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**Listening to women after birth: their perceptions of postnatal support and the potential value of having a postnatal debriefing session with a midwife**

**Jackie Baxter**

A thesis submitted to City, University of London for the  
degree of Doctor of Philosophy

City, University of London  
School of Health Sciences

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## **Abstract**

This thesis examines women's experiences of postnatal care in hospital and on postnatal debriefing. The objectives were to determine what postnatal debriefing is; to understand reasons why some women attend such services; identify the views of women and staff towards this and finally explore women's feelings about their birth experience to identify possible links between this and the need for women to talk to a professional.

A case study utilised secondary data sources to identify women's experiences of care on the postnatal ward. This was followed by a critical literature review of postnatal debriefing which adopted meta-ethnography to analyse the varied research papers retrieved. The literature review was published in a peer-review journal. Finally the fourth research component followed a sequential mixed methods approach. This included a survey to a convenience sample of 447 women following birth and qualitative interviews with 16 women.

The findings of the case study showed that women felt unsupported on the hospital postnatal ward and the environment uncondusive to recovery. The critical review of the literature showed that postnatal debriefing enabled women to have their birth experiences validated by talking and being listened to and being provided with information. Results from the main research study show that women with a high Impact of Events Score (IES) are more likely to want to talk following their birth experience and more likely to rate their experience of birth more negatively compared with those with those with a low IES. Five themes were identified in the qualitative analysis that illuminated women's reasons for needing to talk about their birth experience. Women found the postnatal debriefing service of value. Maternity providers should consider offering a postnatal debriefing service to help meet women's postnatal support needs in advance of further research in this area.

## **Declaration**

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# **Chapter 1: Introduction (Commentary) to the structured thesis**

This introductory chapter provides the rationale for the work, the context within which the thesis is situated and the aims and content of the thesis.

## **1.1 Background to the thesis, rationale and importance of the topic**

This thesis considers the views of women in relation to their recent maternity care experience. In particular it highlights women's support needs following birth, during the postnatal time period. The perceptions of women to one aspect of emotional support, postnatal debriefing, are identified and form the focus of the later chapters.

The thesis results from a structured doctoral programme at City University which included four key components: a case study, a critical review of the literature, an original piece of research and a dissemination artefact. Firstly, a case study was conducted about women's experiences of hospital based postnatal care. This was followed by the second component, a critical review of the literature. This was on postnatal debriefing. The findings of this literature review were subsequently published in "Midwifery" international journal and this work is submitted as another component, the dissemination artefact. The final requirement of the structured doctoral programme was a primary research project. This comprised of a mixed methods study about women's experiences of a Birth Reflections (BR) service and reasons why women may or may not attend.

A scanned copy of the guidelines for the structured doctoral programme provides further detail to the reader and is given at Appendix A. These

guidelines informed the structure and study components of the thesis. The overall structure will be explained in section 1.3 of this introductory chapter. The national debate for improvements in postnatal care provision in the United Kingdom (UK) is ongoing and now even more important than ever. The findings presented and discussed in this thesis highlight the need for support by women postnatally, as well as during labour and birth.

This thesis was first worked on in 2008 when the first published national guideline for postnatal care “Routine postnatal care of women and their babies” (National Institute for Health and Clinical Excellence 2006) highlighted the important value postnatal care provides women. Around the same time two major national surveys of the maternity services were undertaken, incorporating the views of women (Health Care Commission 2007, Redshaw et al 2007). Both surveys identified negative aspects of practice during the postnatal period.

It had been known for some time that inpatient postnatal maternity wards fail to meet the needs of women (Maternity Services Advisory Committee 1985, Garcia et al 1997). More recently, and when the case study was being planned, there was a surge of evidence in the midwifery press highlighting the increasingly difficult environment within NHS hospital postnatal wards (Marchant 2006, Wray 2006a, Dykes 2005, Ockleford et al 2004).

Similar findings were identified at the first study hospital within this thesis, University College London Hospitals NHS Foundation Trust (UCLH). In 2003 an evaluation was conducted of the skill mix in the postnatal wards. The findings revealed statistically significant differences in women’s experiences and satisfaction with care (Baxter and Macfarlane 2005). The study involved 442 women who gave birth by caesarean section during two defined time periods. There was a 68 per cent response rate. However after the changes in skill mix there were still 22 per cent of women who reported overall care at night being poor or very poor. As an experienced midwife practising in this clinical area these findings were shocking.

There became the clear need to further improve care for women in this area, both locally and at national level. Postnatal care aims to promote maternal and infant physical and psychological health, enhance birth recovery and support infant feeding (Bick et al 2015). Quality postnatal care holds the key to hidden potential. Recognising the importance of ensuring that care is satisfying for women and babies and the fact that limited work had been carried out to date in this area was the first step.

For the first two years, when the case study was being conducted, the doctoral programme was supported within my position as the Research and Development Midwife. Following a staffing consultation in 2010 this post was discontinued. This led me to moving to a new post as the Divisional Clinical Governance Midwife at Buckinghamshire Healthcare NHS Trust. As the structured doctoral programme involves undertaking a series of four independent studies relevant to continuing professional practice (case study, critical review of the literature, original piece of research and a dissemination artefact), I was able to move my research focus at this time.

Part of my new position included managing the established “Birth Reflections” service. This service offered women the opportunity of revisiting the hospital after they had returned home to meet with a midwife and discuss their birth experience. This opportunity had been withdrawn in London following the publication of a national clinical guideline in 2007 which identified there was no evidence of benefit for routine postnatal debriefing (NICE 2007). Following this, postnatal debriefing services had been disbanded in London. However the NICE postnatal care guideline recommended the need for women to be offered the opportunity of discussing their birth experience (NICE 2006). Discovering this established service, still running outside London, and seeing women seemingly benefitting from attending, I was curious to find out more about its benefits for women and why they attended. For this reason this became the focus of the next steps of my work in postnatal care, for both the critical

literature review and the research project. Another change in professional position in November 2013 found me back in London at another large teaching hospital where I was appointed as a Full time Supervisor of Midwives. In this role I set up a birth reflections-type service. This was fashioned on the Buckinghamshire model. This was at the time I was completing the data collection and analysis for an exploratory mixed methods research (MMR) study which set out to gain a greater understanding of the nature of postnatal debriefing and possible reasons why women attend the service. It was anticipated using two research methods would enable the gathering of different types of data to provide optimal understanding on this topic.

## **1.2 Overall aims of the thesis**

As discussed in section 1.1 above the original aim of this thesis was to improve the quality of care for women on the hospital postnatal ward. Since that time the direction of focus of this thesis has changed. Whilst postnatal debriefing is situated within the more global topic area of postnatal care the above overarching broad aim still applies. However secondary aims have also been introduced. These are to carry out a case study of women's experiences of hospital postnatal care, to perform a critical review of the literature on postnatal debriefing and finally to undertake a research project on postnatal debriefing. Further aims and objectives of each component of this thesis, which is based on the guidelines of the structured doctorate (Appendix A), are given in the respective sections below.

## **1.3 Overview of the component studies and how they form the structure of the thesis**

### **1.3.1 Case study**

This was about women's experiences of care on the hospital postnatal ward and the first element of the structured doctorate. It was conducted between 2008 and 2010. This came about following earlier research mentioned in section 1.1 which identified that 22 per cent of respondents to a survey considered their care on the postnatal ward as being either poor or very poor. There was the consequent need to understand reasons for this. The overall aim of this case study was to review women's experiences of care on the hospital postnatal ward at an inner London teaching hospital. The objectives were:

- To identify the experiences of women receiving care on the postnatal ward at a NHS Foundation Trust Hospital in inner London.
- To identify possible reasons why some women are dissatisfied with their experience of care on the hospital postnatal ward at the study hospital.
- By situating this case study within the wider United Kingdom literature, to compare the experiences of women receiving postnatal care at a specific NHS Foundation Trust hospital with the experiences of women nationally.
- To conduct a longitudinal study of postnatal care within an NHS Foundation Trust hospital over time to see whether the service is improving.

This case study was pragmatic in that it utilised secondary data to identify women's experiences of postnatal care on the postnatal ward at the study hospital. Gaining a wealth of understanding of the views of women to hospital based postnatal care proved of great value in which to situate the context of the later birth reflections study. This focused on another aspect of postnatal care provision, albeit in relation to labour and birth. Postnatal debriefing is also a form of support for women postnatally (Barimani et al 2015).

The findings of the case study showed that women following birth perceived there was a lack of support and care on the hospital postnatal ward at the study hospital. In addition the qualitative analysis identified the environment of the postnatal ward to be un conducive to recovery following birth according to the participants. These findings concurred with other results and provided further evidence to the ongoing need to review how postnatal care in hospital is provided for mothers and babies nationally. Whilst a planned action research study to improve postnatal care in hospital did not go forward due to a change of position the study was reframed to consider women's postnatal support needs in relation to their emotions and how the birth experience left them feeling. There was a strong likelihood that if women in the case study were left feeling unsupported in relation to physical and practical aspects of care that emotional aspects of support would also have gone unrecognised. Moving to another NHS trust and seeing how some women received support in this way through an established postnatal debriefing service was the impetus for researching postnatal debriefing.

### **1.3.2 Critical review of the literature**

The main aims and objectives of the critical review of the literature were to undertake an analysis of the application of postnatal debriefing, to describe current practice in offering debriefing services to postpartum women and to identify the perceptions of women in accessing these services. This was undertaken throughout 2011. The literature review confirmed that women and midwives perceived it was good for women, following birth, to talk and be listened to by a health professional. However there was, at the time when the main research study was being planned, limited and divergent evidence on the effects of postnatal debriefing. The findings of the critical literature review, together with the fact that little research has been undertaken in this area, triggered the need for further study in relation to postnatal debriefing. This

consequently contributed to informing the subsequent research project on postnatal debriefing.

### **1.3.3 Dissemination artefact**

This is a shortened version of the critical review of the literature described above. This was published in Midwifery journal in February 2014

### **1.3.4 Birth Reflections research project**

The main aims of the research project were to determine the reasons why certain groups of women accessed (or did not use) a postnatal debriefing service and to provide a rich description of their perception of the service. In addition the study also planned to explore women's feelings about their birth experience more generally following birth. Exploring women's feelings in this way it was felt might determine possible reasons why women have the need to attend a postnatal debriefing session i.e. there could be an association between the birth experience and the need to talk following birth.

Ethical approval for the research project was granted in August 2013. Following this a postal survey was administered. Data collection for the qualitative strand of this MMR study continued throughout 2014. This was concurrent with analysis. The final report was completed in August 2015.

## **1.4 Personal interest**

This doctorate has been informed by both my clinical experience and time spent as a research midwife within an NHS clinical facility. I have practised as a clinical midwife in a variety of settings and positions, both in the UK and overseas, for over 30 years. Over the past 20 years I have developed a

particular interest in postnatal care and have regularly practised clinically in this sphere of practice. In 2003 I was a relative newcomer to research. My only previous research experience had been in 1999 when I completed an MSc programme at the University of Surrey and undertook a small research study. This study used both quantitative and qualitative approaches to investigate the experiences of women undergoing HIV testing during pregnancy. This was at a time when treatment options for those who were HIV positive did not exist. The fieldwork was undertaken at a different hospital in outer London where there was high ethnic diversity in the population. The study was published (Baxter and Bennett 2000). This being my first research project set my ongoing direction and my preference for mixed methods approaches. In my mind there is more than one way of seeing the world. Using different approaches provides the opportunity of collecting more data and gaining a stronger dataset to answer a research question.

When I commenced the doctoral programme in October 2008 I was working as a research and development midwife in an inner London teaching hospital. In this role I undertook research activity, including primary studies as well as supporting colleagues with their own projects. This doctorate has been a long personal journey. The structured pathway has allowed me to change direction although remaining with the same overall topic of postnatal care.

## **1.5 Support for women during the postnatal period**

Support became a theme throughout the thesis. A key finding of the case study on women's experiences of hospital based postnatal care was that women were found to lack professional support on the hospital postnatal ward. When undertaking the analysis as part of the main Birth Reflections study the importance of women feeling supported during labour and birth came through strongly. Additionally during the process of this thesis it became clear to me that postnatal debriefing can be viewed as a form of postnatal support. For these

three reasons a literature review of the evidence relevant to professional support in relation to postnatal care has been included to provide a context for this.

## **1.6 The use and contemporary relevance of the doctoral work**

The separate elements of research activity undertaken within this structured doctorate have been utilised as the thesis has developed. Following data analysis the findings of the case study were presented to both the management and clinical teams. The head of midwifery and I worked together on a proposed new model of care for women on the postnatal ward.

The research undertaken within this thesis on postnatal debriefing has also played a role in relation to clinical practice. The critical review of the literature on postnatal debriefing was published in the Midwifery Journal in February 2014. In addition both the findings of this literature review and those of the main Birth Reflections study have helped to support the development of a new birth reflections service at Imperial College Healthcare NHS Trust, where I was employed at the time this thesis was first submitted.

All sections of this work that took place within a structured doctoral programme are of relevance today. The importance of reviewing postnatal care provision is listed as a key principle in a recently published report of a review of the maternity services in England (NHS England 2016). Both aspects of care provision covered in this thesis: postnatal care in hospital and postnatal debriefing, will be of assistance to the transformation teams within the maternity services as the work recommended by the authors of the National Review progresses (NHS England 2016).

Chapter 5 sets out the implications of the separate studies for future research and practice development. Together these findings highlight a need for improved support for women following birth postnatally. This thesis has shown that some women may be supported emotionally through a postnatal debriefing session with a health professional. There is therefore the need to consider whether all women are provided with the routine offer of a postnatal debriefing meeting. This work has also identified potentially a high proportion of women with high post-traumatic stress (PTS) symptoms so there is a consequent need to also consider the possibility of screening women following birth in this regard. Finally the findings of the critical review of the literature and the birth reflections study should contribute to the interventions in future randomised controlled trials (RCT) in relation to the nature of what happens at a postnatal debriefing session.

## **1.7 Chapter summary**

This introductory chapter has explained the background to the thesis and rationale for undertaking this work. The main aims of the individual elements within the structured doctorate have been given. The linkages between these have also been shown. Finally this chapter introduced the importance of professional support in relation to postnatal care. This phenomenon was continually highlighted throughout the various stages of the thesis. The next chapter is dedicated to the case study of women's experiences of postnatal care in hospital.

## **Chapter 2: Case study: Women's experiences of hospital postnatal care**

### **2.1 Introduction and background**

This case study is about women's experiences of hospital postnatal care. It is pragmatic in nature and uses previously collected data from three separate surveys to explore issues raised by women. Both quantitative and qualitative research approaches were used.

In 2002 a significant number of women who gave birth by caesarean section at the study hospital reported that they felt neglected on the postnatal wards. There was a shortage of midwives and a high number of women following caesarean section needing additional care. In order to address this nurses and nursery nurses were recruited and added to the staffing skill mix. As mentioned in chapter 1 above a formal evaluation was conducted and statistically significant findings in terms of satisfaction and care experience were reported when comparing views of care before and after the introduction of additional staff (Baxter and MacFarlane 2005). The freetext comments made by the women respondents who completed the questionnaires were not fully analysed at the time but indicated that some aspects of care on the hospital postnatal ward were found to be lacking.

In 2007 a national maternity care satisfaction survey was undertaken by the previous health care regulator, Health Care Commission (HCC) (HCC 2007). This provided each NHS Trust in England access to data and information about their own maternity service. This survey identified that postnatal care in the hospital environment was rated less highly by women than other aspects of maternity care. It was clear that women's perceptions of postnatal care were

less favourable than other aspects of maternity care, both locally and nationally. The HCC later offered hospital trusts the opportunity of commissioning a repeat survey in 2009. This opportunity was taken up at the study hospital (Quality Health 2009). This allowed me access to three separate data sets of women's views of postnatal care at one NHS Foundation Trust. The rationale for undertaking this work was to further clarify reasons why women find postnatal care in hospital more problematic and less favourable compared with antenatal care and care provision during labour.

The three studies mentioned above formed the basis of this case study. These are the locally conducted caesarean survey and the two surveys undertaken by the Healthcare Commission.

## **2.2 Aims and objectives**

The overall aim of this case study was to review women's experiences of care on the hospital postnatal ward at an inner London teaching hospital. The objectives were:

- To identify the experiences of women receiving care on the postnatal ward at a NHS Foundation Trust Hospital in inner London.
- To identify possible reasons why some women are dissatisfied with their experience of care on the hospital postnatal ward at the study hospital.
- By situating this case study within the wider United Kingdom literature, to compare the experiences of women receiving postnatal care at a specific NHS Foundation Trust hospital with the experience of women nationally.
- To conduct a longitudinal study of postnatal care within an NHS Foundation Trust hospital over time to see whether service is improving.

## **2.3 Postnatal care in hospital**

Postnatal care is the term used for the care provided to women and their babies after they have given birth. This time period has been referred to as the “lying-in” or postpartum period. Traditionally, in the United Kingdom, care at this time has been administered by midwives. This commences when a woman is in hospital immediately following birth and extends to the community setting where women are visited in their homes by midwives. More recently some women receive a mixture of home visits and postnatal clinic appointments.

### **2.3.1 Definition: what is postnatal care?**

As mentioned above the “lying-in” period is a historical term utilised to describe this time period in a woman’s life. Calder used the two terms, puerperium and lying-in period, interchangeably (Calder 1912). During the puerperium the mother recovers from the effects of the pregnancy and labour through three processes: cicatrisation or the healing of wounds; involution and lactation (Calder 1912).

When considering the early regulations for midwifery practice Calder understood these rules applied to the time when a woman was in labour and extending to ten days after (Calder 1912). It is of interest that almost one hundred years since this book was written, midwives in the UK, are still using this definition and continue to visit women for up to ten days following the birth. More recently, Marchant (2006) in her commentary paper in anticipation of the launch of the national postnatal care guideline which was published by the National Institute of Care Excellence (NICE) in 2006, discussed the difference between puerperium and postnatal period. According to this author the former refers to the physiological condition of each woman and the latter term refers to

how this state is viewed with regard to the need for care and support, management and professional responsibility (Marchant 2006).

The National Institute for Health and Clinical Excellence's (NICE) clinical guideline on postnatal care that was current at the time of the case study (NICE 2006) defined postnatal care as care provided for women and babies following birth, which includes physical observation of a mother and her baby, screening of the baby, support with infant feeding and the provision of ongoing information (NICE 2006). This document described care for women and babies to receive as appropriate to their individual needs. A key component of this was the provision of information. The premise of the guideline was that most women experience an uncomplicated recovery following birth. However according to this key policy document, based upon the best available evidence, the overall aim of care at this time is to identify and address any deviation from expected recovery.

### **2.3.2 Historical background**

Towards the end of the nineteenth century social reformers in England, including Florence Nightingale and Zepherina Veitch, campaigned for improved living conditions and health for poor women (Donnison 1988). This was against a backdrop of high rates of maternal and infant deaths in the first few weeks after childbirth and no formal recognition of the midwife (Marchant 2010). Zepherina Veitch was one of the most influential women to promote the education of midwives. Her work with, Louisa Hubbard, the proprietor and editor of the women's journal, "Work and Leisure", led to the establishment of the Trained Midwives' Registration Society, a forerunner to The Royal College of Midwives (Cowell and Wainwright 1981). This activity led to the eventual passing of the Midwives' Act in 1902 in England. This act provided for the regulation of midwives in England. It set the education standards for midwives and introduced state registration. It also prohibited practice by uncertified

midwives (Donnison 1988). The newly formed Central Midwives' Board was responsible for regulations which set out specific standards and tasks to be undertaken by certified midwives. This included postpartum care and clinical observations.

The rationale for the tasks expected to be undertaken by the new certified midwives was set out in text books at the time, written by medical practitioners. This was primarily led by concern over risk of illness and death following childbirth (Calder 1912, Berkeley 1924, Longridge 1906) as opposed to the need for recovery and restoration to normal health (Marchant 2010). Marchant (2010) emphasised that this is still an issue in the 21<sup>st</sup> century.

Two levels of postnatal care or midwifery support is apparent from practice at this time: firstly support that is based on technical skills i.e. undertaking physical observations, and more practical aspects of care such as help with washing and eating. As mentioned above in the early 1900s the prospect of death from disease or blood loss was ever present. The new certified midwives were therefore required to undertake women's observations, including temperature, pulse and respiratory rate. The midwives were also required to undertake palpations of the uterus, observations of the blood loss and lochia, observations of the breasts and provide support with breastfeeding as well as observe bladder and bowel function (Calder 1912). It is also of interest that the need to observe psychological well-being was also stipulated at this time (Marchant 2010).

As well as the need to attend to technical aspects of care provision, discussed in the previous paragraph, women at the start of the 20<sup>th</sup> century also required care following birth in the form of social support (Marchant 2010). This included aspects of practical support such as helping with hygiene through the use of bed baths and irrigation of a woman's genital area; encouraging bed rest; attending to dietary needs and even cooking on occasions and helping with other household chores (Marchant 2010). Midwives at this time also had the

ability to help improve living conditions on behalf of an individual woman by notifying the relevant authority when conditions were found to be lacking (Marchant 2010). It is possible these more practical aspects of care provision were given by an untrained “monthly nurse” leaving the certified midwife to attend to the technical aspects of care discussed above.

In his text book, "Lectures on Midwifery for Junior Students and Midwives" Calder (1912) provided guidance on the management of the puerperium. The list included measuring the maternal pulse and temperature, observing and providing support for pain, monitoring urinary and bowel activity, observing the lochia (vaginal loss) and measuring the involution of the uterus (Calder 1912). The importance of asepsis was also stressed in this book with the need to ensure pads were scorched prior to application on a woman's perineum. In addition the importance of rest and sleep at this time was also advocated by this author (Calder 1912).

### **2.3.3 Postnatal care in the 21<sup>st</sup> century**

The care of postpartum women is not too dissimilar in today's age to what occurred historically, described in the above section. This is despite significant changes in public health, a reduction in maternal mortality through the use of antibiotics and utero-tonics and changes to the role of women in society more generally. Midwives in the UK provide this aspect of care to women, initially in a hospital postnatal ward. This is extended to the woman's home and/or at a postnatal clinic facility. Midwives undertake regular observation of a woman's physical condition, including temperature, pulse and blood pressure, as well as her vaginal loss and the condition of her breasts. As in the historical context, the role of midwives in postnatal care in the 21<sup>st</sup> century is also a practical one where they provide support with breastfeeding and the care of the new baby.

Although not based on evidence there are rules that govern the time periods in which a midwife in the UK should visit a woman in the postnatal period. In the Midwives' Rules in 1998 it was specified that the midwife should visit a woman for not less ten days following birth or more than 28 days (UKCC 1998). The wording was changed in the 2004 version of this document which advises the need for midwives to visit women for "not less than ten days and for such longer periods as the midwife considers necessary" (NMC 2004 p7).

i) *Research evidence*

Research into the timing and content of routine postnatal care only commenced in the early 1990s (Bick 2010). The House of Commons Select Committee in 1992 reviewed all areas of maternity care, including antenatal, intrapartum and postnatal. In relation to postnatal care the report noted that this aspect of maternity care was poorly evaluated and researched. The report also considered that postnatal care was delivered in inappropriate and fragmented ways and it also highlighted the need to improve managerial arrangements for postnatal care by making effective use of resources (House of Commons 1992). Further emphasising the need for research in this area, the "Changing Childbirth" report, the following year, recommended the need to undertake research more broadly in postnatal care. This it was envisaged should include redesigned postnatal services as well as the impact of continuity of care schemes (Department of Health 1993).

To this end the Audit Commission in the late 1990s undertook a survey of the maternity services in England and Wales. This aimed to make recommendations for improving the economy, efficiency and effectiveness of services. The report was aimed at managers and purchasers of maternity services and reviewed the extent and direction of the changes that were occurring in response to policy (Audit Commission 1997). Thirteen NHS Trusts and 12 commissioning bodies were included in this study. Although not all hospitals and health authorities were included there was representation in the

sample from all geographical areas. In addition general practitioners (GP) were included and there was a national sample drawn for a specific survey of women.

Two key recommendations were provided. Firstly there was the need to involve women in the decision about how long they remain in the hospital after birth.

The second recommendation was to clarify the objectives of postnatal care and set standards (e.g. breastfeeding). This report also found that women need time following birth to recover, both physically and emotionally, in order to establish feeding and form relationships with their partner and their new baby. The report also identified that recovery from birth is hampered by a woman's own health problems. Therefore the report recommended the need to ensure that care at this time is properly planned and delivered. Another important finding from this report was the importance of there being a good environment on the postnatal ward. It was identified that facilities on the postnatal ward can contribute to the recovery of mothers from the birth experience and their overall sense of well-being. This includes safety and security, quality of the food and privacy when feeding. Finally this report also made further recommendations in relation to research. This was to research into effective postnatal care for mothers and babies to help the service develop cost effective postnatal care.

In response to the calls for the content of postnatal care to be reviewed and evaluated, since the 1990s, some observational studies on specific aspects of postnatal care have been conducted. These highlight the role of the midwife in relation to physical observations (e.g. uterine blood loss and involution) (Cluett et al 1995, Cluett et al 1997, Garcia et al 1994, Marsh and Sargent 1991, Montgomery and Alexander 1994, Takahashi 1998). There have also been studies undertaken on the role of the midwife and women's psychological well-being, including postnatal depression (Davies et al 2003, Lavender et al 1998, Webster et al 2003). In addition some RCTs of postnatal care interventions have been conducted (e.g. MacArthur et al 2002 and Twaddle et al 1993). However only one has statistically significant findings (MacArthur et al 2002). It

is of interest that these findings have not since been adopted with policy makers (Bick 2010).

Whilst there are pockets of interest within the overall topic of postnatal care that have been researched (e.g. attachment and separation, breastfeeding and postnatal depression) the area of postnatal care in general remains under researched nearly 20 years since the need was raised. There remains a lack of understanding about the constituents of postnatal care, both in relation to physical support as well as more practical aspects, including the transfer of information and advice for new parents to gain confidence in caring for their baby (Marchant 2006, Wray 2006a).

More recently Wray (2006b) has also identified a need to reassess postnatal care. In a paper on her personal reflections of undertaking observations as part of a research study on a postnatal ward, Wray raised the notion of postnatal care becoming deficient in its purpose (Wray 2006b). This paper also included her personal opinion based on her work experience as a midwife in this area. She saw care in the postnatal ward as being undervalued. Following birth on the postnatal ward women were unsupported by staff who themselves were busy and frequently relocated to labour ward. Wray considered that this could be related to the naturalistic nature of mothering and assumptions that women should know what to do as soon as a baby is born. In addition, from a historical perspective Wray recognised that the organisation and delivery of care in this area had not changed much since its inception at the beginning of the twentieth century.

#### ii) *Maternal morbidity*

Research studies, both in the UK and Australia, have identified high levels of physical and psychological morbidity among women following childbirth (for example Brown and Lumley 1998, Glazener et al 1993, Glazener et al 1995 and MacArthur et al 1991). In Victoria, Australia, Brown and Lumley (1998)

administered a postal survey to women between six and seven months following birth. The aim was to describe prevalence of physical and psychological maternal morbidity. One thousand, three hundred and thirty six women responded (62.2%). This study identified 94% of women experienced one or more health problems following birth. These included tiredness, backache, sexual problems, haemorrhoids and perineal pain.

Other researchers in Scotland also set out to describe the prevalence, as well as possible causes, of postnatal maternal morbidity at three different time points: one week following birth in relation to their time whilst still in the hospital after the birth; eight weeks and 12 – 18 months after birth. Seventy six per cent of the sample (n=1249) reported at least one health problem. These researchers also compared differences according to parity and method of birth. Primigravid women were more likely to experience certain problems, including painful perineum and vaginal loss compared with women who had given birth before. In addition women who had a vaginal assisted birth were more likely to report painful perineum, stitches breaking down, constipation and piles (Glazener et al 1993, Glazener et al 1995).

The first large comprehensive survey in the UK was undertaken in 1987 at a hospital in the West Midlands to determine health problems among women after childbirth (MacArthur et al 1991). The original aim of this work was in relation to the after effects of epidural anaesthesia in labour. The authors at this time considered the need to assess possible long term outcomes of the use of epidural anaesthesia. However during the planning of the proposed study they recognised the need of broadening the objectives. The study was consequently extended into a more general investigation of the prevalence of long term health problems following childbirth and their associations with a range of social, obstetric and anaesthetic circumstances and procedures. The authors highlighted that the research literature up until this point had been sparse on this topic area. They considered this would be a valuable addition to knowledge

on postnatal health as well as encompassing the original questions concerning the long term effects of epidural anaesthesia (MacArthur et al 1991).

Data sources used in this large survey were case notes of the female respondents and completed survey forms. The individual women responded to the survey between nine years and 13 months after giving birth. The results showed that morbidity was widespread. Forty seven per cent of the 11,701 women who responded to the survey (39%) reported experiencing one or more new health problems lasting for more than six weeks since the birth. Most frequent symptoms reported by the respondents included backache (14%), headaches and migraines (3.6%), musculo-skeletal (8.2%), stress incontinence of urine (10.6%), haemorrhoids (5.3%) and depression, anxiety and extreme fatigue was experienced by 12.2% of all respondents.

Other reported findings included a powerful association between backache and epidural anaesthesia and higher levels of fatigue among women who were unmarried, breastfeeding and who gave birth to twins (MacArthur et al 1991). In response to these striking findings the authors made urgent recommendations for further study in this area to assist in addressing the issues faced by women (MacArthur et al 1991).

Some of the postnatal morbidity identified in the literature is caused as a direct consequence of the birth process itself (e.g. stress incontinence, perineal pain) whilst other conditions may be related to the impact of caring for the new baby (Bastos and McCourt 2010, MacArthur et al 2003).

The findings on the proportions of women who experience postnatal morbidity are striking. This highlights how women's health can be impaired following childbirth. However it is of interest that relatively few studies have been conducted on this topic, both physical and psychological, and fewer still studies have looked at this from the perspectives of the women themselves (Bastos and McCourt 2010).

One study that did consider the perspectives of the women themselves was undertaken by Bick and MacArthur in the early nineties in the UK. These researchers recognised the need to find more information about how the symptoms were experienced by the women, including the frequency, the impact on their lives and the severity. A postal survey was sent to a sample of women between six and seven months after the birth. Interviews were also conducted with all the women who experienced symptoms as well as a random sample of those who did not. It was reported the response rate to the survey was 80% after 1667 questionnaires were posted. The paper reported on four key symptoms reported by the women. These were backache (46%), headache (20%), extreme tiredness (41%) and stress incontinence (72%). Extreme tiredness measured the highest both in terms of symptom severity and on the effect of activities the women were able to undertake. Seventy five per cent of those who reported this symptom said it affected their lives. In addition this was the third least likely symptom to be reported to a medical practitioner by women in this sample. The authors of this study concluded that the health needs of women are not being met. They suggested that many women consider the various symptoms to be natural consequences of childbirth and accept them rather than seeking help (Bick and MacArthur 1995). It seems these women may well be suffering in silence.

The findings of the study by Bick and MacArthur concur with other studies that raise the important issue that a high proportion of women reporting symptoms of postnatal morbidity do not seek medical consultation. In this study 46% of respondents who had one or more symptom said they consulted a doctor, whilst 86% of those who reported having stress incontinence did not consider the need to consult a doctor.

As the authors to these studies and elsewhere comment, maternal morbidity is frequent and under-recognised (Bick and MacArthur 1995, Brown and Lumley 1998, Glazener et al 1995, MacArthur et al 1991). Further evidence of this

phenomenon comes from a large evaluation of a new model of midwifery care. The researchers undertook a survey. This included a question on type and level of postnatal symptoms they experienced two and 12 weeks after birth (McCourt and Page 1996). This study included women from diverse social groups and those who were at both low and high risk of obstetric complications. The findings showed that many women experienced a wide range of problems postnatally, many of which were more significant at 12 weeks following birth. For example 30% reported leaking urine and around half reported perineal or caesarean wound pain at 12 weeks (Bastos and McCourt 2010, McCourt and Page 1996).

These findings that a significant number of women experience morbidity in this way influenced the development of further studies, as mentioned in the section above, on redesigned models of midwifery care to improve women's experiences of postnatal care. At least four studies were conducted in the UK but only one showed significant findings in relation to outcomes. This study was conducted in the West Midlands of England. Women in the intervention arm were randomised to additional support from a midwife during three home visits: at 10 days; 28 days; and 10-12 weeks following birth (MacArthur et al 2002). Significant differences were found in maternal mental health outcomes at four and 12 months following the birth. In addition secondary outcomes of women's views of care were more positive in the intervention group or did not differ between groups. However, there were no differences in physical health outcomes.

As mentioned above, this is the only RCT conducted to date which has provided evidence that this model could be effective in providing improved support for women from a midwife in the extended postnatal period. This highlights the potential role of the midwife in relation to public health. This is done by preventing morbidity and responding effectively to problems that women experience (Bastos and McCourt 2010). However further studies are awaited to provide additional support for these findings. Whilst this has not been tested in

practice and only within an RCT the authors justified the findings and consequent need to introduce into the NHS (Bick 2010).

High rates of postnatal morbidity have also been recognised in other European countries. A survey was conducted in France and Italy which identified high numbers of affected women at five and 12 months following birth. It is of interest that the prevalence of symptoms was higher numbers for most symptoms at 12 months compared with five months after birth. These authors also considered the social situations women were in at the time. They found associations with between financial problems or a difficult relationship with the partner and the woman's own wellbeing (Saurel-Cubizolles et al 2000) This study raises further concern about the effect of long term conditions on the lives and well-being of women and families.

This high rate of maternal morbidity further highlights the importance of effective postnatal care. It is clear that it is common for women to experience a number of health problems at this time. Some studies highlight the fact that many women do not report their symptoms to a health professional (Bastos and McCourt 2010, MacArthur et al 1991, MacArthur et al 2003). There is therefore the need to encourage women to report any difficulties they experience. When reported they need to be taken seriously by midwives and other health professionals (Bastos and McCourt 2010). However it has been recognised that many of the issues would not be detected during the currently defined "postnatal period" (Bick 2010). Common conditions that impacted on women's well-being identified in these studies included backache, urinary incontinence, headaches and fatigue (Bick and MacArthur 1995).

### *iii) Policy directives*

Becoming a mother is a life-changing event and the transition is not always smooth (Dyer 1963, LeMasters 1957). The findings of the Impact study discussed above were identified through an RCT (MacArthur et al 2002). As

discussed above they have not been tested widely in practice despite calls to introduce this practice into the NHS (Bick 2010).

The findings of the Impact study have been used to inform various policy documents, including the National Service Framework for Children, Young People and Maternity Services (DoH 2004). It recognised that new mothers have much to learn following the birth of a baby and that it is essential that services promote high quality care to meet the needs of parents and children which includes the need for instilling confidence and providing support among new parents (Department of Health 2004). This confirmed the need to ensure the provision of support for women and families following birth. The focus was on high quality care designed around the needs of individual women. This report highlighted the value placed on maternity care in relation to the health and development needs of babies and growing children. It also recommended the need to increase the time period during which midwives are involved in the postnatal care of women. This was subsequently extended to between six and eight weeks after birth and reflected in the Midwives' Rules (NMC 2004).

The RCT study by MacArthur et al (2002) also influenced the recommendations made in a new national clinical guideline on postnatal care in 2006 (National Institute for Health and Clinical Excellence 2006). This guideline utilised evidence from clinical and cost-effective care to develop recommendations for practice for mothers and babies for the first six to eight weeks following birth. Key areas included planning the content and delivery of care and the need for a documented, individualised care plan; maternal health; infant feeding and maintaining infant health. The need to share important information with women about their own and their babies' health was also a key message from this guideline.

"Maternity Matters", built on the national service framework, setting out the context and vision for the maternity services. This also stressed the importance of ensuring that all children are given the best possible start in life (Department

of Health 2007). As with previous reports the importance of women being given choice in relation to their maternity care was recognised. This document also stressed the importance of using resources effectively and fairly to promote health and to reduce inequalities and deliver care that is both of high quality and the safest. Where postnatal care was concerned “Maternity Matters” proposed that women have the choice to have their postnatal care following transfer home, either in their homes or at polyclinics. However this has posed concern that those most vulnerable risk missing out on valuable aspects of care provision (Bick 2008).

There are currently changes to the maternity workforce and professional boundaries are altering. There is mention in “Maternity Matters” about the key role maternity support workers (MSW) play in the maternity services (Sandall et al 2007). Sandall and colleagues (2007) undertook a large scoping study of the role of MSWs in maternity care. Whilst the value of their presence in the maternity wards was highlighted (e.g. breastfeeding support) there were some concerns raised about the risks of boundaries becoming blurred and these support workers might inadvertently undertake midwifery duties they are not trained for (Sandall et al 2007). There is therefore an urgent need to ensure training is undertaken and appropriate tasks undertaken by this new workforce to ensure that women receive care of the highest and safest standard (DoH 2007).

As mentioned above there is a dearth of research evidence on the content of postnatal care. Therefore the prospect of a national clinical guideline in this area should have been acknowledged with open arms by professionals providing postnatal care. However, while most clinical guidelines created by the National Institute of Health and Clinical Excellence (NICE) use quantitative forms of evidence, including randomised controlled trials (RCT) and systematic reviews, the NICE Postnatal Care guideline was based on varying forms of evidence, including different types of study design. This, the authors stated, was due to the nature of the various research questions being posed and the small amount

of published evidence available on the population group relevant to the guideline (NICE 2006). In the absence of RCTs observational studies, surveys and expert formal consensus results were utilised. Whilst there were some RCTs included in the evidence review, it appears the findings and recommendations made in this national clinical guideline have primarily been made through expert opinion and lower grade research evidence.

One on-going concern since the publication of the postnatal care national guideline is the fact that many of the recommendations have not been adopted in mainstream practice. This contrasts with behaviour nationally following the publication of other NICE guidelines (e.g. intrapartum care and antenatal care) where at the time of publication of the new or revised guideline current practice is compared by maternity units at local level with the findings of the newly published guideline and adaptations are made to reflect the new evidence.

#### **2.3.4 Dissatisfaction with postnatal care**

Dissatisfaction with postnatal care is not a recent phenomenon. The period in hospital immediately following birth has become a neglected phase (Bick et al 2002, House of Commons 1992, Wray 2003). There is an ongoing failure to meet women's needs during this time: they are left with undiagnosed morbidity (Glazener et al 1995, MacArthur et al 1991) and feeling unsupported (Garcia et al 1998, Ball 1994, Bhavnani and Newburn 2010, House of Commons 1992, Maternity Services Advisory Committee 1985, Singh and Newburn 2000, Wray 2003).

There are many reasons why women have felt unsupported when on the hospital postnatal ward. These include receiving insufficient rest despite being tired (Beake et al 2005, McLachlan et al 2008, Wray 2006a), experiencing insufficient help with breastfeeding (Brown et al 2005, Dykes 2005, Ruchala and Halstead 1994, Yelland et al 1998) and staff attitudes have been reported as

poor (Beake et al 2010, Bick et al 2008, Brown et al 2005, Redshaw et al 2007, Stamp and Crowther 1994, Yelland et al 1998). This contributes to women feeling they go without attention (Beake et al 2005, Brown et al 2005, Dykes 2005, Forster et al 2006, Rayner et al 2008, Wray 2006a). Insufficient resources have also been implicated as a causative factor (Bick 2010). In addition there is a lack of comprehensive knowledge and research undertaken in this area (House of Commons 1992, Wray 2003). This all goes some way to understanding why postnatal care has become known as a Cinderella service. This name illustrates how this aspect of maternity care provision is undervalued (Oakley 1979, Wray 2003).

There has been increasing evidence in the midwifery press highlighting how shortages of staff impact on care and leave women unsupported on the postnatal ward (Dykes 2005, Ockleford et al 2004, Wray 2006a and b). Two national surveys of the maternity services found women's experience of postnatal care to be poor in comparison to their experience of antenatal and labour care (Healthcare Commission 2007, Redshaw et al 2007), with one in five women rating it as fair or poor (Healthcare Commission 2007). A large proportion of women receiving care on the hospital postnatal wards reported a lack of information and explanations, not being treated with kindness and understanding, and poor standards of cleanliness (Healthcare Commission 2007).

It is clear from Wray's study (Wray 2003) that the emotional wellbeing of women becomes as important as their physical needs at this time and this was reflected in a national maternal mortality report where suicide is identified as the overall leading cause of maternal death (Lewis 2007).

The best way of organising hospital based postnatal care remains unclear. At the time the case study was planned a study in Australia aimed to design and implement strategies to improve hospital-based postnatal care within a metropolitan hospital within an action research framework (Schmied et al 2008).

The strategy most likely to result in improved care or satisfaction identified by the authors was the need for all women to receive more dedicated time with a midwife prior to discharge home.

## **2.4 Local context of the case study**

The study was situated in the maternity unit of an inner London teaching hospital. It drew on three studies which examined postnatal care in this service. Over the time of the three studies the number of births increased. During 2002, 2934 women gave birth at this hospital. This number increased to 3959 in 2007 and in 2009, 5056 women gave birth at this hospital.

The population of women giving birth at this hospital is mixed with just over one third describing themselves as white British, a further 20 percent saying they are white other. The next two largest groups are black African and Bangladeshi with proportions of eight and six percent respectively.

The hospital has a long history of providing maternity and neonatal services to the local population and, in addition, specialist services to women and babies referred from units across a wide geographical area. Approximately 50 per cent of the total maternity activity is taken up by the local population. The remaining 50 per cent comes from women who live outside the area. Many women from beyond the usual boundaries book at this hospital, some because they work in central London, some for specialist services and some book specifically for the birth centre.

## **2.5 Methodological approach and research design**

### **2.5.1 Introduction**

In accordance with the requirements for the structured doctorate, a case study approach has been taken. This used secondary data sources. The descriptive case study is exploratory in nature due to there being limited previous research on this topic of women's experiences of postnatal care in hospital. I looked at what women have said over time in relation to postnatal care in one NHS trust. In order to see whether the findings are unique to this hospital, I wished to set these findings within the context of what was known about satisfaction with postnatal care nationally.

### **2.5.2 Case study research**

Case studies are in-depth investigations of a single entity or a small number of entities (Polit and Beck 2010). Hakim (1987) considered case studies to be the most flexible of all research designs and described a range in levels from simple descriptive accounts of one or more cases through to being used to achieve experimental isolation of selected social factors and therefore offering the ability of conducting experimental research within natural settings (Hakim 1987). According to Yin (2009), the definition of a case study is "an empirical inquiry that: investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomena and context are not clearly evident" (Yin 2009 p18).

This definition fits with the overall aim of this current case study: to describe women's experiences of postnatal care on the hospital postnatal ward, following birth, and gain a deeper understanding of the issues raised. As mentioned above, case study designs can be either single or multiple. Yin (2009) stated that a single case study design can be justified when it is representative of a typical case. In this simple descriptive case study the phenomena of interest are women's experiences and the hospital postnatal ward is the context. The "boundaries" mentioned by Yin in 2009, or "dynamics" as described by Polit and Beck (2010), between the two are what is being investigated and therefore form the case under question.

Women at the study hospital, and also nationally, have been found to rate the postnatal care they receive in hospital less favourably than other aspects of maternity care (e.g. antenatal and intrapartum). It is important to understand reasons for this phenomenon. Gaining an understanding through the voices of women at the study hospital from surveys was needed to assist with making improvements to care provision. This is further supported by other authors in the field of case study research, who stressed the need to capture the complexity of the phenomena in order to understand the case itself (Simons 2009, Stake 1995).

The current case study utilises data from three different surveys. The unique strength of case study research is its ability to deal with a variety of evidence (Yin 2009). To this end the use of both quantitative and qualitative data will serve to answer the research questions.

Case studies can be a useful way to explore phenomena that have not been rigorously researched (Polit and Beck 2010). This is also an important factor with this current study. Whilst there is information highlighting women's discontent with postnatal care provision in hospital it is less well known what is the precise reason for this. It was therefore anticipated that this case study would serve as a "spotlight" or "microscope" (Hakim 1987 p61) to elicit reasons why women are unhappy with this aspect of care provision. Through the process of intensive examination as described above, theoretical propositions may be possible (Burns and Grove 2009, Yin 2009). These findings may then be used to inform further study in this area.

Another strength of case study research is that it is particularly good when "How" and "Why" questions are being asked about a contemporary set of events, over which the investigator has little or no control (Yin 2009). This further supports the use of a case study in this work.

This study could also have been undertaken in other ways. The use of qualitative interviews would have been a valuable way of ascertaining the views of the women who use the service. However due to the requirement of the doctoral thesis at City University to undertake a case study and the availability of the secondary data sources it was agreed within the supervisory team that this was an appropriate and feasible option.

### **2.5.3 Rationale for the data sources accessed**

As has been previously mentioned, the work is pragmatic in nature and makes use of secondary data. Both quantitative and qualitative data have been used. Descriptive and interpretative statistics were used to describe findings and identify differences among groups from the survey data. In addition, I analysed all the freetext comments provided by the women respondents to each of the surveys using qualitative analysis methods. A summary of the data sources can be seen in Table 2.1: Data sources used in case study.

All three survey instruments asked women who received care on the hospital postnatal ward specific questions about their care in this area. Therefore, they provided complementary sources of information about satisfaction with the care received on the postnatal ward. Having this information that was spread over a six-year time period also enabled the opportunity of observing possible changes over time. The national surveys used the same questionnaire in 2007 and 2009, enabling a direct comparison over time. The first survey included in the case study was conducted in 2003 and pertained to women who had had caesarean sections only. Whilst it was appreciated that this was a narrower sample and the earlier local survey data were not directly comparable, this was taken into account in the analysis. However, the sample of women from the local 2003 survey provided a prior picture of some women's experiences of postnatal care in the same hospital.

Some respondents also provided additional freetext comments about their experiences of care on the hospital postnatal wards. These were also utilised. The quantitative findings from the 2007 national survey were reported in both percentage terms and total scores. These were about various aspects of postnatal care (e.g. "Given enough information about recovery after birth") and given by the women who responded to the survey at each hospital trust in England. This allowed direct comparisons between the local trust's performance and other trusts.

This was all therefore considered an appropriate way of obtaining information about women's experiences of postnatal care at the study hospital. Having access to the three data sets was fortuitous. The data sets from the national survey were given to the trust to share knowledge and allow improvements in care provision where needed. The data from the local caesarean survey also belonged to the local trust. Whilst having access to the quantitative data would enable further exploration and comparison with other trusts, it was anticipated the freetext comments would provide further explanation about the experiences of women on the local hospital postnatal ward. This was a valuable opportunity for the local maternity unit to gain a greater understanding of women's experiences in this practice area.

<b>Table 2.1: Data sources used in case study</b>	
<p>2003</p> <p><i>Local post-caesarean survey at study hospital (Baxter &amp; Macfarlane 2005)</i></p>	<ul style="list-style-type: none"> <li>• <i>Quantitative findings from local survey of postnatal care for women who had experienced caesarean section births (analysed by the author)</i></li> <li>• <i>Qualitative freetext comments (analysed by author)</i></li> </ul>
<p>2008</p> <p><i>A review of maternity services in England (includes National maternity Survey (HCC 2007, Quality Health 2007)</i></p>	<ul style="list-style-type: none"> <li>• <i>Quantitative findings from women at study hospital (analysed by National study team)</i></li> <li>• <i>Quantitative findings of local and national indicators from national review of all maternity services in England (analysis by author using “Compare” software)</i></li> <li>• <i>Qualitative comments (analysed by author)</i></li> </ul>
<p>2009</p> <p><i>Locally commissioned version of the National Maternity Survey (Quality Health 2009)</i></p>	<ul style="list-style-type: none"> <li>• <i>Quantitative findings from women at study hospital (repeat of 2007 national maternity survey of all NHS trusts in England - analysis by national study team, Quality Health)</i></li> <li>• <i>Qualitative comments (analysed by author)</i></li> </ul>

#### **2.5.4 Data Sources**

##### *i) 2003 Postnatal care following caesarean survey*

In 2002 a significant number of women at the study hospital, who gave birth by caesarean section, reported that they felt neglected on the postnatal wards. There was a shortage of midwives and to address this, nurses and nursery nurses were recruited and added to the staffing skill mix. A formal evaluation of this was conducted using historical controls (Baxter and MacFarlane 2005).

The design was observational and the methodology was a survey. Data were collected by sending questionnaires to women. Using a survey methodology was considered by the authors to be an effective way of comparing the views of a representative study population before and after the change. Women were asked questions relating to the care they received on the postnatal ward. Questions asked included their experience of transfer to the ward, care on the ward (e.g. wound care, pain relief), help with caring for their baby, help and advice that was offered and overall ratings of their care experiences on the ward. This would be achieved by exploring the prevalence and interrelationships among variables in this population. Before the study commenced the questionnaire was piloted among five women on the postnatal ward who were not among the intended sample. Minor changes were made following this.

The postal questionnaire (Appendix B) was sent to 432 women in the study population who had caesarean sections and live healthy babies during a three-month period prior to (February 2003 – April 2003) and after (September 2003 – December 2003) the introduction of the nurses and nursery nurses. It used a variety of response scales including binary, Likert scales and multiple choice. The questionnaires were sent to women between 5 weeks and 18 weeks following the caesarean section. The participants were identified from the birth register. A letter inviting each woman to join the study accompanied the questionnaire as well as an information leaflet. These were posted in the same

envelope to the women. Reminder letters were sent to women who had not returned the questionnaire two weeks after the first letter was sent.

The accompanying letter invited women for whom English was not their first language to ring the main investigator and an interpreter was arranged (it was assumed that the individual woman receiving the letter would seek help from a relative or friend able to read English to understand the initial message). In these circumstances interviews using the questionnaire were planned to either be conducted over the telephone or at the hospital depending on the preference of the woman. One woman only participated in the study in this way. She chose to speak via an interpreter over the telephone.

Approval was obtained from the local research ethics committee, prior to the questionnaires being sent to women. Women who received postnatal care in other clinical areas (e.g. Intensive Care Unit, main delivery suite) were excluded as well as under eighteen year olds (requirement of local ethics committee).

At the time when the study was conducted, approximately 65 women had caesarean sections at this centre each month. A 65% response rate was assumed from the outset. On this calculation 125 completed questionnaires could be expected from women before the change and another 125 following the change.

An earlier patient satisfaction survey indicated that 25% of all women were dissatisfied with postnatal services. This sample size of 125 at each time point would have at least 80% power to detect a fall in the dissatisfaction rate from 25% before the change to 10% after the change.

The questionnaires from the women were analysed using the Statistical Package for the Social Sciences (SPSS). The written comments were analysed manually by sorting into common themes.

*ii) Towards better births. A review of maternity services in England*

A review of maternity services in England (HCC 2008) was triggered following concern about some maternity services across England. This followed shortly after the publication of a national survey of women in the maternity services in 2007 (HCC 2007). The review was based on three sources of data: a web-based maternity questionnaire completed at trust level, a voluntary web-based survey of maternity staff and a trust level survey of women who had recently given birth (information for this was taken from the national survey of women in 2007 (HCC 2007)).

One hundred and fifty-two maternity services were included in the review, which was conducted in May 2007. More than 26,000 women responded (59 per cent) to the questionnaire and 4,950 staff responded to the staff survey. In addition, there were five engagement events where mothers from minority groups (e.g. women who are disabled and those with learning disabilities), were invited to attend. In total 42 women attended nationally.

The review considered a range of indicators chosen to test performance in three areas: clinical focus, women-centred care and efficiency and capability. These indicators of performance became available on a computer-based tool and NHS trusts were able to undertake comparative analysis of their individual results with other NHS trusts. This tool, called Compare, has been used in this case study.

The content of the survey was developed nationally. Many of the questions were based on the standards of the NSF (Department of Health 2004). Ethics approval was gained at national level and a national Medical Research Ethics Committee (MREC) approval letter covers the ethical issues.

The women respondents to the postal survey were all 16 years and over and gave birth during the month of February by different methods, including

spontaneously and by caesarean section. Women whose baby was either ill or had died were excluded.

Women were asked questions concerning all aspects of the maternity care episode including diagnosis of pregnancy, the birth experience and community based postnatal care by the midwife. For the purposes of this case study only sections E and F were used: "Care in hospital after the birth" and "Feeding your baby". Section E, "Care in hospital after the birth", consisted of questions such as length of stay, the provision of information, food, cleanliness and overall rating of care on the postnatal ward. Section F asked questions about feeding the baby.

*iii) 2009 Listening to women University College London Hospitals NHS Foundation Trust Local Maternity Survey Management Report*

In 2009 the HCC offered all maternity units in England an opportunity to repeat the previous 2007 survey. This was individually commissioned by the study hospital (Quality Health 2009). This survey was sent to women who gave birth at the study hospital where the case study was conducted in February 2009 and was an exact replication of the survey in 2007.

*iv) Freetext comments: analysis*

The surveys were originally intended as a source of quantitative data and therefore not created to extract data for qualitative analysis, even though an opportunity to provide freetext comments was provided in both surveys. Therefore, this case study used the freetext comments provided by the respondents to undertake qualitative analysis, in order to provide a fuller picture of women's views and experiences across the surveys. The two HCC surveys asked the following question: *"Is there anything else you would like to tell us about your care while you were pregnant or since you have had the baby? Please add your comments here"* The local 2003 survey of postnatal care

following birth by caesarean section asked: “*We would be very grateful to hear of any other comments you may have about your postnatal stay?*”

### **2.5.5 Quantitative analysis**

Most statistical tests rely on random samples. However, as many authors have recognised (Parahoo 1997, Polit et al 2000, Punch 2005) it is difficult in most practical circumstances to do this. This study was comprised of secondary data sources. The researchers sent the National Maternity Survey to all women who gave birth in a particular calendar month. This also applied to the sampling plan for the local caesarean survey which used samples of women who gave birth during two defined three-month time periods.

The findings of the previous studies undertaken by, or on behalf of the HCC (i.e. HCC 2007, HCC 2008, Quality Health 2007, Quality Health 2009) were used to answer the case study aims and objectives. They surveyed all women giving birth in England in a particular calendar month. Additional analysis was undertaken using the Compare software. Comparisons were made between national findings and those at the study hospital by using descriptive statistics. The aspects of care under consideration are listed in Appendix C. Most are reported as indicators. These indicators, that were defined by the researchers of the national survey, were derived from the answers given by the women to several different questions. The indicators were created during the primary analysis of the 2007 survey. The formulae used to create the composite variables are described on the tables presented in the findings section of this case study.

The composite variables were made available to trusts in the Compare software. This enabled a comparison of different aspects of postnatal care between maternity units in this case study. The comparisons are broad rankings. This is instead of utilising confidence intervals which could have

provided more meaning to the work. However, Speigelhalter (2004) argued that using composite variables is a valuable technique when evaluating the effect of systems rather than a particular medical intervention.

The statistics from the 2003 survey were not reviewed in relation to the HCC survey as the sample was not comparable since the 2003 survey was focused on the postnatal care views of women who had experienced a caesarean section, rather than all women's views.

### **2.5.6 Qualitative analysis**

The qualitative data from the three different surveys were initially analysed separately and the findings were then synthesised to provide an overall qualitative analysis of women's views of postnatal care at the case study site.

Qualitative data emphasises people's experiences. It is important for the discovery of the meaning people place on life in general (Miles and Huberman 1994:10). Thematic analysis was undertaken, using the process described by Braun and Clarke (2006). I started the process by familiarising myself with the raw data. All the comments provided by the participants to the three surveys were read through by myself on many occasions and codes given to small pieces of text i.e. sentences, phrases, paragraphs. These were entered directly on to the printed transcripts in the margins. This was followed by the identification and review of possible themes that emerged from the codes and the consequent confirmation of themes. Approximately one hundred and thirty different codes were created, which were then grouped into two main themes. In this way categories that recurred in data from other participants were merged under an umbrella of themes. Miles and Huberman (1994:57) refer to this process as "pattern coding".

According to Patton (1990), comments made by respondents in surveys are the most rudimentary form of qualitative data. Having the opportunity of meeting with people and asking more detailed questions and probing for this purpose is more likely to be effective in obtaining more detailed information. However, the inclusion of freetext comments within a survey enables a large number of women respondents to provide their views in a more open way. There is no reason to suppose that these comments made by the women were not their true thoughts and feelings about their time on the hospital postnatal ward. This is therefore useful data to respond to the research questions about the reasons why women may be dissatisfied with the care they receive on the hospital postnatal ward.

## **2.6 Quantitative findings**

The quantitative analysis undertaken considered two main factors: external comparisons of the national sample responses with women at the study hospital and internal comparisons over time.

### **2.6.1 External comparisons**

A series of graphs is presented below which present the opinions of women receiving maternity care at the study hospital, comparing these with the responses of women nationally and also at other hospitals across London.

#### *i) Women's satisfaction with their care after birth*

Figure 2.2a below illustrates the study hospital (UCLH) with an asterisk and its position in relation to women's satisfaction with care following birth is below the lower quartile when compared with all other NHS trusts in England. Figure 2.2b shows that this position is improved when compared with hospitals in London where it lies beneath the mid quartile but within the interquartile range. It

appears that women's overall satisfaction with care in UCLH was worse than the women's satisfaction of care reported in the majority of hospitals in England.

Figure 2.2a Women's satisfaction with their care after birth in England. Source HCC 2007

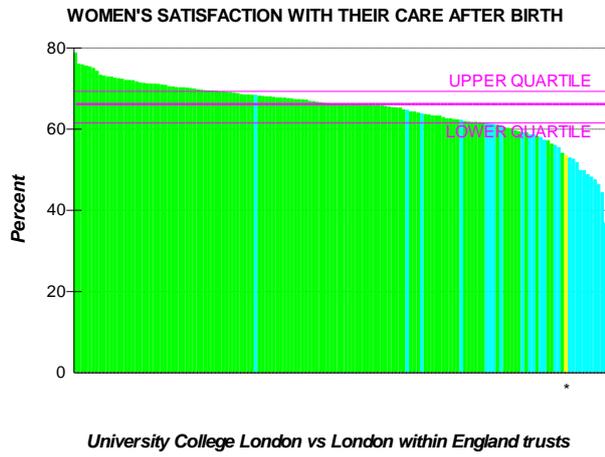


Figure 2.2b Women's satisfaction with their care after birth within London. Source HCC 2007



**Upper quartile 60.4**

**Median 56**

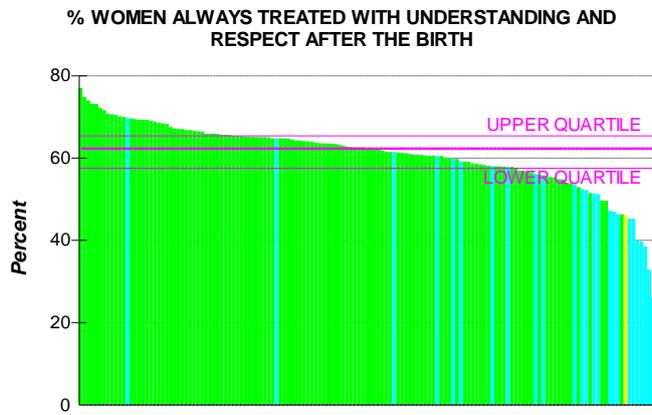
**Lower quartile 49.8**

*ii) Women always treated with understanding and respect after the birth*

Figure 2.3a below finds UCLH situated below the lower quartile when ratings of being treated with understanding and respect after the birth are compared with all other hospitals in England. Figure 2.3b shows that this finding is marginally improved when the results are compared with hospitals in London where UCLH's position is situated just within the lower quartile.

Figure 2.3a Women always treated with understanding and respect after the birth in England.

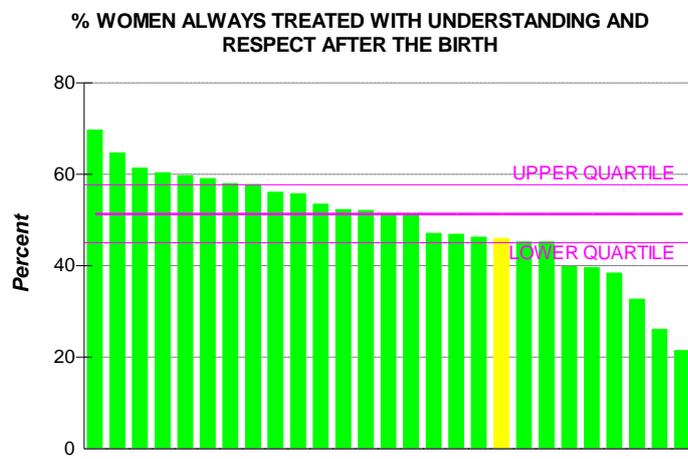
Source HCC 2007



*University College London vs London within England trusts*

Upper quartile 65.5  
 Median 62.3  
 Lower quartile 57.7

Figure 2.3b Women always treated with understanding and respect after the birth within London. Source HCC 2007



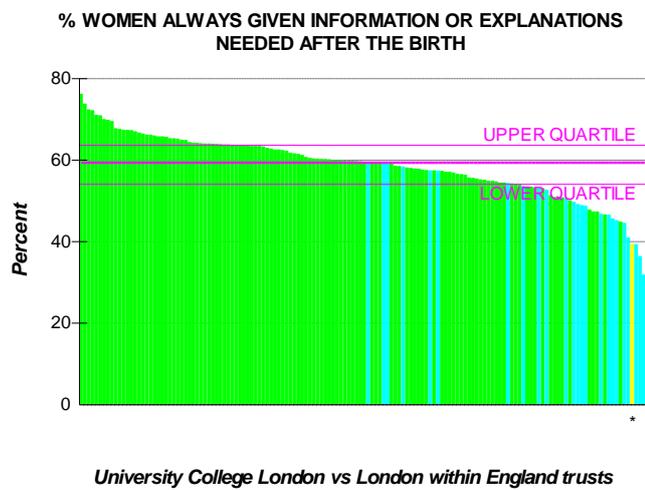
*University College London vs London*

Upper quartile 57.8  
 Median 51.3  
 Lower quartile 45.2

iii) *Women always given information or explanations needed after the birth*

The findings in figures 2.4a and 2.4b below show that UCLH is situated beneath the lower quartile both nationally and London wide. Women at UCLH rate always being given information or explanations needed after the birth less than many other hospitals both within London and nationally.

Figure 2.4a Women always given information or explanations needed after the birth within England. Source HCC 2007



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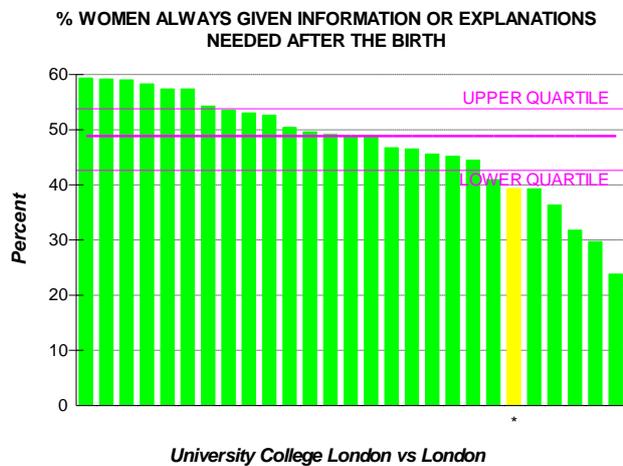
**Upper quartile 63.8**

**Median 59.4**

**Lower quartile 54.3**

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Figure 2.4b Women always given information or explanations needed after the birth within London. Source HCC 2007




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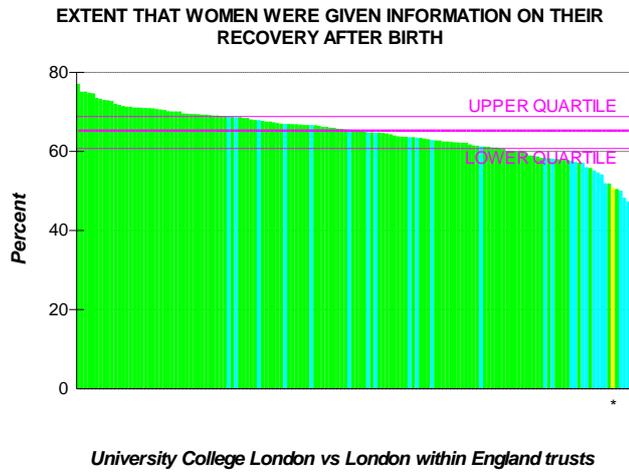
Upper quartile 53.9  
 Median 48.9  
 Lower quartile 42.7

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*iv) Extent that women were given information on their recovery after birth*

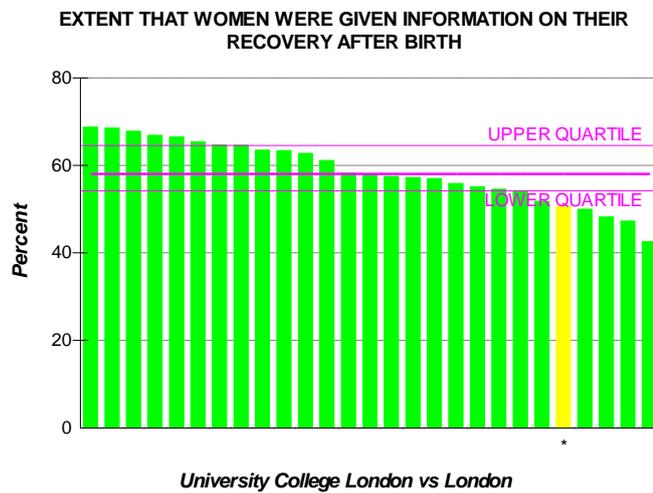
The findings in figures 2.5a and 2.5b below show that UCLH is situated beneath the lower quartile both nationally and London wide. Like the previous section women at UCLH rate the extent that they were given information on their recovery after birth less than many other hospitals both within London and nationally.

Figure 2.5a Extent that women were given information on their recovery after birth within England. Source HCC 2007



Upper quartile 69  
 Median 65.3  
 Lower quartile 60.9

Figure 2.5b Extent that women were given information on their recovery after birth within London. Source HCC 2007

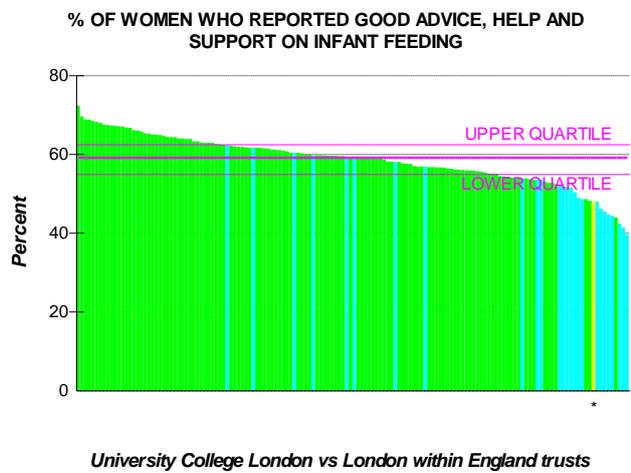


Upper quartile 64.7  
 Median 58.1  
 Lower quartile 54.3

v) *Women who reported good advice, help and support on infant feeding*

Figure 2.6a below shows UCLH's position for women reporting good advice, help and support on infant feeding to be below the lower quartile. Figure 2.6b shows that this result is slightly improved when compared with other hospitals in London where UCLH sits above the lower quartile.

