Submission
No 1072

INQUIRY INTO BIRTH TRAUMA

Name: Mrs Eva Gregory

Date Received: 14 August 2023

This is the author’s version of a work that was accepted for publication in *Journal of Reproductive and Infant Psychology.* Changes resulting from the publishing process, such as peer review, editing, corrections, structural formatting, and other quality control mechanisms may not be reflected in this document. Changes may have been made to this work since it was submitted for publication. A definitive version available is as follows:

Gregory, E. M., & Maddern, R. (2023). The psychosocial experience of traumatic birth in couples: an interpretative phenomenological study, *Journal of Reproductive and Infant Psychology.* Advance online publication . https://doi.org/10.1080/02646838.2023.2225073

The psychosocial experience of traumatic birth in couples: An interpretative phenomenological study

Eva M Gregory

Graduate School of Health, University of Technology, Sydney, Australia

Paper submitted in partial fulfilment of a Master of Clinical Psychology [2022]

Robyn Maddern

Adjunct Fellow, Graduate School of Health, University of Technology, Sydney, Australia

Correspondence:

Let’s Talk Psychology, Shop 6, 1 Normurra Ave, North Turramurra, NSW, 2074

Abstract

Background: One third of women report a psychologically traumatic event during birth; limited research exists on how couples experience and process self-reported traumatic birth. **Aims and objectives:** This study aimed to examine the lived experience and psychosocial impact of traumatic birth in couples. **Methods:** Interpretative Phenomenological Analysis was used to explore in-depth participants' lived experience during and after traumatic childbirth. Four couples were recruited, from women experiencing vaginal deliveries in the public hospital system in Australia during the past five years. Women and men were interviewed individually. **Results:** Three superordinate themes were identified: 'Compassionless care' (experiences of being dismissed, devalued and degraded by care providers), 'Violation and subjugation' (women's bodies and birthing experiences being violated) and 'Parenting after birth trauma' (challenges in caring for a newborn following trauma and recovery from trauma). **Discussion:** Couples described care providers' actions as a major contributing factor to trauma experiences. Couples contextualised care in terms of under-resourced wards and perceived women were treated as a means to an end. Women and men both described feeling fearful, distressed and devalued. Following birth trauma, individual cognitive factors such as negative self-evaluations and avoidance of the trauma memory interacted with family system to shape trauma-related distress. **Conclusions:** Future research would benefit from highlighting the systemic context in which compassionless care occurs, and the family system in which trauma is experienced and processed. Findings reinforce that psychosocial safety must be considered in addition to physical safety for both women and men in maternity care practices.

Keywords: birth trauma, childbirth, maternity care, interpretative phenomenological analysis, parenting

The psychosocial experience of traumatic birth in couples:

An interpretative phenomenological study

Over one third of women report a psychologically traumatic event during birth (Alcorn, O'Donovan, Patrick, Creedy, & Devilly, 2010). Definitions of birth trauma vary greatly (Greenfield, Jomeen, & Glover, 2016), with Beck (2004) asserting trauma is in 'the eye of the beholder', consistent with evidence that trauma experiences do not always align with external criteria (Boals, 2018). Crucially, birth trauma has been shown to contribute to mental health difficulties (Etheridge & Slade, 2017; Fenech & Thomson, 2014), with 3-4% of postpartum women meeting criteria for post-traumatic stress disorder (PTSD; Yildiz, Ayers, & Phillips, 2017). Parental perinatal mental illness is associated with difficulty in parent-infant bonding, child psychopathology and spousal relationship strain (Cook, Ayers, & Horsch, 2018; Delicate, Ayers, Easter, & McMullen,, 2018; Sutherland, Nestor, Pine, & Garber, 2022; Sweeney & Macbeth, 2016), making it an important area of research.

