE, 2020; Oates, 2015). To date, birth trauma research has mainly focused on the effect upon, and treatment of birthing women, and has largely disregarded the needs of partners and the couple as a unit. A recent study of UK healthcare practitioners found that over one third of women and one quarter of partners are perceived to be affected by birth trauma, with up to 30% of couple relationships being impacted (Delicate et al., 2020a). This study also explored access to support for those affected by birth trauma which aimed to examine healthcare practitioners' views of the support women, partners, and the couple relationship require when affected by birth trauma, barriers to gaining such

support, and potential improvements. These findings are reported in the present article.

### **5.3 Method**

The results presented in this article are taken from a wider study which has already reported on healthcare practitioners' perceptions of the observed rates and impact of birth trauma (Delicate et al., 2020a). The study employed an online survey of healthcare practitioners to aid ease of participation and assist sample size and range of practitioner roles represented in the sample (Wright, 2005).

#### **5.3.1 Participants**

Practitioners were eligible to participate if they were currently working in clinical or non-clinical roles within the UK, supporting parents in the first postnatal year. A self-selecting convenience sample of UK healthcare practitioners was utilised, and sample size was not predetermined as the survey was exploratory.

#### **5.3.2 Procedures**

A survey was designed to address the research aims. The survey questions and response criteria were drawn from existing literature and the design process utilised a small trial with practitioners to refine questions and answer categories. At the beginning of the survey birth trauma was defined as having experienced “emotionally traumatic childbirth causing ongoing distress” and participants instructed to respond to the survey based on their experience of working with parents in the first postnatal year. Ethical approval for the study was obtained from the School of Health Sciences at City, University of London.

Participants were recruited between May and September 2018 through social media (Facebook and Twitter) and organisations such as the Institute of Health Visiting, NCT, MIDIRS, and the Royal College of General Practitioners.

Recruitment information enabled practitioners to link to and download the participant information sheet. Participation was voluntary and anonymous and to participate, practitioners were required to give consent at the start of the survey hosted by Qualtrics. Contact information in the form of an email was only collected if the participant indicated they wished to receive a summary of the study findings. Data were collected and stored within the web-based survey tool Qualtrics and exported to the statistical software SPSS 25 for analysis.

### **5.3.3 Analyses**

Geographical data was checked and any participants from outside the UK removed from the sample (n=6). The sample was examined using frequencies for practitioner role and length of qualification. Frequencies were calculated for statements about perceived support needs for women, partners, and couples plus practitioner knowledge, skills, and confidence with birth trauma support. Kendall's tau-b correlations were used to assess relationships between responses to parents' support needs and practitioner aptitude.

Frequencies were calculated for the support practitioners currently offered to couples and which support practitioners viewed as most effective for reducing the impact on the couple relationship. Fisher's exact tests were used to examine differences between the support offered to couples, and practitioner's perception of its effectiveness. The frequencies with which practitioners recommended other organisations to women, partners, and couples were calculated. Practitioner's views of the barriers to couples accessing support, and practitioners providing couples with support were examined using frequencies.

Open question responses for practitioners' views on gaps in support services for couples affected by birth trauma, what would help couples access suitable

support, and enable practitioners to support couples affected by birth trauma, were analysed using an approach similar to content analysis. For each question, participant responses were coded, and related codes grouped into categories. Due to apparent similarities, categories were compared between questions and rationalised to form over-arching themes for the open question data collectively.

## 5.4 Results

A sample of 202 healthcare practitioners engaged in the study and their characteristics are given in Chapter 4 (Delicate et al., 2020a). However, due to participant attrition as the survey progressed, the sample for results reported in this article is 110, and characteristics are detailed in Table 5.1.

**Table 5.1** *Article Sample (n = 110)*

| <b>Practitioner Role</b>             | <b>n (%)</b> |
|--------------------------------------|--------------|
| Doula                                | 13 (11.8)    |
| Family Support Worker (Social Care)  | 2 (1.8)      |
| General Practitioner (Physician)     | 3 (2.7)      |
| Health Visitor (Public Health Nurse) | 29 (26.4)    |
| Breastfeeding Counsellor             | 1 (0.9)      |
| Maternity Care Assistant             | 2 (1.8)      |
| Midwife                              | 31 (28.2)    |
| Parent Educator                      | 24 (21.8)    |
| Psychological Counsellor/Therapist   | 5 (4.5)      |
| <b>Length of Qualification</b>       | <b>n (%)</b> |
| Student                              | 9 (8.2)      |
| 0-4 Years                            | 27 (24.5)    |
| 5-9 Years                            | 30 (27.3)    |
| 10-14 Years                          | 20 (18.2)    |
| 15-19 Years                          | 10 (9.1)     |
| 20 + Years                           | 14 (12.7)    |

#### **5.4.1 Parent Support Needs and Practitioner Aptitude**

Practitioners reported differing levels of need for support from women, partners, and couples, which are detailed in Table 5.2 along with practitioners' perception of their own aptitude for giving birth trauma support. Practitioners reported that 54.5% (n = 60) of '*women want me to support them*' with birth trauma '*a lot*' or '*a great deal*'. Compared to 6.5% (n = 7) of '*partners want me to support them*' and 19.1% (n = 21) of '*couples want me to support them*' with birth trauma '*a lot*' or '*a great deal*'. A strong positive correlation was found between practitioner responses to '*I have the skills and knowledge required to support couples*' and '*I feel confident in supporting couples*' ( $r_b = .80, p < 0.00$ ). Moderate positive correlations were found between practitioner responses to '*I have the resources to offer support to couples*' and '*I feel confident in supporting couples*' ( $r_b = .54, p < 0.00$ ), and '*I have the resources to offer support to couples*' and '*I have the skills and knowledge required to support couples*' ( $r_b = .60, p < 0.00$ ).

**Table 5.2** *Parent Support Needs and Practitioner Aptitude*

|                                                             |     | Not at all | A little  | A moderate<br>amount | A lot     | A great<br>deal |
|-------------------------------------------------------------|-----|------------|-----------|----------------------|-----------|-----------------|
| Statement                                                   | n   | n (%)      | n (%)     | n (%)                | n (%)     | n (%)           |
| Women want me to support them                               | 110 | 2 (1.8)    | 18 (16.4) | 30 (27.3)            | 44 (40.0) | 16 (14.5)       |
| Partners want me to support them                            | 107 | 22 (20.6)  | 60 (56.1) | 18 (16.8)            | 6 (5.6)   | 1 (0.9)         |
| Couples want me to support them                             | 110 | 41 (37.3)  | 46 (41.8) | 11 (10.0)            | 10 (9.1)  | 2 (1.8)         |
| I have the resources to offer support to couples            | 109 | 21 (19.3)  | 40 (36.7) | 30 (27.5)            | 13 (11.9) | 5 (4.6)         |
| I have the skills and knowledge required to support couples | 110 | 10 (9.1)   | 41 (37.3) | 31 (28.2)            | 22 (20.0) | 6 (5.5)         |
| I feel confident in supporting couples                      | 109 | 9 (8.3)    | 35 (32.1) | 36 (33.0)            | 21 (19.3) | 8 (7.3)         |
| I feel that supporting couples is part of my role           | 110 | 6 (5.5)    | 20 (18.2) | 20 (18.2)            | 31 (28.2) | 33 (30.0)       |

#### 5.4.2 *Birth Trauma Support*

Data for the birth trauma support offered by healthcare practitioners is detailed in Table 5.3. The most offered support to couples experiencing birth trauma was listening to the couple (94.5%, n = 104), then referral to a birth listening/debriefing service (72.7%, n = 80), then self-help e.g., books and websites (53.6%, n = 59). Conversely, the support practitioners felt was most effective in reducing the impact of birth trauma on the couple relationship was birth listening/debriefing service (73.6%, n = 81), then listening to the couple (72.7%, n = 80), then referral to a mother and baby unit (46.4%, n = 51). There were significant differences between practitioner's rate of offering support and rating it the most effective support in reducing the impact on a couple's relationship for: watchful waiting, listening to the couple, self-help, and charitable/third sector organisations (Fishers Exact Test,  $p < .001$ ).

When indicating which type of birth trauma support they felt was most effective, two thirds of practitioners (66.4%, n = 73) selected three support types, over a quarter (29.1%, n = 32) selected five or more choices. Of the practitioners (n = 22) that indicated '*other*' as a form of support, 31.8% (n = 7) stated that rewind therapy was offered, six of those seven practitioners indicating they thought rewind therapy was most effective in reducing the impact on the couple relationship.

**Table 5.3** *Current Birth Trauma Support and Differences between Support Offered and Support Viewed Most Effective (n =110)*

|                                      | <b>Offered to Couples<br/>Affected by Birth<br/>Trauma<br/>n (%)</b> | <b>Viewed Most Effective in Reducing<br/>Impact on Couple Relationship<br/>n (%)</b> | <b>Difference<br/>Fisher's Exact Test<br/>P</b> |
|--------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| Watchful Waiting                     | 42 (38.2)                                                            | 14 (12.7)                                                                            | <.001*                                          |
| Listening to the Couple              | 104 (94.5)                                                           | 80 (72.7)                                                                            | <.001*                                          |
| Self Help e.g., Books and Websites   | 59 (53.6)                                                            | 23 (20.9)                                                                            | <.001*                                          |
| Charitable/Third-sector Organisation | 54 (49.1)                                                            | 29 (26.4)                                                                            | <.001*                                          |
| Birth listening/Debriefing service   | 80 (72.7)                                                            | 81 (73.6)                                                                            | .337                                            |
| Individual Psychotherapy             | 12 (10.9)                                                            | 33 (30.0)                                                                            | .178                                            |
| Couple Psychotherapy                 | 7 (6.4)                                                              | 30 (27.3)                                                                            | 1.00                                            |
| Couple Relationship Therapy          | 8 (7.3)                                                              | 33 (30.0)                                                                            | .051                                            |
| Mother and Baby Unit                 | 56 (50.9)                                                            | 51 (46.4)                                                                            | .712                                            |

\* *Significant*

Referral to other organisations, presented in Table 5.4, showed some similarities for third sector services and resources women, partners and couples were informed about. The Birth Trauma Association (women 44.2%, n = 42; partner 33.7%, n = 32; couple 36.8%, n = 35), PANDA (women 32.6%, n = 31; partner 21.1%, n = 20; couple 20.0%, n = 19), Children Centre (women 30.5%, n = 29; partner 14.7%, n = 14; couple 20.0%, n = 19), Relate (women 29.5%, n = 28; partner 24.2%, n = 23; couple 46.3%, n = 44); and MIND (women 27.4%, n = 26; partner 24.2%, n = 23; couple 23.2%, n = 22). In open text responses to ‘*other*’ referrals were to local perinatal mental health charities (n = 12), birth afterthoughts (n = 4), rewind therapy (n = 3), Fatherhood Institute (n = 1), emotional freedom therapy (n = 1), and the GP (n = 1).

#### **5.4.3 Barriers to Birth Trauma Support**

Table 5.5 details practitioners’ views of the barriers that exist to couples receiving support and practitioners providing support. The three most reported barriers to couples accessing support services that practitioners reported to see ‘*a lot*’ or ‘*a great deal*’ were: ‘*long waiting times for support services*’ (68.6%, n = 72); ‘*stigma around disclosing problems with couple relationships*’ (67.3%, n = 70); and ‘*lack of suitable services*’ (61.3%, n = 65). The three most reported barriers to practitioners providing support to couples that practitioners reported experiencing ‘*a lot*’ or ‘*a great deal*’ were: ‘*absence of suitable service to refer couple to*’ (52.5%, n=52); ‘*lack of time to spend personally supporting parents*’ (48.5%, n = 48); and ‘*lack of contact with partners to identify those with birth trauma*’ (45.8%, n = 44).

**Table 5.4** *Recommended Organisations (n = 95)*

|                             | <b>Recommend</b> | <b>Recommend</b> | <b>Recommend</b> |
|-----------------------------|------------------|------------------|------------------|
|                             | <b>Women</b>     | <b>Partners</b>  | <b>Couples</b>   |
| <b>Organisation</b>         | <b>n (%)</b>     | <b>n (%)</b>     | <b>n (%)</b>     |
| Big White Wall              | 1 (1.1)          | 1 (1.1)          | 2 (2.1)          |
| Birth Trauma Association    | 42 (44.2)        | 32 (33.7)        | 35 (36.8)        |
| Birth Trauma Chat           | 9 (9.5)          | 4 (4.2)          | 7 (7.4)          |
| Children Centre             | 29 (30.5)        | 14 (14.7)        | 19 (20.0)        |
| Family Action               | 3 (3.2)          | 2 (2.1)          | 3 (3.2)          |
| Homestart                   | 18 (18.9)        | 5 (5.3)          | 12 (12.6)        |
| MIND                        | 26 (27.4)        | 23 (24.2)        | 22 (23.2)        |
| NCT                         | 16 (16.8)        | 11 (11.6)        | 15 (15.8)        |
| OnePlusOne                  | 10 (10.5)        | 9 (9.5)          | 7 (7.4)          |
| PANDA                       | 31 (32.6)        | 20 (21.1)        | 19 (20.0)        |
| Parent Infant Partnership   | 8 (8.4)          | 8 (8.4)          | 7 (7.4)          |
| Relate                      | 28 (29.5)        | 23 (24.2)        | 44 (46.3)        |
| Tavistock Relationship      | 6 (6.3)          | 6 (6.3)          | 10 (10.5)        |
| The Relationship Foundation | 4 (4.2)          | 5 (5.3)          | 5 (5.3)          |

**Table 5.5** *Barriers to Accessing Birth Trauma Support*

|                                                                   |     | Not at all | A little  | A moderate<br>amount | A lot     | A great<br>deal |
|-------------------------------------------------------------------|-----|------------|-----------|----------------------|-----------|-----------------|
|                                                                   | n   | n (%)      | n (%)     | n (%)                | n (%)     | n (%)           |
| <b>Barrier to couples accessing support services</b>              |     |            |           |                      |           |                 |
| Concerns that requesting support will imply poor parenting        | 105 | 15 (14.3)  | 34 (32.4) | 27 (25.7)            | 16 (15.2) | 13 (12.4)       |
| Lack of awareness of childbirth-related post-traumatic stress     | 102 | 0 (0.0)    | 21 (20.6) | 31 (30.4)            | 33 (32.4) | 17 (16.7)       |
| Lack of childcare provision to access support service             | 104 | 11 (10.6)  | 35 (33.7) | 23 (22.1)            | 25 (24.0) | 10 (9.6)        |
| Lack of contact time with healthcare professionals                | 106 | 2 (1.9)    | 14 (13.2) | 26 (24.5)            | 39 (36.8) | 25 (23.6)       |
| Lack of suitable services                                         | 106 | 1 (0.9)    | 17 (16.0) | 23 (21.7)            | 36 (34.0) | 29 (27.4)       |
| Long waiting times for support services                           | 105 | 1 (1.0)    | 13 (12.4) | 19 (18.1)            | 39 (37.1) | 33 (31.4)       |
| Stigma around disclosing mental health problems                   | 105 | 0 (0.0)    | 14 (13.3) | 27 (25.7)            | 33 (31.4) | 31 (29.5)       |
| Stigma around disclosing problems with couple relationship        | 104 | 0 (0.0)    | 10 (9.6)  | 24 (23.1)            | 37 (35.6) | 33 (31.7)       |
| <b>Barrier to practitioner providing support to couples</b>       |     |            |           |                      |           |                 |
| Absence of suitable screening tool                                | 97  | 20 (20.6)  | 24 (24.7) | 15 (15.5)            | 19 (19.6) | 19 (19.6)       |
| Absence of suitable service to refer couple to                    | 99  | 6 (6.1)    | 18 (18.2) | 23 (23.2)            | 31 (31.3) | 21 (21.2)       |
| Lack of contact with mothers to identify those with birth trauma  | 97  | 30 (30.9)  | 21 (21.6) | 24 (24.7)            | 12 (12.4) | 10 (10.3)       |
| Lack of contact with partners to identify those with birth trauma | 96  | 11 (11.5)  | 15 (15.6) | 26 (27.1)            | 27 (28.1) | 17 (17.7)       |
| Lack of training in this area                                     | 101 | 13 (12.9)  | 18 (17.8) | 25 (24.8)            | 25 (24.8) | 20 (19.8)       |
| Lack of time to spend personally supporting parents               | 99  | 8 (8.1)    | 17 (17.2) | 26 (26.3)            | 23 (23.2) | 25 (25.3)       |
| Parents reluctance to accept support                              | 98  | 16 (16.3)  | 37 (37.8) | 34 (34.7)            | 9 (9.2)   | 2 (2.0)         |
| Lack of collaboration with other healthcare professionals         | 98  | 11 (11.2)  | 25 (25.5) | 28 (28.6)            | 21 (21.4) | 13 (13.3)       |

A strong positive correlation was found between practitioners' rating of '*stigma around disclosing mental health problems*' and '*stigma around disclosing problems with couple relationship*' as barriers to parents accessing support ( $r_b = .73$ ,  $p < 0.00$ ). Exploring barriers to practitioners providing support, a positive correlation was seen between rating of '*lack of contact with mothers to identify those with birth trauma*' and '*lack of contact with partners to identify those with birth trauma*' ( $r_b = .63$ ,  $p < 0.00$ ).