Figure 2.6a Women who reported good advice, help and support on infant feeding within England. Source HCC 2007

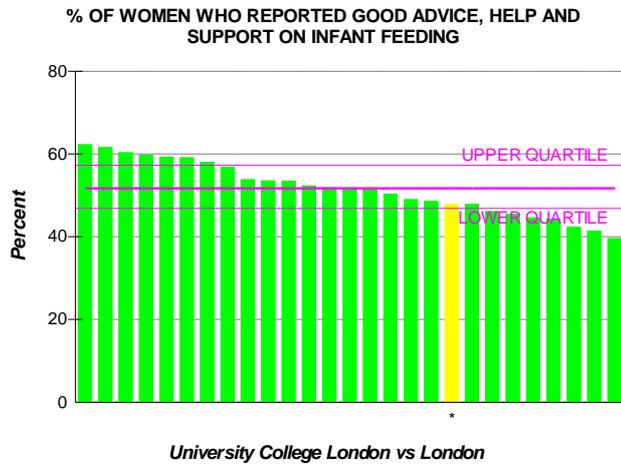


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**Upper quartile 62.6**  
**Median 59.2**  
**Lower quartile 55.1**

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Figure 2.6b Women who reported good advice, help and support on infant feeding within London. Source HCC 2007

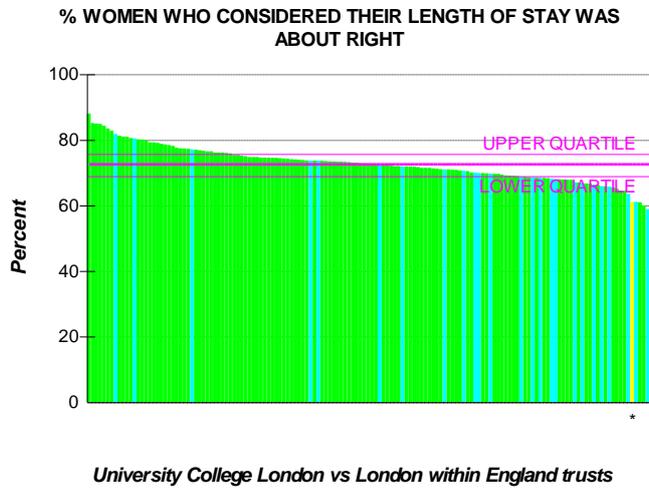


Upper quartile 57.4  
Median 51.7  
Lower quartile 47

*vi) Women who considered their length of stay was about right*

Figures 2.7a and 2.7b show the results for women's views about their length of hospital stay. When compared both across England and within London UCLH is situated beneath the lower quartile for women who considered their length of stay was about right.

Figure 2.7a Women who considered their length of stay was about right within England. Source HCC 2007



Upper quartile 75.9  
Median 72.7  
Lower quartile 69.1

Figure 2.7b Women who considered their length of stay was about right within London. Source HCC 2007

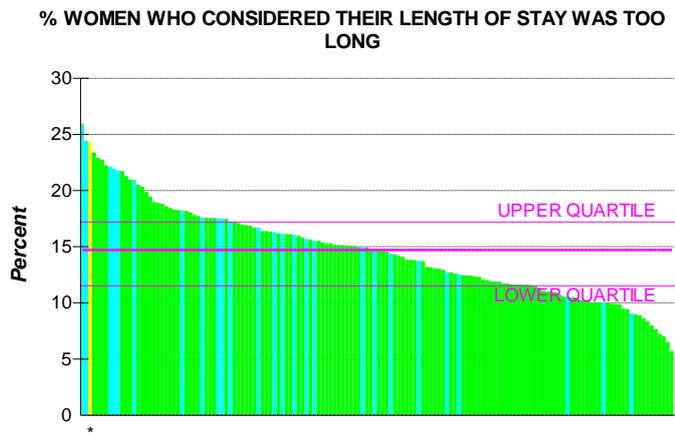


Upper quartile 71.4  
Median 68.5  
Lower quartile 66.1

vii) *Women who considered their length of stay was too long*

Figures 2.8a and 2.8b show that a high proportion of women at UCLH rate their in hospital length of stay as being too long. When compared nationally and within London this rating is situated above the upper quartile for women UCLH.

Figure 2.8a Women who considered their length of stay was too long within England. Source HCC 2007



*University College London vs London within England trusts*

---

**Upper quartile 17.2**

**Median 14.7**

**Lower quartile 11.6**

---

Figure 2.8b Women who considered their length of stay was too long within London. Source HCC 2007




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**Upper quartile 19.5**  
**Median 16.3**  
**Lower quartile 14.5**

---

This section has found that none of the areas evaluated for postnatal care at UCLH are particularly high scoring. The median score for overall satisfaction is 66 for all NHS trusts in England (56 in London). However, within that women receiving care after birth at UCLH consistently rated their care less favourably than other Trusts. A clear pattern became evident that UCLH fared very unfavourably (beneath the lower quartile) when compared with national centres. This ranking was slightly improved in the comparison with other London maternity units but even then women at UCLH cite care situated in the lower quartile in relation to the provision of information.

This was the case for six out of the seven aspects of care mentioned. The only exception to this is “women who considered their length of stay was too long”. For this variable both values given by women at UCLH fell above the upper quartile. UCLH came the second highest nationally and third highest in London. It is clear that women at UCLH are not satisfied with their care following birth.

They are not being provided with sources of information and missing out on practical help in relation to caring for their babies and there is a lack of sensitivity surrounding the provision of care. Women at UCLH are equally dissatisfied with their length of hospital stay where there are a high number of women who state that their length of stay was too long.

### **2.6.2 Internal comparison HCC X 2 years**

This section will compare the views of women at UCLH between two time periods, 2007 and 2009.

A statistical test of proportions was undertaken and as can be seen in Table 2.2 below. There was no apparent difference between the two time-periods. Differences were only found in cleanliness of ward areas and bathrooms. This is not surprising as the women in 2009 received care in a new building.

**Table 2.2 Comparison of the views of women about issues relating to their postnatal hospital stay between 2007 and 2009**

	2007 % (number)	2009 % (number)	Percentage point (ppt) difference
Length of stay about right	58% (151)	59% (190)	1 ppt
Given enough information about recovery	31% (152)	31% (192)	0
Always offered choice of food	77% (150)	80% (192)	3 ppt
Given right amount of food	75% (150)	69% (192)	-6 ppt
Rating of food very good	7% (152)	10% (192)	3ppt
Hospital room or ward very clean	36% (152)	58% (192)	22 ppt
Toilets/bathrooms very clean	23% (148)	51% (191)	28 ppt
Spoken to in a way that could be understood	59% (151)	66% (191)	7 ppt
Treated with respect and dignity	50% (151)	55% (189)	5 ppt
Treated with kindness & understanding	47% (152)	49% (188)	2 ppt
Given information/explanations	39% (151)	45% (190)	6 ppt

Footnote: numbers exclude missing data.

## 2.7 Qualitative findings

This was an analysis of the freetext comments made by the women responding to all three phases of the data collection. The total number and proportion of women who gave comments is illustrated on Table 2.3 below. The amount of text received from each woman ranged between one sentence and several paragraphs. The comments in 2007 and 2009 that did not relate to postnatal care in hospital were not analysed.

	<i>Completed questionnaire</i>	<i>Gave additional freetext comments</i>	<i>Proportion of women who commented</i>
2009	192	121	63%
2007	152	45	30%
2003	288	184	64%

Two overarching themes were identified:

- 1) Lack of professional support
- 2) An uncomfortable environment on the postnatal ward

The themes occurred in each of the three episodes of data collection. The codes during the three times periods are illustrated at Appendix D.

### 2.7.1 Lack of professional support

This theme relates to the perception amongst the respondents about not receiving sufficient support from staff on the postnatal ward. Seven subthemes were identified and will be discussed below:

- Not enough staff
- Did not want to bother busy staff
- Sense of abandonment
- The needs of women immediately following birth on the postnatal ward
- Lack of confidence in staff
- Inconsistent advice
- Attitude of staff and delivery of care

*i) Not enough staff*

The respondents in all three phases described the staff as being too few and overstretched and this led to many women receiving insufficient care.

*“I ended up discharging myself from hospital as the staff on night time shift were very thin on the ground, only 1 midwife, 1 nurse and 1 assistant for 18 high dependency women – all c section. The care received during the night was poor for this reason: staff tried their best but could not attend to the needs of all the mothers or babies. I would have benefitted from staying another night in hospital but felt I was better off at home due to the lack of staff”*

Caesarean birth 2007

*ii) Did not want to bother busy staff*

The respondents generally considered the staff to be very good. However according to the respondents there was an apparent staff shortage and this affected the ability of staff members to provide care. Whilst the respondents were empathetic to staff in this very difficult situation, they felt that standards of care on the ward were compromised as a result of there being too few staff available to care for women. One woman reported:

*“All staff was very nice – I’m lucky enough to have someone in my family who helps and was then helping a lot too. Therefore I didn’t need much attention. But I feel strongly sympathetic for your staff overloaded with work, especially at night (not enough staff!)”*

Caesarean birth 2003, Teacher

As a consequence many respondents felt they did not want to trouble busy staff. Other respondents described having to press hard to get help. Women reported that they did not want to impose on busy staff or that they had to compete with other women for help.

*iii) A sense of abandonment*

As a consequence of being left without support women experienced a sense of abandonment. Some women were left with the feeling that they would be better off at home.

Women reported having to wait for long periods before their calls for help were answered. One woman wrote:

*“The overall problem was too little staff. It took up to 30 mins for someone to come and help after I rang the bell.”*

Caesarean birth 2003, Journalist

*iv) The needs of women immediately following birth on the postnatal ward*

The respondents in all three time periods stated that in order to get any help they had to ask for it. Requests for help included changing sanitary towels, getting out of bed and having help with a shower. One particular need the women had was help to care for their babies.

*“I feel strongly that there is not enough midwife support for new mothers, especially when recovering from a C section. There is minimal attention on 1<sup>st</sup> night then nothing after this when one can barely move and must care for newborn”*

2009 Birth by caesarean

It could be argued from the quote above that the service has failed to recognise the needs of women following birth, particularly by caesarean section. At this time women need help both for themselves in terms of mobility and also to care for their babies. This possible failure to recognise the needs of this group of women is also evident in the fact that women were being left to walk unaccompanied to see their babies in the neonatal unit on a different floor of the building and sometimes without pain relief

It is clear the respondents felt they required more help than was actually offered. In order to receive help they often had to ask the staff, which they felt uneasy about doing as the staff often appeared very busy. As a result on occasions women in neighbouring beds would help out.

*“I found postnatal care very POOR. When you call for help it took ages sometimes 30 minutes for someone to help. The first night my baby was born, the lady in the next bed helped me change my baby’s clothes and nappy because the midwife said my hospital bag was too far away for her to get. If hospital staff are too busy or unwilling to help they should allow our partners to stay. This incident happened 3 hours after my child was born.”*

Caesarean birth 2003 Area support officer

Women described being left to struggle to move about by themselves. They appeared surprised that offers of help were not forthcoming. It appears that the staff did not always recognise the needs of the women. This could relate to the apparent staff shortage identified previously. However, when staff were

available they were not always helpful, appeared distant and when they asked for help the women felt they were disturbing the staff.

*“The first night the midwife told me if I did not bottle feed my baby that she would have a seizure as her BM was 2.3. She then left 2 bottles at the end of the bed on the table and walked away. I had to call her back and ask her what to do and she asked me had I never had a baby before?? I desperately wanted to breastfeed and had gone to 2 lots of breast-feeding classes. I had to bottle feed till the breast feeding midwife assisted me next day, otherwise no-one else helped.”*

Nurse, birth by caesarean 2003

There also appears to be a dichotomy between what care the women expect to receive and the actual care provided. Staff become frustrated when women are not able to self-care. Women received curt responses from staff when ringing their bedside call bells according to staff for inappropriate reasons

*“I rang the bell for the midwife to come, for more than 20 minutes she did not turn up. I rang the bell again, she came round turned the bell off and told me off, saying I should not ring the bell again that I am not crippled and I should walk to her where she was sitting and speak to her, she walked off”*

Method of birth not known, 2007

v) *Lack of confidence in staff*

Women reported a lack confidence in care provided by staff. The need for a greater awareness of the needs of new mothers and the provision of appropriate and sensitive communication and care were identified. One woman reported:

*“Some members of staff don’t seem to fully understand the nature of the mother – baby bonding process and need to be more sensitive to mothers’ feelings. Example, helper picked up my baby without my permission and disappeared for five minutes without telling me anything. I was really upset.”*

Caesarean birth 2003, Student

vi) *Inconsistent advice*

Contradictory and conflicting advice was also identified as a problem for new mothers

*“At night I was advised to give my baby formula because she ‘obviously wasn’t getting enough from me’. The next day the day midwife said I shouldn’t have done it.”*

Caesarean birth 2003, TV executive

Not only is there a need to improve the communication skills of staff in relation to women but the respondents also spoke of the need for improved communication between staff on different shifts, the lack of which they felt impacted on their experiences of care on the postnatal ward. They also identified that a lack of communication between groups of staff also impacted on the care of the babies.

*“Postnatal stay in hospital was very traumatic. Inconsistent advice from different midwives and nurses made it very stressful and confusing. More communication between shift staff would have been good – especially between day and night shifts. Information was not passed accurately and consistently between staff.”*

Method of birth unknown 2009

vii) *Attitude of staff and delivery of care*

Respondents seemed to lack confidence in the ability of some staff to provide support. The respondents seemed doubtful about aspects of the care they would receive. When women did highlight problems with their care they were not addressed. One woman wrote:

*“...After the section I was in a lot of pain and all I could hear was the midwife at the desk joking with her colleagues about me very loudly. Whenever I asked for pain relief she was very busy despite my distress. I did confide in a night midwife who told me my carer could be changed but nothing happened. After 2 ½ days I discharged myself”*

Caesarean birth 2007

As previously described the women respondents did not always feel they could freely ask the staff for help. They clearly were in search of a more approachable and caring response from the staff.

Women felt they were imposing on staff, when they asked for help

*“I had fantastic care on the labour ward but felt abandoned when on the postnatal ward. I do understand the problems within the NHS, however, as a new mum I expected more help/advice e.g. I wasn't told to call for help when picking up my baby which was very difficult and I felt if I asked for help I was bothering them.”*

Caesarean birth 2003, Supermarket manager

As in the two previous surveys the respondents in 2009 also found some members of staff to be uncaring. Poor attitudes were reported and the need for increased basic caring skills identified (e.g. compassion, sensitivity, respect). Women reported being treated in an insensitive way. In the quote below one woman describes feeling like she had been to hell and back

*“...I feel that a sensitivity course is due for all health care practitioners. My biggest issue is the lack of compassion I experienced before, during and especially after giving birth. ....I felt as if I had been to hell and back after being in the hospital and experiencing such compassionless attention. Attitudes need to change - a smile goes a long way”*

Normal birth 2009

This section has identified that the respondents to the surveys during all three time periods felt that there were too few staff available to provide optimal support to individual women. As a consequence of this apparent shortage of staff women went without the professional support which they had expected to receive during their postnatal stay in hospital. The women were sympathetic to the few staff present: not wanting to overburden the staff the women were reluctant to ring their call bells for help. When they did ring for help, the bells remained unanswered for long periods of time.

Women did not always receive spontaneous offers of help from staff providing care and that if they required assistance they had to ask for it. It was also apparent that staff did not always seem to be recognisant of the needs of women recovering from birth on the hospital postnatal ward. It was as though the staff felt that the women should be self-caring. Women reported being left to care for their babies unaided. Others described leaving the ward to visit their babies in the Neonatal Unit on another floor of the building unaccompanied soon after giving birth, regardless of method of birth. As a consequence women experienced a sense of abandonment following birth on the hospital postnatal ward.

This all led the respondents in all three surveys to experience a lack of confidence in staff to provide care. They felt that some staff needed improved attitudes and communication and sensitivity skills, both in relation to providing care to women and babies as well as between themselves. Poor

communication led to contradictory breastfeeding advice and women becoming confused and frustrated.

### **2.7.2 An uncomfortable environment**

Four aspects of the postnatal environment were identified as contributing to women's experience of care. The respondents in all three surveys identified aspects about the environment of the hospital postnatal ward as being un conducive to their recovery following birth. Four subthemes emerged from the data which are listed and will be discussed below under the respective headings:

- Cleanliness of the ward
- Lack of privacy and rest
- Poor discharge home process
- Engendered negative emotions

#### *i) Cleanliness of the ward*

The respondents reported incidences of poor cleanliness, both in terms of their own personal hygiene and also relating to the ward facilities during all three time periods. The women were not helped to change bloodstained clothing and bed linen:

*“First night: staff rude and unsupportive. Midwife “angry” response to blood on floor (as I tries to pick baby out of crib) and to questions regarding what medication I was being given. No help washing, despite requests. Went full 24 hrs covered in blood- clothes and bed clothes unchanged. Not told where toilets were etc. or when I should get up.”*

Caesarean birth 2003, Lawyer

One woman reported that the sheets on her bed were not changed for over one week and out of desperation her husband ended up changing the bed linen.

*“No-one attempted to change the sheets – on which I placed immediately after caesarean – all week. My husband had to take bedding from the linen cupboard and do it himself...”*

Caesarean birth unknown 2009

There was also constant criticism from the respondents about a lack of cleanliness in the bathrooms and toilets. This was a consistent criticism throughout the three surveys and there was great surprise that even following the move to a new building in 2009 that this lack of cleanliness was a continuing issue. Women complained about the lack of cleanliness.

*“...The only thing was when I was brought up to the wards the toilets were filthy and not cleaned during my stay blood clots blocking the drains they were filthy and disgusting. In my whole stay they were not once cleaned. Which made my stay very uncomfortable...”*

Method of birth unknown 2009

#### *ii) Lack of privacy and rest*

The respondents spoke of a lack of rest during the three survey periods, and being disturbed when trying to do so. Rest was found to be difficult for many different reasons, including bright lighting, call bells ringing, the voices of staff and other people's visitors. The entire environment was described as being very noisy, both in terms of excessive sound levels and as physical interruptions by staff to administer care and hospitality. One woman likened her postnatal ward experience to being at a party:

*“...One issue for long stays in hospital. The lack of privacy and hence inability to get any sleep due to other patients visitors, mobile phone calls, being woken at 5am for blood pressure, being woken to be asked if*

*you want a cup of tea etc. Makes it harder to recover, get sleep and made me very stressed. Overall though UCLH is wonderful.”*

Method of birth unknown, 2009

*iii) Poor discharge home process*

Women identified problems with their discharge home. Women commented on the length of time they had to wait for completion of their discharge, sometimes having to wait for several hours. The process whereby the women were discharged home was found to be chaotic and identified consistently throughout the three surveys when women would find themselves waiting for their babies to be checked by paediatricians, paperwork or medications before they could go home.

Some women spoke of being asked to go home before they felt ready. A shortage of beds seemed apparent on occasions and this was a problem for some of the respondents, particularly in 2009.

*“I had a caesarean section on the 19<sup>th</sup> Jan 09 and was discharged on the 21<sup>st</sup> Jan 09. I felt I needed more time in hospital to recover and am not satisfied that I was discharged so early....”*

Birth by caesarean 2009

*iv) Being on the ward engendered negative emotions*

Being on the hospital postnatal ward was an upsetting experience for some of the women throughout the three phases. According to some respondents the environment of the hospital postnatal ward instilled negative feelings including fear, stress, a sense of abandonment and emotional upset.

*“When I got wheeled onto Hunter ward after my operation – I was not spoken to and got left in a cubicle – expecting someone to come and*

*explain everything to me – I could not reach the buzzer and was quite scared and upset.”*

Caesarean birth 2003, Nanny

This seemed to be due to poor staff attitudes, poor communication between different staff providing care and inconsistent advice

*“Postnatal stay in hospital was very traumatic. Inconsistent advice from different midwives and nurses made it very stressful and confusing. More communication between shift staff would have been good – especially between day and night shifts. Information was not passed accurately and consistently between staff. More practical help with breastfeeding would have been desirable – ideally a breastfeeding consultant. Having the same midwife or nurse throughout would have helped.”*

Method of birth unknown 2009

The need for cleanliness is very important to women. This section has identified that the respondents in all three surveys commented on poor levels of cleanliness, both in terms of not being helped with their own personal hygiene and having their bed clothes changed as well as the toilet and bathroom facilities. This section has also shown that women on the hospital postnatal ward are going without the rest that is so much needed following birth. Women during the three time periods also commented on the discharge home process. This was often described as being chaotic and an inconvenience to the women. It was also revealed that some women felt that they were being asked to go home too soon and before they felt ready to do so. Finally this section has also shown that some women find their experience on the hospital postnatal ward traumatic.

## 2.8 Discussion

This exploratory case study has identified that women on the hospital postnatal ward have unmet needs. The quantitative findings identify high proportions of women who do not report overall satisfaction with their care after birth and who are not receiving sensitive care (e.g. care delivered with understanding and respect). The qualitative synthesis provides further description taken from the respondents about the experience of staying on a postnatal ward. Namely there is the perception of too few staff members being available to provide help and when they are available they appear busy and can be insensitive and oblivious to the women's needs. It was of interest that through the analysis of the qualitative comments provided by women in all three surveys that the same issues were raised by women. This was independent of the type of birth they experienced. Whilst women who give birth by caesarean section have additional needs, all women responding to the three surveys had had the experience of giving birth and being on the hospital postnatal ward.

Dissatisfaction has previously been identified in relation to care on the postnatal ward (Ball 1994, Bhavnani and Newburn 2010, Garcia et al 1998, HCC 2007, House of Commons 1992, Maternity Services Advisory Committee 1985, Redshaw et al 2007, Singh and Newburn 2000, Wray 2003). The same findings are replicated in the results of the current case study.

This dissatisfaction seems in part due to the lack of support reported by the women. Lack of support is an overwhelming finding from this work. The women described the need for more physical, informational and practical support. They sought practical support with both their own needs and those of their babies and also support in the form of information provision. Women also perceived a lack of staff being available to provide support postnatally. These findings concur with the work of other researchers in this area who have identified that women feel unsupported with breastfeeding experiencing insufficient help with

breastfeeding (Brown et al 2005, Dykes 2005, Ruchala and Halstead 1994, Yelland et al 1998) and staff attitudes have been reported as poor (Beake et al 2010, Bick et al 2008, Brown et al 2005, Redshaw et al 2007, Stamp and Crowther 1994, Yelland et al 1998).

The women in the case study commented on the need for help with handling the baby. This they stated was particularly difficult during the first 24 hours following birth. Wray (2006a) in another part of the United Kingdom in a study exploring women's experiences of postnatal care also identified the need for more support in relation to infant feeding and baby care. Other authors internationally have also identified the need for more support for women at this time caring for their new babies and also in general for women receiving care in hospital during the first few days following birth (Brown et al 2005, Ruchala and Halstead 1994, Yelland et al 1998).

Other needs that also go unmet are being provided with information and positive support with breastfeeding. As this case study was reaching its conclusion it is of interest that a national survey of postnatal care which included 1536 mothers had just been published (Bhavnani and Newburn 2010). This national survey reported similar findings to the case study where only approximately half of all women stated that they experienced sufficient emotional, physical and informational support. In addition four out of ten (42%) felt there were not enough midwives to provide them with the care they needed on the hospital postnatal ward.

It could be argued that having a baby is a natural life event and that women are socially conditioned to know what to do following the birth of a baby (Wray 2006b). However the women in this study were looking for support from the staff. Those who gave birth spontaneously felt there was a lack of support provided. Giving birth by caesarean section was also found to add to a woman's support needs at this time immediately following birth.

Expectations of care provision during this time are not being met. Some women mentioned that they received help from their family which enabled them to cope during their postnatal stay. Others wanted their partners to remain with them. The value of social support to vulnerable pregnant women was recognised in a ground breaking randomised control trial (Oakley 1992); however, it appears that focus on support to women has not been enhanced since that study. It is not always professional support that is required. Peer support from other new parents can also be of value to new mothers and fathers (McGuire and Gottlib 1979). Furthermore in a qualitative study of the transition to motherhood Barclay and colleagues (1997) identified both positive and negative influences of care provided by midwives at this crucial time in the lives of women (Barclay et al 1997).

One explanation for why women are failing to receive support in the form of information on the hospital postnatal ward is a lack of time and this was supported by the qualitative analyses in this case study. In an ethnographic study of encounters between midwives and breast-feeding women in postnatal wards in England Dykes (2005) identified a sense of “temporal pressure” on midwives with the consequence that information-giving was hurried with women struggling to comprehend all that was being delivered by the midwives. Other studies, set both in the UK and Australia, have described the busyness and chaotic nature of hospital postnatal wards (Brown et al 2005, Dykes 2005, McLachlan et al 2008, Rayner et al 2008, Schmied et al 2011, Wray 2006a, Yelland et al 2007). This concurs with this case study, which identified a lack of professional staff presence. It is unsurprising that women fail to gain supportive care in such environments which in turn leads to overall dissatisfaction with care. Midwives being rushed and too busy had the greatest negative impact on the overall rating of postnatal care (adjusted OR=4.59 [95% CI 3.4 – 6.1]) in a study of women’s views and experiences of postnatal hospital care in Victoria, Australia (Brown et al 2005). This concurs with the original findings from the local caesarean survey in 2003 where 53% women who responded, reported staff being too busy to help them (Baxter and Macfarlane 2005).

Staff on occasions seemed to disregard how individual women had given birth and seemed to expect all women to be self-caring, including those who had given birth by caesarean section. Consequently some women were left to go downstairs to the Neonatal Unit (NNU) unescorted whilst others were left to make unaided attempts to feed their babies. This concurs with commentary made by Ball in her work in the nineteen eighties where mothers, regardless of whether or not they had perineal sutures and consequently found sitting uncomfortable, were expected to sit and bath their babies on the third postnatal day (Ball 1994). Whether this is in reaction to staff holding too large a case load of women and consequently being very busy or whether there is a genuine feeling that women should already know what to do following birth. This phenomenon must be further understood to ensure care is both safe and of a high quality for women.

Consequently, there appears to be a lack of clarity regarding hospital based postnatal care during the first few days following birth. This case study identified that the women felt they were being left unsupported in an environment they found uncomfortable. The reason for this reduction in staff support is unclear: this may be due to insufficient numbers of staff on the staffing establishment or there may simply be a misunderstanding about the nature of postnatal care provision in hospital and what is expected from staff by women.

Poor attitudes affecting the experiences of women in hospital postnatal wards have been identified in other studies (Bick et al 2008, Brown et al 2005, Redshaw et al 2007, Stamp and Crowther 1994, Yelland et al 1998). It is possible that there is a need for enhanced training in communication skills. The need for an improvement in this area within the context of the hospital postnatal ward has also previously been identified (Brown et al 2005, Yelland et al 2007). This case study suggests women expect the provision of support as one of the aims of postnatal care to new parents.

If the very environment where support is provided causes women to become upset and traumatised the aim of care in this area will not be successful. The participants in the current study on occasions reported difficulty with individual staff members in terms of their attitudes and ability to communicate with both the women in their care and also with other members of staff. This resulted in a reduction in confidence in the care the women received. The way care is organised risks influencing women's experiences and outcomes (McLachlan et al 2008). Discussions have centred around the provision of care by teams of midwives who base care on continuity and relationships (McCourt and Stevens 2009, Sandall et al 1997). There is also ongoing debate about the possibility of delegating some aspects of postnatal care, traditionally undertaken by midwives, to support workers (Sandall 2007).

One quality improvement study in hospital based postnatal care was underway in another part of England at the time of this case study. This included 1400 women and was named "The Hospital to Home" study (Beake et al 2012, Bick et al 2012). Systems and process changes were introduced over a ten month time period. Changes were in the form of differing types of support interventions for women. These included workshops with staff to help them enhance communication with women; the creation of a more detailed postnatal health record; a revised postnatal care information booklet for women and revisions to the provision of breastfeeding support for women. The primary outcome was breastfeeding uptake and duration at 10-12 days and 3 months postpartum. Improvements were seen which were statistically significant. In addition there was a significant impact on some aspects of maternal physical morbidity, women's views and satisfaction.

This present case study has found that the reasons why women continue to feel unsupported during their hospital postnatal stay need further exploration and clarification. This may account for their rating of postnatal care overall. For a long time nationally women have been found to perceive their postnatal care less favourably than antenatal care and care during labour and birth. It will also

be important to include the views of staff working in this area. This case study did not consider the staff and there is little research evidence in this area.

## **2.9 Strengths and limitations**

It is important to highlight the strengths and limitations of this study. Important points in relation to the three studies, that provided the data for the secondary analysis in this case study, are discussed below in the first section: the constituent studies. This is followed by a section relating to issues pertaining to the case study overall.

### **2.9.1 The constituent studies**

#### *i) Questionnaires*

The questionnaire used by two of the three studies in 2007 and 2009, conducted by the HCC, was created at national level and used at all NHS trusts in England in 2007 in a wider maternity survey. Results from the separate surveys were consistent which provides some assurance when undertaking secondary analysis of the data. On-going national usage and consistency of findings over time both suggest the tool is of good quality for use among the childbirth population.

However the tool used for the 2003 caesarean survey was created locally. This was modelled from one used by Jane Sandall to analyse views and experiences of maternity care (Fitzgerald et al 2002) and adapted for use among women who had had caesareans. This was piloted on five women in advance of data collection taking place, who met the study criteria but who were not included in the main study, and minor changes made. As mentioned in the section below a good response rate was achieved which highlight the tool's ease of use by women and thus its ability to generate accurate data.

This 2003 questionnaire aimed to find out about the postnatal experiences of women who gave birth by caesarean section. There is therefore some heterogeneity between the three studies and consequently a greater input from women who had caesarean sections in this case study. However, all three studies sought the views of women about their recent birth experience, including aspects of care on the postnatal ward.

*ii) Timing of the surveys in relation to birth*

The two samples of women who responded to the national surveys all gave birth in the preceding February. The questionnaires were posted to the women in between May and July in 2007 and May and August in 2009. This meant that there was a range in terms of time since birth when the women received the survey, between three and six months. The local caesarean section survey was sent to women between 5 and 18 weeks of giving birth. It is possible that women's perceptions of their experiences of the care they received on the hospital postnatal ward might have changed over time. This is a limitation of this work. There is much debate regarding the ideal timing of obtaining feedback from women following childbirth. More negative perceptions have been reported following longer gaps of time (Simkin 1992, Bennett 1985, Erb et al 1983).

However this case study is exploratory in nature. It is important to note that even the two national surveys were administered at slightly different time points where there were ranges between three and six months in relation to giving birth when the respondents received the survey. The instrument was created with the intention of being administered over time to provide comparison. This is the nature of conducting a survey. The only way of ensuring more precise measurement would have been to conduct a randomised controlled trial (RCT).

### *iii) Response rates*

Receiving the questionnaire at home allowed the women the choice as to whether or not to complete it. There was an identifying number on the 2003 questionnaire to allow the researchers to send reminder letters, which may have indicated to the women that the survey was not entirely anonymous.

The response rates were reasonable but as with any survey there is always the possibility that the non-responders will have different views. The overall response rate for the 2003 survey was 68 per cent. Two hundred and eighty eight women were recruited. This was achieved following one reminder. The response rates for the Healthcare Commission surveys were less good with 55 per cent women responding in 2007 (n=154) and 49 per cent in 2009 (n=194). It is not clear whether a reminder was sent. With lower response rates there is the risk of bias. For example it is possible that a greater number of women wishing to complain about their experience will be represented. It is also possible that it will have been skewed towards white middle class women.

## **2.9.2 The case study overall**

### *i) Secondary analysis of data*

This case study is a re-analysis of three studies which used questionnaires to gauge women's opinions of their maternity experience. The case study considered the data relating to women's experiences of care in hospital postnatally. The views of some 632 local women who responded to the three different studies have been reviewed in this case study and further analysis conducted. This is a reasonable number of women on which to base the findings.

Analysing secondary data sources is a pragmatic way of undertaking research due to the reduction in time for collecting data (Polit and Beck 2010) and improved quality (Punch 2005). Existing large data sets collected for national

studies, such as those undertaken by the HCC utilised in this case study, should be of a high quality.

A key disadvantage of using secondary data is the fact that the original research questions are not relevant to the present research problem. There is the consequent challenge of forcing the data to answer new research questions (Punch 2005). It was therefore necessary for careful planning and consideration of the data in the light of the proposed research. This was undertaken within the wider supervisory team at the time of planning who provided experienced advice. However the overall aims of all three original surveys were broad and in line with the case study aims and objectives to gain an understanding of women's views to their experience of care on the postnatal ward. Whereas the local caesarean survey was focussed on care on the hospital postnatal ward this aspect was a small part of the whole in the national surveys. Therefore it was only the postnatal ward information that was utilised from the national studies.

It is therefore important to show caution and consider the challenges of interpreting the data sources when undertaking secondary analysis. Furthermore in case study research there is a need to address any problems with the design which threaten the value that can be placed on the research findings and therefore the use that can be made of the findings (Bryar 1999).

The interpretation of secondary data is dependent on primary data collection and analysis. It can be argued that the data sources in this case study are an unconventional juxtaposed set of three sources of data. Whilst I personally collected the data for the 2003 survey the data for the two national surveys were collected by the previous researchers. This meant I was reliant on processes described in the written reports. However I considered these to be adequate. In addition, and as mentioned above, the fact that two of the studies were undertaken on behalf of the then health watchdog, the Healthcare Commission, provided further reassurance about the quality of the data.

### *ii) Heterogeneity of the surveys*

It is important to note the 2003 survey was only sent to women who had given birth by caesarean section. The later HCC surveys in 2007 and 2009 had slightly different aims and target audiences compared with the local caesarean survey. The two HCC surveys asked all women, regardless of birth method, about all aspects of their maternity care experience which included a section entitled "Care in hospital after the birth".

Women who give birth by caesarean section have greater and some differing needs compared with women who give birth vaginally (Davies 1982, Hillan 2000, National Institute of Clinical Excellence 2011, Royal College of Midwives 2000). However the two groups will also have some common experiences and needs.

It is also important to be aware the three surveys were conducted at different time periods within a six year time period. However, despite the different timings and populations, the same issues were identified by all groups of women in the qualitative results regardless of how they had given birth.

### *iii) Qualitative analysis of the freetext comments*

It is also important to be aware of how the different data sets were collected in relation to the qualitative analysis. Whilst some of the data used in the qualitative part of the case study was produced by the researchers of the national surveys I collected the comments from the women personally in the local survey. For this reason I was therefore more likely to have had a greater awareness in advance of the analysis of the issues raised by the participants from the local caesarean survey. However the comments from the women who responded to the national surveys were generally more succinct which aided clarity with synthesis and analysis of the three different sets of data.

It is also important to highlight the low proportion of women who provided comments to the 2007 survey. Table 2.3 shows the quantity of data provided by the respondents as comments. In 2009 and 2003 the proportions were 63% and 64% respectively however in 2007 only 30% of the women made additional comments.

### **2.9.3 Interpretation of findings**

There is no reason to believe that the responses provided by women were not their true perceptions of how they experienced care on the hospital postnatal ward. However it is important to be aware of the “halo effect” where patients are more likely to rate care and satisfaction with care as higher at the time or after discharge. It is therefore possible that more negative comments were given between four and six months later when the respondents received the questionnaires.

The need for credibility of the research findings is of importance in all research studies. In relation to case study research Hamel and colleagues in 1993 identified two key problems in this regard: ensuring the representativeness of the case and the rigor of the collection of data and analysis associated with bias on the part of the researcher and the research participants (Hamel et al 1993). The selection of the case was also considered of paramount importance to Yin (2009). In this study there was much debate between myself and the other members of the supervisory team at the time to ensure clarity about what exactly the case is. This is the interface between women receiving care on the hospital postnatal ward and the actual physical context of the postnatal ward itself. Without having this clarity there was the risk of not measuring the phenomenon that I set out to measure and resulting in a loss of rigor.

As mentioned above there was also the need for rigor in the data collection as well as the role of the researcher. To this end I have aimed to provide a clear description of the research process and methods used. This includes the context in which the study took place as well as the methods used. This helps the reader to understand the precise steps and processes taken to decide if transferability is achieved.

Where the need to consider the place of myself, the researcher in this study, is concerned it was important to ensure a reflexive approach was taken (Finlay 2003). Self-awareness of the interaction between myself in the research process was essential. This is a fundamental aspect of all research, including case study.

Although I did not have direct contact with the respondents, all of whom completed questionnaires, I was familiar with the postnatal ward. I regularly practised in this area. Having familiarity with this setting in this way could have affected my understanding and interpretation of the context of the experiences of the women explored. In order to address this I kept a reflexive diary detailing the progress of the research and emerging patterns. I was able to share this information as well as other issues raised about life on the postnatal ward with the wider supervisory team. Regular meetings took place where any assumptions were challenged. For example on one of these occasions I mentioned the need to highlight the value of midwives providing postnatal care. My supervisors at the time, one of whom was not a midwife, questioned this and pointed out what evidence I had for this.

There is also the need to consider generalisability and the possibility of generalising from a case study. Clearly this would be dependent on the above measures. However due to the nature of case study research and its onus on the individual case, it is often thought the ability to generalise is not possible. Yin (2009) does not agree. This author argued the value of generalising to theoretical propositions (analytic generalisation) rather than in the statistical sense (statistical generalisation) where generalisation is most commonly considered by

researchers (Yin 2009). In this study the possibility of generalising is left to the reader. Consideration of this is made possible through the detailed description of the research process given.

## **2.10 Conclusion**

This case study was pragmatic in that it utilised secondary data to identify women's experiences of postnatal care on the postnatal ward at the study hospital. Some reasons for the dissatisfaction of hospital based postnatal care have been identified. The findings showed that women following birth perceived there was a lack of support and care on the hospital postnatal ward at the study hospital. In addition the qualitative analysis identified the environment of the postnatal ward not to be conducive to recovery after birth according to the participants. These findings concurred with other results and provide further evidence to the ongoing need to review how postnatal care in hospital is provided for mothers and babies nationally. The findings also raised questions about how to improve postnatal support.

How to address this effectively remains unclear and presents a gap in the body of knowledge. There is the need to ensure that both the professionals providing care for women following birth and the women themselves agree the aim, content and how best this aspect of care should be organised to ensure women receive the support they require following childbirth in the United Kingdom.

Gaining a wealth of understanding of the views of women to hospital based postnatal care has proven to be of great value in which to situate the context of the next components of this thesis. One area of postnatal support is postnatal debriefing. This provides an opportunity for women to be listened to following birth. Postnatal debriefing is also a form of emotional support for women postnatally. Whilst a planned action research study to improve postnatal care in hospital did not go forward, the study was reframed to consider women's

postnatal support needs in relation to their emotions and how the birth experience left them feeling. There was a strong likelihood that, if women in the case study were left feeling unsupported in relation to practical aspects of care, that emotional aspects of support will also have gone unrecognised. Moving to another NHS trust and seeing how some women were being provided with support in this way, through an established postnatal debriefing service, provided the trigger for researching postnatal debriefing.

## **2.11 Chapter summary**

This chapter has described a case study of women's experiences of postnatal care at an inner London teaching hospital. For reasons of convenience it utilised secondary data sources and employed both quantitative and qualitative research approaches.

As mentioned above the results showed that women at the study hospital consistently rated key aspects of their care less favourably than women at other trusts. For example women were not being provided with sources of information and they missed out on practical help in relation to caring for their babies and there was a lack of sensitivity surrounding the provision of care. Themes were derived from the qualitative data to understand the issues more fully. Two key themes found that women perceived they lacked support from staff on the postnatal ward. In their eyes the environment was not conducive to recovery from the birth experience.

In summary, this case study provides more evidence about how women leave their birth experiences feeling unsupported and disappointed following their stay on a hospital postnatal ward. Some women who leave the hospital following birth with these feelings seek out other ways of receiving help as new parents. This may start with a visit to a postnatal debriefing service where women have the opportunity of asking questions about their overall birth experiences. For this reason a critical review on postnatal debriefing follows this case study in the

next chapter. That in turn later informed the research project on a birth reflections service in England in Chapter 4.

## **Chapter 3: Critical review of the literature**

### **What is current practice in offering debriefing services to postpartum women and what are the perceptions of women in accessing these services: a critical review of the literature?**

#### **3.1 Introduction**

The case study of women's experiences of postnatal care, described in chapter 2, showed a lack of support on the hospital postnatal ward. According to the women participants they did not receive the support they expected to receive in this area. This related to practical and physical elements of support. This finding raises the potential possibility that women may also miss out on emotional support provision. Postnatal debriefing is a form of emotional support for women postnatally. For this reason, this aspect of care provision forms the focus of a critical review of the literature presented in this chapter.

This critical review of the literature focuses on aspects of postnatal debriefing which were not considered in the various RCTs that have been conducted in this important area of practice. In order to gain an understanding of the effectiveness of this intervention following birth, it is also important to determine the precise nature of what postnatal debriefing is and how it is perceived by both the women who receive it and the staff delivering postnatal debriefing. To this end, this study plays a key complementary role in the study of postnatal debriefing to that played by experimental studies. The findings will provide support for researchers planning intervention studies in the future.

This review was undertaken following my change of position at the hospital which formed the basis of the case study presented in chapter 2. While my new position was in a maternity unit that had an established postnatal debriefing

service, a similar service in my previous unit in London had been discontinued following the publication of the NICE guideline on antenatal and postnatal mental health (NICE 2007). This highlighted a lack of evidence for routine debriefing. However, in line with the national postnatal care guideline (NICE 2006), which recommended that women are offered the opportunity to discuss their birth experience with a health professional, the service continued in my new unit. It is anomalous that the guidance about discussing the birth from NICE in 2006, on the subject of routine postnatal care, was not adopted universally. However this may reflect uncertainty about understanding around debriefing more generally.

This divergence in service provision for postnatal support interested me. The findings of the case study in chapter 2 of this thesis, on women's experiences of postnatal care on the hospital ward, highlighted a lack of practical and physical support in this area as perceived by the women participants. Undertaking a critical review of the literature and learning more about postnatal debriefing and how it may provide support to women following birth was a valuable opportunity for me, whilst working at a centre which provided a postnatal debriefing service, to investigate further the questions that arose from my case study about women's emotional support needs following birth and how to provide for them more effectively. The success of all research is dependent on a full review of the literature being undertaken (Hart 1998, Randolph 2009). There was also the need to ensure that the questions and the data fitted with each other (Punch 2005). In view of this a clear protocol was created in advance to guide this study. This supported a focused search, review and data synthesis.

## **3.2 Background**

In the late 1990s a Department of Health report recommended that women be offered debriefing by a midwife following their experience of childbirth (Department of Health 1999). This aspect of midwifery practice had previously

remained informal and was not routinely offered to women by maternity services. The report by the Department of Health cited the work of a group of midwives in Winchester. This service in Winchester had been set up between 1992 and 1993 and was described as a “listening and information” service and given the title “Birth Afterthoughts”. It provided information and gave women the opportunity to talk in depth to a midwife about their recent birth experience (Charles and Curtis 1994). Following the publication of the report by the Department of Health (Department of Health 1999), units across the United Kingdom set up similar services to the one in Winchester and women were invited to meet a health professional, usually a midwife, to discuss their birth experience. This was in addition to routine postnatal care provision.

This coincided with the advent of clinical governance initiatives in the NHS to ensure that care was both safe and of good quality for patients (Department of Health 1998). Some maternity units viewed the setting up of a debriefing service as a way of reducing the number of complaints. For these units, this new service was established as a risk management strategy and hence of direct benefit to the organisation rather than primarily for the individual woman receiving care (Baxter et al 2003, Collins 2006, Smith and Mitchell 1996).

Some RCTs were conducted prior to the widespread setting up of debriefing services in the UK (Lavender and Walkinshaw 1998, Ryding et al 1998, Small et al 2000) and some other non-research papers were also available on the topic of postnatal debriefing (e.g. Allott 1996, Charles and Curtis 1994, Smith and Mitchell 1996) before the report by the Department of Health advised the setting up of formal services (Department of Health 1999). Whereas other studies were published later. These included randomised controlled trials (RCT), conducted to evaluate the services and to test whether the services reduced psychological morbidity (e.g. Gamble et al 2005, Priest et al 2003, Kershaw et al 2005) and other non-research papers describing the services that had been set up (e.g. Axe 2000, Hatfield and Robinson 2002). It was found that women valued these services. It is of interest that, despite the advent of evidence based practice, the

Department of Health had recommended the introduction of these services on a widespread basis without sufficient research evidence to support their use.

The RCTs were not always comparable. Criteria for eligibility and interventions used differed between studies. For example some services that were evaluated offered debriefing to only those women who experienced instrumental births, while others included all postpartum women.

For these reasons it was difficult to identify effects. A Cochrane systematic review was undertaken to assess the effectiveness of brief psychological debriefing for the management of psychological distress after trauma, and the prevention of post-traumatic stress disorder (PTSD) (Rose et al 2002). However, this Cochrane intervention review was of outcomes of debriefing in the general literature and not specifically pertaining to the maternity context. In the updated version in 2010, Rose and colleagues undertook meta-analysis on nine of the 15 included trials. Three of the trials were about childbirth and these were summarised only as the authors did not consider them as comparable with other included studies (Rose et al 2002). In 2008 a separate Cochrane review was planned by Bastos and colleagues to include solely trials in the maternity context (Bastos et al 2008).<sup>1</sup>

The key finding from the first review by Rose and colleagues was that a single debriefing session did not prevent post-traumatic stress disorder (PTSD) or reduce psychological distress compared to the control group. In addition those receiving the debriefing intervention did not report a reduction in severity at all time periods assessed. There was also no evidence that debriefing reduced

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<sup>1</sup> At the time of conducting the review reported here, the findings of another Cochrane review, which specifically focused on debriefing following childbirth were awaited (Bastos et al 2008). That review was published in 2015, after the completion of this review; therefore, the findings are described in the discussion section of this chapter 3.10.

general psychological morbidity, depression or anxiety. Another important finding from this work was that one trial reported a significant increased risk of PTSD amongst people receiving debriefing one year after the debriefing intervention was conducted (OR 2.51(95% CI 1.24 to 5.09) (Rose et al 2002).

The authors of the first Cochrane review considered possible reasons why the treatment might have been ineffective. These included the possibility that either the interventions themselves or the follow up assessments were too short. The randomisation process might also not have been effective and there was a risk that the timing of the intervention was inappropriate. They also considered possible reasons for the adverse effect in the intervention group a year later. “Secondary traumatisation” was put forward as affecting some people where the debriefing process leads to further adverse effect by causing the victim to relive the traumatic event during a vulnerable period (Rose et al 2002).

The variety of different debriefing interventions as well as outcome measures used in the separate studies also may have reduced the ability to gain a greater understanding of the effectiveness of debriefing through the process of meta-analysis.

Whilst there was a lack of sufficient evidence of effect of a single session of debriefing within four weeks of the traumatic event, this review identified evidence of possible harm. In light of these findings, Rose and colleagues stressed the need to cease undertaking the practice of routinely providing debriefing for victims of trauma. This was reflected in the subsequent NICE guideline on post-traumatic stress disorder in 2005.

As mentioned above a variety of different debriefing interventions were utilised in the different studies included in this systematic review by Rose and colleagues. Many debriefing interventions utilised within the maternity context are different and many use unstructured, listening-type sessions. However, as also mentioned above there were three trials which included obstetric

populations that were not included in the meta-analysis (Lavender and Walkinshaw 1998, Priest et al 2003, Small et al 2000). Even within these three studies there were two different populations and debriefing interventions. Whilst the first two included low risk women during childbirth, the latter only included women who had operative deliveries. Whereas Lavender and Walkinshaw and Small and colleagues both used listening-type services where women received an unstructured postnatal debriefing session with a midwife, Priest and colleagues utilised a more formal approach, psychological debriefing. These three studies also had differing findings. Lavender and Walkinshaw identified postnatal debriefing with a midwife to be beneficial, where reduced rates of anxiety and depression following birth were identified amongst women who received postnatal debriefing, whilst Priest and colleagues did not identify any benefits. Finally Small and colleagues identified possible harmful effects amongst the intervention group. There were more cases of depression at six months postpartum and poorer health status among women who had been debriefed compared with those who were not debriefed. Rose and colleagues recognised and stated the need in their report for further randomised controlled trials in this area.

There was a clear need to gain a fuller understanding of the effects of debriefing, both in general and also specifically focused in the context of childbirth. As mentioned above another Cochrane review in the obstetric setting by Bastos and colleagues (Bastos et al 2008) was underway in 2010, at the time when the current literature review was being planned.

Following the publication of the 2002 Cochrane review, as mentioned in the introduction section, 3.1 above, whereas some units closed services others continued to offer postnatal debriefing. In addition in 2006 another NICE guideline made the recommendation for women to be offered the opportunity to talk about the birth experience and ask questions about the care received in labour. This was published in the NICE postnatal care guideline in 2006 (NICE

2006). One such unit is Buckinghamshire Healthcare NHS Trust where a small minority of women access the “Birth Reflections” service.

Despite gaps in the evidence (a majority of the trials reviewed in the Cochrane review did not apply to maternity and little research has been undertaken in this area), further research study was not listed among the research recommendations provided in a NICE guideline on antenatal and postnatal mental health (NICE 2007). It is also of note that the research recommendations from NICE concentrated on women with pre-existing signs and symptoms of mental illness (e.g. depression). There was the urgent need to review the provision of postnatal debriefing. At the time it appeared that only a very small proportion of women giving birth were offered this potential benefit. At the same time other women might be missing out on this hidden aspect of care. It appeared at the time nationally that an inequitable service was being provided for women who give birth.

Part of the rationale for the focus for this critical review of the literature was that the findings of trials have been inconsistent and unclear. This lack of clarity of the trials may be because of variation in services and lack of definition or clarity about what they involve. Heterogeneity between the RCTs is a probable reason why results of effectiveness have been difficult to obtain. Despite further RCTs of postnatal debriefing being undertaken since the first Cochrane review in 2002, which was updated in 2010, there has remained a heterogeneity between the trials.

There was therefore a need to understand more clearly the precise nature of postnatal debriefing: the range of models or approaches being provided, by which professionals and to which women, and when. There was also a need to explore in more depth women’s experiences and views of the intervention. This provided the rationale for undertaking this critical review of the literature. The literature review reported here aimed to gain a fuller analysis and understanding of postnatal debriefing than had been provided in the prior systematic review of

trials, and to complement a concurrent Cochrane systematic review of trials of postnatal debriefing in maternity care that was in process at the time (Bastos et al 2008).

There were three specific objectives. The first involved assessing the views of both the women who use the service and the midwives who undertake the session; the second was to describe the provision of postnatal debriefing and the third, to identify specific approaches taken

### **3.3 Definition: what ‘debriefing’ means**

Different terms have been used for this practice, of which debriefing appeared to be most common, as well as being the term used in the Cochrane review already cited (Rose et al 2002). Others include ‘counselling’ and ‘listening’. For this review, all such terms were grouped under the general umbrella ‘debriefing’, but the review goes on to analyse and explore the range of approaches used and how they are described.

Debriefing is a psychological intervention whereby a client is given the opportunity of speaking about a critical incident with a trained professional. Formal debriefing is guided. The person is encouraged to re-process a traumatic experience. According to Parkinson, critical incident stress debriefing (CISD) is a treatment for those involved in traumatic incidents, including both the victims involved and the professionals called to the scene (Parkinson 1997). CISD is based on the psychoanalytical assumption that talking helps and usually takes place within a group setting.

Parkinson (1997) described structured stages through which the ‘debriefers’ guides the ‘debriefees’. During the first stage, all debriefees are encouraged to describe the facts of what happened. In stage two feelings and sensory impressions are addressed as the debriefer helps debriefees identify situations

that might cause future reactions. In stage three the way forward and the future are considered. This stage includes discussion of both negative and positive reactions experienced by the debriefees. The debriefer helps the debriefees to understand that their feelings are normal and provides information to support debriefees in the future should they experience possible further reactions. In addition, sources of support are identified for debriefees before they part from the debriefer.

Shalev was also clear on the importance of supporting and not negating the human response to others' suffering. To him debriefing provides a structure for this and the process should only be used to achieve appropriate effects i.e. a reduction in distress. This takes place through humanity and caring (Shalev 2000).

### **3.4 Historical background and origins of debriefing**

The concept and process of debriefing originates from its use in the armed services (Mitchell 1983) when it was used after a critical incident occurred (CISD) or following a traumatic incident. The same technique has also been used in civilian life with victims following major incidents. Raphael and colleagues (Raphael et al 1995) discussed the effectiveness of debriefing following psychological trauma. The authors felt that popular opinion sees debriefing in a positive light despite there being no real evidence that it works. People who have been debriefed following a critical incident emphasise the importance of having been debriefed. It appears that the very process of debriefing provides comfort to recipients (Raphael et al 1995). However, others advise caution about the risk of interrupting the natural recovery cycle (Raphael et al 1995). More recently, as discussed above with respect to the Cochrane review of debriefing (Rose et al 2002), the value of debriefing has been questioned and research evidence to its effectiveness found to be lacking.

### 3.5 Debriefing in the maternity services

Niven provides a useful definition of how the “debriefing” process may help women postnatally, utilising a less structured approach:

*“just listening to fears, worries and problems and not seeking to obliterate or solve them but to facilitate their ventilation is a crucial part of psychological care”*

(Niven 1992 p34)

The above quote suggests quite subtle but potentially important differences in meaning and interpretation between the original structured psychological debriefing concept and how debriefing is typically used in maternity care. This could underlie the differing findings from the three maternity trials that were covered in Rose et al's (2002) Cochrane Review.

A range of approaches to postnatal debriefing have been recognised. Alexander urges caution with terminology here suggesting the use of ‘debriefing’ be kept for the application of formal psychological interventions and preferring the term “defusing” for the more simple listening style techniques more commonly undertaken by midwives (Alexander 1998).

In many maternity units in the UK ‘debriefing’ or ‘listening’ is offered by midwives to postnatal women. This suggests that the basic skill is within the remit of a practising midwife. However, the importance of referral to an expert in psychology or psychiatry where appropriate has been stressed (Nursing and Midwifery Council 2004, Smith and Mitchell 1996).

Debriefing in the maternity services generally constitutes one session. This is an opportunity for a woman to have a one-to-one confidential meeting with a midwife for approximately one hour. The structure of the session is based

around the woman being invited to tell her story of her birth experience and have explanations provided (Smith and Mitchell 1996, Axe 2000). The meeting is often guided by the maternity record (Allott 1996, Madden 2002, Smith and Mitchell 1996). In addition and unlike other debriefing sessions, feedback from women is fed back into the service (Smith and Mitchell 1996).

As mentioned above in the background section 3.2 the clinical trials were inconsistent and came to contrasting conclusions with a resultant lack of clarity around what practice should be in maternity care. This was partly due to ambiguity in defining the intervention used in the trial. This literature review set out to enhance understanding of these issues which are about the nature of postnatal debriefing.

As has been discussed above a range of approaches are used under the umbrella term “postnatal debriefing”. Alexander in a commentary paper in 1998 urged caution on the use of the term “debriefing” in the maternity services, preferring “defusing”. However this has not been adopted in practice. In order to maintain consistency and reduce the risk of confusion throughout this thesis the term “postnatal debriefing” will be adopted. This continues to be the most commonly used term for the medley of different approaches taken. It is also the term used in the RCTs which also adopt a range of different approaches, including informal listening and structured psychological interventions

### **3.6 Psychological trauma following childbirth**

Women following traumatic birth experiences may develop post-traumatic stress disorder (PTSD). The overall aim of debriefing services in the maternity setting is to prevent psychological morbidity (Ralph and Alexander 1994, Raphael-Leff 1991). Statistics vary about the proportion of women affected by PTSD. Creedy

et al (2000) in an Australian study found six per cent of women to meet the diagnostic criteria for PTSD at 4-6 weeks postpartum.

Women following birth by caesarean section or instrumental vaginal delivery have been found to be at increased risk of developing postnatal depression (Astbury et al 1994). Post-traumatic stress disorder (PTSD) is also associated with vaginal operative and emergency caesarean sections (Gamble and Creedy 2005).

One definition of PTSD refers to effects of “an event outside the range of usual human experience” (Ralph and Alexander 1994 p29) while Czarnocka and Slade (2000) report the re-experiencing of a trauma, avoidance of reminders and hyperarousal as key symptoms. It seems anomalous that women should be at risk of this disorder following childbirth, which is a normal part of human existence. Birth should be as positive a psychological experience as possible.

Other factors also contribute to women’s emotional state postpartum. Often women’s expectation of their birth experience contributes to psychological morbidity after birth. Green and colleagues (1998) studied the emotional well-being of 825 women by using questionnaires at 30 and 36 weeks of pregnancy and about 6 weeks after birth. The authors concluded that women with lower expectations of childbirth had worse psychological outcomes than women with high expectations. Low emotional well-being was associated with caesarean section, inadequate information, lack of control over staff or over own body, and dissatisfaction with what happened regarding interventions. It is interesting that in this study obstetric interventions themselves were not independently related to emotional well-being. Women’s perception of the necessity for intervention during labour and birth rather than the intervention itself was more important in determining women’s emotional well-being. What mattered to the woman was that she herself perceived the intervention to be necessary i.e. “it was the right thing to do”.

The relationship a woman has with her care provider has also been found to influence her overall birth experience. If professionals communicated well with the woman about interventions and helped her to feel in control, then her experience of birth generally was less negative. Negative perceptions have developed as a consequence of not being satisfied with this relationship (Green et al 1998).

### **3.7 Scope, research question and objectives**

As already mentioned a systematic review was concurrently being conducted on postnatal debriefing in maternity services (Bastos et al 2008) at the time of undertaking this review. To complement that Cochrane review, which was focused on outcomes of clinical trials, this review was focused around a different research question:

- What is current practice in offering debriefing services to postpartum women and what are the perceptions of women in accessing these services?

Following the guidelines identified by Hart (1998) the objectives of the literature review were:

- To assess the perceptions of users and maternity care staff of postnatal debriefing
- To provide a typology of the approaches and terms being used in debriefing in postnatal care
- To undertake an analysis of the application of postnatal debriefing in practice, including content, style and underpinning theory

- In relation to the previously stated objectives, to identify the gaps in the body of knowledge on debriefing in maternity services

### **3.8 Methods of the review**

#### **3.8.1 Search strategy used to identify the studies**

When undertaking a research synthesis there is the need for clarity of what is being undertaken. This includes an explicit list of objectives, materials and methods to satisfy the need for reproducibility (Mays et al 2005). In this study the PICO mnemonic created by the Joanna Briggs Institute was utilised (Joanna Briggs 2008). This incorporates the Population, the Phenomenon(a) of Interest and the Context and facilitated the systematic identification of search terms. This framed the question of this literature review.

When applying the PICO mnemonic to this study the "population" is postpartum women and the "phenomena of interest" are current practice and women's experience of the debriefing service. The "context" relates to the period of time following childbirth (postpartum) and the maternity services.

Using this model a comprehensive set of search terms was constructed that are listed on Table 3.1 below.

<b>Table 3.1 Search terms derived through the use of the PICO model</b>			
<i>Population</i>	<i>Phenomena of Interest</i>	<i>Context</i>	<i>(Outcome)</i>
childbirth	Debrief*	Psycholog*	
Postnatal	Counsel*	Anxiet*	
Pregnan*		Trauma	
Postpartum		Depression	
Antenatal		Post-traumatic	
Pregnanc*		PTSD	
birth			

A search was conducted of the major electronic databases: MEDLINE, CINAHL, Cochrane Library, DARE, Embase, PubMed, Ovid Medline, Social Science Index, Maternity and Infant Care, PsychoINFO and Social Policy and Practice using search indicators as pre-specified at the outset. In addition, key papers were hand searched to identify any further relevant references.

### **3.8.2 Inclusion/exclusion criteria and types of studies included**

The search to identify the studies was broad. All research studies on the topic of postnatal debriefing, provided by either midwives or obstetricians, published and written in English were included in this review. In addition, no time limit was imposed. All types of research were included, including randomised controlled trials, as it was considered that these would be helpful for the description of the content of the interventions used as well as the findings of some surveys that were conducted within the trial design.

### **3.8.3 Identification of the studies**

The steps taken to identify the included studies are listed below. These were repeated for each electronic database. The number of studies retrieved are listed at Table 3.2 below:

1. All terms for population combined with Boolean term “or”
2. All terms for phenomena of interest combined with Boolean term “or”
3. Steps 1 and 2 combined with Boolean term “and”
4. All terms for context combined with Boolean term “or”
5. Steps 3 and 4 combined with Boolean term “and”

<b>Table 3.2 Results of searches of the electronic databases</b>			
<i>Search engine</i>	<i>Database</i>	<i>Number of hits</i>	<i>Comments</i>
OVID	Maternal and infant care	382	
OVID	Embase	382	
OVID	EBM reviews	71	
OVID	AMED	4	
OVID	Global Health	114	
OVID	HMIC	6	
OVID	OVID Nursing Full Text	128	
OVID	Social Policy and Practice	20	
EBSCO Host	CINAHL	184	
EBSCO Host	Psychinfo	368	
EBSCO Host	MEDLINE	608	
EBSCO Host	Psychology and Behavioural Sciences Collection	75	
EBSCO Host	PsycARTICLES	337	

As described above hand searching of key papers identified further papers which were added to the search. Finally, all relevant papers were included in the literature review following a review of the titles and abstracts of all retrieved papers as listed on Table 3.2. In total 32 papers were identified, including 20 research papers and 12 commentary/opinion papers.

#### **3.8.4 Processes for completing the review, including assessment of methodological quality**

At the outset of this study it remained uncertain as to the nature of the papers in terms of methodological approach that would be included in the review. The research question provided some clarity and expectation that qualitative papers would be identified. However, it was also possible that some quantitative studies would also be included.

Once the papers were retrieved and the decision made to include all primary research papers I spent a sustained time-period immersed in the papers and reading them all through on several occasions each. Once I was acquainted with the content of the papers I undertook a systematic critical appraisal of each paper.

There was the need to ensure that papers included in the review met an accepted level of methodological and theoretical quality. Quality criteria of the individual studies were assessed using critical appraisal guidelines appropriate to the type of research. The main framework for use in this review was the Critical Appraisal Skills Programme (CASP) 1993. The CASP tools cover a range of different research methods including randomised controlled trials (RCTs), qualitative research and systematic literature reviews. As the CASP programme does not have a template for surveys I used an instrument that I had used in a previous post when I was a research and development midwife. This was constructed by a colleague and shared with me from I.K. Crombie "The Pocket Guide to Critical Appraisal" British Medical Journal 1996. All points on the respective CASP tool (or in the case of surveys the one mentioned above) were applied to each of the included studies. A separate tool was used for each research paper to help determine the quality of the study. This process facilitated a consistent approach and helped to ensure the appraisal was systematic and uniform (Aveyard 2010).

Due to the small number of studies retrieved a decision was subsequently made by the review team not to reject any papers on the grounds of quality. There were no disagreements in data extraction amongst the review team. Whilst it was agreed by the supervisory team to include all studies that met the criteria due to the low number of papers identified, through the critique process it was possible to identify and be aware of any major methodological shortcomings when interpreting the data. It was planned that the findings, from any papers where major methodological flaws were evident, would only be included in the synthesis when drawing out themes in conjunction with the same findings of other included studies of a higher quality. All data retrieved from the different studies are reported as they were originally presented. All quotes and statistical information are exactly reproduced.

In addition, commentary papers were identified and put aside whilst the analysis of the research papers was conducted. These were read through separately once the critique of the research studies was complete and key points identified to provide any additional information that might be of use in drawing conclusions from the analysis.

### **3.8.5 Data synthesis**

Integrating studies with different methodological backgrounds when undertaking systematic literature reviews is problematic and difficult (Thomas et al 2004, Lucas et al 2007). There is the need to consider different epistemological and theoretical perspectives (Mays et al 2005) and the development of robust ways of incorporating qualitative evidence into systematic reviews (Dixon-Woods et al 2005). There is also a choice between integrative and interpreting techniques to be made. However, Dixon-Woods et al (2005) argue that there is an overlap and a range of methods that can be utilised.

Pope and Mays (2006) described four broad approaches that can be taken by researchers when considering integrating qualitative and quantitative types of evidence. These they stated are distinguished as narrative, qualitative, quantitative and Bayesian (Pope and Mays 2006). These authors described the use of a “qualitative qualitative-quantitative synthesis” (Pope and Mays 2006p148). This approach was adopted in the present study where the findings of the quantitative studies were converted into a qualitative textual format prior to conducting the synthesis in the secondary analysis using a meta-ethnographic approach as described by Noblit and Hare (1988). This aimed to produce new concepts through second or third order interpretations to explain the findings from the different studies.

### **3.8.6 Meta-ethnography**

As described above meta-ethnography was chosen as the approach for synthesising the data. It was anticipated at the outset of this review that this interpretative method of synthesis would be in line with the type of research extracted following the literature search. Undertaking synthesis in this way can involve a re-interpretation of the included studies and in this way goes beyond traditional integrative methods for a literature review (Britten et al 2002).

Meta-ethnography is an interpretive approach to research synthesis. The interpretive paradigm seeks an explanation for social or cultural events based on the perspectives and experiences of the people being studied. Noblit and Hare (1988) when describing meta-ethnography stressed the need for the synthesis to be interpretive rather than merely aggregating evidence. According to these authors, conducting synthesis of research evidence in this way enables “interpretive explanations” (Noblit and Hare 1988 p11) and therefore increased understanding of the phenomena under study.

*“Interpretive accounts, above all, provide a perspective and, in doing so, achieve the goal of enhancing human discourse”* (Noblit and Hare 1988 p18).

Noblit and Hare (1988) adapted Turner's (1980) notion that all explanation is essentially comparative and takes the form of translation. Therefore, through the process of undertaking meta-ethnography a researcher translates qualitative studies into one another to produce second and third order constructs.