A current theory of post-traumatic stress following childbirth (Ayers, Bond, Bertullies, & Wijma, 2016) is based on evidence that PTSD symptoms are influenced by vulnerability factors (e.g. history of trauma), risk factors during birth (e.g. staff support) and postpartum factors (e.g. stress). Both objective events and subjective experiences are associated with birth trauma, with care provider actions increasingly recognised as a major contributing factor (Harris & Ayers, 2012; Reed, Sharman, & Inglis, 2017). Notably, over time the association between birth factors and PTSD decreases, whereas the association between postpartum factors and PTSD increases (Ayers et al., 2016). This is congruent with theories (e.g. Ehlers & Clark, 2000) and evidence (Vossbeck-Elsebusch, Freisfeld, & Ehring 2014) that distinguish between factors that influence symptom onset and cognitive factors, such as idiosyncratic negative appraisals of trauma and avoidance of the trauma memory, that

foster a sense of current safety threat and thereby maintain trauma symptoms. It indicates conceptualisations of birth trauma should go beyond the event and its impact to consider how trauma experiences are shaped by both birth and the postpartum period.

Additionally, it is important to recognise that birth trauma is a unique trauma given the way it is situated within family and social systems. Firstly, childbirth is co-experienced by couples, although they assume different roles, with evidence men can be marginalised in maternity care (Etheridge & Slade, 2017; Inglis, Sharman, & Reed, 2016). Following birth, trauma responses are dyadic and both shape/are shaped by relationship processes (Marshall & Kuijer, 2017). This is consistent with research demonstrating individual experiences independently predict partners' distress reactions, and emotional support moderates the effect of birth trauma on symptoms (Gürber, Baumeler, Grob, & Surbek, 2017; Iles, Slade, & Spiby, 2011; Lemola., Stadlmayr, & Grob, 2007). Trauma responses are also complicated by caregiving for the infant, who can act as a reminder of the event (Stuijfzand, Garthus-Niegel, & Horsch, 2020). Secondly, birth trauma occurs in contrast to positive societal narratives about childbirth (Ketley, Darwin, Masterson, & McGowan, 2022), which may contribute to suppression of experiences.

To date, two qualitative studies have examined birth trauma with couples as participants (Attard, Iles, Bristow & Satherly, 2022; Nicholls & Ayers, 2007). Gender-specific themes emerged from birth experiences, such as violation and dehumanisation reported by women, and helplessness and shock described by men (Nicholls & Ayers, 2007). Quality of care was highlighted as influential, with Attard et al. (2022) describing "system failures" which both shaped trauma and made it difficult to access effective support post-trauma. Negative effects were apparent on parent-infant bonds and the couple's relationship across studies, with emphasis on the difficulty of processing trauma in the context of caring for a newborn, and emergence of coping mechanisms such as emotional avoidance (Attard et

al., 2022). Importantly, most people who experience birth trauma will not meet criteria for PTSD and there remains limited literature on how trauma is experienced and processed within the couple in a broader sample. Consequently, this study aimed to examine the lived experience and psychosocial impact of traumatic birth in couples, whereby birth trauma was defined by participants regardless of objective events or trauma response.

Methods

Design

This qualitative study utilised Interpretative Phenomenological Analysis (IPA; Smith, 2015) to explore participants' lived experience and how trauma is shaped. Ethical approval was granted by the University of Technology Sydney Human Research Ethics Committee.

Recruitment

Purposive sampling aimed to recruit four participant couples in Australia with relatively homogenous birth experiences, which is considered an optimal sample size for IPA so that insight into their particular experience can be investigated in an in-depth, descriptively rich manner (Alase, 2017). An online post promoting the study and linking to an eligibility survey was distributed by the Centre of Perinatal Excellence on Facebook, with 35 women responding and 15 women meeting eligibility criteria. Eligible women were contacted by the researcher, and three couples agreed to participate. A fourth couple was then recruited via a psychologist and recruitment finalised given the desired sample size was fulfilled. Informed consent was obtained. Eligibility was as follows: vaginal deliveries that occurred ≥ two months and ≤ five years prior in the Australian public hospital system, participants ≥ 18 years at time of birth, partners present at birth and women's pregnancies classified as 'low risk' prior to labour onset. The time frame for eligibility was to ensure participants had time to reflect on the birth, memories were relatively recent, and the sample was homogenous in regards to the broader state of the healthcare system they were birthing in. Eligibility required

couples to be in an intimate relationship involving shared parenting. At least one member of the couple must have self-reported a traumatic birth, felt distressed about the birth and responded ‘yes’ to the eligibility survey question on feelings of intense fear, helplessness or horror during birth. Couples were ineligible if they experienced stillbirth, or if the infant was admitted to a special/intensive care unit.