#### **5.4.4 Potential Improvements to Birth Trauma Support**

Four themes emerged from the responses to questions about practitioners' views on: '*what are the gaps in support services for couples affected by birth trauma*' ( $n = 84$ ); '*what would help couples access suitable support for birth trauma*' ( $n = 77$ ); and '*what would help practitioners to support couples affected by birth trauma*' ( $n = 73$ ). Theme (1) raising awareness and knowledge of birth trauma, (2) prevention of birth trauma (3) identifying those in need of support with birth trauma, and (4) need for suitable birth trauma support. These four themes for potential improvements to birth trauma support are presented with supporting data in Table 5.6, and Figure 5.1 proposes how the themes may interact in the perinatal phase.

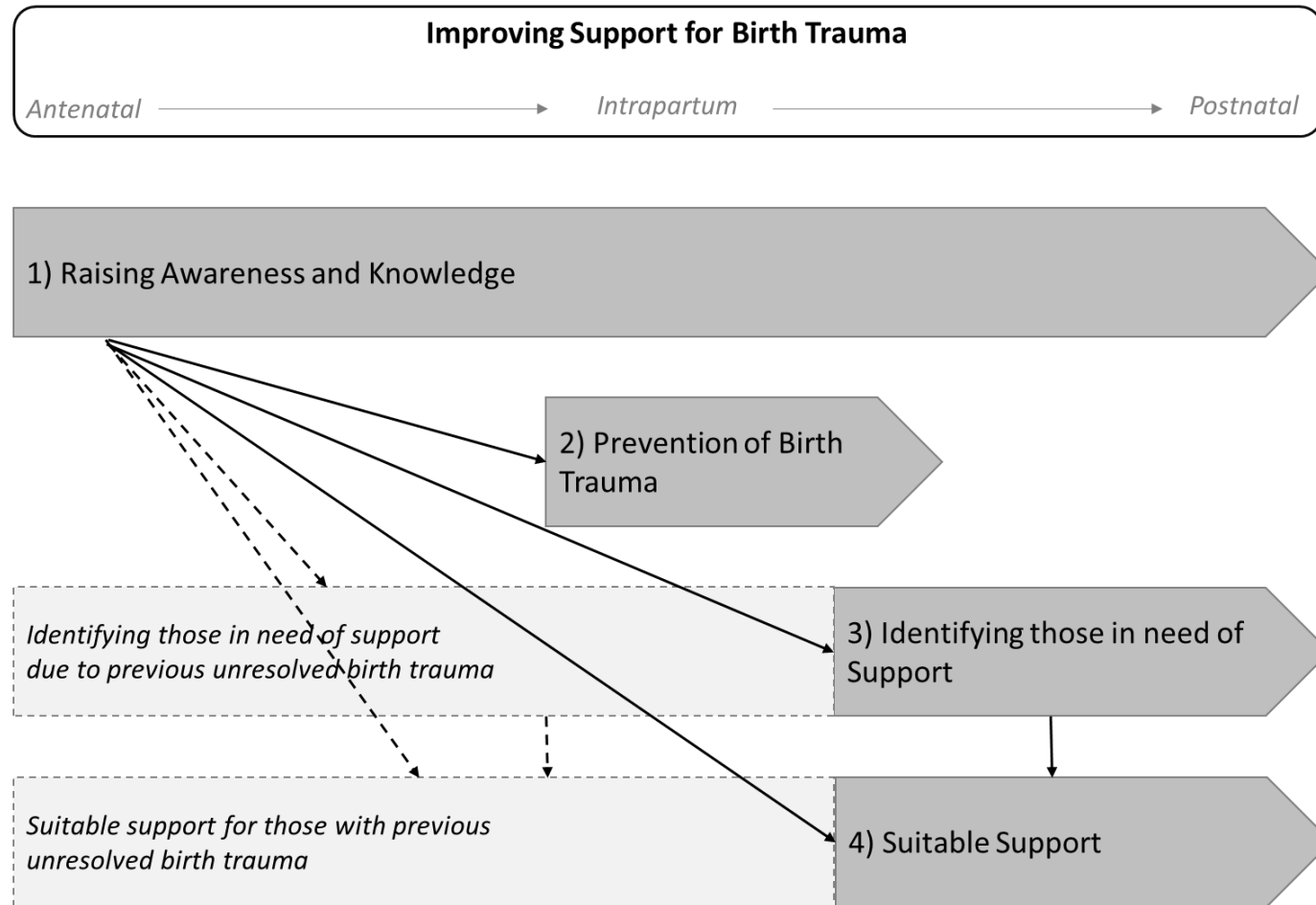
Theme 1, raising awareness and knowledge of birth trauma, was highlighted as important for both parents and practitioners. Within this theme was a need to improve information to parents and enhance training for practitioners in how to support couples with birth trauma. Theme 2 was prevention of birth trauma, which was identified as possible through improvements to intrapartum care to ensure care is respectful and based on informed consent. Likewise, improvements to mental healthcare could enable secondary prevention of PTSD after birth trauma.

**Table 5.6** *Data Supporting Themes for Potential Improvements to Birth Trauma Support*

| <b>Question</b>                                        | <b>What are the gaps in support services for couples affected by birth trauma?</b><br>(n = 84)                                                                                                                                                                                                                                                      | <b>What would help couples access suitable support for birth trauma?</b><br>(n = 77)                                                                                                                                                                                                                | <b>What would help practitioners to support couple affected by birth trauma?</b><br>(n = 73)                                                                                                                                                                                   |
|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Theme 1</b>                                         |                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                |
| <b>Raising awareness and knowledge of birth trauma</b> | <i>'There is no validation of a traumatic birth ever. So parents go home without any information on support services and are left to suffer alone and do their own research.'</i> (doula)<br><i>'The assumption that healthy Mum and baby must be the only measure of a positive birth, not considering the emotional side of birth.'</i> (midwife) | <i>'Information at all stages of contact [with parents], public awareness campaigns'</i> (GP)<br><i>'Greater recognition of trauma in those professionals who see the couples early on...for everybody in the world to never again say "a healthy baby is all that matters".'</i> (parent educator) | <i>'Wider emphasis on the postnatal period and mental health. Birth trauma is often forgotten!'</i> (midwife)<br><i>'Further training in supporting couples with this specific issue.'</i> (health visitor)                                                                    |
| <b>Theme 2</b>                                         |                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                |
| <b>Prevention of birth trauma</b>                      | <i>'In my view, more should be done to avoid the trauma in the first place by addressing the gaps in midwifery training and the lack of woman centred care in birth.'</i> (lactation consultant)<br><i>'Securely funded, well signposted local support groups specifically for perinatal issues...thorough physical and mental</i>                  | <i>'Reducing the point of trauma, ensuring consent, dignity and environment are priorities.'</i> (midwife)<br><i>'All healthcare professionals involved in birth should have training on how to prevent birth trauma.'</i> (health visitor)                                                         | <i>'A trauma led care pathway with flagging tool to determine likelihood of trauma and more immediate feedback of couples experiences.'</i> (midwife)<br><i>'Autonomy to discuss in immediate postnatal period without fear of reprimand for causing complaint.'</i> (midwife) |

|                                                                                     |                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                     | <i>postnatal check from GP and midwife and health visitor where appropriate, which include questions designed to flag potential PTSD.’ (parent educator)</i>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                  |
| <b>Theme 3</b><br><br><b>Identifying those in need of support with birth trauma</b> | <i>‘Often difficult to see as couple due to partner working or not wanting to admit there is a problem.’ (health visitor)</i><br><br><i>‘Issues not being picked up or diagnosed quickly enough after birth. Watching and waiting too long sometimes.’ (health visitor)</i>                  | <i>‘A thorough postnatal screening tool used across the professions for both parents with adequate services to back it up.’ (parent educator)</i><br><br><i>‘Continuity of care, someone...who had built a relationship of trust so couples would feel able and willing to disclose deeply personal problems.’ (parent educator)</i> | <i>‘Better communication between the multi-professional teams.’ (health visitor)</i><br><br><i>‘Protected time to spend talking about birth experiences with every couple soon after birth.’ (health visitor)</i>                |
| <b>Theme 4</b><br><br><b>Need for suitable birth trauma support</b>                 | <i>‘There’s virtually nothing unless either the person is incredibly debilitated by the trauma and can’t look after their child or the person actively demands help.’ (counsellor)</i><br><br><i>‘Support available weekends and evenings once father returns to work.’ (health visitor)</i> | <i>‘Publicising really clearly what is on offer and destigmatising the support.’ (parent educator)</i><br><br><i>‘More services and less waiting lists. Immediate referral after traumatic delivery in hospital.’ (midwife)</i>                                                                                                      | <i>‘Better joined-up services, clear referral/ support pathways, access to written materials or online resources.’ (health visitor)</i><br><br><i>‘Easy to refer service with specialist knowledge.’ (family support worker)</i> |

**Figure 5.1** Themes for Improving Support for Parents Affected by Birth Trauma



Theme 3 was identifying those in need of support with birth trauma. This was highlighted as possible through practitioners having more time to spend with parents and continuity to build a relationship, particularly with partners. Similarly, increased communication between practitioners was reported as a potential facilitator to recognising parents in need of support, as was having an effective birth trauma assessment tool. Theme 4 was the need for suitable birth trauma support. Practitioners expressed the need for clearer referral pathways to specialist services that can address differing levels of birth trauma distress. Such support needing to be available in a timely way and be accessible by women, partners, and couples.

## **5.5 Discussion**

The present study aimed to examine healthcare practitioners' views of the support women, partners, and the couple relationship require when affected by birth trauma, barriers to gaining such support, and potential improvements. Perception of support needs varied according to whether it was for the women, partners, or the couple as a unit. The most offered support was practitioners listening to parents, followed by referral to birth debriefing, and signposting to self-help. Findings highlighted potential barriers to getting birth trauma support along with insight of improvements.

Results suggest that practitioners see less demand for birth trauma support from the couple as a unit, or partners, compared to women. Conversely, practitioners highlighted lack of contact with partners as a barrier to providing birth trauma support, and a potential improvement being enhanced services for partners. Further indications that perinatal health services need to consider the needs of partners (Burgess & Goldman, 2018) and engage them in support services (Nystedt & Hildingsson, 2018).

Collaborative working in perinatal mental health is associated with reducing barriers to parents accessing support (Smith et al., 2019) and more effective support for families (Myors et al., 2013). Results from the present study support these findings and suggest improved communication between professionals could improve the identification of couples in need of support. This is pertinent as current variation in birth trauma assessment creates a barrier to effective support through omission of those in need (Delicate et al., 2020a).

Despite no conclusive evidence for the routine use of birth debriefing (Bastos et al., 2015), study results are consistent with previous research suggesting it is provided by many postnatal services in the UK (Ayers, Claypool & Eagle, 2006). With practitioners in the survey perceiving debriefing to be the most effective support for couples affected by birth trauma. Whilst research has shown that some women like and seek out debriefing (Baxter, 2019), its effectiveness as an intervention is questionable and likely to be influenced by its timing and the level of trauma symptoms (Meades et al., 2011).

Similarly, the present study found some practitioners referring to rewind therapy which is not currently an evidence-based PTSD treatment (NICE, 2018a). However, at the time of this study rewind therapy was being promoted to NHS practitioners as a birth trauma treatment (Mullan, 2017) and was accredited by the Royal College of Midwives despite no evidence for its effectiveness. This questionable use of rewind therapy for birth trauma (Moore, 2020) may be due to it being available and accredited at a time when health practitioners are looking for birth trauma treatments, in the absence of any solid evidence about effective interventions for birth trauma. In addition, more intensive, evidence-based treatments

for PTSD may be inappropriate if women or their partners do not have PTSD, as well as being more costly.

Likewise, widespread referral to self-help reported by practitioners in the survey could be due to a lack of suitable services to refer to, or long waiting lists for receiving treatment (Thomson & Garrett, 2019). However, it may serve to reinforce the notion that parents often need to cope on their own with birth trauma (Delicate et al., 2020a). Significant differences were found between rates of referral to, and perceived effectiveness for reducing the impact on the couple relationship for: watchful waiting, listening to the couple, signposting to self-help, and referral to third party/charitable organisations. Therefore, some practitioners are referring parents to support they perceived to be inferior, with most practitioners suggesting effective treatment consists of support from multiple sources. This reinforces previous research that more evidence-based birth trauma interventions (Lapp et al., 2010) and referral pathways are required (NHS, 2018).

Reported barriers to practitioners supporting parents were in concordance with previous research findings. Lack of time to spend with parents (Noonan et al., 2018), limited perinatal mental health training (de Vries et al., 2018), and absence of suitable services to refer parents to (Bayrampour et al., 2018). The correlation between practitioners reporting having the skills and knowledge to support couples and feeling confident in giving support further emphasises the need for increased perinatal mental health training for practitioners (NHS, 2015; Thomson & Garrett, 2019). There is limited evidence regarding the most effective way to train practitioners, and indeed which practitioners are best placed to support parents with birth trauma.

Developed from the present study results, Figure 5.1 depicts potential improvements in birth trauma support across the perinatal phase. Increased awareness and knowledge of birth trauma with parents may reduce barriers to parents accessing support (Smith et al., 2019), through easing stigma, improving help seeking behaviours, and developing acceptance of support (Button, 2017). A key element of raising awareness and knowledge of birth trauma in practitioners is through effective professional education and training (de Vries, 2018; Thomson & Garrett, 2019). To enable practitioners working with parents to have the time and resources to support parents birth trauma, awareness also needs to improve at service commissioning and development level (Bauer et al., 2014).

Knowledgeable and birth trauma aware healthcare practitioners could help prevent birth trauma. In the antenatal phase prevention can result from assessing and dealing with prior mental health vulnerability and enabling effective childbirth preparation (Simpson et al., 2018). During intrapartum care prevention could be enabled by reducing obstetric interventions and facilitating a positive birth experience (Ayers et al., 2016; Dekel et al., 2017). In the postnatal period, birth trauma aware practitioners and services are needed to help identify those in need of support and assist them in gaining the support they require.

Whilst reassurance and a watch and wait approach may be suitable in the early postnatal weeks (NICE, 2018b), the present study suggests that improvements are required to effectively identify women, partners and couples affected by birth trauma. Consistent with other perinatal mental health problems, once birth trauma is identified, practitioners need clear referral pathways to support that can address varying levels of distress (Noonan & Doody et al., 2017). It is recognised that

identifying those in need of support may be appropriate for some parents antenatally due to prior birth trauma (Greenfield et al., 2019).

### ***5.5.1 Strengths and Limitations***

The main limitation of the present study is the self-selecting convenience sample which is not representative of the range of healthcare practitioners working with parents in the postnatal period. Sample size was relatively small and low participant rates from some practitioner groups means their perspective is underrepresented in the findings. Study results should be construed as exploratory due to the use of an unvalidated survey and practitioners responding retrospectively based on a range of observations of parents but not clinical diagnoses.

In contrast, the study findings add to a limited body of evidence of healthcare practitioners' perspectives of birth trauma. Results illustrate current practice in birth trauma support, practitioners' proficiency, and insight into how support may be improved. These findings are important for healthcare practitioners, service providers, commissioners and researchers engaged in the perinatal phase. Results also have implications for the development of policy and practice to aid the prevention of birth trauma and the provision of effective support services.

### ***5.5.2 Conclusions***

Practitioners indicated that some women, partners, and the couple as a unit require support for birth trauma and identified some barriers to accessing effective support. Suggested improvements include preventing birth being perceived as traumatic in the first instance, raising birth trauma awareness in practitioners and parents, and improving identification of those requiring support. The birth trauma support that is currently being offered is often not evidence-based and relies on practitioner's perceptions of effectiveness and/or availability. It is important that

further research is conducted into appropriate birth trauma treatments and that services offer evidence-based support to meet the needs of parents as individuals and the couple as a unit.

## **6      The Impact of Birth Trauma on the Couple Relationship and Related Support Requirements: a Framework Analysis of Parents’ Perspectives (Article 5)**

Delicate, A., & Ayers, S. (submitted). The Impact of Birth Trauma on the Couple Relationship and Related Support Requirements: a Framework Analysis of Parents’ Perspectives. *Midwifery*.

Delicate, A. (2021, November 10-11). The impact of birth trauma on the couple relationship and related support requirements [Oral Presentation]. *8<sup>th</sup> Annual School of Health Sciences Doctoral Research Conference*, City, University of London, UK.

## **6.1 Abstract**

Experiencing childbirth as traumatic can lead to ongoing distress, which can affect personal well-being and the couple's relationship. The present study aimed to explore the lived experience of the impact of birth trauma on the couple relationship and related support requirements. A purposive sample of men and women who had experienced childbirth as traumatic (N=18) were recruited and interviewed remotely in 2021. Data were analysed using framework analysis in NVivo 12. Twenty-seven themes were reported which were mapped against negative and positive aspects of the impact of birth trauma and related support. Findings suggest the impact of birth trauma on the couple relationship can be negative and distressing, or for some lead to a strengthened relationship. Current support for birth trauma was appraised as varying in effectiveness and potential improvements to support are suggested.