Postnatal debriefing is a social event and the perceptions of women using this service were sought in the research question. For these reasons using a meta-ethnographic approach and undertaking interpretive synthesis as described above was considered a useful method for furthering understanding in this under researched area. This it was hoped would be achieved by identifying possible second order constructs through the process of translating the different studies into each other.

*i) The process of meta-ethnography*

Noblit and Hare (1988) provided a seven-step approach for undertaking a meta-ethnography: "getting started"; "deciding what is relevant to the initial interest"; "reading the studies"; "determining how the studies are related"; "translating the studies into one another"; "synthesising translations" and "expressing the synthesis".

The process of the synthesis of this current literature review followed the steps taken by Britten et al in their worked example of a meta-ethnography in 2002 (Britten et al 2002). These authors made use of a table (grid) – see Table F1 (Summary of studies) at Appendix E. Details of the study setting and research design are listed together with the key concepts or findings of each study. Using the table in this way allowed me to become further immersed in the research reports and make comparisons across the different studies. This process ensured comparison between the different studies whilst at the same time preserving the original metaphors, concepts or themes.

In meta-ethnography interpretation and explanation in the original studies are treated as data, and are translated across several studies to produce a synthesis. The process involves induction and interpretation. This encourages the researcher to understand and transfer ideas, concepts and metaphors across different studies (Britten et al 2002). I made use of the term concepts rather than metaphors or themes.

The use of written notes, with the key concepts from the individual studies, on colour coded paper also proved of benefit to the process of the synthesis. The colours related to issues relating to the four key research questions: the provision of postnatal debriefing, aspects of providing the services, women's perceptions of postnatal debriefing and midwives' perceptions of postnatal debriefing. It was planned that the subsequent research report would be written under these headings to provide clarity for the reader.

The process taken in stages one and two have already been described above. In relation to the third stage described by Noblit and Hare, the importance of careful reading of the included studies has already been mentioned above. A thorough knowledge of the research papers was gained during this stage. Also, during the reading phase a search for common and recurring concepts (themes) was undertaken. The use of the table as mentioned in the above section assisted with this process which allowed me to become immersed in the papers. Being immersed in this way supported the identification of key concepts (or themes) pertaining to postnatal debriefing. These were subsequently presented in the thesis within categories related to the research questions.

During the fourth stage, "determining how the studies are related", I looked across the papers for common and recurring concepts. Again, the grid helped me to compare these across the studies.

During the stage “Translating the studies into one another” the findings were matched between the papers and “puzzles” or questions were created. Answers were sought: this formed the process of translation, ensuring that all the key concepts were encompassed. During this process, relationships between the concepts according to the different studies were identified and possible second order constructs or explanations created. One example of a second order construct identified in this way was validation of the birth process. The research papers had identified women’s expressed need to talk about their birth experiences and be listened to by a health professional. Through the process of meta-ethnography the concept validation of the birth process became apparent.

Third order constructs might also have been possible during the “Synthesising translations” stage. However, this was not possible due to the limited data (number and data richness of papers retrieved). This might have been in the form of a line of argument developed from the key concepts and second order constructs (Britten et al 2002). Data produced during this synthesis is the interpretation and explanations of previous studies’ findings. In this way meta-ethnography appropriately proceeds by translating the interpretations of one study into the interpretations of another study, while also maintaining the sense of the original study concepts.

The final step in the process of meta-ethnography as proposed by Noblit and Hare, “expressing the synthesis”, refers to the dissemination of the synthesis and potential audiences. The findings of the critical review of postnatal debriefing were published in *Midwifery, International Journal* in 2014. I envisaged that midwives were the key audience and would be interested in the practical and clinical implications of this work for their own practice.

### **3.9 Findings**

This section commences with an in-depth critique of the identified studies. This is also summarised in Tables F1 to F4 in Appendix E and in sections 3.9.2. Following this, the key concepts (or themes) identified from the data in this critical review of the literature are presented within categories related to the research objectives.

#### **3.9.1 In-depth critique of the included studies**

Twenty papers were identified from the literature search. The list of studies includes one mixed method study, three qualitative studies and four surveys. In addition eight randomised controlled trials and one pragmatic trial were utilised for aspects of their findings, including survey results of midwives' views and the postnatal debriefing intervention employed. Three literature reviews about postnatal debriefing were also identified from the search. Although not included in the analysis these were available when considering the background literature and to compare findings in the discussion as needed. An illustration of the process of selecting the studies to include in the review is shown below at Figure 3.1. This continues from Table 3.2 above "Results of searches of the electronic databases".

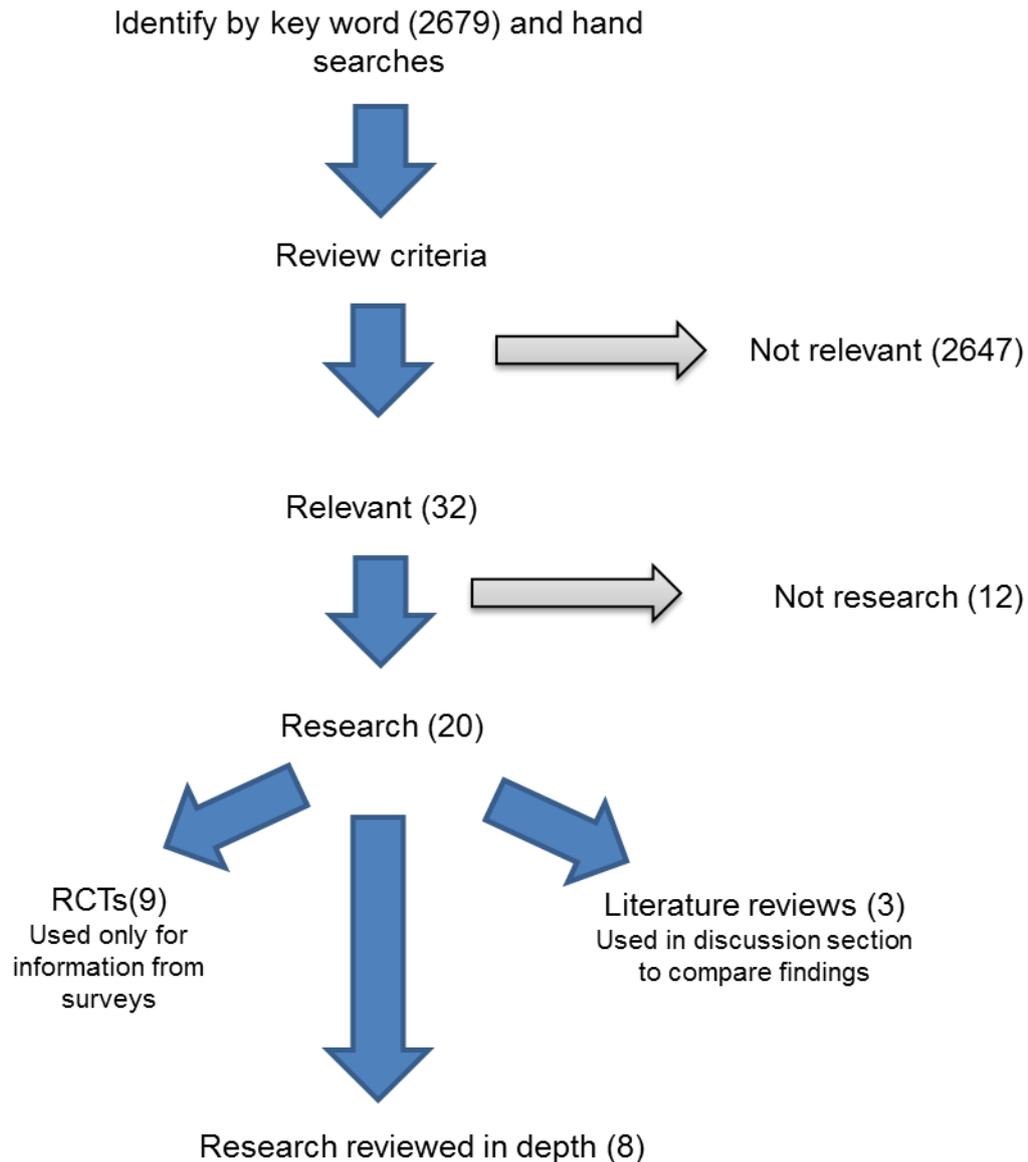


Figure 3.1 Process of selecting the studies to include in the review

A critique of each of the first eight studies mentioned above is provided below. These are grouped by type of study and are followed by a summary of the key critical points that have been identified from reviewing these papers. The mixed methods study is presented to start with and followed by the qualitative studies. The three surveys are described lastly.

As mentioned above all twenty studies identified in this review are summarised at Appendix E, Tables F1 and F3. Further information relating to the in-depth critique is given at Table F2 which gives a summary of the critical appraisal of each of the reviewed studies described below in this section.

**Inglis 2002** undertook what she described as a mixed methods evaluation study, to examine the objectives of a postnatal debriefing service in the north of England from the perspective of its users (Inglis 2002). This researcher used a postal survey and telephone interviews to respond to the research questions. However no quantitative findings were reported.

A clear rationale for this study was provided. This was the fact that a negative birth experience can affect the transition to parenthood and risk poor mental health. Debriefing was considered to support psychological well-being. There were some methodological weaknesses in this study, including a lack of clarity about the rationale for the mixed methods approach and how this was undertaken, how the samples were formed and how the qualitative and quantitative data were analysed. In addition there was a lack of consideration about the relationship between the researcher and the participants.

**Dennett 2003** preferred the use of the term “talking about the birth” rather than debriefing. This researcher administered a postal survey to a convenience sample of 100 women who had given birth 8-10 weeks earlier in Birmingham (Dennett 2003). In the study respondents were asked if they were given an opportunity to talk about their birth, and if so whether or not it was at the right time or of benefit. Only the qualitative findings from the open-ended questions on the questionnaire were reported due to the low response rate of 29% (this is the reason why this study is listed among the qualitative papers in this section). This low response rate therefore diminished the ability to generalise the findings to other settings. Unfortunately, no information was provided about the usual practice for postnatal debriefing in the unit where the research was undertaken.

**Bailey and Price 2008** used a grounded theory methodology to explore a purposive sample of seven women's experiences of a "Birth Afterthoughts" service in Bristol (Bailey and Price 2008). This study was of overall good quality. It formed an evaluation which aimed to identify aspects of the service of benefit to the women, all of whom had used the local service. At least five had been diagnosed with psychological morbidity as a consequence of giving birth. A good literature review was given and steps to avoid bias shown.

This study considered both the experiences of women receiving postnatal debriefing and their perception of the role of the professional midwives who provide the sessions.

**Gamble et al 2004a** investigated childbearing women's views on counselling strategies to facilitate recovery from childbirth-related stress and trauma. This was conducted in Queensland, Australia. A qualitative approach was adopted (Gamble et al 2004a).

Some methodological flaws were apparent in this study, including the need for more clarity about the process taken for the thematic analysis and a lack of critical evaluation of the researchers' roles in relation to the research. However there was also evidence of good quality research practice, including steps taken to avoid bias. The three researchers all undertook thematic analysis individually and then met up to agree themes.

**Gamble et al 2004b** investigated midwives' views on counselling strategies to facilitate recovery from childbirth related stress and trauma (Gamble et al 2004 b). This took place in Queensland, Australia and a qualitative approach was taken which included two focus groups with separate groups of midwives. To inform the discussion during the second of the two focus groups the midwives were provided with feedback about the issues raised by the women participants in the study listed above (Gamble et al 2004a).

One methodological weakness of this study was that the participants were recruited by their manager. However, an independent researcher led the focus groups. Another flaw in the research design related to the fact that the findings of the study above describing the views of women to postnatal counselling/debriefing were shared with the participants as part of this study. There was the possible risk of cross-pollination of views and these were evident in the findings.

**Olin and Faxelid 2003** undertook a survey, in Stockholm, to describe parents' experiences of childbirth and their views of having a postpartum talk (Olin and Faxelid 2003). Unlike many of the other included studies, the authors provided a theoretical framework to situate the study. The researchers stated that individual women cope differently to demands of childbirth. A woman with a strong sense of coherence (SOC) is more aware of her feelings and may express them better than someone with a weak SOC. Talking after birth allows women and men to express feelings, discuss experiences and understand what happened. These authors also drew on stress theory, adapted for pregnancy and childbirth, where three elements become essential: "comprehensibility", "manageability" and "meaningfulness". "Comprehensibility" is about ensuring women understand the process of childbirth and "manageability" refers to an individual woman having resources to meet her needs during pregnancy and the entire childbirth journey. When considering "meaningfulness" this suggests the need to find a meaning to giving birth.

This was a well-designed survey and generally of good quality. Good response rates were obtained. These were 68% for women and 64% for men. However on occasions vague comments were made by the researchers about the findings but there are no percentages reported to back up such statements. As a result it was not possible to support the conclusions made on occasions.

**Steele and Beadle 2003** undertook a survey of service provision of postnatal debriefing (Steele and Beadle 2003). This aimed to explore current practice and

describe the provision of postnatal debriefing in two health regions in England. The results reflected 43 maternity units.

This study was generally of a good standard and a good response rate was achieved (93%). However as only two health regions were included, despite being randomly selected from all English health regions, these units may not be representative of all units in England.

**Ayers et al 2006** undertook another survey of postnatal debriefing services. This was a cross-sectional telephone survey of postnatal services in the United Kingdom (UK). This study aimed to establish the type and availability of postnatal services in the UK for women who have a difficult or traumatic birth (Ayers et al 2006).

Computer randomisation was undertaken and 93 obstetric units were included. A clear description of the questions asked was provided and a good response rate achieved (76%). The interviews were completed by senior staff, including heads of midwifery, senior midwives and consultant obstetricians, who were all likely to know what practice takes place at their respective units. However, there was the risk that they might overstate or exaggerate the service offered by their individual unit.

### **3.9.2 Summary of the included studies following the in-depth critique of the literature**

As mentioned above eight studies form the main focus of this critical review of the literature on postnatal debriefing. Following the above critique of each of the individual studies, these are summarised below under three key headings in relation to the aims of the various studies: 'Perceptions of women to postnatal debriefing', 'Midwives' perceptions of postnatal debriefing' and 'Service provision of postnatal debriefing'.

i) *Perceptions of women to postnatal debriefing*

Four studies employed qualitative approaches to assess the perceptions of women to postnatal debriefing. All four were undertaken by midwives, some clinically based while others were academics from one university. Three of these were conducted in England and one in Queensland, Australia. Only one of these four studies was of a high quality. The authors had a clear rationale for undertaking this work: they considered the benefits of postnatal debriefing to be unclear. They used grounded theory to explore and evaluate women's experiences of postnatal debriefing. Seven women following a traumatic birth experience formed the convenience sample (Bailey and Price 2008).

A second study from researchers in Queensland, Australia, demonstrated some good qualities in their study of the perceptions of women to counselling strategies that may facilitate recovery following a traumatic birthing experience. These included positive steps to avoid bias where the three researchers independently undertook thematic analysis and then met to agree themes and a second review of the transcripts to determine that information relevant to the question was not omitted or contradictory information present. However there were also some methodological flaws identified during the critical appraisal. The sample consisted of six women who all participated in one focus group (Gamble et al 2004a).

The two remaining studies were of a poorer quality. Inglis (2002) in a maternity unit in the north of England examined objectives of postnatal debriefing from a user's perspective. This researcher professed to have undertaken a mixed methods research approach. However no quantitative results from the survey that was mentioned were reported. In addition the sampling process was not given. However the qualitative elements were clear.

Finally Dennett (2003) in Birmingham asked women following birth whether they had been given an opportunity to talk about their birth and if so did it take place at the right time and was it beneficial. This researcher sent a postal survey to 100 women between eight and ten weeks following birth. Unfortunately the response rate was low which resulted in the responses to the qualitative open ended questions only being analysed and presented in the research report. Another flaw in relation to this study pertains to the fact that no context was provided in relation to usual practice at the study unit in terms of debriefing.

A fifth study was undertaken in Sweden about the perceptions of both parents' and their experiences of having a postpartum talk (Olin and Faxelid 2003). The survey was administered to 350 mothers and 343 fathers following birth. This study utilised a survey technique, was well-designed and generally of a reasonable quality which achieved a good response rate. Another good point in relation to this study was that the authors suggested possible theoretical frameworks in which to situate the study. One methodological weakness related to the presentation of some findings. Whereas most of the statistical information was clearly presented in the paper some of the more detailed subject matter was not clear and there were no figures to support the conclusions made.

As mentioned above five papers provided evidence to answer the objective of describing women's perceptions of postnatal debriefing (Bailey and Price 2008, Dennett 2003, Gamble et al 2004a, Inglis 2002, Olin and Faxelid 2003). As none of the authors of these papers explicitly stated that CISD was used, it is assumed that the style of the debriefing session that took place was in the form of a more flexible listening approach. It is not clear whether the participants from the paper by Gamble and colleagues actually had personal experience of attending a postnatal debriefing. These participants were recruited from a self-help group for women wanting a vaginal birth after caesarean section (VBAC). The four other papers related to services that were offered routinely to all women following birth. Three of these utilised a qualitative approach (Bailey and Price 2008, Gamble et al 2004a, Inglis 2002). The approach taken by the

authors in two of the qualitative studies differed slightly from that of the authors of the third study. Both the Inglis and Bailey and Price studies set out to evaluate the midwifery led debriefing services, both situated in the UK, whereas Gamble et al in an Australian setting asked women who had experienced a traumatic birth to identify counselling strategies that may facilitate recovery following a traumatic birth (Gamble et al 2004a). As mentioned above Bailey and Price and Gamble and colleagues both undertook thematic analysis. However, the explicit stages taken were not clear in the latter paper and although Inglis clearly stated that thematic content analysis was undertaken no explicit themes were identified. The author described common findings that centred on communication and information needs.

*ii) Midwives' perceptions of postnatal debriefing*

An analysis of midwives' beliefs and perceptions was also undertaken in the review of the literature. This review finds that there is limited literature on this topic. Only one small qualitative study on the views of midwives to postnatal debriefing was identified. This investigated midwives' counselling strategies to facilitate recovery from childbirth-related stress and trauma (Gamble et al 2004b). Two focus groups with midwives were undertaken.

It is not clear whether the participants of the qualitative study routinely undertook, participated in or facilitated debriefing sessions. The study included 16 midwives in two focus groups (eight in each), most of whom had many years of experience. They were recruited by their manager and the focus groups were conducted by an external researcher. The possible limiting risk of being recruited by the manager was not recognised by the researchers. During the second focus group the midwives were provided with feedback about what a group of women had said during earlier field work as part of the same study. This did not take place during the first focus group. It would have been helpful to see what participants said spontaneously first, then to see how they responded when provided with what the women said. The authors failed to provide a justification for this which is a weakness in the reporting of the findings. The

wider study considered the views of both women and midwives (Gamble et al 2004a and b).

Although the authors did not always comment on the differences between the first and second focus group discussions, the themes that emerged were similar to those that were created in the analysis of the women's part of the study. It would also have been useful to gain an understanding about what the midwives thought about postnatal debriefing without any triggers from the women.

One key methodological flaw in the design of this study related to the fact that the findings of an earlier study of the views of women to postnatal counselling/debriefing were shared with the participants as part of this study. There was the possible risk of cross-pollination of views and this was evident in the findings.

iii) *“Service provision of postnatal debriefing”*

Two surveys were identified from the search that considered service provision of postnatal debriefing services in England and the UK more widely. Steele and Beadle in 2003 administered a survey in two health regions in England, randomly selected. They aimed to describe service provision of postnatal debriefing by asking maternity units to select from a list of descriptors the types of services offered to women at their hospital. Due to the fact that only two health regions were involved, albeit selected randomly, this limits the study. It is not possible to know whether these areas are representative of all regions in England. Apart from this limitation the study was of a reasonable quality, including a good rationale for undertaking the work and supported by an adequate literature review.

The second study of service provision was a cross-sectional telephone survey of postnatal services across the UK (Ayers et al 2006). This survey aimed to establish type and availability of postnatal services in the UK for women who had a difficult or traumatic birth. This was also of a good standard.

The study by Ayers et al (2006) focussed on services for women following difficult or traumatic birth experiences whereas Steele and Beadle (2003) considered the availability of postnatal debriefing services for all women following birth.

### **3.9.3 Introduction to the findings of the critical review of the literature**

Following the critical appraisal of the included studies the findings of this critical review of the literature are given in the following four sections: 'The provision of postnatal debriefing', 'Aspects of providing the services', 'Women's perceptions of postnatal debriefing' and 'Midwives' perceptions of postnatal debriefing'. The key concepts (or themes) identified from the data in this critical review of the literature are presented within categories related to the research objectives

### **3.9.4 The provision of postnatal debriefing**

#### *i) Introduction*

This section will describe how postnatal debriefing is provided and what is included in the sessions. Three main concepts (as described by Noblit and Hare (1988) and discussed in section 3.8.6) were identified and will be discussed below: 'Structured interview', 'Unstructured discussion' and 'Confusion about what individual services provide'. In the following section I set out six more concepts identified from the review in relation to the delivery of the services.

Information in the qualitative papers is lacking regarding the format taken in the sessions. The clinical trials are generally better at describing the interventions used. The data for this section primarily comes from randomised controlled trials and surveys of maternity services. It is unclear whether the interventions undertaken in the RCTs are also in everyday use.

*ii) Structured interview*

Five out of the nine RCTs utilised a structured format for the debriefing session with women. Three of these utilised the psychological approach Critical Incident Stress Debriefing (CISD) (Kershaw et al 2005, Priest et al 2003, Selkirk et al 2006). One of the papers explicitly stated that their intervention was modelled on CISD (Priest et al 2003). However the other two studies failed to comment on this but the exact same headings were used to guide the session (e.g. “Facts phase”, “Findings phase”, “Symptoms phase”).

Ryding and colleagues in their first study did not use CISD technique (Ryding et al 1998). These researchers used a different approach. This consisted of three or four consultations. At the first the woman was invited to tell her own story about the delivery and consider her feelings during six phases of the delivery process. At the second the woman was encouraged to talk about her worst memories and feelings about the delivery. During the third consultation the woman was given a copy of her labour and delivery record. This was examined and feelings discussed (e.g. shame or guilt about her performance during delivery). The woman’s feelings and thoughts about the delivery were examined again at the fourth consultation, including what she had learnt from the experience. In addition at the fourth consultation the woman was invited to consider the possibility of a future pregnancy. The format was structured and undertaken by an obstetrician trained in psychotherapy.

Finally Gamble and colleagues created an original counselling model for their RCT (Gamble et al 2005). This did not utilise a psychological approach. In their paper these authors explicitly stated that the intervention did not require psychotherapeutic skills and was aimed at being undertaken by midwives. This was considered by the authors to be evidence based, who explained that it evolved from theory, focus group primary research with childbearing women

and midwives (these are included in this study and described in other sections) and two reviews of the literature undertaken by the same research team in Australia. It is of interest that various elements described in Ryding et al's paper above were apparent in this model (e.g. the examination of possible guilt feelings and the discussion of existential issues).

*iii) Unstructured discussion ('Listening services')*

Four RCTs utilised less formal approaches to the debriefing following birth (Lavender and Walkinshaw 1998, Meades et al 2011, Ryding et al 2004, Small et al 2000). Researchers in Australia have recognised and make mention of 'listening services' that have been set up in the UK (Gamble et al 2004b). It may be that this concept is linked to such "listening services". As far as it can be seen from the current literature review these sessions included discussions surrounding the birth. These served as an opportunity for women to air their feelings and ask questions about their birth experiences.

Meades and colleagues in their study in the United Kingdom (UK) also described a general discussion (Meades et al 2011). This discussion includes aspects of the birth, mention of feelings, emotions and concerns that the woman might have and future births. The maternity record was available to clarify events and provide further information.

It is of interest that the researchers from Sweden changed their approach between different studies from a formal counselling session to a session that seems like a friendly chat (Ryding et al 1998, Ryding et al 2004). The rationale for this is not clear. At the beginning of the group session women in the latter study were invited to tell their story and the remainder of the session was unstructured according to the needs of the group. The facilitator concluded the session by talking about similarities and differences in the women's experiences. This was very different to the more structured sessions identified in the first study.

In an RCT in Australia the intervention comprised of a discussion with a midwife (Small et al 2000). This provided women the opportunity of discussing their labour, birth and post-delivery events and experiences. The content of the debriefing was determined by each woman's experiences and concerns.

In another RCT in the UK Lavender and Walkinshaw described the intervention as a respondent led "interactive interview" (Lavender and Walkinshaw 1998 p 216). Women were encouraged to speak freely and discuss labour, ask questions and explore their feelings. This included both positive and negative aspects of their experiences.

A survey of mothers and fathers during the first few days following birth in Sweden explored parents' need of a "postpartum talk" (Olin and Faxelid 2003). The authors described the postpartum talk where parents are able to "express their experiences, thoughts, feelings and fantasies in order to understand what happened" during their childbirth experience (Olin and Faxelid 2003 p154). The respondents were invited to give suggestions for the content of the "Postpartum talk" (which as stated was not defined). The respondents said that they wanted to talk about the birth process and wanted many questions answering such as Was the delivery normal? What was the reason for the delivery being prolonged and for the complications that occurred?

Individual partners within a couple were identified as having had different perceptions of the birth experience. They sought the opinion of the midwife undertaking the talk about his/her view of what happened during the birth (Olin and Faxelid 2003). This same survey also identified that some women experience a sense of guilt and disappointment in relation to the birth and they wanted to discuss their own behaviour. Pain relief was also considered an important area for discussion. Fathers were also included in this survey and they felt they could have been provided with more information from the midwife about how they could have supported their partner in labour.

*iv) Confusion about what individual services provide*

Two surveys have been undertaken in the UK to assess service provision. One survey identified 88% of units offered debriefing to women who felt traumatised (Ayers et al 2006). The other (Steele and Beadle 2003) found 94 per cent of units offered a service to all women. The difference in the proportions is small. The reason for this is unclear. It may be those units offering the service to women following a difficult birth were also broader, offering the service to other women too. The authors of the first paper commented on this high proportion. Set against the context of postnatal care receiving poor review it seemed surprising to them that such a rich resource was available at the majority of units (Ayers et al 2006).

It is clear from these two studies that there is confusion in terms of what is provided. In their background discussion to the study Ayers and colleagues described three different types of postnatal debriefing: structured psychological debriefing as proposed for use following traumatic events, midwife or obstetrician led debriefing where professionals review the events of a woman's pregnancy and birth experience with her and finally "Birth Afterthoughts" services run by midwives to discuss the events of birth and express their feelings (Ayers et al 2006). The same authors identified a variety of types of services that were being undertaken across the UK. In the results of their survey 13 per cent of services cared for women who had a difficult or traumatic birth in a "Birth Afterthoughts" service, 45 per cent had a "debriefing with a midwife or obstetrician", 20 per cent had a "debriefing with a midwife counsellor" and 14 per cent are seen by a psychotherapist.

Steele and Beadle (2003) did not identify the professional who undertook the postnatal debriefing session. These authors created a list of nine activities and events undertaken within a postnatal debriefing session and asked heads of

midwifery in two health regions in England to state which of these are undertaken within their units. Three groups were identified. "Group A" consisted of units where all nine activities were stated and this was considered to be defined as structured psychological debriefing. This comprised 14 per cent of participants. "Group B" consisted of 28 per cent of participants and was made up of units that stated routine postnatal care type activity was only undertaken. The largest group, "Group C" was made up of 58 per cent of participants who selected combinations of descriptor statements from the list. The names provided for this service in "Group C" included birth afterthoughts (n=2), debriefing (n=6), routine postnatal care (n=8). This highlights the confusion that still exists about the provision of a postnatal debriefing session with a health professional.

There is no clear universal model for a postnatal debriefing. Gamble et al created a midwifery model for their RCT, which found some effect in terms of fewer adverse outcomes among the intervention group (Gamble et al 2005). No evidence has been found from the literature that this model has been replicated in other centres.

### **3.9.5 Aspects of providing the services**

This section will identify various individual elements deemed necessary for the composition of postnatal debriefing with a health professional as identified in the literature. Six concepts have been identified: 'Optimal timing of the postnatal debriefing', 'Practitioner (who undertakes postnatal debriefing)', 'Groups of women who are offered postnatal debriefing', 'The presence of partners during postnatal debriefing' and 'Number of sessions'. These are summarised at Appendix E, Table F4.

*i) Optimal timing of the postnatal debriefing*

The time in relation to the birth when women access a postnatal debriefing session with a health professional varies. This is not provided in all papers. A large range is reported in the studies as can be seen at Table F4. A significant number, six of the studies, reported that women had a postnatal debriefing with a health professional before they left the hospital whilst others accessed the service some 12 months later (Inglis 2002). And some in between these two time points (Bailey and Price 2008). Table F4 shows the length taken for the session. Each session ranged between 40 minutes and 120 minutes. A recent pragmatic trial cited 72 months as the latest time a woman accessed that service (Meades et al 2011).

Some authors commented on the importance of the postnatal debriefing taking place early (within a few weeks) (Priest et al 2003) whilst others suggested the need for a break between the birth and the debriefing session (Dennett 2003). However the studies did not explain a rationale for the timing. This is interesting, as the pre-existing Cochrane review considered a month to be the minimum time an intervention should take place following a traumatic event (Rose et al 2002). This was also reflected in the subsequent NICE guidelines (NICE 2007, NICE 2005).

Some of the participants in the Inglis study accessed a postnatal debriefing session when they were planning future pregnancies. By attending this service the authors commented that these women felt this would enable them to influence any future episode of care provided to them personally by the same maternity service, although it is unclear how this might have happened.

Women who had used the service were sent a self-response questionnaire in the post (Inglis 2002). There is a significant difference in time when women accessed the service between the Inglis and Bailey and Price studies. In the Bailey and Price study women were traumatised. It could be that traumatised

women seek debriefing sooner following birth and that others are able to wait until they are planning a subsequent birth.

One important finding from the limited qualitative literature seems to be that, for the women accessing the service, it seems important for them to attend for a postnatal debriefing session when they feel ready to do so or when they wish to reconsider their birth experience (Bailey and Price 2008, Inglis 2002). Although the service was available to women at any time immediately following birth, the six women self-referred to the Birth Afterthoughts service between six and 14 weeks in the grounded theory study (Bailey and Price 2008). This is supported by the wider trial evidence on debriefing for PTSD generally, where it is recommended that it should be available when people seek support, not thrust on people too quickly (Rose et al 2002).

*ii) Practitioner (who undertakes postnatal debriefing)*

In all studies with the exception of one, the postnatal postnatal debriefing session was carried out by a midwife. Some midwives were provided with additional training for this role (Kershaw et al 2005, Meades et al 2011) such as counselling techniques and how to undertake critical incident stress debriefing (CISD). Two RCTs in Sweden report the service being provided by an obstetrician trained in psychological techniques (Ryding et al 1998, Ryding et al 2004).

The participants in the grounded theory study highlighted valuable qualities of midwives in the context of having a postnatal debriefing session (e.g. caring, empathy, understanding) (Bailey and Price 2008). It was considered by these participants that the midwife's professional role facilitates an understanding of childbirth experience.

The need for the midwife present at the birth to undertake the postnatal debriefing session was identified by two studies (Olin and Faxelid 2003, Dennett

2003). The professional present at the birth was considered to be the best person to undertake a postnatal debriefing. The person present has more knowledge of events to be able to conduct the session. In practice this is very difficult in the current organisation of maternity care in hospitals where women receive care from midwives working shift patterns who are not known to them. In the Dennett study the women received the postnatal debriefing session from their community midwife who was known to them. Despite not being able to speak with the midwife who was at the birth this same study found that 19/29 participants said they talked with the most appropriate midwife.

*iii) Groups of women who are offered postnatal debriefing*

Whilst in some studies the postnatal debriefing service was offered to all women following birth (Bailey and Price 2008, Inglis 2002, Selkirk et al 2006) other studies stipulated certain groups of women (e.g. those who had an operative birth (Kershaw et al 2005, Small et al 2000), those who exhibited trauma symptoms (Gamble et al 2005, Meades et al 2011). As discussed in the previous section two surveys were undertaken to describe current service provision. One study asked the question to heads of midwifery about what is provided in general (Steele and Beadle 2003) whilst the other study asked units what is provided to women following a difficult or traumatic birth (Ayers et al 2006).

As mentioned above some of the studies have only provided a service for particular groups of women. This was likely to have been a consideration for the methodological approach only and not necessarily a reflection of real life. When considering setting up services providers should be aware that it is not always obvious which women are traumatised. Some women who have an uncomplicated spontaneous vaginal birth can leave hospital following the birth feeling traumatised. Furthermore not all women who have an operative vaginal delivery experience traumatic feelings.

*iv) The presence of partners during a postnatal debriefing session*

Not many of the studies mentioned the partner. The second RCT undertaken in Sweden identified the need for fathers to have been present in the debriefing sessions (Ryding 2004).

Olin and Faxelid included fathers in their survey of parents' need to talk about their experiences of childbirth (Olin and Faxelid 2003). Key findings were that 66% of first time mothers and 74% of multiple time mothers and 58% of first time fathers and 30% of multiple time fathers wanted to talk about the delivery. The precise reasons for parents' need to have a postpartum talk were not given and were not explored in this survey. However it is clear that particularly first time fathers have a strong need to talk with a midwife following birth.

Dennett also identified the need for partners to be included in her UK study (Dennett 2003).

*"Talking about it reassured my husband that although he thought I was struggling and it seemed as though something awful might happen I was fine and in safe hands."*

(Dennett 2003 p 26, no other identification of participant given).

The helpfulness of the woman's partner also being present during a postnatal debriefing session was also apparent in another study in Australia. One of the participants remembered talking about the birth with her partner and finding that they had differing perceptions of what had happened during their birth experience.

*"G [partner] and I talked about it [the birth]....It was very interesting to compare our perceptions of what went on and what he saw and we pieced together a lot of things"*

("Debbie", Gamble et al 2004a p14)

Without further explanation of events in labour and during birth from a midwife this couple could have been left with misconceptions of what occurred. The midwife during postnatal debriefing can ensure that there are no gaps in the story of events and that both partners gain a full understanding of what happened.

v) *Number of sessions*

The majority of studies cited the offer of a single session only (Bailey and Price 2008, Dennett 2003, Inglis 2002, Lavender and Walkinshaw 1998, Meades et al 2011, Selkirk et al 2006, Small et al 2000). These included women who had experienced debriefing as an intervention for an RCT and also other women who received postnatal debriefing as part of their maternity experience (Bailey and Price 2008).

It is possible that postnatal debriefing undertaken on more than one occasion or as part of a series of sessions is more beneficial to women. Further research is required to test this with larger samples of women and to include long term assessment.

### **3.9.6 Women's perceptions of postnatal debriefing**

i) *Introduction*

Three main concepts and two subthemes were drawn out from the studies which examined women's perceptions of postnatal debriefing: '*Postnatal debriefing satisfies the need to be listened to or need to talk*', '*Postnatal debriefing provides women with information and a greater understanding of their experience*' and '*Postnatal debriefing provides women with validation of the birth experience*'. The third concept is comprised of two subthemes: '*A sense of relief when understood what happened*' and '*Reassurance when understood what happened*'

*ii) Postnatal debriefing satisfies the need to be listened to or need to talk*

Women expressed a need to be listened to and this was facilitated by telling the story of their birth experiences to a midwife. They needed to tell someone how they experienced the birth (Bailey and Price 2008, Gamble et al 2004a, Inglis 2002).

The quantitative studies illustrated the proportion of women to whom this applied. In a Swedish survey 66 per cent of first time mothers and 74 per cent of multigravid mothers and 58 per cent of first time fathers and 30 per cent of multiple time fathers wanted to talk about their experiences of childbirth (Olin and Faxelid 2003). The detail of the debriefing is not clear from all studies. Olin and Faxelid (2003) in the Swedish survey identified that parents wanted to know if the birth had been normal or not. In the event of complications they needed to understand why these occurred. These parents sought advice about how they had behaved in labour and whether the outcome would have been the same had they behaved differently. Women also wanted to talk about their pain, pain relief and why pain relief was not given.

The strong need to discuss the birth experience (Bailey and Price 2008) led some women to try speaking with their friends and family but it was acknowledged that this was not always possible or successful (Inglis 2002). Gamble et al (2004a) identified that individuals within couples came away from the birth experience with different perceptions of what happened.

According to the women who participated in the studies their experience of discussing their birth experience with family and friends did not have the same perceived impact or results as attending a debriefing session with a health professional (Gamble et al 2004a, Inglis 2002). It is unlikely that a woman's support partner or members of her family will have the depth of knowledge about maternity care provision compared to a health professional. There is an

assumption that women may also have some reservations or guilt feelings about burdening family or friends.

Some women reported having negative feelings such as fear, self-blame for what happened during the birth experience and members of staff who they felt had impacted negatively on their birth experience (Gamble et al 2004a). Women sometimes came away from their birth experience with unanswered questions and being provided with details and explanations of what happened during the birth provided understanding and reassurance (Bailey and Price 2008).

It is of interest that women who were not given the opportunity to talk with a midwife wanted to do so (Dennett 2003, Olin and Faxelid 2003). Dennett (2003) highlighted distress in one mother. This woman had blocked her childbirth experience from her mind for some weeks and started crying after this point. Other authors have also identified the phenomenon of deliberately not thinking about the childbirth experience immediately following birth (Bailey and Price 2008).

Debriefing was found to be therapeutic. Women who had experienced a traumatic birth felt they had benefitted. Some women who had a traumatic birth experienced flashbacks. Talking about and recounting their experiences helped relieve some of their symptoms. For example one woman recalling her birth experience said,

*“I was still thinking about it every day and reliving it when I was half asleep....which is a long time, to be, you know thinking about it all the time, playing it over and over again, and probably distorting things on the way”*  
(Bailey and Price p55 Participant 6).

However it was not only women with trauma symptoms who felt they had benefited. Other women also needed to have their voice heard and air their feelings about their birth experience (Inglis 2002).

The process by which debriefing had helped these women was not always explored nor made explicit. However the opportunity of talking and identifying concerns and having questions answered may have provided the necessary support in the form of information to enable a woman to gain an acceptance of what happened to her during her birth experience.

*iii) Postnatal debriefing provides women with information and a greater understanding of their experience*

Postnatal debriefing provided women with information and a greater understanding of their experience of labour and birth. For example one woman explained how debriefing helped her understand why she was not able to have a vaginal birth. She reported:

*“Or you weren’t able to push him out because of this, and sometimes that happens. And that fact was really helpful to me”*

(Bailey and Price 2008 p 56 Participant 2)

This is also supported by Gamble and colleagues (2004a). These authors also identified that an understanding of events and why they happened helped women reconcile their birth experiences.

The need for clarification of terms, events, times and facts from the woman’s view point was identified from the studies (Bailey and Price 2008, Dennett 2003). This was important to women’s understanding. One example in the literature was a simple explanation of the mechanism of labour given to women by a midwife using a doll and pelvis (Inglis 2002).

Postnatal debriefing also provided an opportunity for midwives to give women a detailed breakdown and explanation of the events that occurred during their labour and birth using the maternity case notes (Dennett 2003, Gamble et al 2004a). Midwives were able to read through with a woman the records made by midwives and obstetricians during her labour. This provided further clarity to the woman about how progress was made and the events that occurred. It became clear that women had been left with gaps in their memory and this resulted in a lack of understanding about what happened to them when they were in labour. This raises the assumption that women were left with gaps in their memory. However this fact was not explicitly stated by any of the authors except for Collins (2006) but might explain the fervour among some women to talk and gain an understanding of events. The maternity record was commonly reviewed to achieve this. The authors might have had some reservations on this, given that notes are inevitably a selective record, kept by particular people for particular purposes. Issues such as choice and consent may be recorded particularly poorly (see Beake et al 1998, Berg et al 1996). There is the need to confirm through research whether women come away from their labour experience with gaps in their memory as well as in their understanding and knowledge.

*iv) Postnatal debriefing provides women with validation of the birth experience*

The concept '*Postnatal debriefing provides women with validation of their birth experience*' has been created by the present literature review. This is an example of a second order construct and forms part of a dynamic process. This is dependent on the two other themes created in the present review and discussed above: '*Postnatal debriefing satisfies the need to be listened to or need to talk*' and '*Postnatal debriefing provides information and a greater understanding of their experience*'. If women are not given the opportunity to talk and be listened to and if they are not provided with an understanding of

their childbirth experience it is not possible for their birth experience to be validated.

Validation of any life changing experience is an important aspect of that experience and requires certain conditions to be met (e.g. acknowledgement of the life changing experience, understanding of the personal experience, and identification of feelings). Many of the studies reviewed discussed these outcomes from women's experience of debriefing, therefore it is fitting that these outcomes (that featured as "categories" during the analysis are situated under this concept). Furthermore three of the authors have already alluded to validation in their work (Bailey and Price, Gamble et al 2004a and Inglis 2002). However none of these studies described this phenomenon as an explicit theme.

Two sub themes form the body of this concept: '*A sense of relief when understood what happened*' and '*Reassurance when understood what happened*'. These are described below and together comprise the meaning of the main concept.

(a) *A sense of relief when understood what happened*

Women valued the opportunity of speaking with an informed and supportive professional. This allowed women to have their story acknowledged and validated (Gamble et al 2004a, Inglis 2002). Acknowledgement of having had a hard time was of importance to some women (Bailey and Price 2008). This is also a form of validation. These women were relieved when they understood what happened and to learn that their experience had been genuinely difficult.

These women valued having a difficult experience validated. It seemed that women had left the hospital following birth troubled and blaming themselves for their own personal experience. In the Australian study (Gamble et al 2004a) all

women expressed a sense of failure and self-blame (e.g. due to succumbing to an unwanted procedure such as an epidural). Talking with a midwife and gaining a fuller understanding of what happened allowed the practitioner to convey this information to women. This provided relief to women.

*“I felt reassured that it wasn’t me being pathetic....that, you know, actually what I went through was quite tough, and it um, I wasn’t a complete wimp”*

(Bailey and Price 2008 p 56, Participant 3)

This shows that some women have a lack of self-confidence or perhaps the birth experience itself knocks women’s self-confidence.

#### (b) Reassurance when understood what happened

Postnatal debriefing helped women come to terms with what had happened to them (Dennett 2003, Bailey and Price 2008). Women were reassured after speaking with a midwife and understanding what happened to them. Some were reassured when they learned the reasons for any complications in labour and heard all had gone well when interventions were required. For those women who had experienced a traumatic birth debriefing provided them with the reassurance that birth is not always traumatic (Gamble et al 2004a). This provided further reassurance for future birth experiences.

*“Knowing about how your last birth could have been different is in a way planning for the next one”* (Joan, Gamble et al 2004a)

As previously mentioned women were found to have experienced feelings of failure and self-blame (Gamble et al 2004a). Postnatal debriefing facilitated challenge to this in the form of a discussion of alternative courses of action that might have taken place during the current birth experience. In this way women regained confidence to consider future pregnancies.

One study identified that women, through the process of debriefing, found closure to their experience of childbirth (Bailey and Price 2008). This resulted in them no longer feeling the need to talk about their birth experience which they were able to put behind them following the debriefing session. The present literature review has placed the phenomenon of closure under the subtheme of reassurance and the main concept of validation i.e. reaching closure occurs following validation of the birth experience.

One study mentioned the “positive and cathartic” experience that postnatal debriefing provides women (Bailey and Price 2008 p 55) and this is highlighted at the top of a diagram depicting a model of a temple. However these authors do not explain why the women found the experience of postnatal debriefing cathartic. The present literature review suggests the experience is about validation.

### **3.9.7 Midwives’ perceptions of postnatal debriefing**

#### *i) Introduction*

Only two studies considered midwives’ perceptions of postnatal debriefing. One small qualitative study in Australia investigated midwives’ counselling strategies to facilitate recovery from childbirth-related stress and trauma (Gamble et al 2004b). The three themes identified in this study were; ‘Opportunities to talk about the birth’, ‘Developing an understanding of events’ and ‘Minimise feelings of guilt’.

Within a RCT where the debriefing intervention was conducted by community midwives, the midwives were given a questionnaire to complete (Kershaw et al 2005). This was returned by 16/27 (60%) of the midwives.

#### *ii) Key findings of the qualitative study*

When midwives were asked about provision of a debriefing service they generally discussed issues around service delivery. None of the midwives in the focus groups discussed how they felt women had benefitted being given the opportunity to discuss their birth experience. However there was an unequivocal feeling amongst the midwives that counselling was beneficial.

The theme '*Opportunities to talk about the birth*' identified consensus amongst the midwives that postnatal debriefing should be unstructured and led by women. The midwives also stressed the need for women to be supported to tell their own story of the birth. The midwives felt women needed to come to terms with a past negative birth experience to prevent an adverse effect on a subsequent pregnancy. It is assumed that this is what postnatal debriefing achieved in the eyes of the midwives but this was not explicitly stated by the researchers in their findings section of the paper about midwives' perceptions.

The second theme was '*Developing an understanding of events*'. According to the midwives women needed a clear picture of what happened to them and it is the role of the midwife to answer questions and fill in "missing pieces". One midwife highlighted this need of women from this quote: "*You know from some of the questions that things aren't always clear*".

The third theme in the midwives' study is '*Minimise feelings of guilt*'. The midwives wanted to ameliorate the women's feelings of guilt. They attempted to placate these feelings by supporting and giving praise for the decisions made by the women "*I think that was a really good decision*". The midwives were trying to protect and support the decisions made by the women during their labours. To these midwives suggesting to the women a different choice would have led to a different outcome could be harmful. This contrasts with what the women felt:

*"Knowing about how your last birth could have been different is in a way planning for the next one"* Joan (Gamble et al 2004a p 14)

In the women's opinion the knowledge that a different decision could have led to a different outcome gave them hope for future births. This conflicting finding between what the women wanted and what the midwives felt should be offered to women highlights the concerns raised by Gamble and colleagues (2004a) that midwives do not explore women's needs deeply enough during postnatal debriefing. The authors suggested that midwives might not be equipped to undertake counselling. There is the need for consideration of different approaches by professionals when talking with women about their birth experiences. It is important to consult and work with psychologists to ensure midwives are providing safe support for women during postnatal debriefing.

*iii) Key findings of the small survey as part of the RCT*

The findings are considered here under three key headings: 'Is postnatal debriefing beneficial to women (according to midwives)?', 'Midwives feel comfortable undertaking postnatal debriefing' and 'Factors that helped and prevented midwives to undertake postnatal debriefing'.

(a) Is postnatal debriefing beneficial to women (according to midwives)?

Forty three per cent (n=7) of midwives felt postnatal debriefing benefits women following traumatic delivery and a further 12 per cent (n=2) felt that postnatal debriefing was beneficial to some women. The views of the remaining seven midwives was unclear on this point. This raises the suggestion that not all midwives consider postnatal debriefing is beneficial to women.

(b) Midwives feel comfortable undertaking postnatal debriefing

Seventy five per cent (n=12) of midwives felt comfortable undertaking postnatal debriefing. From the three midwives who were not comfortable, one did the postnatal debriefing on the first postnatal visit to the woman and two midwives felt they required more training.

(c) Factors that helped and prevented midwives to undertake postnatal debriefing

Continuity of care, the training for the postnatal debriefing intervention (as part of the RCT) and quietness in the woman's home all helped the community midwives to undertake the process.

Factors that prevented the midwives from undertaking postnatal debriefing were lack of time (n=5), women not wanting it (n=6) and inappropriate referrals (n=2). Midwives felt recruiting teenagers was inappropriate. The authors do not give any further explanation for this finding.

This study provides some help in understanding some possible effective elements to undertaking postnatal debriefing (e.g. continuity of care, the quietness of the woman's home). The findings of the main trial found no significant difference in the WDEQ fear of childbirth scores in the short term following the intervention. This was provided from community midwives. Two structured debriefing sessions were offered to all women who gave birth by operative delivery.

However the results of the small survey should be taken with caution. It is not possible to generalise the results of this small study. However it is of interest that the results of this survey identified that over half of the midwives felt that

postnatal debriefing was beneficial. It is also of interest that not all (75%) of the midwives felt comfortable undertaking postnatal debriefing.

These two studies identified that a significant proportion of midwives considered postnatal debriefing to be beneficial to women. The survey showed that 43 per cent of midwives felt that postnatal debriefing was beneficial to women following traumatic childbirth and a further 12 per cent considered the intervention beneficial to some women. The qualitative paper identified an unequivocal feeling amongst the participants that postnatal was beneficial to women.

Furthermore the authors of the qualitative paper expressed concern that midwives might not be conversant with the needs of women in relation to postnatal debriefing (Gamble et al 2004b). This is illustrated in their comparisons of a sister paper which considered the perceptions of women to counselling strategies which found differences in the needs of the women compared with the proposed strategies given by the midwives (Gamble et al 2004a). Not all the midwives in the quantitative paper were satisfied with their formal training in the intervention. According to these midwives this affected their ability to deliver the postnatal debriefing intervention within the RCT (Kershaw et al 2005).

### **3.10 Discussion**

The NICE postnatal care guideline (2006) recommends all women are offered the opportunity to discuss their birth (NICE 2006). The general term 'debriefing' has been used in this review but the findings identified a range of approaches and terms that might be included under that general category. It is important to be aware that in the context of general healthcare another NICE guideline on post-traumatic stress disorder suggests that the term debriefing covers all brief, single-session interventions to reduce PTS symptoms (NICE 2005).

This critical review of the literature aimed to clarify what postnatal “debriefing” means in practice. This study has identified that a range of approaches and services are included under this badge, some of which fit better with the formal psychological debriefing model than others.

The researchers, in the large majority of the included papers, when describing postnatal ‘debriefing’ alluded to a discussion between the woman and health professional about the labour and birth experience. In addition the content was often determined by the individual woman. Indeed Rowan and colleagues (2007) in their literature review report confirmed that the term ‘debriefing’ was interpreted broadly by UK services. According to these authors, ‘debriefing’ was seen as an opportunity for women to discuss their childbirth experiences and to be provided with information and explanation about this event (Rowan et al 2007). This explanation is also confirmed by other authors of the included papers in this literature review (Ayers et al 2006, Olin and Faxelid 2003). As previously mentioned above, some of the studies utilised a structured psychological approach to debriefing such as CISD, however most of the authors of studies accessed described postnatal ‘debriefing’ in terms of a meeting where women are invited to talk about their recent birth experience with a health professional.

It is of interest that the recommendation from NICE about the need for women to be given the opportunity to discuss their birth experience does not make use of the term ‘debriefing’ but simply describes the same process mentioned in many of the included studies in this literature review. These are considered unstructured forms of debriefing. It is also important to highlight that in the practice setting midwives do not commonly use the term ‘debriefing’ when meeting a woman to discuss her birth experience. Midwives appear to refrain from using this term and, on occasions in my experience in clinical practice, categorically deny undertaking what they consider to be debriefing. This current review has also highlighted a lack of evidence on the views of midwives to

postnatal debriefing. This is clearly an under researched area and further studies are required.

Women were found to value postnatal debriefing. The strength of opinion in favour of this process is paradoxical, given the lack of clinical trial evidence of effectiveness. This overwhelming positive reaction by women during the postnatal period to the debriefing with a health professional is similar to the reactions of people in the general literature on debriefing. Professionals and victims of traumatic incidents alike highly value the opportunity to talk the events through, but the evidence is lacking for other benefits gained such as a reduction in psychological morbidity. This is the reason why a single session is no longer recommended routinely (NICE 2005).

The findings of the Cochrane review on debriefing interventions for the prevention of psychological trauma in women following childbirth were published at the time of finalising this thesis (Bastos et al 2015). Seven trials were included in this review. The trials took place in three countries and there was heterogeneity between studies and contexts. Debriefing was not narrowly defined, or dependent on being labelled debriefing, which allowed the inclusion of the maximum number of studies. As identified in the literature review within this thesis (Baxter et al 2014 and chapter 3) the authors of the Cochrane review by Bastos and colleagues in 2015 also identified two main types of debriefing: postnatal debriefing and psychological debriefing. Postnatal debriefing is commonly with a midwife where women go through their birth events with the assistance of the medical notes. Psychological debriefing is more structured and usually involves a set of procedures aimed at preventing psychological morbidity. This Cochrane review set in the maternity context did not find clear evidence that debriefing reduced or increased the risk of developing psychological trauma during the postpartum period. However the authors highlighted that other forms of postnatal discussion with women following birth, such as the unstructured form, as recommended by the health watchdog NICE (NICE 2014a, NICE 2007), should be allowed to continue (Bastos et al 2015).

Due to the poor quality of the evidence in general, and in particular, for the main outcome measure, prevalence of psychological trauma and depressive symptoms, and the heterogeneity between the identified studies, including different sample groups, measurement tools and outcomes, the researchers had to confirm that there is still no robust evidence that debriefing reduces or increases the risk of developing psychological trauma during the postpartum period (Bastos et al 2015). For this reason the authors concluded that routine psychological debriefing for women after childbirth cannot be supported (Bastos et al 2015). There is the clear need for more high quality RCTs, using similar groups of women, interventions and outcome measures, in order to address this lack of robust findings.

Whilst women who experienced a postnatal debriefing were strongly positive towards the intervention other women decline. This was identified from one of the two studies on the views of midwives (Kershaw et al 2005). It seems that not all women may require a postnatal debriefing and review of their experience of labour and birth. This concurs with the findings of the first Cochrane review on debriefing in the general population conducted by Rose et al in 2002. This concluded that debriefing should not be offered routinely in the aftermath of a traumatic event. However the focus should be on early detection of those at risk of developing psychopathology and early interventions should be aimed at this group.

The women in the samples of the studies in the current literature review varied. Some studies included only women who had experienced a traumatic birth. However a definition of the meaning of traumatic was not always provided. Other services offered the debriefing to all women who had given birth. The type of birth (e.g. emergency caesarean section) has been considered a trigger for women considering their birth experience as traumatic and some researchers have included only this group of women in their sample. However it is known that women can experience signs of trauma following an

uncomplicated spontaneous vaginal birth. This critical review of the literature has identified the need to understand what it is about the birth experience that causes individual women to feel traumatised.

There is the need to consider whether midwives require further training to undertake a postnatal debriefing. Some of the midwives in the survey in the UK felt that the training they had received to deliver the intervention in the RCT helped them to undertake debriefing (Kershaw et al 2005). However, this was a structured psychological type of debriefing which is less familiar to most practising midwives. As was mentioned in section 3.2 of this chapter Shalev recognised that debriefing takes place through humanity and caring (Shalev 2000). These are fundamental aspects of midwifery practice. This suggests that all midwives should have the core skills required to undertake unstructured postnatal debriefing.

Few theoretical frameworks were identified from the papers included in this study. These are specifically identified by two groups of authors only (Gamble and Creedy 2004, Olin and Faxelid 2003).

Gamble and Creedy (2004) in their literature review of content and processes of postpartum counselling identified a model that these authors considered explains emotional distress after childbirth. The model stems from earlier work with survivors of childhood sexual abuse. The key elements of the model are physical damage, stigmatization, betrayal and powerlessness. This does not assume that trauma is caused by the same event for all women and that personality and interpersonal factors also play a part. The same authors commented that providing women with an opportunity to discuss their birth experiences also draws on Rogerian humanistic psychotherapeutic principles which involve interpersonal counselling skills, such as active listening, paraphrasing and reflection of feeling (Watkins 2000).

As mentioned in 3.9.1. Olin and Faxelid (2003) drew on sense of coherence (SOC) and stress theories. Whereas some of the underlying principles are consistent with postnatal debriefing neither of the theoretical frameworks described above are a perfect fit or serve as a conceptual model. It appears this theory is still awaited.

It is of interest that the non-research papers highlighted similar issues to those identified from the research papers in this review. The need for a clear definition and further research into the process of a woman meeting with a midwife to discuss her birth experience is evident in the other papers reviewed.

The large majority (n=9) of the non-research papers identified in this review saw the postnatal debriefing session with a midwife as an opportunity for women to review the labour and birth, recognising that many women leave their experience of birth with unanswered questions. The importance of listening and talking to achieve this end was also identified: emotions were seen as being unwrapped during the process. It is of interest that the authors of three of these non-research papers mention validation, a key concept identified in the synthesis of the research papers (Axe 2002, Leach 2010, Smith and Mitchell 2006).

It seems from these non-research papers that at the end of their birth experiences some women find that their expectations have not been met. Feeling discontent in this way can lead women to making complaints. While some authors of these papers argue that having a service where women can access discussions with midwives following birth reduces complaints, they do not provide statistical evidence of this. In some accounts, it appears that the process of offering women to meet with a midwife to discuss their birth experiences may have been set up as a risk management tool to protect the organisation from unwanted publicity; some of these papers mentioned competing priorities between the needs of the individual women who use the service and those of the organisation (e.g. Leach 2010).

### **3.10.1 Strengths and limitations**

I consider this critical review of the literature on postnatal debriefing to be of a high standard. It was thorough and comprehensive and undertaken systematically. Once the papers were retrieved, a clear set of criteria was applied to assess the quality of the research papers that were retrieved. The process was undertaken by myself and each stage was closely checked by the second supervisor.

As a part-time doctoral student, and the fact that I retrieved only 20 research papers which informed this study, I feel I had sufficient time to really immerse myself in the limited work that has been undertaken in this area. This has enabled a thorough understanding of the research knowledge available to date in this under researched area and the consequent further synthesis which produced the results presented.

Meta-ethnography was chosen as the approach for the synthesis. Whilst this has been a useful method when analysing written text form produced by the research reports, this proved cumbersome and awkward at times when answering the research objectives. Whilst it was possible to identify some second order constructs as part of the secondary analysis of data within the literature review process, no third order constructs were retrieved. This is likely to be due to the limited data retrieved in the small number of studies.

## **3.11 Conclusion**

The key research questions for this critical review of the literature on postnatal debriefing were to describe current practice in offering debriefing services to postpartum women and learn about the perceptions of women accessing these services. The review utilised a meta-ethnographic approach to the synthesis.

Twenty papers were identified for inclusion. These included four surveys, three qualitative studies and one mixed methods study. Eight randomised controlled trials (RCTs) and one pragmatic trial provided additional information from alongside surveys and descriptions of interventions. In addition three literature reviews provided further support following the main analysis in the discussion. Two main types of debriefing were identified: structured and unstructured.

The more formal psychoanalytic forms took place within the RCTs whilst the unstructured discussion sessions, commonly with midwives, were identified in other research papers. In addition, the review identified that there is confusion amongst service providers about the nature of debriefing and what is delivered. Various aspects of providing a postnatal debriefing service were considered, including the lack of clarity about optimal timing, specific groups to be offered debriefing or the number of sessions offered. Postnatal debriefing enabled women to have their birth experiences validated by talking and being listened to and being provided with information. Finally from the limited literature identified relating to midwives' perceptions of postnatal debriefing there was an overall feeling from midwives that they considered it to be beneficial to women. The findings of this literature review imply that women's responses to receiving postnatal debriefing are generally positive. Women appear to value talking and being listened to by a midwife following birth. They seem to have a strong need to have their story heard. This discussion also allows the women to have questions answered and information given where necessary. The whole process places a seal on a woman's birth experience which is thereby validated.

Whilst women's perceptions cannot be seen as objective factual information this finding is paradoxical, given the findings from the Cochrane review of lack of measurable benefits in relation to maternal psychological morbidity. However psychological morbidity is an extreme and relatively rare occurrence when considering the total number of women in the population who give birth. Using satisfaction as an outcome measure in the RCTs is more likely to have

identified statistically significant differences amongst women in the intervention group compared with the controls.

### **3.12 Chapter summary**

This chapter has described the process of the critical review of the literature on postnatal debriefing. Once the scope and research questions relating to the study were decided a search was conducted of the major electronic databases relevant to the health sciences. There was no time limit and all research studies on the topic of postnatal debriefing, undertaken by either midwives or obstetricians, published and written in English were included in this review. Quality criteria of the individual studies were assessed using critical appraisal guidelines appropriate to the type of research. Using a meta-ethnographic approach to the analysis enabled the construction of second order concepts.

This work identified that there is limited literature in this area. The findings of the review highlighted the process of an unstructured postnatal debriefing session. Other key findings showed that women were very positive about having a postnatal debriefing session. They perceived that the process validated the entire birth experience which in turn enabled women to leave memories of their birth experience behind them and move on following their experience of giving birth. This could be described as a healing process.

The findings of this critical review of the literature have shown that women are provided with support through the process of attending a postnatal debriefing session. Whilst the participants from the studies in the review were found to value a postnatal debriefing session and how they benefited from it, it was unclear what led them to attending. There is therefore a need for further study in this area to gain a greater understanding about what prompts women to attend a postnatal debriefing service. It is also important to identify reasons why other women do not attend these services. This was also not recognised from

the literature review results although it was identified that some women decline the offer to attend this service. Knowing the proportion of women who feel the need to attend will assist managers as they plan services in the future.

At the completion of this review a primary research study is being planned to address the issues described in the above paragraph. This will also attempt to provide further understanding of the perceptions of women to this service. In addition some participants in the studies included in the literature review experienced what was perceived as a 'traumatic' birth experience and this led to them attending a postnatal debriefing session. When considering further study in this area there is also the consequent need to explore reasons why women leave the birth experience with unmet emotional needs in this way and consider how a postnatal debriefing session may be of benefit. This next study will be presented in the following chapter.

### **3.13 Dissemination artefact**

#### **What is current practice in offering debriefing services to postpartum women and what are the perceptions of women in accessing these services: A critical review of the literature**

This manuscript was submitted to Midwifery journal in August 2013 and published in February 2014 (Baxter et al 2014).

## Chapter 4: Birth Reflections Study

### 4.1 Introduction

This section sets the scene and provides a general introduction to the research study. This includes the rationale for undertaking this work. This is followed by the research question and aims and objectives. An overview of the study background is given in the next section.

The study detailed below stems from a recent critical review of the literature of postnatal debriefing (Baxter et al 2014 and chapter 3 in this thesis). The literature review identified that the precise nature of what having a postnatal debriefing session, commonly with a midwife, means to the women who experience it is vague and unclear. Many services have been set up with various names such as “Birth Reflections” and “Birth Afterthoughts”. The literature review found that women and midwives perceive it is good for women, following birth, to talk and be listened to. However, as discussed in chapter 3, there is limited and divergent evidence on the effects of postnatal debriefing. This will be covered in the next section.

The literature review identified two types of postnatal debriefing sessions: structured and unstructured (Baxter et al 2014 and chapter 3 in this thesis). The unstructured form consists of a general discussion between the woman and health professional. It is usually the unstructured type of session that is used by midwives in services with names such as “Birth Reflections” or “Birth Afterthoughts”. These sessions have also become known as “listening services”. This study is focused on a service that fitted with this common definition.

As mentioned in chapter 3 of this thesis the motivation to undertake a critical review of the literature on postnatal debriefing was triggered following my move from a teaching hospital in London to Buckinghamshire Healthcare NHS Trust.

The debriefing service set up at the London maternity unit had been discontinued in 2008 following the publication of the NICE guideline in 2007. However the routine offer for women to meet and discuss their childbirth experience continued in Buckinghamshire, in line with NICE guidance on postnatal care provision (2006). This was of interest to me coming from a unit where this practice had been discontinued. Undertaking a literature review (Baxter et al 2014 and chapter 3 in this thesis) was the first step to identifying the key issues in relation to this practice and to address questions that had not been answered by the existing Cochrane review of evidence (Rose et al 2002) or any NICE guidance pertaining to this area of practice.

At the time this study was being planned only a very small proportion of women took up the offer of the Birth Reflections service at the study hospital. There was a need to understand the reason for this, given the generally positive responses from women identified in the literature reviewed (Baxter 2014 and chapter 3). It was possible that some women might simply not be aware that such a service existed whilst others might not have felt the personal need to meet with a midwife with the specific purpose of discussing their birth experience. However for those women who did have the need to discuss their birth experiences with a health professional this study also intended to explore reasons for this and gain an insight into the nature of the discussions between women and health professionals at a postnatal debriefing session. Gaining this information would help to understand more fully women's support needs immediately following birth and plan services accordingly. It would also add to the limited research in this area. Postnatal debriefing can be viewed as a form of postnatal support (Barimani et al 2015). A literature review has been included to provide a context for this at section 4.4. A critique of the evidence relevant to professional support and postnatal care is given. This literature was considered important for this research study for two additional reasons. First, women in the case study reported a lack professional support on the hospital postnatal ward. Second, when undertaking the analysis as part of the main Birth Reflections study the importance of women feeling supported during labour and birth came through

strongly. This led to the need to review literature at a later stage on the impact of birth and how women are supported during the postnatal period in relation to this.

This exploratory study utilised a mixed methods approach. It was felt by using mixed methods that optimal information on this phenomenon would be captured through the use of different methods. The study also intended to serve as a service evaluation to provide further evidence to inform service provision for the local management team. This would help ensure that appropriate services are offered to local women in the future. At the outset, and as mentioned above, it was also intended that this work would help support further research activity in this developing area. Knowing more about the precise nature of a postnatal debriefing service would help inform future randomised controlled trials.

#### **4.1.1 Aims and objectives**

As identified in the literature review within this thesis (Baxter et al 2014 and chapter 3) the research evidence in this area to date is unclear. In the maternity context there is a vague understanding that women want to be listened to and talk with a health professional in relation to their birth experience. However, various aspects remain unknown such as the characteristics of women who use such services, the reasons why some women attend whilst others do not, and there is the need to gain a fuller understanding of what the postnatal debriefing session provides individual women. In addition the literature review, undertaken as part of this thesis and described in chapter 3, has identified that some women are left with gaps in their memory about events during labour and birth. Some are also left with unmet emotional needs (Baxter et al 2014).

Consequently there is a need to understand more clearly how women are left feeling following birth and what such services offer them and how they may be helped as a result. Reaching a precise definition of what a postnatal debriefing

session with a midwife is and how it is helpful to women will support practice and enable further research in this area, including better, more focused randomised controlled trials of effects.

Therefore, this exploratory study aimed to determine the reasons why certain groups of women accessed (or did not use) a postnatal debriefing service and to provide a rich description of their perception of the service. In addition the study also planned to explore women's feelings following birth about their birth experience more generally. It was felt that this might have a bearing on women's need to talk to a health professional following birth. A mixed methods approach was proposed. It was anticipated that using a quantitative survey would help to understand women's overall thoughts in this area, while in-depth, semi-structured qualitative interviews would provide richer data on the topic and provide explanations to issues identified in the survey.

The research question was:

*"How does postnatal debriefing support women following birth?"*

A mixed methods approach was used to address the following research objectives:

- To determine the characteristics of the women who attend a birth reflections service.
- To understand the reasons why some women choose to attend or not to attend.
- To gain an understanding of the expectations of women prior to attending a birth reflections service.