Participants

Data has been deidentified and pseudonyms assigned. Participants were from two states (VIC and NSW), three couples lived in urban areas within major cities, and one couple lived outside of a major city. All births described were first births with spontaneous labour onset and vaginal delivery. All women and one father self-reported birth trauma. Complications arose with all women and three infants (see Table 1.) Having engaged with mental health services was not an eligibility requirement, however at least one member of every couple had accessed support since the birth. The terms women/men are used in alignment with referenced research, however it is recognised that these terms are not reflective of all birthing people and their partners.

Table 1. Sample characteristics and labour experiences

Pseudonym	Index birth; parity	Time since index birth	Self-reported trauma	Continuity of care*	Labour characteristics	Complications
Audrey & Arthur	1st; 2	4 years	Audrey	Yes (antenatal); assigned midwife absent for birth	Spontaneous onset; infant posterior; episiotomy	Pre-eclampsia developed during labour, concerns over infant's heart rate; caesarean section proposed
Brianna & Brandon	1st; 1	7 months	Brianna; Brandon	No	Spontaneous onset; artificial rupture of membranes; 3rd degree perineal tear	Concerns over potential *'cardiac arrest'* (Brianna), concerns over infant's heart rate; caesarean section proposed
Carole & Carey	1st; 2	3 years	Carole	No	Spontaneous onset; infant posterior; augmented (oxytocin); episiotomy; forceps delivery	Concerns over infant's heart rate; caesarean section proposed
Daphne & Dylan	1st; 2	4 years	Daphne	No	Spontaneous onset; 3b perineal tear	Tear required repair in theatre post-birth (separated from infant)

Note: Index birth refers to the traumatic birth explored in the interview
*Antenatal care was primarily provided by general practitioners and various midwives, with the exception of Audrey who participated in a Midwifery Group Practice program.

Data collection and analysis

The semi-structured interview schedule (see Appendix 1.) was designed following IPA guidelines (Smith, 2015) and accompanied by a distress protocol. Open-ended questions, such as 'Did you and your partner have a similar understanding of the birth experience?' were asked regarding appraisal of the birth, spousal relationship and parent-infant relationship. Prompts were given when required with emphasis on responsiveness to participant-led processes. Interviews were conducted individually over videoconferencing software, audio recorded and transcribed verbatim. Women were interviewed first, immediately followed by their partners, with the exception of one couple due to an unforeseen delay.

The primary researcher analysed the data, with feedback on themes and alternative explanations provided by the secondary researcher, resulting in revisions. Analysis followed IPA guidelines (Smith, 2015), including transcript immersion and an iterative coding process to establish themes grounded in participant experience. Analysis aimed to develop a coherent narrative that best fit all participants' experiences.

Reflexive account

IPA recognises that data interpretation is influenced by the researchers' experience. Integrity was supported through reflective journalling and supervision sessions. The primary researcher is a psychologist working in perinatal mental health and experienced one non-traumatic, albeit complicated birth while completing this research. The secondary researcher/ supervisor is a clinical psychologist, qualitative methodologist and has not personally experienced birth.

Results

Data analysis yielded three superordinate themes, two related to the birth experience, and one to the postpartum experience of trauma. Eight subordinate themes emerged. Daphne

and Dylan did not influence the first two superordinate themes to the same extent as other couples, as trauma occurred following delivery. A summary of events related to the first two subordinate themes are provided in Table 2.