## **6.2 Introduction**

Ongoing distress following a traumatic birth experience, commonly known as birth trauma, can lead to PTSS and may result in diagnosis of PTSD (Dekel et al., 2017; Simpson et al., 2018). Research shows 20-40% of women report their birth to be traumatic (Alcorn et al., 2010; Creedy et al., 2000; Dikmen-Yildiz et al., 2017b; Soet et al., 2003). With ongoing birth trauma related distress seen in 10 to 12.5% of women (Ayers, 2004; White et al., 2006) and the prevalence of childbirth-related PTSD in women being 4% (Yildiz et al., 2017). Witnessing a traumatic birth can cause distress in partners (Hinton et al., 2014) and lead to anxiety (Bradley et al., 2008) and PTSS (Elmir & Schmied, 2016).

In addition to negative impacts on personal health (Beck, 2011) birth trauma can impact upon the couple relationship, with the potential to cause relationship distress (Campbell & Renshaw, 2018) and a decline in relationship satisfaction (Garthus-Niegel, Horsch & Handtke et al., 2018). Appreciating the impact of birth trauma on the couple relationship is important as good relationships are associated with improved personal health (Figueiredo et al., 2008; Robles et al., 2014). The quality of the couple relationship between parents can also impact on infant well-being (Sroufe, 2005), with relationship conflict being associated with an insecure infant-parent attachment (Finger et al., 2009; Wong et al., 2009). The breakdown of the parental relationship is associated with further negative child outcomes such as poverty, poor health, and behavioural problems (Coleman & Glenn, 2009).

There is limited research on the impact of birth trauma on a couple relationship with conflicting results between quantitative and qualitative studies (Delicate, Ayers, Easter & McMullen, 2018). Quantitative research has found that childbirth-related PTSD is not associated with negative impacts on the couple

relationship (Ayers et al., 2007), or that impact is mediated by depression (Parfitt & Ayers, 2009; Figueiredo et al., 2018). However, a meta-synthesis of qualitative studies on the impact of birth trauma reported four negative themes: strain on relationship, negative emotions, lack of understanding and support, loss of intimacy, and one positive theme of strengthened relationship (Delicate, Ayers, Easter & McMullen, 2018). Furthermore, the TTP is a major life event with its own stresses (Ayers et al., 2019) and potential to effect relationships (Delicate, Ayers & McMullen, 2018).

Assessment of birth trauma and PTSD are important as this enables those requiring support and treatment to be identified. Despite the availability of validated birth trauma measures such as the City Birth Trauma Scale (Ayers et al., 2018; Webb et al., 2021), routine assessment for birth trauma remains limited. Even without routine birth trauma assessment in the UK, healthcare practitioners perceive over one quarter of couple relationships to be impacted by the experience of birth trauma (Delicate et al., 2020a).

Evidence-based treatment for PTSD is either trauma-focused CBT or EMDR (NICE, 2018b). Though this guidance is not specific to childbirth-related PTSD and would not apply to parents experiencing PTSS in the absence of a PTSD diagnosis. Parents indicate that they want support with birth trauma (Etheridge & Slade, 2017; Watson et al., 2020) and despite lack of evidence for effectiveness (Bastos et al., 2015) referral to midwifery led debriefing is commonplace in some countries (Ayers, Claypool & Eagle, 2006; Baxter, 2019).

There are no interventions for birth trauma specifically developed for couples. However, there is evidence from PTSD research in other populations that

couple-based trauma counselling can reduce trauma symptoms and prevent decline in relationship satisfaction (Greenman & Johnson 2012; Monson et al., 2015).

Therefore, the present study used a qualitative approach to investigate the lived experience of birth trauma and answer four research questions: (1) How do parents experience the impact of birth trauma on their couple relationship?; (2) How do couples deal with the impact of birth trauma on the couple relationship?; (3) Where do couples obtain birth trauma support, and how effective do they perceive such support?; and (4) what would facilitate more acceptable birth trauma support for couples?

### **6.3 Method**

To ensure robust reporting of study information this article follows guidance from the COREQ checklist (Tong et al., 2007).

#### **6.3.1 Participants**

Purposive sampling was used to recruit parents with a lived experience of birth trauma. Participants were eligible if they or their partner had experience birth trauma defined as “emotionally traumatic childbirth causing ongoing distress”. The birth took place in the UK, after 37 weeks of gestation, resulting in a live infant who was between six months and five years of age at the time of the interview. Participants needed to be currently or previously in a relationship with their child’s other parent since the birth. Participation in the study was voluntary and anonymous. The sample size was set at six to ten participants of each sex; a small enough sample for the experience of individuals to be heard, but large enough for wider conclusions to be drawn (Robinson, 2014).

### **6.3.2 Recruitment**

Ethical approval was obtained from the School of Health Sciences Research Ethics Committee at City, University of London. Recruitment commenced in January 2021 during the COVID-19 pandemic and consequent government restrictions. To reach parents across the UK, recruitment was conducted via social media, predominantly Facebook and Twitter, using parenting and birth trauma networks such as the Birth Trauma Association, Make Birth Better, Fatherhood Institute, NCT, and Dads Matter. Initial recruitment strategies were successful at recruiting women who had given birth. As the study aimed to analyse the experiences of both partners, amendments to ethics were applied for and granted in May 2021 to enable targeted recruitment of men and to offer a gift voucher as a thank you for participating. Recruitment ran until June 2021.

All potential participants enquiring about the study were sent the participant information sheet which detailed the rationale and aims of the study and information on eligibility criteria. A consent form and support information on birth trauma services were also sent. For those indicating they wanted to participate and who provided consent, an interview date was arranged with the doctorate candidate via email.

### **6.3.3 Data Collection**

All data collection activities were conducted remotely due to the COVID-19 pandemic. Participants completed demographic information and the consent form using an online survey platform Qualtrics. Individual semi-structured interviews were conducted using Microsoft Teams or via telephone whilst participants were at home or work.

All interviews were conducted by the doctorate candidate, supported by the primary supervisor, an experienced qualitative researcher. The doctorate candidate attended interview training prior to conducting the research. Interviews were in English, and audio recorded on an encrypted device. Length of interviews varied from 29 to 119 minutes, with an average length of 59 minutes. Participants were not required to answer all questions, and conversely responses were not restricted to the interview guide.

Audio files were transcribed verbatim. Transcripts were not returned to participants as the interview involved discussing the traumatic experience. Therefore, reading a transcript had the potential to cause distress and re-traumatise.

#### **6.3.4 Data Analysis**

Demographic data were analysed using descriptive statistics to examine sample characteristics such as parent age, cultural background, educational level, and employment status. Interview data were analysed using framework analysis. As a form of systematic thematic analysis, framework analysis provided a way to manage the large qualitative data set. Furthermore, ensuring systematic treatment and analysis of all data, that acknowledged the depth and breadth of experiences within the sample (Hackett & Strickland, 2018; Srivastava & Thomson, 2009), with the ability to provide results that could contribute to theoretical insight (Goldsmith, 2021).

Framework analysis does have limitations that needed to be considered and managed within the study. The method can be time and resource intensive, and whilst some of this burden was reduced by using computer software, it was important to remember that software is not a replacement for the intellect of the researcher (Ritchie et al., 2013). Furthermore, the matrix format of the framework

can entice quantification of data which is not appropriate for qualitative sampling (Gale et al., 2013).

Whilst framework analysis was originally described for use in the social sciences, it has since been implemented in many settings and fields (Ritchie et al., 2013). Due to the health science background of the doctorate, the present study used the stages of framework analysis described for application in health research (Gale et al., 2013): transcription; familiarisation; coding; developing an analytical framework; applying the framework; charting data into the framework; and interpreting data. Deductive and inductive codes were used to inform the analytical framework to encompass prior understanding of the phenomena from research, as well as meaning derived from the empirical data.

The transcripts were read several times and underlying concepts were noted. Analysis of data for men and women was originally conducted separately but due to similarities in emerging themes, and the dyadic focus of the study, data were combined for synthesis. Using the research questions as a guide, inductive concepts from the data, and deductive concepts from prior research (Delicate, Ayers, Easter & McMullen, 2018; Delicate et al., 2020a; 2020b) were used to create an analysis framework.

Anonymised transcripts were imported to NVivo 12 for coding. For each transcript, data were assigned to relevant framework codes. Once all transcripts had been coded, data allocated to each code were reviewed at participant and sample level. For each research question, codes sharing key characteristics were combined to create emergent themes. The emergent themes for each research questions were compared across the data set to explore similarities and differences. This resulted in emergent themes being rationalised into final themes that spanned across all four

research questions and sub themes that related either to the impact of birth trauma or birth trauma support.

Participants were not asked to feedback on analysis due to concerns that exposure to synthesised findings could potentially re-trigger trauma and affect emotional well-being. However, participants were able to request a summary of the study results once completed.

## **6.4 Findings**

In total 38 people (17 women and 21 men) enquired about taking part in the study, however four did not meet inclusion criteria (three women and one man). Of the remaining 34 enquiries, 14 people decided not to participate. The reasons for this are unknown as due to the sensitive topic no follow up took place. The final sample comprised of 20 participants (9 women and 11 men) who consented and completed an interview. Prior to analysis two men were removed from the sample because their experiences of trauma were not related to the birth.

### **6.4.1 Sample**

Eighteen participants were included in analysis, nine women and nine men. All participants were currently in married, heterosexual relationships. One married couple are included in the sample; all other participants had no connection. All participants were resident in England when the traumatic birth took place and stated English as their first language. Five participants experienced the traumatic birth during the COVID-19 pandemic (3 women and 2 men). Table 6.1 provides further demographic information.

### **6.4.2 Themes**

Data synthesis identified 27 themes and Figure 6.1 depicts how themes relate to positive and negative aspects of the impact of birth trauma on the couple

relationship and associated birth trauma support. Thematic results are presented below along with examples of indicative data. Results indicate which participants supported each subtheme (participants are numbered 1 to 9 for men, M and women, W).

Themes 1 to 8 illustrate the negative aspects of parents' perspectives of the impact of birth trauma on the couple relationship.

Theme 1 - Relationship distress was reported as being created by having to deal with the impact of birth trauma on an individual and relationship level (M1, M8, M9, W2, W3, W4, W8).

*It's definitely had a very negative experience, well initially negative experience in our relationship who knows, you know kind of, taking off those layers might be what's needed for us to have a more real and sustainable long-term relationship, but it has been very, we've both been very distressed in our relationship. W2*

Distress was also reported as resulting in strain on the relationship, which for some resulted in heightened reactions between partners.

*It was causing a strain on our own relationship because one of us would be saying the right thing, being able to rationalise it... and the other person would be flying off the handle and getting really frustrated and agitated or depressed. M8*

Theme 2 - Changed relationship functioning was reported negatively in terms of relationship roles being altered due to the impact of birth trauma (M2, M3, M5, M7, M8, W2, W3, W4, W5, W8).

*The experience which left me, really very vulnerable, not in a particularly good place... I was usually the strong one, the very practical pragmatic*

*keeping everything going, keep being the one to keep us safe...I just couldn't any more...I wasn't able to do that anymore and you know things got very, very difficult. W2*

In addition, negative effect on sexual functioning was also reported.

*A lack of intimacy over the last couple of years. Not completely abstinent but in the sense in which that has affected her quite strongly. I mean we don't have a healthy sex life, we do have a sex life but it's not healthy in the sense of a couple because there's a few barriers. M5*

**Table 6.1** *Sample Demographics*

| <b>Participant Demographic</b>                                    | <b>Complete Sample<br/>N = 18</b>                                                                        | <b>Women<br/>n = 9</b>                                                   | <b>Men<br/>n = 9</b>                              |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------|
| <b>Age</b>                                                        | 28 - 47 years<br>Average 34 years                                                                        | 29 - 40 years<br>Average 33 years                                        | 28 - 47 years<br>Average 36 years                 |
| <b>Number of children</b>                                         | 14 first time parents (2 pregnant with second child at time of interview)<br>4 parents with two children | 9 first time parents (2 pregnant with second child at time of interview) | 5 first time parents<br>4 parents with 2 children |
| <b>Time passed since the traumatic birth at date of interview</b> | 8-60 months<br>Average 22 months                                                                         | 8-20 months<br>Average 14 months                                         | 11-60 months<br>Average 31 months                 |
| <b>Ethnicity</b>                                                  | 15 White British<br>2 Other white<br>1 Asian British                                                     | 6 White British<br>2 Other white<br>1 Asian British                      | 9 White British                                   |
| <b>Highest level of education</b>                                 | 8 higher degree<br>10 degree                                                                             | 6 higher degree<br>3 degree                                              | 2 higher degree<br>7 degree                       |
| <b>Employment status</b>                                          | 15 employed<br>1 self-employed<br>2 unemployed                                                           | 7 employed<br>0 self-employed<br>2 unemployed                            | 8 employed<br>1 self-employed<br>0 unemployed     |

**Figure 6.1** *Overview of Themes*

| <b>Impact of Birth Trauma on the Couple Relationship</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Birth Trauma Support</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Negative</b>                                          | <ol style="list-style-type: none"> <li>1. Relationship distress</li> <li>2. Changed relationship functioning</li> <li>3. Negative communication</li> <li>4. Magnification of the strain of being a new parent</li> <li>5. Fear of relationship breakdown</li> <li>6. Different viewpoints of the birth experience</li> <li>7. Unable to emotionally support one's partner</li> <li>8. Men being focused on providing practical support</li> </ol> | <ol style="list-style-type: none"> <li>14. Unavailability of help from friends and family</li> <li>15. Unhelpful birth debriefing services</li> <li>16. No personal awareness of birth trauma</li> <li>17. Absence of trauma validation from health care professionals</li> <li>18. Lack of awareness of the emotional needs of men</li> <li>19. Barriers to accessing psychological services</li> </ol>                                                                                                                                          |
|                                                          | <ol style="list-style-type: none"> <li>9. Strengthened relationship</li> <li>10. Prior strength of the relationship was protective</li> <li>11. Importance of effective communication</li> <li>12. Willingness to listen and understand</li> <li>13. Agreeing a plan for a subsequent birth</li> </ol>                                                                                                                                            | <ol style="list-style-type: none"> <li>20. Connecting with peers was valuable</li> <li>21. Psychological services to support the couple relationship</li> <li>22. Supporting parents to understand the traumatic events</li> <li>23. Facilitating parental feedback on maternity services</li> <li>24. Birth trauma informed antenatal preparation</li> <li>25. Proactive early signposting of support</li> <li>26. Improving access to specialist psychological services</li> <li>27. Compassionate parent centred maternity services</li> </ol> |

Theme 3 - Negative communication styles were reported within the relationship such as conflict and arguments (M1, M6, M7, M8, M9, W1, W2, W3, W4, W5, W6).

*So we argued quite a lot at that point...we'd sort of been occupying the same space and doing a lot of functional but we'd not really seen each other, not really had any time with each other meaningfully, in a long time. M9*

Theme 4 - Magnification of the strain of being a new parent was reported due to the additional physical demands that came from dealing with birth trauma (M2, M6, M8, M9, W2, W3).

*With the first child it was relatively fine so she stayed in hospital for a week and then brought her home and we managed...the second [traumatic] one because essentially I'm looking after 3 people it was just impossible. M2*

In addition, dealing with the emotional impact of birth trauma also added to the strain of being new parents.

*Initially afterwards things were really really bad, it had a huge devastating impact on our relationship. It was obviously trying to learn to be new parents, whilst also dealing with, the fact that, I mean I didn't cope well at all afterwards understandably I completely shut down...it made our first few months of being parents really really difficult. W3*

Theme 5 - Fear of Relationship Breakdown was reported due to high levels of emotions and distress in the relationship (M6, M7, W1, W2, W3).

*I remember thinking that my marriage was falling apart because I just constantly felt p\*\*\*ed off with him for everything....saying things like "I can't stand you, like I'm going to leave you." W1*

Theme 6 - Different viewpoints of the birth experience was reported as creating difficulties between some partners. Typically, one partner having a non-traumatic view of the birth, which meant they were unable to recognise or empathise with the distress of the traumatised partner (M1, M4, W1, W2, W3, W4, W6, W7, W8, W9).

*I couldn't contextualise it myself because I didn't really get what it was and then obviously a year and a half, 2 years later when she says "oh, I'm thinking its birth trauma", then I looked back on those events and thought oh well, f\*\*king obviously now that makes perfect sense, no wonder you were having a hard time. M1*

Theme 7 - Unable to emotionally support own partner regarding the birth trauma due to own personal level of distress was reported as a negative effect on the couple relationship (M6, M8, W1, W2, W3).

*She would get particularly upset at me not talking to her about it and she would insist that she could handle it, but then a few times when I did sort of try, I could see how much it was upsetting her....so I just never really felt comfortable opening up about it when I could see how much of an effect it had on her. M6*

Similarly negative was being unable to support a partner with emotional issues unrelated to the birth trauma due to own birth trauma distress.