- To explore women's perceptions and experiences of a birth reflections service (the perceptions of those women who have not used the service were also explored. This, it was felt, would provide further understanding in this area).
- To explore reasons why some women may feel the need to talk with a health professional following birth.
- To explore reasons why some women may leave the birth experience with emotional distress.

As mentioned above the study was exploratory in nature. The main study outcomes in the survey included measures of post-traumatic stress through the use of the Impact of Events Score (IES) (Horowitz et al 1979). The IES was used in the survey as a tool to help understand the women's postnatal experiences and motivation to attend the Birth Reflections service, or not. Other intended survey outcomes at the outset included women's satisfaction with care during labour and birth, women's feelings about the birth experience and women's expectations of labour and birth. It was also anticipated at the outset that further outcomes might be identified when reviewing the data during analysis.

## **4.2 Background**

As discussed in chapter 3, section 3.2, in the late 1990s a Department of Health report, "Making a Difference – Strengthening the nursing, midwifery and health visiting contribution to health and healthcare" recommended that women be offered debriefing by a midwife following their experience of childbirth (Department of Health 1999). "Active debriefing" in this way was considered to benefit the long-term psychological well-being of women as well as the immediate health of women following childbirth (Department of Health 1999).

Following the publication of this report, many maternity units across the United Kingdom set up services and women were invited to meet a midwife to discuss their birth experiences. These services were commonly referred to as “Listening” or “Birth Afterthoughts” and the term debriefing was used less frequently.

The literature review set out in chapter 3 identified limited research in this area (Baxter et al 2014). Furthermore there is controversy in the general literature about the value of debriefing. Victims of unexpected atrocities value the intervention. Initially in the 1980s, when debriefing became prevalent, many professionals felt debriefing would be very effective in preventing trauma symptoms. However, as discussed in chapter 3, the research evidence did not support this expert view (Rose et al 2002) and so professional opinion and approach to such services changed.

As also discussed in chapter 3 the Cochrane review, by Rose and colleagues, review found no evidence that debriefing, carried out on an individual basis and delivered in a single session, was of value in preventing post-traumatic stress disorder after a traumatic incident (Rose et al 2002). Furthermore there were only three RCTs in the maternity context listed in this Cochrane review (Lavender and Walkinshaw 1998, Priest et al 2003, Small et al 2000). These had differing outcomes. Despite further RCTs of postnatal debriefing being undertaken since the Cochrane review in 2002 there has remained a heterogeneity between the trials. In addition an update of this review was undertaken in 2010 and a protocol published for a review of debriefing in the childbirth context (Bastos et al 2008). The update review did not alter the conclusion of the original one in 2002 (Rose et al 2002). The results of the latter planned review were published in 2015 as this thesis was completed (Bastos et al 2015). These findings have been discussed in the discussion in chapter 3.

Compared with the Cochrane review by Rose and colleagues in 2002, the NICE postnatal recommendations, published in 2006, were more in accord with the

work described in this thesis. Aspects relating to postnatal debriefing were situated within the section on mental health and well-being. In relation to postnatal debriefing this NICE guideline, on routine postnatal care more generally, focuses on informal approaches rather than a formal debriefing intervention. It is therefore very important to note that formal debriefing of the birth experience was not recommended in the postnatal care guideline in 2006. This recommendation was made on level 1+ evidence found in three trials in the maternity context (Gamble et al 2005, Lavender and Walkinshaw 1998, Small et al 2000). Two of these were summarised in the first Cochrane review (Lavender and Walkinshaw 1998, Small et al 2000). The NICE guideline in 2006 “Postnatal care: Routine postnatal care of women and their babies” recommended that women be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour. This meant that there was support nationally for women to receive informal debriefing approaches like the one provided in the Birth Reflections service at the study hospital.

The findings by Rose and colleagues (2002) also informed the findings of a later expert review by the National Institute of Health and Clinical Excellence (NICE 2007) on antenatal and postnatal mental health. This guideline recommended that postnatal debriefing should not be offered routinely and did not advocate the routine use of formal debriefing to women who have had a traumatic birth. However the 2007 guideline has since been replaced and there is more recent guidance relating specifically to women who have had a traumatic birth. The recommendation now is not to offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who have a traumatic birth (NICE 2014a).

The lack of clarity in definitions means the research that has been undertaken encompassed a range of approaches to 'debriefing', which were often poorly described. There was therefore the urgent need to review the provision of postnatal debriefing. At the time the current mixed methods research study was planned only a very small proportion of all women who gave birth experienced a

postnatal debriefing session at the study hospital. It was possible that this opportunity might be beneficial to more women. It appeared at the time that nationally there was an inequitable service being provided for women giving birth. This was partly owing to gaps in the evidence.

The literature review aimed to gain a fuller understanding of postnatal debriefing and identify the gaps in the body of knowledge on debriefing in maternity services (Baxter et al 2014 and chapter 3 in this thesis). There were three specific objectives of the literature review. The first involved assessing the views of both the women who use the service and the midwives who undertake the session. The second was to describe the provision of postnatal debriefing and the third to identify specific approaches taken. Part of the rationale for this focus was that findings of the trials had been inconsistent and unclear. This might have been because of variation in services and lack of definition or clarity about what they are.

With the findings of the literature review (Baxter et al 2014 and chapter 3 in this thesis) it became apparent that there was a lack of clarity about precisely what these services were established to do. In addition the needs of the women attending them were only vaguely defined, if at all. In order to obtain reliable findings from further RCTs it became evident there was the need to reach a clear definition about the precise nature of a postnatal debriefing service and how it supports individual women.

#### **4.2.1 Section summary**

This section has provided a context to this research study and given a rationale about why it was undertaken. The effects of postnatal debriefing remain unknown despite a series of clinical trials. Services were discontinued at some maternity units following the publication of national guidance in 2007 (NICE 2007). However other maternity services continued to offer unstructured

postnatal debriefing to women in accordance with the NICE postnatal care guideline (NICE 2006). A literature review was conducted (Baxter et al 2014 and chapter 3 in this thesis), which identified a lack of clarity about precisely what these services were established to do and how they operate. In addition the needs of the women attending them were only vaguely defined. There was the need to reach a clear definition about the precise nature of a postnatal debriefing service and how it supports individual women. The next section will provide a discussion on the literature pertaining to support and postnatal care. As mentioned in the introduction, section 4.1 above, postnatal debriefing has been recognised as a form of postnatal support (Barimani et al 2015). This literature was also reviewed for two other reasons. Firstly because women in the case study in chapter 2 of this thesis reported a lack of professional support on the postnatal ward. This literature was also reviewed as when undertaking the analysis as part of this study the importance of women feeling supported came through strongly. This led to the need to review literature at a later stage on the impact of birth and how women are supported in this regard postnatally.

### **4.3 Women's need for support following birth and during the postnatal period**

#### **4.3.1 Introduction**

Although the notion of support has been an ongoing feature within this thesis, this literature review on support in relation to postnatal care was undertaken at a later point in the chronology. This was after completing the analysis for this study, since the findings (like those of the earlier case study) indicated a lack of focus on supportive care in maternity services.

As well as having physical and practical needs in relation to both their own and their babies' recovery and their new role as mothers, some women also experience emotional distress as a direct consequence of the birth experience (Creedy et al 2000, Czarnocka and Slade 2000, McKenzie-McHarg 2015, Soet et

al 2003). The provision of support throughout the maternity period is therefore highly relevant to postnatal care and women's feelings following birth. The case study in chapter 2 of this thesis highlighted women's dissatisfaction with postnatal care in the hospital setting. Furthermore the findings of this case study also showed that women did not feel well supported on the hospital postnatal ward. Understanding more about what is meant by postnatal support may help to identify important aspects of care provision as perceived, and needed, by the users of the maternity service. With this information, it is hoped that services can be revised in response to women's needs. This will in turn increase satisfaction with this aspect of care provision and should also help to contribute to postnatal well-being. Factors that make postpartum support adequate or effective, and how best to provide this aspect of care in hospital or at home, still remain to be established (Barimani et al 2014).

This section provides an overview and discussion of key aspects of the literature on women's needs for support following birth and during the postnatal period. It also covers aspects of maternity care more generally. This is due to the fact that maternity care takes place across a continuum. For this reason it is important to consider the different parts when focusing on one area. The effect of one part may impact on another.

The search strategy involved a search of the major electronic databases. This included MEDLINE, CINAHL, Cochrane Library, DARE, Embase, PubMed, Ovid Medline, Social Science Index, Maternity and Infant Care, PsychoINFO and Social Policy and Practice. This was not undertaken as a systematic search but as a scoping search, which looked for a range of literature that would be useful to situate thinking about the study. For these reasons a different type of search was needed from a systematic search designed to identify research evidence on a specific question. A formal appraisal tool was therefore not used. General terms such as support, need, professional support, childbirth and postnatal were used. In addition other documents were also obtained by means of

reviewing the respective reference lists. A search using the same terms was also used on City University's main library catalogue.

#### **4.3.2 Women's experiences of receiving support in general maternity care in England**

Within the context of the UK two recent national maternity surveys provide an indication of how women currently rate maternity care provision generally (Care Quality Commission (CQC) 2013, Redshaw and Henderson 2015). The strengths of the national surveys include having good samples, being well-designed with similar questions used over a series of surveys which enables comparison over time. The limitations are that there is a possible skew in who responds, the inability to drill down to the detail and the fact that it is possible to be unhappy yet satisfied, as satisfaction relates to expectations.

The authors of an earlier report about maternity care and practice in 2010 stated most women reported being treated well. According to these researchers only a small proportion of women did not feel they were treated with kindness or respect by one or more midwives or medical staff providing their care overall (Redshaw and Heikkila 2010). The 2015 report relates to practice in 2014. This shows similar findings where perceptions of the quality of midwifery labour care were high, reflected in always being talked to in a way women could understand (90%) and always being treated with respect (89%) and kindness (89%).

In addition, and similar to the findings of the 2010 report, the 2015 report shows that over 80% of women always felt they had confidence and trust in the staff caring for them during labour and birth, a further 16% said they sometimes felt this and small proportions (3%) reported this as 'rarely' or 'never'. The proportions were similar for first-time mothers and women who had given birth previously (Redshaw and Henderson 2015)

Despite evidence of improvements since the healthcare regulator's previous survey, the report by the Care Quality Commission in 2013 highlighted areas of practice that had not improved and where experiences fell short of expectation by women. An overriding finding, across all areas, was inconsistency of support in the form of information and clinical care. On occasions basic knowledge such as medical history was not known. In addition this finding was more prevalent amongst women giving birth for the first time. Information needed to make choices was also not provided consistently and the choices themselves were not always offered to women. This was echoed in the findings of Redshaw and Henderson (2015) who identified that 75 per cent of women were not aware of four possible options for place of birth. Furthermore, this finding was only marginally improved from the results of the previous survey where 80 per cent of women were found to not being aware of the four different options (Redshaw and Heikkila 2010).

Across all three surveys, women were more critical of the care provided to them postnatally. This is consistent with previous literature on postnatal care provision, which has been discussed in the case study section of this thesis in chapter 2. The findings of the most recent survey in 2015 show no improvement in postnatal care whereas there are improvements during the antenatal and intrapartum time periods (Redshaw and Henderson 2015).

#### **4.3.3 What support do women need from health professionals in the early postnatal period?**

Whilst there is much evidence on the views of women to the care they received postnatally and their dissatisfaction, as mentioned in the above section and in the case study in chapter 2 of this thesis, there is the need to understand more fully what women feel is important in terms of support from a professional as they are adjusting to motherhood. The findings of studies from two research

teams in the UK and Sweden were identified as being most relevant to this current literature review. These are discussed below.

A small qualitative study conducted in the south of England, used a grounded theory approach to explore women's perceptions of their support needs in the first few weeks after birth (Wilkins 2005). This study explored the experiences of first time mothers to find out what areas of support these women found empowering and eased their adjustment during the first few weeks of motherhood. This study highlighted the role of professional support in the postnatal context where the participants reported being helped to build confidence, skills and knowledge to care for their baby effectively. One overriding concern of the mothers was to develop confidence and skills to give optimal care to the baby. This grounded theory study identified that advice was the key to building confidence amongst novice mothers. The immediacy of advice from health professionals in a birth centre setting was particularly valued by women. This was less likely to be available to women on a postnatal ward when staff appeared busy, which rendered them unapproachable by the women seeking their support for advice. As this was a small qualitative study, the author made no claims to generalisability but the clear audit trail and the report itself established the credibility and trustworthiness of the findings. The author concluded that the focus of professional support in the immediate postnatal period should be extended from physical examinations to address women's individual needs for support in ways that build confidence and empower them to feel that they have the ability to care effectively for their babies (Wilkins 2005).

It is important not to conclude too much from one small study; however, there is additional evidence to support the above findings. Although set in a different national context, a research programme in Sweden provides further assistance with the understanding of the support needs of women during the postpartum period (Barimani et al 2014, Barimani et al 2015, Barimani and Vikström 2015). The aim of the first study was to assess mothers' perceived satisfaction with professional support during the first two weeks after childbirth and the extent to

which mothers seek emergency care during the same period (Barimani et al 2014). The researchers identified that 18% of respondents (from a convenience sample of 363 women) reported their experience of postnatal support by a professional to be either insufficient or completely insufficient. In addition, 17% of the original sample of women reported visiting hospital emergency departments in the first two weeks following birth for reasons pertaining to the delivery, breastfeeding or infant problems. Furthermore mothers who had a poor perception of professional support, a low sense of coherence (SoC) score or a complicated birth experience were more likely to contact emergency departments (Barimani et al 2014).

It was clear that a significant number of women needed additional support from health professionals following discharge from the maternity service. These women did not know how to access assistance and therefore resorted to attending emergency departments. When interpreting these findings it is important to understand that the context of care in Sweden is slightly different from that of the UK. In the UK women receive care from a community midwife, either in their homes or at a clinic facility. This is after they are discharged from hospital care after the birth and for at least ten days. Women in Sweden remain under the care of midwives in hospital for one week after birth. After that time the baby's care is transferred to the child health clinics and the woman is followed up at a postpartum visit by a separate midwife from the primary health department, within 12 weeks of the birth. This midwife is from the same team of midwives who provided the antenatal care.

Even though the context is different, the reduction in home visiting in recent years in the UK may have reduced the differences in the systems. It might therefore be useful to consider whether emergency or readmission rates have increased in the UK.

Further information about the more precise aspects of support women were looking for is available from a separate analysis within the same research

programme in Sweden (Barimani et al 2015). There was a large discrepancy between levels of satisfaction with antenatal, postpartum and child health and 38% of the respondents reported insufficient support during the first two weeks postpartum. Mothers were satisfied with the support from child health nurses, but missed follow up contact from the antenatal and postpartum midwives. These women wanted more attention paid to their own physical and emotional needs and they wanted to talk about their feelings after childbirth. They also wanted the nurses and midwives to be more caring and supportive and reported some midwives on the postnatal ward as being unfriendly. Whilst they reported being unhappy about meeting too many different midwives on the hospital postnatal ward they were also displeased about an apparent lack of support in terms of continuity from the primary care midwife who had provided antenatal care for these women (Barimani et al 2015).

Further evidence that women require more information and advice prior to discharge from hospital is provided in the findings of the third study from the Swedish research team (Barimani and Vikström 2015). The researchers investigated perceptions of early postpartum care continuity and how the continuity related to parenting support. This qualitative study utilised focus groups with 18 women and 16 men. The researchers used deductive content analysis and compared their findings with three pre-existing categories of continuity: “management continuity”, “informational continuity” and “relational continuity”. The key finding from this work is that women needed to know how to access help and advice following discharge from hospital. This was presented as an aspect of “management continuity”. In terms of “informational continuity” this work also identified that new parents needed information that is related to their individual needs. Information provided by a health professional was considered to be empowering by the new parents leading to self-efficacy. Issues pertaining to “relational continuity” included the need for women to talk about the birth (Barimani and Vikström 2015).

Studies as described above, both in the UK and Sweden, have highlighted women's important need for support in the form of ongoing information and advice during the immediate postnatal period as they are adjusting to becoming new parents. Without this women felt they struggled. Having access to continuing information and advice by health professionals in this way increased their confidence and was considered to be empowering to new mothers by the research teams. Furthermore the need to ensure care was individualised for each woman was also highlighted in these studies.

#### **4.3.4 Continuity of care**

The concept of continuity of care was clearly important to the women in the study from Sweden discussed above (Barimani and Vikström 2015). Having familiarity with the midwife through continuity of care was also found to ease communication and was also highly valued by the women in the qualitative study in south England discussed earlier by Wilkins (2005). Continuity of support has been found to be particularly important for women and their partners. Continuity of care has become a fundamental aspect of modern day maternity care in the UK. It is a key theme in the recently published review of maternity services (NHS England 2016). Evidence for this came from a Cochrane systematic review of models of maternity care which identified favourable birth outcomes among women who received midwife-led continuity of care compared with controls (Sandall et al 2015). It is interesting that most of these outcomes are focussed on the birth experience. There were very few outcomes in relation to postnatal care. This may reflect the fact that there is a greater focus on antenatal and labour care compared with care following birth in the UK.

As has been identified from the research team in Sweden, the importance of continuity of carer is also highly relevant in the context of postnatal care (Barimani and Vikström 2015). Further evidence of this was identified in a

cluster RCT in the UK which aimed to assess a more personalised model of community postnatal care compared with normal care provision (MacArthur et al 2002). The intervention was a redesigned model of midwifery-led postnatal care that was flexible and tailored to individuals, including extended home visits to individual women. This also included the development of evidence-based guidelines for various postpartum disorders to support management by midwives of psychological and physical conditions. These guidelines also included criteria for referral to general practitioners. Women in the intervention group received postnatal care provision for up to three months. The redesigned community postnatal care model was associated with positive psychological health outcomes in women four months following birth. However physical health measures did not differ. The authors suggested this finding of the improvement in psychological health was likely to be explained by the early postpartum detection and management of emotional disorders (MacArthur et al 2002).

As mentioned above national policy in the UK recognises the need for continuity of support postnatally. However, as also mentioned in the first paragraph of this section in the findings of the Cochrane systematic review by Sandall and colleagues, outcomes relating to postnatal care were very limited. Despite there being less evidence for postnatal care compared with intrapartum and antenatal care, having a named care provider on discharge from the hospital postnatal ward is the recommendation for all women following childbirth in the national clinical guideline on postnatal care (NICE 2006). Whilst there is no domiciliary postnatal care in Sweden it could be argued that if this system was adopted there it is possible that the need for women to attend emergency departments with issues relating to maternity and childcare would be reduced.

#### **4.3.5 Effectiveness of professional postnatal support**

It is also important to consider the effectiveness of professional support provided to women postnatally. Other researchers have established various postnatal

interventions and set up RCTs to assess the effectiveness of these additional support measures compared with routine postnatal care provision. These include telephone contact with health professionals, support groups and one to one support from a midwife. Many of these projects were included in a systematic literature review of effectiveness of postpartum support in 2006. The researchers reported a range in terms of the quality of the 22 trials included in the review. There were four key outcome measures considered across all the trials reviewed by the researchers: maternal parenting, mental health, quality of life and physical health. The authors identified one key finding from this review. This they cited was evidence of effects amongst high risk groups i.e. studies that focussed on specific high risk groups identified positive results. However this was not the case when researchers included what the review team called “unselected” groups of women in their samples and who were offered the various interventions (Shaw et al 2006). This review included the trial by MacArthur et al (2002) mentioned in the previous section and chapter 2 of this thesis. In their analysis of the systematic review, the reviewers considered the trial by MacArthur and colleagues to have focussed on high risk groups of women solely due to the nature of the intervention. However this was not the view of MacArthur and colleagues who considered their intervention was provided to all women at the outset with additional support being provided to individual women as necessary (MacArthur et al 2002).

Despite efforts by various researchers to show benefits from trials of the effectiveness of professional support provision to women postnatally there is limited evidence of this. As already mentioned in the case study in chapter 2 of this thesis the study undertaken by MacArthur and colleagues in 2002 is the only RCT in the UK to have identified a positive benefit to an intervention designed as a routine universal measure of postnatal care. MacArthur and colleagues redesigned care by community midwives. The intention was to manage and identify the individual needs of women during the first four months following birth. Key features of this model, that might have explained the more positive findings, were that it was: offered to all women (as opposed to groups specifically chosen),

midwife-led, flexible or tailored to individual women's needs (MacArthur et al 2002).

Both the systematic review by Shaw and colleagues in 2006 and in particular the trial by MacArthur and colleagues in 2002 have identified the need to tailor the provision of support postnatally to the individual needs of women (MacArthur et al 2002, Shaw et al 2006).

#### **4.3.6 Environment where support is provided**

The provision of professional support for postnatal women can be affected by the environment in which it is given. The results of a seminal study highlighted this issue (Dykes 2005). Dykes undertook a critical ethnography of interactions between midwives and breastfeeding women on two postnatal wards in the north of England in 2005. She used participant observation and focused interviews. The participants included 61 postnatal women and 39 midwives. The findings showed interactions between midwives and women were encompassed by the global theme of 'taking time and touching base'. However, most encounters were characterised by an absence of 'taking time' or 'touching base'. This related to midwives' experiences of temporal pressure and inability to establish relationality with women due to their working patterns. The global theme was underpinned by five organising themes: 'communicating temporal pressure'; 'routines and procedures'; 'disconnected encounters'; 'managing breast feeding'; and 'rationing information'. Dykes concluded the organisational culture within the postnatal wards contributed to midwives experiencing profound temporal pressures and an inability to establish relationality with women. Within this context, the needs of breast-feeding women for emotional, esteem, informational and practical support were largely unmet (Dykes 2005).

Another more recent observational study shows the way in which the postnatal environment affects the quality of support provided in the UK (Hunter et al 2015).

This also highlighted the effect time pressures on staff have on the ability to provide support. This small study was set in the context of challenges encountered when implementing interventions in the practice environment. The number of observations was small. Three observations were undertaken in total, each lasting six hours. In addition there were 10 interviews conducted on an ad hoc basis with staff present in the postnatal ward during the observations. Whilst the researchers felt data saturation was reached they mentioned in the report that it was possible more themes might have been identified if there had been more observations. The researchers found that midwives and maternity care assistants were not in control of their time or space. As a consequence task allocation took precedence over relational care and hence breastfeeding support was not considered as a priority (Hunter et al 2015).

The busyness of the postnatal ward environment was also mentioned by women who responded in the national survey discussed earlier (CQC 2013). It is clear there is a link between the busyness of the postnatal ward environment and reduced professional support. Additional themes identified in the qualitative syntheses of the case study in chapter 2 of this thesis also addressed the pressures of time on staff and women in the postnatal ward.

The attitude and behaviour of staff on postnatal wards has also been identified as a barrier to care provision. The women participants in the cross-sectional survey in Sweden mentioned above also identified the need for midwives and nurses on the postnatal ward to be caring and supportive and some staff in this area were considered unfriendly (Barimani et al 2015). The need for staff on the postnatal ward to be approachable was also identified by Wilkins in England in her grounded theory study (2005) who identified that women in need of help and advice would struggle unattended rather than call someone they considered unapproachable (Wilkins 2005). The impact of staff behaviour has also been highlighted in other studies (e.g. Beake et al 2005). There appears to be a consistent pattern with this evidence.

#### **4.3.7 Postnatal support needs in relation to the actual birth experience/how the birth experience impacts on postnatal feelings and support needs.**

As well as understanding the general support needs of women during the postnatal period there is also a need to determine how women are feeling in relation to the actual birth experience. It is known that some women consider their birth experience as being negative and others consider their birth to have been traumatic. (e.g. Hodnett 2002, Storksen et al 2013, Waldenstrom et al 2004). In a study about fear of childbirth, Storksen and colleagues identified that 117 women from their sample of 1357 (8.6%) subjectively rated their previous birth experience as negative. The authors used a numerical rating scale in which women who rated their overall birth as 9 or 10 out of 10 (upper 10<sup>th</sup> percentile) were considered to have experienced a negative birth according to these authors (Storksen et al 2013). Storksen and colleagues identified a strong association between a negative previous birth experience and fear of childbirth in a subsequent pregnancy (Odds ratio 4.8). Perceiving their previous birth experience to have been negative was much stronger than the association between previous obstetric complications and fear of childbirth (Storksen et al 2013).

Waldenstrom and colleagues (2004) in a longitudinal cohort study to investigate the prevalence and risk factors of a negative birth experience in Sweden identified a prevalence rate of 7% for negative birth among their sample of 2541 women. One year following the birth women were sent a questionnaire. In relation to their memory of their birth one question asked them to assess their birth, by choosing one number of seven where "1" was very negative and "7" very positive. This measure was used as the outcome variable in the analysis to identify a negative birth experience. It appears this phenomenon is an international issue. In order to avoid the possible halo effect among women by

coming through birth safely as mentioned above these researchers waited until one year following the birth to assess women's overall experience of birth. They identified four key categories of risk for a negative birth experience: having an unexpected medical problem such as an emergency caesarean section or augmentation in labour; factors from a woman's social life, such as unwanted pregnancy or lack of partner support; the woman's feelings during her labour (e.g. pain, lack of control); and the care a woman was given (e.g. lack of support in labour, administration of pain relief). These authors concluded a lack of support from caregivers, lack of control and not being involved in decision-making increased the risk of a negative birth experience. This is also important as midwives and obstetricians cannot prevent the problems in women's lives and sometimes interventions are clinically needed, but they can improve the way they support and communicate with women and families, and each other, to improve care quality, as indicated in the literature discussion above.

The findings discussed above are similar to those identified in a review of satisfaction of the childbirth experience undertaken by Hodnett in 2002. Hodnett (2002) undertook the review to summarise what is known about satisfaction with childbirth, with particular attention to the roles of pain and pain relief. She identified four key factors that impacted upon women's satisfaction: personal expectation, amount of support from caregivers; quality of the caregiver – patient relationship and involvement in decision-making. The influences of pain, pain relief, and intrapartum medical interventions on subsequent satisfaction were found to be less strong than the influences of the attitudes and behaviours of the caregivers. This finding of a strong effect of staff attitude and behaviour on maternal satisfaction with childbirth compared with medical interventions has been replicated in a more recent study on fear of childbirth in Norway as discussed earlier in this section (Storksen et al 2013).

In a qualitative study of satisfaction with childbirth during a premature birth Sawyer and colleagues also identified the important role of the professional caregiver in relation to satisfaction with the birth experience. For example

women valued being listened to by staff and when this process broke down this contributed to a negative experience of care as reported by some women (Sawyer et al 2013).

Whilst studies have been undertaken and described the negative and traumatic effects birth can have there is a dearth of evidence in relation to how best to support women who report a negative or traumatic birth experience. Whilst women with confirmed PTSD will need the support of a psychologist or psychiatrist there is a much larger subgroup of women with lesser symptoms who report their birth experience as being either negative or traumatic or both. Without support many women can experience increased fear in future pregnancies (Ballard et al 1995, Thomson and Downe 2010).

Two RCTs have been conducted in Australia of counselling interventions provided by midwives. The first involved 103 women with clinical trauma symptoms. The intervention group received face to face counselling 72 hours following birth and again via the telephone at four to six weeks postpartum. Whilst there was a trend towards improvement in the number of women meeting the criteria for PTSD at three months postpartum there was a significant difference between the intervention and control groups at three months postpartum of PTSD total symptom scores. In addition there were significant differences between groups in depression scores at three months postpartum. The authors concluded this brief counselling intervention was effective in reducing symptoms of trauma, depression, stress and feelings of self-blame (Gamble et al 2005). Further detail on this trial can be found in chapter 3 of this thesis.

The second RCT was of midwife-led counselling in a subsequent pregnancy for women with high levels of childbirth fear. The authors hypothesised that women receiving midwife-led telephone psycho-education during pregnancy would report improved postnatal mental health six weeks after birth, experience higher levels of vaginal birth (reduced CS) and prefer a vaginal birth in a subsequent pregnancy compared to the control group. Three hundred and thirty-nine (n=339)

women, with a fear score  $\geq 66$  on the Wijma Delivery Expectancy / Experience Questionnaire (W-DEQ), were randomised (intervention n=170; controls n=169). One hundred and eighty-four women (54%) returned data for final analysis at six weeks postpartum (intervention n=91; controls n=93). Although the main outcome relating to a reduction in planned caesarean sections was not achieved and there were no differences in postnatal depression symptoms scores, parenting confidence, or satisfaction with maternity care between groups, the women in the intervention group were less likely to experience distressing flashbacks during the postnatal period (Fenwick et al 2015).

In order to understand how best to support women who report negative and distressing feelings in relation to their birth experience, another small study from Australia is worthy of consideration (Martin et al 2015). This has shown a midwifery intervention during pregnancy to increase the number of women who stated their intention to attempt to give birth vaginally in a subsequent birth experience following a previous caesarean section. This was not a RCT but a comparative descriptive design and included 103 women between the intervention and control groups. Whilst the findings did not reach statistical significance the authors felt the intervention worthy of further consideration. This was provided between two time points: immediately following a woman's first birth experience and during the second pregnancy. The intervention was designed to integrate several specific interventions including antenatal continuity of midwifery care, evidence-based information and opportunity for women to talk through their caesarean experience with a midwife (Martin et al 2015).

There are two other possible support options reported for women who self-report a traumatic birth. The first being the option (if available) of attending a postnatal debriefing session to discuss the birth and review case notes with a maternity professional. The literature for this is fully covered in the critical review of the literature in chapter 3 of this thesis. Postnatal debriefing is a form of support to women (Barimani et al 2015). Although it takes place during the postnatal period it most commonly relates to the labour and birth experience. Although the

process of debriefing takes place in the postnatal period, women link this with the birth itself (Waldenstrom et al 2006).

The second option is in relation to targeted antenatal planning in a subsequent pregnancy. Two qualitative studies have been undertaken to show how specific support from health professionals can help a woman recover from a previous traumatic birth experience during a subsequent pregnancy and birth experience. An Internet study of 35 international women from the United States (US), the United Kingdom (UK), New Zealand, Australia and Canada was conducted by researchers in the US. In this phenomenological study the participants were asked to describe the meaning of their experiences of a subsequent childbirth after a previous traumatic delivery. Four key themes were reported. The key messages from this work are that the subsequent pregnancy was found to have the power to either heal or re-traumatise women. Also, in the subsequent pregnancy women needed permission and encouragement to grieve their prior traumatic birth to help remove the burden of their invisible pain (Beck and Watson 2010).

The second qualitative study was undertaken in the UK. This also used a phenomenological research design to explore women's experiences of a traumatic birth and subsequent positive childbirth event. Fourteen women were recruited, all of whom had either had a subsequent birth experience or were in a subsequent pregnancy. The birth stories showed how women changed their previous negative childbearing narratives through preparing for and experiencing a positive joyful birth. Four key themes were presented: 'Resolving the past and preparing for the unknown', 'Being connected', 'Being redeemed' and 'Being transformed'. The findings offer important insights into how women who have experienced birth trauma may be supported during a future pregnancy. The authors concluded preparing women for uncertainty and providing opportunities for them to build trust in themselves and their caregivers may provide a bridge to a "redemptive" experience (Thomson and Downe 2010).

Whilst many of the women in the two qualitative studies of positive birth following a previous traumatic birth experience reported the benefits of a healing experience this was at a later point in time in relation to their first traumatic birth experience and when they were pregnant again. Not all women following one traumatic birth experience will gain the confidence to become pregnant again and therefore these women will not be helped in this way. Furthermore other women being supported in the subsequent pregnancy may endure many years of distress and anxiety before becoming pregnant again. The value of what is known as postnatal debriefing is that this is available at any point following birth.

Research needs to continue to focus on how midwives can better meet women's emotional needs in the postpartum period to reduce fear and increase confidence for their next pregnancy and birth experience (Martin et al 2015). The support needs of women at this time are highlighted in another qualitative study undertaken to explore how women experienced and made sense of the range of emotional distress states in the first postnatal year (Coates et al 2014). This was undertaken by researchers in the UK. Data were analysed using Interpretive Phenomenological Analysis (IPA). This included 17 women who experienced psychological problems in the first year after birth. The results of this study highlighted the importance of social support from partners, families and friends for women with various types of postnatal psychological distress. The findings showed that women needed contact with others at this time. Some felt let down by the health professionals who appeared too busy to help them with practical and emotional support. These women reported a failure of staff to listen and communicate with their needs. Talking with others was also an important aspect of the social support required by the participants who stressed how valuable this was to them. The researchers also reported the women felt they needed support with resolving feelings around traumatic births. A desire to validate and normalise feelings through talking with health care providers was universal (Coates et al 2014).

At the time of finalising this thesis a scoping survey study has been published (Thomson and Downe 2016). The researchers acknowledged this study to be the “first of its kind to be undertaken” and confirms a lack of research literature in this area. The aim of this study was to identify the emotional and support needs of pregnant multigravida women who had experienced adverse responses associated with a previous childbirth experience. The survey was given to eligible women at their routine 18 week anomaly scan appointment. One hundred surveys were administered at four separate maternity units in the North West of England. Unfortunately the response rate was low at 28% which is a limitation of the study. In particular the participants were asked about the optimal time to receive support following birth and the type and provider of support they had accessed or would have liked to access. Two key types of support for emotionally traumatised women following birth were being made aware of support options and being provided with opportunities to discuss the birth experience with a health professional. Another interesting finding was that among those women who had received support for their negative emotions following birth (54%) more women were likely to turn to their personal networks. Those who had not accessed any support, or who felt they had not accessed the right type of support, were more likely to state their preferred support option would have been a midwife (Thomson and Downe 2016). As the authors stated there were limitations to this exploratory scoping survey and further work is required. However it is reassuring that women with ongoing emotional support needs, generated as a consequence of giving birth, are finally being acknowledged as a research priority.

#### **4.3.8 Section summary**

This section has provided an overview of key aspects of the literature in relation to the support needs of women following birth and during the postnatal period.

Through this work it was found that support is a broad topic. It overlaps with care provision and women's experiences. Literature in relation to postnatal care was critiqued in the case study in chapter 2 of this thesis. This section has therefore provided an extension of this discussion. It is clear from a wide span of literature that women need support following birth and during the postnatal period. A lack of support was an overwhelming finding from the case study "Women's experiences of hospital postnatal care" in chapter 2 of this thesis. The women in the case study described the need for more physical, informational and practical support. They sought practical support with both their own needs and those of their babies and also support in the form of information provision. There was a perception on the part of the women, of a lack of staff being available to provide support at this time. These same issues were also identified in this review of the literature on professional support in postnatal care provision.

Key findings from the national and international evidence relating to professional support provision in the postnatal period have been discussed. Through an overview of the most recent evidence from national surveys it has also been highlighted that a small proportion of women having babies in England are missing out on important aspects of supportive care. There were fewer improvements in relation to postnatal care provision compared with antenatal and intrapartum care in the most recent survey (Redshaw and Henderson 2015). Despite the administration of regular, large national maternity surveys in England, significant numbers of women are continuing to report on unsatisfactory care provision. Whereas there appears to have been an improvement overtime in antenatal and intrapartum care this is not the case with postnatal care.

Women following birth need continual advice and information. This leads to increased confidence in caring for their babies and empowerment. This is further facilitated through continuity of care schemes. Whilst there have been many clinical trials set up to test intervention models of professional support,

only one identified statistically significant findings to support the intervention (MacArthur et al 2002). The environment where professional support is provided was not always found to be conducive. The final part of this review focussed on the need for some women to be supported following a distressing birth experience. These women need specific support in relation to their emotional state as a consequence of this. It was found that there is very little research in this area which is a gap in the evidence base. There is the need for further research to address this.

There is an urgent need to review the provision of postnatal support, including how support is best offered to women who experience a negative or distressing birth. It is important to consider the optimal way of organising and providing care for women at this time. This seems to be particularly urgent for women following birth on the hospital postnatal ward as they move forward into the transition to parenthood. These findings concur with the findings of the case review at the beginning of this thesis in chapter 2 which was completed in 2010.

## **4.4 Methodology**

### **4.4.1 Introduction**

This section follows on from the background and describes the process of the research study. It is divided into six sections as follows: “Mixed methods”; “Research approach”; “Phase One: Quantitative”; “Phase Two: Qualitative”; “Validity and reliability” and “Ethical considerations”.

The study used a triangulation mixed methods design in which different but complementary data were collected on the same topic. A quantitative survey was conducted to determine women’s need to talk following birth and their understanding about what a birth reflections-type service is. This also asked more general questions pertaining to the woman’s overall labour and birth experiences and measured her feelings following birth. Following this data collection, qualitative interviews explored women’s experiences of the Birth Reflections service at Buckinghamshire NHS Trust and their experiences of giving birth and how they felt afterwards, more generally. The reason for collecting both quantitative and qualitative data was to bring together the strengths of both research approaches to build on the separate results.

### **4.4.2 Mixed methods**

Mixed methods research (MMR) utilises both quantitative and qualitative research approaches, using appropriate tools or methods to answer the research question. The use of the term mixed methods is not accurate in the sense that methods relates to the tools used to undertake research. There is also the need to consider methodology. This relates to a particular way of thinking about research and the nature of knowledge. There is no exact correlation between methodology and method.

Over time, purists from different paradigms (e.g. positivism, constructivism) have criticised the utilisation of mixed methods (Lincoln and Guba 1985). According to these researchers there is the need for the paradigm to determine how the research is conducted. Utilising more than one paradigm in this way assures the incommensurability (and incompatibility) thesis (Tashakkori and Teddlie 2010).

In the eyes of Lincoln and Guba (1985) the different paradigms cannot be merged in this way. For example, from an ontological point of view, positivists believe there is only one single reality whereas constructivists' understanding is that there are multiple realities rather than a single, actual truth. In terms of epistemology in the positivist tradition the knower and what is known are independent whereas the knower and what is known are inseparable according to constructivists. In positivism, enquiry is value free whereas constructivism incorporates values into the research process. Positivists link real causes to effects but constructivists are unable to separate causes from effects. Finally, logic is deductive in positivism from a general theory or hypothesis to particular conclusions whereas in constructivism logic is inductive. In induction, a particular construct is identified which can become generalised with further study (e.g. grounded theory).

There are many different ways of looking at the world and paradigms change over time. For example positivism has been mainly replaced by post-positivism where it is acknowledged that certainty is not absolute. The paradigm foundations supporting this study were post-positivist and constructivist in phase one and phase two respectively. It is important to remember, however, that the underpinning principles of methodologies may conflict, which can be a problem for combining them. The use of mixed methods has become known as the third paradigm (Tashakkori and Teddlie 2010) and there is ongoing growing evidence that different research approaches can be successfully combined. Tashakkori and Teddlie (2010) highlight three key components to mixed methods research (MMR): conceptual orientation (i.e. philosophical, theoretical

and socio-political), methods and methodology and the contemporary application of MMR itself.

One of the three conceptual stances pertaining to MMR described by Tashakkori and Teddlie (2010) is pragmatism. This is considered the best philosophical position for mixed methods research (Cresswell and Plano Clark 2011). Pragmatists believe that both quantitative and qualitative research approaches are useful and research may be both objective and subjective. In addition the decision about what method to use should rest with the research question (Teddlie and Tashakkori and 2009).

Critical realism is also considered by some mixed methods researchers. This sits on a continuum between positivism and constructivism and is therefore very compatible with mixed methods approaches. Maxwell and Mittapalli (2010) described their version of critical realism which combines a realist ontology (this claims a real world exists independent of our perceptions) with a constructivist epistemology (understanding of the real world is based on our own perspectives and points of view).

In summary, there is the need to consider the worldview in MMR. This includes awareness of the implicit worldview of the researcher (Cresswell and Plano Clark 2011). There has been a long debate on the merit of combining quantitative and qualitative data. Bryman (1988) highlighted two key discourses: epistemological and technical. As mentioned above controversy surrounds the issue of bringing together two different epistemologies. Lincoln and Guba (1985) found the consideration of research methods to be of secondary importance to that of paradigm.

#### **4.4.3 Research approach**

##### *i) Explanatory sequential design*

This study used an explanatory sequential design in which different data were collected on the same topic. In this research design there are two distinct phases: in this case quantitative followed by qualitative (Creswell and Plano Clark 2011). A quantitative survey was first conducted to determine women's need to talk following birth and their understanding about what a birth reflections-type service is. The survey also asked more general questions pertaining to the woman's overall labour and birth experiences and also measured their feelings following birth. The Impact of Events Scale (IES) was used in the survey as a tool to help understand the women's postnatal experiences and motivation to attend the Birth Reflections service, or not. The study also aimed to compare women who do or do not take up this service according to different demographic factors (e.g. parity, method of birth). However, as there was only one woman who completed the questionnaire and attended the service, this was not achieved. Sequential to this data collection, qualitative interviews explored women's experiences of the Birth Reflections service at Buckinghamshire NHS Trust. The interviews also explored the women's experiences of being in labour and giving birth and whether or not they needed to talk about this afterwards. More detail of the methods is provided in the following sections.

The reason for using this design and collecting both quantitative and qualitative data was not only to obtain quantitative results but to explain such results in more detail (Creswell and Plano Clark 2011). Gaining information in this way during the first phase of the research study allowed further development of the interview guide in the second phase and the potential for richer data about women's experiences of birth and possible need for postnatal debriefing.

As mentioned above, a key intention of this exploratory study was to understand reasons why women following birth may attend a postnatal debriefing session. Whilst the literature had identified certain groups may be at a higher risk of PTSD (e.g. women who have operative deliveries), the population base for this survey included all women following birth. It has been recognised that women

who experience birth normally and have no complications may still go home following birth unhappy about elements of the childbirth experience. Whereas previous research in this area has focussed on women who have attended a postnatal debriefing session, sending a questionnaire to a convenience sample of all women who gave birth at a maternity unit with an established birth reflections-type service allowed focused questions about the need to talk after birth to a larger sample of women. Through this approach it was hoped that an understanding would be gained about the number of women affected and their consequent reasons for needing to discuss their birth experience with a health professional.

Using a mixed methods design and having more than one data source enabled the use of triangulation in this study. This technique was used to both enhance the data collection and synthesise the data. A visualisation diagram of this process is given below at Figure 4.1

## Visual representation of research design

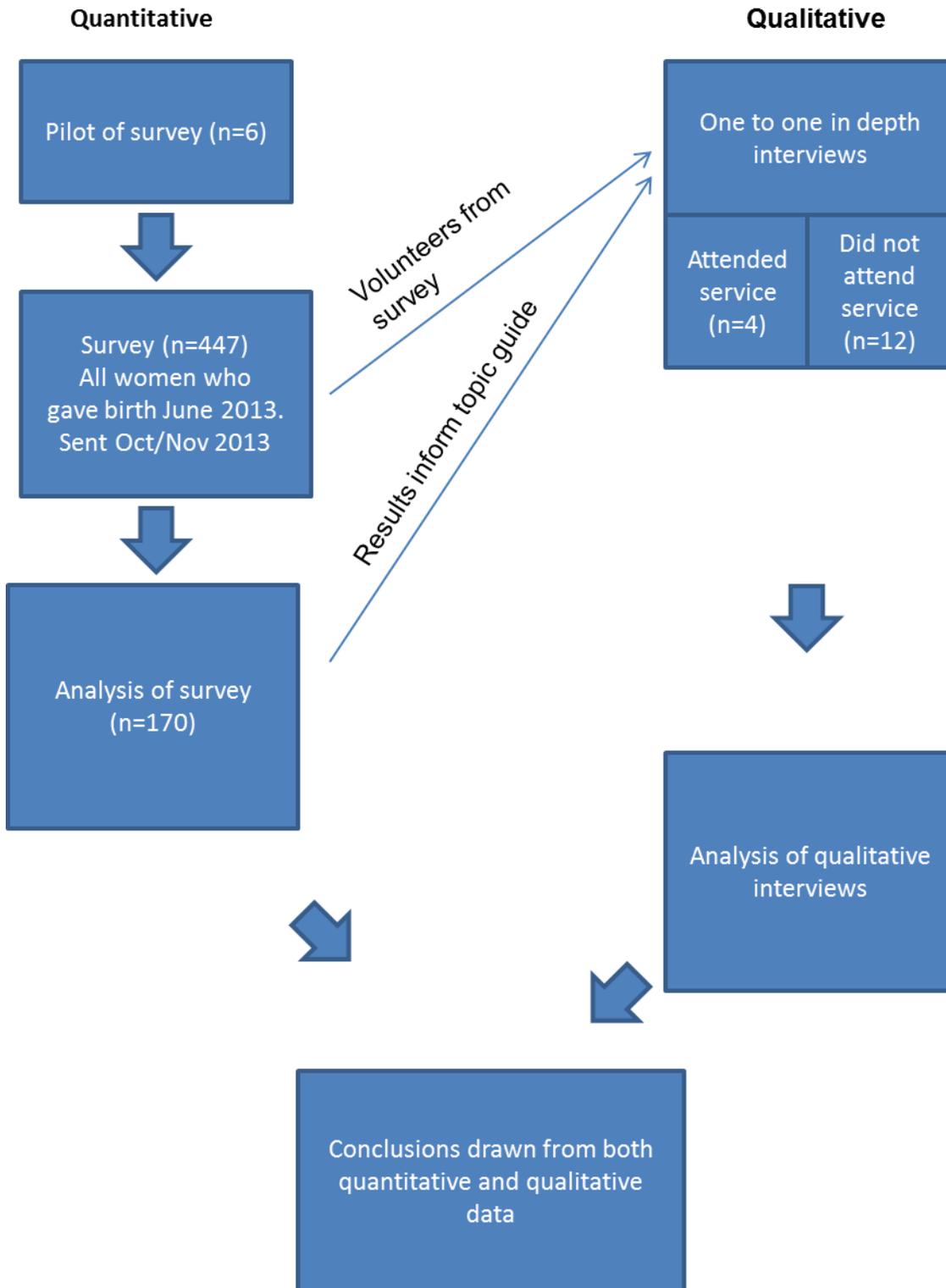


Figure 4.1 Visual representation of research design

The term triangulation originates from navigation where two measures are plotted to confirm position on a map or chart. The notion of triangulation sits centrally in mixed methods research (MMR). There are many opinions on how it can be used in research and according to Teddlie and Tashakkori (2009) the term has become overused.

Triangulation most commonly refers to the use of more than one research source or method to study an individual phenomenon. By taking several different bearings the researcher can obtain a more accurate fix on a problem (Jick 1979). Proponents of triangulation say that the strength of one research method can be used to compensate for the weakness of another (Flick 2009, Jick 1979). Sim and Sharp (1998) agreed that triangulation allows the researcher to widen the scope of the study by looking at different aspects of the same phenomenon.

In the early years when two different quantitative tools were used to measure the same phenomenon the researcher was able to conclude accurate measurement when two findings were the same (Campbell and Fiske 1959). Later in time Moran-Ellis et al (2006:47) referred to this as the “increased validity” model of triangulation.

The concept of triangulation provides an underpinning framework for mixed methods design. It enables the researcher to compare findings on the same phenomenon (Bryman 1988) and combine where possible. Triangulation also provides the basis for contemplation and further study where the findings of the different research approaches to the same phenomenon differ (Bryman 1988). Moran-Ellis et al (2006) in their paper on the processes of multiple methods highlight the epistemological claim that more can be learned about a phenomenon when the findings from different data are brought together. According to these authors triangulation is particularly valuable when researching the social world due to its multi-faceted complex nature. The use of

triangulation in this context allows a richer understanding of phenomena to develop.

The notion of triangulation in relation to methodology has evolved over time. It has been described as a “methodological metaphor” (Erzberger and Kelle 2003:459). As has been discussed, historically triangulation has been used as a means to increase validity (Campbell and Fiske 1959, Moran-Ellis et al 2006). As well as serving as a strategy for improving the quality of the research process triangulation is also used as a way of gaining better knowledge from the research (Flick 2009). In this way a more complete understanding of the phenomenon under study is enabled (Erzberger and Kelle 2003).

According to Teddlie and Tashakkori (2009) mixed methods research provides more comprehensive evidence through its ability to use all available research methods, including both quantitative and qualitative approaches. According to these authors there are three areas where MMR is superior to other research approaches: MMR simultaneously addresses a range of confirmatory and exploratory questions with both qualitative and quantitative approaches; MMR provides stronger inferences and MMR provides the opportunity for a greater assortment of divergent views. In this way mixed methods are utilised in this study to ensure the best possible picture of the focus of interest (Bryman 1988).

As mentioned above a mixed methods approach allows the researcher to simultaneously address a range of confirmatory and exploratory research questions (Tashakkori and Teddlie 2010, Teddlie and Tashakkori 2009). Using both quantitative and qualitative techniques will lead to a wider range of data collection leading to a greater depth in understanding. Bryman (1988) provided an example with a research study of “Moonies”. Information about general perspectives and feelings before joining the movement came from quantitative data derived from a survey whereas information about how Moonies view the world and what being a Moonie means to them was derived qualitatively.

In this study the two research traditions, quantitative and qualitative, were brought together for reasons that focus on the need to use methods that are suited to the specific research problem. Bryman (1988) also referred to this as the technical account. In this way this study took the form of a component design (Polit and Beck 2010). The qualitative and quantitative aspects were treated separately and remained distinct during both data collection and analysis. Data was brought together at the point of theoretical interpretation (Moran-Ellis et al 2006). In this way the two research approaches complemented each other and added strength to the findings.

*ii) The local "Birth Reflections" service*

A pragmatic decision was made to limit the study to one site only. The Birth Reflections service on which this study focused was developed 14 years before the fieldwork for this study took place. This was at a time when other similar services were being set up. It was likely that the service in Buckinghamshire was modelled on the other services and was therefore a fairly typical case study of such a service. Buckinghamshire NHS Trust is situated in the same health region as other units with similar services including the one in Winchester cited in the Department of Health's report mentioned in the background section above and 3.2. Practicalities of the research process would be minimised if the study was conducted at this site only. This was further helped as I was employed at this Trust at that time, although not involved in the provision of this service.

The Birth Reflections service had been set up in Buckinghamshire in the early 2000s. All women, on leaving the hospital after giving birth, were provided with a flyer in their discharge packs about the service and how to arrange an appointment if they wished to meet with a midwife to discuss their birth experience. This could take place at any stage in relation to the birth. The flyer also served as a vehicle for women to give feedback about their childbirth experience more generally. The Birth Reflections service was run by one

midwife who led a weekly clinic at the hospital. It was also supported by an administrative clerk who organised appointments for women who contacted the service.

### *iii) Data sources*

The data sources for this mixed methods study comprised of two samples of women. One group responded to a quantitative postal survey and the other consisted of women who attended qualitative interviews. The survey aimed to facilitate an understanding of the experiences of a convenience sample of women following birth.

The data collection methods are outlined below:

- Postal survey to a sample (from the general population) of women who had given birth within the selected service. (A single focus group with women service users was conducted prior to this with the sole purpose of piloting this instrument).
- Semi-structured interviews with women who had experienced postnatal debriefing with a midwife and other women who had declined/not attended a postnatal debriefing.

As previously mentioned the findings of the survey were used to further develop the interview guide for the qualitative part of the study. It was anticipated that in-depth, semi-structured interviews with participants would provide richer data from individual women. In this way, mixed methods research facilitated a greater understanding than would have been achieved through just one of the research approaches used.

#### **4.4.4 Phase one: Quantitative**

##### *i) Survey participants*

The survey sample consisted of women who gave birth at Buckinghamshire NHS Trust during a specific one-month period (June 2013). Approximately 500 women give birth at Buckinghamshire NHS Trust each month. The National Maternity Survey was sent to all women who gave birth in February 2012. This included women at the study hospital, which achieved a response rate of 53%. Therefore, it was anticipated that around 50 per cent would respond, which should have provided a minimum of 250 completed questionnaires. With the convenience sample of all women who gave birth during the period of one month it was expected that data would have been obtained from more than 200 women. As occurred when previous surveys were undertaken, the sample excluded women under 18 and those with very serious outcomes (e.g. maternal death, neonatal death, stillbirth). In my role as clinical governance midwife when the study was planned it was possible for me to identify these women.

As discussed in the case study in chapter 2 of this thesis, since 2007 there has been an ongoing national maternity survey. A re-run of this was planned for the women who were due to give birth in February 2013. These women received a postal questionnaire in June 2013. It would therefore not have been appropriate to expect the same women to complete an additional survey. For this reason the sample to receive the questionnaire in this study included all women who gave birth at Buckinghamshire NHS Trust during a different month (June 2013).

As mentioned above the total number of women expected to respond to the survey was planned for broadly. However, the need for a more formal power calculation was not considered necessary at the time of planning the survey as this was not an experimental or a before and after comparison study. This study was more exploratory in nature and was observational rather than intended to test a hypothesis. Therefore, the aim was to include a sample that would provide a good quality description, including a cross-section of women. Based

on the numbers of women giving birth in this service and the proportion who had responded to the National Maternity Survey locally, it was anticipated that inviting all women who had given birth within a particular month would provide an adequate sample.

*ii) Data collection (survey)*

The postal survey was administered in October and November 2013. The covering letter was signed by the audit department.

To be in line with the National Maternity Survey, women were sent the Birth Reflections survey around four months after giving birth. For the majority who completed the survey soon after receiving it this would have been between four and five months postnatally. Among those respondents who completed the survey in response to the reminder letter there might have been a slightly longer gap between birth and completing the questionnaire. Having a gap between giving birth and filling in the survey allowed women time to digest the events in their minds before providing information.

*iii) Survey instrument*

The questionnaire is at Appendix F. This was piloted during a focus group discussed above in section 4.4.3, iii). The questionnaire was developed by myself, based on information obtained in the recent literature review. In this way, the questions follow directly from the operation statement of the issues to be investigated and hence linked to the conceptual framework, as recommended by Oppenheim (1992). In addition, some questions were taken from other pre-existing instruments previously used in other studies, adding to validity (Beake et al 2001, Fitzgerald et al 2002). It was also essential to ensure accuracy of measurement of the concepts (Bryman 1988). Bryman considered concepts used by quantitative researchers are derived from prior literature reviews rather than theories.

Among the questions, women were asked about their feelings following birth and whether they understood what had happened to them during their birth experience. They were also asked whether they felt the need to have a discussion with a health professional after they went home.

*iv) Impact of events scale (IES)*

The women in the survey were also asked to complete the Impact of Events (IES) scale and answer each of the 15 questions regarding the psychological constructs avoidance and intrusion.

The Impact of Events scale (Horowitz et al 1979) was included within the questionnaire and the respondent was informed that this is in relation to her childbirth experience. It was intended that this would measure the emotional state of the respondents at the time they completed the survey i.e. 4-5 months following birth. This instrument is well established and has been in use for over 30 years. The Impact of event scale (IES) is used to assess subjective distress for a life event and the testing is described in Horowitz et al (1979). The instrument was originally given to 66 adults who sought psychotherapy in the United States (US) as a result of serious life events including bereavement, violence, accidents or surgery. There were two types of measure: one based on the frequency of unhappy memories and the other based on intensity.

The possibility of women developing PTSD as a result of childbirth is increasingly being recognised by professionals in maternity services (Ayers et al 2008, Czarnocka and Slade 2000). In order to measure this phenomenon there is a need to use carefully chosen questionnaires with established validity and reliability to reduce measurement error as much as possible. In the childbirth context, there is the additional need to use valid and comparable questionnaire measures that are appropriate for women in pregnancy and postpartum (Ayers 2001). Considering this, in this study the Impact of Event (IES) was chosen to measure the distinct construct post-traumatic stress symptoms. The event in

question was childbirth. The IES is the most widely used measure of PTS symptoms available and as such offers a well-standardized and highly comparable measure of PTS symptoms (Ayers 2001). Although not formally validated for use in this area, it has been used in both gynaecological and obstetric samples. Being more widely used and among obstetric samples gives it greater validity for use in childbirth populations. Another measure of PTSD is the Reaction Index. However, there is less evidence to support the use of this amongst maternity populations. In addition, data regarding internal consistency and validity of the Reaction Index is scarce (Ayers 2001).

As discussed above in the section on data collection, the survey was sent to women between four and five months following birth. Whilst PTS symptoms usually develop during the first month after a traumatic event there can be a delay of months or even years before symptoms start to appear. The IES has been administered at different time points from one week to 24 weeks amongst childbirth populations (Ayers 2001). Although symptom levels reduce over time, it was anticipated that administering the IES within the survey at this time point would capture evidence of PTS symptoms in this sample of women. Using the IES in this way, for research purposes within this exploratory study, was considered an acceptable way of retrieving this information. The findings were not intended to be used in clinical treatment but to compare groups of women with other variables.

However when selecting the questionnaire measurement it was also important to be aware of the possibility of other psychological co-morbidities and markers of psycho-pathology in pregnancy and/or postpartum such as postnatal depression (PND) and anxiety. These conditions might have a possible influence on the questionnaire responses of the individual women. In a larger study in order to control for these other conditions instruments such as the Spielberger State-Trait Anxiety Inventory (STAI), the Hospital Anxiety and Depression Scale (HADS) and the General Health Questionnaire (GHQ) could be useful (Ayers 2001). These have all been used in the different randomised controlled trials that have been

undertaken on postnatal debriefing and described in the most recent Cochrane review (Bastos et al 2015). However this was not considered necessary in the current exploratory study. This is due to the fact that this study did not set out to test an intervention. This work intended to obtain a good picture of women's feelings following birth and their perceptions around the need for, or value of a postnatal debriefing service.

*v) Data analysis for the survey*

As previously mentioned the questionnaire used in the survey is at Appendix F. The data from the questionnaires was managed and analysed using the Statistical Package for the Social Sciences (SPSS).

Most statistical tests rely on random samples. However, as many authors have recognised (Parahoo 1997, Polit et al 2000) it is impossible in most practical circumstances to do this. To get a pure random sample each person has to have an equal chance of being included in the sample and therefore the researcher has to have a complete list of the population to ensure this happens (Parahoo 1977). Most studies therefore use "samples of convenience" and in this case a complete month's worth of data is used, so that in effect all women giving birth in the selected time period had an equal chance of participating. The study therefore makes the assumption that women who give birth in the particular month are representative of women using the service as a whole.

The questions in the survey are a mixture of:

- Likert scales. These rank data ordinally (e.g. "excellent", "very good", "good", "fair", and "poor") but the spacing between adjacent values is not assumed to be equal. Questions 3, 4, 5, and 6 are examples of such scales.

- Categorical or “yes” /”no” where there is not a numerical relationship between them (e.g. what type of birth did you have). Questions 1, 8,9,10,11,12-16.
- Categorical variable of whether the PTS score was low (<9) or high (9 or higher).
- A small number of cardinal variables (e.g. how long were you in labour) Questions 2 and 22 (second part).
- IES score was treated as cardinal.

An initial exploration of the dataset produced simple descriptive statistics. For the categorical and ordinal variables these were as frequency distributions and for the cardinal variables means and standard deviations were calculated.

Cross tabulations of data examined whether the responses were different for different groups. For example, are the questions about how people felt about their birth experience (Questions 3-7) related to the need to speak to a professional (Q9). A chi-square test was the obvious way to test for these differences in distributions where the variables were categorical, taking into account the need for any small sample corrections.

Alternatively for comparing the results of questions (3-7) against “yes”, “no” variables such as whether the woman has given birth before, a non-parametric test such as Mann Witney was useful as it utilises the fact that the scores for feelings about birth experience are ordinal, unlike the chi-squared test.

The inclusion of questions allowing an IES score to be computed provided an opportunity for further in-depth analysis. The study looked at whether higher IES scores could explain levels of satisfaction and how women felt about their labour and birth experiences. However, that could be influenced by demographic and obstetric variables as much as IES. The approach taken was along the lines as suggested by Field (2013), which was to:

- identify which demographic and obstetric variables are likely to be related to IES. This was done by performing a one way analysis of variance on the mean scores for each demographic and obstetric variable and discarding those where the variation was not significant.
- transform each categorical variable into a series of dichotomous dummy variables with one level as the control. For example for type of birth, “normal birth” was the control set at zero for all dummy variables
  - Instrumental: 1 when birth was instrumental, 0 for all other types of birth.
  - Elective Caesarean Section: 1 when birth was elective caesarean, 0 for all other types of birth.
  - Emergency Caesarean Section: 1 when birth was emergency caesarean, 0 for all other types of birth.
- run a regression for each of the dependent variables (e.g. satisfaction with care) in blocks with the first block consisting of the demographic/obstetric variables and the second block the total IES score.
- as adding extra independent variables to a multiple regression will always increase the  $R^2$  statistic an F test was conducted to see whether the additional variable of IES increased the  $R^2$  statistic between the two blocks significantly.

However, not all the analysis of IES was in terms of regression and analysis of variance. Instead some of the analyses are presented in terms of high/low PTS scores rather than measuring the mean IES. Horowitz (1982) specified bands of symptoms as follows: 0-8 low; 9-19 moderate; 20+ severe but for simplicity, analyses in this thesis combined the moderate and severe categories to give a dichotomous classification of low (0-8) and high (9 and above). The arguments for and against this are finely balanced. Mean IES scores will have more power and it could be argued that splitting the scores into high/low based on a threshold is arbitrary. However, using dichotomous variables does allow a clearer and more accessible presentation of the results and this has been used on occasions for this reason.

There were also a number of freetext questions. Comments from these were grouped together in themes where possible.

#### **4.4.5 Phase Two: Qualitative**

##### *i) Interview participants*

The participants in the qualitative part of the study consisted of two groups of women who had given birth within this service. One group had attended the Birth Reflections service while the other group included women who had not attended a session. This ensured appropriate representation for the qualitative interviews of both women who had experienced a postnatal debriefing session and women who had not attended. It was anticipated that some of the women who had not attended would have made a deliberate decision not to do so.

The original planned sample was to recruit ten women who had attended the Birth Reflections service and 10 women who had not attended from among the survey respondents. Although twenty interviews were planned at the outset of this study a formal sample size calculation was not considered necessary. Numbers are slightly meaningless in qualitative research. For example, sample sizes may be too small to support claims of having achieved either informational redundancy or theoretical saturation, or too large to permit the deep, case-oriented analysis that the qualitative research approach focuses on (Sandelowski 1995). It was therefore planned in this study that a final decision regarding the total number of interviews to be achieved would not occur until during the conduct of the interviews. The rationale for this was based on theoretical sampling and data saturation and resulted in an eventual sample of 16 women, four of whom had attended the Birth Reflections service.

The sample was drawn in two ways: first through women completing the questionnaire and second through the records of the Birth Reflections service.

A question was included at the end of the survey questionnaire asking women whether they would be willing to attend for an interview, and if so, to provide their contact details to the researcher on a return slip or by telephone. However, as only one respondent had attended the service this group was recruited through the local Birth Reflections service database file.

Women who had accessed the Birth Reflections service were contacted by the administrator of the service. One woman was selected by the administrator who had given birth in each of the four months between April and July 2013 and subsequently attended the Birth Reflections service. The administrator gave each woman a verbal outline of the study and asked whether she would be happy for the researcher, myself, to contact her directly. Four women were contacted in this way and all four agreed to take part in the study. I was then able to contact them by telephone and explain the study further. I subsequently arranged a mutually agreed time to meet for an interview. The administrator sent a study information sheet to each woman before the interview date. This gave them further information about the study ahead of the interview and the opportunity to cancel if they had wished to do so. None of the women cancelled after agreeing to participate.

Women who accepted the interview were offered the interview at their home or in the hospital if they preferred. Interviewing participants in their own homes usually means they are more likely to be relaxed (Hammersley and Atkinson 1995). All the women agreed for the interview to be held in their homes.

For the remainder of the sample (women who had not attended the service) a process of randomisation was undertaken for the selection of women who had agreed to an interview through means of the survey. The identity number in the survey of all women who agreed to participate in this way was entered onto an Excel spreadsheet. A random number between 0 and 1 was generated for each entry. The twelve women with the highest random number were identified in this way. These women were subsequently contacted by myself. I provided further

information and they all agreed to participate. A date and time for the meeting was subsequently agreed.

Prior to commencing the interviews all the women were given an information sheet about the study and given time to read this through. They were subsequently asked if they had any questions and the interviewer (myself) reminded them that they were participating in a voluntary capacity and were free to withdraw at any stage. Written consent was taken.

*ii) Data collection (interviews)*

The interviews were recorded and subsequently transcribed. An interview guide was used to ensure consistency of questions. This is at Appendix G. All information provided in the interviews was treated in the strictest confidence. The interviews focused on the informants' experience and views about the possible need and attending a birth reflections service. However, there was also discussion about the birth experience in general and the participants were invited to tell the story of their birth.

"Depth" interviews (Jones 1985) were used as the data collection tool. Fielding (1993) proposed the use of unstructured interviews when discovering new ground in order to extract the most valuable data. However, Jones (1985) argued that there has to be some element of structure within the interview. To obtain underlying attitudes the whole issue needs to be personalised and this was made possible through semi-structured interviews.

It was considered that the use of semi-structured interviews would provide greater flexibility: non-verbal behaviour would indicate non-comprehension and the semi-structured approach would therefore allow words to be changed to aid comprehension (Barriball and While 1994). This technique allowed the exploration of perceptions and opinions regarding personal and sensitive issues. A more standardised approach i.e. the use of data collection with a self-

completing questionnaire or a questionnaire completed by the author with the participant during an interview could have been adopted. However, it was felt that the use of in-depth interviews would produce a richer insight into how each individual woman thinks about her birth experience following birth. This was achieved by talking to her in such a way that she was able to tell her story in her terms. It also helped to gain an understanding of the woman's priorities and beliefs: thus emphasising the dynamic, holistic and human experience (Polit and Hungler 1991). It was anticipated that the reports of the participants might be unclear or ambiguous. Therefore the freedom allowed in semi-structured interviews to probe would also prove a useful tool and would ensure greater reliability.

The sensitive nature of the topic area dictated that the interviews would need to be conducted on a one to one basis and not in group discussions. It was anticipated that women would not want to open up in a group.

To secure validity interviewers need to have an understanding of the subject being investigated (Barriball and While 1994). They should also be friendly and relaxed, thus putting the participants at their ease. All participants were interviewed by the author, myself, who had gained a thorough knowledge base in the subject, having practised as a midwife and managed a Birth Reflections service as well as also having undertaken a literature review on postnatal debriefing.

Talking about the birth experience can raise sensitive issues so it was important to ensure that participants felt relaxed during the interviews. This was achieved by giving participants the opportunity to warm up at the start of the interview by discussing more general pregnancy issues (e.g. "How did you feel when you first found out you were pregnant?") It was also important that participants felt reassured that what they had to say was important, so this was constantly reinforced throughout the interviews. Oppenheim (1992) stated that the quality of the data obtained depends on the motivation of the participant. It was hoped

that participants in this study would be highly motivated and this was realised and clearly evident in their enthusiastic responses to questioning.