Table 2. Summary of traumatic aspects of birth experience

Pseudonym	Dismissed by care providers	Devalued and degraded	Violation of safety*	Violation of informed consent and control	Violation of expectations
Audrey & Arthur	Inattentive/ unempathetic care providers, advised not to attend hospital, concerns dismissed	Sense of being a burden, partner required to leave after birth	Fear of mother and baby dying	Denied adequate pain relief, violation of informed consent (medical procedures)	Expectation of pain varied (back labour)
Brianna & Brandon	Hostile/ unempathetic care providers, advised not to attend hospital, extended waiting time, concerns dismissed	Perceived dehumanisation, secondary support person denied, partner required to leave after birth	Fear of mother and baby dying, lack of communication	Denied adequate pain relief, violation of informed consent (fetal scalp monitor), subjugation re mode of delivery	Expectations regarding involvement, guidance and support violated
Carole & Carey	Unempathetic care providers, advised not to attend hospital, extended waiting time, concerns dismissed	Sense of being a burden, perceived dehumanisation, partner forgotten by care providers after theatre transfer	Fear for baby's safety, lack of communication	Denied adequate pain relief, violation of informed consent (medical procedures), subjugation re mode of delivery	Expectation of guidance and support violated
Daphne & Dylan		Perceived dehumanisation, separated from infant and partner post-birth	Fear of mother dying, fear of long-term physical damage, lack of communication		Inadequacy of birth education on complications

*Note: All births contained physical safety threats, as specified in Table 1 (Complications)

Superordinate theme one: Compassionless care

This theme encompasses the experience of poor quality care that was experienced.

Dismissed by care providers

Couples reported being dismissed from onset of labour. Three couples were told not to attend hospital: *'the midwife… told me that it was not labour and I could not come into the hospital'* (Audrey). This contributed to distress, as with Brianna who described *'feeling really scared'*. Upon arrival at hospital, couples often experienced lengthy delays to see a midwife. Carey described *'feeling like you're in a bit of a queue'*. When they were attended to, couples felt unsupported: *'The first midwife wasn't really… very switched on, as to what her needs were'* (Arthur). They also remarked on a sense of hostility: *'everyone was just like, stale towards us'* (Brandon), with Brianna identifying 'the lack of compassion' as most distressing.

Couples reported men tried to advocate for women despite feeling uncomfortable: '*he just wanted the best for me… he couldn't get the answers either'* (Brianna). Later on, women's concerns about feeling unwell were often dismissed until it became apparent there was a medical emergency, as with Audrey who developed pre-eclampsia: *'I was feeling unwell, and they were telling me… you're in transition, and that's a good sign.'* Couples emphasised the positive impact when women-centred care was received: '*the two of them were amazing… my feeling of being cared for from that point changed'* (Carole)

Devalued and degraded

All women reported feeling devalued and degraded at times by care providers:

> *I just got made to feel like [infant] was the priority and I was the afterthought… I was just another person clogging up their beds and they didn't have time for me* (Carole).

The sense of being dismissed, or even dehumanised by care providers, often contributed towards degradation, as with Brianna who described feeling like a *'pet in a pet shop'* and said: *'what I really wanted… talking to me like a human not just like a, get her in,*

get the baby out, get her going'. Similarly, Daphne described her experience in theatre as impersonal: '*it's just a body and they're fixing it'*, noting *'they don't talk to you they talk over you and about you.'* Self-worth was especially degraded after women tried to unsuccessfully advocate for themselves: *[it] just made me feel really, really small',* which lead to feelings of being a burden: *'I'm being annoying, I'm the problem'* (Audrey).

Support people were also devalued, which exacerbated women's anxiety. One couple experienced COVID-19 restrictions, with Brianna unable to have her mother as a second support person. After Carole was transferred to a theatre room, care providers forgot to retrieve Carey. Daphne experienced surgery without her partner and was separated from her infant, which she identified as contributing to trauma. Women remarked on the difficulty of caring for a newborn alone after trauma: *'I felt so sick, I still had to look after this little baby, my husband couldn't stay with me'* (Audrey).

> *We went through this massive experience together, and then… my partner had to go home. So there wasn't even that time to spend together to deal with that emotion* (Brianna).

Superordinate theme two: Violated and subjugated

This theme encompasses both women being violated and their expectations of the birth experience being violated.