*There was a death of, a family friend of my husband's and he was so distraught about it and he was crying...I've literally never seen him crying and I sort of just stood there and I was like "Oh, that's sad" and then I just walked off, and it just felt like that is just not me...I was just in my own like bubble unable to empathise with him, it was really bizarre. W1*

Theme 8 - Men being focused on providing practical support was described as negative for the couple relationship as it led to a lack of communication and emotional support between partners (M3, M4, M6, M7, M8, M9, W2, W3, W4, W7).

*Again, he sympathised but because he doesn't, he just had a you know, quite a different approach to things he's very good for the sort of on the ground support and you know, doing things, task-based things but then I guess the emotional side he's just not...I do feel the burden on myself to process this further. W7*

Themes 9 to 13 describe positive impacts of birth trauma on the couple relationship or potential ways in which the impact of birth trauma could be curtailed.

Theme 9 – Strengthened relationship was reported by some participants due to the process of going through the traumatic birth together. Likewise, working through the impact of birth trauma together was also reported as a process that strengthened the relationship (M1, M3, M5, M7, W2, W3, W4, W6, W9).

*I think it's definitely strengthened our relationship...in ways I didn't expect, and I think we are definitely a lot closer just purely from kind of, from the birth element but also kind of it didn't go to plan and it wasn't what either of us wanted but it really did happen to us together. M3*

Likewise, working through the impact of the birth trauma together was also reported as a process that strengthened the relationship.

*I would say, initially sort of, it felt like we've been gone through something horrific together...now that more recently I sort of worked through the therapy and talked, talked to him so much more about different things and opened up a bit I would say were stronger, were stronger for it... for you know what has been the bumps along the way. W4*

Theme 10 – Prior strength of the relationship was protective for some participants. A strong foundation being reported as the reason for withstanding the impact of birth trauma on the couple relationship (M1, M7, W1, W3, W5).

*It's taken us a long time but like now we can talk about it...we are very fortunate that we have a very incredibly strong relationship and we've always been really good at communicating, so thankfully having that foundation I think saved us, because we were able to, eventually as we both started to come to terms with things individually we were able to break through that and start actually having conversation and share our grief. W3*

Theme 11 - Importance of effective communication between partners was reported as key to enabling mutual support regarding birth trauma (M4, M7, W3, W5, W9).

*[struggling with addiction] sort of made me bring up the way I was feeling about the PTSD and the traumatic birth, and then since then we have spoken about it quite a lot this year, because we made a pact on that day that we would be more open and talk about how we're feeling more... I do think talking more is making it better. M4*

Theme 12 - Willingness to listen and understand was highlighted as a positive element of recovery for some women; feeling that their partner really listened and understood their distress (W1, W3, W4, W5, W9).

*So I decided to write everything down because I thought it could be quite like therapeutic, and then I asked him if he could read it...and since that day, I feel like now he actually understands what happened, and I would say it's only since...I wrote that, because he read it, that our relationship feels normal now, like it used to be before I gave birth. W1*

Theme 13 - Agreeing a plan for subsequent birth to limit anxiety and risk of further trauma was reported as positive emotional support (M1, M2, M3, M7, M8, W1, W2, W3, W4, W5, W8, W9).

*We've already decided...I would just have a planned caesarean next time so it will be a completely different experience...I just wouldn't want either of us to have to go through [labour], because every little thing would be a reminder and I just don't think going in already concerned and anxious and scared is conducive to having a great experience. W3*

Which for some participants meant deciding not to have more children.

*The whole process of birth you know has basically made both of us go yeah we don't to risk going through any of that ever again and you know, the reason why [baby] got stuck, the one thing we do know is that if we want to have another child again it would have to be a caesarean...were like no we don't want to risk going through all of that again at all. M8*

Themes 14 to 19 detail parents' experiences of negative aspects pertaining to current birth trauma support.

Theme 14 - Unavailability of help from friends and family added to the difficulties some parents had coping with birth trauma on a practical level (M2, M4, M6, M9, W2, W6, W7).

*Some of the grandparents did come and look after [sibling] whilst we were in the hospital and that was helpful but then essentially the moment that birth happened, they vanished off again. I mean I think some of that was out of a desire not to be in the way, but it would have been helpful to have somebody there. M2*

Unavailability of help from friends and family was also perceived on an emotional level.

*I have noticed that I probably, withdrawn is a strong word, but I probably have pulled back from talking to my mom about it, because she does that, she's very "let's think positive". W6*

Theme 15 - Unhelpful birth debrief services. All 9 of the women participants engaged in some form of birth debrief service and 3 of the men accompanied their partner to such a service. Feedback on debriefing was on balance negative and reported as unhelpful for dealing with the trauma (M3, M6, W1, W2, W4, W5, W6, W7, W8, W9).

*I've had a session with the senior midwife at the hospital, one of those debrief things and it, I, I found that it didn't really help at all and so I still struggle with that. W7*

Indeed, some participants reported that attending a debrief service added to their distress.

*I had a birth debrief and she kind of said "we don't tell you the risks because if we tell the risks it will scare you", and I just thought that's not how it should be and that, the birth debrief I think set me even further back, because of her attitude, like we don't tell you the risks, and I kept saying "but I didn't make an informed choice", and she was like "well we don't tell you", and it was just like a viscous circle. W9*

Theme 16 - No personal awareness of birth trauma delayed acknowledgment of the traumatic birth experience and its impact for some participants (M1, M4, M8, M9, W1, W3, W4, W5).

*Firstly, I didn't even know that birth trauma was even a thing because I had honestly never heard of it, and then I began to realise that other people had been through like similarly horrifying things...in hindsight all the [PTSD] symptoms were really obvious. W1*

Likewise, lack of awareness of birth trauma was a barrier to gaining support. *I had never considered birth trauma, I'd never consider that it could be an event in the same way that a car crash could be an event you know...people don't really talk about birth as a potentially traumatic event or a potentially uncontrollable event...and knowing that might have given [partner] or my myself an edge earlier after birth to go maybe this [difficulty] is because of all of that. M1*

Theme 17 - Absence of trauma validation from healthcare professionals in acknowledging the experience of the traumatic birth added to parental distress (W2, W3, W5, W7, W8, W9).

*I was congratulated on having had a vaginal delivery...I think both me and my husband basically felt I'd been raped, and I'd nearly died...you should not be congratulating women who feel they have just been tortured by the gestapo you know, it's not ok. W5*

Similarly, lack of understanding from healthcare professionals about the ongoing impact of birth trauma was also perceived as unhelpful.

*I just wanted to be at home and then it kind of continued the trauma being at home, like a midwife came to see us and I couldn't breastfeed him, and she said "you can breastfeed him and you will breastfeed him"...I said to her "I've had a really traumatic birth I think he's really traumatised", he was*

*quite jaundiced as well, and she was like “you need to get over that now it’s done, you need to focus on feeding your baby”. W9*

Theme 18 - Lack of awareness of the emotional needs of men from friends and family, employers, and healthcare professionals resulted in a lack of support (M2, M3, M4, M6, M7, M8, M9, W2, W3).

*You know I talk about my experience of the birth trauma a lot...and there is, there was nothing for him there has been nothing for him... I have really encouraged [partner] to speak to someone to try and get some kind of structured supportive talking space. He called his employee assistance programme and spoke to them about it, and they basically said to him he should take vitamin D and get better sleep, yeah so that wasn't very helpful.*

*W2*

As well as a sense of needing to cope with birth trauma alone.

*It was just me working through it...I don't feel like anyone ever asked me how I was doing really...so again I resented that a little bit because I was feeling so awful and I'd spend a lot of time in the car by myself and I'd be thinking “why does no one care, why is no one asking me how I'm feeling?” ...everyone just expect you to be happy when you have a baby. M4*

Theme 19 - Barriers to accessing psychological services were reported.

Barriers included own doubts about being worthy of receiving NHS resources and lack of availability of specialist services (M3, M4, M6, W1 W2, W3, W4, W5, W6, W7, W8).

*So, we spoke to a consultant midwife, who diagnosed me with PTSD...she offered me some [counselling]...but because we weren't based in [city], the people that she recommended I wasn't eligible to speak to, so then it was a*

*case of okay well I've now got to go away and find someone to speak to and I never did that. M4*

Participants also reported difficulty finding the right therapist to meet their needs and complex referral processes as barriers to gaining support.

*I tried to reach out to a charity, initially got in touch with them and they sent me a form to fill in. I filled in the form then they sent me another form and I just couldn't face filling in yet another form, so I didn't end up getting any further with that. W4*

Themes 20 to 27 report positive aspects of the birth trauma support parents experienced, or their perspectives on how birth trauma support could be improved.

Theme 20 - Connecting with peers being valuable for gaining acknowledgement of current distress and removing the sense of being alone (M1, M7, M8, W3, W4, W5, W6, W7, W8, W9).

*I found it really helpful reading other people's stories, peoples experiences...[partner] likes listening to podcasts...he tells me snippets of other men's experiences of mental health, and he says I can relate to it like that, so I think he finds that helpful. W9*

Theme 21 – Psychological services to support the couple relationship were reported as being required to enable partners to work through the birth trauma and impact together (M3, M4, M6, M7, M8, W1, W2, W3, W8).

*I think honestly dealing with us as a couple would have been better for us than individual therapies, which is not to say they weren't helpful for her but a lot of the stress that it put on our relationship could have been avoided if we were able to speak to somebody together rather than everything being done separately. M6*

In addition, the need for provision of services that tackle specific relationship functioning issues such as sexual health.

*We both need individual counselling, and we need couples counselling...you know also that includes a look at the physical intimacy. W2*

Theme 22 - Supporting parents to understand the traumatic events was reported as being important for overcoming birth trauma. Participants appeared to value having opportunities to ask questions about what happened, why, and to explore any future ramifications (M2, M3, M4, M5, M6, M7, M8, W2, W5, W7, W8).

*So we were fortunate in that sense that he [the obstetrician] went through it with both [partner] and I and answer questions that we had, appreciated that it had been really really difficult and scary for both, and then at my 6 week appointment he did the same thing again he had all the notes and offered to go through it again...he even said like, he'd do it, if a year after his born if you still have questions he said you can ring me and I will talk you through. W3*

Theme 23 - Facilitating parental feedback of maternity services was reported as positive. Enabling participants to feel that their negative experience and concerns were acknowledged and that services would develop accordingly (M3, M5, M6, W1, W4, W5).

*There's some feedback mechanisms as well but maybe make them more accessible to people so they can feedback on their experiences...I'd like people's outcomes both clinically and emotionally to be better than ours and I think you know the [hospital] probably need to take that on board. M3*

Theme 24 - Birth trauma informed antenatal preparation was reported by participants to be an area of potential improvement in parent support. To build parental awareness of the realities of childbirth and coping strategies for preventing or managing difficult experiences (M1, M8, M9, W4, W5, W6, W8).

*My expectations for [antenatal classes] was all about honestly but...I went to the birth being so under prepared for the reality of what can happen, and it was hugely detrimental and I think we do women a massive dis-service. W8*

In addition, the need for preparation that raises awareness of birth trauma, how to recognise it, and gain support to curtail the impact.

*I did an [antenatal] course before the birth I wish that within that was sort of birth trauma sort of symptoms and PTSD symptoms to look out for... I think if we'd known but before that might have been helpful. W4*

Theme 25 - Proactive early signposting of support that is appropriate and accessible for both parents was reported as potentially being beneficial (M1, M4, M7, M8, W3, W5, W7).

*I know about a charity called Dad Matters, and if I had known about them sooner that would have been helpful... I don't think I was capable of a, being aware that I needed support and b, being able to navigate, and find that support and this is the problem. M8*

Theme 26 - Improving access to specialist psychological services was stated as being a potential enhancement to birth trauma support. Services which are available to both parents in a straightforward, timely, and affordable way (M3, M4, M6, W1, W2, W3, W4, W5, W6, W7, W8).

*I think I would definitely benefit from speaking to someone about it in detail, I think even just a couple of hours on a couple of separate occasions to just*

*talk it through with someone who maybe had a bit of experience, who was a professional counsellor would have been great or would be great in the future. M3*

It is notable that six participants mentioned that they or their partner had accessed NHS therapeutic services yet 11 said that they or their partner had accessed private services.

*I think another thing that might be worth noting for you know anyone looking at couples' needs is the financial burden. There is a financial burden of seeking private care, you know it's putting quite a financial burden on us each month... and affects things like we can't do childcare, it effects savings all that kind of stuff. W2*

Theme 27 - Compassionate parent-centred maternity services were reported as being required to support both parents to have a positive experience of birth (M2, M3, M5, M7, M9, W1, W2, W3, W4, W5, W6, W7, W8, W9).

*I mean really, I don't think it had to happen, and I would have liked it not to have happened and that was where the systematic change campaigning comes in because I think a lot of women are having a really traumatic time giving birth and...I don't think it's necessary and I don't think it's acceptable and I think there are things that could be done differently. W5*

The need for such compassionate parent-centred maternity services also extended to the postnatal period in providing physical and emotional support for those experiencing birth as traumatic.

*In terms of support...afterwards it's been really bad, we literally had nothing...not once did the midwife say [to my partner] "how are you feeling?, how is your mental well-being?, is there anything we can do about*

*that?” and I think that really put her off reaching out for the support from the NHS. M7*

## **6.5 Discussion**

The present article reported the findings of a study exploring the impact of birth trauma on the couple relationship and related support requirements. Twenty-seven themes were reported which are summarised in Figure 6.1 and report both positive and negative aspects.

The present study supports previous findings that birth trauma can cause distress (Campbell & Renshaw, 2018) and strain in relationships (Delicate, Ayers, Easter & McMullen, 2018). As well as impacting upon relationship functioning such as reduced sexual relations (Elmir et al., 2010) and increased negative communication (Kendall-Tackett, 2014). Becoming a parent can be stressful due to adjusting to life with a baby and changing relationships (Ayers et al., 2019). The present study finding that birth trauma can magnify new parent strain is consistent with prior research suggesting that birth trauma can make parenting overwhelming for mothers (Molloy et al., 2021) and fathers (Elmir & Schmied, 2022).

Conversely, findings further suggest that birth trauma can lead some to report their relationship as stronger or strengthened (Kendall-Tackett, 2014; Nicholls & Ayers, 2007). In line with literature on the general TTP, the strength of the relationship pre-childbirth (Lawrence et al., 2008) appears to be a factor in managing impact on the couple relationship. As a key characteristic of strong relationships (Wiley, 2007) effective communication also appears to be helpful in mitigating the impact of birth trauma on the couple relationship.

Findings indicate that birth trauma support could be enhanced through provision of psychological services aimed at supporting the couple relationship.

Broader PTSD literature indicates couple focused counselling can reduce trauma symptoms and improve relationship satisfaction (Greenman & Johnson, 2012; Monson et al., 2015). However, research is needed to identify effective couple relationship interventions related to birth trauma. Furthermore, as found in other areas of perinatal mental health (Darwin et al., 2017; McLeish & Redshaw, 2017), findings illustrate how connecting with peers can be valuable in birth trauma support. The importance of support from family and friend in the TTP is well documented (Deave et al., 2008; Halle et al., 2008); with the unavailability of help from family and friends being reported as difficult in the present study.

Understanding trauma and its effects was found to be important for overcoming the impact of birth trauma. Supporting prior findings of the importance of talking about and seeking information on the traumatic birth (Shorey & Wong, 2020). Some women reported their partner's willingness to listen, and understand their distress, was pivotal in limiting the impact of birth trauma on their relationship. Aligning with prior birth trauma work that reported apathy (Taghizadeh et al., 2013) and lack of understanding (Ayers, Eagle & Waring, 2006) between partners having a negative impact on the relationship.

Findings substantiate birth trauma debriefing being commonplace (Ayers, Claypool & Eagle, 2006) and something women utilise (Baxter, 2019). Lack of understanding about what happened during the traumatic birth appears to magnify distress and be the motivation for attending debriefing activities. However, as previously found, the effectiveness of debriefing for helping deal with the impact of birth trauma appears variable (Bastos et al., 2015; Meades et al., 2011). The present study provides further evidence for the development of safe and effective opportunities for couples to explore and understand a traumatic birth experience

(Baxter, 2019; Daniels et al., 2020). Equally, the present study illustrates parents want the process of understanding birth trauma to be two-way, and for mechanisms to be in place to facilitate feedback of their experiences to improve service quality.

In agreement with prior research, parents indicate that they wished they had been more prepared for childbirth (Etheridge & Slade, 2017; Watson et al., 2020). The present study reporting that effective antenatal preparation could help prevent birth trauma through representing the realities of childbirth (Hollander et al., 2017) and development of strategies for informed decision making, keeping a sense of control (Watson et al., 2020), and self-efficacy (İsbir et al., 2016). Antenatal preparation could also provide secondary prevention through enabling parental awareness of birth trauma symptoms, and knowledge of support resources (Delicate et al., 2020b).

Consistent with previous research, findings highlight how important emotional support can be for those affected by birth trauma (Fenwick et al., 2013; White, 2007). Negative impacts on the couple relationship included being unable to support each other emotionally due to their own distress (Allen, 1998; Ayers, Eagle & Waring, 2006). Findings suggest that positive emotional support could come from a couple agreeing a plan for future birth that limits anxiety and risk of further trauma (Greenfield et al., 2019), which for some means deciding not to have more children (Allen, 1998; Beck, 2004b).