In order to elicit as much spontaneous information as possible from a participant, questioning was open ended. The art of the researcher remaining quiet during the interviews allowed for more spontaneity on the part of the participants. Sometimes it became necessary to clarify and expand upon what participants were saying. Therefore probes were used. These needed to be as neutral as possible and great care was taken to avoid putting words into the mouths of participants.

*iii) Data analysis: qualitative*

Analysis of the qualitative data was originally intended to be undertaken through the use of a framework approach. Framework is a more structured approach to qualitative analysis. However, although systematic and disciplined, it relies on the creative and conceptual ability of the researcher to determine meaning. Framework analysis stems from the “thematic framework” and is used to classify and organise data according to key themes, concepts and emerging categories (Ritchie et al 2003).

It was anticipated during the planning stages of this study that this would be a useful way of organising and analysing the data with the use of a series of matrixes. In this way it was anticipated that key themes would be identified from the data and listed on large charts. A “thematic chart” would be created for each of the key themes and evidence in relation to these displayed from the transcripts of each individual research participant. Framework analysis also allows for a prior coding framework to be used. To this end it was planned that concepts and themes identified in the literature review and the survey would be integrated into the process of analysis.

However this process did not work out as planned and basic thematic analysis was adopted instead. Data from the interviews were transcribed verbatim. The tapes and transcripts were listened to and read through by myself on many occasions. I created a thematic framework or index identifying initial themes and concepts according to the Framework approach described by Ritchie et al. I then applied a process of indexing to the raw data (transcripts). This is a process whereby the thematic framework or index is systematically applied to the data in its textual form. This index list consisted of key substantive headings and a higher number of subthemes. It was shared in a rudimentary format with the supervisory team. I explained the processes I had followed to organise the data in accordance with the Framework approach. However the supervisory team were confused. They did not consider that the subject headings that I had used to be themes. To them this was different from thematic organisation of the data and did not feel like the previous experience of one of the supervisors in relation of how Framework analysis should be undertaken. What we all agreed I had done was more like content analysis and a more quantifying experience. However, it was felt by the supervisory team the process I had adopted was useful in sorting the data into categories. The initial codes listed under the subject headings were grouped together to form categories. We were subsequently able to identify themes developing across the lists of different subject headings. We all felt it useful to be able to look across the different subject headings with lists of subcategories and see themes emerging. There was one such example of this. Expectations being met or not ran through many of the subject.

Familiarisation of the data was therefore enabled through the early stages in the Framework approach. Having the lists of key themes and subthemes supported the transition to the process of thematic analysis. Work continued with further immersion in the transcripts. Codes were subsequently generated from the items on the original index list and through the use of thematic analysis, phrases used by the participants were coded and grouped together in themes. These codes were entered directly on to the printed transcripts in the margins.

Codes with similar meanings were at a later stage grouped together into larger themes. Through the use of pattern coding (Miles and Huberman 1994) common themes were subsequently identified and patterns and relationships within the data were sought out (Miles and Huberman 1994). The process identified key issues that answered the research objectives.

*iv) Data analysis within the mixed methods design*

As described above the two datasets were analysed separately. The qualitative data were analysed independently and thoroughly. Similarities and differences between the quantitative and qualitative data results were then described and integrated in the discussion section of the thesis. For example statistical results from the quantitative findings were followed up by a quote from one of the participants in the qualitative findings or with information about a theme that confirms or disconfirms the quantitative result.

#### **4.4.6 Validity and reliability**

When considering the nursing context Graneheim and Lundman (2004) identify the need to ensure all research studies are evaluated in relation to the procedures used to generate the findings. In addition and according to Lincoln, Lynham and Guba (2011), at the start of a debate about how validity is conducted and the need for change in the application of validity, there is the need for rigour in the application of interpretation as well as method. Without high quality data any research study will be compromised. Data quality in MMR is determined by the separate standards of quantitative and qualitative approaches (Teddlie and Tashakkori 2009). According to Teddlie and Tashakkori (2009) if both quantitative and qualitative strands are valid and credible an MMR study will have high overall data quality.

Regardless of research approach there are two key questions that require answering when the data collection is being planned. The first is in relation to validity or credibility. This sets out to ensure that the researcher is really

capturing what is intended. The second pertains to reliability or dependability and asks whether measurement is consistent and accurate (i.e. yields little error).

Firstly there is the need to consider validity and reliability for the quantitative part of the study. Measurement validity in human research is assessed by comparing and contrasting the components of the obtained results (Teddlie and Tashakkori 2009)

Polit and Beck (2010) describe three key aspects of validity: content validity, criterion-related validity and construct validity. Content validity relates to the need to ensure optimal use of previous knowledge in the area when designing a research tool. Polit and Beck (2010) both acknowledge the need for human judgement about the extent and precision of what information is included as well as the importance of utilising expert agreement on the topic. Whilst a formal panel of experts has not been arranged for this study the Birth Reflections questionnaire incorporates some questions previously used in other surveys as well as the well-known "Impact of Events Scale". In addition other questions are raised from the findings of the literature review. It was anticipated that these would enhance the content validity of this work.

According to Polit and Beck (2010) criterion-related validity is where the scores received on an instrument are compared with an external criterion. A validity coefficient is computed using a mathematical formula that correlates scores on the instrument with scores on the criterion variable. This process is referred to as concurrent validity by Teddlie and Tashakkori (2009). It was anticipated that this process would be possible for the Impact of Events Scale.

The third aspect in relation to validity according to Polit and Beck (2010) is construct validity. According to these authors this questions whether the abstract concept of interest is captured. One way of testing this is to compare

groups whose reactions in particular circumstances are known to differ. This is also known as discriminant or divergent validity (Teddlie and Tashakkori 2009).

As well as ensuring the measurement process attains validity in the quantitative part of the study it is also paramount to secure reliability. This means that a measurement tool is accurate when the same results are achieved when it is used on different occasions (Teddlie and Tashakkori 2009). In addition error is cancelled out over time when extreme variation in responses occurs between different respondents. For example if one individual rates a phenomenon positively and another rates the same phenomenon negatively, this will lead to cancellation of any possible error.

Trustworthiness relates to the quality of qualitative research (Locke et al 2000). At the completion of this study it was essential to show that the findings are valid and to be clear about how this was achieved (Mason 2002). For the qualitative aspects this was achieved through the use of the framework for qualitative inquiry proposed by Lincoln and Guba (1985). These authors suggest four criteria for developing the trustworthiness of a qualitative study: credibility, dependability, confirmability and transferability.

According to Lincoln and Guba (1985) credibility relates to an overriding aim of qualitative research and this is about the truth of the data and interpretations of them. It was essential that this study was carried out in a way that ensured the findings are believable. Later steps were taken to highlight credibility to readers of the research. The inclusion of the focus group at the start of the study is one such attempt to ensure the data collected is valid. Inviting service users to review both the questionnaire and interview guide helped to ensure the questions were clear and understandable and related to the topic under consideration.

Dependability is linked to credibility. This relates to the reliability or stability of data over time and conditions. The overarching assumption is that if the same

study was repeated with the same participants, essentially the same data and findings will be achieved. There was therefore the need to ensure depth and clarity of the processes used throughout the study.

Confirmability relates to the need for congruence between two or more independent people about the accuracy, relevance or meaning of the data i.e. the data represents that information provided by participants and that the interpretation is agreed with others. This highlights the importance of ensuring the focus on the voice of the participant and the elimination of any bias from the researcher. To this end another researcher reviewed a selection of the transcripts and the coding process to ensure agreement and consistency of themes. Finally and as in all qualitative research studies there was also the need for me to provide a thorough examination of my personal role and potential influence in the research process. There is a discussion on reflexivity at section 4.7.8 in this chapter.

Transferability relates to the ability of the findings being transferred or having applicability in other settings. Lincoln and Guba (1985) recognised the need for the researcher to provide sufficient description in the research report to allow the reader to evaluate applicability in his/her setting. Again clarity in the report writing was essential to assist with this.

Bias in qualitative research can threaten trustworthiness. Such influences on the research process can affect the overall interpretation and the meanings identified. Therefore, it is important to take steps to guard against possible routes of bias. This can result from a number of factors, ranging from the researchers themselves and the study participants to the data collection methods used (Polit and Beck 2010). Issues in relation to myself, the researcher and the study participants are discussed later in this chapter in the section on reflexivity but a key consideration was that although I worked in the service concerned, I was not involved in providing the Birth Reflections service and would not have provided direct care to the women included in the survey or

interviews. Regarding methods of data collection, I have emphasised the rigorous data collection above in the section on research tools. The choice was made for semi-structured interviews. These allowed for the women to tell their birth stories whilst at the same time ensure questions in the interview guide were completed. This ensured that optimal data was gained to answer the research objectives.

#### **4.4.7 Ethical considerations**

The Data Protection Act 1998 stipulates that data is only used for the purpose it is given by the owner i.e. when patients attend an NHS health care provider the reason is for treatment and not to participate in research. As it was not possible for me to access the women directly, I organised for the survey to be sent out by the team in the Trust's audit department as a service evaluation measure. An information sheet was sent with the questionnaire to all survey recipients. Consent was considered implicit through its completion. The basic ethical principle governing research states that above all no harm should come to the participant (Oppenheim 1992). The need for informed consent is emphasised (DoH 2001, Association for Improvements in the Maternity Services/The National Childbirth Trust 1997). Each participant was made fully aware of the research process and it was explained to her that she was able to withdraw at any time. She was also informed that the interviews would be recorded with a tape-recorder and that the tapes would be anonymised and kept securely. Confidentiality was also promised and informed consent obtained.

Unfortunately, it was not always possible to know when approaching a research participant in this study whether her baby had died at a subsequent stage following discharge from hospital. This is an extremely rare event and in my experience of running the Birth Reflections service and in my practice as a midwife in general many women following the loss of a baby appreciate any contact that would be usual for all other mothers. When approaching

participants and discussing possible recruitment with all women there was an ongoing need to be sensitive to any event that might have taken place within the family. Although very unlikely, if such a situation had become evident condolences would have been offered and a sincere apology offered for disturbing the family at this time.

The women included in the focus group to pilot the survey were initially contacted via the Chair of the Maternity Services Liaison Committee (MSLC) who circulated information sheets to the women. As the chief investigator I contacted the MSLC chair and she organised the date and venue for the meeting. Consent was not taken as this group of women only served to review and pilot the questionnaire and interview guide.

In terms of confidentiality there was minimal threat to the well-being of the women involved in this study. Only myself, the clinical governance coordinator and the auditor from the audit department were aware of the identity of the women included.

A separate identity number was given to each questionnaire returned. Data from each form were entered into the SPSS database. The completed questionnaires remained anonymous unless the respondents volunteered to participate in the qualitative interviews or wished to receive a copy of the final research report. If a woman chose to participate in the qualitative part of the study or wished to receive a copy of the report they wrote their name and address on the form. This was used for two purposes only: recruitment to the qualitative part of the study and/or to send the research report following the completion of the study

The interviews with the women were recorded and were transcribed by an independent person. A separate number was given to each participant. The transcriptions were marked with the same number. There was one written index of the names with the allocated numbers and this was also stored in a

locked cupboard at the hospital trust whilst the study was conducted. The transcripts were kept to hand until the final report was completed. Following the completion of the study the transcripts will be stored for ten years at City University. However all personal information will be destroyed as soon as the study is completed.

Empathy is a key characteristic of the process of qualitative research and demanded of the researcher (Bryman 1988). It is also essential that this is neutral (Locke et al 2000). It was anticipated that the combination of both empathy and neutrality would reassure and relax the research participants in this study and allow them to provide optimal information during the interviews. As a midwife I am very experienced in providing empathetic care to women. As well as ensuring quality data this would also help to keep the participants free from harm in the form of research exploitation. I hope my empathetic and neutral stance enhanced individual rapport between myself and the 16 female participants who generously agreed and became participants.

It was possible that profound concerns might have been unearthed during the interviews. For this reason, a support system was prepared in advance. In the event of a participant becoming distressed the interview would have been stopped and the Birth Reflections midwife was available to provide support/counselling. In the rare situation where a participant experienced severe distress the Birth Reflections midwife was available to ensure that the woman was referred to a medical practitioner. Neither situation arose during the interviews.

It is recognised that some participants in the qualitative interviews would not have experienced a postnatal debriefing meeting with a midwife. When learning about this service for the first time they might have requested to access it. This did occur on a few occasions when I explained the process for referral to the service and gave the woman the telephone number for the Birth Reflections service.

A National Research Ethics Committee application was made and permission obtained to proceed with the study in August 2013.

#### **4.4.8 Conclusion**

This section has described the process for this research study. It has also explained the rationale for the use of a MMR approach in this study on postnatal debriefing. The quantitative survey provided broad data from a larger sample of convenience of women about how they are feeling following their birth experiences and whether they feel the need for further discussion about their labour and birth with a health professional. The findings of the survey influenced the generation of the interview guide used during the second phase of the study. In-depth qualitative interviews were held with different groups of women: those who accessed the Birth Reflections service and those who had not. This provided richer data. To this end it was anticipated at the outset of this study that MMR would facilitate a greater understanding of the phenomena of interest compared to what would be achieved from either a quantitative or qualitative approach alone.

## 4.5 Survey Findings

### 4.5.1 Introduction

As previously described in the methods section of this chapter, following the piloting of the questionnaire on a small group of women who also gave birth at the study hospital during an earlier time point, a postal survey was sent to a sample of women who had given birth at the study hospital in June 2013. This sampling approach was modelled on the National Maternity surveys as discussed in chapter 2 of this thesis. Four hundred and forty seven questionnaires were posted in October 2013. A reminder letter with a second copy of the survey was posted to those women who had not yet returned the survey, completed or to decline participation. Some uncompleted questionnaires were returned unopened indicating some women were no longer residing at the address to which the first questionnaire was sent. These women were not sent a repeat questionnaire.

In total 170 completed questionnaires were returned and answered (38%). This is a much lower response rate than to the survey sent to women used in the case study (see chapter 2 in this thesis) where there was a 68% response rate. However this was administered over ten years ago in 2003. It is possible people nowadays are less likely to respond to surveys. Indeed this appears to be part of a wider trend as observed by Redshaw and Henderson in their report of their national survey (Redshaw and Henderson 2015). It is of interest that in 2012 the National Maternity survey was sent to all women who gave birth in February at the same study hospital so it did not overlap with the current study. This achieved a response rate of 53%. Since then the national response rate to the most recent maternity survey by the Care Quality Commission was 46% (Care Quality Commission 2013).

Sending the survey to these women at this point in time meant that they responded to the questionnaire between four and five months (16-20 weeks) following birth. This reflects the same time periods when women complete the regular nationally administered maternity survey by the Care Quality Commission and its predecessor, the Health Care Commission before that.

The findings are presented in three main sections: demographic characteristics, women's experiences of labour and birth and evaluation of the Birth Reflections service.

#### **4.5.2 Demographics**

Table 4.1 overleaf shows the sample predominantly was comprised of white, highly educated women. On other demographic and obstetric characteristics the sample was representative of the UK population of childbearing women. The characteristics of the sample are similar to other surveys undertaken with women who give birth at this hospital. This is situated outside London in the home counties of England where the highest proportion of women are from a White British ethnic background. The second largest group is that of White Other followed by Pakistani who account for 4.7% of the respondents to the survey.

More women in this sample were first time mothers (51%) compared with the most recent national findings in England in 2013 - 2014. Where parity was known 37% of women who gave birth in England were primigravid (Health and Social Care Information Centre 2015). There appears to be a slightly higher number of respondents with operative or instrumental birth compared to UK statistics. Forty four per cent of women had an operative or instrumental birth in this sample. This is higher than the norm for the UK, which is 39% (Health and Social Care Information Centre 2015).

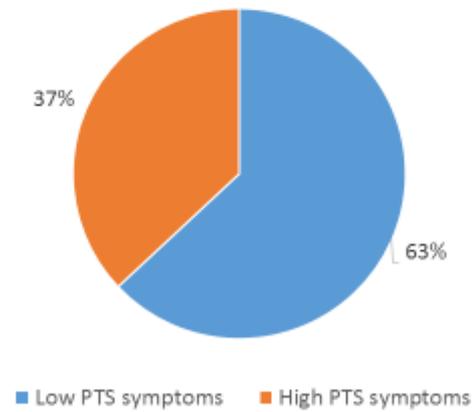
**Table 4.1 Demographic and obstetric characteristics of the sample**

Characteristics		N (%)
Ethnicity	White British	136 (80)
	White other	13 (7.6)
	White and Black African	1 (0.6)
	White and Black Caribbean	3 (1.8)
	White and Asian	2 (1.2)
	Indian	2 (1.2)
	Pakistani	8 (4.7)
	Other Asian background	3 (1.8)
	Other ethnic group	1 (0.6)
Age	20 – 24 years	14 (8.2)
	25 – 29 years	29 (17.1)
	30 – 34 years	71 (41.8)
	35 – 39 years	45 (26.5)
	40 years or over	11 (6.5)
Education level	GCSE	18 (11.5)
	A level or diploma	28 (17.9)
	Degree	80 (51.3)
	Postgraduate degree	17 (10.9)
	Professional including NVQ	13 (8.3)
Parity	Primiparous	86 (50.6)
	Multiparous	84 (49.4)
Type of birth	Normal vaginal	95 (55.9)
	Ventouse	8 (4.7)
	Forceps	28 (16.5)
	Elective caesarean section (CS)	13 (7.6)
	Emergency CS	26 (15.3)

### **4.5.3 Post-traumatic stress following birth**

As part of the analysis the sample of women was split to illustrate how women rated their birth experience according to whether they exhibited high/low PTS symptoms. Figure 4.2 below shows the participants according to whether they had high or low PTS symptoms after birth. It is of interest that 37% of women in this sample had high PTS symptoms. Impact of event (IES) scores that were 9 and above were used to denote high PTS symptoms.

## High versus low PTS symptoms (%)



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Figure 4.2 PTS symptoms

Figure 4.3 below shows type of birth cross tabulated by PTS score. There was a difference in PTS symptom scores according to type of birth with women who had normal vaginal births or planned caesareans being more likely to have low PTS scores.

## Type of birth X High versus Low PTS symptoms (n= 157)

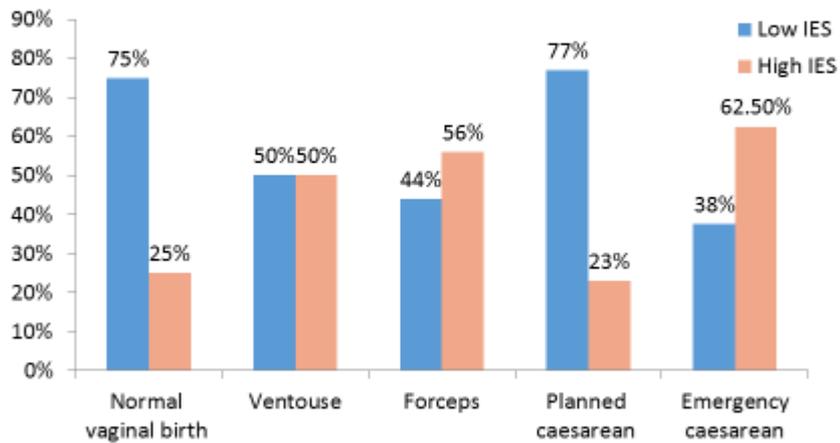


Figure 4.3 Type of birth vs PTS symptoms

*Is there a relationship between the IES scores and demographic and obstetric characteristics?*

Firstly, the mean total IES score was compared for some of the demographic variables in Table 4.1 above and obstetric characteristics or interventions. The results are shown in Table 4.2, which indicates that age and type of birth are related to IES scores.

As older women tend to have more interventions it is possible that these may not be independent, with level of interventions emerging as a key factor. This was considered in the next stage of the analysis (below).

<b>Table 4.2 Mean IES scores compared across demographic variables</b>					
	Mean IES	N	Degrees of freedom	F	Significance (p)
<b>Age</b>			(4,151)	2.7	0.035 *
20 - 24 years	20.8	13			
25 - 29 years	9.3	27			
30 - 34 years	9.8	64			
35 - 39 years	7.1	43			
40 years or over	11.0	9			
Total	9.9	156			
<b>Education</b>			(4,141)	0.56	0.691
GCSE	7.1	18			
A level or diploma	11.0	28			
Degree	10.6	74			
Post graduate degree	10.1	14			
Professional including NVQs	5.8	12			
Total	9.8	146			
<b>Parity</b>			(1,154)	2.917	0.09
Previous babies	8.1	79			
No babies	11.8	77			
Total	9.9	156			
<b>Ethnicity +</b>			(1,154)	1.268	.262
British	9.3	124			
Other	12.4	32			
Total	9.9	156			
<b>Type of Birth +</b>			(3,152)	10.2	0.000 **
Normal vaginal birth	5.9	85			
Instrumental birth	13.7	34			
Elective caesarean	6.3	13			
Emergency caesarean	20.9	24			
Total	9.9	156			

+ some of the categories were combined because of small numbers

\* Significant at 95% level \*\* significant at 99% level

This table shows that age and type of birth are related to IES scores.

#### **4.5.4 Women's experiences of labour and birth**

Table 4.3 below summarises the main findings for the experiences of labour and birth of the women in the sample. The results show that women with high PTS symptoms rate all aspects of the birth experience as worse (e.g. satisfaction with care, feelings about the birth experience).

**Table 4.3 Women's experiences of labour and birth**

	Total†	Low PTS group	High PTS group	Mann Whitney U (P)
<b>Satisfaction with care</b>	(N = 157)	(N = 99)	(N = 58)	0.016*
Excellent	68 (43%)	49 (50%)	19 (33%)	
Very good	60 (38%)	36 (36%)	24 (41%)	
Good	16 (10%)	10 (10%)	6 (10%)	
Fair	9 (6%)	3 (3%)	6 (10%)	
Poor	4 (3%)	1 (1%)	3 (5%)	
<b>Feelings about the birth experience</b>	(156)	(98)	(58)	0.000**
Very disappointed	10 (6%)	2 (2%)	8 (14%)	
Disappointed	21 (14%)	6 (6%)	15 (26%)	
Neither / nor	24 (15%)	13 (13%)	11 (19%)	
Pleased	56 (36%)	41 (42%)	15 (26%)	
Very pleased	45 (29%)	36 (37%)	9 (16%)	
<b>How well they feel they managed labour</b>	(157)	(99)	(58)	0.074
Very well	64 (41%)	44 (44%)	20 (35%)	
Quite well	53 (34%)	33 (33%)	20 (35%)	
Alright	31 (20%)	22 (22%)	9 (16%)	
Not very well	6 (4%)	0 (0%)	6 (10%)	
Not at all well	3 (2%)	0 (0%)	3 (5%)	
<b>Expectations of labour met</b>	(146)	(90)	(56)	0.017*
Much better	26 (18%)	17 (19%)	9 (16%)	
Better	30 (21%)	22 (24%)	8 (14%)	
About the same	46 (32%)	32 (36%)	14 (25%)	
Worse	31 (21%)	14 (16%)	17 (30%)	
Much worse	13 (9%)	5 (6%)	8 (14%)	
<b>Expectations of birth met</b>	(154)	(97)	(57)	0.000**
Much better	41 (27%)	31 (32%)	10 (18%)	
Better	33 (21%)	25 (26%)	8 (14%)	
About the same	38 (25%)	26 (27%)	12 (21%)	
Worse	24 (16%)	10 (10%)	14 (25%)	
Much worse	18 (12%)	5 (5%)	13 (23%)	
<b>Overall labour and birth</b>				0.01**
Awful	18 (12%)	6 (6%)	12 (21%)	(chi-square. Excludes 'other')
OK in the end	52 (34%)	29 (30%)	23 (40%)	
Hard work but wonderful	72 (47%)	51 (53%)	21 (37%)	
Other	11 (7%)	10 (10%)	1 (0.7%)	

\* significant at 95% level \*\* significant at 99% level (p<0.01)

† Total for those women who had a PTS score

Percentages may not add to 100% because of rounding

*Is there confounding between the IES scores and demographic and obstetric characteristics?*

As age and type of birth were significant they were taken forward to the next stage of the analysis. Each measure of the women's experience of birth was regressed against:

- Block 1. The Demographic variables Age, and a dummy variable for Normal vaginal vs Instrumental, Normal vaginal vs elective caesarean, normal vs emergency caesarean.
- Block 2 IES score.

Table 4.4 overleaf gives the results.

**Table 4.4: Regression of women's experiences against IES scores and demographic/obstetric characteristics**

	Dependent variable					
	Satisfaction with birth	Birth experience	How well they managed labour	Labour as expected	Birth as expected	Overall experience
<b>Block 1</b>						
Age	-.015	-.054	-.102	-.012	.076	.042
Type of birth: normal vs instrumental	.183*	-.382**	.235**	.225**	.31**	-.362**
Type of birth: normal vs elective cs	-.025	.033	-.038	-.039	-.023	-.024
Type of birth: normal vs emergency cs	.136	-.381**	.292**	.260**	.426**	-.247**
<b>Block 2</b>						
Age	.007	-.084	-.096	-.002	.10	.018
Type of birth: normal vs instrumental	.14	-.324**	.225**	.205*	.277**	-.314**
Type of birth: normal vs elective cs	.027	.039	.038	-.042	-.025	-.018
Type of birth: normal vs emergency cs	.062	-.28**	.275**	.223*	.357**	-.165*
IES score	.195*	-.266**	.047	.091	.18*	-.216**
R square	.076	.286	.141	.103	.244	.193
Δ R square	.031*	.058**	.002	.007	.027*	.039**
F	2.5*	11.9**	4.9**	3.2**	9.5**	6.98**

\* Significant at 95% level \*\* significant at 99% level

Table 4.4 shows that the further addition of IES was significant in satisfaction, expectations of birth being met and overall labour and birth experience, but not in expectations of labour met.

#### **4.5.5 Women's expectations of labour and birth**

The mean time for all women in labour was just under 13 hours. This was much longer among women giving birth for the first time for whom the mean length of time in labour was just under 17 hours. Over 90% of women were satisfied with the care they were provided during labour and birth. However 16/170 (10%) women reported their care at this time as being fair (11) and poor (5). The questionnaires of these 16 women have been further interrogated to identify further meaning about possible reasons why they rate this aspect of their experience less favourably. See Section 4.5.6 for additional analysis on these data. Table 4.3 above compares the women's ratings of their satisfaction with care with their individual IES scores. It is clear that women who rate satisfaction as fair or poor have a high IES score.

Women respondents to the survey were asked how they felt about their overall experience of labour and birth. These findings reflect the findings above when asked about overall satisfaction with care. More respondents (64%) were pleased or very pleased in this regard. However 15% reported being neither disappointed nor pleased and 21% said they were either disappointed or very disappointed about their birth experience. Figure 4.4 below compares the women's ratings of how they felt about their birth experience with their individual IES scores. It is clear that women who were disappointed or very disappointed had a high IES score.

## How feel about birth and High versus Low PTS symptoms

(n= 156)

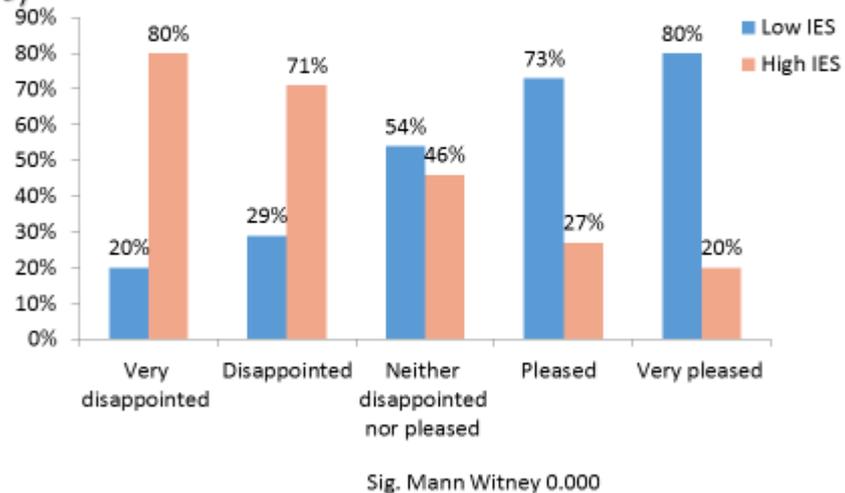


Figure 4.4 How feel about birth by PTS symptoms

The large majority (93%) of respondents felt they managed labour alright, quite well or very well. A very small number, twelve (7%), felt that they had not managed very well or at all well. In the questionnaire the women were also invited to describe their experiences of labour and birth separately. Thirty one per cent and 28% respectively considered these periods as being either worse or much worse than expected. However 39% and 49% of women respectively said that labour and birth were either better or much better than expected. It seems that overall approximately one third of women have a worse experience of labour and birth than expected. The women respondents were asked a question about their view of their overall labour and birth experience. Whilst 13% reported labour and birth as being awful 33% felt it was OK in the end and a further 47% said it was hard work but wonderful. It appears that the large majority of women considered labour and birth to be challenging but positive ratings are given. However a small proportion described it as being awful.

There was a statistically significant difference between whether or not women's expectations of labour and birth were met when cross tabulated with key

variables relating to women's overall view of their birth experiences (see Table 4.5 below). Chi-square tests were undertaken to determine these findings, which are shown on the table below. There appears to be an association between expectations of labour and birth not being met and a more negative rating of the overall birth experience.

**Table 4.5 Cross tabulation whether expectations of labour were met with other variables**

	<b>Total†</b>	<b>Much better than expected</b>	<b>Better than expected</b>	<b>About the same</b>	<b>Worse than expected</b>	<b>Much worse than expected</b>	<b>Chi-square (P)††</b>
<b>Satisfaction with care</b>	(N=158)						0.001**
Excellent	69 (44)	21 (70)	15 (47)	19 (40)	12 (35)	2 (13)	
Very good	55 (35)	6 (20)	13 (41)	19 (40)	13 (38)	4 (27)	
Good	19 (12)	1 (3)	4 (13)	7 (15)	3 (9)	4 (27)	
Fair	10 (6)	2 (7)	0	2 (4)	4 (12)	2 (13)	
Poor	5 (3)	0	0	0	2 (6)	3 (20)	
<b>Feelings about the birth experience</b>	(N=158)						0.000**
Very disappointed	12 (8)	2 (7)	0	1 (2)	3 (9)	6 (40)	
Disappointed	22 (14)	0	1 (3)	7 (15)	9 (26)	5 (33)	
Neither / nor	25 (16)	0	8 (25)	9 (19)	8 (24)	0	
Pleased	55 (35)	9 (30)	11 (34)	23 (49)	9 (26)	3 (20)	
Very pleased	44 (28)	19 (63)	12 (38)	7 (15)	5 (15)	1 (7)	
<b>How well they feel they managed labour</b>	(N=158)						0.000**
Very well	63 (40)	20 (67)	17 (53)	16 (34)	7 (21)	3 (20)	
Quite well	53 (34)	9 (30)	7 (22)	20 (43)	12 (35)	5 (33)	
Alright	30 (19)	0	8 (25)	9 (19)	11 (32)	2 (13)	
Not very well	9 (6)	1 (3)	0	1 (2)	4 (12)	3 (20)	
Not at all well	3 (2)	0	0	1 (2)	0	2 (13)	
<b>Overall labour and birth</b>	(N=157)						0.000**
Awful	21 (13)	1 (3)	1 (3)	4 (9)	6 (18)	9 (60)	
OK in the end	51 (32)	5 (17)	9 (28)	20 (43)	14 (41)	3 (20)	
Hard work but wonderful	74 (47)	20 (69)	19 (59)	20 (43)	13 (38)	2 (13)	
Other	11 (7)	3 (10)	3 (9)	3 (6)	1 (3)	1 (7)	

† Total for those women who had an IES score

†† In calculating this statistic categories were combined to minimise cells where expected level was less than 5

#### 4.5.6 Freetext comments

Two separate freetext comments were analysed. One based on how women felt about their birth experience and the other in relation to their overall experience of labour and birth.

##### i) How women felt about their birth experience

From the 170 women who completed the questionnaire 95 (56%) made additional comment when invited to do so in response to the question asking how they felt following their labour and birth experience. When reviewing these comments three key themes were clearly identifiable: it was not the birth I planned (n=29), good support from midwives (n=41), poor support from midwives (n=25).

##### Not the birth I planned.

Women wrote that birth was “not the birth I planned”, which included being transferred from the freestanding birth centre during labour to general disappointment about having an assisted birth (e.g. the need for a forceps delivery despite being adamant that this was the least wanted outcome by the woman), a woman having her labour induced when she had planned a homebirth, postpartum haemorrhage and the need to rush to theatre and undiagnosed breech identified in advanced labour when hoping for a vaginal birth.

Often this change in plan for the birth was perceived negatively by the women. However some women seemed pleased with the final outcome despite the change to the original plan.

For example, the below quote illustrates the helpful effect of supportive care following a change to the plan for birth:

*“This was my second, birth and (like the last time) I had to be induced. Last time went badly, but this time the staff listened to my concerns and monitored me properly and the birth was much better. Also, my midwife was simply fantastic. I used Birth Reflections last time because things went so badly, this time I filled in the form so I could praise/thank my midwife.”* (Respondent 41).

As mentioned above the other two key categories from the women’s comments in this area relate to the provision or lack of supportive care.

#### Good support from midwives

Just under half of all women who made a comment praised the supportive care they received, primarily from midwives. Examples of good support included having things explained, staff listening to concerns, feeling well looked after, staff making the experience fun, staff helping me feel calm, staff talking with me and helping to raise my spirits and staff being reassuring.

#### Poor support from midwives

There were far fewer comments about the experiences of women where there was a lack of support. Examples of poor support included not being given pain relief, feeling unsupported by midwives (they thought I was making a fuss), being sent home during labour inappropriately by midwives, not feeling that they were being listened to, being left alone in labour, midwife being preoccupied with other matters, not being provided with information, not being given help when pushing, not kept informed of problems in labour and poor communication between staff. It is also important to note that some women mentioned that for them postnatal care was poor.

Also emerging from the comments from some respondents comes a sense that some women may leave their birth experiences with a firm/fixed understanding about what took place. However there is a possibility that these women’s views are at variance with the health professional’s opinion and in some cases with

the facts There may be concerns following birth about the events that would be resolved by a clear explanation of the clinical reasons. For example one woman was transferred from the freestanding birth centre due to apparent failure to progress in labour. This woman blamed the midwives for this occurrence due to their lack of care in labour. Another woman felt that she had an assisted delivery due to the timing of the pain relief she was provided in labour. These differing beliefs may aggravate the women's sense of disappointment in their birth experiences.

*ii) Overall labour and birth*

In the questionnaire women were also invited to comment further about their overall labour and birth. Sixty-six respondents (46%) gave comments.

Nine broad issues were raised by the respondents. These were: labour being perceived as traumatic, the pain of labour, supportive care, consideration of another birth experience, feeling lucky to have had an easy birth experience, baby's arrival, interventions (e.g. forceps, induction of labour, Syntocinon), poor memory and anxiety. A brief summary of these comments will be mentioned below.

Whilst three women used the word traumatic to describe their labour and birth experience, others used terms such as terrifying, awful and "my worst nightmare". This contrasts with other women who felt lucky to have had what to them seemed a relatively easy birth experience. Many described the labour as being more difficult than they anticipated. The pain of labour was mentioned by seven respondents and an eighth mentioned lasting back pain following birth which she linked to having had an epidural for labour pain. For some the pain of labour was worse than expected and the consequent need for pain relief was paramount. Following on from the section above in relation to support some respondents mentioned their experience of good support provided by staff

whilst others cited poor support. Some women mentioned having a poor memory of what happened during their labour and birth.

There is the need to understand why some women leave their birth experience with unfavourable ratings of the care they received. The questionnaires completed by the women who said their satisfaction with the care they received was either fair or poor were reviewed further. It is of interest that 11 out of these 16 women had a high IES. In addition nine of these women reported elements of poor care in the free text comments box attached to this question (e.g. feeling unsupported by the midwife, lack of pain relief, not feeling listened to by the midwife when reporting signs of being in labour and subsequently coming close to giving birth before arrival at the hospital in the car). Finally three of these women were unhappy about how their labour had been managed by the staff. In the opinion of these women this management had been inappropriate. An example of this is the situation where a woman considered she should have been offered an ultrasound scan to determine the position of her unborn baby who later showed signs of being distressed during her labour.

#### **4.5.7 Evaluation of the Birth Reflections service**

Table 4.6 overleaf shows the findings relating to the views of the Birth Reflections (BR) service according to the women in the sample. However it is important to clarify that these are hypothetical in relation to the service as only one woman used it. This would also apply to any views on issues that could be related to the local Birth Reflections service that was the focus of this study.

**Table 4.6 Women's evaluation of matters relating to the Birth Reflections service**

	<b>Total†</b>	<b>Low PTS group</b>	<b>High PTS group</b>	<b>Chi-square (P)</b>
<b>Think about labour at home</b>	155	97	58	0.000
Yes, often	75 (48)	32 (33)	43 (74)	
Yes, sometimes	61 (39)	46 (47)	15 (26)	
No	19 (12)	19 (20)	0 (0)	
<b>Need to talk to a professional</b>	154	97	57	0.001
Yes but I did not do so	15 (10)	4 (4)	11 (19)	
Yes and I spoke with a midwife about this but not as part of the Birth Reflections service	33 (21)	18 (19)	15 (26)	
Yes and I spoke with another health professional about this but not as part of the BR service	14 (9)	6 (6)	8 (14)	
Yes I attended the Birth Reflections service	1 (1)	1 (1)	0 (0)	
No	83 (54)	64 (66)	19 (33)	
Don't know	8 (5)	4 (4)	4 (7)	
<b>Like to talk more about labour and birth</b>	156	99	57	0.000
Yes, someone who was there	35 (22)	11 (11)	24 (42)	
Yes, someone who was not there	3 (2)	1 (1)	2 (3)	
Yes, whether or not they were there	16 (10)	5 (5)	11 (19)	
No, not really	102 (65)	82 (83)	20 (35)	
<b>Understood what happened during labour and birth</b>	156	99	57	0.000
Yes	115 (74)	85 (86)	30 (53)	
No	26 (16)	9 (9)	17 (30)	
Don't know	15 (10)	5 (5)	10 (18)	
<b>Satisfied with understanding of labour and birth</b>	157	99	58	0.016
Yes	122 (78)	84 (85)	38 (66)	
No	16 (10)	6 (6)	10 (17)	
Don't know	19 (12)	9 (9)	10 (17)	

**Table 4.6 Women’s evaluation of matters relating to the Birth Reflections service  
(continued)**

	Total†	Low PTS group	High PTS group	Chi-square (P)
<b>Remember receiving a Birth Reflections (BR) form</b>	156	98	58	0.643
Yes	69 (44)	41 (42)	28 (48)	
No	44 (28)	30 (31)	14 (24)	
Don’t know	43 (28)	27 (28)	16 (28)	
<b>Reason for not attending BR</b>	145	90	55	0.008
I knew about the service but deliberately chose not to attend as I did not feel the need	27 (19)	23 (26)	4 (7)	
I knew about the service but didn’t use for other reason	18 (12)	10 (11)	8 (15)	
I did not know about it but would not have attended anyway	44 (30)	30 (33)	14 (25)	
I did not know about it and would have like to have attended	56 (39)	27 (30)	29 (53)	

† Total for those women who had an IES score

*i) Thinking about the labour and birth experience at home following discharge from the hospital*

The respondents in the questionnaire were also asked to provide any further comments they wished after answering the tick box question, which asked “After you went home following the birth of your baby did you ever think about what happened to you during your labour and birth?” One hundred and twelve (70%) of those who responded to the question whether or not they thought about their experience of labour and birth after they arrived home also gave a comment in this section. These comments were all very different but could be placed under six key headings: “Feelings after leaving the hospital after birth”, “Observations”, “Visions of the entire experience (“*Replayed the experience in*

*my mind often*)”, “Difficult aspects of labour and birth”, “The Midwife” and “Questions forming”.

The various issues mentioned by the respondents are placed under the six subject headings and can be seen in the boxes below. These data suggest some women have emotional feelings following their experience of labour and birth. Examples of such feelings include disappointment with the birth outcome if not as planned, joy at meeting her new baby, apportioning blame about the birth outcome (either to herself or to staff present at the time) and pride in the achievement of giving birth. Women also make observations about the events of labour and birth, for example they compare their experiences with those of others and their own previous experiences. The data also indicate that women mull over the events in their minds: they speak about reliving the experience. The respondents also mentioned thinking about difficult aspects of their labours and births such as being induced and the pain of contractions. In addition they highlighted thinking about the role of the midwife. Support from this role was perceived both favourably and sometimes less favourably when support was not forthcoming. Finally the comments indicate that some women formulate questions, for example the reason why a woman needed to go to theatre for her forceps delivery.

### Feelings after leaving the hospital after birth

- Disappointment partner not arrive in time to be at the birth
- Relief baby in good condition
- Traumatic/horrendous experience
- Shock of speedy birth
- Feels happy remembering birth
- Disappointment had 2<sup>nd</sup> caesarean
- Pride in what had achieved
- Disappointment birth not as planned
- Upset being left alone in labour
- Painful aspects haunted me at night (but did not affect me as much due to my overall positive experience)
- Felt like I had been to war
- Joy of meeting baby/seeing for 1<sup>st</sup> time
- Positive thoughts about the birth this time
- Has failed baby/blames self
- Coped well despite horrendous experience
- Blames staff for what happened
- Feels failure as did not give birth normally
- Emotions (e.g. excitement/anxiety/worry)

### Observations

- Comparison with first birth (caesarean section)
- Considered how I might have asked for a different option had I known the anaesthetist was not available for the epidural
- Amazing experience – everything done to promote calmness on the birth centre
- The fuss I made (was terrified)
- My behaviour (noise I made)
- How straightforward birth with an elective caesarean is
- How lucky myself and the baby are to be alive
- Didn't have the birth that I planned
- Thinking about having to do it again
- How quick birth occurred after induction
- How I could have managed better
- Good job baby was being monitored as cord was around neck
- What a good experience I had

### Visions of the entire experience

#### *"Replayed the experience in my mind often"*

- The birth itself
- Baby being transferred to the neonatal unit
- The stay in hospital
- Rapid labour – arriving just in time
- Going to theatre for delivery
- The size of the baby
- The caesarean section
- Events before arrival at the hospital
- The facilities
- Relived the experience in a good way
- Epidural not working on one side
- Coming close to giving birth in the car park
- The pushing stage
- Holding the baby

### Difficult aspects of labour and birth

- Lack of postnatal support
- Separation from baby
- Induction of labour is painful
- Traumatic experience
- Not knowing what is going on
- Not being given pain relief in labour/lack of pain relief
- Pain of contractions
- Lack of support from midwife in labour
- Hard process

### The Midwife

- Not supportive
- Lack of skills
- Behaviour
- Positive experience with midwife
- Excellent/amazing midwives at the birth centre
- Midwives being helpful to me
- How good all staff were

### Questions forming

- Why I needed to go to theatre for a forceps delivery
- Why 3 epidurals did not work
- Why was there an urge to push at 4cm dilated
- Concern about possible damage from the forceps
- How labour and birth could have been better
- Why the midwife did not give Entonox until after the examination
- Would I have had a normal birth if I had pushed earlier
- What would have happened if I had gone home when the midwife said to do so

*ii) Needed to talk to a professional following the birth*

Forty two per cent of respondents felt they needed to talk with a professional after the birth of their baby. However 52% reported not having this need. Of the 70 women who reported the need to speak with a health professional 19 did not do so, 51 said they spoke with a midwife or another health professional and one woman only attended the Birth Reflections service. From this finding we can deduce that many women are finding opportunities and talking with other professionals following birth.

*iii) Like to talk more after the birth (about the labour and birth)*

Whereas 36% of respondents said they would have liked to have talked more about their birth experience a greater proportion (64%) felt this was not necessary. This finding suggests that approximately one third of women feel a need to talk with a health professional more following their experience of giving birth. However, from this sample of women only one woman accessed the Birth Reflections service.

When considering the various variables in relation to women's experiences of labour and birth (e.g. satisfaction with care, overall view of labour and birth) it is of interest that women who rated their experiences of giving birth more negatively were more likely to feel the need to talk about it to someone following birth. Statistically significant results have been achieved when chi-square tests have been undertaken on these variables together with the need to talk.

There were also statistically significant differences according to whether or not women's expectations of labour and birth were met when cross tabulated with key variable "Would have liked to have talked to a professional following the birth". Mann Whitney U tests were undertaken to determine these findings. According to these findings it appears that if expectations of labour or birth are

not met women have an increased need to talk with a professional following the birth.

*iv) Understanding of what happened during the labour and birth*

The majority (73%) of respondents reported having a clear understanding of what happened to them during their experience of labour and birth. However 17% said they did not have an understanding of what happened to them and 9% did not know. This suggests 26% of women from this sample left their birth experience without a full understanding of what happened to them.

*v) Satisfied with your understanding of labour and birth*

In order to further probe women about whether or not they understood what had happened to them during their labour and birth experience a separate question was asked regarding their satisfaction in this area. Seventy eight per cent of respondents were satisfied with their understanding of what took place but 11% were not and a further 11% did not know.

The previous two findings on women's understanding of their experiences of labour and birth suggest it is possible for women not to have a full understanding but to be satisfied about this, even though level of understanding was generally associated with satisfaction. A cross tabulation was run looking at these two variables "satisfaction with understanding of labour and birth" and "understands what happened during labour and birth". Eighty six per cent of women who were satisfied with their understanding of what happened also understood what happened. Similarly to the converse 67% women who were not satisfied with their understanding did not understand what happened. This finding was statistically significant ( $p < 0.1\%$ ). This shows that dissatisfaction in this way is associated with a lack of understanding about what happened during the labour and birth.

*vi) Attendance at Birth Reflections service*

From this sample of women only one woman accessed the Birth Reflections service.

*vii) Reason for not attending the Birth Reflections service*

Women were asked in the questionnaire the reason why they did not attend the Birth Reflections service. Thirty per cent of women respondents said they knew about the service but chose not to attend and another group of respondents did not know about it but felt they would not have attended anyway. However one key finding is that 40% said they were unaware of the service and would have liked to have had the opportunity to attend. It is of interest that more women in this group were found to have higher IES scores (Figure 4.5).

*viii) Birth Reflections service form received before leaving the hospital*

Forty two per cent of respondents remember receiving a form in their discharge pack when leaving the hospital and going home following the birth. However 30% said they did not remember receiving a form and a further 28% of respondents were not sure if they received a form to access the Birth Reflections service. This and the over 40% of women who said they were unaware of the service highlights the wealth of information provided to women on discharge from hospital and the busyness of new parents' lives at this time. This may help to explain the low attendance at the service in the light of women's comments about the need to talk.

## Reason for not attending Birth Reflections (BR) service n=145

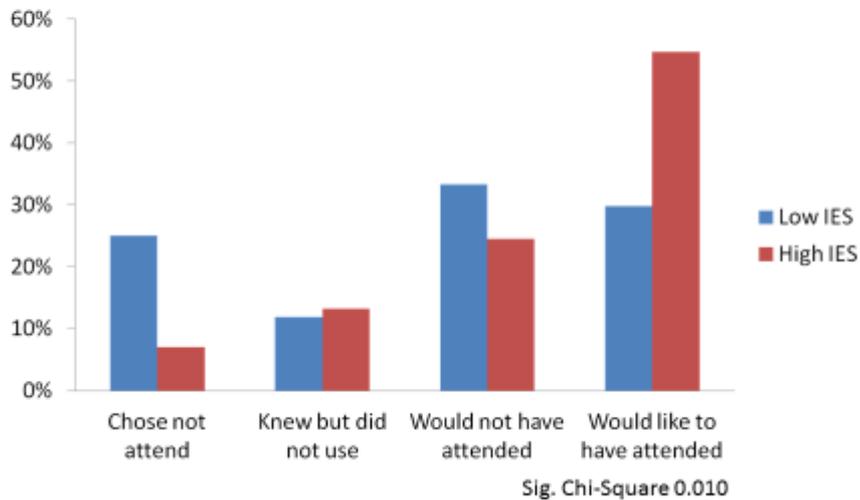


Figure 4.5 Reasons for not attending birth reflections service

ix) *Freetext comments in response to question “After your birth experience and at the time when you were discharged by the community midwife to the health visitor, do you feel you had a full understanding of what happened to you during this latest labour/birth experience?”*

As described above approximately one quarter of all women from this study may have left their birth experience with a lack of knowledge and unanswered questions. Thirty-eight women (22%) from the 170 who ticked a box in the first part of this question provided further comments. Many of these comments relate to the women having a lack of knowledge about certain aspects of their labour and birth experience. Examples of this include not knowing the reason for the caesarean section and the reason why the baby underwent a lumbar puncture. There is an additional need for women to be given explanations about processes (e.g. why the woman waited for a long time before the obstetric registrar came to assess her; not sure what happened during complications with retained placenta).

Another key finding from these comments is the fact that some women were unable to remember all of what happened to them during their labour and birth experiences. This compounded the risk of women being left with a lack of knowledge. Some women whose partners or families were present were able to feed back some information about what happened to them.

One woman reported not being able to process information at this time due to being ill:

*“I think I felt so ill I wouldn’t have taken on board a lot of info. When I felt ready and had my birth reflection I felt I had all the info. My family said they felt informed”*

Respondent 2br

#### **4.5.8 Conclusion**

The survey findings highlight the fact that some women need to talk about their birth experience after they have left the hospital and gone home following birth. Analysis indicates that women with a high IES score are more likely to want to talk and continue talking following their birth experience. Many other women also want to talk to a health professional following birth and are finding opportunities to achieve this without the Birth Reflections service.

Another key finding is that 40% of respondents said they were unaware of the Birth Reflections (BR) service and would have liked to have had the opportunity to attend. It is also of interest that more women in this group were found to have higher IES scores.

Finally this work also identifies differences in IES scores among women who responded to the survey. It appears that women with a high IES are more likely to rate their experience of birth more negatively compared with those with those

with a low IES. It is unclear whether the high IES score itself has a direct effect on the need to talk or whether it is the negative perceptions of the birth that cause women to need to talk, or indeed a mix of the two.

## 4.6 Interview findings

### 4.6.1 Introduction

Sixteen women were recruited for semi-structured in-depth interviews. Twelve were identified through the survey and four through the Birth Reflections service as discussed in the methodology section 4.4.5. Further details of these women are shown at table 4.7 below.

**Table 4.7 Details of participants interviewed**

<b>Participant Number</b>	<b>Previous Births</b>	<b>Method of Birth</b>	<b>Age (years)</b>	<b>Attended Birth Reflections Service</b>
1	0	Forceps	35-39	No
2	0	Emergency cs	30-34	No
3	0	Ventouse	20-24	No
4	1	Normal vaginal	25-29	No
5	0	Forceps	30-34	No
6	1	Normal vaginal	35-39	No
7	1	Normal vaginal	30-34	No
8	0	Normal vaginal	30-34	No
9	1	Normal vaginal	30-34	No
10	1	Normal vaginal	30-34	No
11	1	Elective cs	35-39	No
12	3	Normal vaginal	35-39	No
1br	1	Emergency cs	*	Yes
2br	1	Forceps	*	Yes
3br	1	Forceps	*	Yes
4br	1	Forceps	*	Yes

\* Information on age for women who were recruited through the Birth Reflections service was not collected.

Five key themes were identified in the analysis of the interviews with a sample of women who did and did not use the Birth Reflections service. These were: “Giving birth is traumatic/horrific”, “Making sense through the blur”, “Professional behaviour”, “The need to attend a Birth Reflections-type service” and “Lasting emotions linked to the birth process”.

The themes were used to answer the research objectives and are described below under the respective headings. Some of the raw data is provided which is largely presented exactly as it occurred in the interviews and appeared in the transcripts. Verbatim passages have been found to play an important role in qualitative research. This is due to the generative and enhancing power of the participants’ people’s own accounts (White et al 2003). According to White and colleagues the purpose of verbatim quotes is largely to provide illustration in order to extend an understanding of the findings to the reader (White et al 2003).

#### **4.6.2 Giving birth is traumatic/horrific**

This theme identifies that some women considered their birth experience to be traumatic or horrific. These are the actual words used by the women to describe their experiences of giving birth. These words were very much in evidence across many of the transcripts. This effect seemed more common among women having their first babies. Furthermore, some of the participants during a subsequent birth experience remembered their first birth experience as being particularly negative, traumatic or horrific:

*“...if you’d asked me a couple of months ago I would have said “I’ll never do it again it was most horrific” Participant 1*

As the above quote illustrates, a consequence of this negative effect led some women to saying that they would not consider having another baby.

Furthermore, on learning she was pregnant again, following her previous poor experience during her first birth, one participant reported panicking. She was terrified about having another similar birth experience.

As a consequence of the entire negative birth experience another participant was also put off having another baby:

*“But it has put me off of having another baby. I would love to have another one but I don’t think I can because I am too traumatised”* Participant 2

Flashbacks and glimpses of the negative birth experience were reported by some participants. It is not surprising that women who are left with the perception of their birth experience as being traumatic or horrific report experiencing flashbacks as the below quote shows. This comment also illustrates how some women muse on their birth experience, trying to make sense of their emotional reaction to it:

*“I just found the whole thing traumatic because I was frightened I was going to die and then all these things.....When I was in the theatre and they panicking and they were running around and then they were trying to sort out the PPH and there was all sorts of stuff going on, for a long time the shock of that made me very depressed and I was obviously ....my brain was obviously trying to deal with it ‘cause I would forget something and suddenly remember it and be in floods of tears. A part of me was saying, “That’s not normal to feel like that.” If I had a terrible car accident, fair enough but with a birth....”*

Participant 11

This theme, “Giving birth is traumatic/horrific”, is further broken down into seven sub themes: “Medical interventions”, “The pain of labour”, “Being rushed to theatre”, “Baby’s condition at birth”, “Post-partum haemorrhage”, “Thinking about what if something happens to me during birth” and “The effect of poor

staff communication". These were all identified as being contributory factors to women's traumatic feelings.

*i) Medical interventions*

These traumatic feelings, experienced by some of the women in the study, appear to be related to the use of medical interventions. Induction of labour was mentioned by many of the participants as being a particularly difficult experience for them. When asked the direct question about what precisely in your eyes makes the birth experience horrific one participant listed a series of procedures that were undertaken during her labour and birth. This is shown in the quote below:

*"Um, I think from the three days of labour um, to having the waters broken um because [E] (baby's name) was so far down into the birth .... Um pressing on the birth canal they had to push her up to break the waters. To ..... you know, to you know, having the monitor on her head. Then to having second degree tear and being stitched um. Yeah, all I could think about up until a couple of months ago was the ring of fire and I can still sense the pain from that."*

Participant 1

Participant 1 also had a long induction of labour process. Looking back when at home, she considered that her birth was horrific. As can be seen from the quote above she alluded to a "ring of fire" which seemed to reflect her lasting memory of pain and her baby moving through the birth canal.

This participant also described having a fetal scalp electrode (FSE) placed on her baby's head to monitor the baby as traumatic for her. There is a lot of other evidence in the data on this procedure being traumatic for women:

*“That took about 45 minutes to put on and I was just um.....I had my Mum and my other half literally almost holding me down.”*

Participant 1

The use of fetal scalp electrodes seemed particularly uncomfortable for another woman who considered the application of this device as being more painful than the actual contractions .

One participant described how she actually ‘blacked out’ during the procedure to introduce a fetal scalp electrode:

*“...I do remember that bit being the most painful....That was the time I do remember being quite hysterical then which was quite unusual for me because I’m normally quite calm [laughs] and I’d been quite calm and everything was going well and I hadn’t had an epidural at that stage...”*

Participant 6

Women also described vaginal examinations as being very painful:

*“Yeah, um.... and they’d examined me god knows how many times. His head was turned the wrong way so they had to turn his head inside. The internal examinations, they’re painful .....I never quite realised how painful they were.”*

Participant 5

Most of the women described how interventions made the birth experience harder. The quote below shows how Participant 6 reflected on the impact being induced had on her birth experience. After the birth she considered what would have happened had she gone into labour spontaneously:

*“....but you do sometimes think if you hadn’t, if it had all happened naturally, would it have been a completely different experience and you might not have*

*had the complications and the forceps or the Oxytocin drip, all those things that kind of make it harder”*

*Participant 6*

Participants also found the doctor coming into the room to be traumatic. This was a cause for concern for women and suggestive that something was wrong. Not knowing what was going on, and the doctor coming into the room unexpectedly, could lead to fearful thoughts and feelings, as can be seen in the below quote:

*“... Because that was the bit that was for me the most traumatic because um, I think the doctor coming in makes you think – Oh something could be going wrong.”*

*Participant 6*

#### *ii) The pain of labour*

As can be seen in the above section the pain of labour was implicated in the women’s perceptions of labour and birth as being traumatic. It is therefore also clear that the feelings of trauma also seem to be to do with how well the women felt they had coped with or been supported with labour pain. For the women who expressed feelings of trauma the pain of labour appears to be unlike any other pain and they felt it is not possible to prepare for it:

*“Ah, no but is....can you ever prepare [laughs]. I guess it was.... yeah. You can’t prepare yourself for the pain, you’ve never experienced that sort of pain so... and nobody can ever tell you what you thought it was going to be?”*

*Participant 5*

*“Yeah I think...again I just wanted to feel more in control when it came to pushing and all those sort of things because I know my body is fairly strong so I*

*thought- Well, I can get through it without that (epidural) [laughs]. I didn't realise how painful it was going to be then [laughs].*

Participant 7

*"So I did do fine but it is just .... I mean it is a shock isn't it? You don't realise how painful it's going to be."*

Participant 10

One participant described her overall experience of labour as being awful. She remembered being *"in agony with pain"*. According to this participant the pain was so severe that she thought she was going to die. In addition, she remembered the situation being so distressing that her partner was crying. She spoke with him afterwards:

*"Um, I spoke to [D] (man's name) a little bit. It was just more, I was sort of emotional because of what happened. I felt like I'd been beaten up and I couldn't really believe what had happened...."*

Participant 2

As mentioned above the pain of labour did not only affect the women. The partners of other participants were also affected seeing their loved ones in severe pain. One participant recalled her husband screaming in the corridor, in her words, fighting to get help for her when she was in pain during labour. Another man thought his partner was going to die due to the pain. It is clear that without appropriate support, the woman's pain in labour has a wider emotional impact.

Women having a baby for a second time had the advantage of being more prepared and being able to make plans for how they can cope better during the successive birth experience. Another participant remembered the pain of her first birth experience as being horrific. As a consequence, for her second birth experience she had planned to have an epidural:

*“I mean .....It’s just.....I just don’t like pain, well no one does to be honest but it’s just sort of.....yeah it was just such a horrific pain because I was having these contractions over so many days,....”*

Participant 4

It was not only during established labour when women struggled to cope with severe pain. A prolonged latent phase of labour was also identified as a very difficult time for the women. Managing the pain during this time was considered hard for them:

*“But the pre labour is horrific. Is it four centimetres, or is it two and a half I don’t know?”*

Participant 8

### *iii) Being rushed to theatre*

Needing to go to theatre in an emergency situation was also found to be traumatic for some women. This could be due to the unexpected event:

*“So they threw clothes at [D] (man’s name) and said “Right, get changed, we’re going straight in and that was it””*

Participant 2

*“...Because you know when you are rushed to theatre it’s all a bit...and it was so quick it was like, “Right, we have to get you there now,” so it was all a bit like ....and I think that bit was a bit kind of... that ... I just didn’t know what was going to happen....”*

Participant 6

Another woman described her forceps birth as being brutal. She thought her baby had died when she was rushed down the corridor to theatre. She remembered being in the labour room and someone saying “We’ve lost the baby’s heartbeat” and then being taken to theatre in a hurry. This was a particularly traumatic situation for this woman whose own sister had died in a similar scenario. She remembered thinking her dead sister had saved her baby’s life. As this participant identified there is a need in such situations to ensure the words used by staff to explain what is going on are sensitive:

*“Um... but it all unfortunately got very dramatic because at the point, I had been pushing for an hour and ten minutes and basically... what... the use of language was, ‘We’ve lost the baby’s heartbeat,’ and then they pressed the panic button and then everybody rushed in and then I got rushed down to theatre and I was signing something on the way and all I heard was, ‘We’ve lost the baby’s heartbeat,’ and I did... they did that rush down the corridor with me laying down and the only thing I thought was, Oh my goodness, the baby has died and now my life is over. ...”*

Participant 4 Attended a birth reflections session (br)

There were also occasions when the anaesthetic procedure prior to a caesarean section did not go smoothly and women reported panicking when feeling unable to breathe.

However, the need to be rushed to theatre to deliver the baby in an emergency was not traumatising for all women. One participant reported feeling trust in the staff despite not being able to take in all the information that was being conveyed to her as she was signing the consent form. To her the staff seemed calm and were letting her know what was happening. It is clear that there is a need for women and their partners to be kept fully informed about what is happening during this time.

Another participant was taken to theatre in an emergency for the second occasion during her subsequent birth experience. She felt because she had already had experience of being transferred to theatre during labour that she was more aware of what was going on for the second planned birth in theatre:

*“...that was probably a bit more traumatic in the sense that after I had her they did rush me... no before I had her they rushed me to theatre, “cause you start thinking- What’s going on?” And obviously at [hospital name] they didn’t have to rush me to theatre but it’s ....so I suppose maybe if I’d been asked about what happened with that birth I might have been a bit more emotional about it”*

Participant 6

#### *iv) Baby’s condition at birth*

The effect of labour on the baby was also apparent in some of the accounts of the participants. Participant 9 recalled her first birth as being difficult when her baby did not breathe immediately at birth:

*“...from my first experience, that was really hard and when [C] (child’s name) came out she wasn’t breathing and like, we had loads of the crash team coming and everything so with me, that was a lot worse....”*

Participant 9

The baby needing to be transferred to the Neonatal Intensive Care Unit (NICU) was difficult for new mothers. One participant’s baby contracted meningitis and she blamed this outcome on the fact that in her eyes she had been left to labour too long before having a caesarean section. This woman’s baby needed to remain in the hospital for ten days which apart from the emotional trauma of having her baby in the NICU this led to a delay in the woman and her partner adjusting to the needs of their new baby and also the early discontinuation of breastfeeding.

Women also made mention of the cord being around their babies' necks. This was shocking to them. One participant spoke of the shock she experienced when she was told at a later stage about the cord being around her baby's neck two times. She reflected on the actual birth and remembered how calm the midwives had appeared at the time. This was despite what to her is a very shocking situation.

v) *Postpartum haemorrhage*

Some participants spoke about bleeding heavily following birth. This was very frightening for them:

*"Yeah and there was all this blood and then she called another midwife in from the Labour Ward and they had to knead my stomach and get all the clots out because my placenta had haemorrhaged. At the time it was quite scary and it was a bit like "Oh my god," there was just all this blood everywhere and I kept cramping and they had to keep kneading my stomach and ....It was scary because everything had gone so well...."*

Participant 9

vi) *Thinking about what if something happens to me during birth*

Some participants also mentioned considering the possibility that they might have died during their birth experience. Women who had, had previous babies were concerned about what might happen to their children should they die around the time of birth.

*" I think yeah, emotionally the thought of leaving her (first child) and thinking if something happened to me then I might not be there so I think that sort of stuff plays on your mind."*

Participant 6

Some women having their first child also spoke about the possibility of dying. This was in relation to the distress of the birth experience itself. In addition there is evidence in the data that some partners also held memories of thinking their partner was going to die.

*vii) The effect of poor staff communication*

On occasions women described their birth experience as being traumatic following episodes of poor communication with staff in labour. One participant described how she went through her entire first labour experience (at a different centre in a large City) without communication with the midwife allocated to her and providing her care. This woman later reflected on the situation. She was left wondering whether her experience had been normal:

*“Um, I was told off for screaming. I was told, I think the midwife was trying to make a joke but one of the few things she said to me was, “If you don’t stop making such a fuss, I’ll have to get a doctor”, you know. This was at the end and I was having my stitches then I think and I wasn’t screaming then but I burst into tears.... Because I was quite I think, quite traumatised and um, just because no one was reassuring me at all and I think, I didn’t know, I couldn’t tell whether my experience has been normal”*

Participant 10

Another participant continues to remember her first birth experience as being traumatic. This was due to the pain and what to her was a very long labour. She had been told by staff on previous shifts that there was no clinical reason to undertake a caesarean section. At a later point a different doctor came on duty and took over her care. Shortly after this time she underwent a caesarean section. At a later time the doctor informed her that she would never have given birth normally. As a consequence, she was left with worrying feelings that if the caesarean had been performed at an earlier point then her baby might not have

contracted meningitis and needed to remain in hospital for ten days following birth:

*“Yep, yeah and [D] (woman’s partner) did and still does feel quite a bit of bitterness because [L] (baby’s name) was poorly and it probably was as a direct result because he was so distressed when he was inside um, they explained that meningitis is an infection of the brain but it can come from anywhere, and if he would have been... if I would have been given a caesarean earlier he may not have been poorly because he pooped twice within a 12 hour period so it, you know.”*

Participant 2

This highlights the importance of good continuous communication by staff with women during labour.

In summary a worrying proportion (approximately half) of the women used the words traumatic and horrific to describe their experiences of giving birth. This was more common among women giving birth for the first time. It is likely that the first birth is more difficult for women and they do not know what is normal and what to expect and some felt shocked by it. One woman clearly stated that it was not possible to prepare for the pain of labour.

Key factors contributing to the sense of trauma and horror which some women in the study described included medical interventions, the extreme pain of labour and a lack of communication by staff providing care. One example of how a breakdown in communication with staff may lead some women to perceive their birth as traumatic is not being kept informed or knowing what is happening (e.g. something happening unexpectedly or thinking that something has gone wrong when a doctor suddenly appears in the labour room). The role communication plays is also important in relation to pain. It seems that it is not as simple as pain per se, but about the level of informational or emotional

support for women to cope with it. If this is not forthcoming some women may alternatively perceive the pain as traumatising.

#### **4.6.3 Making sense through the blur**

There appears to be a need for women to understand what occurred during their experiences of labour and birth. In this section on the theme “Making sense through the blur” I will show how women helped themselves to gain a fuller understanding of the events of their labour. This theme comprises of five subthemes: “Gaps in memory”, “Thinking about the birth at home”, “Speaking to others about the birth”, “Answering questions” and “Moving on after the birth”.