Violation of safety

All couples described emergency situations unfolding which threatened safety: '*I said, something doesn't feel right, I feel like I'm going to die'* (Audrey). Information was often poorly communicated or withheld, which exacerbated couples' fear. Brandon described feeling as though his *'worst fear'* was being realised, after he overheard staff discussing the possibility of Brianna experiencing cardiac arrest. Brianna described this as *'terrifying'*. Similarly, Dylan reported wondering: *'How normal is this? … Is she going to die?'* after

observing Daphne's blood loss. Couples described feeling confused and often expressed they still did not understand what happened.

Violation of informed consent and control

Some women described being physically violated as consent was not obtained before procedures:

They were… asking my consent, but not really waiting for my consent, expecting that I would give it, and… sort of asking for it while they were doing a procedure (Audrey).

He didn't come in and say we think that the cord is wrapped around her neck, he's just straight in and just… shoved his hand, straight up my vagina (Carole).

Women described authoritarian language and subjugation from care providers: '*They weren't going to let me try to do a natural birth'* (Brianna). Carole described being told to have an emergency caesarean: '*Next thing I've got this form shoved in my face to sign... Without any explanation as to even who this woman was, let alone, why?'* This included care providers dictating when, if, and what type of pain relief women could access. Audrey described being told: *'no, no, you don't need it'* when asking repeatedly for analgesia. Brianna was told unless she used the gas, which she had stopped as it made her vomit, she could not access other analgesia, which was *'really distressing'.*

Violation of expectations

Women expected they would be involved and supported in labour by care providers: '*I expected… to be, able to be more involved in it. But I really, I really wasn't'* (Brianna). Couples described being unsure of what to expect given it was their first birth and wanting guidance: '*But where was that duty of care to make sure as first-time parents, you know what you're doing?'* (Carole). Daphne reflected on how birth education differed from her

experience: *'I was angry because I felt woefully, inadequately prepared for what happened to me'*.

Parenting after birth trauma

This theme encompasses the experience of trauma in the postpartum period.

Struggling with a newborn and trauma

Couples described challenges associated with their newborns: *'what we didn't know was that [infant] had allergies… so that put stress on us, we were all sleep-deprived'* (Arthur). This exacerbated mental health difficulties and strained relationships. Brianna said: *'we weren't talking, he had a lot of really like heavy feelings about it'.* All couples remarked that there was no time to discuss birth trauma: '*we had a baby, we had to move on'* (Brianna). Daphne described other challenges with debriefing: *'it is very hard to find the people who… are a safe outlet for you.'* This was also reflective in some instances of avoidance of the memory: '*I would avoid talking about it… I would sort of have a little flashback and then I would just immediately dismiss it'* (Audrey).

Rejection and protection of infant

Often following traumatic birth there was an unexpected lack of connection with infants, and avoidance of the infant as they served as a trauma reminder:

> *I didn't want her, but at the same time, I couldn't be away from her… I could not let her out of my sight, but I would still have thoughts, if I put this on her face then she might stop crying and I could get to sleep* (Audrey).

Carole similarly spoke of wishing to give her infant away: *'When people say… I can't believe a woman left a baby on the side of the road… I understand how someone could do that.'* Brianna described Brandon: '*he didn't want to hold her, he didn't want to play with her, talk to her, acknowledge her…'*

Avoidant parents also described extreme protectiveness: *'I just want to put this kid in a bloody big bubble wrap'* (Brandon). Brianna partially attributed this protectiveness to birth trauma:

> *I think that kind of ties back to that birth experience that because he's not understanding, bad things are happening… now… he's expecting bad things to happen* (Brianna).

Affected parents emphasised their relationship with their child was no longer negatively affected by birth trauma. However women expressed strong emotions about how it had impacted the newborn bond. Carole described anger, sadness and grief, saying: *'I feel like that newborn stage got taken away from me… this is something that will never leave me'*. Brianna reported being unable to remember anything for hours after the birth, which impacted her self-worth when she was later unable to recall other events: *'I feel a lot of guilt… I feel quite inadequate as a mother'*. Audrey described: *'feeling a little bit ashamed'* after recounting the intrusive thoughts she had experienced.