In the present study parents, particularly men, encountered barriers in accessing individual psychological services. Barriers were apparent at the parent level, such as lack of awareness of birth trauma, and at an organisational level such as inadequate supply of support resources (Smith et al., 2019). A pertinent issue being that most participants in the study had accessed privately sourced and funded

support. As well as a financial burden, private services could also be problematic due to lack of regulation and validation of some providers. The present study further illustrating the need to improve access to evidence-based (Ayers, 2004), specialist psychological services for birth trauma (Delicate et al., 2020b).

As previously reported, the present study highlights a lack of awareness of the emotional needs of men following childbirth (Baldwin et al., 2018; Daniels et al., 2020). Which for some men leads to distress being undisclosed (Elmir & Schmied, 2022) and coping alone with limited support (Etheridge & Slade, 2017). Furthermore, the study presented a theme that some men focused on providing practical help at home to the detriment of emotional support in the relationship. These findings suggest that a dyadic approach to emotional support is required for birth trauma; both within the relationship and from external sources.

Similarly, findings suggest the need to develop compassionate parent-centred maternity services. Such services could enable birth trauma prevention. Primary prevention could come from providing safe and supportive care which meets the needs of both parents. Enabling couples to experience childbirth and the early postnatal period together in a positive way (Elmir & Schmied, 2016; Hollander et al., 2017). Then secondary prevention through provision of individualised postnatal support (McLeish et al., 2020) and proactive signposting to specialist services (Noonan & Galvin et al., 2017; Viveiros & Darling, 2019).

The present study provides insight into the impact of birth trauma on heterosexual, highly educated people in married relationships in England. The study adds to the literature by providing understanding of how some couples effectively navigate the impact of birth trauma to report a strengthened relationship.

Furthermore, robust data collection and analysis provided parent perspectives on the

efficacy of current birth trauma services, including valuable insight into potential improvements. Whilst the homogeneous sample enabled conclusions about that cohort, it is acknowledged that the impact of birth trauma and resulting need for support may be quite different for groups with diverse needs such as those from ethnic minority or poor socio-economic groups. Future research is required to gain detailed understanding of the birth trauma phenomena in more diverse samples.

In addition, based on the findings of the present study, research is required to develop guidelines for compassionate, trauma-informed maternity services that support the needs of all parents. Research is also required to identify or develop evidence-based birth trauma interventions that support the individual, and the couple relationship.

Implications for practice from the present study are based on healthcare practitioners providing good quality emotional care to parents. Antenatally enabling realistic childbirth preparation that generates awareness of birth trauma and understanding of supportive relationship traits. In the postnatal period providing care that adapts to personal circumstances such as the impact of birth trauma on parenting and availability of support from family and friends. Furthermore, practitioners may need to assist parents in understanding their trauma, in giving feedback on their experience, and in gaining appropriate support.

## **6.6 Conclusions**

Birth trauma can have an impact on the couple relationship which can be negative and distressing, but for some lead to a strengthened relationship. The present study provided magnifying and mitigating factors for the negative impact of birth trauma on the couple relationship. These factors are pertinent for perinatal

services and practitioners to consider when preparing parents and supporting them in the TTP.

The birth trauma support women and men currently access is appraised as having varying degrees of success. Study findings suggest potential improvements to birth trauma support for couples could be effective antenatal preparation, trauma-informed parent-centred care, evidence-based services that facilitate trauma understanding, and enhanced availability of psychological services for an individual and the couple relationship. Proactive early signposting to support for birth trauma, including enabling connections with peers, was also highlighted as beneficial.

## **7 Overall Discussion**

This chapter provides an overview of thesis findings and examines how they relate to prior research. Firstly, findings on the impact of birth trauma on the couple relationship are discussed, followed by consideration of associated requirements for birth trauma support. This chapter also summaries the strengths and weaknesses of this thesis before outlining the implications of thesis findings on research and practice.

### **7.1 Summary of Thesis Findings**

After outlining the background literature in Chapter 1 this thesis presented distinct yet connected articles investigating the impact of birth trauma on the couple relationship and associated requirements for birth trauma support. Table 7.1 provides a summary of the key findings from each study presented in this thesis.

Chapter 2 presented a systematic review and meta-synthesis of the impact of childbirth-related PTSD or PTSS on a couple's relationship. As a comparison, Chapter 3, presented a systematic review and meta-synthesis of the impact of becoming parents on the couple relationship. From a survey study with UK healthcare practitioners, Chapter 4 presented healthcare practitioners' assessment and observations of birth trauma in mothers, partners, and the impact on the couple relationship. Further findings from the survey study are detailed in Chapter 5 which presented healthcare practitioners' views of the support women, partners, and the couple relationship require for birth trauma. Finally, from an interview study with parents, Chapter 6 presented findings on parent perspectives of the impact

of birth trauma on the couple relationship and associated requirements for birth trauma support.

The study presented in Chapter 6 was conducted during the COVID-19 pandemic. As such some participants experience of birth trauma took place during exceptional circumstances. The pandemic led to changes in healthcare services such as restrictions to place of birth (Jardine et al., 2020), birthing partner support (Iacobucci, 2020), parental visits to a sick or premature baby, and face-to-face healthcare (McKinnell, 2020). These issues along with the related stresses that the pandemic brought to daily lives contributed to increased parental concerns about their mental health (Saunders & Hogg, 2020), lower parental well-being, and raised anxiety symptoms (Cusinato et al., 2020).

Therefore, the interview topic guide was adapted to acknowledge the ability for the pandemic to influence the lived experience of birth trauma. However, during analysis, the narrative of participants whose birth trauma experience had taken place during the pandemic were not remarkably different to the rest of the sample. Whilst it is acknowledged that pandemic restrictions may have increased rates of birth trauma (Ostacoli et al., 2020), no findings were reported in this thesis relating to COVID-19 and the impact of birth trauma on the couple relationship and associated support.

**Table 7.1** *Summary of Key Thesis Findings*

| <b>Chapter</b>   | <b>Key Findings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Chapter 2</b> | Five themes of perceived impact of birth trauma on the couple relationship were reported. Four negative themes: (1) relationship strain; (2) negative emotions; (3) lack of understanding and support; (4) loss of intimacy; and one positive theme (5) strengthened relationship.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Chapter 3</b> | Six themes of perceived impact of the TTP on the couple relationship were reported. Four themes that illustrated both positive and negative effects: (1) adjustment phase; (2) focus on the baby; (3) communication; and (4) intimacy. One negative theme (5) strain on the relationship; and one positive theme (6) strengthened relationship.                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Chapter 4</b> | <p>Practitioners assessed 50.3% of women and 25.9% of partners for birth trauma.</p> <p>Practitioners observed 34.4% of women and 25.0% of partners to be affected by birth trauma and perceived the couple relationship to be impacted by birth trauma for 29.8% of women and 26.9% of partners.</p> <p>The most observed effects of birth trauma on the couple relationship by practitioners were lack of intimacy, increased negative emotions, lack of understanding, reduced communication, and strain on relationship.</p> <p>Practitioner's perception of the impact of birth trauma on the couple relationship produced four themes: (1) the impact can be profound; (2) parents often cope alone; (3) stigma is a barrier to getting support; and (4) more personalised support for birth trauma is required.</p> |

|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Chapter 5</b> | <p>The support most offered by practitioners to those affected by birth trauma were practitioners listening to parents, referral to birth debriefing, and signposting to self-help.</p> <p>The support perceived by practitioners to be most effective for those affected by birth trauma were referral to birth debriefing, listening to parents, and referral to a mother and baby unit.</p> <p>Practitioners reported the most common barriers to couples accessing birth trauma support were long waiting times for support services, stigma around disclosing problems with couple relationship, and lack of suitable services.</p> <p>Practitioners reported the most common barriers to them providing support to couples were absence of suitable service to refer to, lack of time to spend personally supporting parents, and lack of contact with partners to identify those with birth trauma.</p> <p>Practitioner insight into potential improvements for birth trauma support reported four themes: (1) raising awareness and knowledge of birth trauma; (2) prevention of birth trauma; (3) identifying those in need of support with birth trauma; and (4) need for suitable birth trauma support.</p> |
| <b>Chapter 6</b> | <p>Parent perspectives of the impact of birth trauma on the couple relationship and their related support requirements reported twenty-seven themes indicating positive and negative aspects of the impact of birth trauma on the couple relationship and related support requirements.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

## **7.2 Impact of Birth Trauma on the Couple Relationship**

As outlined in Chapter 1, it is important to understand the impact of birth trauma on the couple relationship because the quality of the relationship between partners is associated with a range of personal outcomes (Reynold et al., 2014). Good quality relationships are associated with higher personal well-being (Proulx et al., 2007), enhanced physical health (Robles et al., 2014), and related health behaviours such as diet and exercise (Kiecott-Glasser & Wilson, 2017). Furthermore, a supportive relationship between parents is associated with greater parent-child involvement (Carlson et al., 2011) which is associated with child development and well-being (Sunderland, 2006). Following parental relationship breakdown children may be at increased risk of their well-being being affected by poverty and poor parenting (Mooney et al., 2009).

The systematic review and meta-synthesis of the perceived impact of childbirth related PTSD or PTSS on the couple relationship reported four negative themes: relationship strain, negative emotions, lack of understanding and support, and loss of intimacy. Plus a fifth positive theme of strengthened relationship. A proposed model of the impact of childbirth-related PTSD or PTSS on the couple relationship (Figure 2.2) was also presented (chapter 2).

However, from the systematic review findings it was not possible to conclude if the perceived impact of birth trauma on the couple relationship was different to the general impact of parenthood on the couple relationship. Therefore, a systematic review and meta-synthesis of the perceived impact of becoming parents on the couple relationship was undertaken (chapter 3). Findings reported four themes that illustrated both positive and negative effects: adjustment phase,

focus on the baby, communication, and intimacy. Plus, one negative theme of strain on the relationship, and one positive theme of strengthened relationship.

Findings from the two systematic reviews were compared to consider if the impact of birth trauma on the couple relationship was different to the impact of becoming parents on the couple relationship. This comparison, which was the subject of an oral conference presentation, concluded that whilst impact themes from the two meta-syntheses were similar, birth trauma had a more negatively perceived impact on a couple relationship compared to the general TTP.

The survey study with UK healthcare practitioners (chapter 4) reported that whilst formal assessment for birth trauma was limited, practitioners perceived the couple relationship to be impacted by birth trauma for over a quarter of parents. Commonly observed effects of birth trauma on the couple relationship were reported as lack of intimacy, increased negative emotions, lack of understanding, reduced communication, and strain on relationship. Analysis of practitioner perceptions of the impact of birth trauma on the couple relationship produced themes of the impact can be profound, and that parents often cope alone.

From the interview study with parents (chapter 6) negative aspects of the impact of birth trauma were reported in themes of: relationship distress, changed relationship functioning; negative communication; magnification of the strain of being a new parent; fear of relationship breakdown; different viewpoints of the birth experiences; unable to emotionally support one's partner; and men being focused on providing practical support. Positive impact of birth trauma on the couple relationship, or potential prevention of impact were reported in themes of: strengthened relationship; prior strength of the relationship was protective;

importance of effective communication; willingness to listen and understand; and agreeing a plan for subsequent birth.

### ***7.2.1 Model of the Impact of Birth Trauma on the Couple Relationship***

The proposed model of the impact of childbirth related PTSD and PTSS (Figure 2.2) from the systematic review and meta-synthesis has been updated considering relevant findings reported in the studies with healthcare practitioners (chapter 4) and parents (chapter 6). The final model of the impact of birth trauma on the couple relationship is presented in Figure 7.1.

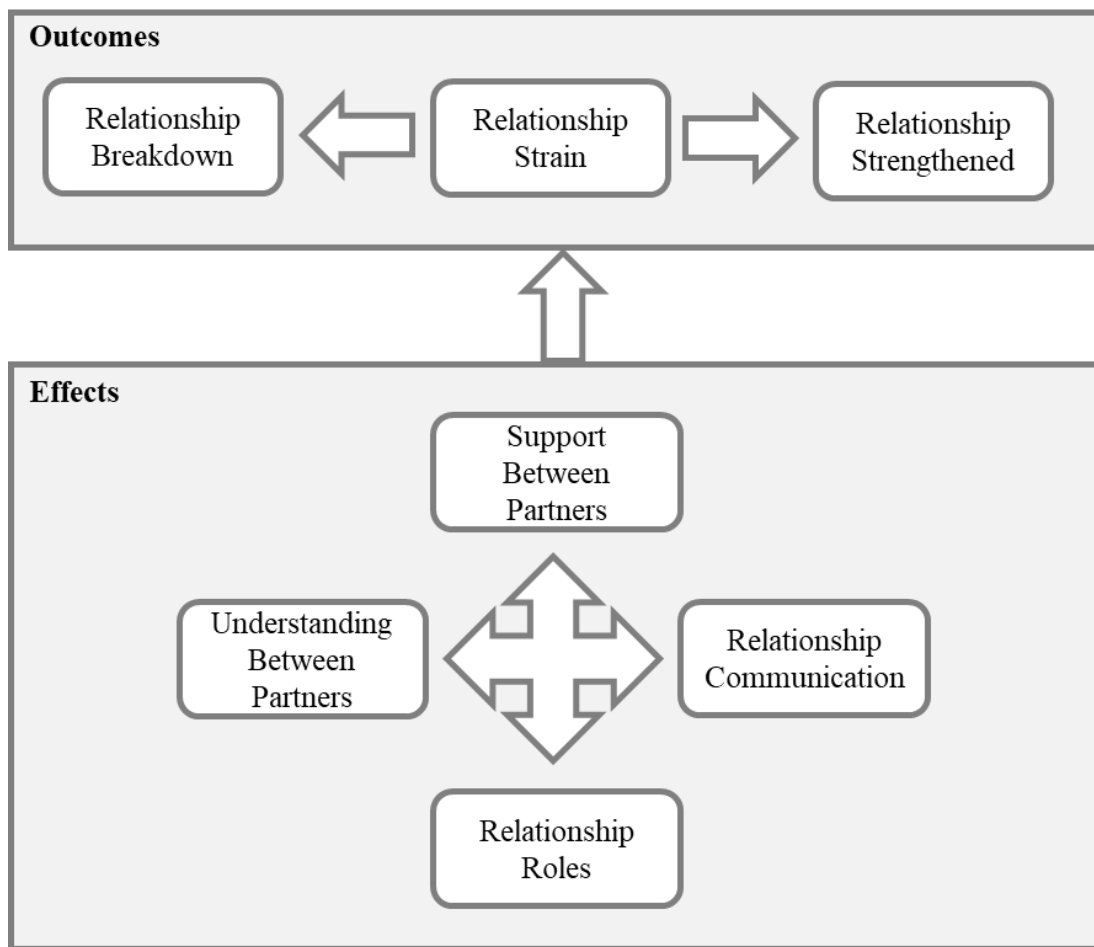
The model depicts that the effects of birth trauma on the couple relationship are reported in the categories of support between partners, understanding between partners, relationship roles, and relationship communication. Figure 7.1 also illustrates how these effects may be connected and how one effect may be related to another. These effects of birth trauma are then leading to the impact of relationship strain, which for some parents can lead them to fear, or experience, relationship breakdown. Conversely, other parents report the process of their relationship being tested by the impact of birth trauma leading to the couple relationship being strengthened.

The proposed model of the impact of birth trauma on the couple relationship has features that are consistent with current theories of PTSD. Ehlers & Clark's (2000) cognitive model of PTSD argues that how an individual appraises and responds to their trauma affects how it is processed and whether there is resolution or maintenance of PTSD symptoms. Support, understanding, and communication between partners may play a role in reducing negative appraisals of trauma and its effects, thus reducing the sense of current threat, and supporting recovery from trauma.

The strength of the couple relationship and effect on relationship roles highlighted in the model are consistent with social ecology theories of PTSD. Charuvastra and Cloitre's (2008) social bonds theory proposes that safe and reliable interpersonal connections are needed to help regulate emotions and support the effective processing of traumatic events. Furthermore, the couple adaption to traumatic stress model (Goff et al., 2005) suggests couples' functioning such as attachment, intimacy, communication, and conflict are associated with exacerbation or resolution of trauma within a dyad.

More specifically for birth trauma, a diathesis-stress model of the aetiology of birth-related PTSD (Ayers et al., 2016), indicates how trauma appraisal and related behaviours can be affected by factors such as coping strategies and support. The positive dyadic coping reported in this thesis such as, effective communication and willingness to understand, may enable an individual to overcome their experience of traumatic childbirth and prevent an ongoing trauma response and associated impacts.

**Figure 7.1** *Model of the Impact of Birth Trauma on the Couple Relationship*



#### **7.2.1.1 Relationship communication.**

From thesis findings (chapters 2, 4 & 6) birth trauma appears to have an impact on communication within the couple relationship. This can result in reduced communication for which there is no prior supporting evidence, and negative communication such as blame, anger, and conflict which has been previously reported (Beck, 2015; Elmir & Schmied, 2016).