##### *i) Gaps in memory*

Whereas some women left the birth experience with a clear picture of the events that took place others were left with a dazed or muddled memory of what happened. These women were unable to remember the timings and order of the events in labour and during birth. These were not always the same women who described labour as horrific or traumatic. However it is likely these issues were associated amongst some women. This is illustrated in the following quote from a participant who compared her two birth experiences, the most recent being by having a planned caesarean section. Whilst events during her first labour were hazy after she had given birth her memory of her second birth experience (an elective caesarean section) was clear:

*“...the nice thing is I can look back and I can remember when he was born, I remember when [S] (child’s name) was born but it’s quite hazy and full of panic but when he was born it was lovely because I could look at him and enjoy the moment.”*

Participant 11

Other examples of coming away from the birth experience with an incomplete picture of what occurred during labour and birth are seen below. On occasions this was related to pain relieving agents:

*“When the pain just ramped up that much more that I kind of... It’s all a bit fuzzy after that. Unfortunately, I didn’t have as much gas and air as I probably could have done because I was so intent on trying to concentrate on my breathing.”*

Participant 8

*“Maybe with the Oxytocin drip and everything it was all a bit... I s’pose it was all a bit, my body was being forced to do a lot of things that obviously it wouldn’t be naturally doing. And so that’s the only negative bit I think, just that stage when the doctor came in and it all started going a bit... And as I said I did black out for like, it seemed to me like a long time and I sort of woke up crying [laughs] because I think... You know when you are just out of it and you are like – What’s going on? But [P] (partner’s name) seems to think it might have been because I took in too much gas and air but I think that was probably because of the pain and I was like, ‘Get the gas and air down me to try and get through this horrible bit,’ and it was just...]. So that was the only negative bit I would say.....”*

Participant 6

There were also instances reported where women did not feel present during periods of time in the labour and birth. This might explain why some women were left with gaps in their memories about events during labour and birth.

*“Yeah um [laughs] and then during labour his heart rate was going down um... and then... So I was pushing for about an hour and a half and he wasn’t coming so then they used Ventouse um and the cord was ‘round his neck which is what caused his heart rate. Um, but no it was all a bit of a blur really, I feel like I wasn’t really... wasn’t really there if that makes sense [laughs].”*

Participant 3

One participant identified being physically unwell with preeclampsia. This could be a possible cause for her hazy memory and lack of understanding about what took place during her labour. She went on and highlighted the value of talking with a midwife during a postnatal debriefing session to obtain a clearer picture of what happened:

*“So I kind of knew what had happened but yeah, there were gaps, you forget about things um... yeah so um... so... it was good to be able to go through it when I wasn't ill, when I was clear of mind, it was several months later you know...”*

Participant 1br

Whilst some participants had gaps in their memory and wanted to know more about what happened to them during their labour and birth experiences, other women considered memory loss following birth as being protective and having therapeutic value. Unfortunately according to the participant in the quote below this effect did not help the partner in his recovery:

*“Well and the gas and air takes you off to wonderful places doesn't it and there are big... I mean there is nature's way isn't there I think of wiping bits of your memory because I think if you remembered it all in excruciating detail I don't think you'd go on to have any more so I think that, I think for the men or the birth partner or whoever it is because I know a lot of people choose to have women as their birth partners, I think that perhaps it's more difficult on them because they are there the whole time, they...”*

Participant 3bf

According to this participant it seems that whilst nature may protect the woman who underwent labour, the birth partners may be at risk of having lasting memories of what happened and therefore possible unanswered questions.

This also shows that not all women wish to gain a full understanding of events. It is apparent that some women have gaps in their memories of events during their labour and birth experiences. Whilst some wish to piece these gaps together following the birth with an understanding of what took place, others may feel content not to be provided with the precise details of what happened to them during their birth experiences. For some people it is clearly healthier not to try to relive traumatic memories (Rose et al 2002). The evidence in relation to PTSD suggests that for those who experience PTS symptoms it may be very important to gain an understanding about what took place, while for those who are able to just forget, this may be a healthy response.

*ii) Thinking about the birth at home*

Nonetheless, the labour and birth experience remained in women's minds after they had left the hospital and were at home. These women seemed to review their experience of giving birth. Whilst for some who had, had good experiences this was a joyous feeling, others who reported bad experiences had painful memories of this event. These thought processes led some women to weighing up the whole event and remarking how well it had gone. As can be seen in the quote below, Participant 9 went over events in her mind. She made observations and compared her second birth experience with the first. To her this one was much more joyous:

*"Yeah, I think when I got home I thought about it a lot more because I think I was just so in awe of how quickly my labour went and how much I enjoyed my labour and actually having her and I think I was just in awe with the fact that I had another girl because I was so sure that I was having a boy because I didn't find out. And the fact that she was so small because even though I didn't get as big this time my bump was quite impressive and she was... my first one was 8, 4 and she was only 6,7."*

Participant 9

Through the process of thinking about the birth some women generated questions which they asked their partners and families about. This might be soon after birth or at a later stage, among women who were preoccupied with other needs such as breastfeeding or postnatal depression. Other women also continued trying to piece together the events of their first labours for some time afterwards. Another woman also compared her first and second birth experiences. Whilst her second birth was clear in her mind she still pondered over what happened during the first birth. She said this continued for over two years. This woman was keen to attend a birth reflections session to address this, which she arranged as a consequence of responding to the study:

*"I think with [O] (baby's name) it was straightforward, I don't know whether I'm still trying to find bits and pieces to sort of make myself feel better I suppose about when I had [H] (boy's name) [ball bouncing]."*

Participant 4

As also mentioned above, thinking about their labour and birth experiences was found to be joyous by some women. On occasions this led to a sensation of wanting to have another baby:

*"...spent a lot of time thinking about it because it was amazing and why would you not think about that you know? I don't think about it now because if I think about it now I would want to have another one [laughs]."*

Participant 7

However thinking about the birth and talking about it was a painful reminder of a more negative birth experience for other women.

*"Um, just me being tired and sore um... We were both quite emotional about the labour, I felt like I couldn't really talk about it for a while because it was so painful."*

Participant 2

Some women also rated their own behaviours during labour and birth. They reported feeling proud of themselves in general. One woman, who gave birth to her second baby, said she was proud for not going home when advised to do so by the midwife. This was because the baby was born soon after her conversation with the midwife. This woman had an inner sense that the birth was imminent.

As has been shown, many women were found to think about their labour and birth experiences after leaving the hospital. It seems that whilst some women derive happiness and joy when thinking about this others are unable to do so due to being unhappy and thoughts of the birth lead to painful feelings.

*iii) Speaking to others about the birth*

As previously mentioned, in addition to thinking about the birth many participants also reported that they spoke about the labour and birth experience to their partners, mothers and community midwives and asked them questions in relation to the experience. There seemed the clear need for these women to be reminded of the event and understand everything that happened. Some compared notes as is seen in the quotes below:

*“Yeah, quite often um... It was just, I don't know it was quite weird because it was almost like little flashbacks kept coming back and then I would think about it and then ask you know, my Mum or [M] (partner's name) you know, 'Was this how you saw it?' 'Cause this is how I saw it...”*

Participant 1

*“In the few days afterwards yeah and sort of telling other people about it while you are together and one of you would say, 'Oh no, this happened,' or...”*

Participant 7

In such cases, women asked questions in an attempt to fill in gaps in their memory. Some women reported being helped in this endeavour by reading notes written by their partner:

*“But it did help that [P] (partner’s name) had written it down because I could read through it. But I think maybe I would have like to have talked through – Why did that happen? And you know...”*

Participant 6

It is clear that women speak with others present during the labour and birth experience, primarily their partners, about what happened to them during this time. It was shown above that couples compare notes. This practice helps obtain a clear picture of events of labour and birth. As can be seen from the quotes above, some women reported feeling the need and speaking with their partners, or others present during the labour and birth, about what happened to them during this time. This helped them to understand what happened and fill in any gaps in their memories. They valued this opportunity to talk about this event in their lives and clarify specific points.

#### *iv) Answering questions*

Many women spoke about the need to have questions answered to gain a full understanding of what happened during their birth experiences. One woman who attended the Birth Reflections service said she did so to have specific questions about her birth experience answered:

*“Um, and I was kind of out of it so although I kind of knew what had happened I wanted... And I waited about six months actually, I wanted to sit opposite someone and just talk through it step by step, exactly what had gone wrong and it was quite cathartic really just to be able to do that. I had questions obviously over the formula that they gave my daughter but also I had questions about*

*exactly what had happened and this was the first time I think, I'd heard HELLP Syndrome, before then I thought it was just sort of you know, pre-eclampsia."*

Participant 1br

For those women who did not think or talk about their birth experiences after they had gone home from the hospital, some were reminded of it by having questions asked of them about their birth experiences, including how it had gone. In this way women were reminded of the birth experience.

*"Oh ok, well people asked... Just when people asked how it went really, I'd explain that... [baby crying]"*

Participant 3

*"And that's the lovely thing about having a baby, everyone wants to know don't they? And come and see you".*

Participant 10

Being reminded of the birth experience in this way gave these women the opportunity to think and talk about their experiences of giving birth. On occasions this prompted lingering questions that required answering which was not always possible by friends and family. Answers to more specific questions required the expertise of a health professional:

*"I don't think I really thought about it until a couple of days after and I started seeing people and they were like, 'So, how did it go?' and we started talking about it."*

Participant 9

The above section shows that whilst some women think about the birth afterwards themselves and generate their own questions aimed at both their partners and health professionals, others are reminded about it through the questions posed to them by others.

v) *'Moving on' after the birth*

However there came a point where individual women felt the need to 'move on' following the birth experience and to place the birth behind them. To clarify that this term was not used often by the women. They also spoke about the importance of placing the birth experience behind them, in the past. This is illustrated in the quotes below:

*"That was part of [E] (baby's name) being born you know, that's kind of like in the past now, it's that little package, she's happy, she's healthy um... I don't think I'd be scared to have another one."*

Participant 1

*"No I think I probably would have just... not forgotten it but just –That's in the past, move on."*

Participant 5

The time when this stage is reached is different for individual women. One woman, who was diagnosed with postnatal depression following her first birth experience, which she confirmed as being traumatic, said she thought about her first birth experience for two years. As a consequence this woman worried about dwelling on her second birth experience which was positive. She was concerned that by doing so her previous experience of postnatal depression would recur. It is possible that some women are unable to 'move on' when their birth experience has been traumatic or horrific. By thinking about her first birth in itself might have led to her postnatal depression (PND). It is also of interest with her second birth experience she said that she took active steps not to think about this birth after she went home as she feared she might get PND again. It seems in her eyes that spending time in thought and being troubled and preoccupied by the birth might delay the natural healing process and prevent her being able to place the birth experience in the past. This suggests that some women are unable to 'move on' when their birth experience has been negative, traumatic or horrific.

The global theme “Making sense through the blur” has shown that some women following birth have a need for a fuller understanding of the events and what happened to them during labour and the birth process. Some women reported having gaps in their memory. Women continued to think about the birth after they left the hospital following birth. For some this was a happy experience whereas others found thinking about the birth to be painful. Thinking about the birth, for some women, led to the generation of questions and discussions with partners and others, including health professionals on occasions. The final subtheme related to the need for some women to ‘move on’ and to place the labour and birth experience behind them, in the past.

The subthemes in this section can be seen as steps in a woman’s emotional recovery following birth. However it is important to recognise there are a range of experiences and not all women need to recover or place the birth experience behind them. To the contrary for many women, birth can mean emotional growth, feeling more empowered or a rite of passage. It appears many women think about the birth afterwards and generate questions. These questions can be responded to by a midwife or other health professional at informal or unstructured postnatal debriefing. At these sessions the maternity record is commonly available and a midwife or other health professional will read through the notes and respond to questions.

#### **4.6.4 Professional behaviour**

The third theme “Professional behaviour” considers the impact of staff behaviour on women’s experiences of birth. Staff members were found to play a key role in an individual woman’s experience of labour and birth. Five key categories are listed under the theme “Professional behaviour”. These are “Trust in staff”, “The need for sensitive communication”, “Relationships with staff”, “Supported by staff” and the “The need for information”

i) *Trust in staff*

The importance of women being able to place their trust in the health professionals providing care was evident from the analysis. It was clear from the data that the women needed to be able to trust the staff who provided care to them. An example of this is shown in the below quote from a woman about when she was being prepared to go to theatre for an emergency delivery:

*“Theatre, that’s the word um and that was all very quick and everybody explains something to you but because I just couldn’t take it all in, there is so many people, so many faces telling you what they are doing to you, you just agree to everything. I’m signing some consent form even though I’ve... because something they’ve pumped into me I’m shaking like an egg whisk I’m just signing a form thinking- yep, I trust you all, I trust you all but I have no idea what you’ve just asked me.”*

Participant 5

Another situation that supports the importance of trust in staff, is shown in the quote below. This woman is standing up for the midwife, in whom the woman had clearly placed her trust, when a doctor enters the labour room. The issue of significance here is not simply that the woman felt she had to stand up for the midwife but also the way in which interactions between staff are not respectful. Such relationships may undermine the trust and confidence in the professionals that is so important for women:

*“And they brought a doctor in and I just felt she was a little bit um... what’s the word? A bit belittling to the midwife um, that was one thing I noticed um and I felt really sorry for the midwife because she’d been doing a really good job and I think it sort of interfered with the kind of, whole... because we were all doing quite well until [laughs]. I know the doctor probably had to come in to try and be*

*helpful um, but it just was a bit like the midwife was pushed out of the way when you kind of...*

Participant 6

One other woman reported how the midwife providing care for her in labour took control following a discussion with a doctor about the possible need for her to go to theatre in an emergency situation to deliver her baby. This woman also seemed to place all her trust in this midwife when the midwife challenged the decision made by the doctor and kept the woman in the room where the baby was born shortly after:

*"Yeah and actually control is a massive... that is the key word - there were a couple of occasions where I lost it a little bit and the midwife was assertive, she was confident, she made me believe that I was going to be able to do it. ...To actually be given direction because your body goes to a point where you are completely out of control and you need somebody to almost go [banging noise] 'Stop. Listen. What we are going to do is this.' And I was like... completely focused and then like I said, within half an hour you know, he was born."*

Participant 12

Women's trust in staff was displayed in many different ways. Some women mentioned the skills of the midwives looking after them. One woman highlighted the midwife's thoroughness at suturing following the birth:

*"Yeah, it felt like I was there for a long time but I think she was just very thorough."*

Participant 8

Another woman acknowledged the unique skills a midwife has in supporting women during labour, which contrasted to the role of the doctor.

Staff were also described by the women as being calm and this also generates a feeling of trust in the health professional providing care. One woman found out at a later point that her baby's umbilical cord had been wrapped around her neck during the birth. This she said was shocking to her but she felt she had been protected by the midwife and this was displayed in her calm, professional manner:

*"But it was how calm they were because I didn't feel any [sigh] what's the word I am looking for? Any worry, any you know, I didn't feel, I didn't get that from them when they took her out"*

Participant 1.

Another woman's baby was born with an unexpected congenital abnormality. This is a rare occurrence nowadays. Talipes had not been identified during the routine antenatal ultrasound screening test. This woman described how calm the midwives were when her son was born and the abnormality was first recognised:

*"... They are checking to see if there are any tears and stuff you know, I'm holding the baby going, 'Oh my god, he's got funny feet,' and then everyone's like, 'Do you know what, we won't worry about that now, we'll sort him out, lets clean him up, we'll put his clothes on him,' and I was like, 'Yeah ok,' and sort of, it was all done in a way that... You know I don't have anything negative to say about it, I feel, I felt at the time that he was going to be alright."*

Participant 12

This subtheme, "Trust in staff" identified in this analysis highlights how women during labour and birth value the importance of having trust in their care providers. This provided reassurance to them during this challenging period of time. It also illustrates ways in which staff behaviours and professional relationships and interactions may support or undermine this trust.

ii) *The need for more sensitive communication*

The second subtheme in this section relates to the need for sensitive communication. As well as identifying the importance for women of having trust in the midwife there were also many examples of superlatives in the data describing midwives (e.g. “Lovely”, “brilliant”, “amazing”, “fantastic”). However some women were upset by their encounter with midwives and doctors. Unfortunate interludes in communication, both between the health professional and the woman, and also between health professionals themselves but witnessed by the woman were identified in the data. This led women to feeling less confident in the staff providing care and consequently less supported. Lack of sensitive communication was shown to lead to misunderstandings and consequent unhappiness among women. One woman was informed by the obstetrician following birth by emergency caesarean section that she would never have given birth naturally. This was very alarming to this woman who had been encouraged by the previous obstetric team on duty to continue in labour. As a consequence this woman was left with the worrying thoughts that her baby was placed at risk. When her baby subsequently developed meningitis soon after birth and needed to stay in the Neonatal Intensive Care Unit (NICU) for ten days this woman considered (incorrectly) this was due to the fact she was left in labour too long by the first obstetric team, thus illustrating the way in which her confidence and understanding of events had been undermined:

*“Yeah, yep. Um, the doctor that actually did my caesarean said afterwards that I shouldn’t have been made to give birth naturally because I’m quite small and my trunk is very small, he was 7, 13 so he was quite big. She said I never would have given birth naturally”.*

Participant 2

Some women reported feeling that they were not being listened to by the staff providing care. Being asked to go home again after being admitted with painful contractions, at what was thought to be the start of labour, is one example from this subtheme of women feeling that staff did not listen to them. The below

quote from a woman who incidentally gave birth shortly after this encounter illustrates this phenomenon:

*“Yeah, and we got there and we got to the Birthing Centre and the lady, the midwife, she said that I was only one centimetre dilated and I had to go back home and I was just... I started crying because I just knew, I personally felt that she was wrong and I said I wanted to go in the pool and stuff and she was, ‘There is no point, you can’t go into the pool until you are x amount of centimetres,’ I can’t remember what she said. And I was just like, ‘She’s just not listening,’ and I said to my sister, ‘She is not listening to me, I know that she’s wrong, I know that she’s wrong,’ and then my husband and her were talking and they were trying to get me to calm down because I was getting a bit upset...”*

Participant 9

According to the women’s accounts, some staff on occasions even resorted to threatening women to get them to act in the way staff felt necessary. One participant described this behaviour that occurred with her in her first birth experience as being “negative encouragement” which she did not consider as being helpful. This woman could have been given more positive encouragement from staff. She contrasted the negative stance of staff during her first birth experience with the positive encouragement provided by her friend who was present during her subsequent labour and birth:

*“Yeah. Um because at one point she said if I don’t push hard enough they’re going to have to take me to the theatre and they would have to do something in the theatre and I just.... I didn’t feel sort of... You know when I was giving birth to [O] (baby’s name) ‘cause my friend was there I suppose she said all the right things and was nice encouragement, it wasn’t a negative encouragement, but the way she said it...”*

Participant 4

A perception of being handled roughly during vaginal examinations by a doctor was also reported by one participant:

*“Basically um [laughs] by the time I got into the operating room she’d done the final internal exam and she hurt me so much that I more or less kicked out.....Before we’d even gone down. She didn’t speak directly to me she just very quickly... She came in with two colleagues and read my chart and then this... ‘That hurts, that hurts, that hurts, that hurts,’ she was um... just treating me as... you know, there is somebody here and I need to solve the problem. She didn’t speak to me and it hurt so much.”*

Participant 2 br

Following this painful procedure this same woman reported that the doctor continued to fail to speak with her prior to and during the subsequent forceps delivery which she also described as being painful. She pleaded with the doctor to wait until she had been given some pain relief. This woman described the doctor as being rough with her and heavy handed.

Women also spoke of not being kept in the loop with what was happening during their labour. This is also an example of a lack of sensitive communication on the part of staff groups:

*“And I’m thinking - Why are you even talking about... And I actually said, ‘Are you serious? Why are you talking about a caesarean?’ And they were like stopped um. So I was looking at the boys... my son’s Dad going, ‘Why are they talking about caesarean? I’m not even in labour,’ and nobody had given me any indication that there was a massive problem so that annoyed me quite a lot. The fact that that conversation was had directly in front of me as if I wasn’t there.”*

Participant 12

In addition, having the plan of care changed by a different doctor was frustrating for some women. If this becomes necessary there is the need for the reason

and the new plan to be communicated sensitively. This was particularly important for this woman following a previous traumatic birth experience. She had been told she could have a planned caesarean section by a different doctor at a previous appointment:

*“... ‘I think you are making a fuss, I think the postnatal depression is not documented apart from once on a GP form.’ I said, ‘Well I saw the GP about four times,’ she went, ‘I don’t see any evidence of it.’ Terribly rude to me, said, ‘I think you are wasting NHS money and time, I want you to have a natural labour and if it goes wrong then we will take you in for an emergency caesarean.’ Well I had an emergency caesarean the first time. So I came away and I spoke to my midwife, well my husband was nearly crying in the meeting he just went, ‘Is she going to die in labour because that’s what nearly happened last time?’ And the doctor just said, ‘You are making a fuss.’ So this is really horrible, that was the horrible bit of all that pregnancy really.”*

Participant 11

Being treated in this insensitive way had a profound effect on this individual woman who was diagnosed with postnatal depression following her first traumatic birth experience. Behaviour like this by staff can also lead to women developing a lack of confidence and feeling let down by the staff who provide care at such a critical time during labour and birth. Another quote from a woman below also highlights the experience of insensitive communication on the part of staff to a woman in labour. This woman needed to attend the Birth Reflections service in her subsequent pregnancy as a result:

*“...looking back and discussing it with [H] (woman’s name) it’s quite clear that things didn’t go the way that they should have done. Not necessarily, it was nothing medically that was so bad but the way I was treated by [Name of hospital] was particularly bad and I think then that impacted on my pregnancy with [E] (baby’s name) because as I say birth with [E] (baby’s name) was fantastic and then we just sort of did a bit of a debrief afterwards which has then*

*set me up for you know, we might want more children, we might not want more children but I know now that I am not in the place that I was five years ago.”*

Participant 3br

This subtheme has highlighted the importance of staff being sensitive in their communication with women during labour and birth. If this is absent women are left feeling under-confident as new parents and with misunderstandings about outcomes. They are also unhappy about their care experience, which may result in their perception that birth was negative.

*iii) Relationships with staff*

This work has also shown the importance of developing a positive relationship with the care provider. Some participants spoke of a relationship between themselves and the midwife providing care. In some cases, this had formed during the antenatal period and these women felt they had the good fortune of being provided care in labour by the same midwife they had seen for their antenatal appointments. Others recognised this bond developing with the midwife during the labour itself and this led to supportive care in labour. The below quotes illustrates the value of the relationship between a woman and her midwife during labour:

*“I significantly remember the midwife assertively taking control and not making me feel intimidated, bullied or harassed or anything. Which whenever I speak to anybody else... you know, they kind of go, ‘I didn’t have a relationship with my midwife, she made me feel bad,’ and like I said I’ve had the luxury of giving birth four times with no pain relief, no tears, no stitches, no anything but I have nothing but you know, positive things to say about my experience”.*

Participant 12

*“But I just felt a bit sorry for the midwife at that point because she was doing really well and we were all doing quite well with just one midwife um, and I suppose they had to bring a doctor in... This was the only negative of the whole*

*thing I have to say. And they brought a doctor in and I just felt she was a little bit um... what's the word? A bit belittling to the midwife um,*

Participant 6

Empathy being shown by the woman to the midwife is another aspect of relational care. This was also evident in the data. This is illustrated below in a situation where a woman was left feeling upset by the midwife during her first birth experience at a different hospital in a large city. Despite this, this woman was empathetic to the midwife's situation:

*"Yeah, I realised later on that you know, she was, she wasn't doing her job properly. I imagine that it must be quite hard sometimes, particularly if you are working in a busy hospital and you've got so many patients, it must become a bit you know, you almost must become anaesthetised to the role sometimes and maybe that personal bond you develop with the patient, if you are seeing so many women in one day... you know she's having an off day, 'I can't be bothered with this,' but..."*

Participant 10

Another woman showed empathy towards the midwife who had been providing care for her, when the anaesthetist arrived in the room prior to administering an epidural:

*"And I remember the original midwife saying, 'I've got to go now and good luck with everything,' but she'd been really lovely and I just felt a bit sorry for her when the doctor came in because she was just sort of, she'd been doing all of it and it's like we were coping and she thought we'd get there but I know, it's just hard isn't it if they think they have to do those things. But I think she could tell I wasn't coping with the pain of the kind of the, whatever... that things..."*

Participant 1

This subtheme “Relationships with staff” has shown the value women place on having a relationship with the midwife providing care during labour and birth. Reciprocity in this regard has also been highlighted where women empathise with the midwives’ situations.

*iv) Supported by staff*

As mentioned above women felt supported by a midwife with whom they developed a relationship in labour. There were lots of reports in the data of women feeling supported by staff, together with examples of what precisely supportive care was for them. These included the continuing presence of the midwife, which was supportive in itself, and the provision of comfort measures. Examples of this phenomenon are given in the quotes below:

*“Um, just things like trying to make me as comfortable as possible um even though these two monitors were on me and I kept moving um... There to answer questions, yeah, just generally.....It was nice when you are in that room that you’ve always got somebody with you, there’s always a midwife in that room with you so nobody leaves you so that’s nice to know that...”*

Participant 5

*“Well they were, I’d had the epidural by that point and they did the hormone drip and everything and were good... and were distracting me with lots of stories about anything but being in labour really [laughs].”*

Participant 11

*“Yeah and actually control is a massive... that is the key word, there were a couple of occasions where I lost it a little bit and the midwife was assertive, she was confident, she made me believe that I was going to be able to do it.*

Participant 12

The quote below shows how having the midwife present for most of the time in her second labour contrasted with the first labour when the midwife was out of the room more often:

*“I remember at [hospital name] with [J] (first child’s name) there were long periods of time when it was just me and [B] (partner’s name) in the room. I don’t remember that at all at [study hospital name] there was always somebody, or if there wasn’t somebody with us they would say, ‘I am just nipping out, I need to get this, I need to do this, I am just ‘round the corner,’ I always remember a presence, there was always somebody with us.”*

Participant 3br

On occasions women did not feel supported by the staff providing care. One participant reported feeling well supported by the first midwife who she described as being younger than the second midwife who looked after her. This second midwife failed to provide the support this woman needed. According to this participant the second midwife seemed preoccupied with paperwork and failed to notice the increasing levels of pain she was experiencing. This conveys the effect on how the woman felt about the apparent lack of care, especially being dismissed and told she is not in pain when she feels she is. It is this kind of behaviour by staff that affects women’s experience more than the pain per se. How labour pain is processed emotionally is key:

*“...she was really sort of, she was really stern, she was an older lady and I was saying, ‘Help me,’ when I was going through the contractions and she just... My Mum said she was, because I was sort of zoned out, she was more interested in making sure that the paperwork was up straight and when the epidural had popped out, it had been popped out for about an hour um, I had a bit of relief when it first was in um, because obviously then was in the right place but she said that I wasn’t in pain, when I was in so much pain and it had popped out um, it was only that [D] (partner’s name) had said, ‘Look, you need to get somebody*

*to look at this epidural because she is in pain,' that the anaesthetist came back and checked and said, 'Yeah you are in pain'.*

Participant 1

Some women also reported on the important need for them to feel staff were listening to them and that they were involved in decisions. One woman compared her first birth experience at a different hospital where she remembered being told what to do during her labour and birth. At the second unit suggestions were offered for her to accept or decline as she chose which resulted in her feeling involved in her care:

*“...There was never any of, 'We must do this now because...' and at [hospital name] it very much felt like they were telling me what I needed to do whereas at [study hospital name] they would be suggesting what they thought was best but if I said, 'No,' there was a case of, 'Well that's fine, we will come back in half an hour or an hour and we will talk about it again.'”*

Participant 3bf

Women seemed to reach the conclusion that birth is usually very difficult but the outcome can be positive with the right support from staff. This is illustrated with the quote below from a woman following her second birth experience who had, had an extremely difficult first birth experience but who felt supported much more effectively by staff during her second birth experience:

*“No, as I say, I felt... and I wish I knew the mid... I did send a thank you card but the midwife who dealt with me when I was having her was just fantastic. I felt like she read my birth plan and she um, reassured me and... listened to me and took our concerns seriously. I think she was, I don't know if you would say, the head midwife or the midwife in charge but um, she was fantastic and afterwards if I am honest, I think it all boils down to the people around you, I think it does, that made a difference to our first and second, awful labours aside.”*

## Participant 2bf

This section has highlighted the value to women of optimal support in labour. This includes the continuous presence of the midwife who is attentive to all care needs, including pain relief, and ensures the woman is included in care decisions. The importance of women feeling listened to was also identified within this subtheme “Supported by staff”.

### v) *The need for information*

The participants also identified the importance of being provided with regular, clear information from staff. An example of the need for this is provided in the quote below. This relates to a woman receiving information about her premature baby’s needs on the ward following birth:

*“And they are very good at explaining everything that they are doing and what’s going on um... and even after when... ‘Cause I was on the ward for three days afterwards um and I just kept saying to them, ‘Why did he have a lumbar puncture?’ You know, poor little mite and he was being poked and prodded until the cows come home and they did explain to me and they said later, ‘Do you still understand,’ and I said, ‘No, to be honest no, I still don’t understand,’ so they got somebody else to come and explain to me um, I think because my head was just a complete mess I couldn’t process anything. But they tried and sat down with me to go through things and explain in layman’s terms what was going on, so they were very good.”*

## Participant 5

Being constantly updated with clear information about what was happening led one woman who, despite having had a traumatic birth experience due to severe preeclampsia, to rating her birth as positive. This she felt was down to staff at all times informing her about what was going on and she emphasised this at many different points during the interview:

*“Cause both our health’s were at risk and I understood that. I always understood it because as I said they were so... every single person who came in, ‘This is what’s going on with you, this is what we are doing and this is why,’ so good.”*

Participant 1bf

This same woman contrasted the continuing dialogue she remembers she had with the obstetricians prior to her birth with the lack of explanation from paediatricians about why her baby was given a complementary feed of formula milk.

This short section relating to the subtheme “The need for information” has shown that women require continuous information during labour and birth and also postnatally. This is in relation to both themselves and their babies. Even though in emergency situations, this might be challenging, a few well-chosen words could make all the difference to a woman’s experience.

More generally the global theme “Professional behaviour” has shown how the behaviour of the health professional impacts on the individual woman’s experience of giving birth. Staff members were found to play a key role in an individual woman’s experience of labour and birth. Supportive aspects of care provision were identified from the interview transcripts. When there is: a trusting reciprocal relationship; sensitive communication where women feel listened to; care perceived as supportive and information continually provided, women are able to experience birth positively.

#### **4.6.5 The need to attend a birth reflections-type service**

This theme focuses on aspects relating to women’s reasons for attending a birth reflections-type service. It is drawn from four key subthemes: “Interest versus psychological need to attend”, “Provision of further information and clarification

of events”, “Timing of the birth reflections session” and “Reassurance for future births”. These are described below under the respective headings.

*i) Interest versus psychological need to attend*

The data highlights a division in the views of the women as to the purpose for attendance at a birth reflections service. It was considered by many that this is mainly for women following a traumatic or negative birth experience. One woman said she heard about the Birth Reflections service through another mother whose baby needed brain cooling therapy at a regional hospital following birth. This participant’s view was that the Birth Reflections service was for women who had experienced poor outcomes and did not consider the service available to all women following birth:

*“I mean for her, her situation was obviously a lot worse. Her daughter was born with a really bad temperature and had to go into the ice cooling thing to stop swelling..... Yeah the brain cooling and stuff like that and she had to go to [hospital name] and she’s had loads of like meetings to get answers for billions of questions that she’s had. So I understood it as that, as like a forum to clarify if you have any problems and stuff. But I never really, really thought about it as being, even if you don’t have problems you can just go and talk to them about birth in general and postnatal in general.”*

Participant 9

According to another participant a member of the medical team considered the need for her to have attended a birth reflections session following a previous traumatic birth experience. It was apparent that this obstetrician considered the Birth Reflections service to be of value where women can experience a review with a health professional of a difficult or traumatic birth soon afterwards. In the below quote the participant even suggests that had she attended the service, it might have prevented her developing postnatal depression and the consequent delay between planning a second baby:

*“I think one of the reasons I had postnatal depression is I had no meeting after [S] (first child’s name) birth. That was one of the things that the very good registrar had queried in [M] (baby’s name) pregnancy is why had no one called me back for some sort of meeting or reflection to talk about what had happened with [S] (child’s name). I just never went back to [study hospital name] afterwards and I never heard from anyone and she wonders whether I talked about things I might have come to the point of having a baby much sooner.”*

Participant 11

Whereas the Birth Reflections service was considered by some to be reserved for women with poor outcomes and traumatic births other women who had not had poor outcomes appeared curious and interested in attending the Birth Reflections service to find out more about what happened to them, although there were no untoward outcomes for them personally. The quote below shows that this woman was merely interested to find out more about her birth but worried that this would be wasting the time of the professionals running the service:

*“Yeah, but I’ve always been interested to go back and read the notes and see actually when did that happen. But because it’s just interest, it’s not like I have any sort of psychological need to do it, I wouldn’t want to waste their time really.”*

Participant 7

The different perspectives about eligibility for the service is shown in the quote below. Participant 5 explained the difference in her own personal need to attend which she described as being for reasons of curiosity only compared with a possible need for her sister-in-law who had a traumatic birth experience and therefore had emotional or psychological needs for the service:

*“Yeah. It’s mainly from, it’s not from an emotional point of view or anything, it’s mainly from a curiosity point of view..... Completely, my sister-in-law is pregnant for the second time now but she... perceived to herself to have had a very traumatic birth first time around and so something like this for her um, I think would be very beneficial. I’ll mention it to her actually.”*

Participant 5

It is of interest that a number of women considered the service to be solely for women following poor outcomes or traumatic birth experiences. However, the local Birth Reflections service had always been open to all women, including those in whose births there were no apparent complications. This lack of clarity about the service was also an important finding for the evaluation of the local service. As can be seen at section 4.5, the survey findings, fifty six (40%) of the women who responded to the questionnaire said they were unaware of the local Birth Reflections service and would have liked an opportunity to attend. A further 44 (30%) women said they did not know about the service but would not have attended anyway.

*ii) Provision of further information and clarification of events*

This theme shows that some women need more information about what happened to them during their experiences of labour and birth. This is therefore considered by these women as one of the roles of a birth reflections-type service. One participant who learnt about the Birth Reflections service through the research study wished she had attended this service following the birth of her first baby. This woman felt there were gaps missing from her memory relating to events in labour and she did not understand what happened during her first birth experience. However, she did not consider there to be a need for her to discuss the current birth experience as this she viewed as having been straightforward and she understood everything that took place. The fact that she chose to speak a lot about her first birth experience, rather than the more recent birth that was the planned focus of the interview shows that she was still trying

to understand issues relating to her first birth at the time of giving birth to her second child:

*“See I would quite like to do that with [H] (first child’s name) because I’m kind of... missing bits and I know after I had him as well that I started to haemorrhage three days later.....I think with [O] (baby’s name) it was straightforward, I don’t know whether I’m still trying to find bits and pieces to sort of make myself feel better I suppose about when I had [H] (first child’s name) [ball bouncing].”*

Participant 4

Another participant who also did not attend the Birth Reflections service following her first birth at a different hospital wished she had done so. She reasoned that this would have been to ask specific questions about what happened:

*“But you do sometimes think you know, if you had stood your ground and said you know, ‘What if I did wait a week,’ or whatever, they may have said, ‘Yes you can but it’s up to you,’ but you do sometimes think if you hadn’t, if it all happened naturally, would it have been a completely different experience and you might not have had the complications and the forceps or the Oxytocin drip, all those things that kind of make it harder. So I think in that sense you wonder a little bit about it but I think that’s why it might have been nice to ask a medical professional those things. They might not have had the answers but just to talk it through a bit because I know you can’t change it once it’s happened but I think it would still be nice if you had the chance to talk to a specialist about it and [coughs].”*

Participant 6

The two above participants had given birth to second babies at the time of the interviews but it is apparent they still had questions about their first birth experiences that required answering. This could have been facilitated in a birth

reflections-type service. Both these women were given the details of the local Birth Reflections service by myself after the interview for them to make a self-referral should they have the continuing need to have their questions answered.

Gaining knowledge about the events of her labour two years afterwards provided emotional relief for another woman. This woman had come away from her first birth experience at a different hospital in a large city feeling guilty and ashamed of her own behaviour. Not having given birth before, she did not know what to expect. It was at the birth reflections-type meeting with the Head of Midwifery where she was informed the midwife had behaved inappropriately and as a consequence would be disciplined. This woman came away from what she perceived as a negative experience blaming herself. It is noteworthy that she experienced postnatal depression, which lasted for several years.

*“Yeah when I was in labour there was no explanation as to what was happening and the midwife didn’t talk to me at all throughout the whole thing and I think yeah, we um, in the end we went back and we had an interview, it was two years after I had [S] (first child’s name) we went back and went through my birth notes and everything and heard that she’s been reprimanded for other things [baby rattle]. It was definitely worth it because they explained what she did was very wrong and you know, at the time I didn’t know that so that helped me a lot but just the fact that she didn’t communicate with me at all so I...”*

Participant 10

It has been shown above that attending a birth reflections session was found to be particularly helpful for women who had a traumatic experience, but nonetheless, women who had a more straightforward experience also valued it. This enabled women to speak about their birth experience and be provided with information. They were consequently able to understand what happened to them. However, it was also identified that some women were so angry about what happened to them in labour that they refused to attend as a result. One woman who attended the Birth Reflections service at a later time learned how

her anger had been misdirected and that the staff who provided care did not cause the wound infection she had blamed them for, for two years. She recognised that had she attended a birth reflections session earlier she would have understood sooner and not spent a long period of time when her baby was young falsely worrying. Analysis of the women's accounts indicates that attending a birth reflections-type service helps women understand the events of their labours and experiences of birth. This process is particularly helpful where women leave the birth experience with negative misunderstandings about what occurred.

*iii) Timing of the birth reflections session*

"Timing of the birth reflections session" was another issue discussed by some of the women in the interviews and became the third subtheme under this global theme on women's need to attend a birth reflections-type service. There was an element of opinion suggesting the need to discuss the birth experience at a birth reflections-type session during the first few weeks following birth. Other women considered attendance to be more beneficial around six months following the birth. This they considered to be a time when emotions are still running high and can be worked through. This was recognised by one woman who had been extremely angry and refused to attend the Birth Reflections service when first offered soon after birth but who had gone to a session when requested to do so by the consultant when she requested a caesarean section in her subsequent pregnancy:

*"It would have saved us an awful lot. As I say, I dealt with my anger about um, the first few weeks of motherhood but obviously yeah, I hadn't cleared up an awful lot of these big dark questions that were in my mind. Yeah, should have done it. I would say if a woman is going to, go within the first six months when you still have got the emotions there and you can work through them [baby crying] but that's just... What do you need my darling, what do you need?"*

Participant 2br

Other participants mentioned about the busyness of life with a new a baby and the consequent difficulty returning to the hospital to attend a birth reflections session. However there was strong opinion about the benefit of attending a birth reflections session at the time of thinking about having another baby.

*“I can see that that might be useful if I did want another one, to go back to my you know, notes before and say look, ‘I’ve been induced both times now [laughs] what is going on? Is there anything that can be done about it? Or is there any way I can opt out of being induced? I suppose there might be questions I would ask, I’d probably maybe slightly do things differently or try and put off the induction I suppose if it was possible [pause]. I mean like, with [I] (child’s name) I probably could of really waited a bit if I wanted to but I think you do listen to the doctors a lot, if they think there is a reason they think you should be induced you know...”*

Participant 6

It has been shown that the participants in this study considered three key time points for when it is desirable for women to attend a birth reflections-type service. These are within the first few weeks following birth, at around six months postpartum and when considering having another baby. Although not stated by the women during the interviews, as with all maternity care provision there should be the need to individualise timing of attendance with the needs of women and their specific birth experiences and requests. As has been mentioned in the section “Interest versus psychological need to attend” there is the need to consider what triggers an interest in attending. Whilst some women may have a psychological need to do so, others are merely curious about what occurred during their experience of giving birth. Finally the practical difficulty many women have returning to the hospital with a new baby was mentioned by the women. This is all important information when planning services.

*iv) Reassurance for future births*

The final subtheme in this section is “Reassurance for future births”. Gaining reassurance about what happened during the current birth experience was shown to provide reassurance for future births. One woman was particularly keen to attend following her second birth experience to glean any possible key information in case she had another baby. This woman was particularly keen to do so as she had not attended a birth reflections session following her first birth after which she developed a profound fear of giving birth again. Following her second birth experience, which was much more positive than the first had been, she elected to attend a birth reflections session to gain reassurance for a possible third pregnancy. Having this session would dispel the fear of giving birth that she experienced in her second pregnancy

*“No, no, no, the position after [J] (first child’s name) birth was that I didn’t really understand what had happened and we’ve always had in the back of our minds that we might want to have another one... and I mean I loved being pregnant both times around particularly enjoyed being pregnant with [E] (second baby’s name) but it was always marred by this fear of giving birth and if we were to go on and have another baby I would want to enjoy the pregnancy without that fear at the end. So I took advantage of the Birth Reflections because it wasn’t something that had been offered to me before and I wonder whether if I’d had the opportunity to have it before... whether...”*

Participant 3bf

This final subtheme “Reassurance for future births” has shown that attending a birth reflections-type service following an earlier birth experience provided reassurance for other pregnancies and birth experiences in the future.

In summary the final theme, “The need to attend a birth reflections-type service” has identified some practical issues in relation to running a postnatal debriefing service. It is of interest that whilst some of the women considered a postnatal debriefing session is only for women following extreme outcomes others were

curious about finding out what was documented in the maternity record relating to their birth experience. The latter seemed keen to attend but erroneously felt it would not be appropriate for them to do so as they had not experienced complications with their personal birth experience. When advertising services it is important for care providers to ensure the correct message is given.

This theme has also confirmed the key aspect of attending a birth reflections-type service is the need for some women to gain a fuller understanding about what occurred during their labour and birth experiences. This remaining unresolved can lead to problems in subsequent pregnancies i.e. fear of giving birth. The women also gave different suggested timings about when they felt a postnatal debriefing session should take place. This ranged from within weeks following birth to when a woman is planning a subsequent pregnancy. Finally, this theme showed that women were provided with reassurance about a future pregnancy and birth experience by attending a birth reflections-type meeting and having a postnatal debriefing.

#### **4.6.6 Lasting emotions linked to the birth process**

The final theme is “Lasting emotions linked to the birth process”. This theme shows that some women are left with heightened emotions which may be linked to the birth experience. This theme comprises three subthemes: “Anger”, “Fear of giving birth again” and “Living in an emotional bubble”. These are described below.

##### *i) Anger*

As has already been shown some women left the birth experience with angry feelings. They apportioned blame to the staff involved in their care and this was sometimes misplaced. There was a general lack of understanding about complications that had arisen. Unfortunately, the angry feelings prevented these women gaining a clear understanding of the reason for the unexpected poor outcome. Their anger stopped them taking up the opportunity of attending the

Birth Reflections service and having the conversation with staff that would have clarified matters

One woman waited two years before finding out the perineal wound infection that she sustained was not the result of poor quality care from the doctor who undertook the delivery of her baby and the suturing of her wound. Whilst declining an appointment at the Birth Reflections service instead she underwent a counselling session as a result of her extreme emotional reaction:

*“No, angry at the treatment from the hospital [Child talking] I know darling... Angry at how I felt, the way I was treated while I was in labour and the birth itself. I felt like it had gone horribly wrong you know, just for me um, I was very angry at the whole experience, in fact I had counselling about it”.*

*Participant 2br*

After refusing to meet with staff at the maternity unit following her first birth experience to attempt to address her feelings of anger this woman sought out a caesarean section when she became pregnant for the second time. She was encouraged to attend the Birth Reflections session during this pregnancy, which was two years later. It was at this session when she learned her anger had been misdirected but was also reassured that her care would be improved:

*“Well as I say, we had misdirected anger, it wasn’t the way they stitched me ... she did say, ‘Yes, I don’t think you got the highest standard of care possible,’ and that made us feel like, Ok, we are not just imagining all of these problems, it could have been handled differently and that was big for us to think Ok, next time that won’t happen. She changed our whole pregnancy, our whole pregnancy, I went from wanting a C-section to being ok with going into natural labour um... We literally spent two years worrying about our second labour and it was so helpful, so, so helpful to us.”*

*Participant 2br*

By attending the Birth Reflections service and gaining a full explanation about what caused this woman's infection gave her the much needed knowledge and reassurance to alter her plan for a caesarean section during her second pregnancy.

*ii) Fear of giving birth again*

"Fear of giving birth again" was the second subtheme under the theme about women's ongoing emotions after birth. This phenomenon has already been identified above in section 4.6.5, iv) "Reassurance for future births". It is of interest that all of the four women who were interviewed who had attended the Birth Reflections service expressed degrees of hesitation about becoming pregnant for a second time and having to face giving birth again. One woman rushed to get pregnant again as she knew she needed to have another child at some point. Due to the negative and traumatic experience of her first birth she wished to get the subsequent experience over with as soon as possible. The remaining three women all shared their fear of giving birth again. They were terrified of doing so as illustrated in the below quote:

*"So it was actually the experience with [J] (first child's name) that impacted on pregnancy with [E] (second baby's name) and whenever I was going to my um, Community Midwife appointments for some reason, inexplicably I would end up in tears because I was so terrified about giving birth again because of what had happened first time 'round um and she ended up referring me to [H] (health professional's name)..."*

Participant 3br

Another woman, whose first birth experience had been positive yet traumatic due to being diagnosed with severe pre-eclampsia and undergoing an emergency caesarean section, became very anxious about the possible need for her to have another medicalised birth. She had been keen to have a vaginal birth after caesarean section (VBAC). This woman broke down in tears on the

day of her induction of labour when a complication with the baby arose, as can be seen in the quote below:

*“...the midwife came in and I just broke down in absolute tears. Suddenly it dawned on me that I was, that I was going to sort of have a baby that day and she was like, ‘What’s the matter,’ and I said. ‘I am just absolutely petrified of it all going wrong again and me ending up with a C-section,’ and she was trying to sort of calm me down”*

Participant 1 br

Two examples of how women are left in fear about a subsequent birth following a first birth experience have been shown above. However, despite this fear, with the help of professional support in the form of a Birth Reflections service during subsequent pregnancies they both came to feel prepared for another labour and to give birth vaginally. This highlights how attendance at a Birth Reflections service can provide the support women need to plan subsequent birth experiences.

*iii) Living in an emotional bubble: “I was just existing”*

This last subtheme “Living in an emotional bubble” highlights how women can be left emotionally incapacitated more generally. Attendance at the Birth Reflections service went a long way to helping the women as mentioned in the above sections. However, for others an emotional bubble remained for many months following birth and had an effect on the subsequent pregnancy. This could lead to anxiety and fear of giving birth again, as mentioned above. It seemed that the midwife at the Birth Reflections service was not always appropriately equipped to give psychological support. The women considered that attending a birth reflections-type service was generally a good forum for having questions about the birth answered but that thoughts about how women were emotionally were not always dealt with at such a meeting. This is shown in the quote below:

*“It’s that element, it’s good to be able to talk through something but I don’t think that the midwives are properly trained in that emotional psychological element, the counselling element and you know, as I said, talking through a traumatic experience, getting answers is great and you know...”*

Participant 1 br

Another woman also felt the need for more emotional support. She felt she did not engage with her baby and that she was merely existing for the first few months after the baby was born. It took five months for her to seek help from the Birth Reflections midwives after being referred to the service by her health visitor:

*“Yeah, exactly but I knew that I was not coping as well just by listening to other people’s experiences and how wonderful things were and I was so uptight and on edge and anxious and I was driving, having flashbacks of the birth for up to six months. So... I did go...”*

Participant 4br

This same woman stressed the need for health service providers to ask women how they are feeling after birth. This was not her experience despite meetings with her health visitor, general practitioner and birth reflections midwife.

This final theme “Lasting emotions linked to the birth process” has shown that some women are left with negative emotions following birth. Whereas some of these manifestations (e.g. anger and fear of birth) can be supported through the provision of a birth reflections-type service there are other women who have a more serious psychological need who require referral to other professional specialists. However, the most important matter pertains to the need for early recognition of women who are unhappy following birth.

#### **4.6.7 Conclusion**

Five themes were identified from the data and have been described in this chapter. These are: “Giving birth is traumatic/horrific”, “Making sense through the blur”, “Professional behaviour”, “The need to attend a Birth Reflections-type service” and “Lasting emotions linked to the birth process”. These themes will be brought together in the following discussion chapter alongside the quantitative findings to answer the study objectives.

As well as responding to the research objectives, the two sets of data i.e. quantitative and qualitative, coming together in this way have the potential to identify other findings. It will be seen that the two separate concepts of “negative” and “traumatic” birth experiences are unearthed in this way.

## **4.7 Discussion**

### **4.7.1 Introduction**

As described in section 4.4 under methodology in this discussion chapter the findings of the quantitative and qualitative parts of the study are brought together to allow a fuller understanding of the issues in order to answer the study objectives. The overall findings are synthesised and also discussed in relation to the wider literature. They are presented here under the respective headings linking to each research objective: “Reasons why women choose or do not choose to attend the Birth Reflections service”, “The expectations of women prior to attending a birth reflections session”, “Women’s perceptions about what a birth reflections service is” and “Lasting emotions following birth”. These sections are then followed by a discussion on the concept of a negative birth experience and how this links with the notion of a traumatic birth experience. The discussion section ends with an account of the strengths and limitations of this study, including a section on reflexivity.

### **4.7.2 Reasons why women choose or do not choose to attend the Birth Reflections service**

Through the use of a mixed methods approach, this research study has identified that a large proportion of women go home following birth, continuing to think about this event. Thinking about the birth in this way was found to generate both joyous and painful feelings in women depending on their overall rating of the birth experience i.e. positive or negative. The process of thinking leads to some women reviewing the birth experience and raising questions. This finding fits in with those of some other authors who have identified that women talk to family and friends following birth (Inglis 2002) and process their memories of birth (Ayers 2007). However, these studies do not explicitly mention that women are thinking about the birth. This appears to be the only study that has identified the earlier action of thinking about the birth.

Both sets of data within this mixed methods research study identified that a number of women continue to think about their labour and birth experiences after leaving the hospital and going home following the birth. This applied to 88% of the women who completed the survey.

Ayers (2007) in a qualitative study showed all women processing their memories of birth, including those with PTS symptoms (Ayers 2007). The same author described this as a “postnatal appraisal process” (Ayers 2007:262). There seems to be a need for some women to discuss their birth experience with a health professional who is able to respond to their unanswered questions. This is achieved during postnatal debriefing at a birth reflections-type service.

As mentioned above there was evidence in the data of women following both positive and negative experiences of labour and birth, talking about these events and formulating questions about their experiences. Some women spoke with their partners and significant others, who had been present during the labour and birth, about this. Sometimes answers to questions were provided in this way and there was no need for further discussion with a health professional. Inglis (2002) and Gamble and colleagues (2004a) also identified that women used their family and friends to speak with after birth. However, this was not always successful and their ‘significant others’ were not able to provide the necessary reassurance about the birth. Some partners and family members who were present at the birth will be able to help a woman by providing an empathetic understanding and answer some questions about what happened. However not all partners or family members will be able to provide support in this way. There may also be other more technical questions that can only be responded to by a professional.

This study has identified an exploratory statistic about the proportion of women from a small sample of women who gave birth at a maternity unit in England in

2013 who wished to discuss their birth experience with a midwife. To my knowledge, the proportion of women who wish to attend a birth reflections-type service has not been reported elsewhere. This may be replicated in other samples and therefore has implications for maternity service providers. The results of this study show that approximately just under a half of all women who responded to the survey had a desire to talk with a health professional about their experiences of labour and birth. According to the findings of the quantitative analysis, while 52% said they did not need to speak with a health professional following their birth experience, a further 43% wished to do so. An even starker finding is that 40% of the total sample of women responding to the survey said they did not know about the Birth Reflections service and had they done so they would have chosen to attend this service. This finding, that women wished to talk about their experience of labour and birth afterwards, is supported and further elaborated in the findings of the qualitative analysis. The content of the qualitative theme “Making sense through the blur” provides further explanation as to the aspects many women wished to talk about, usually to a health professional.

This finding of the need of many women to talk following birth concurs with findings from the critical review of the literature described in chapter 3 (see also Baxter et al 2014). The review showed women had a need to tell someone about their birth experience. This served two key purposes: it allowed them to have their voices heard and it also helped them to air their feelings about the birth experience. Conversely those women who were not offered the chance to discuss their birth experience with a midwife in the literature review wished to do so (Baxter et al 2014 and chapter 3 in this thesis).

Some women in the qualitative analysis of the current mixed methods study were identified as having gaps in their memories of events during their labour and birth experiences following birth. These women had questions about their experiences of labour and birth (e.g. the timing of events) which when answered filled the memory gaps. This finding also concurs with the critical review of the

literature which identified that women may have gaps in their memories following labour and birth (Baxter et al 2014 and chapter 3 in this thesis). Although not explicitly stated by any of the authors from the individual papers in the review this seemed to explain the fervour among some women to talk and gain an understanding of events by having their questions answered. The identification of gaps in some women's memories has been confirmed by the current mixed methods study. It is of interest that the findings of another qualitative study of women with and without PTS symptoms showed that not remembering aspects of the labour and birth was only identified among women with PTS symptoms (Ayers 2007).

This contrasts with another author who identified women having vivid memories of their childbirth experiences. Simkin (1992) compared 20 women's reports of their experiences of labour and birth over 20 years. These women completed a structured labour and birth questionnaire and unstructured account shortly after their babies were born. This was repeated with the same women 15 –20 years later when an interview also took place where the women's memories and perceptions were discussed. In this study Simkin identified the women's memories were generally accurate over the 15-20 years and were often strikingly vivid. However in common with the current study the same author also identified the need for women to talk about their labours and births in order to understand what really happened to them during their experiences of giving birth. According to Simkin (1992:77) women leave the birth experience with an "inner reality" of what occurred but this needs to be matched with the "outer reality" of what others saw. This involves a process of integrating and understanding. Simkin mentioned the need for women to make sense of the story of their birth experiences and they need to put the story into words. She stated that this involves memorising by having questions answered and undergoing a general process of review, discussion, repetition and evaluation. This could be an early version of a current day postnatal debriefing session in a birth reflections-type service.

The fact that women are needing to have questions answered in this way suggests that despite vivid memories of their birth experiences over time some information is missing from their memories following birth. In addition, Simkin identified a second dimension in association with birth memories. This relates to the recall or reliving of feelings associated with the birth i.e. emotional memory. This finding also concurs with the present study and will be discussed in a later part of this discussion chapter. It seems that no individual woman will have a comprehensive memory of her labour and birth experience. All women's memories will not be identical to those of others. In addition, memories of events during labour will be affected by different forms of pain relief that can affect mental processing. It is also important to recognise that women with PTS symptoms are more likely to have difficulty remembering aspects of their labour and birth. This has implications for service provision when planning services. The qualitative findings of this current mixed methods research study also identify there is a point in time when women feel the need to move on emotionally from the birth experience. Having their questions answered helps this process, which was described by one woman as being cathartic. This was also identified from the critical review of the literature (Baxter et al 2014 and chapter 3 in this thesis) and confirmed in this study.

The discussion so far has highlighted the main reason why women wish to attend a birth reflections service is to talk to a health professional, about their experiences of labour and birth. Understanding the reasons why women wished to attend a postnatal debriefing session was one of the objectives for this study. The need for women to talk following birth was also identified in the critical review of the literature (Baxter et al 2014 and chapter 3 in this thesis). It has been previously recognised in the cancer setting that the opportunity to discuss feelings, particularly negative ones, can be considered to be a type of social support in itself (Wortman and Dunkel-Schetter 1979).

Possible reasons why women do not attend a birth reflections-type service have not been previously identified. Based on the survey reported here,

approximately half of all women do not feel the need to attend. Women were given the opportunity in the questionnaire to give free-text comments about this. One hundred and six out of 170 (62%) women responded to this question. The largest number of comments (twelve) related to women being busy with their babies and not having time to attend a meeting to discuss their birth experiences. It is also helpful to have been informed by five women who also responded to this free-text question in the questionnaire that they felt they received too much information at this time, which provides further evidence that women may also be overwhelmed with their new lifestyle as a parent, suggesting that the timing of the offer may need further consideration. Attending a birth reflections service might be seen as an additional burden in the busy lives of these women. This might also be the reason why a high proportion of women did not read the information given to them about the Birth Reflections service in their discharge packs as identified in the quantitative findings of the current study.

Women who leave the birth experience with positive feelings about this event (as reflected in a low IES score) were less likely than those who had a high IES score to perceive the need to speak about it afterwards. This is a statistically significant finding from the quantitative analysis, which is also supported by the qualitative data. The qualitative analysis unpacks this phenomenon further and finds that many women who are content about their birth experience also have a full understanding of what occurred during their labour and birth. This finding suggests having an awareness and knowledge about what happened during their experiences of labour and birth reduces the woman's need to talk about it with a professional. This was confirmed in the quantitative findings by a chi-square test. There were statistically significant differences between the two variables: women's ratings of their satisfaction with care and women's understanding of what happened during their labour and birth. There seems to be an association between a positive birth experience and understanding about events during labour and birth. This is a key finding from this mixed methods study and contributes to the evidence base. It supports the value midwives play

in supporting women during the birth experience and indicates that this may reduce the number of women who wish to access a postnatal debriefing service as a result of a negative birth experience.

#### **4.7.3 The expectations of women prior to attending a birth reflections session**

As described above around half of women responding wished to talk following their experiences of labour and birth. The findings of the qualitative part of the study provide more detailed information regarding women's understanding of what a birth reflections session is and how it may help the women who attend. The analysis identified a misconception among some women about the purpose of a birth reflections-type session. There appeared a common view among some women in the qualitative sample that attendance at such a service was reserved for women with psychological need only. Some of the participants who had not attended a birth reflections-type service felt that it is for women who had had poor outcomes (e.g. the baby was born in poor condition and needed care in a neonatal intensive care unit (NICU)). Some other women expressed an "interest" to attend and see their maternity records. This they felt would help them to learn more about what occurred. These women admitted to being curious to find out more about what happened to them during their birth experiences but erroneously felt the service was not for this more perfunctory reason. To these women, only women with serious emotional needs following birth or those who perceived their birth experience as being traumatic, were eligible to attend.

The literature review (Baxter et al 2014 and chapter 3 in this thesis) highlighted the confusion among professionals that still exists about the provision of postnatal debriefing within a maternity service with no clear universal model for postnatal debriefing. It is clear from the discussion above that the present research has identified that women service users are also confused in this

regard. This effect upon women was not identified in the findings of the critical review of the literature (Baxter et al 2014 and chapter 3 in this thesis). It appears that this is the first study to have considered women's perceptions in this way. One of the teams of researchers whose paper was included in the critical review of the literature described a medley of services where different groups of women could attend (Ayers et al 2006).

#### **4.7.4 Women's perceptions about what a birth reflections service is**

The views of women as to what takes place within a birth reflections-type meeting leads on from the section above where the expectations of women to a birth reflections session were identified. The participants in the qualitative part of the study who had experienced using the service helped further understanding about what is the actual experience of a birth reflections-type meeting.

It was identified that at this meeting women had their questions responded to and also gained a clarification of the events that occurred. The qualitative findings of the present mixed methods study also revealed how it is possible for some women to go home following birth with a misunderstanding of aspects of their care and what happened to them. On occasions such women can be left feeling angry unnecessarily. Attendance at a birth reflections session therefore provides women with the opportunity of gaining a clear understanding of what happened to them during their experiences of labour and birth and prevents the risk that some women may misinterpret the causes of certain events and consequently leave the hospital concerned about possible poor practice or negligence on the part of staff. On occasions this will lead women to making formal complaints. Reacting in this way does not always resolve a woman's view of what happened to her. Attending a birth reflections meeting and having the opportunity of seeing the maternity record and discussing the events with a trained member of staff is more likely to help a woman gain an understanding

about what happened. The qualitative findings in this study also highlight how this session can help women to be reassured about what happened during one birth experience to prepare them for a possible subsequent experience in the future and prevent the risk of fear of giving birth again. Gaining an understanding of what happened and “Making sense through the blur” in this way was found to help women in coming to terms with their birth experiences and being able to ‘move on’ emotionally.

This appears to be the first study where the data suggests that what women lacked was a clear enough account of why certain things happened to them and how these can be supported during a postnatal debriefing session.

The findings of the present study concur with those of the critical review of the literature (Baxter et al 2014 and chapter 3 in this thesis), which also identified that postnatal debriefing provides women with information and a greater understanding of their birth experience. Gaining an understanding of events in this way and feeling listened to provided women from the studies in the literature review with a validation of the birth experience. Together, these two pathways allowed women to reach closure by having their experiences validated and consequently move on with their lives (Baxter et al 2014 and chapter 3 in this thesis). Although the women in the present mixed methods study did not talk explicitly about having their birth experiences validated through the process of discussing their experiences with a midwife, there was mention of the need to move on after the birth and place it in the past by some women in the qualitative findings.

Furthermore some of the themes suggest that some women did indeed feel their experience was more validated through this process. For example having the specific questions responded to, that are raised through the process of thinking and reviewing the birth, shows women are gaining a sense of the support and healing that is generated through validation.

The participants of the qualitative part of the present study held differing views about the best time in relation to the birth to attend a birth reflections session. A range of opinion on this was spoken about by the participants. Some felt it was useful to attend soon after the birth. Others thought it could take place at a later stage around six months after the birth. Another opinion about the best time to attend this service is when a woman is considering becoming pregnant again and having another baby, when it would be helpful to review the events of previous birth(s) experiences and make plans accordingly. However while there is a rationale provided for each, this needs more investigation. This echoed the findings of the literature review (Baxter et al 2014 and chapter 3 in this thesis). where the timings actually used ranged between shortly after birth and before going home from the hospital up to 12 months postnatal when women were considering having a subsequent baby.

As discussed above, the present study shows that individual women may access this service for a variety of reasons. There is therefore the need to consider the various reasons to be able to understand optimal timing for the meeting for individual women. For example, a woman who is experiencing emotional sequelae may need to attend at an earlier time point, whereas there is a less urgent need to attend among women who are purely curious about the events that occurred. This fits with the findings of other studies where the need for the individual woman to select the best time for herself to attend a birth reflections-type service was found to be important. However there is a risk that this may conflict with the psychological evidence. There is therefore a need to remember the recommendations of the Cochrane review by Rose et al (2002). This advised the need to offer debriefing at least one month after a traumatic event, as well as more in accordance with the individual wishes of the person who experienced the trauma.

#### **4.7.5 Lasting emotions following birth: the perception of having had a traumatic birth experience**

The final research objective was to explore reasons why some women may leave the birth experience with emotional distress.

Overall approximately one third of the respondents' IES scores was raised above eight, suggesting they were experiencing some PTS symptoms. There is a need to be aware that the sample may be skewed as women who had a traumatic experience might have been more likely to respond to the postal survey. However this sample was very informative

This finding concurs with the work of other authors in the field who set out to examine psychological trauma during childbirth (Ayers 1997, Creedy et al 2000, Czarnocka and Slade 2000, Gamble and Creedy 2005, McKenzie-McHarg et al 2015, Soet et al 2003). For example Creedy et al (2000) in Queensland, Australia, undertook a prospective longitudinal study to determine the incidence of acute trauma symptoms and post-traumatic stress disorder in women as a result of their labour and birth experiences. Telephone interviews were conducted with 499 women between four and six weeks following birth. These researchers found that one in three women (33%) identified a traumatic birthing event and reported the presence of at least three trauma symptoms.

Similarly Soet et al in the United States in 2003 obtained a sample of 103 women. These were recruited in late pregnancy from childbirth education classes when they conducted a survey. They also were asked to complete a questionnaire at a follow up telephone interview at approximately four weeks postpartum. The Traumatic Event Scale for use in researching post-traumatic stress disorder resulting from childbirth was used (Wijma et al 1997). These researchers found that 34% of women considered their birth experience as traumatic.

A different measure, the Impact of Events Scale (IES), was used to measure post-traumatic stress disorder symptoms in the present mixed methods study in England. Although not validated for childbirth it has been frequently used when researching this group. Whereas Creedy and colleagues and Soet and colleagues selected their samples in late pregnancy and used telephone interviews approximately four weeks after birth, the present study sent a postal survey to women between four and five months following birth. However according to all three studies up to one third of women giving birth may leave the birth experience perceiving as having been traumatic. The present study shows symptoms continue at a later point in time. It is of interest that Creedy and colleagues in 2000 highlighted that no other study had commented on the proportion of women who were distressed but who did not meet the DSM-IV criteria. The present study has also identified the group of women who may be suffering in this way following birth at a much later time point in relation to the birth. It is apparent that women may experience symptoms lasting for many months following birth.

Utilisation of the IES on the sample of women in the present mixed methods study also enabled cross tabulation between groups of women, to explore these issues further. Women's experiences of labour and birth were different according to their IES score. Women with a raised IES were more likely to have a negative birth experience, wished to talk with a health professional and attend a postnatal debriefing session. In comparison women with a low IES were more likely to rate the birth experience positively and less likely to wish to attend the service. Whilst other researchers have identified a link between trauma and fear of birth this appears to be the first study to identify an association between birth trauma and need to talk following birth.

In the present mixed methods study the findings of the quantitative analysis concurred with the qualitative findings. Some of the women who participated in the qualitative interviews also identified themselves as having had a traumatic birth experience. There is a possibility that women may overuse terms such as

“traumatic” and “horrific” when describing their birth experience. However it is clear in the quantitative findings of this work that a significant proportion of women experience some PTS symptoms. With or without actual symptoms according to the IES score it is always important to consider the perceptions of women when they say their birth has been traumatic. When trying to find a definition for this concept it appears women who say they have had a traumatic birth experience are alluding to the physical or emotional impact the birth process has had on them.

These findings concur with current knowledge in this area. Obstetric intervention was a strong predictor of acute trauma symptoms in a study of the incidence and contributing factors of trauma symptoms following childbirth (Creedy et al 2000). When a woman received a high level of obstetric intervention and poor maternity care, the risk of trauma reactions increased ( $\beta = 0.319$ ) (Creedy et al 2000). This finding is further supported in a study by Gamble and Creedy (2005). These authors examined the relationship between type of birth and symptoms of psychological trauma at four to six weeks postpartum. The results showed that women who had an emergency caesarean section or operative vaginal delivery were more likely to meet the diagnostic criteria for PTSD than women who had an elective caesarean section or spontaneous vaginal birth (Gamble and Creedy 2005). This was echoed in the findings in this present study of an association between a high IES score and birth intervention.