Recognising trauma - 'that was not okay'

Mental health difficulties were often initially suppressed: *"I never spoke about them… I just… pushed them down'* (Audrey). It took couples months or years to recognise that their experience was traumatic and to seek help, which often occurred around the time of a subsequent pregnancy: '*Being pregnant again brought on a lot of anxiety'* (Daphne). Couples used their second birth to contextualise their first birth:

> *'Now after having a second child… we can go back and identify that some of the things that actually happened to us… certainly weren't okay'* (Carey).

Although men identified women's birth trauma, the extent of mental health difficulties were often not initially recognised: *'for the vast majority of it, I didn't necessarily know that she wasn't coping'* (Carey). Carole described Carey reassuring her *'we'll be fine'*

upon learning she was pregnant again. She said: *'that response made me really anxious because I was like, well, I wasn't fine.'* Similarly, Daphne remarked: *'you carry these things a long time… I don't think he appreciated how anxious it made me about the second child'.*

All couples described striving to improve their relationship, with some reporting positive growth: *'it's strengthened our relationship'* (Dylan). Arthur said: *'if you go through that, there's not much you can't go through'*. Open communication was often identified as the mechanism through which relationships were strengthened.

Discussion

This study provided an in-depth illustration of how birth trauma is co-experienced by couples. All experiences involved objective safety threats (i.e. health complications), often a prerequisite to definitions of trauma (Alcorn et al., 2010). However, consistent with previous research, participants described trauma predominantly in terms of care providers' assuming control, acting without consent and dismissing women's 'embodied knowledge' of their labour and wellbeing (Attard et al., 2022; Harris & Ayers, 2012; Reed et al., 2017). Couples also provided context to their experiences, emphasising under-resourced hospital wards where they perceived they were treated as a means to an end. Collectively, these factors fostered fear and distress as couples felt unsupported despite attempts to advocate for themselves. Furthermore, women's experience of care provider actions degraded self-worth, consistent with reports of gendered dehumanisation in birth trauma (Nicholls & Ayers, 2007). Men were also devalued, although this was described in terms of restrictions preventing their ongoing involvement, aligned with evidence they are often marginalised in maternity care (Etheridge & Slade, 2017; Inglis et al., 2016). Overall, findings reinforce that medical complications must be interpreted within the context of care provided, with poor quality care interpreted as a safety threat within its own right, and negative impacts evident on women, men and the family system.

This study also examined the psychosocial experience of the couple following birth trauma. The findings support the role that cognitive factors play in shaping trauma in the postpartum period (Vossbeck-Elsebusch et al., 2014). Furthermore, they illustrate how individual cognitive factors, such as those described by Ehlers and Clark (2000), interact with the family system through dyadic processing (Marshall & Kuijer, 2017). Aligned with findings in Attard et al. (2022), couples described difficulty in processing trauma given the demands of caring for a newborn, which reduces opportunities for 'therapeutic reliving'. Limited discussion about the birth was also often driven by avoidance of the trauma memory, which can prevent effective integration of the memory. Avoidance sometimes extended to rejection of infants, with difficulties bonding subsequently shaping negative self-evaluations – an event theorised to contribute to an ongoing sense of threat (Ehlers & Clark, 2000). Furthermore, men were often unaware of the extent of the impact of trauma on their partners, while affected parents also suppressed mental health struggles. This coupled with a lack of information to identify birth trauma often delayed help-seeking. Overall, findings support the applicability of cognitive models to birth trauma and the unique nature of birth trauma as it is experienced in the family system.

Strengths and limitations

A strength of this research is that it explored birth trauma as defined and experienced by couples, thereby expanding upon existing literature that utilised more restrictive samples. However, couples self-selected for participation which may introduce bias as the sample could reflect couples with more stable relationships, given women and men needed to be comfortable speaking about birth trauma in reference to their relationship. Longitudinal research that tracks couples throughout the perinatal period may address this limitation. Notably, all births were first births, which may reasonably have influenced findings as couples navigated the birth experience and maternity system for the first time.