However, this relationship communication effect needs to be considered cautiously as it may not be novel to the experience of birth trauma. Increased negative communication also being reported as a theme in the impact of the general TTP on the couple relationship (O'Reilly Treter et al., 2020). Likewise,

disagreements are not always perceived as negative as they are considered a normal part of the development of partners becoming parents (Ahlborg & Strandmark, 2001). Furthermore, effective communication has been reported as a positive attribute of strong romantic relationships (Wiley, 2007), and efficacious TTP for the couple relationship (Premberg et al., 2008).

However, where the importance of relationship communication may be unique to the impact of birth trauma on the couple relationship, could be how communication interacts with other reported relationship effects. General trauma literature indicating that communication is associated with support, understanding (Henry et al., 2011), and relationship functioning (Campbell & Renshaw, 2018). Furthermore, as seen in prior work (Goff et al., 2006) and discussed in section 7.3, for some, communication is an important aspect of effective couple relationship support following trauma.

#### **7.2.1.1 Understanding between partners.**

Whilst the importance of understanding between partners had been reported in general trauma literature (Donnellan et al., 2014; Goff et al., 2006) this thesis provides a unique perspective on this issue in trauma related to childbirth. In agreement with limited prior research all relevant studies in this thesis (chapters 2, 5 & 6) reported lack of understanding between partners to be a potential impact of birth trauma on the couple relationship (Elmir et al., 2010). This effect being reported as negative, for example a partner not understanding the distress of their significant other (Coates et al., 2014). Women and men can have different perspectives on childbirth and ways of processing a traumatic experience (Nystedt & Hildingsson, 2018). This thesis highlighting that partners having different viewpoints

of the birth experience can lead to a lack of empathy and ability to support one another (Elmir et al., 2010).

Conversely, understanding between partners was also reported as positive. Feeling understood by their partner could enable an individual to overcome distress related to the trauma and protect the couple relationship from negative impact. Furthermore, another potential positive aspect of understanding between partners was highlighted as agreeing a plan for subsequent birth (Greenfield et al., 2019), which for some meant agreement not to have more children (Beck, 2004b).

The impact of lack of understanding of birth trauma between partners, and conversely the potential protective effect of there being understanding, supports the need for more inclusivity of partners in perinatal services (Baldwin et al., 2018; Darwin et al., 2017), including preparation for subsequent pregnancy and birth (Beck & Watson, 2010), so that the couple can experience the journey together and aid understanding.

#### **7.2.1.2 Support between partners.**

Whilst prior research has highlighted that emotional support following traumatic birth is important for women (Fenwick et al., 2013) and men (Elmir & Schmied, 2016), this thesis provides new insight into the need for emotional support between partners. Healthcare practitioners reported (chapter 4) that parents are often coping alone with birth trauma, supporting prior findings of a general lack of birth trauma support (Bayrampour et al., 2018; Thomson & Garrett, 2019). As seen in general perinatal mental health literature (Ruffell et al., 2019) limited external support for birth trauma would imply that parents rely on their own partner for support.

This is problematic as thesis findings on the impact of birth trauma on the couple relationship show a lack of support between couples (chapter 2). This may be due to one partner being unable to support the other due to their own distress, and men being focused on providing practical support which undermines emotional support (chapter 6). If partners are unable to support each other, this is challenging for individual well-being and the couple relationship, providing further impetus for effective external birth trauma support.

#### **7.2.1.3 Relationship roles.**

Intimacy plays an important role in most couple relationships and the reduced intimacy reported in this thesis has been widely described in the literature on the impact of the TTP on the couple relationship (Faircloth, 2015; MacAdam, 2011; Olsson et al., 2010; Williamson et al., 2008), and the impact of birth trauma on the couple relationship (Elmir & Schmied, 2016; Olde et al., 2016; Taghizadeh et al., 2013; White, 2007).

The study with parents (chapter 5) provided further insight into how birth trauma can affect relationship roles (Ayers, Eagle & Waring, 2006), which can impact on the couple relationship. Relationship roles such as who is the strong, pragmatic, or practical partner in the partnership may change due to an individual's birth trauma related distress, or the negative effect of birth trauma on the couple relationship. Whilst this thesis provides limited findings to support relationship role changes having an impact on the couple relationship, this is observed in the general trauma literature (Donnellan et al., 2014; Mills & Turnbull, 2004).

#### **7.2.1.4 Relationship strain.**

It is important to highlight that quantitative research on the impact of birth trauma on the couple relationship, whilst limited to three published studies, reported no impact. Concluding that there is no association between postnatal PTSS and changes to the couple relationship (Ayers et al., 2007), or that postnatal PTSS was related to symptoms of depression which were associated with poorer relationship satisfaction (Garthus-Niegel, Horsch & Handtke et al., 2018; Parfitt & Ayers, 2009).

However, all thesis findings on the impact of birth trauma on the couple relationship (chapters 2, 4 and 6) support prior qualitative research that birth trauma can cause relationship strain (Beck, 2015), distress (Campbell and Renshaw, 2018), and have a profound negative effect on the relationship (Fenech & Thomson, 2014; Inglis et al., 2016). The general trauma literature reporting trauma symptoms to be related to marital satisfaction (Weinberg et al., 2017) and perceived negative relationship effects (Goff et al., 2006).

Furthermore, findings from the study with parents (chapter 6) reported that the relationship can be tested due to birth trauma magnifying new parenting strain. This finding reinforcing prior work that birth trauma can make parenting overwhelming for mothers (Molloy et al., 2021) and fathers (Elmir & Schmied, 2022). This is an important reminder that the impact of birth trauma cannot be looked at in isolation from an individual, or even a couple perspective as birth trauma can affect the whole family (Horesh et al., 2021; Darwin et al., 2021).

#### **7.2.1.5 Relationship breakdown.**

Whilst there is less evidence in this thesis for the impact of birth trauma on the couple relationship leading to relationship breakdown it is still notable.

Findings from the systematic review of the impact of childbirth related PTSD or PTSS on the couple relationship (chapter 2) supported earlier research that actual breakdown of relationships has been attributed to the impact of birth trauma (Beck 2015; Joseph 2011). The study with parents (chapter 6) added further evidence for the potential for relationship breakdown, as it reported a theme of fear of relationship breakdown due to the level of distress experienced from the impact of birth trauma.

Whilst probably a rare result, the breakdown of a couple relationship is an important issue as it can result in negative outcomes for individuals (Reynolds et al., 2014) and their children (Coleman & Glenn, 2010). Even when the relationship does not end, concern around the stability of a partnership and fear of breakdown can affect family well-being (Marjoribanks et al., 2016a). Thus, providing further impetus for prevention of birth trauma and impact on the couple relationship.

#### **7.2.1.6 Relationship strengthened.**

Supporting prior work (Engström & Lindberg, 2012; Hinton et al., 2015) thesis findings (chapters 3 & 6) reported that for some, the experience of the impact of birth trauma on the couple relationship resulted in the relationship being strengthened. Until now, little was known about how the experience of birth trauma could result in the couple relationship being strengthened although it was surmised it might be due to post-traumatic growth (Beck & Watson, 2016; Joseph, 2011).

Findings from the study with parents (chapter 6) adds to the understanding of how the impact of birth trauma on the relationship can be buffered and lead to a reported strengthening of the partnership. As seen in the general TTP literature, reporting a strong relationship prior to birth provides protection against negative relationship effect (Lawrence et al., 2008). Likewise, thesis findings show that

effective communication (Wiley, 2007) and a willingness to listen and understand between partners (Elmir et al., 2010) could protect from the impact of birth trauma or even enhance the relationship. Understanding the mechanisms of how the experience of trauma can strengthen a relationship is important, as it can provide insight into how to protect a relationship from impact when birth trauma is experienced.

### **7.3 Birth Trauma Support Requirements**

Due to the reported impact of birth trauma on the couple relationship the empirical studies of this thesis also investigated the associated requirements for birth trauma support. Thesis findings support prior research that healthcare practitioners and parents indicate women and men want birth trauma support (Ayers, Eagle & Waring, 2006; Watson et al., 2020). Findings discussed in section 7.2, highlight that such support needs are multifaceted. Initially thinking about support to buffer or overcome any negative impact of birth trauma on the couple relationship. Equally, understanding what role support has in the experience of birth trauma resulting in a strengthened couple relationship.

Practitioner perceptions of birth trauma support (chapter 5) showed that the support they most commonly gave parents was personally listening to parents, referral to birth debriefing, and signposting to self-help. However, practitioners reported that they felt the most effective birth trauma support as firstly referral to birth debriefing, then personally listening to parents, and thirdly referral to a mother and baby unit. Common barriers to parents accessing birth trauma support were highlighted as long waiting times for support services, stigma around disclosing problems with the couple relationship, and lack of suitable services. Likewise, common barriers to practitioners providing support to parents were

absence of suitable services to refer parents to, lack of time to spend personally supporting parents, and lack of contact with partners to identify those with birth trauma. Practitioners gave insight into potential improvements for birth trauma support which reported four themes: (1) raising awareness and knowledge of birth trauma; (2) prevention of birth trauma; (3) identifying those in need of support with birth trauma; and (4) need for suitable birth trauma support. These themes were depicted in Figure 5.1 proposing how the themes may interact over the perinatal period.

Parent perspectives (chapter 6) of the impact of birth trauma on the couple relationship and their related support requirements reported themes indicating positive and negative aspects of birth trauma support. Negative aspects of birth trauma support were reported in themes of: unavailability of help from friends and family; unhelpful birth debriefing services; no personal awareness of birth trauma; absence of trauma validation from health care professionals; lack of awareness of the emotional needs of men; and barriers to accessing psychological services. Positive aspects of birth trauma support or indication of potential improvements in support were reported in themes of: connecting with peers was valuable; psychological services to support the couple relationship; supporting parents to understand the traumatic events; facilitating parental feedback on maternity services; birth trauma informed antenatal preparation; proactive early signposting of support; improving access to specialist psychological services; and compassionate parent centred maternity services.

### ***7.3.1 Model of the Birth Trauma Support required for the Couple Relationship***

Findings regarding birth trauma support were considered together and drafted into a model of the birth trauma support required by the couple relationship (Figure 7.2). The model illustrates how the provision of parent-centred, trauma-informed perinatal services could initially provide primary prevention of birth trauma as they could prevent childbirth from being experienced as traumatic. Whilst there is limited evidence in this thesis relating to primary prevention of birth trauma it is addressed in wider literature that experiencing birth as traumatic can be preventable (Hollander et al., 2017; Simkin, 2011; Vesel & Nickash, 2015).

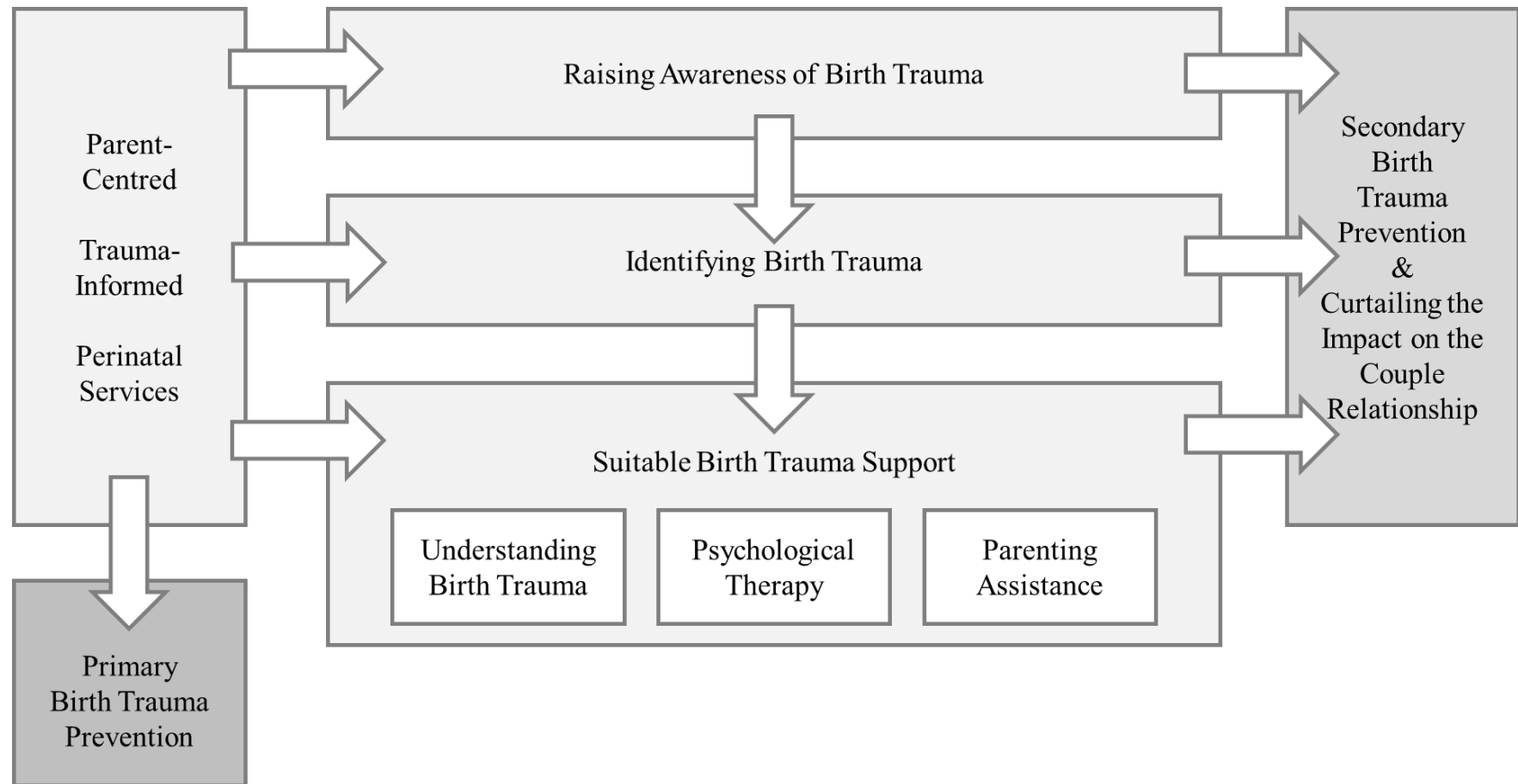
When childbirth has been experienced as traumatic, secondary prevention of ongoing distress and related impact on the couple relationship could come from parent-centred, trauma-informed perinatal services that raise awareness of birth trauma, effectively identify those affected by birth trauma, and then refer them to suitable birth trauma support. Such support needs to enable parents to understand the birth trauma, access psychological therapy, and gain parenting assistance.

Current UK clinical guidance indicates offering support to women who have had a traumatic birth and to consider the potential effect on a partner (NICE, 2020). If treatment for PTSD is indicated, trauma-focused CBT or EMDR should be offered, and it is cautioned not to offer single-session psychological interventions with a focus on re-living the trauma (NICE, 2018b). However, there is no clinical guidance on an evidence-based pathway for those who experience sub-clinical PTSD.

Some of the potential improvements to birth trauma support presented in the model (Figure 7.2), align with the key principles for the transformation of the perinatal mental health pathways in the UK. Namely to increase awareness of

perinatal mental health to promote early identification of problems; give women timely access to evidence-based treatment; promote a positive experience of care; and encourage more support for partners and families (NHS, 2018). Furthermore, in the UK, a commitment has been made to develop services that target mental health problems related to the maternity experience, such as birth trauma (NHS, 2019).

**Figure 7.2** *Model of the Birth Trauma Support Required by the Couple Relationship*



### **7.3.1.1 Parent-Centred Trauma-Informed Perinatal Services.**

Thesis Chapters 2, 4, 5 and 6 all indicate that birth trauma can have an impact on the couple relationship. These reported impacts provide further impetus for the prevention of childbirth being experienced as traumatic, or when that is not possible, the secondary prevention of ongoing distress and impact.

There are known risk factors for birth trauma in the antenatal, intrapartum, and postnatal periods which could provide the foundation for trauma-informed services (Ayers et al., 2016; Dekel et al., 2017; Hollander et al., 2017; Simpson et al., 2018). Also widening the focus of perinatal mental health services from depression (Higgins et al., 2018) and severe disorders (Russell et al., 2017), and acknowledging birth trauma and childbirth-related PTSD as a unique disorder with distinct characteristics (Horesh et al., 2021).

Thesis findings (chapter 6) support prior research highlighting a general lack of awareness of the emotional needs of men in the TTP (Baldwin et al., 2018; Rowe et al., 2013) and specifically relating to birth trauma (Daniels et al., 2020). It has been reported that the distress of postnatal men appears to go undisclosed (Elmir & Schmied, 2022) which in turn means men must cope with limited support (Etheridge & Slade, 2017). Similarly, healthcare practitioners (chapter 5) identified that having limited contact with partners was a barrier to identifying birth trauma and offering associated support. Offering parent-centred maternity services would enable the current lack of consideration of the emotional needs of partners to be addressed (Burgess & Goldman, 2018; Nystedt & Hildingsson, 2018).