Labour pain was also found to be a reason for the perception by some women as birth being traumatic in the qualitative part of the current study. This concurs with the work of many others who have previously identified pain as a significant predictor of the development of post-traumatic stress disorder (PTSD) (e.g. Allen 1998, Creedy et al 2000, Reynolds 1997, Soet et al 2003). However this finding may not be as simple as it sounds. Childbirth is painful and many women experience the pain but do not develop PTSD or some of the symptoms of PTSD. It may be the associations with the pain and emotional processing of it

that lead to the perception of trauma. So rather than the pain itself having the effect it might be fear associated with the pain or perceived lack of control because of the pain, rather than simply experiencing pain, or even the level of pain. Providing support with pain in labour is a key role for midwives. This study has highlighted how midwives impact on an individual woman's birth experience. It seems that trauma relating to the birth event may be mediated by professional behaviours and how supportive they are. There is growing evidence about the effect staff have on a woman's perception of birth as traumatic. These studies highlight how the actions or inactions of staff can result in care being experienced as dehumanising, disrespectful or uncaring (Elmir et al 2010, McKenzie-McHarg et al 2015).

Anger relating to their birth experience was another emotion described by some of the women in the qualitative strand. Ayers (2007) highlighted how anger has not been widely examined during childbirth and how during or following the birth experience anger can be a possible sign of PTSD (Ayers 2007). These women leave the hospital environment feeling unhappy and with unresolved issues. They may or may not know about the Birth Reflections service, but even when this service is offered to them they may refuse to attend due to their angry feelings. These feelings are often directed towards the care providers themselves. These women seem to need to distance themselves from the hospital organisation.

In summary, along with other researchers, this mixed methods study has confirmed that some women leave their birth experience with ongoing negative emotions. This is reflected in the raised PTS symptoms identified from the quantitative analysis. In addition the qualitative analysis provides further support and explanation in this regard. This strand from the mixed methods study also reveals that some women leave the hospital following their birth experience with feelings of anger, fear of giving birth again and feeling distanced from others and not feeling like other mothers ("living in an emotional bubble").

#### **4.7.6 The concept of a negative birth experience**

This study also contributes to the evidence base about what constitutes a negative birth experience. It has highlighted this concept in both strands of the MMR study and provided further evidence. Women respondents to the survey whose expectations of labour and birth were not met were more likely to be dissatisfied with the care provided them in labour, have less positive feelings about their birth experience and how they managed labour. They were also more likely to have a more negative view of their overall labour and birth. Three additional key results from the quantitative analysis found that 11 (7%) and 5 (3%) respectively of women reported that their satisfaction with care was fair or poor. Also when the respondents were asked what were their feelings about their birth experience 21% reported that they were either disappointed or very disappointed with it. Finally 21/170 (13%) respondents reported that their birth was “awful”.

Therefore according to this work a negative birth experience comprises some or all of the above outcomes. These findings indicate that a negative birth experience is consistent with a lack of satisfaction with the birth experience.

The present mixed methods study has also shown how the behaviour of staff can impact on an individual woman's experience. Some women in the qualitative interviews spoke of their unhappiness about aspects of their birth experience. This was often in relation to the interaction with the health professional providing care. Although many women rated the support they received by staff in labour positively, there were others who described poor experiences of care and support with the midwives and medical staff providing care. In addition, a small minority of respondents to the quantitative survey also rated their satisfaction with care as being fair or poor compared with excellent, very good or good. This concurs with a study undertaken by Harris and Ayers in 2012 in their innovative work using hotspots to understand the nature of possible traumatic reactions during childbirth (Harris and Ayers 2012). Hotspots

stem from the trauma literature and are also a feature of therapy in psychotherapy. These researchers identified a high rate of PTSD amongst their internet sample of women who had experienced a traumatic birth. The majority of participants (57.2%) fulfilled criterion A for a traumatic birth and 18.8% had PTSD. Harris and Ayers found that emotions and cognitions, experienced during hotspots as chosen and described by the participants, appeared to be influenced by the type of event that occurred. Three key groups were identified: interpersonal, obstetric complications and complications with the baby. Interpersonal difficulties during birth were associated with negative emotions and were the strongest predictor of PTSD with over four times higher risk. Interpersonal events mostly concerned lack of support during labour (e.g. being ignored, feeling unsupported or abandoned).

It is clear that a small but significant minority of women are unhappy and disappointed in relation to their birth experience. This study has highlighted the concept of a negative birth experience within the UK context. Being disappointed in relation to labour and birth leads women to perceiving their birth experience as negative. In addition, this study has identified the effect of the support provided by the individual care professional as a key factor associated with a negative birth experience. This finding on the effect of staff on a woman in labour and during birth is supported in other international studies (Creedy et al 2000, McKenzie-McHarg et al 2015, Sawyer et al 2013, Waldenstrom et al 2004).

#### **4.7.7 The overlap between a negative birth experience and traumatic feelings**

There are some areas that link the two concepts traumatic and negative birth experiences discussed above. These relate to two key findings from this mixed methods study: the impact of staff on individual women's experiences of birth and unexpected happenings. These will be considered in this section. As

previously mentioned the notion of birth as being traumatic relates to physical or emotional symptoms caused directly by the birth process. This includes both women's perceptions of birth being traumatic and actual PTS symptoms. A negative birth seems more to do with satisfaction of the birth experience.

The effect of staff interaction bridges both negative and traumatic birth experiences. As well as contributing to a negative birth experience the impact of staff interaction can also lead to the perception of birth as being traumatic. This is borne out in the current study and is a key finding from both strands of this mixed methods study contributing to the wider evidence base. The effect of staff interaction during childbirth is also evident in a study of women's perceptions and experiences of severe maternal morbidity (e.g major obstetric haemorrhage, severe pre-eclampsia, critical care admission). These were found to be compounded by inadequate clinical management and care (Furuta et al 2014).

It seems that it is not only women who experience emergency complications during labour and birth who find labour and birth to be difficult. Women without apparent complications also perceived birth as being difficult in the current study. Indeed some perceived it as being traumatic. Many women in the quantitative findings of this current study had a raised PTS symptom score to further support this finding. Going without effective support at this critical time, as well as leading to dissatisfaction with the overall birth experience, also risks increasing undesirable emotional sequelae among women. From reviewing the literature in this area in relation to these findings it is clear that there is the risk that women who have negative perceptions of their birth experiences risk developing a fear of childbirth in the future (e.g. Storksen et al 2013, Tatano-Beck and Watson 2010, Thomson and Downe 2016, Thomson and Downe 2010). Some of these women also experience a perception of having been traumatised (Ayers 1997, Creedy et al 2000, Czarnocka and Slade 2000, Gamble and Creedy 2005, McKenzie-McHarg et al 2015, Soet et al 2003) and this continues after they go home after the birth.

The qualitative strand of the present study also identified poor staff communication as contributing to women's perceptions of birth as being traumatic. The findings of an association between women's interaction with staff and their perception that birth was either negative or traumatic concurs with the work of other researchers (for example Creedy et al 2000, Czarnocka and Slade 2000, Elmir et al 2010, Wijma et al 1997). The women in Creedy et al's study of acute trauma symptoms in childbirth who reported care to be poor were more likely to be dissatisfied with the decisions made by staff about their treatment; to perceive that they were not consulted or respected and to report procedures as painful. Wijma et al (1997) in their cross-sectional study in Sweden, of prevalence of PTSD after childbirth and women's cognitive appraisal of the childbirth experience, also identified an association between contact with staff and PTSD. The sample consisted of 1640 women who were recruited by the researchers one year after birth. These researchers also found that meeting the criteria for PTSD was statistically associated with ratings of the contact with delivery staff (Wijma et al 1997). Another research team in the UK set out to identify the prevalence and potential predictors of PTS symptoms six weeks after birth in a sample of 264 women who had normal births. Czarnocka and Slade (2000) used stepwise regression models for predicting outcome variables. They identified that perceptions of a low level of support from staff by women were found to be particularly related to experiences of PTSD (Czarnocka and Slade 2000). These findings also concurred with a qualitative meta-synthesis of women's perceptions and experiences of a traumatic birth. In this study a theme "To be treated humanely" was formulated which included mistreatment from health professionals and distress when large numbers of staff came into the room without prior explanation (Elmir et al 2010).

Green and colleagues (1998), in their work on women's expectations of birth, also identified the need for clear information provision for women in the context of interventions during labour and birth. There were few ill effects on emotional

well-being when they received a clear understanding for the need for the interventions and were involved in the decision-making (Green et al 1998).

The issue of control is also pertinent to the discussion on negative and traumatic birth experiences in relation to the provision of care by staff. This relates to external control rather than a woman's internal control which is about her own behaviour (Green et al 1998, MacLellan 2015). Having a low level of control was a core category in Allen's study in 1998 of the process, mediating variables and impact of traumatic childbirth. Low perceived control in labour has been seen by many other authors as predictors of perceptions of the childbirth experience as traumatic (Czarnocka and Slade 2000, Elmir et al 2010, Menage 1993, Reynolds 1997, Soet et al 2003). Some allude to women reporting feelings of powerlessness in these situations. One key example of this comes from a study about psychological stress associated with obstetric and gynaecological procedures (Menage 1993). Significant differences were found between women with PTSD and those whose experiences ranged from "slightly distressed" to "very good". These groups differed on feelings of powerlessness during the procedures, as well as other variables suggestive of reduced control on the part of the woman (e.g. amount of information received, the experience of physical pain, perceived unsympathetic attitude by health professionals and clearly understood informed consent) (Menage 1993). As well as being an important predictor of women perceiving their birth experience as traumatic, loss of control has also been found to be associated with a negative birth experience, decreased satisfaction and postnatal depression (Green et al 1990).

The present study did not directly identify control to be a factor however the issue of trust was raised by the women in the qualitative findings. Trust can be seen as a component of control. It is of interest that Green and colleagues (1998), in their landmark prospective study of women's expectations of birth, commented on the importance of trust. They stated in the introduction chapter of their work that women feel in control when they trust that the person caring

for them will respond positively should they say that they wish their care to be altered in any way. This seemed to these authors to be an essential precursor to women feeling in control (Green et al 1998). Bluff and Holloway (1994) in their qualitative study of women's views of midwives also identified a core construct relating to the concept of trust in the professional providing care "They know best".

The unexpected nature of events has also been shown in this study to lead to both a traumatic and negative birth experience in some cases. As mentioned above some women in the qualitative part of the study described their birth as being horrific or traumatic. When interrogating this data it seems that in many of these examples, from the women's verbatim comments in the transcripts, that the traumatic situation was a surprise or an unexpected event. For example one woman stated that it was not possible to prepare for the pain of labour. In addition, being rushed to theatre in an emergency situation is unlikely to have been considered by many women in advance of their labour. In the same way a baby being transferred to the NICU, when unexpectedly born in poor condition, is unlikely to have been planned in the mind of a woman in advance of her going into labour and giving birth. It is therefore possible that the negative effect in the form of perceptions of trauma and horror may be due to the shock of something happening or having an effect that had not been considered by women in advance of labour. This suggests that the unexpected occurrence of events may lead women to perceiving their birth experience negatively and also to women's perceptions of trauma and horror. Furthermore in the quantitative analysis, women with unmet expectations of their birth experience and those who had raised PTS symptoms, were more likely to have negative perceptions of their birth experiences compared to women with low PTS symptoms and whose expectations of labour and birth were better than expected.

This finding concurs with other research in this area. In their study of the incidence and contributing factors of acute trauma symptoms following childbirth, Creedy and colleagues discussed the unexpected nature of events

leading up to emergency procedures (e.g. emergency caesarean section) and how these were perceived as traumatic by women (Creedy et al 2000). Creedy and colleagues suggested the consequent need for frank discussions with women about emergency procedures in advance of labour. When undertaking such conversations midwives would therefore need to ensure these women have realistic and flexible, but positive expectations about their forthcoming birth. Waldentrom and colleagues, in their study in Sweden of risk factors for a negative birth experience, also found factors related to unexpected medical problems, such as emergency operative delivery, induction of labour, augmentation of labour and the need for transfer of a baby to the neonatal intensive care unit leading to women perceiving their birth as negative (Waldenstrom 2004). It is important to add that the findings of the current survey suggest that negative ratings apply more commonly to women following emergency caesareans and vaginal instrumental deliveries and less frequently to women having an elective caesarean section. This is further supported in the qualitative findings where a woman compared her first emergency caesarean, which was considered traumatic, to the more controlled and calm scene at her subsequent elective caesarean section. This woman specifically sought out and requested this planned caesarean section following her previous traumatic experience with her first child.

A consequence of a negative or traumatic birth experience has been shown in studies to be fear of giving birth in a subsequent pregnancy (e.g. Storksen et al 2013, Tatano-Beck and Watson 2010, Thomson and Downe 2016, Thomson and Downe 2010)). In the qualitative findings of the current mixed methods study all four women who had attended the Birth Reflections service experienced this phenomenon. In addition there were others who had not attended the service who said this was an issue for them. This fear was often an after effect of a difficult birth experience. This might be due to the behaviour of staff, who had failed to provide appropriate support, or the fear could be a direct effect following what had been perceived by the woman as a traumatic incident. For example, one woman left feeling like she was “in an emotional

bubble”, feared giving birth again following her first birth experience. This according to her was due to the fact that she had been moved to theatre from her labour room in an emergency after the staff had been unable to hear her baby’s heartbeat. This woman thought her baby was dead. In addition she was taken into an operating theatre, which brought back personal memories of the death of her sister at the age of 21 years.

There is the possibility that with improved communication between the staff providing care and this woman that the intensity of this woman’s feelings might have been reduced or prevented. As a consequence she spent many months following her birth in her words “just existing” and seeing other women with their babies who she felt were behaving very differently from her. She felt distanced from her baby during this time. This situation also highlights the case for more continuity of care. In these models women feel more supported. In addition working in this way is beneficial for midwives as they get to know the women and what their fears or difficult past experiences might have been as well as their hopes and wishes (McCourt and Stevens 2009).

This section has highlighted two key areas identified in this mixed methods research study that play a key role in women’s perception of their birth as being either negative or traumatic. Both the impact of the professional providing care and medical interventions that are unexpected were highlighted in both strands of the study.

#### **4.7.8 Reflexivity**

Below is an account on my personal efforts at being reflexive throughout this research study. All researchers are searching for the truth and the true state of human experience. Reflexivity is also used in qualitative research to guard against personal bias in making judgments (Polit and Beck 2010). There is the consequent need for researchers to take note of personal values that could

affect data collection and interpretation. This is a critical reflective process which is presented below. Reflexivity is integral to all types of research, including qualitative approaches (Finlay 2003, Mason 2002). There are different ways of being reflective and engaging in reflexivity and it has become a contested term (Gough 2003) but it is a process through which the impact and influence of the researcher on the research process are considered. However, Finlay (2003:40) describes the process of reflexivity as “coming clean” about how subjective elements have impinged on the research process, in order to increase the integrity and trustworthiness of the research (Finlay 2003).

Reflexivity should take place throughout the entire research process and be treated as central to the research question itself (Maso 2003). Through the process of reflexivity researchers are able to develop a greater critical awareness in relation to their research i.e. how they formulated the question, their explanatory constructs, the process of undertaking the research and analysing the data. Maso (2003) highlighted the importance of a full understanding of what motivated the researcher to undertake the study. By asking numerous questions about what beliefs lie behind the research question and the consequent development of a conceptual framework a greater understanding of the research process is facilitated (Maso 2003). In this way reflexivity is part of the theoretical framework and becomes an inherent part of the research process itself (Maso 2003).

Sharing plans for the current study with others, including professional colleagues, at an early stage helped me to think about various issues relating to the research question and include these in the conceptual framework. This process was also helpful with protecting the study from the risk of bias being introduced through possible preconceptions of myself, the researcher.

During the planning stages and at the outset of the data collection I managed the local Birth Reflections service but very rarely conducted consultations with women. However since that time I have moved to a different hospital where I

have successfully set up another birth reflections service. In this new service I do provide care in a professional capacity. Both positions have assisted with the research process by enabling me to be exposed to the essential nature of the practice and the various aspects and issues that occur.

It is clear being a midwife and practising in this area afforded benefits for the research. However as a midwife and being so close to the research topic area could have led to some possible challenges. For example in my previous position as clinical governance manager I was responsible for the Birth Reflections service and it might have been harder to stand back and take a critical view, or to question whether the research was worthwhile. My personal responsibility in this post ended when the survey was being administered and before the interviews were conducted. These took place after I had left the study hospital and when I was in a new position as a full time supervisor of midwives at an NHS trust in London. This would have eliminated any possible risk in this way to the analysis.

When considering the actual conduct of the study Finlay (2003) stated that reflexivity has the potential to be a valuable tool to help examine the impact of the position, perspective and presence of the researcher. Each of these aspects are discussed below under the respective headings.

*i) Position*

At the outset and when designing the research I was acutely aware of the impact my position as a midwife and working in the same service where the research was being undertaken might have had on the participants. There was a risk that women might be more reluctant to be critical or to question things. It was therefore essential for me to separate my two roles as midwife and researcher. This I felt I would be able to do quite well due to a similar experience professionally. At the time I was employed as the clinical governance manager, I also qualified as a supervisor of midwives. Being a

supervisor of midwives is for most supervisors of midwives an additional professional commitment to their main substantive role. In this role a midwife is accountable to the Local Supervising Authority, not their employing NHS Trust, and on certain occasions their interests can conflict. Undertaking investigations in governance was a different process to the investigations I am required to undertake as a supervisor of midwives. In order to do this I adopted the use of a metaphorical hat to remind me of the two separate roles and to ensure I wore only one hat at a time. I felt I would therefore be able to adopt a similar method when I was involved with maternity service users as part of the research process. As regards separating my role as a midwife with that of a researcher it was difficult on a few occasions during interviews when women tried to discuss aspects of midwifery care with me. However to ensure consistency of approach it was essential that I always referred them to their current care provider which was often a general practitioner (GP).

I soon became very aware that as a researcher I was speaking with women for a different purpose to the one in clinical practice. On reflection I felt slightly nervous when visiting the women in their homes in my role as a researcher. As a relatively new researcher I was concerned the women might feel I was intruding in their busy lives and consequently wasting their time. However it was important to ensure my emotional state was not conveyed to the women. My aim was to appear relaxed which would put them at ease to help them tell me the story of their birth experiences. On reflection I need not have worried. My nervous state soon dissipated once I was with the women. They were all very receptive to me and seemed interested in the research study itself. They were all extremely generous with the information they provided and accepted my offer of a copy of the final report. However on occasions, as mentioned above, my role as a midwife was introduced and there became the need to explain aspects of birth in a general context. I also gave some women participants who asked, information about how to access the Birth Reflections service.

## *ii) Perspective*

There was also the need to consider the impact of my perspective as the researcher on the research process. When the local Birth Reflections service was first set up in London in 2002, as a midwife I was quite excited that this would serve as an opportunity for women to reflect on the process of giving birth. I soon became disappointed that instead of talking about aspects of the birth itself, women commented on negative issues including the behaviour of staff members.

The impact of staff on an individual woman's experience is a central theme in the qualitative findings of this work. This highlights how the researcher's perspective can influence the research to glean knowledge. Discussing it in this way as part of the reflexive process assisted with clarity leading to improved credibility and quality of the study.

At a later time I took over the management of the Birth Reflections service. This was in December 2010 when I took up a new position outside London. The Birth Reflections service was a small part of my overall role as a clinical governance manager and the first time I became aware of this service. As I have already mentioned similar services in London were disbanded following the publication of a NICE guideline that stated there was no evidence for routine debriefing following birth (NICE 2007, NICE 2014a). Whilst having an interest in this area of practice I do not believe I was either a firm supporter or opponent of the process. Having undertaken the critical review of the literature as part of the structured doctorate (Baxter et al 2014 and chapter 3 in this thesis) there was a need to gain more knowledge in this area. Becoming the manager of the service around the same time as the research was being designed meant that I had not developed a strong link and was therefore neutral to whether or not it was beneficial to women.

### *iii) Presence*

Finally a discussion on the presence of the researcher is considered. As well as being reflexive in this regard my presence also assisted with my attempt to protect this study from bias through the influence of the participants. I recognised the need for valid and reliable data and there was the potential that the participants might have shown a lack of candour or desire to please. Being aware of this I was able to guard against this possibility during the interviews. To this end I helped the participants to become relaxed in their own homes to be able to provide frank information. As mentioned above I was nervous when first knocking on the door and meeting the women for the first time. Also as a midwife the importance of being respectful when visiting women in their own homes is paramount. Once settled in the homes of women participants I invited them to talk in general about their birth experiences. This allowed them to open up and speak freely about information that was important to them. Once the women had said all they wanted I was then able to review the interview guide and ask any questions they had not spontaneously talked about. It was very important to me as the researcher that the women were in control of the process, which allowed them to provide the information they wanted. Most women like to talk about their birth experiences and speaking to me in this way did not prove difficult for the participants. Reading through the transcriptions reflexively was another way I was able to see myself in the data. This allowed me to become aware of my role in generating the data and to reflect on my interactions with the women.

### *iv) Insider researcher*

It is also important to consider the role of the insider researcher. In this study being an insider researcher was useful in practical terms when accessing the site. In action research this has been found to play a beneficial role (Coghlan and Casey 2001). However in other research approaches this issue can be problematic. As the clinical governance manager and researcher in the same organisation it was essential that the two roles did not become blurred. Insider

research demands that researchers maintain a high level of consciousness about the role and that they monitor their internal state and interactions with others (Polit and Beck 2010). It was imperative that I remained aware of the two separate responsibilities. On a daily basis at that time I was already juggling the two separate roles as senior midwife employed by the NHS Trust and independent statutory Supervisor of Midwives, protecting the public from harm. I considered this experience would also help me to ensure my clinical governance and researcher roles remained distinct.

As the manager of the Birth Reflections service there was the risk of bias if the two roles became blurred. To reduce this risk the data entry and analysis of the questionnaires was checked by a second person. Similarly in the qualitative part of the study the analyses were checked by my two academic supervisors.

I also practise clinically in my professional role. However there was minimal risk of a conflict of my clinical and research roles. The women who participated in the study were unlikely to be receiving care by the maternity service at the time they completed the surveys, although this might have been possible in a subsequent pregnancy. If this had been the case it was most unlikely that I would have been providing care. In my role as clinical governance manager at Buckinghamshire NHS Trust I was practising clinically for only two sessions per month. No cases arose in the study sample where I provided clinical care.

#### *v) Summary*

In summary being a midwife and having lengthy experience in professional practice has helped me as a researcher to access the women who participated in this study. My knowledge of birth as a professional in the field also provided material for the conceptual framework. However having an in-depth working knowledge of midwifery also raised potential challenges and possible bias, in relation to personal preconceptions, to the research process. It was therefore important to wear the metaphorical hat on occasions as discussed above to

delineate my roles as a clinician and a researcher. To this end the critical process of reflexivity was used to both enhance the research process and protect it from bias. On a more technical perspective I feel my skills as a midwife in listening to women also helped the participants to open up in the interviews. On the rare occasions that women needed more encouragement to speak I had the interview guide with prompts to assist. I do not feel women held back from speaking out and they shared both positive and negative aspects of their experiences with me.

#### **4.7.9 Strengths and limitations**

This research study included the views of 170 women who responded to a postal survey during October and November 2013 about their experiences of birth in June 2013. In addition 12 of these respondents also participated in an in-depth, semi-structured interview. Four other women who had attended the local Birth Reflections service also participated in an interview. This led to an extensive collection of data.

Using a mixed methods research approach has provided the opportunity of gathering different types of data. This has increased the ability to answer most of the objectives. It was not possible to address the research objective to determine the characteristics of the women who access a birth reflections service. This was due to the fact that only one woman in the survey attended the service.

Rich qualitative data were generated from the in-depth interviews during which the participants were able to provide information about how they perceived their experiences of labour and birth and possible need to attend a postnatal debriefing session. The result is a clear picture of what was important for these women during this time. This adds further understanding of the quantitative

data. These in turn, through the use of statistical tests, have resulted in findings that apply to the study population.

It is important to note that the questionnaire for the survey was developed specifically for this study. Whereas some questions were taken from other pre-existing instruments previously used in other studies and adding to validity, others were compiled especially for this study. The IES questionnaire was also included. As mentioned in the methodology section, 4.4.4 "Research tools", this has not been formally validated for use in maternity however despite this several other researchers have used it in the maternity context. One strength is that the Birth Reflections questionnaire was piloted with a group of women who were not part of the study. Ease of use was proven by these women and no changes were considered to be required.

It is possible that these results may also be generalised to other maternity populations but there is a need for caution for several reasons. Unfortunately the response rate to the survey, anticipated in the planning stages of the study at around 50%, was lower than hoped for at 38%. This observation coincides with a national decline in response rates to surveys but it is therefore possible that the responses were skewed to women with particular views or from particular backgrounds. More women than average in this sample had experienced an instrumental birth, for example. This has already been discussed in the survey findings in section 4.5. This clearly indicates the need to recognise that the women who responded to the survey could be different from the women who did not respond. Indeed also as mentioned within the survey findings during the discussion of demographics the women in the sample were highly educated. This reflects to some extent the demographics of the context of the study, but clearly a wider study would be needed to be able to generalise to wider populations.

It is also important to be aware that there may have been a higher number of women in this study who were traumatised. However this sample was very informative.

This study took a retrospective approach, which also has its limitations. One possible limitation relates to the issue of the recall of the women in the qualitative part of the study. The women who responded to the survey all did so at the same time point in relation to their birth experience i.e. between four and five months following the birth. This was after they had left the maternity unit where they had given birth and following a period of time at home when they had had time to reflect on their maternity care (Clark et al 2015). In addition the timing of the distribution of the survey was modelled on a rolling programme of a national maternity survey (e.g. CQC 2013, HCC 2008). However there was a range in time gap since the birth experience among the women who participated in the qualitative interviews. This was further compounded by women who had two prior birth experiences and who included both episodes in the discussion during the interviews. It was possible that these women's memories of what happened to them changed over time. However there have been discussions in the literature about the ability of women to vividly and accurately recall their birth experiences after many years (e.g. Simkin 1992). This seems to have applied to the women in this study who provided clear accounts of their one or two birth experiences during the interviews. Furthermore having two experiences facilitated the added benefit of the ability for the woman to make comparisons, which further enriched the data.

#### **4.7.10 Implications for practice**

Three key recommendations for practice are discussed below. These relate to the groups of women offered postnatal debriefing, the optimal timing for postnatal debriefing and finally the potential for this valuable service to be combined within standard postnatal care provision is considered.

*i) Who should be offered a postnatal debriefing meeting at a Birth Reflections service*

It appears there are various different groups of women who may benefit from attending a birth reflections session and have a postnatal debriefing following birth. The clinical trials included in the Cochrane review utilised a medley of different groups of women in their samples, including those with experience of a traumatic birth, those with operative interventions and a sample of all women who gave birth to base their outcome measures on (Bastos et al 2015). From a methodological perspective this is one cause for the heterogeneity identified among the studies in this area.

However the fact that different groups of women have been considered to have a possible need to undergo formal psychological debriefing or to have a more informal meeting with a health professional and discuss their birth experience may indicate the need for all women to be offered the service. Whilst it is possible to clearly identify some women who may be at particular risk of psychological trauma (e.g. following an emergency event during the birth experience) there will also be other women affected by the birth experience who go home from the hospital silently and struggle to come to terms with what happened to them. This was the intention at the study hospital. In the current study, the qualitative analysis identified that some women were curious about what happened to them and wished to go through their birth story for reasons of interest only. So it appears by having a postnatal debriefing session with a health professional, as well as helping women who have traumatic or distressing symptoms come to terms with what happened, other women who have not experienced physical or emotional trauma may also benefit from this postnatal service.

*ii) Optimal timing of a postnatal debriefing meeting*

There is also a need to consider when is the best time in relation to the birth experience for women to attend a birth reflections-type meeting. This may be linked to the emotional condition of the woman herself. Due to the timing of the outcome assessments in the trials of the Cochrane review it is of interest that the debriefing intervention sessions were conducted during a limited time range. The earlier ones were undertaken within days of birth whilst the women remained in the hospital and the latest was 10 weeks postpartum. The qualitative findings in the current mixed methods study showed a range of opinion about when is the best time to attend this service. This was found to range between a few weeks following birth up to one year and beyond, at a time when women were considering another pregnancy. This reflects the timing for the four women in the qualitative sample who attended the Birth Reflections service. Two attended around six months postpartum while the remaining two attended two and three years respectively following their first birth experiences. In the latter cases this was when they were pregnant again and requiring support to understand what happened to them during the first labour to be able to plan for the current forthcoming birth.

*iii) The need to standardise postnatal debriefing within routine postnatal care provision*

The findings of the qualitative analysis also showed that women had busy lives as new mothers and finding time to attend a birth reflections meeting proved difficult. This finding was supported by freetext comments by women in the survey. However this study has identified the need to identify women's feelings following their experiences of giving birth. It may be more practical to undertake this within standard postnatal care provision. However the case study in chapter 2 of this thesis and other work has shown this is often of poor quality and not always perceived well by women. In addition there have been recent steps taken to reduce home visits by midwives in England.

Managers of these services should be more wary of reducing postnatal home visits as midwives undertaking these do not only identify physical clinical problems but should ideally also recognise if a woman is struggling emotionally. Women's feelings are unlikely to be picked up on in busy postnatal wards and this may well be too early to do so anyway. Traditionally, community midwives who knew the women, would be observing them on home visits when they have the opportunity of asking women how they are feeling and can even observe this. However as mentioned above this kind of care is being withdrawn in favour of asking women to seek care if they need it.

There is the dual need to both improve postnatal care provision whilst at the same time introducing universal postnatal debriefing sessions for women on an opt-out basis. This will ensure women's feelings following their birth experiences are addressed appropriately, leading to increased support. This will also lead to increased satisfaction of postnatal care by women, while ensuring that those who do not wish to have such a discussion are not required to do so.

## **4.8 Chapter summary**

Using a mixed methods approach has provided more evidence about various aspects of postnatal debriefing. The respective findings of the quantitative and qualitative strands were integrated in the discussion section above to provide evidence from different sources in support of the overall findings.

The Birth Reflections study has identified that a large proportion of the women in the sample said they thought about the birth after they had gone home from the hospital. In addition approximately half of all women in the quantitative sample wanted to attend the Birth Reflections service and talk to a health professional about the birth. This was more likely among women with raised

PTS symptoms and less likely by women who had positive feelings towards their birth.

However it is of interest that not all women understood what this service is. Women were identified as being unclear about the nature and what is a birth reflections service. Whilst some felt this service was only for women who had psychological needs others were curious to read their own maternity record kept by the hospital out of interest only. This study has identified the clear need when setting up postnatal debriefing services to ensure what is on offer is clear to all women.

The findings of this study also highlight the important need for some women to understand what happened to them during labour and birth and have questions answered. Sometimes this is possible with their family but most often women wished to speak with a health professional. This study has confirmed that some women leave the birth experience with gaps in their memories. Postnatal debriefing aims to reduce these by explaining events and answering questions. The women in this study who attended the Birth Reflections service confirmed that at a birth reflections-type meeting women had their questions relating to their birth experience answered and aspects of their labour and birth were clarified so that they were left with a fuller understanding about what happened. However this study has also identified that another group of women may prefer to forget about their birth experience. They felt being oblivious to what happened during their labour and birth experiences afforded them protection.

This work has also shown that a proportion of women following birth are left with unprocessed emotions. A third of the sample in the quantitative part of the study had a raised IES score, displaying PTS symptoms. Furthermore some women in the qualitative strand reported their birth experience as being “traumatic” or “horrific”. Women with a raised IES score were more likely to report the need to talk with a professional and attend a Birth Reflections-type meeting. This group was also more likely to be less satisfied with their birth experience and have

less of an understanding about what happened during labour and birth compared with women with a low IES score.

The concept of a negative birth experience was also highlighted in this work and how this overlaps with a traumatic birth experience. These experiences can be accentuated or mediated according to the communication skills of the care provider. Support provision during labour and birth is essential to ensure women have good experiences and reduce the risk of feelings of trauma and negativity which can in turn lead to secondary fear of childbirth. Attending a birth reflections-type service provides the opportunity for women to talk with a health professional, who is usually a midwife, and gain a fuller understanding of the events that took place and have questions answered. This process helps some women to place their birth experience in the past and move on emotionally. "Moving on after the birth" was a subtheme in the qualitative findings of the Birth Reflections study (see chapter 4.6.3, v in this thesis). These were the actual words used by one participant but other women alluded to placing the birth experience behind them in the past.

A key incidental finding of this mixed methods study is the impact of the midwife and other key staff members on the birth experiences of individual women. When this is not well received by women and communication is poor women experience their birth as negative. On occasions staff behaviour may also be the cause of women's reports of birth being traumatic. As a consequence women are left with gaps in their memory and understanding about what happened to them during this time. This has also been shown to lead to misconceptions in the minds of women. These women are left unhappy with painful memories of their birth experiences. Meeting with a midwife and reading through the maternity record at a postnatal debriefing session has been shown to provide support to gain a clearer understanding about the actual events that occurred. However this study has also shown that approximately half of women following birth do not feel the need to attend. This may be due to the fact they felt well supported during labour and birth and have a full understanding of the

events that took place. These women leave their birth experience with a more positive stance on what took place and therefore do not feel a need to attend an informal postnatal debriefing session. It may therefore be possible to reduce attendances in such services through improved communication between midwives and women during labour and birth.

As discussed in chapter 3.10, the findings of the Cochrane review on debriefing interventions for the prevention of psychological trauma in women following childbirth were published at the time of finalising this thesis (Bastos et al 2015). This review examined the evidence for debriefing as a preventative intervention for psychological trauma following birth.

It is disappointing to hear confirmed that there is still no robust evidence that debriefing reduced or increased the risk of developing psychological trauma during the postpartum period. However it is reassuring that the authors of the recent Cochrane review concluded that other forms of postnatal discussion between care providers and women following birth, as recommended by the health watchdog NICE (NICE 2014a, NICE 2007), should be allowed to continue as this was not included as an objective of this review. Also, these are not intended to prevent PTSD or provided as a debriefing intervention (Bastos et al 2015). Whilst neither harms nor benefits of the debriefing interventions were identified from the meta-analysis there was insufficient evidence to draw a conclusion on the effectiveness for psychological or formal postnatal debriefing. There is the clear need for further RCTs. It is hoped the findings of this present mixed methods study will be helpful when researchers design interventions in the future.

It is possible that there is the need to measure or identify the feelings of all women following their experience of giving birth (e.g. using a self-completion score such as the IES following validation for use in the childbirth context). In this way women who currently leave the birth experience and go home from hospital with unmet emotional needs can be identified and offered the

necessary support to come to terms with what took place during the labour and birth. Such needs might be met through attendance at a birth reflections-type session where a woman has the opportunity of meeting with a midwife and reviewing her maternity notes (Meades et al 2011). It may mean for some other women there is a need for a referral to a psychologist. However there may be a danger of over-medicalising or psychologising women postnatally. Many women are content and do not want to attend such a service. The quantitative findings of the present study within this chapter, which included a survey of a sample of women in the home counties of England, identified that just under half of all women who answered the question wished to have attended a birth reflections service given the opportunity to do so.

The next chapter will sum up what each element of this thesis has contributed to the evidence base. It will also give recommendations both for practice and for future research in this area.

# Chapter 5: Conclusions and recommendations of the thesis

## 5.1 Introduction

This chapter sums up what each element of this thesis has contributed to the evidence base. These were undertaken on a part time basis, as part of the structured doctorate programme at City University between 2008 and 2015. As stated in the university guidelines these are brought together as one thesis in this chapter, submitted in partial fulfilment of the requirements of the degree of Doctor of Philosophy (PhD) (Appendix A).

Each contribution to knowledge is described below under the respective parts of the thesis. In summary and firstly, by using secondary data sources the findings of the case study of women's experiences of care on the hospital postnatal ward provided possible explanation about why women responded negatively to quantitative questions from national surveys. Two key themes were identified: "Lack of professional support" and "An uncomfortable environment". Furthermore it is likely that there is an association between the two themes.

Following on from the case study, the critical review of the literature of postnatal debriefing has identified, that through talking and being listened to by a health professional and having questions answered, women's birth experiences are validated. A seal is placed over the whole episode of care and women can move on emotionally.

Finally the Birth Reflections study supports the findings of the critical review of the literature and provides further support for the notion of validation through postnatal debriefing. This study also found an association between a high IES score and a negative birth experience. Women with a high IES were statistically more likely to have a negative birth experience; wish to talk with a health

professional or to attend the Birth Reflections service. Women who have increased levels of distress are more likely to need support from professionals.

Following the reviews of each element of the thesis, recommendations for practice and future research are given. This chapter is completed with a final conclusion for the overall thesis.

## **5.2 Case study: contribution to the evidence base**

Dissatisfaction with postnatal care in hospital has been reported by women service users since the 1990s in the UK. The case study has identified some possible reasons for the dissatisfaction of women about hospital based postnatal care. Qualitative research techniques were used to analyse the free-response comments made by the respondents to three separate surveys. The findings provided possible explanation about why women responded negatively to quantitative questions from the surveys. These questions related to women's views about different aspects of support, including "satisfaction with care after birth", "being treated with understanding and respect after birth" and feeling they were "always given information or explanations needed after the birth". The findings were summarised within two key themes that emerged from the data: "Lack of professional support" and "An uncomfortable environment". Women in this case study reported feeling uncomfortable in the physical environment of the hospital postnatal ward. In addition they went without professional support. This second finding was due, on occasions, to a perception by women of an apparent lack of staff being available. However at other times, when present, staff showed a lack of sensitivity. There was also evidence of poor attitudes amongst some staff which led to women becoming upset on occasions.

These results highlighted two key aspects of care that women considered impacted on their overall experience on the hospital postnatal ward. These were the physical environment and the care provider. It is possible that these issues

raised by the women about care on the hospital postnatal ward may be related. When women consider staff to be busy and the physical environment to be un conducive to receiving the support required at this time, it is unsurprising that women perceive a lack of care, support and sensitivity.

The original plan for this thesis was to develop and test a service improvement strategy as part of an action research study. Changing circumstances meant that was no longer a consideration. However the findings of the case study pointed to a more general lack of priority in services given to meeting women's postnatal support needs. The plans were therefore reconsidered with the aim of focussing on the support needs of women following birth on the hospital postnatal ward. This, and the fact that the maternity service at the study hospital where the case study was undertaken had discontinued its postnatal debriefing service based on the Cochrane review evidence (Rose et al 2002), while the new service had not, this led me to consider the need for a critical review of the qualitative evidence on postnatal debriefing.

### **5.3 The critical review of the literature: contribution to the evidence base**

The critical review of the literature on postnatal debriefing has shown that there is very limited evidence in this area on which to base practice. Twenty papers in total were identified, including nine RCTs. Meta-ethnography was utilised to identify further constructs from textual data. This has not been previously used in relation to postnatal debriefing. The review identified and differentiated two main types of debriefing for postnatal women: structured and unstructured. The authors of the recent Cochrane review also mentioned these two different approaches. They stated it is the unstructured type or the more informal discussion with a health professional that is utilised by the maternity services (Bastos et al 2015). However a medley of different approaches to postnatal debriefing were utilised by the RCTs that have been undertaken. The structured

format utilises formal psychological techniques whereas unstructured sessions are more informal in nature and have been described as “listening visits” where women and health professionals meet together to discuss matters relating to the birth experience. The critical review of the literature also found no clear definition for these services: techniques used by maternity services in England were unclear to the managers responsible for them. These findings were identified by two research teams whose papers were included in the review.

The key finding from the analysis was that talking and being listened to by a health professional and having questions answered provided women with a clearer understanding about what happened during their experiences of labour and birth. This entire process placed a seal on a woman’s birth experience, which was validated, and allowed her to move on emotionally and place the birth experience in the past. This work clarified how the process of being listened to by a health professional and having questions answered and gaining an understanding about what happened led to the experience of the birth being validated by women and consequently allowing them to move on emotionally.

The critical review of the literature has added understanding that complements the Cochrane reviews that have been conducted on postnatal debriefing (Bastos et al 2015, Rose et al 2002). It has enabled a better understanding of the nature of the intervention itself and how it may vary. This can provide support for guideline and service development by helping to make sense of the mixed findings of trials, as well as to identify more clearly what it is that women value about it.

The recently updated Cochrane review, which now includes seven trials in the maternity services, still found contradictory results (Bastos et al 2015). Some found evidence that debriefing is helpful whilst others did not find evidence of effect. In addition there is also a contradiction between measured benefits and what the women say they experience. It is therefore possible that the researchers undertaking the trials are not focussing on the right outcomes. To

this end the analysis undertaken within the current review, which has identified the issue of validation, could support an improved RCT design in future.

#### **5.4 The main research study: contribution to the evidence base**

Both the findings of the case study and the results of the critical literature review influenced the focus of the Birth Reflections research study. The case study identified a lack of support provided to women in the hospital postnatal ward shortly after birth. The literature review, mentioned in the above section, described the content and process about how women may be provided with support through postnatal debriefing. The literature review also identified that few research studies have been undertaken in this area. Together these findings triggered the need for further study in relation to how postnatal debriefing can provide support for women following birth.

As has been discussed in the above section the results of the literature review showed that some women were helped to place the birth experience behind them and move on emotionally following a postnatal debriefing session. The findings of the Birth Reflections study also highlight a need for some women to understand what happened to them during labour and birth and have questions answered. By talking and being listened to by a midwife or other health professional and having questions responded to, enabled a clearer understanding of what happened to them. The entire process allowed them to place the experience behind them in the past and move on emotionally. Sometimes this was possible with their family but most often women wished to speak with a health professional. These results therefore provide further support for the process of the birth experience being validated through postnatal debriefing.

An observation from the qualitative findings provides additional support for postnatal debriefing. The subtheme “Reassurance for future births” showed that attending a postnatal debriefing session following an earlier birth experience provided reassurance for other pregnancies and birth experiences in the future. With rising levels of childbirth fear being reported this could be another value of attending a birth reflections-type meeting and experiencing postnatal debriefing. This has not been examined in previous studies.

A need for all women to receive supportive care during labour and birth was an additional finding of this work. Although previous studies have highlighted this issue, the review of the literature provided in chapter 4 identifies that services have not improved over time in this respect. The concept of a negative birth experience was highlighted and how this overlaps with a traumatic birth experience. These experiences can be accentuated or mediated according to the communication skills of the care provider.

This study has added to the literature on what is known in this area. This was through the utilisation of the IES on a sample of all women who gave birth during June 2013. This enabled a cross tabulation between groups. For example, women’s experiences of labour and birth were different according to their IES score. Women with a high IES were more likely to have a negative birth experience, wish to talk with a health professional or to attend the Birth Reflections service. If the IES was low women were more likely to rate the birth experience positively or less likely to want to attend the Birth Reflections service. These findings provide further evidence for the concept of a negative birth experience. They also highlight an association between this and emotional distress. Furthermore women who have increased levels of distress are more likely to need additional support from professionals.

Support provision during labour and birth is essential to ensure women have good experiences and reduce the risk of feelings of trauma and negativity which can in turn lead to secondary fear of childbirth. This study provides more

evidence to support this view. Although limited in size and scope, this study, has also identified an association between whether the women felt supported and the impact of the labour experience on them. Attending a birth reflections-type service provides the opportunity for women to talk with a health professional, who is usually a midwife, and gain a fuller understanding of the events that took place and have questions answered. This process helps some women to place their birth experience in the past and move on emotionally.

Another contribution of this study is the proportion of women who appeared to have had a negative or even traumatic birth experience. Although this could possibly be attributed to self-selection in terms of who responded or not, it seems important to investigate this further as it also suggests services are not getting support right in some way.

## **5.5 The need for supportive care during childbirth**

The notion of support connects all parts of this thesis, formed as part of the structured doctorate. This section considers the contribution across all the different elements of the thesis. Although this was a structured doctorate, with distinct elements, there were threads that ran through the whole and the key thread is the need for supportive care during childbirth. The importance of support provision is highlighted in these as a key aspect of care provision for women during their childbirth experiences.

Evidence from the initial case study found that, despite prior research on women's relative dissatisfaction, women were reporting a lack of supportive care postnatally. From the critical review of the literature certain aspects of why women value a postnatal listening or debriefing session were identified. These may have been overlooked in some of the existing trials. Finally evidence from the Birth Reflections study highlighted that many women are coming away from their birth experience with negative feelings or even trauma symptoms. These

do need to be addressed. This also provides yet further evidence that services need reconsideration to focus better on support.

In the case study examples of the type of support women required during their stay on the hospital postnatal ward were reported by the women. These included help with infant feeding and practical help with the baby. The findings from both the critical review of the literature on postnatal debriefing and the main Birth Reflections study showed that women were positive about having the opportunity of reviewing their labour and birth. These women valued talking and being listened to and also being provided with information through answers to their questions.

The findings from the Birth Reflections study also highlighted the supportive role midwives play for women in labour and during birth. Many women were very positive to the support they received from midwives during this time. However some other women reported a poor experience in relation to their interaction with the midwife providing care. The importance of women feeling they are listened to by staff was identified in the subtheme “Professional behaviour” in the qualitative findings in section 4.6.4. Poor communication with staff members led to feelings of trauma for some women in this study. This led to the perception of a traumatic and/or negative birth experience by the individual woman. Furthermore it was this group of women who were more likely to have raised IES scores in the quantitative analysis in section 4.5.3. These women also had a greater likelihood of wanting to access the Birth Reflections service.

Where support was not perceived as being available to women on the hospital postnatal ward, women in the case study also reacted negatively. In this area the physical environment was considered by some women to be uncomfortable. This area, the postnatal ward, engendered negative emotions and this became a subtheme during the analysis. Women in the case study also felt a lack of support through a perception of there being a lack of staff. As in the main Birth Reflections study the negative impact some staff had on individual women was

also identified in the case study. When staff were present some impacted negatively on women through a lack of sensitivity and poor attitudes.

The negative effect on a woman's birth experience where there is a lack of support and care during labour has previously been recognised (Waldenstrom et al 2004). In addition the behaviour and attitude of the caregiver impacts on ratings of satisfaction (Hodnett 2002). Lack of support in this way also risks women perceiving their birth experiences as being traumatic. Furthermore, and as previously discussed in chapter 4 above in section 4.7.6, interpersonal difficulties between a woman and the staff providing care was the strongest predictor of PTSD (Harris and Ayers 2012).

## **5.6 Emotional safety**

The overwhelming finding from the case study is that women do not feel supported on the hospital postnatal ward. A lack of supportive care was also identified in the Birth Reflections research study. As well as there being the need to support women's physical needs with technical skills during the birth process, including blood pressure measurement and the administration of drugs, there is also a need to ensure women receive emotional support.

Some emotional support is provided by a woman's partner but not all women are in relationships and birth partners may also have their own emotional support needs during birth. In the labour context it is clear from this study that women also need emotional support from the midwife providing care during labour and the birth. The value of the formation of a relationship between the woman and her midwife has also been highlighted. Women gain trust in this relationship which provides them with confidence and in turn coping ability to get through their labour experience. This type of support is further achieved through the "presence" of the midwife who also has good interpersonal and communication skills.

It is not only in the context of labour and birth when women need emotional support, it is clear from both the case study and the Birth Reflections study that they also require emotional support during the postnatal period. This is both in the hospital and also after they have gone home. This thesis has identified that women think about their labour and birth experience at this time and some need to talk with a health professional and have questions responded to before they are able to place the birth behind them and move on emotionally.

Postnatal debriefing is a form of supportive care. There is the possibility that physical aspects of care provision have also been prioritised in this area of practice over emotional safety. There has been little consideration given to women's emotional needs after giving birth (Beake et al 2010). As well as there being a possibility of adverse physical consequences there are also risks to women psychologically following birth. This is a life-changing event for all women, in particular those having their first babies, and emotional support provision is also of great importance. There is valuable evidence to support this. A cluster randomised controlled trial of a model of midwifery-led postnatal care that included extended home visits to individual women compared with normal postnatal care provision identified improved outcomes in women in terms of maternal mental health (MacArthur et al 2002). Unfortunately this model has not been implemented despite the positive results. It is possible that due to constrained resources physical care provision has been prioritised. However this risks being to the detriment of the emotional or psychological support many women also need at this key time in their lives as they are adjusting to their new social role, becoming mothers. Serious risks may be going undetected. Furthermore without women receiving support in this way this can lead to developmental problems in the baby (Stein et al 2008).

## 5.7 Recommendations for practice

Three key recommendations have been identified from this thesis. These are discussed below under their respective headings.

### 5.7.1 The need for improved support for women from professionals on the hospital postnatal ward

There is an urgent need to consider how best to provide more effective care for women and babies in the hospital in England. For nearly 20 years national surveys have repeatedly identified a lack of satisfaction among women relating to this aspect of care (e.g. Garcia et al 1998, HCC 2008, CQC 2013, Redshaw and Heikkila 2010, Redshaw and Henderson 2015). The case study of this thesis concurs with these findings.

This thesis highlights a need for an overview of what support is required by all groups of women on the hospital postnatal ward following birth and how this may be delivered most effectively. For example, a quality improvement study of hospital postnatal care in England identified beneficial aspects for women where revisions were made to routine systems and processes (Beake et al 2012, Bick et al 2012).

The national maternity review report “Better Births” has been published in the interim, between submitting the original thesis and undertaking amendments (NHS England 2016). In this report postnatal care was identified as needing review and a greater focus was given to perinatal mental health as well. The present thesis may provide further evidence about how services can or should approach these aspects of care provision.

When undertaking such a review there will also be the need to consider the actual care provider (Bick et al 2011). In appropriate circumstances midwives

can be supported when delivering care by other professional colleagues. Earlier work in England showed the introduction of nurses and nursery nurses to be beneficial to women on the postnatal ward following caesarean section (Baxter and Macfarlane 2005). Prior to this time maternity support workers on the postnatal wards were trained to undertake some roles that had previously only been conducted by registered midwives (Sandall et al 2007).

One possible solution would be to further implement caseload midwifery in more areas in maternity services. Women who experience care within these models receive continuity of care provision from a small number of midwives. This has proven benefits for both the women receiving care, who feel more supported, and also for midwives providing it who get to know the women and understand their hopes and wishes (McCourt and Stevens 2009).

Midwifery Units (MUs) also provide more hotel-type settings to women postnatally. Some women who give birth in MUs or birth centres, where midwives are the lead professionals, are able to remain in these areas after birth. Furthermore national guidelines in the UK now recommend that all low-risk women should be offered MU care as the standard model (NICE 2014b). There may be the need to give more resources to postnatal care, both within the hospital setting and at home. It is of interest to this discussion that over the past five years or so, and during the time of this doctoral programme, that many maternity services in England have reduced the number of home visits by community midwives and replaced these with hospital based postnatal clinics. This seems a pity in view of the discussion on emotional safety in section 5.6 above. As discussed there, childbirth is a life-changing event for all woman and emotional support provision is as important as physical aspects of care provision. Community midwives, and nowadays midwives in caseload schemes, have the valuable opportunity of reviewing women who are ideally known to them in their homes. This process allows more time to undertake observations. Practising in this way provides a greater chance of identifying risk factors for morbidity, including postpartum depression (PND) and PTSD. The Birth

Reflections study identified a high number of women with raised IES, suggestive of the need for emotional support from a health professional. In addition seeing women in the home environment has provided the opportunity for community midwives to undertake Birth Reflections-type sessions (Kershaw et al 2005).

### **5.7.2 The offer of a postnatal debriefing meeting**

Women participants in the Birth Reflections study were positive towards the opportunity of meeting with a health professional to discuss their recent experience of labour and birth at a postnatal debriefing meeting. Women with PTS symptoms were more likely to wish to talk about their birth experience compared with women with low IES scores. This study highlights the need to ensure all women are provided with the opportunity of meeting with a health professional to discuss their birth experience. This has been shown to help some women come to terms with their experience of labour and birth and the critical review of the literature described in chapter 3 identified that validation of their experience was an important aspect for women. This was further supported by the findings of the research study set out in chapter 4. Whereas the most recent Cochrane review on debriefing interventions for psychological trauma did not identify either a positive or an adverse effect of formal debriefing for women following childbirth, the authors clearly stated in their report that this did not preclude the use of other forms of postnatal discussion following birth i.e. these are not provided as an intervention nor intended to prevent PTSD (Bastos et al 2015). The findings of the work presented in this thesis suggest that it is possible there could be other benefits to women that were not identified in these trials.

As already mentioned in the above section there is the need to review how postnatal support is provided for women following birth on the hospital postnatal ward. This should include both physical and emotional support as well as the

offer of having an unstructured postnatal debriefing session to discuss the birth experience.

### **5.7.3 Screening for PTS symptoms**

The Birth Reflections study with a sample of women following childbirth has shown that approximately one third of the women had a raised IES score. Furthermore women with raised scores were more likely to wish to talk about their birth or report a negative experience. If routine screening was offered to all women following birth, this group of women with high IES scores could be identified and consequently given the opportunity of attending a postnatal debriefing meeting where they could discuss the experience with a health professional. However if postnatal debriefing was to be offered universally to all women, it might be that attendance at this session could include a screening test for PTSD. This would be another way of identifying women with raised PTS symptoms.

This measure could lead to a greater identification of women who go on to develop fear of birth at an earlier point in time and help them to prepare for a subsequent birth experience. This would also provide the small number of women with PTSD with the opportunity of receiving treatment in a more timely manner.

However it is important to acknowledge that the Birth Reflections study was undertaken at one local maternity service with small numbers in the sample. Before introducing such a screening programme in this way a larger study is needed, ideally with a random sample of women nationally, to test whether this is a more generalisable finding.

In the meantime there is a need for health promotion about PTS symptoms and PTSD itself among health care professionals working with women following birth as well as among the women themselves.

## **5.8 Future research**

The work presented in this thesis also identifies further research requirements. Ideas for future research will be given in this section under three key headings: “Postnatal debriefing”; “Maternity care environment” and “Emotional safety”.

### **5.8.1 Postnatal debriefing**

It is clear from the findings of the literature review (Baxter et al 2014 and chapter 3 in this thesis) and also the results of the recently published Cochrane systematic review of debriefing following childbirth (Bastos et al 2015) that there is a need for further RCTs to assess the effectiveness of postnatal debriefing for the prevention of psychological trauma. It is understood that there are some already ongoing (Bastos et al 2015). Bastos and colleagues (2015) also highlighted the importance of understanding the precise nature of debriefing (e.g. the number of sessions, the professional who undertakes the procedure) as well as ensuring all groups in society, as well as those women for whom English is not their first language are included when considering future research in this area. In addition, the critical review of the literature in this thesis and Bastos et al’s review identified that both formal psychological debriefing as well as postnatal discussion sessions (“listening services”) with midwives may be required and these would need to be more clearly distinguished in research studies. The present Birth Reflections study findings will help to inform the content of interventions in future studies. When considering outcome measures in RCTs such as psychological trauma there is also the need to use a validated tool for women specific to the maternity context (Bastos et al 2015).

In relation to postnatal debriefing with a midwife there is also a need to understand the views of midwives to this practice. This is important as midwives are one of the few professional groups involved to date in this aspect of care.

They may hold the key to future service provision in this area. Only two papers were identified in the critical review of the literature that considered midwives' perspectives in this area (Baxter et al 2014 and chapter 3 in this thesis). These findings were limited.

### **5.8.2 Maternity care environment**

The very environment where women receive care, including where they give birth to their babies also deserves further attention. The findings of the national Birthplace in England research study have already provided support in relation to the environment where birth actually takes place. The Birthplace case studies also showed that women particularly valued MUs for the postnatal environment as well as the birth (McCourt et al 2011).

The environment of the postnatal ward was one of two key themes identified in the qualitative analysis in the case study of this thesis. On occasions the postnatal ward setting seemed hostile to the women receiving care in this area. This together with the lack of support women experienced from staff in this area led to women's feelings of dissatisfaction. There is therefore a need to gain a fuller understanding about what is the optimal environment for women after they have given birth and before leaving the hospital and going home. Reviewing postnatal care provision in the MU environment will be a valuable step in this endeavour.

Therefore following on from the Birthplace studies the emerging issues for research might be to consider how traditional postnatal wards might work, with fewer women but a higher proportion of whom being high risk and having more birth interventions.

### **5.8.3 Emotional safety**

The concept of emotional safety needs to be further explored to increase the evidence base in this area as well as to heighten awareness amongst key stakeholders in maternity services. The Birth Reflections study identified good examples of exemplary support provided to women by midwives. However, there were also examples of poor staff interaction with women which led to ineffective communication and subsequent poor outcomes on occasions. This resulted in a negative birth experience as well as the perception of birth being traumatic for some women.

The effect of the professional care provider on a woman's overall labour and birth experience is very powerful. There appears to be a need for all staff to be supported to provide optimal relational care to women. Practising in the hospital environment can be problematic and staff may have allegiances to the organisation at the expense of the woman receiving care. However, following the publication of the Birthplace in England study there is now clear evidence that it is safe for women to give birth in alternative settings, including home and in a birth centre as well as in the conventional labour ward setting (Birthplace in England Collaborative Group 2011). Midwives practising in these areas were more likely to have skills in normal birth, which include skills for physiological birth, compared with midwives in the obstetric unit (OU) (Rayment et al 2015). Rayment and colleagues also identified a "Skills hierarchy" amongst staff where medical skills were more highly valued amongst some groups of midwives compared with skills for physiological birth (Rayment et al 2015:32). Reviewing midwives' skills in general may also help to identify other skills, including interpersonal skills.

### **5.8.4 Routine screening for PTS symptoms**

The Birth Reflections study identified one third of a sample of all women following birth to have raised PTS symptoms between four and six months

following birth. It might be the case that routine screening is required. However before doing so further exploratory research is needed and subsequent plans towards a research programme to test the potential and value of offering this as a routine part of care provision in the future. This will include the need for an instrument validated for use in the childbirth context. The first step, as mentioned in section 5.7.3 above, is for a larger study to test whether the findings are replicated nationally and the present study obtained a generalisable finding.

## **5.9 Final conclusion of the thesis**

The overall topic of this thesis is that of postnatal support for women following birth. All the work undertaken within this structured doctorate was situated in the context of the postnatal period following birth. It highlights some of women's needs at this time, although it also clarified that many of women's postnatal support needs are closely related to their prior experiences, particularly those of care and support during their labour and birth. This thesis has included a case study on women's experiences of postnatal care in hospital, a critical review of the literature of postnatal debriefing and a study of women's experiences of postnatal listening/debriefing services.

Listening to the views of service users is an essential part of maternity care provision nowadays. This thesis initially set out to further understand why women gave low ratings in surveys about postnatal care in hospital. The findings of the case study clarified that some women needed more support on the postnatal ward. This highlights a need to determine the support needs of women in this area. It appears women may not be receiving vital aspects of care provision. This is despite the publication of a national guideline on this area of care in 2006 (NICE 2006). This postnatal care guideline formed a comprehensive summary of the many different aspects of care provision required by women at this time, including breastfeeding and physical and

emotional health. As previously mentioned in this thesis, this guidance also recommended the need for all women to be given the opportunity of talking with a health professional about their birth experiences and the care they received in labour. There is therefore a simultaneous need to understand why this policy document has not been universally adhered to (Debra Bick 9 June 2016, personal communication) as well as identifying the specific support needs at this time of women more generally.

It is therefore unsurprising at the conclusion of this thesis, eight years on, that women continue to respond negatively in surveys to the care they received on the postnatal wards in hospital. As mentioned previously, at the time of finishing this thesis, in order to try and address this matter, a national review of maternity services has included postnatal care as one of the key areas for improvement (NHS England 2016).

The second key aspect of this thesis relates to postnatal debriefing. The critical review of the literature provided further evidence about the nature of an unstructured postnatal debriefing session. The Birth Reflections study also highlighted that some women consider their birth experiences to be negative or traumatic or both. There is the consequent need for further support for these women following birth, in addition to the need for improved support during labour and birth. This can be provided during a postnatal debriefing meeting with a midwife.

An additional finding from this work is that it has identified significant relationships between level and type of support in labour/birth and postnatal feelings. The case study and the Birth Reflections research study raise implications for service design and for further research. They both show that providing good quality midwifery support and information can have important psychological, as well as physical health implications. This adds to the evidence from prior research on models of care and psychological, as well as physical clinical outcomes

This thesis has shown that the labour and birth experience impacts on how an individual woman is feeling emotionally following birth. Although recommended by NICE (2006) for health professionals to speak with women about the birth, and to also ask women at each postnatal contact about their emotional well-being, it appears that some women may silently leave the hospital after birth and miss out on supportive care necessary to address their concerns. Without the support of a postnatal debriefing with a health professional some women's suffering risks going unrecognised by care providers. In addition this may impact negatively as they endeavour to bond with their babies and develop their parenting skills (Stein et al 2008). This could affect their relationships, both with their partners and their babies. A woman who does not have a partner to support her will struggle even more.

Finally, through the use of a mixed methods research approach, the Birth Reflections study has provided new knowledge for the evidence base in relation to unstructured postnatal debriefing. By being offered support in this way this study has shown that some women are helped to move on emotionally following their childbirth experiences. This study has also shown from a convenience sample of women who gave birth at a hospital in England that a third of these women were identified as having some PTS symptoms. Moreover those with high PTS symptoms were more likely to report a negative childbirth experience or need to discuss their birth experience with a health professional. With this information, professionals and maternity services alike, can be assisted to improve aspects of postnatal care provision for women.

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# Appendix A: Scanned copy of Structured PhD route guidelines

## APPENDIX II

### Structured PhD route

#### PhD (Professional Practice), PhD (Practice and Services Development)

The structured PhD route is aimed at mid-career professionals who wish to develop their research expertise through supervised engagement with a series of independent studies, each relevant to their continuing professional practice. Candidates will submit a single bound volume for assessment, containing five practice-focused elements (elaborated below). These ensure development of a spectrum of high-level skills pertinent to practice or service development and professional leadership. Most candidates will choose to explore three closely related questions through their case study, literature review and research.<sup>1</sup> ALL elements of the submission must be at D level.

#### Commentary

A succinct commentary will explain what is to follow. It offers the opportunity to set out the starting point of the candidate and the rationale for the work undertaken. It will outline linkage between the subsequent elements and draw attention to the current or planned use of the doctoral work within relevant practice contexts. It will place the work in its overall context, describe its contemporary relevance and outline the implications of the work for future research and practice development.

#### Case Study (approximately 10 000 words)

The case study may concern front-line practice, teaching, supervision, management or consultancy in which the student has been a primary participant. Situational analyses will be accepted as case studies. This element emphasises the skills and knowledge required to be a reflective practitioner.

#### Critical Review of Literature (approximately 10 000 words)

This differs from the analysis of literature that will be needed to conduct the research project. It is a coherent free-standing enquiry. It should start from the identification of problems or questions pertinent to practice critically evaluate the available literature and make recommendations for practice and research. Candidates should aim for an analysis that, with relatively little modification, would be acceptable for publication. This element emphasises evidence-informed practice.

#### Research (maximum 50 000 words)

This should comprise an original piece of research, reflecting the same level of quality and originality as a PhD thesis, but less extensive and usually with an applied focus. This does not preclude the development of theory or philosophical argument, provided the relationship to developing practice is discussed.

<sup>1</sup> Candidates working in rapidly developing service areas and those who change their professional role during their doctoral registration may be more likely to select different foci for these elements. Nevertheless the commentary should identify any linkage and must clearly identify the contribution(s) to knowledge made by the doctoral submission as a whole.

**A dissemination artefact and plan (approximately 7000 words in total)**

The dissemination artefact will often be a manuscript, ready for submission to a relevant journal, distilling the findings of the Critical Literature Review or the Research Project. The journal should be identified and candidates should ensure compliance with its instructions to authors. Alternative, innovative dissemination artefacts may be submitted (e.g. training materials). The dissemination plan will recognise multiple stakeholders within practice and research. It will address the communication of findings in a manner that develops practice.

## **Appendix B: Caesarean Survey Questionnaire**

CONFIDENTIAL

HOSPITAL NUMBER

**CAESAREAN SURVEY**

**THIS  
PREGNANCY**

1. Was your Caesarean:

*Please tick one reply*

a) **planned**, that is, decided by you and the doctors before you went into labour

Yes

Go to 3

b) **emergency**, that is, the doctors advised you that this would be the best thing for you and the baby when you were in labour

2. Approximately how long were you in labour for? .....hours

3. What was the main reason why you had a Caesarean?

*Please tick one reply*

I did not progress in labour.....

There were signs of distress in the baby on the monitor.....

I had a previous Caesarean.....

I had a medical or pregnancy-related condition e.g. diabetes, preeclampsia.....

The baby was lying in the breech position.....

The placenta was lying low (placenta praevia).....

The only reason was that I asked for one.....

Other reason, *please write here*

<p>4. How do you feel about not having had a vaginal birth? Please tick box which best describes your feelings</p>	Very Disappointed	Disappointed	Neither disappointed nor pleased	Pleased	Very pleased
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any further comments on this question?

**TRANSFER TO THE POSTNATAL WARD**

5. How long did you stay in hospital after the birth? Please write number of days

6. Which postnatal ward did you stay on?

Hunter	Nixon
<input type="checkbox"/>	<input type="checkbox"/>

7. Which staff member received you when you first arrived on the ward?

*Please tick one box*

- Midwife.....
- Health care assistant.....
- General nurse.....
- Nursery nurse.....
- Other please state.....
- Don't know.....
- Can't remember.....