Future research

There is a need for future research into practices to prevent birth trauma, and interventions to treat birth trauma (McKenzie-McHarg et al., 2015). This study suggests research into improving maternity care would benefit from consideration of systemic contextual issues, such as staff resourcing and attitudes towards consent and decision-making. Future research into treatment of birth trauma should consider the role of dyadic trauma responses.

Implications for practice

This study reinforces the importance of compassionate maternity care and adds to growing calls (e.g. Reed et al., 2017) that risk discourse must adequately consider psychosocial safety in addition to physical safety. It suggests benefit in midwives and obstetricians recognising and valuing women's embodied knowledge of their labour, wellbeing and requirements for care, and highlights the importance of respect for women's rights to make informed decisions during birth experiences. It also appears couples would benefit from more readily accessible information and support for birth trauma, and perinatal mental health practitioners could enhance services through working with the family unit collectively.

Conclusions

This study illustrated how care provider actions contribute to traumatic births that are co-experienced by couples. Couples described feeling distressed, degraded and devalued. Furthermore this study demonstrated how cognitive factors and family systems interact to shape trauma experiences in the postpartum period. Future research would benefit from consideration of the systemic context in which poor quality care occurs, and the family system in which trauma is processed. Findings reinforce that psychosocial safety must be considered in addition to physical safety for both women and men in maternity care practices.

Acknowledgements

We thank the couples who shared their stories with us, the Centre of Perinatal Excellence for assisting with recruitment and Associate Professor Christine Catling and Brooke Owen for their feedback from a midwifery perspective on the study design.

Disclosure statement

No potential conflict of interest is reported.

Funding

This research was part of the primary researchers' Master of Clinical Psychology at the University of Technology, Sydney. Financial support was provided for the videoconferencing software.

References

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies, 5*, 9-19. https://doi.org/10.7575/aiac.ijels.v.5n.2p.9

Alcorn, K. L., O'Donovan, A., Patrick, J. C., Creedy, D., & Devilly, G. J. (2010). A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events. *Psychological Medicine, 40*(11), 1849-1859. https://doi.org/10.1017/S0033291709992224

Attard, R., Iles, J., Bristow, F., & Satherley. (2022). An interpretative phenomenological analysis of the experience of couples' recovery from the psychological symptoms of trauma following traumatic childbirth. *BMC Pregnancy Childbirth, 22,* 798. https://doi.org/10.1186/s12884-022-05091-2Ayers, S., Bond, R., Bertullies, S., & Wijma, K. (2016). The aetiology of post-traumatic stress following childbirth: A meta-analysis and theoretical framework. *Psychological Medicine, 46*(6), 1121-1134. https://doi.org/10.1017/s0033291715002706

Beck C. T. (2004). Birth trauma: In the eye of the beholder. *Nursing Research*, *53*(1), 28–35. https://doi.org/10.1097/00006199-200401000-00005

Boals, A. (2018). Trauma in the eye of the beholder: Objective and subjective definitions of trauma. *Journal of Psychotherapy Integration, 28*(1), 77–89. https://doi.org/10.1037/int0000050

Cook, N., Ayers, S., & Horsch, A. (2018). Maternal posttraumatic stress disorder during the perinatal period and child outcomes: A systematic review. *Journal of Affective Disorders, 225*, 18–31. https://doi.org/10.1016/j.jad.2017.07.045

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

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*(4), 319–345. https://doi.org/10.1016/s0005-7967(99)00123-0

Etheridge, J., & Slade, P. (2017). “Nothing’s actually happened to me.”: The experiences of men who found childbirth traumatic. *BMC Pregnancy and Childbirth, 17*(1), 80. https://doi.org/10.1186/s12884-017-1259-y

Fenech, G., & Thomson, G. (2014). Tormented by ghosts from their past': A meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery, 30*(2), 185-193. https://doi.org/10.1016/j.midw.2013.12.004

Greenfield, M., Jomeen, J. & Glover, L. (2016). What is traumatic birth? A concept analysis and literature review. *British Journal of Midwifery, 24,* 254-267. https://doi.org/10.12968/bjom.2016.24.4.254