Findings from healthcare practitioners (chapter 5) and parents (chapter 6) indicate that birth trauma support could be enhanced by considering the needs of the couple relationship. Whilst prior research on dyadic birth trauma support is limited,

wider literature has identified that trauma can affect the whole family (Marshall & Kuijer, 2017), that the mental health of partners following childbirth appears interlinked (Atkinson et al., 2020; Iles et al., 2011), and that there is a need for a dyadic perspective on emotional well-being in early parenthood (Gillis et al., 2019).

### **7.3.1.2 Raising Awareness of Birth Trauma.**

This thesis provides further evidence that, in hindsight, parents (chapter 6) wanted to be better prepared for childbirth (Etheridge & Slade, 2017) and that adequate preparation may have helped prevent a traumatic birth experience (Hollander et al., 2017; Simpson et al., 2018). Furthermore, as reported in the general perinatal mental health literature (Viveiros & Darling, 2019), parents perceive that being made aware of birth trauma symptoms antenatally would have enabled them to identify birth trauma and engage in relevant support in the postnatal period.

Stigma around experiencing mental health problems still exists (NCT, 2017) with parents reporting feeling guilt around experiencing negative emotions at a perceived time of happiness (Smith et al., 2019), and being affected by the birth experience when the societal perception is that a healthy baby is all that should matter (Moore, 2019). As seen in general mental health literature (Henderson et al., 2017; Javed et al., 2021) the barrier of stigma could be overcome by raising awareness of birth trauma and its potential to impact the couple relationship.

It was also reported that there is a need for awareness of birth trauma to be improved in healthcare practitioners (chapter 5) including enhancing knowledge and training which is previously reported (de Vries et al., 2018). Developing healthcare practitioners understanding and empathy towards birth trauma could improve the support of parents, not least through validation of the traumatic birth

experience and its impact. Furthermore, broadening awareness of birth trauma in society may enhance the empathy and support parents encounter from family, friends, peers, and employers.

#### **7.3.1.3 Identifying Birth Trauma.**

Raising awareness of birth trauma in parents and healthcare practitioners could enhance the identification of those requiring birth trauma support. In line with general perinatal mental health research, barriers to healthcare practitioners (chapter 5) identifying birth trauma were reported as lack of time to spend personally supporting parents (Noonan et al., 2018), and lack of contact with partners (Darwin et al., 2021) to identify those with birth trauma.

Thesis findings (chapter 4) support prior evidence that currently there is no universally accepted assessment for birth trauma (Nilvér et al., 2017) and formal assessment is limited (Byrne et al., 2017; Noonan et al., 2018) even though validated measures are available (Ayers et al., 2018; Handelzalts et al., 2018). Healthcare practitioners (chapter 5) highlighting a potential improvement to birth trauma support to come from robust identification of those affected by birth trauma and therefore in need of support.

#### **7.3.1.4 Suitable Birth Trauma Support.**

Research on the effectiveness of interventions specifically for childbirth-related PTSS is growing (Furuta et al., 2018; Shorey et al., 2021; Slade et al., 2021; Williamson et al., 2021). However, thesis findings (chapters 4, 5 & 6) support prior evidence of the need for more effective support (de Graaff et al., 2018; Smith et al., 2019). Support that is specialist and tailored to the individual (Howard & Khalifeh, 2020; NHS, 2018; Lapp et al., 2010), flexible, convenient, and proactively inclusive of partners (Shorey et al., 2021).

The timing of much birth trauma support, and indeed PTSD interventions, can be weeks or months after the traumatic birth. This can leave parents to cope with the intervening distress and perhaps ASD with limited support. Parents (chapter 6) reported that early, proactive signposting of support services was beneficial. The importance of signposting having already been reported in prior perinatal mental health research (Noonan & Galvin et al., 2017; Viveiros & Darling, 2019), as well as the value of being made aware of information and support relating to birth trauma (Thomson & Downe, 2016). Knowing about sources of support early on may also buffer against the risk of parents coping alone with birth trauma or only seeking help once distress is severe (Slade et al., 2016).

On the topic of enhancing suitable birth trauma support the thesis findings add additional understanding by providing insight into how such services could be developed to address the impact of birth trauma on the couple relationship. Namely, facilitating understanding of birth trauma, provision of psychological therapy, and parenting assistance.

**7.3.1.4.1 Understanding Birth Trauma.** Thesis findings (chapters 5 & 6) support that even though there is a lack of evidence-base (Bastos et al., 2015), the use of debriefing services in the UK is common practice (Ayers, Claypool & Eagle, 2006) and something that women want to explore (Baxter, 2019). Healthcare practitioners (chapter 5) rated debriefing as the most effective birth trauma support currently offered to parents. However, in concordance with prior research, attending a debriefing service was not perceived by parents (chapter 6) to be effective for alleviating trauma symptoms (de Graaff et al., 2018; Meades, 2011) or supporting the couple relationship.

Parent perspectives on effective birth trauma support highlight how important it is for parents to gain information on a traumatic birth (Shorey & Wong, 2020), understand, and make sense of the trauma (Slade et al., 2021). The current use of debriefing services may be driven by the absence of other mechanisms to facilitate this understanding. Therefore, enhancements to birth trauma support could come from developing evidence-based interventions that focus on enabling parents to understand the traumatic birth. Furthermore, parents perceive that support could be improved by the process of understanding to be two-way. For parental feedback of maternity services to be facilitated for the purpose of service development and trauma prevention.

**7.3.1.4.2 Psychological Therapy.** Thesis Chapters 5 and 6 supported the existence of barriers to parents accessing psychological therapy. Such as the lack of suitable services and long waiting lists for available services (Thomson & Garrett, 2019). Findings from the study with parents (chapter 6) also flagged further barriers of the complexity of the referral process, difficulty finding the right therapist, and needing to pay for private services.

Consequently, healthcare practitioners (chapter 5) and parents (chapter 6) reported that enhancement to birth trauma support could come from providing suitable support. Parents further indicated the need to improve access to specialist psychological support for an individual and the couple relationship. Currently evidence-based treatment for PTSD is trauma-focused CBT and EMDR (NICE, 2018b), and whilst evidence for the effectiveness of those treatments for trauma related to childbirth is growing, further understanding is required (Chiorino et al., 2020; Futura et al., 2018; Shorey et al., 2021).

Although couple counselling in the TTP has been associated with improved relationship quality (Spielhofer et al., 2014) and wider PTSD literature indicating that couple-based trauma therapy can reduce trauma symptoms and increase relationship satisfaction (Greenman & Johnson, 2012; Monson et al., 2015). Treatment for birth trauma in the absence of a PTSD diagnosis is unclear and lacks an evidence-base. Similarly, no specific dyadic psychological treatments for birth trauma exist.

**7.3.1.4.3. Parenting Assistance.** Negative perception of the birth experience has been associated with parental stress (Holopainen et al., 2020) and the postnatal period is already a notably stressful transition period for parents (Ayers et al., 2019; Deater-Deckard, 2008; St John et al., 2005). Chapter 6 provided further understanding of how experiencing birth trauma can magnify the strain of being a new parent. This is important as required support, particularly in the early weeks, may need to include parenting assistance as well as emotional support. Findings further highlighting the need for postnatal support to be individualised based on personal circumstances (McLeish et al., 2020).

Unavailability of help from family and friends was reported as a negative aspect of birth trauma support from the perspective of limiting practical and emotional support (chapter 6). This is understandable as the importance of family and friend support (Deave et al., 2008; Halle et al., 2008) in the TTP, and social support following traumatic childbirth (Vesel & Nickasch, 2015) is documented. Likewise, peer support is also reported as valuable birth trauma support as seen in other perinatal mental health conditions (Darwin et al., 2017; McLeish & Redshaw, 2017). Finding ways to encourage support from friends, family, and peers is a potential area of birth trauma support development.

## **7.4 Strengths and Limitations**

The strengths and limitations for individual articles included in this thesis are detailed within each relevant chapter. This section provides an overview and consideration of strengths and limitations pertaining to the overall thesis.

### **7.4.1 *Strengths***

This thesis provides in-depth research on the impact of birth trauma on the couple relationship and associated birth trauma support requirements, supporting comprehensive understanding of the phenomena. A major strength of this thesis being the examination of doctorate aims from multiple perspectives. Namely, through synthesis of prior research (chapters 1 & 2) and investigation of the perceptions of healthcare practitioners (chapters 4 & 5) and parents (chapter 6). Likewise, quantitative findings enabled consideration of the magnitude of the problem with qualitative work producing deeper understanding of the lived experience of birth trauma.

Furthermore, the recruitment of partners as well as birthing women to the interview study (chapter 6) is a further strength. Much of the previous understanding of the impact of birth trauma on the couple relationship has been drawn from samples of birthing women with no perspective from partners being gained (Allen, 1998; Ayers, Eagle & Waring, 2006; Beck 2004b; Kendall-Tackett, 2014; Taghizadeh et al., 2013). Likewise, prior qualitative work of the impact of birth trauma on the couple relationship has only been a small part of the study aims, with only one prior study having focused entirely on investigating the couple relationship in relation to birth trauma (Nicholls & Ayers, 2007). The dyadic

focus of this thesis has enabled better understanding of the impact of birth trauma on the couple relationship and in turn the associated birth trauma support needs of the dyad.

A key output of this thesis is the model of the impact of birth trauma on the couple relationship illustrated in Figure 7.1. The model depicts the effects and resulting impact of birth trauma on the couple relationship. This model provides three important purposes. Firstly, impetus for the primary and secondary prevention of birth trauma to protect the couple relationship from the demonstrated impact. Secondly, as understanding of the phenomenon for use as education with perinatal healthcare practitioners and parents. The final purpose is to provide a theoretical model that can be used to investigate if the impact of birth trauma on the couple relationship in more diverse populations is comparable.

Previously little was known about the types of birth trauma support that is offered to parents, particularly support that was aimed at the couple relationship. Therefore, this thesis adds to the body of evidence by providing understanding of parent and healthcare practitioner perceptions of the effectiveness of current birth trauma support. Furthermore, findings propose recommendations for how birth trauma support for the couple relationship could be enhanced so the impact of birth trauma on the couple relationship can be prevented, buffered, or indeed strengthen the relationship.

A further key output of this thesis is the model of birth trauma support required by the couple relationship illustrated in Figure 7.2. The model provides information for those developing and implementing perinatal services, so they are birth trauma aware and the support needs of those affected by birth trauma are

accommodated. However, it is widely acknowledged that there is a lack of evidence-based treatments for birth trauma (Lapp et al., 2010; Thomson & Garrett, 2019), particularly those dyadic in focus. Therefore, the model can be used in the research and development of interventions to ensure that the couple relationship perspective is addressed.

#### **7.4.2 Limitations**

There are several sampling limitations in this thesis to consider. In the empirical work the number of participants were limited, 202 and 110 participants in the survey study with healthcare practitioners reported in Chapters 4 and 5 respectively, and 18 participants in the interview study with parents (chapter 6). Likewise, sampling was convenient and purposive. Recruitment for these two empirical studies predominantly took place via social media.

Whilst this was done to enable wider advertising of the study to support recruitment, it is acknowledged that this may have limited the diversity of the sample. In particular, the interview study with parents (chapter 6) had a homogeneous sample of highly educated, married, heterosexual couples from a mainly white ethnicity background. In addition, the survey study with healthcare practitioners (chapters 4 & 5) had a sample mainly drawn from midwives, health visitors, and parent educators, with a notable absence of insight from doctors and mental health professionals.

Although the systematic review of the impact of birth trauma on the couple relationship (chapter 2) had a non-traumatic childbirth comparison (chapter 3) this was not a feature of the studies with healthcare practitioners (chapter 4 & 5) or parents (chapter 6). This could mean that the thesis findings relating to the later

studies are not entirely novel to birth trauma and may well be relevant to the couple relationship after a non-traumatic experience of birth.

In addition, there was no standard measure of birth trauma such as PTSS or PTSD diagnosis applied to sampling, or verification of participants capacity to respond on the topic. For the survey study with healthcare practitioners (chapters 4 & 5) and interview study with parents (chapter 6) participants were asked to respond based on a birth trauma definition of “emotionally traumatic childbirth causing ongoing distress”. Likewise, the survey study with healthcare practitioners used unvalidated questions and the semi-structured interviews used in the parent study were not clinical. This may mean a wide range of distress and resulting impacts are included in the study results, from mild transient distress through to clinical diagnosis of PTSD.

Apart from the systematic review of the impact of birth trauma on the couple relationship (chapter 2) where data analysis was verified by a second researcher, data analysis on other studies was only conducted by the thesis author under doctorate supervision. Additionally, findings from the studies with healthcare practitioners (chapters 4 and 5) and parents (chapter 6) were not taken back to participants for verification. It is acknowledged that the absence of these steps will reduce confidence in thesis conclusions.

Owing to the lack of available literature the systematic reviews of the impact of birth trauma on the couple relationship (chapter 2) and the impact of becoming parents on the couple relationship (chapter 3) contained studies conducted outside the UK. This limits the ability to conclude that thesis findings give a conclusive depiction of the impact of birth trauma on the couple relationship

and associated birth trauma support requirements in the UK. Conversely, due to the empirical studies being conducted with a UK sample, thesis findings may not readily translate to other countries. This may be particularly true for countries with different systems of healthcare and population demographics compared to the UK.

## **7.5 Implications**

The implications for research and practice relating to individual articles included in this thesis are detailed within each chapter. This section provides an overview of important implications pertaining to the overall thesis.

### **7.5.1 Implications for Research**

The theoretical models presented in this thesis of the impact of birth trauma on the couple relationship (Figure 7.1), and birth trauma support required by the couple relationship (Figure 7.2) require refinement through further research. Initially to address limitations of this thesis by verifying present findings with the current population and then investigating if the models are valid in more diverse samples. Further understanding of the phenomena and strengthening of the models could come from research that is longitudinal, with pre and post childbirth measurements, and a comparative non-traumatic childbirth sample.

Research is also needed to clarify concepts in the models that have less supporting evidence from prior work and findings presented in this thesis. Within the model of the impact of birth trauma on the couple relationship (Figure 7.1) examining the prevalence and mechanism of relationship breakdown. Furthermore, whilst the evidence for loss of intimacy is comprehensive in this thesis (chapters 2, 4 & 6) and prior literature (Elmir et al., 2010; Olde et al., 2006; Simpson et al., 2018), more research is needed to understand the impact of birth trauma on other relationship roles.

Whilst validated screening tools for birth trauma exist for birthing women and partners (Ayers et al., 2018; Webb et al., 2021), they are currently not used universally. Therefore, research is required to evaluate the efficacy of such screening for timely identification of parents who require birth trauma support. Prior evidence (Daniels et al., 2020; Thomson and Garrett, 2019) and thesis findings support the need for research to identify suitable birth trauma support. Furthermore, ascertaining support that is couple relationship focused that can address the need to understand birth trauma, provide psychological support, and facilitate parenting assistance (Figure 7.2).

It is clear from this thesis (chapters 5 & 6) and prior findings (Ayers, Claypool & Eagle, 2006; Baxter, 2019; Meades et al., 2011) that despite the absence of a robust evidence-base (Bastos et al., 2015; de Graaff et al., 2018), debriefing services are commonly accessed in the UK. Likewise, perception of such services is varied but on balance deemed ineffective in alleviating the impact of birth trauma on the couple relationship. Being able to understand the birth trauma appears to be an important issue for parents, along with being able to give feedback on their experience of healthcare with the aim of improving future services. Therefore, there is scope for research to identify an effective debriefing type of intervention that enables understanding, facilitates feedback, and supports reduction of the impact of birth trauma.

Finally, thesis findings (chapters 5 & 6) indicate there may be opportunity in investigating the role that antenatal preparation can play in primary prevention of experiencing childbirth as traumatic and enabling secondary prevention of the impact of birth trauma. Likewise, researching models of care that are parent-

centred and trauma-focused may provide further understanding of primary and secondary birth trauma prevention.

### **7.5.2 *Implications for Practice***

Thesis findings indicate the need for perinatal healthcare practitioners and services to be aware of the wide-ranging impact of birth trauma on the couple relationship and associated requirements for birth trauma support. The model of birth trauma support required by the couple relationship (Figure 7.2) provides perinatal services and practitioners with guidance on how to provide effective services to prevent or curtail the impact of birth trauma on the couple relationship.

As lack of awareness of birth trauma in maternity services is a barrier to parents obtaining support, this suggests the need for perinatal healthcare services and practitioners to expand their focus to be trauma-informed. Furthermore, there needs to be an expansion of care to support not just the birthing woman but also the partner, the couple relationship and the wider family. Systematic use of validated birth trauma assessment for birthing women and their partners could enable robust identification of both the individuals and the couple relationships that may require support. Healthcare practitioners can personally support parents with birth trauma by validating the traumatic experience and its impact and proactively signposting to suitable support.

Whilst it has been acknowledged in the implication for research section that more research is required to develop suitable birth trauma support, practitioners hold a key role in providing, signposting, or referring parents to support. The model of birth trauma support required by the couple relationship (Figure 7.2) highlighted that suitable birth trauma support may include enabling understanding of the birth trauma, psychological treatment for the individual and/or couple, and

parenting assistance. When referring or recommending support or treatment for birth trauma, healthcare practitioners need to be clear with parents about the evidence-base and discuss the potential benefits and risks of engaging with non-evidence-based services and treatments.