Gürber, S., Baumeler, L., Grob, A., Surbek, D., & Stadlmayr, W. (2017). Antenatal depressive symptoms and subjective birth experience in association with postpartum depressive symptoms and acute stress reaction in women and men: A longitudinal path analysis. *European Journal of Obstetrics, Gynecology, and Reproductive Biology*, *215*, 68–74. https://doi.org/10.1016/j.ejogrb.2017.05.021

Harris, R., & Ayers, S. (2012). What makes labour and birth traumatic? A survey of intrapartum 'hotspots'. *Psychology & Health, 27*(10), 1166-1177. https://doi.org/10.1080/08870446.2011.649755

Iles, J., Slade, P., & Spiby, H. (2011). Posttraumatic stress symptoms and postpartum depression in couples after childbirth: The role of partner support and attachment.

Journal of Anxiety Disorders, 25(4), 520–530. https://doi.org/10.1016/j.janxdis.2010.12.006

Inglis, C., Sharman, R., & Reed, R. (2016). Paternal mental health following perceived traumatic childbirth. *Midwifery, 41,* 125-131. https://doi.org/10.1016/j.midw.2016.08.008

Ketley, R., Darwin, Z., Masterson, C., & McGowan, L. (2022). Women's experience of post-traumatic growth following a traumatic birth: An interpretive phenomenological analysis. *Journal of Reproductive and Infant Psychology,* 1–12. Advance online publication. https://doi.org/10.1080/02646838.2022.2070608

Lemola, S., Stadlmayr, W., & Grob, A. (2007). Maternal adjustment five months after birth: the impact of the subjective experience of childbirth and emotional support from the partner. *Journal of Reproductive and Infant Psychology, 25*(3), 190-202. https://10.1080/02646830701467231

Marshall, E. M., & Kuijer, R. G. (2017). Weathering the storm? The impact of trauma on romantic relationships. *Current Opinion in Psychology, 13*, 54-59. https://doi.org/10.1016/j.copsyc.2016.04.013

McKenzie-McHarg, K., Ayers, S., Ford, E., Horsch, A., Jomeen, J., Sawyer, A., Stramrood, C., Thomson, G., & Slade, P. (2015). Post-traumatic stress disorder following childbirth: An update of current issues and recommendations for future research. *Journal of Reproductive and Infant Psychology, 33*(3), 219–237. https://doi.org/10.1080/02646838.2015.1031646

Nicholls, K., & Ayers, S. (2007). Childbirth-related post-traumatic stress disorder in couples: A qualitative study. *British Journal of Health Psychology, 12*(4), 491–509. https://doi.org/10.1348/135910706X120627

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy Childbirth, 17*(1), 21. https://doi.org/10.1186/s12884-016-1197-0

Smith, J. (2015). Qualitative Psychology (3rd ed.). SAGE Publishing.

Stuijfzand, S., Garthus-Niegel, S., & Horsch, A. (2020). Parental birth-related PTSD symptoms and bonding in the early postpartum period: A prospective population-based cohort study. *Frontiers in Psychiatry, 11*, 570727. https://doi.org/10.3389/fpsyt.2020.570727

Sutherland, S. & Nestor, B. & Pine, A. & Garber, J. (2022). Characteristics of maternal depression and children's functioning: A meta-analytic review. *Journal of Family Psychology, 36*. https://doi.org/10.1037/fam0000940

Sweeney, S., & MacBeth, A. (2016). The effects of paternal depression on child and adolescent outcomes: A systematic review. *Journal of Affective Disorders, 205,* 44–59. https://doi.org/10.1016/j.jad.2016.05.073

Vossbeck-Elsebusch, A. N., Freisfeld, C., & Ehring, T. (2014). Predictors of posttraumatic stress symptoms following childbirth. *BMC Psychiatry*, 14, 200. https://doi.org/10.1186/1471-244X-14-200

Yildiz, P. D., Ayers, S., & Phillips, L. (2017). The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *Journal of Affective Disorders, 208,* 634-645. https://doi.org/10.1016/j.jad.2016.10.009