Although there is limited evidence in this thesis for the role of parenting assistance in effective birth trauma support (chapter 6), the connection between additional parenting stress and birth trauma is supported by prior work (Elmir & Schmied, 2022; Molloy et al., 2021). Therefore, whilst more research is needed to understand the role of parenting assistance in birth trauma support, there are findings which indicate the benefit of healthcare practitioners providing individualised postnatal support, facilitating peer support, and encouraging parents to engage help from family and friends.

## **7.6 Conclusions**

In summary, the studies presented in this thesis provide a greater understanding of the impact of birth trauma on the couple relationship and associated birth trauma support requirements. Notwithstanding the limitations of the research, this thesis makes original contribution to this field. It provides a multi-perspective analysis of the magnitude of the impact of birth trauma on the couple relationship. Furthermore, this thesis is novel in providing understanding from both birthing women and partners of the lived experience of birth trauma and associated support. In addition, this thesis advances understanding of the effectiveness of current birth trauma support and proposes potential areas for enhancements. This thesis makes further contribution to the field through two proposed theoretical models.

Firstly, this thesis provides a model of the impact of birth trauma on the couple relationships. The impact is reported as negatively effecting relationship communication, understanding and support between partners, and relationship roles. Such effects leading to relationship strain which for some results in fear of, or actual relationship breakdown. Conversely, some report the experience to result in a strengthened relationship.

In addition, a model of birth trauma support required by the couple relationship is presented. Thesis findings highlighting effective birth trauma support to come from parent-centred, trauma-informed, perinatal services, which promote primary and secondary prevention of birth trauma and impact on the couple relationship. Such services need to raise awareness of birth trauma, enable identification of birth trauma, and facilitate referral to suitable support. Such support needs to encompass the ability for parents to understand the birth trauma, access individual and where appropriate couple psychological therapies, and encourage parenting assistance.

This thesis provides implications for research and practice that address the limitations of the present work, and refinement and validation of the proposed models. Furthermore, highlighting research and practice opportunities to enhance birth trauma support in relation to the impact of birth trauma on the couple relationship.

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## **9 Appendices**

### **Appendix 1 Full List of Search Terms for the Systematic Review of the Impact of Childbirth-Related Post-Traumatic Stress on a Couple's Relationship (chapter 2)**

Patient:

Couple, Dad, Father, Mom, Mother, Mum, Parent\*.

Pregnancy & Childbirth Intervention/Interest:

\*atal, \*birth, Delivery, Labo?r, Pregnanc\*, Prematur\*, \*term, Viable.

Psychological Intervention/Interest:

\*aternal Illness, Anxiety, Death, Depression, Distress, Loss, Post-traumatic stress disorder, Psycho\*, PTSD, PTSS, Stress\*, Trauma\*.

Outcome:

Attachment, Consequence, Couple\* Relation\*, Effect, Impact, Marital, Parent-baby bond, Partner\*, Primary care, Problem, Quality, Spous\*, Support.

## **Appendix 2 Full List of Search Terms for the Systematic Review of the Impact of Becoming Parents on the Couple Relationship (chapter 3)**

Patient:

Couple\*, Relation\*, Marital, Marri\*, Spous\*, Roman\*, Wife, Husband, Partner\*.

Parenthood Intervention/Interest:

\*birth, Pregnanc\*, Famil\*, Parent\*, Child\*, Baby, Post\*.

Outcome:

Consequence, \*ffect, Impact, Problem, Quality, Transition, Change, Experience, Satisfaction, Happiness, Function\*.

## Appendix 3 Ethical Approval for Healthcare Practitioner Survey Study (chapters 4 & 5)



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**Reference Number: MCH/PR/PhD/17-18/02**

**Name: Amy Delicate and Susan Ayers**

**Title: Birth trauma and the couple relationship; health care professionals' views**

26 April 2018

Dear Amy and Susan

**Re: Full Ethical Approval**

Following on from MCH proportionate review, I am pleased to confirm that your application has full ethical approval. Please also find attached details of the full indemnity cover for the studies.

Under the School Research Governance guidelines the applicants are requested to contact me once the projects have been completed, and they may be asked to complete a brief progress report six months after registering the project with the School.

If you have any queries please do not hesitate to contact me as below.

Yours sincerely

Alison Welton  
Research Governance Officer



## **Appendix 4 Qualtrics Online Healthcare Practitioner Survey Questions**

**(chapters 4 & 5)**

### **Birth trauma and the couple relationship - healthcare professionals' views**

Q1 Title of study: Healthcare professionals' views of the impact of birth trauma on a couple's relationship and the support required.

You are invited to take part in this research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please read the participant information sheet carefully and discuss it with others if you wish.

[Participant information sheet](#)

#### **Do you consent to take part in this study?**

1. I confirm that I have read the participant information sheet. 2. I understand that this study will involve me answering an online questionnaire about my observations of the impact of birth trauma on a couple's relationship. 3. I understand that my participation is voluntary and that I can withdraw from completing the questionnaire at any time. 4. I understand that my participation is anonymous and if I chose to supply an email address I consent to this being used to provide me with a summary of the study results.

- ☐ Yes, I agree with the above statements and give my consent to participate in this study
- ☐ No, I do not give my consent to participate in this study

Q2 What is your main healthcare profession?

- ☐ Counsellor/Therapist
- ☐ Family Support Worker
- ☐ General Practitioner
- ☐ Health Visitor
- ☐ Maternity Care Assistant
- ☐ Midwife
- ☐ Nurse
- ☐ Other - please state \_\_\_\_\_

Q3 How long have you been qualified in this healthcare profession?

- ☐ I am still training
- ☐ 0-4 Years
- ☐ 5-9 Years
- ☐ 10-14 Years
- ☐ 15-19 Years
- ☐ 20 years +

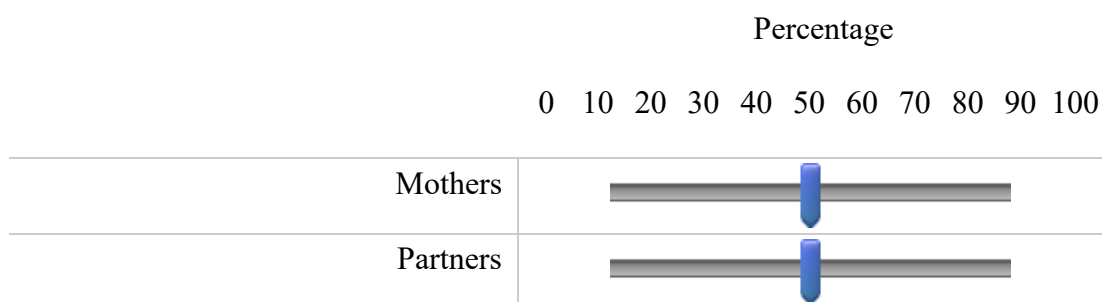
Q4 What is the first half of the postcode at your main place of work?

---

Q5 The remainder of questionnaire will focus on your experiences of the impact of birth trauma on parents and specifically the couple's relationship. For this survey, birth trauma is defined as emotionally traumatic childbirth causing ongoing distress. Please base your answers on your experience of working with parents in **the first year after birth**.

Q6

What proportion of parents you see have experienced birth trauma?



Q7 Do you screen parents for birth trauma?

|          | No                       | Yes                      |
|----------|--------------------------|--------------------------|
| Mothers  | <input type="checkbox"/> | <input type="checkbox"/> |
| Partners | <input type="checkbox"/> | <input type="checkbox"/> |

Q8 How do you screen parents for birth trauma?

*Please identify if there are any differences in screening for mothers and partners*

---

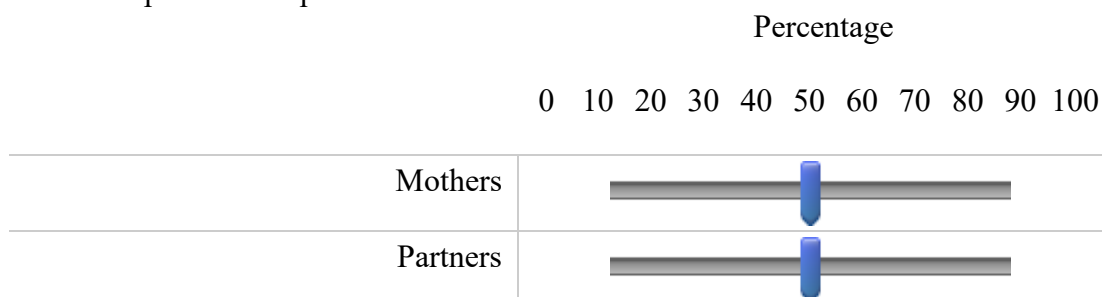


---

Q9 In your experience, what are the most common symptoms in parents after birth trauma?

|                                                                                                                                                                          | Mothers                  | Partners                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| <b>Re-experiencing Symptoms</b> - e.g., Nightmares, flashbacks or distress at trauma reminders                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Avoidance Symptoms</b> - e.g., avoiding thoughts, feelings, people, or situations related to the trauma                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Negative Changes in Thoughts and Feelings</b> - e.g., unable to recall key features of trauma, reduced interest in pre-trauma activities or feeling isolated/detached | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Arousal and Reactivity Symptoms</b> - e.g., irritability/aggression, hypervigilance, or difficulty sleeping/concentrating                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Other</b> - please state                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |

Q10 What proportion of parents indicate that birth trauma has affected their relationship with their partner?



Q11 Have you observed the following effects of birth trauma on a couple's relationship?

|                               | Not at all               | A little                 | A moderate amount        | A lot                    | A great deal             |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Increased conflict            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Increased negative emotions   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of intimacy              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of understanding         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of support               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reduced communication         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Relationship breakdown        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Strain on relationship        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Strengthening of relationship | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other - Please state          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Q12 Please rate the following statements regarding your experience of the support couples need for birth trauma

|                                                             | Not at all               | A little                 | A moderate amount        | A lot                    | A great deal             |
|-------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Mothers want me to support them                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Partners want me to support them                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Couples approach me together for support                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have the resources to offer support to couples            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have the skills and knowledge required to support couples | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel confident in supporting couples                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel that supporting couples is part of my role           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Q13

In your view, which healthcare professional(s) are best placed to support couples affected by birth trauma? *Select all that apply*

- ☐ Counsellor/Therapist
- ☐ Family Support Worker
- ☐ General Practitioner
- ☐ Health Visitor
- ☐ Maternity Care Assistant
- ☐ Midwife
- ☐ Nurse
- ☐ Other - please state \_\_\_\_\_

Q14 What support do you offer couples affected by birth trauma? *Select all that apply*

- ☐ Watchful waiting
- ☐ Listening to the couple
- ☐ Self-help information such as books and website
- ☐ Charitable/third sector organisations
- ☐ Birth listening/debriefing service
- ☐ Individual psychotherapy
- ☐ Couple psychotherapy
- ☐ Couple relationship therapy
- ☐ Perinatal mental health service
- ☐ Other - please state \_\_\_\_\_

Q15 Which type of support do you feel is most effective in reducing the impact of birth trauma on a couple's relationship? *Select all that apply*

- ☐ Watchful waiting
- ☐ Listening to the couple
- ☐ Self-help information such as books and website
- ☐ Charitable/third sector organisations
- ☐ Birth listening/debriefing service
- ☐ Individual psychotherapy
- ☐ Couple psychotherapy
- ☐ Couple relationship therapy
- ☐ Perinatal mental health service
- ☐ Other - please state \_\_\_\_\_

Q16

Which other organisations do you refer individuals or couples to for support with

birth trauma? *Select all that apply*

|                                 | Mother                   | Partner                  | Couple                   |
|---------------------------------|--------------------------|--------------------------|--------------------------|
| Big White Wall                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Birth Trauma Association        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Birth Trauma Chat (Twitter)     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Children Centres                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Family Action                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Homestart                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mind                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| NCT                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| OnePlusOne                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PANDA                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PIP (Parent Infant Partnership) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Relate                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tavistock Relationships         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The Relationship Foundation     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other - please state            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Q17 In your view what are the gaps in support services for couples affected by birth trauma?

---

Q18 In your view, which barriers prevent couples accessing support services for birth trauma?

---

|                                                                  | Not<br>at<br>all         | A little                 | A<br>moderate<br>amount  | A lot                    | A great<br>deal          |
|------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Concern that requesting support<br>will imply poor parenting     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of awareness of birth<br>trauma                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of childcare provision to<br>access support service         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of contact time with<br>healthcare professionals            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of suitable support services                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Long waiting times for support<br>services                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stigma around disclosing mental<br>health problems               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stigma around disclosing<br>problems with couple<br>relationship | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other - please state                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Q19 What would help couples access suitable support services for birth trauma?

---



---

Q20 Which barriers prevent you from providing support to couples with birth trauma?

|                                                                   | Not<br>at<br>all         | A little                 | A<br>moderate<br>amount  | A lot                    | A great<br>deal          |
|-------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Absence of suitable birth trauma screening tool                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Absence of suitable services to refer parents to                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of contact with mothers to identify those with birth trauma  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of contact with partners to identify those with birth trauma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of training in birth trauma                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of time to spend personally supporting parents               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parents reluctance to accept support                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of collaboration with other healthcare professionals         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other - please state                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Q21 What would help you support couples effected by birth trauma?

---



---

Q22 Do you have any other comments about the effect of birth trauma on the couples relationship?

---



---

Q23 Would you like to receive a summary of the results from this study?

☐ Yes

☐ No

Q22 Do you have any other comments about the effect of birth trauma on the couples relationship?

---



---

Q23 Would you like to receive a summary of the results from this study?

- ☐ Yes
- ☐ No

Q24 To receive a summary of the results of the survey please email your request to ANON

## Appendix 5 Ethical Approval for Parent Interview Study (chapter 6)



Dear Amy

**Reference:** ETH1920-0277

**Project title:** Couples' experiences of the impact of birth trauma on their relationship and the role of support.

**Start date:** 15 Jul 2020

**End date:** 31 Aug 2021

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the School of Health Sciences Research Ethics Committee. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Please ensure that you are familiar with [City's Framework for Good Practice in Research](#) and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

### **Project amendments/extension**

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

### **Adverse events or untoward incidents**

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:



- a) Adverse events
- b) Breaches of confidentiality
- c) Safeguarding issues relating to children or vulnerable adults
- d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the School of Health Sciences Research Ethics Committee, I do hope that the project meets with success.

Kind regards

Nicholas Drey

School of Health Sciences Research Ethics Committee

City, University of London

## Appendix 6 Parent Interview Topic Guide (chapter 6)

| Pre-Interview                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>○ Thank you for offering your time to talk to me and add to this important research.</li> <li>○ I am a PhD student and my research is looking at the impact of birth trauma on the couple relationship and the role of support. I am also a parent practitioner with the NCT and through this role I support parents with birth trauma.</li> <li>○ This research study is looking at gaining parents experiences of dealing with birth trauma and thinking about whether this has had any impact on the couple relationship. It is also investigating what support is needed to help parents and couples.</li> <li>○ I have some questions to guide the interview, but the key element is that you talk about anything that you feel is relevant or you want to share.</li> <li>○ Please pass on any question that you don't want to answer. If you need to take a pause from the interview or indeed to stop it completely then please just say.</li> <li>○ Check still happy with the consent for that they completed online and PIS?</li> <li>○ Do you have any questions or concerns at this point?</li> <li>○ Begin recording – Inform participant.</li> </ul> |
| Interview Topics                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p><b>Opening Question/Icebreaker</b><br/>Please tell me about your family.<br/><i>Prompts</i><br/>- Age of child/ren<br/>- Time with partner</p> <p><b>Background to Birth Trauma</b><br/>What has been your experience of birth trauma?<br/><i>Prompts</i><br/>- when/how did you notice the impact of the traumatic birth?</p> <p><b>Relationship</b><br/>How has your relationship been with your partner since the birth?<br/><i>Prompts</i><br/>- Do you feel this is connected to the birth trauma? / Has birth trauma affected your relationship?<br/>- Do you know if your partner shares these feelings?<br/>If there is a previous child – Is this experience any different from when you had your previous child?<br/>Do you feel that the COVID-19 pandemic had any effect on the relationship experiences you have shared?</p>                                                                                                                                                                                                                                                                                                                                                               |

**Support**

Can you describe any support you have had for birth trauma?

*Prompts*

*- What about your partner / as a couple?*

*If support has been accessed - Did you/they find it helpful?*

*- Is there any support that you would have liked to have had? - How would that have helped you/your partner.*

*Has the COVID-19 pandemic had any impact on support for birth trauma?*

**General Probes**

- Please can you say a little more about...

- Could you give me an example of...

- Thank you for that insight, I would like to know your thoughts on...

**Post-interview**

- Is there anything you would like to add that we have not discussed?
- Do you have any questions?
- Stop recording – inform participants.
- How are you feeling? Would you like to talk about how you feel?
- Are you aware how to access support with emotional distress?
- Inform them that you will send them the support information again via email at the end of the interview.
- Thank the participant.
- End the call.