8. When you were transferred to the postnatal ward did the staff member who received you (*please tick the boxes that apply*):

a) introduce him/herself to you

Yes

No

Can't  
remember

b) tell you where toilets and bathrooms are

c) tell you when meals were served

d explain who all the different members of staff are and how each would be able to assist you

9. Did you receive <b>regular medication</b> to prevent pain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
10. Did you ever have to ask a member of staff for pain relief because you were in pain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	I took them myself from cupboard provided <input type="checkbox"/>
If yes roughly how long was it before you received the pain killer:			
i) 5 minutes or less	<input type="checkbox"/>		
ii) 6 – 15 minutes	<input type="checkbox"/>		
iii) ) more than 15 minutes	<input type="checkbox"/>		
11. When you were on the postnatal ward where was your baby?	With you on the ward	In the neonatal unit	
a) on the first day, following birth	<input type="checkbox"/>	<input type="checkbox"/>	
b) second day	<input type="checkbox"/>	<input type="checkbox"/> <i>Go to 13</i>	
12	Yes	No	
a) If your baby was with you on the ward did you find it difficult trying to care for him or her?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Did you receive sufficient support from staff to get into comfortable positions for holding and feeding your baby?			
<i>Please tick <u>one</u> box only</i>			
Always	<input type="checkbox"/>		
Sometimes	<input type="checkbox"/>		
Rarely	<input type="checkbox"/>		
Never	<input type="checkbox"/>		

13. Did the staff look at your wound dressing during the first 24 hours after the operation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Can't remember <input type="checkbox"/>
14. Did the staff check your catheter and urine bag regularly during this time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Can't remember <input type="checkbox"/>
15. Were you offered help with your personal hygiene or with walking out to the bathroom by a staff member?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
16. Were there any problems with your wound healing? If yes, please describe what complications you experienced?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
<b>FEEDING YOUR BABY</b>			
17. Before your baby was born how had you planned to feed him/her?	Breast <input type="checkbox"/>	Bottle <input type="checkbox"/>	
18. Did you ever put your baby to the breast?	Yes, even if it was once only <input type="checkbox"/>	No, never <input type="checkbox"/> <i>Go to21</i>	

19. Are you still breastfeeding your baby?	Yes <input type="checkbox"/> <i>Go to 21</i>	No <input type="checkbox"/>	
20. a) How old was your baby when you last breast fed him/her?		.....weeks	
b) What were your reasons for stopping breastfeeding? <i>Please describe</i>			
21. Did you always feed your baby yourself or did the staff on the ward ever feed him/her? Always fed baby myself	<input type="checkbox"/>	<input type="checkbox"/> <i>Go to 23</i>	
Staff sometimes fed baby	<input type="checkbox"/>		
22. If staff fed your baby for you did you:	Yes	No	
Feel pressured to agree?	<input type="checkbox"/>	<input type="checkbox"/>	
Were happy about allowing this to happen	<input type="checkbox"/>	<input type="checkbox"/>	
<b>HELP AND ADVICE</b>			
23. While you were in hospital were you given <u>enough</u> help and advice about each of the things listed below?  <i>Please tick one box on each line</i>	Yes, enough	No, not enough	Staff probably felt they didn't need to because I have had a baby(ies) before
Feeding the baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How to handle, settle and look after the baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your baby's health and progress and any problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your own health and recovery after the birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. Did you ever feel that the staff were too busy to spend enough time with you? Often too busy Sometimes too busy No not really	<i>Please tick one box</i>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
25. Were you confused or worried because different staff gave you conflicting advice about anything?	Yes <input type="checkbox"/>		No <input type="checkbox"/>		
26. Generally speaking during your postnatal stay in hospital did you find staff to be supportive and caring? <i>Please tick on box only</i> Always Sometimes Usually Rarely Never	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
<b>POSTNATAL CARE OVERALL</b>					
27. Are you satisfied with the amount of rest and sleep you experience on the postnatal ward?	Yes <input type="checkbox"/>		No <input type="checkbox"/>		
28. How would you rate your care in the postnatal ward overall:					
	Excellent	Good	Average	Poor	Very poor
During the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. Below is a list of areas of postnatal care that some women have said need improving. Are there any aspects of care that you feel need improving?

Yes/No (*Please circle as appropriate*)

If so please tick any of the areas below that you feel need improving and add any others not listed.

Help with baby care.....	<input type="checkbox"/>
Arrangements for discharge home.....	<input type="checkbox"/>
Number and availability of staff.....	<input type="checkbox"/>
Privacy.....	<input type="checkbox"/>
Care after Caesarean section.....	<input type="checkbox"/>
Cleanliness of the ward area.....	<input type="checkbox"/>
The way staff speak to you.....	<input type="checkbox"/>
Visiting times.....	<input type="checkbox"/>
Quality of the food.....	<input type="checkbox"/>
Other, please specify.....	<input type="checkbox"/>

30. We would be very grateful to hear of any other comments you may have about your postnatal stay?

**ABOUT YOU**

31. How old were you when your baby was born?

Under 20 years.....

20 – 24 years.....

25 – 29 years.....

30 – 34 years.....

35 – 39 years.....

40 years or over.....

32. To which of these groups do you belong?

White.....

Black Caribbean.....

Black African.....

Black – neither Caribbean nor African...

Indian .....

Pakistani.....

Bangladeshi.....

Chinese.....

None of these .....

33. What was your main job before you went on maternity leave or left to have your baby?

34. What did you do mainly in your job?

**YOUR PREVIOUS PREGNANCIES**

	Yes	No
35. Have you had any previous pregnancies that lasted longer than 6 months (24 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>
If so how many babies have you had?		<i>Go to 36</i>
		.....babies

	Yes	No
36. Is this your first Caesarean section	<input type="checkbox"/>	<input type="checkbox"/>

**Thank you very much for your help with this study by completing this questionnaire. If you would like to receive a copy of the final please report please tick this box**

**Appendix C: Aspects of care highlighted in the case study with definitions of the analysis from the HCC 2007 survey**

<i>Indicator code(if applicable)</i>	<i>Question response/Indicator description</i>	<i>Type of response</i>	<i>Indicator formula/categories of response to question</i>
MT21A8	Women's satisfaction with their care after birth	Composite variable	Survey of Mothers data: $(4 * \text{Women responding excellent on care after birth} + 3 * \text{women responding very good to care after birth} + 2 * \text{women responding good to care after birth} + 1 * \text{women responding fair to care after birth}) / (4 * \text{Women responding to H9c}) * 100$
MT21A9	Women always treated with understanding and respect after the birth	Composite variable	Survey of Mothers data: Women who responded that they were always treated with respect and dignity (E10b=1) and kindness and understanding (E10c=1)/ Women providing an opinion on how they were treated in terms of dignity and kindness (E10b In 1,2,3 and E10c In 1,2,3)*100

MT23A5	Women always given information or explanations needed after the birth	Composite variable	Survey of Mothers data: Women who responded that they were always given information or explanations they needed (e10d=1)/ Women providing an opinion on information and explanations given (e10d In 1,2,3)*100
MT27L1	Extent that women were given information on their recovery after birth	Composite variable	Survey of Mothers data: (1*Women who were given enough information on recovery after birth (e3=1) + 0.5*Women who were given insufficient information on recovery after birth (e3=2)) / Women who reported needing information given on recovery (e3 in 1,2,3) * 100
MT28A8	Women who reported good advice, help and support on infant feeding	Composite variable	Survey of Mothers data: (1* women who received consistent advice+0.5 women who generally received consistent advice +1* women who received practical help+0.5 women who generally received practical advice + 1* women who received support+0.5 women who generally received support)/ (Women responding help required in question F4a + Women responding help required in question F4b + Women responding help required in question F4c)*100
	Looking back, do you feel that the length of stay in hospital was.....	Direct from question	Too long Too short About right Not sure/don't know

## Appendix D: Qualitative analysis – codes from women’s comments

Code	2009	2007	2003	Comment
Separated from my baby was difficult	*			
Good care throughout continuum	*			
Postnatal care much better compared to 2006	*		n/a	
Information not given	*	*	*	
Lack of support from midwife	*	*	*	
Needed help to mobilise	*	*	*	
Needed help with baby	*	*	*	
Visitors stop rest	*			
Breastfeeding advice incorrect	*		*	

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
No sleep	*			
Poor postnatal care	*	*	*	
Call bell not answered	*	*	*	
I helped other woman with crying baby	*		*	
Midwives overstretched	*	*	*	
Midwives unable to provide sufficient support	*	*	*	
Lack of staff/not enough staff to go around	*	*	*	
Delays getting help	*	*	*	
Midwives stressed	*	*	*	
Poor quality care	*	*	*	
Noisy environment	*	*		

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
Lack of privacy	*		*	
Disturbed while sleeping	*			
Stressful feelings	*	*	*	
Insufficient food	*	*		
Unsupportive staff	*	*	*	
Chaotic discharge procedure	*	*	*	
Felt sorry for staff	*		*	
No help with breastfeeding	*	*	*	
Turfed out of bed	*	*		
Insufficient help with breastfeeding	*	*	*	
Pressure to breastfeed	*			
Contradictory feeding advice	*		*	

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
Difficult to breastfeed	*			
Staff unhelpful	*	*	*	
Staff not respond to requests	*	*	*	
Waited long time for baby check	*			
Stressful on postnatal ward	*	*	*	
Inconsistent advice	*		*	
Need for better communication between shifts	*		*	
Needed more help with breastfeeding	*	*	*	
Need for continuity of care	*	*		
Wanted debrief (following difficult birth)	*			

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
Baby given formula rather than help with breastfeeding	*	*		
Had to ask for cannula to be removed	*		*	
Had to ask to empty catheter	*		*	
Pressure to go home too soon	*	*	*	
Lack of confidence in staff	*	*	*	
Not given help with breastfeeding	*	*	*	
Not given help with baby care	*	*	*	
Excellent breastfeeding support from counsellor	*			
Needed help with baby	*	*	*	

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
Lack of compassion	*	*	*	
Expected to self-care (after difficult birth)	*	*	*	
Not given help to mobilise	*	*	*	
Need for common room	*			
Need for sensitivity	*		*	
Midwife too busy to help me	*	*	*	
Poor postnatal care – night	*	*	*	
“I felt as if I had been to hell and back”	*	*	*	
Poor attitudes	*	*	*	
Lack of communication	*		*	
Poor cleanliness in postnatal care	*	*	*	

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
Staff accused me of asking for help too often	*	*		
Traumatic experience in postnatal care ward	*	*	*	
Lack of care	*	*	*	
Not given help	*	*	*	
Told to wash antiembolic stockings by midwife (as too expensive to throw away)	*			
Bed linen not changed	*		*	
Poor breastfeeding advice	*	*	*	
Offered formula feed by midwife (much to my great relief!)	*			
Needed more help with breastfeeding	*	*	*	
Pressure to breastfeed	*			

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
Need for individualised care	*			
Medical staff not interested	*			
Poor discharge process	*	*	*	
No obs.	*	*	*	
Inconsistent advice	*		*	
Had to remind staff	*	*	*	
Had to ask for pain relief	*	*	*	
Poor pain relief	*	*	*	
Poor communication between staff	*		*	
Inconsistent support/care	*		*	
Lack of compassion	*		*	
Contradictory breastfeeding advice	*		*	

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
Lack of support to breastfeed	*	*	*	
Baby given bottle without my consent	*		*	
Felt like an inconvenience/burden to staff	*	*	*	
Marched to discharge lounge	*	*		
Home too early	*	*	*	
No beds available therefore had to wait in discharge lounge	*			
Felt unsupported at night	*	*	*	
Needed more help and advice at night	*	*	*	
Poor policing visiting policy	*			
Visitors noisy – unable to rest	*			

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
Difference between day and night staff	*	*		
Shouted at by midwife/unkind staff	*	*		
Unfriendly atmosphere	*	*		
Wanted my husband with me all the time	*			
Waited long time for pain relief	*	*	*	
Staff noisy at night	*	*		
Staff unhelpful	*	*	*	
Staff distant	*	*	*	
Felt bothered staff when asked for help	*	*	*	
Felt abandoned on postnatal ward	*	*	*	
Did not receive any help	*	*	*	
Night staff unhelpful	*	*	*	

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
Lack of communication	*			
Neonatal staff good	*	*	n/a	
No compassion	*	*	*	
Felt upset/vulnerable	*	*	*	
Not given help with twins at night	*	*		
Better off at home	*	*		
Not given help when I asked for it	*	*		
Unable to care for baby in cot beside bed	*		*	
Rang bell but help not forthcoming	*	*	*	
Informed of staff shortage	*			
Pain relief poor	*	*	*	
Given good support		*	*	
Given good care		*	*	
Supportive staff		*	*	

<b>Code</b>	<b>2009</b>	<b>2007</b>	<b>2003</b>	<b>Comment</b>
Given good support post op		*		
Took baby to give me rest		*		
Support from other women		*	*	
Staff reception desk		*		
Lights dimmed		*		
Positive experience	*	*		
Help only during the day		*		
Claustrophobic environment				
Some staff excellent			*	

## Appendix E: Literature Review – tables

Table F1 Summary of included studies

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
S Inglis  United Kingdom  2002  Delivery Suite Manager	Accessing a debriefing service following birth	To examine the objectives of the service from the perspective of its users	Mixed: questionnaire to 46 women who had used the service and telephone interviews to 23 women who consented on the self- response questionnaire that they would be willing to participate in a follow-up interview.	<p><i>Timing of access</i></p> <ul style="list-style-type: none"> <li>• Average 12 months after birth</li> <li>• Readiness to speak about birth experience</li> <li>• Debriefing session supportive when conducted around the time of subsequent birth experience</li> <li>• Debriefing should not be made routine i.e. individual women should say if and when it is appropriate for them</li> </ul> <p><i>Information and communication</i></p> <ul style="list-style-type: none"> <li>• Assumption by women that access to a debriefing service provides reassurance that the consultation will influence a subsequent contact with the maternity service.</li> <li>• Need to air feelings and be heard by professionals (not possible with friends and family)</li> <li>• Need for explanation about birth experience e.g. description of the mechanism of birth and how the baby became stuck in the birth canal</li> </ul>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
				<ul style="list-style-type: none"> <li>During the normal birth process lack of time for professionals to discuss issues in any depth with women. The debriefing process highlighted this to the extent that women felt that they were not given choices. This became evident during the debriefing session</li> </ul>
<p>S Dennett UK 2003 Consultant Midwife</p>	<p>Talking about the birth with a midwife</p>	<p>To explore the provision for talking about the birth as a postnatal routine. Four main questions were asked:</p> <ul style="list-style-type: none"> <li>if they were given an opportunity to talk about the birth</li> <li>whether it was the right time</li> </ul>	<p>Mixed: postal questionnaire to convenience sample of 100 women who had given birth 8-10 weeks earlier</p>	<p>29/100 women responded 24/29 talked with a midwife following the birth 19/24 felt had spoken with most appropriate midwife</p> <p><i>Benefits</i></p> <ul style="list-style-type: none"> <li>Positive comments given by women about debriefing session “useful”, “helpful”, “nice”</li> </ul> <p><i>Most appropriate professional to provide debriefing session</i></p> <ul style="list-style-type: none"> <li>The midwife who provided care in labour and birth considered best person (although most of the respondents received their debriefing session from their community midwife). The midwife present at the birth would be familiar with events of labour and birth and more able to answer questions.</li> </ul> <p><i>Timing of debriefing session (in relation to birth)</i></p> <ul style="list-style-type: none"> <li>Most common very soon after the birth - X 8 women had talk before leaving delivery room, X5 less than 24hrs, X</li> </ul>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
		<ul style="list-style-type: none"> <li>• with the most appropriate midwife</li> <li>• was it beneficial</li> </ul>		<p>8 between 1 and 3 days, X 2 between 4-9 days and X1 more than 10 days</p> <ul style="list-style-type: none"> <li>• having the talk at a later point e.g. 3 - 4 weeks later might have been more helpful</li> </ul> <p><i>Fathers' needs in terms of debriefing</i></p> <ul style="list-style-type: none"> <li>• Partner requires the opportunity to debrief.</li> </ul> <p><i>Women who did not talk about the birth</i></p> <ul style="list-style-type: none"> <li>• Women who did not speak with a professional about the birth stated that they would have wished to.</li> <li>• Did not want to think about the birth initially - "Blocked" it out</li> </ul> <p><i>Reading through the labour and birth records</i></p> <ul style="list-style-type: none"> <li>• Valued by women</li> </ul>
<p>Steele A, Beadle M (UK) 2003</p> <p>Midwifery lecturers</p>	<p>A survey of postnatal debriefing</p>	<p>To explore current practices and describe the provision of postnatal debriefing within two health regions.</p> <p>Clarify the meaning of the term debriefing</p>	<p>Quantitative survey: postal questionnaire</p>	<ul style="list-style-type: none"> <li>▪ 88% of unit offered women the opportunity for women to discuss their experiences of maternity care.</li> <li>▪ 3 groups of "debriefing" identified as being used <ul style="list-style-type: none"> <li>▪ Group A – services here listed all 9 descriptor statements, therefore service in keeping with more formal structured debriefing (but the name given to this service was not always debriefing) 14% (n=6) units</li> </ul> </li> </ul>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
		Make recommendations on the provision of postnatal debriefing		<ul style="list-style-type: none"> <li>▪ Group B – services chose descriptor statements pertaining to routine postnatal care activities 28% (n=12)</li> <li>▪ Group C – services chose a variety of descriptors and hence inconsistent therefore neither debriefing nor postnatal care. 58% (n=25)</li> </ul>
<p>Olin R, Faxelid E 2003</p> <p>Sweden</p> <p>Dept. Obstetrics and Gynaecology/ Dept Public Health Sciences</p>	<p>Parents' need to talk about their experiences of childbirth</p>	<p>To describe parents' experiences of childbirth and their views about having a postpartum talk</p> <p>To analyse factors during pregnancy and childbirth which might influence the wish for such a talk</p>	<p>Survey</p>	<p>66% of first time mothers and 74% of multiple-time mothers and 58% of first time fathers and 30% of multiple time fathers wanted to talk about the delivery.</p> <p>The issues which the parents thought should be included in the postpartum talk were the birth process, normal/complicated delivery, feelings of failure, pain and pain relief.</p> <p>Parents mainly wanted to talk to the midwife who delivered the woman and the best time for the postpartum talk seems to be at the maternity ward before discharge.</p>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
Gamble J, Creedy D, Moyle W  Australia  2004 (a)	Counselling processes to address psychological distress following childbirth: perceptions of women	To explore women's views of counselling strategies that may facilitate recovery following a traumatic birthing experience	Qualitative focus group	<p><i>Opportunities to talk about the birth</i> Talking about the birth met several needs including, being heard and understood, having birth story acknowledged and accepted, feeling validated, chronology developed and gaps in understanding identified, discuss fears experienced in labour.</p> <p><i>Developing an understanding of events</i> Speaking with supportive people helps to develop an understanding of events (partner or health professional) and reconcile the birth experience. Until a satisfactory understanding is achieved women described replaying birth events over and over in their minds to work out what went wrong.</p> <p><i>Reviewing labour management</i> Women expressed a sense of failure. They blamed themselves for succumbing to unwanted procedures e.g. epidural. Women needed to review decisions and procedures, to gain an understanding of how the traumatic event may have been avoided by considering alternative courses of action. This provided a retrospective sense of control.</p> <p><i>Discussing future childbearing</i> Women said that their fears and anxieties were not acknowledged or addressed by staff in attendance around the time of the birth. Sometimes staff contributed to women's anxieties and fears, particularly in an emergency situation when there was less communication by staff. Following a traumatic birth women did not want to have another child.</p>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
Gamble J, Creedy D, Moyle W (Australia)  2004 (b)	Counselling processes to address psychological distress following childbirth: perceptions of midwives	To investigate midwives' views on counselling strategies to facilitate recovery from childbirth- related stress and trauma	Qualitative focus groups	<p>Unequivocal support among midwives for postnatal debriefing, particularly if birth complicated.</p> <p>According to these midwives debriefing helps women to come to terms with and integrates their birth experiences.</p> <p>Process (used by midwives) not structured (e.g. CISD)</p> <p><i>Opportunities to talk about the birth</i> Women should be able to tell birth story "at her own pace", share their perceptions, write their own birth story, partners also need to be included and express their own feelings. Midwives also recognised the importance of addressing past negative experiences prior to a subsequent birth experience to prevent adverse outcomes.</p> <p><i>Developing an understanding of events</i> Women need to know why certain actions or interventions occurred. Role of midwife is to listen, answer questions and fill in missing pieces about the birth – important for women to develop a clear picture of events and coherent narrative. One strategy used = to go through the birth record.</p> <p>Plans in local unit to extend role to medical staff to debrief women after instrumental births.</p> <p><i>Minimise feelings of guilt</i></p>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
				This was identified in some women by midwives who suggested ways to ameliorate such feelings. Women need to be reassured that they made the correct decisions – this would help in subsequent pregnancies to be more confident about the forthcoming repeat birth experience.
Ayers S, Claypool J, Eagle A (UK)  2006  Senior lecturer health psychology, research psychologist, Consultant clinical psychologist	What happens after a difficult birth?  Postnatal debriefing services	To establish the type and availability of postnatal services in the UK for women who have a difficult or traumatic birth	Quantitative survey: postal questionnaire	<ul style="list-style-type: none"> <li>• 94% of obstetric hospitals have services in place for women who have a difficult birth experience <ul style="list-style-type: none"> <li>▪ - 65% “Debriefing” services</li> <li>▪ 13% “Birth afterthought”</li> </ul> </li> <li>• Psychotherapists are involved in 23% of services</li> <li>• 70% of services provided by O&amp;G depts.</li> <li>• 87% funded from midwifery budgets</li> <li>• Majority of services open to all women and informed by a midwife after birth</li> <li>• Most services evolved in response to need</li> <li>• 5% started on basis of research evidence</li> <li>• 34% of services had been formally evaluated.</li> </ul>
Bailey M and Price S	Exploring women’s experiences	To explore women’s experiences of	Grounded theory, semi- structured	Two main themes identified – listening and explaining.  <i>Need to talk</i>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
UK 2008  Senior Midwife/ Consultant Midwife	of a Birth Afterthoughts Service	using a Birth Afterthoughts Service (accessible by any woman who wishes to discuss her birth experience with a midwife) in order to evaluate it, or what aspects of the service are of benefit to the women	interviews with 7 women who had used the service	<ul style="list-style-type: none"> <li>• Common theme of needing to be listened to in order to deal with the symptoms they experienced (e.g. flashbacks, blame and depression)</li> <li>• Blocking out the experience of childbirth</li> </ul> <p><i>Clarification of terms</i></p> <ul style="list-style-type: none"> <li>• Women needed clarification of terms used during labour as important to their understanding</li> </ul> <p><i>Understanding their experience</i></p> <ul style="list-style-type: none"> <li>• Gaining an understanding of what happened during the labour helped women come to terms with the experience</li> </ul> <p><i>Acknowledgment of hard time</i></p> <ul style="list-style-type: none"> <li>• Having someone listen to a woman's story validated her experience as being difficult or traumatic. This was helpful to her</li> </ul> <p><i>Reassurance for future births</i></p> <ul style="list-style-type: none"> <li>• The women needed to understand their fears before facing another pregnancy</li> </ul> <p><i>Feelings of relief</i></p> <ul style="list-style-type: none"> <li>• Women felt a sense of relief once they started to understand what had happened</li> </ul> <p><i>Closure</i></p> <ul style="list-style-type: none"> <li>• The Birth Afterthoughts service put closure to their experience.</li> </ul>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
				<p><i>The role of the midwife</i></p> <ul style="list-style-type: none"> <li>• Caring and empathy were qualities in midwives that allowed the women to feel listened to.</li> </ul>
<p>Gamble J, Creedy D (Australia)</p> <p>2004</p> <p>Master of midwifery programme convenor</p> <p>Dean, Faculty of Nursing and Health</p>	<p>Content and Processes of Postpartum Counselling After a Distressing Birth Experience: A Review</p>	<p>To critique published papers describing and/or testing postpartum counselling for use with women who had a distressing birth experience and identifies common content and processes.</p>	<p>Literature review</p>	<ul style="list-style-type: none"> <li>• Consensus about debriefing processes including the below:</li> <li>• Provide women with opportunities to talk about their birth experience, express feelings about what happened, have questions answered and have gaps in knowledge or understanding of events addressed so that they could make sense of what happened, connect events with emotions and behaviours, talk about future pregnancies and explore existential issues such as childbirth as a rite of passage.</li> <li>• Timing of intervention not addressed but publications describing the provision of counselling services stated that counselling support was provided at any time after the birth even after one year. Other authors implied that counselling should be offered sooner within a few days to several weeks after birth.</li> <li>• The inclusion of partners in discussions about birth</li> </ul>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
				<ul style="list-style-type: none"> <li>• Caution identified about a formal single debriefing session</li> </ul> <p>No disagreement or controversy was mentioned about the content to be addressed in counselling postpartum women.</p>
<p>Collins R (UK) 2006  Undergraduate midwifery student</p>	<p>What is the purpose of debriefing women in the postnatal period?</p>	<p>To determine why women want to debrief and whether or not debriefing reduces trauma caused by events in childbirth. To explore the role of debriefing in risk management and the organisation of debriefing services within the maternity services.</p>	<p>Literature review</p>	<p><i>Investigating the need for women to debrief</i> The author suggests possible reasons for the need for debriefing:</p> <ul style="list-style-type: none"> <li>▪ Women's perceptions of their childbirth experience</li> <li>▪ Mode of delivery</li> <li>▪ Previous psychopathology or trauma</li> <li>▪ Gaps in memory</li> <li>▪ Differences in expectations and reality</li> </ul> <p><i>Does debriefing reduce childbirth trauma?</i></p> <p>3 RCTs all used different populations and assessment tools measuring different outcomes (e.g. anxiety, depression) including EPND score and Revised Impact of Event Scale 2 trials found no reduction in outcome assessed and 1 did therefore no evidence debriefing reduces psychological morbidity.</p> <p><i>Does debriefing help women finish the journey?</i></p> <ul style="list-style-type: none"> <li>• Women need to discuss the experience of birth with someone</li> </ul>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
				<ul style="list-style-type: none"> <li>• Gaps closed (to make sense of events ) by discussion of birth experience and provision of information from professionals</li> <li>• One technique used to help women make sense of their experience described which utilises 4 steps – normalising, mediating, validating and activating the story</li> </ul> <p><i>Does debriefing act as risk management?</i></p> <ul style="list-style-type: none"> <li>• Reduction of complaints</li> <li>• Not clear whether having a debriefing service reduces complaints in an organisation.</li> <li>• Changes to practice and organisation of care. Debriefing acts as a quality assurance instrument as an opportunity to pick up positive and negative feedback to improve service.</li> <li>• Debriefing identifies women who require further clinical referral.</li> </ul> <p><i>What is the organisation of debriefing services?</i></p> <ul style="list-style-type: none"> <li>• Range of different services identified</li> <li>• The appropriate practitioner carrying out the debriefing</li> <li>• Midwife “because they (midwives) have up- to- date knowledge of midwifery and obstetric practice, access to</li> </ul>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
				<p>the notes and have good listening and communication skills”</p> <ul style="list-style-type: none"> <li>• Possible need for further training to conduct debriefing (e.g. in psychological techniques)</li> <li>• Timing and location. During first few days whilst still in hospital or later?</li> </ul> <p>Use of maternity notes to guide discussion</p>
<p>Rowan C, Bick D, da Silva Bastos M (UK)  2007</p>	<p>Postnatal Debriefing Interventions to Prevent Maternal Mental Health Problems After Birth: Exploring the Gap Between the Evidence and UK Policy and Practice</p>	<p>To identify evidence of the effectiveness of postnatal debriefing and the availability and current provision of debriefing offered in UK maternity services</p>	<p>Structured literature review</p>	<p>Women valued opportunities to discuss their birth</p> <p>2 RCTs found evidence of positive associations related to psychological interventions but both were associated with methodological flaws.</p> <p>6 RCTs no differences in outcomes identified, one identified possible harm from debriefing.</p> <p>No standard intervention was used in any RCTs or service intervention</p> <p>Evidence to support content and timing of service provision and effectiveness is lacking.</p> <p>The role of debriefing after birth is clearly confusing.</p> <p>Wide differences exist between content of debriefing implemented in RCTs and those provided within the maternity</p>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
				<p>service evaluations. Some RCTs the intervention was based on psychological approaches, such as CISD whereas service provision often involved talking with a woman about her labour and delivery guided by the notes. It was clear from descriptions of service provision that an opportunity for women to talk about their childbirth experience was provided rather than a structured psychological intervention.</p> <p>No data on health outcomes.</p> <p>Need to consider whether debriefing interventions are able to take account of women's individual coping styles and defensive strategies.</p> <p>? should routinely offer to all women the opportunity to discuss birth.</p> <p>Need to differentiate between service provision of a post childbirth discussion as part of good postnatal care and the offer of a more formal debriefing which is not supported by evidence.</p>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
Lavender T, Walkinshaw S (UK)  1998  Research midwife/ Consultant in Feto- Maternal Medicine Liverpool Women's Hospital	Can Midwives Reduce Postpartum Psychological Morbidity? A Randomized Trial	To examine if postnatal debriefing by midwives can reduce psychological morbidity after childbirth	RCT	<p>Women who received the intervention were less likely to have high anxiety and depression scores after delivery when compared with the control group.</p> <p>Listening, support, counselling, understanding and explanation from midwives is a beneficial process for women irrespective of management of labour or mode of delivery.</p> <p>Women in the intervention group were less likely to have high anxiety (<math>p &lt; 0.0001</math>) and depression scores (<math>p &lt; 0.0001</math>) 3 weeks after delivery compared with the control group.</p> <p>Experimental group women were more satisfied with the amount of information they received and were less likely to return home with unanswered questions.</p> <p>Only 1 woman in experimental group wished to discuss her labour further</p> <p>Midwives are capable of reducing psychological morbidity. Providing women with the opportunity to discuss their labour should therefore be an integral part of midwifery care.</p>

<b>Author(s)/year/ country</b>	<b>Title of paper</b>	<b>Aims and objectives</b>	<b>Method</b>	<b>Main findings</b>
Small R, Lumley J, Donohue L, Potter A, Waldenstrom U (Australia)  2000  Research fellow, professor, research midwife, research midwife, professor	Randomised controlled trial of midwife led debriefing to reduce maternal depression after operative childbirth	To assess the effectiveness of a midwife led debriefing session during the postpartum hospital stay in reducing the prevalence of maternal depression at six months postpartum among women giving birth by caesarean section, forceps, or vacuum extraction	RCT	88% response rate  More women allocated to debriefing scored as depressed at 6 months postnatal than women allocated to usual postpartum care 81(17%) v 65 (14%) although difference not statistically significant  Women allocated to debriefing had poorer health status on 7 of the 8 SF-36 subscales, although this difference was significant only for role functioning (emotional).  The possibility that debriefing contributed to emotional health problems for some women cannot be excluded.  200 (43%) women rated debriefing session as “very helpful”  237 (51%) women rated debriefing session as “helpful”  26/463 (6%) women rated debriefing session as “unhelpful”
Priest S, Henderson J, Evans S, Hagan R (Australia)	Stress debriefing after childbirth: a randomised	To assess whether a short session of critical incident stress debriefing led by	RCT	No significant differences between control and intervention groups on all psychological outcomes – depression and stress disorder.

<b>Author(s)/year/ country</b>	<b>Title of paper</b>	<b>Aims and objectives</b>	<b>Method</b>	<b>Main findings</b>
2003	controlled trial	a midwife reduces the incidence of postnatal psychological disorders in women who have recently given birth		<p>A session of midwife-led, critical incident stress debriefing was not effective in preventing postnatal psychological disorders, but had no adverse effects</p> <p>31.5% birth experience did not meet expectations</p> <p>Two thirds of women rated the debriefing session as moderately or greatly helpful, 23% as minimally helpful and 10% as not at all helpful.</p> <p>No effect on the prevalence of stress disorders or depression, either in the whole group or in subgroups of primiparous or multiparous women, or those who underwent operative delivery.</p>
Ryding E, Wiren E, Johansson G, Ceder B, Dahlstrom A (Sweden)  2004  Consultant obstetrician, delivery ward midwives,	Group Counselling for Mothers After Emergency Cesarean Section: A Randomized Controlled Trial of Intervention	To test a model of group counselling for mothers after emergency caesarean section, and to study its possible effects	RCT	<p>No difference found between intervention and control groups but trend towards lower levels of psychological outcomes in counselling group. Women in both groups reported about the same frequency of posttraumatic stress symptoms related to recent childbirth and the same amount of postnatal depression symptoms.</p> <p>Positive comments to questionnaire women found the counselling session helpful. It was good and felt supportive to talk with other mothers in similar situation.</p> <p>Critical comments to questionnaire also included need for fathers to have attended groups and that groups too small.</p>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
maternity and child welfare psychologists.				<p>Authors list below reasons for failure to identify evidence of effectiveness of the group counselling intervention:</p> <ul style="list-style-type: none"> <li>• ? measuring tools inappropriate</li> <li>• Counselling session “too insignificant (21% said sessions were too few, 47% would have liked further follow up)</li> <li>• Timing might have been wrong</li> <li>• ? counselling group too small</li>   <li>• ? chose wrong sample group ? should have been women with experience of perceiving their birth as traumatic</li> </ul>
Kershaw K, Jolly J, Kalvinder B, Ford J (UK)  2005	Randomised controlled trial of community debriefing following operative delivery	To determine if two debriefing sessions following operative delivery could reduce a woman’s fear of childbirth	RCT	<p>In the short term no significant difference in the WDEQ fear of childbirth scores (although = lower throughout the study for debriefing group) following structured debriefing using critical incident stress debriefing technique performed on 2 occasions by community midwives trained in this procedure.</p> <p>This study measured signs of post-traumatic stress and fear of labour (but not depression as in other studies)</p>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
				<p>Continuity of care, the training and quietness in the woman's home helped the community midwives to undertake the debriefing process</p> <p>43% midwives felt debriefing benefits women following traumatic delivery</p> <p>Midwives felt recruiting teenagers was inappropriate</p> <p>75% midwives felt comfortable doing debriefing</p> <p>Factors that prevent midwives doing debriefing</p> <ul style="list-style-type: none"> <li>• Time</li> <li>• Women not wanting debriefing</li> <li>• Inappropriate referrals</li> </ul> <p>No comments from women's questionnaire specifically about debriefing despite a number making comments (questions re birth process only reported)</p>
Gamble J, Creedy D, Moyle W, Webster J, McAllister M, Dickson P (Australia)	Effectiveness of a Counselling Intervention after a Traumatic Childbirth: A	To evaluate a midwife-led brief counselling intervention for postpartum women at risk of developing	RCT	<p>Some evidence from this paper that something is happening in depression, anxiety and stress scores at 3 months i.e both EPDS and DAS scores were improved</p> <p>Some positive results at 3 months and more if sample was larger</p>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
<p>2005</p> <p>Research Centre for Clinical Practice and Innovation, Griffith University, Director of Nursing and Women's Health (JW) Research Centre at the Royal Brisbane and Women's Hospital</p>	<p>Randomized Controlled Trial</p>	<p>psychological trauma symptoms</p>		<p><i>PTSD and trauma symptoms</i></p> <p>No statistical difference (but trend toward improvement in intervention group) between number of women meeting criteria for PTSD at either 4 or 6 weeks postpartum or 3 months postpartum. An independent samples t-test of PTSD total symptoms scores revealed no differences between groups at 4-6 week follow up but a significant difference at 3 mths postpartum. This suggests that the intervention had a positive effect in reducing trauma symptoms over the longer term</p> <p><i>Depression</i></p> <p>At 3 months postpartum significant difference in number of women in intervention group with score greater than 12 EPDS (depression) compared with control (4 v 17) denoting more depression in control. This finding is further supported by 3 women in intervention group compared with 14 in the control reported DASS 21 depression scores higher than 13</p> <p><i>Self-blame and confidence about a future pregnancy</i></p> <p>The debriefing had a positive effect on constructs related to self-blame and confidence. Intervention group women reported reduced levels of self-blame about the birth and greater confidence about a future pregnancy than control group women</p>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
				<p><i>Participants' perceptions of intervention</i> 43 (86%) women rated the intervention highly (8-10/10) Most women (45/50(90%) initial opportunity to talk about the birth should be within few days of birth. 3 women said it was more valuable to talk about the birth after time to "sink in"</p>
<p>Selkirk R, McLaren S, Ollerenshaw A, McLachlan A (Australia)  2006  University of Ballarat/Ballarat Health Services</p>	<p>The longitudinal effects of midwife-led postnatal debriefing on the psychological health of mothers</p>	<p>To assess the effect of midwife-led postpartum debriefing on psychological variables.</p>	<p>RCT</p>	<p><i>Participants' perceptions of intervention</i> 43 (86%) women rated the intervention highly (8-10/10) Most women (45/50(90%) initial opportunity to talk about the birth should be within few days of birth. 3 women said it was more valuable to talk about the birth after time to "sink in"</p> <p><i>Effect of medical intervention on women's perceptions of their birth experience was evident</i> Women who experienced high levels of medical intervention during the birth and who were debriefed had more negative perceptions of the birth compared to women who had low levels of medical intervention and who were debriefed.</p> <p>Debriefing does no significantly affect psychological variables (measures of personal information, depression, anxiety, trauma, perception of the birth or parenting stress) related to</p>

Author(s)/year/ country	Title of paper	Aims and objectives	Method	Main findings
				<p>depression, anxiety or trauma symptoms at any assessment point following birth.</p> <p>Some indication that debriefing may arrest declines in dyadic satisfaction. This only affects the high risk group</p> <p><i>Women's views</i> Women appreciate the opportunity to talk and gain information about their birthing</p> <p>Over 90% of all participants rated the debriefing positively and indicated that debriefing was not threatening (97.5%) or intrusive (91.5%) and that it was very (21%) or extremely (73.1%) important for all women to have the chance to be debriefed</p> <p>Authors in discussion raise the question of what is required in a "birthing review" (current term = debriefing) i.e. ? psychological debriefing necessary or some other form of self-reflection. Also raise the question about whether debriefing may be harmful to women who experience more medical intervention</p>

**Table F2 Summary of appraisal of reviewed studies**

Study and type	Explicit theoretical framework or literature review?	Appropriate sample & recruitment?	Methodological & analytical quality	Data presented to support conclusions?	Steps to avoid bias?	Attempts to control for confounders?
Inglis 2002 Mixed methods	Limited review of the literature however clear rationale for study given. The rationale shows that it is common knowledge that birth experience can negatively affect transition to parenthood. This places mental health at risk. Postnatal "debriefing" service established to enable women to talk with midwives following their birth experience to support psychological well-being. No explicit theoretical framework mentioned.	Not clear if sample consisted of all women who had used the service in 6 month period. 46 women sent survey, 23 of whom participated in telephone interviews.	Relationship between researcher and participants not adequately considered. No mention of ethics approval. States mixed methods used but analysis appears primarily qualitative which is in keeping with philosophical perspective. No response rate given. Questionnaire not shared. Not clear if there was any quantitative analysis. No mention of confidentiality of data. Thematic analysis reported as being carried out but no explanation given or themes described.	Yes. Findings explicit. Overall aims and objectives achieved. Qualitative aspects of the study most evident. Unable to review the quantitative strand therefore mixed methods approach not apparent.	Independent assessor reviewed interview transcripts for accuracy of analysis.	Not applicable
Dennett 2003 Survey	Limited review of the literature however clear rationale for study given. Childbirth places women's psychological health at risk. There are possible benefits to enabling midwives to talk with women following birth. No explicit theoretical framework mentioned.	Convenience sample 100 women who had given birth 8-10 weeks previously	No information provided about usual practice for debriefing in unit where research undertaken. Ethics approval. Poor response rate, 29%. Findings reported from open ended questions. No description of how analysis conducted.	Overall aims and objectives achieved.	Questionnaire piloted.	Not applicable
Bailey and Price 2008 Grounded theory	Good literature review and rationale for study. No explicit theoretical framework mentioned. Benefits to women who attend postnatal "debriefing" services are unclear.	Purposive sample of 7 women who had used Birth Reflections service	Ethics approval. Data collection stopped at acknowledgement of saturation. To enhance trustworthiness a counselling approach was used which included the use of repetition and reflection. Relationship between participants and researchers explained. Good use of quotes to support the	Overall aims and objectives achieved.	Both researchers recognise the possible risk of bias due to their close involvement in the Birth Reflections service but take steps to ameliorate by choosing the sample from women they have not personally provided care to. Additional attempts to add validity to the study asking the	Not applicable

Study and type	Explicit theoretical framework or literature review?	Appropriate sample & recruitment?	Methodological & analytical quality	Data presented to support conclusions?	Steps to avoid bias?	Attempts to control for confounders?
			findings. Clear explanation of the process of the analysis.		women participants to check the written transcripts for accuracy.	
Gamble J, Creedy D, Moyle W 2004 (a) Qualitative focus groups	Good literature review and rationale for study. No explicit theoretical framework mentioned. Psychological stress and trauma is apparent in women following birth and debriefing/counselling attempts to reduce this.	Convenience sample of 6 women who had given birth within last 3 years and identified that they had a traumatic birth experience. Recruited by coordinator of self-help group for women wishing to have vaginal birth after caesarean section (VBAC)	Clear justification for use of focus groups - for discussion and sharing of ideas to generate data. Questions developed in advance by research team. Groups facilitated by first researcher who is a midwife. Ethical issues weak. No critical evaluation of researchers' roles in relation to the research. Post-feminist approach for analysis. Thematic analysis used but process of analysis lacks clarity.	Overall aims and objectives achieved. Findings are explicit and quotes from participants provide illustration.	Women recruited by non-researcher. Individual researchers independently undertook thematic analysis then met to agree themes. Second review of transcripts to determine that information relevant to the question was not omitted or contradictory information present.	Not applicable
Gamble J, Creedy D, Moyle W 2004 (b) Qualitative focus groups	Good literature review and rationale for study. No explicit theoretical framework mentioned. Psychological stress and trauma is apparent in women following birth and debriefing/counselling conducted by midwives may reduce this.	16 midwives formed 2 focus groups	Participants recruited by manager. Ethics approval and good efforts to protect confidentiality. The findings of the study above describing the views of women to postnatal debriefing were shared with the participants as part of this study. There is the risk of cross-pollination of views.	Overall aims and objectives achieved. Findings are explicit and quotes from participants provide illustration.	The primary author and co-authors independently conducted a thematic analysis of transcripts then met to discuss identified themes. Data was reviewed to determine that information relevant to the question was not omitted or contradictory information present.	Not applicable
Ayers S, Claypool J, Eagle A 2006 Postal survey	Postnatal "debriefing" being offered to prevent postnatal stress disorder (PTSD). Clear rationale for study. Limited literature review. No explicit theoretical framework.	All obstetric units within 304 randomly chosen UK hospitals 93/304 = one quarter of all units in UK included	Good response rate (76%) Clear description of questions asked. Interviews completed by heads of midwifery, senior midwives and consultant obstetricians.	Clear table of key findings	Telephone survey Computer randomisation to select units to be included.	Not applicable
Steele and Beadle	No explicit theoretical framework given.. Women experience psychological	All maternity units (=46) within 2 regions	Good response rate (93%- 43 units)	Yes	Selected units randomly chosen from all English health regions.	Not applicable

Study and type	Explicit theoretical framework or literature review?	Appropriate sample & recruitment?	Methodological & analytical quality	Data presented to support conclusions?	Steps to avoid bias?	Attempts to control for confounders?
2003 Descriptive postal survey	disturbance following birth. Postnatal “debriefing” is intended to prevent this. Clear rationale for study. Good literature review.		Questionnaire included list of postnatal debriefing descriptor statements i.e of activities undertaken during “debriefing” sessions – descriptions taken from the literature. Questionnaire pilot tested Ethical approval obtained		? these units representative of all units in England “Other” area on questionnaire for respondents to provided additional description.	
Olin R, Faxelid E 2003 Survey	Yes. Individual women cope differently to demands of childbirth. A woman with a strong sense of coherence (SOC) is more aware of her feelings and may express them better than someone with a weak SOC. Talking after birth allows women and men to express feelings, discuss experiences and understand what happened. These authors also draw on stress theory adapted for pregnancy and childbirth where three elements become essential: “comprehensibility”, “manageability” and “meaningfulness”. “Comprehensibility” is about ensuring women understand the process of childbirth and “manageability” refers to an individual woman having resources to meet her needs during pregnancy and the entire childbirth journey. When considering “meaningfulness” this suggests the need to find a meaning to giving birth.	350 mothers and 343 fathers following birth in a maternity ward in a hospital in Stockholm during a 4 week period in 1999.	Ethics approval. Good response rates 68% (women) 64% (men) Questionnaire created locally and piloted on a separate group of parents and amended. Content of questionnaire given. Statistical tests clearly described. Findings included 19 variables in the analysis.	Yes presented clearly in tables. Some detail of the detailed subject matter unclear which did not support some of the conclusions made i.e. vague comments made by the researchers but no % to back up the statement.	Included all parents who gave birth during a defined time period.	Not applicable

Study and type	Explicit theoretical framework or literature review?	Appropriate sample & recruitment?	Methodological & analytical quality	Data presented to support conclusions?	Steps to avoid bias?	Attempts to control for confounders?
	Limited literature review					
Gamble and Creedy 2004 Literature review	Yes. Clear rationale but theoretical framework not explicitly stated. A distressing birth experience can cause psychological trauma. One model identified that explains emotional distress after childbirth. This does not assume that trauma is caused by the same event for all women and that interpersonal factors are at the core of trauma.	19 publications identified	Clearly focused question used and search terms. Clear description of the search strategy including use of all major databases. No description of the process taken to assess the quality of the papers included. Many of these papers are non-research. However explanation given and reason for including due to the dearth in research evidence.	Yes	Not applicable	Not applicable
Collins 2006 Literature review	No explicit theoretical framework given.	20 papers identified  3 RCTs 2 cohort studies 5 cross sectional surveys 5 reviews 1 professional opinion 2 descriptive studies 2 authors' reflections	Good description of search strategy. No description about data management or how analysis undertaken. Recognises ethical considerations Does not include papers about counselling Utilises critical appraisal techniques (CASP) No mention if there were any excluded studies following critical appraisal	Yes	Not applicable	Not applicable
Rowan C, Bick D, da Silva Bastos M (UK) 2007 Literature review	No explicit theoretical framework given. Some women develop psychological and psychiatric ill health following birth. Routine postnatal care has neglected emotional aspects of care and concentrated on physical care provision. Postnatal "debriefing" has been introduced into the	8 RCTs, 7 observational studies	Critical appraisal of RCTs appears to have been undertaken but process not described. No apparent critical appraisal of service descriptions/ evaluations Not all research papers No mention of any excluded studies No description of technique for analysis	Yes	Not applicable	Not applicable

Study and type	Explicit theoretical framework or literature review?	Appropriate sample & recruitment?	Methodological & analytical quality	Data presented to support conclusions?	Steps to avoid bias?	Attempts to control for confounders?
	maternity services to reduce psychological distress and prevent the onset of psychiatric illness (e.g. PTSD)					
Lavender T, Walkinshaw S (UK) 1998 RCT	Literature review appears inclusive (limited literature at this time). Clear rationale for study given but no explicit theoretical framework given.	120 postnatal primigravidae with singleton pregnancies and cephalic presentations in spontaneous labour at term and proceeded to have a normal vaginal delivery of a healthy baby.	<p>Trial appears valid</p> <p>Randomization by ward staff but using consecutively numbered envelopes</p> <p>Women, researchers and study personnel all unblinded</p> <p>No mention of ethics approval.</p> <p>All participants invited to discuss their birth experiences at completion of study (= nice gesture and good ethical consideration)</p> <p>Power calculation given</p> <p>95% response rate</p> <p>High level of morbidity in control group – one half anxious and more than half depressed.</p> <p>HAD scale utilised not validated for postnatal care but piloted at the study hospital on 100 women prior to trial</p> <p>Intervention unstructured (respondent led)</p>	In text and on tables	None apparent	No apart from within RCT framework. Groups similar and shown on table. Clear inclusion criteria

Study and type	Explicit theoretical framework or literature review?	Appropriate sample & recruitment?	Methodological & analytical quality	Data presented to support conclusions?	Steps to avoid bias?	Attempts to control for confounders?
Ryding E, Wijma K, Wijma B (Sweden)  1998  RCT	No explicit theoretical framework mentioned. Emergency caesarean sections lead to posttraumatic stress reactions. Good literature review and clear rationale for study.	Small sample (n=99) and no power calculation	Ethics application. Informed consent obtained after randomisation process. Randomisation process dependent on human action i.e. every second case from birth register – not fully described how achieved. Groups similar in parity and age. Procedure for trial, intervention, measures used and statistical tests for analysis all clearly explained.	Yes on tables	The effect of the counsellor was considered. Counsellor did not provide obstetric or midwifery care to participants. Also counsellor did not meet women following intervention in relation to the post-counselling investigation. This was carried out by questionnaire	No apart from within RCT framework. Groups similar in parity and age.
Small R, Lumley J, Donohue L, Potter A, Waldenstrom U (Australia)  2000  RCT	Debriefing reduces postnatal depression amongst women following operative birth. Good literature review.	Good sample size (1316)	Power calculation. No ethics application Dearth of information on the content of the debriefing session undertaken by the research midwife. Standard inferential statistical tests used (e.g. Student t test, odds ratios)	Yes, in written description and tables.	Double entering of data. Intention to treat analysis.	Considered possible effect of midwife (X 2 research midwives conducted the debriefing sessions) Analysis of primary outcomes by research midwife
Priest S, Henderson J, Evans S, Hagan R (Australia)  2003  RCT	Clear rationale to assess whether critical incident stress debriefing led by a midwife reduces the incidence of postnatal psychological disorders. Good literature list.	Good. Large sample. 1745 women who delivered healthy term infants	Ethics approval. High proportion of women with depression Clear description of methods and data collection, including randomisation process. A range of different inferential statistical tests used including Fisher's exact test, Wilcoxon rank sum test, t test. 801/2824 women refused to participate (? High number)	Results presented in written description and tables.	Randomisation process – participants chose one envelope from 6 sealed envelopes  All researchers blinded to group allocation except research midwife. Analysis on intention to treat basis	Subset analysis on women who had an unplanned operative delivery

Study and type	Explicit theoretical framework or literature review?	Appropriate sample & recruitment?	Methodological & analytical quality	Data presented to support conclusions?	Steps to avoid bias?	Attempts to control for confounders?
Ryding E, Wiren E, Johansson G, Ceder B, Dahlstrom A (Sweden)  2004  RCT	Extensive literature review. Clear rationale but no explicit theoretical framework. Assumption counselling reduces symptoms of posttraumatic trauma.	162 Swedish-speaking women	Content of intervention not clear (sounds like a group chatting session rather than counselling)  20% women in intervention group declined to participate  Power calculation not described fully (mentions being based on previous work in discussion section)- ? study underpowered to test hypothesis Control group provided with offer of counselling session after completion of questionnaire	Results presented in written description and tables.	Randomisation conducted by project leader - ? risk of bias Women analysed in groups randomised to.	Analysis included non-participants to group intervention.
Gamble J, Creedy D, Moyle W, Webster J, McAllister M, Dickson P (Australia)  RCT  2005	No explicit theoretical framework but clear rationale for study (to evaluate midwife-led brief counselling intervention for women at risk of developing psychological trauma symptoms. Good literature review.	103/348 women screened = positive for trauma symptoms	No ethics approval Good description of the counselling content Small sample size – when testing for binary events need larger samples No power calculation. Clear description of methods and data collection, including randomisation process. Use of standardised instruments A range of different inferential statistical tests used including Pearson's correlation and chi - square tests	Results presented in written description and tables.	Second research midwife blinded to randomisation conducted 3month follow up telephone interview.	DSM-IV criterion A for posttraumatic stress disorder used to screen for inclusion criteria into both arms of trial
Selkirk R, McLaren S, Ollerenshaw A, McLachlan A (Australia)  2005  RCT	Clear rationale for study and good literature review.	149 women in the third trimester of pregnancy	Randomisation conducted but blind trial not possible due to nature of intervention. Small sample size and no power calculation despite ten different standard measures assessed. Ethics approval. Clear description of methods and data collection.	Results presented in written description and tables.	Sequence of administration of various questionnaires varied to reduce sequence effect.	Controls for variables that have been identified in previous research as confounding variables.

Study and type	Explicit theoretical framework or literature review?	Appropriate sample & recruitment?	Methodological & analytical quality	Data presented to support conclusions?	Steps to avoid bias?	Attempts to control for confounders?
			Clear description of intervention Descriptive and inferential statistics used to analyse various measures used.			
Kershaw K, Jolly J, Kalvinder B, Ford J (UK)  2005  <b>RCT</b>	Limited literature review but clear rationale.	319 mothers who delivered a first child by operative delivery  27 community midwives	Power calculation reported and numbers in each group well above required numbers but - ? small sample 78% response rate Clear description of methods and data collection. Descriptive and inferential statistics used including two tailed independent t test and Mann-Whitney <i>U</i> tests. Eighteen mothers in the debriefing group did not receive any debriefing and 13 did not receive the session at 10wks Some community midwives undertook debriefing prior to women completing first questionnaire at 10 days post birth. Response rate to midwives' questionnaire 60% Authors' credentials not given.	Results presented in written description and tables.	Analysis on intention to treat basis	The women recruited to the study were similar in terms of age, marital status, employment and mode of delivery to those who declined to take part or were excluded.
Meades R, Pond C, Ayers S, Warren F (UK) 2011  Pragmatic trial	Good literature review. Clear rationale. No explicit theoretical framework given.	80 women No power calculation. Could be underpowered	Ethics approval obtained First study to examine the effectiveness of postnatal debriefing in naturally heterogenous clinical setting Two very different groups i.e. women who attended debriefing group differed on a number of variables to comparison group e.g. older, had more caesareans therefore unable to rely on findings.	Results presented in written description and tables.	Questionnaires chosen for reliability, validity and appropriateness for postnatal women.	Controls for obstetric and demographic factors

Study and type	Explicit theoretical framework or literature review?	Appropriate sample & recruitment?	Methodological & analytical quality	Data presented to support conclusions?	Steps to avoid bias?	Attempts to control for confounders?
			No clear definition of debriefing used and authors state 2 different midwives with differing approaches Clear description of research process, method and analysis.			

**Table F3 Summary of Literature reviews**

Author(s)/year/ country	Title of paper	Aims of review	Method	Findings
<p>Gamble J, Creedy D (Australia)</p> <p>2004</p> <p>Master of midwifery programme convenor</p> <p>Dean, Faculty of Nursing and Health</p>	<p>Content and Processes of Postpartum Counselling After a Distressing Birth Experience: A Review</p>	<p>To critique published papers describing and/or testing postpartum counselling for use with women who had a distressing birth experience and identifies common content and processes.</p>	<p>Literature review</p>	<ul style="list-style-type: none"> <li>• Consensus about debriefing processes including the below: <ul style="list-style-type: none"> <li>▪ Provide women with opportunities to talk about their birth experience, express feelings about what happened, have questions answered and have gaps in knowledge or understanding of events addressed so that they could make sense of what happened, connect events with emotions and behaviours, talk about future pregnancies and explore existential issues such as childbirth as a rite of passage.</li> </ul> </li> <li>• Timing of intervention not addressed but publications describing the provision of counselling services stated that counselling support was provided any time after the birth even after one year. Other authors implied that counselling should be offered sooner within a few days to several weeks after birth.</li> <li>• The inclusion of partners in discussions about birth</li> <li>• Caution identified about a formal single debriefing session</li> </ul>

				No disagreement or controversy was mentioned about the content to be addressed in counselling postpartum women.
Collins R (UK) 2006 Undergraduate midwifery student	What is the purpose of debriefing women in the postnatal period?	To determine why women want to debrief and whether or not debriefing reduces trauma caused by events in childbirth. To explore the role of debriefing in risk management and the organisation of debriefing services within the maternity services.	Literature review	<p><i>Investigating the need for women to debrief</i> The author suggests possible reasons for the need for debriefing:</p> <ul style="list-style-type: none"> <li>▪ Women's perceptions of their childbirth experience</li> <li>▪ Mode of delivery</li> <li>▪ Previous psychopathology or trauma</li> <li>▪ Gaps in memory</li> <li>▪ Differences in expectations and reality</li> </ul> <p><i>Does debriefing reduce childbirth trauma?</i></p> <p>3 RCTs all used different populations and assessment tools measuring different outcomes (e.g. anxiety, depression) including EPND score and Revised Impact of Event Scale 2 trials found no reduction in outcome assessed and 1 did therefore no evidence debriefing reduces psychological morbidity.</p> <p><i>Does debriefing help women finish the journey?</i></p> <ul style="list-style-type: none"> <li>• Women need to discuss the experience of birth with someone</li> <li>• Gaps closed (to make sense of events ) by discussion of birth experience and provision of information from professionals</li> <li>• One technique used to help women make sense of their experience described which utilises 4 steps –</li> </ul>

				<p>normalising, mediating, validating and activating the story</p> <p><i>Does debriefing act as risk management?</i></p> <ul style="list-style-type: none"> <li>• Reduction of complaints</li> <li>• Not clear whether having a debriefing service reduces complaints in an organisation.</li> <li>• Changes to practice and organisation of care. Debriefing acts as a quality assurance instrument as an opportunity to pick up positive and negative feedback to improve service.</li> <li>• Debriefing identifies women who require further clinical referral.</li> </ul> <p><i>What is the organisation of debriefing services?</i></p> <ul style="list-style-type: none"> <li>• Range of different services identified</li> <li>• The appropriate practitioner carrying out the debriefing</li> <li>• Midwife “because they (midwives) have up- to- date knowledge of midwifery and obstetric practice, access to the notes and have good listening and communication skills”</li> <li>• Possible need for further training to conduct debriefing (e.g. in psychological techniques)</li> <li>• Timing and location. During first few days whilst still in hospital or later?</li> </ul> <p>Use of maternity notes to guide discussion</p>
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<p>Rowan C, Bick D, da Silva Bastos M (UK)</p> <p>2007</p>	<p>Postnatal Debriefing Interventions to Prevent Maternal Mental Health Problems After Birth: Exploring the Gap Between the Evidence and UK Policy and Practice</p>	<p>To identify evidence of the effectiveness of postnatal debriefing and the availability and current provision of debriefing offered in UK maternity services</p>	<p>Structured literature review</p>	<p>Women valued opportunities to discuss their birth</p> <p>2 RCTs found evidence of positive associations related to psychological interventions but both were associated with methodological flaws .</p> <p>6 RCTs no differences in outcomes identified, one identified possible harm from debriefing.</p> <p>No standard intervention was used in any RCTs or service intervention</p> <p>Evidence to support content and timing of service provision and effectiveness is lacking.</p> <p>The role of debriefing after birth is clearly confusing.</p> <p>Wide differences exist between content of debriefing implemented in RCTs and those provided within the maternity service evaluations. Some RCTs the intervention was based on psychological approaches, such as CISD whereas service provision often involved talking with a woman about her labour and delivery guided by the notes. It was clear from descriptions of service provision that an opportunity for women to talk about their childbirth experience was provided rather than a structured psychological intervention.</p> <p>No data on health outcomes.</p>
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				<p>Need to consider whether debriefing interventions are able to take account of women's individual coping styles and defensive strategies.</p> <p>? should routinely offer to all women the opportunity to discuss birth.</p> <p>Need to differentiate between service provision of a post childbirth discussion as part of good postnatal care and the offer of a more formal debriefing which is not supported by evidence.</p>
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**Table F4 Approaches to postnatal debriefing from the research studies**

	Bailey and Price 2008 UK	Inglis 2003 UK	Ryding et al 2004 Sweden	Small et al 2000 Australia	Gamble et al 2005 Australia	Kershaw et al 2005 UK	Meades et al 2011 UK	Selkirk et al 2006
No of sessions	1	1	2	1	2	2	1	1
Professional	Midwife	Labour Ward manager (midwife)	2 group leaders at each session X1 psychologist and X1 midwife	Midwife	?? + Research midwife	Community midwife (specially trained)	Midwife (specially trained)	Midwife (specialist midwife)
Group of women offered to	All women	All women	Post emergency caesarean section	Operative birth	Traumatic symptoms	Primigravidae instrumental birth	??	All women
Individual or group session	Individual	Individual	Group	Individual	Individual	Individual	Individual	Individual
When undertaken	Any time after birth	Accessed on average 12 months post birth	1 and 2 months following birth	Prior to leaving hospital	Within 72 hours of birth and 4-6 months	10 days and 10 weeks	1.3 – 72.2 months (median 16 weeks)	Within 3 days of birth
Place of session		Home or hospital	? hospital – not stated	Hospital	Hospital and home	Home	?	Hospital
Length of session		Over 60 minutes	120 minutes	60 minutes	40 – 60 minutes		60 – 90 minutes	30-60 minutes

	Bailey and Price 2008 UK	Inglis 2003 UK	Ryding et al 2004 Sweden	Small et al 2000 Australia	Gamble et al 2005 Australia	Kershaw et al 2005 UK	Meades et al 2011 UK	Selkirk et al 2006
Technique		Not clear ?general discussion	Women invited tell story/unstructured according to group needs.	Discussion labour, birth, post birth events	Structured counselling intervention (described)			Structured counselling intervention ( 8 phases)
Intervention for research study	No	No	Yes	Yes	Yes	Yes	Yes	

## **Appendix F: Questionnaire Birth Reflections study**

October 2013

CONFIDENTIAL

### **BIRTH REFLECTIONS SURVEY**

1. What type of birth did you have?	Please tick one box
a) a normal vaginal delivery	<input type="checkbox"/>
b) an assisted vaginal delivery (suction)	<input type="checkbox"/>
c) an assisted vaginal delivery (forceps)	<input type="checkbox"/>
d) a planned caesarean delivery <b>go to question 3</b>	<input type="checkbox"/>
e) an emergency caesarean delivery	<input type="checkbox"/>

2. For approximately how long were you in labour?	.....hours
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	Excellent	Very good	Good	Fair	Poor
3. Overall how do you rate the care you received during your labour and birth?	<input type="checkbox"/>				

	Very Disappointed	Disappointed	Neither disappointed nor pleased	Pleased	Very pleased
4. How do you feel about your birth experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any further comments on this question?

5. How do you feel you managed during labour and the birth?	Please tick one box
I managed very well	<input type="checkbox"/>
I managed quite well	<input type="checkbox"/>
I managed alright	<input type="checkbox"/>
I did not manage very well	<input type="checkbox"/>
I did not manage at all well	<input type="checkbox"/>

6. Could you look at these phrases and say which one best describes:  
a) your labour and b) your birth:

	Labour Please tick one box	Birth Please tick one box
Much better than I expected	<input type="checkbox"/>	<input type="checkbox"/>
Better than I expected	<input type="checkbox"/>	<input type="checkbox"/>
About the same as I expected	<input type="checkbox"/>	<input type="checkbox"/>
Worse than I expected	<input type="checkbox"/>	<input type="checkbox"/>
Much worse than I expected	<input type="checkbox"/>	<input type="checkbox"/>

7. Overall was labour and giving birth	Please tick one box
Awful	<input type="checkbox"/>
Ok in the end	<input type="checkbox"/>
Hard work but wonderful	<input type="checkbox"/>
Other	<input type="checkbox"/>
Comments	

8. After you went home following the birth of your baby did you ever think about what happened to you during your labour and the birth itself?	Please tick one box
Yes, often	<input type="checkbox"/>
Yes, sometimes	<input type="checkbox"/>
No	<input type="checkbox"/>
If yes, what aspects did you think about?	

9. At any time after the birth of your baby did you ever feel the need to talk with a professional?	Please tick one box
<b>Yes</b> , but I did not do so	<input type="checkbox"/>
<b>Yes</b> , and I spoke with a midwife about this but not as part of the Birth Reflections service	<input type="checkbox"/>
<b>Yes</b> , and I spoke with another health professional about this but not as part of the Birth Reflections service	<input type="checkbox"/>
<b>Yes</b> , I attended the Birth Reflections service	<input type="checkbox"/>
<b>Yes</b> , I returned for a debriefing appointment with the obstetrician	<input type="checkbox"/>
<b>No</b>	<input type="checkbox"/>
<b>Don't know</b>	<input type="checkbox"/>

10. If you spoke with a health professional was that person present during the birth?	Please tick one box
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

11. Would you like to have talked more to any health professional about your labour and delivery?	Please tick one box
<b>Yes</b> , someone who was there	<input type="checkbox"/>
<b>Yes</b> , someone who was not there	<input type="checkbox"/>
<b>Yes</b> , whether or not they were there	<input type="checkbox"/>
<b>No</b> , not really	<input type="checkbox"/>

12. After your birth experience and at the time when you were discharged by the community midwife to the health visitor, do you feel you had a full understanding of what happened to you during this latest labour/birth experience?	Please tick one box
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
If <b>no</b> please explain what information you were missing	

13. Are you satisfied with your understanding of what happened to you when you were in labour and during the birth?	Please tick one box
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

14. Were you given a Birth Reflections survey form (questionnaire) when you left the hospital following the birth of your baby?	Please tick one box
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

**15. If you attended the Birth Reflections service:**

a) What was the reason for this?	
b) Did it help you?	Please tick one box
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
c) If it helped, how did it help you?	

16. If you did not attend Birth Reflections what was the reason?	Please tick one box
I knew about the service but deliberately chose not to attend as I did not feel the need	<input type="checkbox"/>
I knew about the service but didn't use for other reason	<input type="checkbox"/>
I did not know about it but would not have attended anyway	<input type="checkbox"/>
I did not know about it and would have like to have attended	<input type="checkbox"/>
Other, please explain?	

## 17. Impact of Event Scale

*Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments have been true for you during the past week. If they have not occurred during this time, please mark the "not at all" column.*

### **All the questions refer to your experience of childbirth**

	Not at all	Rarely	Sometimes	Often
I thought about it when I didn't mean to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I avoided letting myself get upset when I thought about it or was reminded of it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I tried to remove it from my memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had trouble falling asleep or staying asleep because of pictures or thoughts about it that came into my mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had waves of strong feeling about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had dreams about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I stayed away from reminders of it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt as if it hadn't happened or it wasn't real	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I tried not to talk about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pictures about it popped in to my mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other things kept making me think about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was aware that I still had a lot of feelings about it but I didn't need to deal with them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I tried not to think about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any reminders brought back feelings about it

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My feelings about it were kind of numb

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<b>ABOUT YOU</b>	
18. What is your ethnic group? Choose one section from A to E, then tick one box to best describe your ethnic group or background?	
<b>A. White</b> <input type="checkbox"/>	<b>C. Asian/Asian British</b>
English/ Welsh/ Scottish/ Northern Irish/British <input type="checkbox"/>	Indian <input type="checkbox"/>
Gypsy or Irish Traveller <input type="checkbox"/>	Pakistani <input type="checkbox"/>
Any other white background, (write in) <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>
<b>B. Mixed/Multiple Ethnic Groups</b>	Chinese <input type="checkbox"/>
White and Black Caribbean <input type="checkbox"/>	Any other Asian background, (write in) <input type="checkbox"/>
White and Black African <input type="checkbox"/>	<b>D. Black/ African/ Caribbean/ Black British</b>
White and Asian <input type="checkbox"/>	Caribbean <input type="checkbox"/>
Any other mixed/multiple ethnic background, write in <input type="checkbox"/>	African <input type="checkbox"/>
	Any other Black/ African/ Caribbean background (write in) <input type="checkbox"/>
	<b>E. Other ethnic group</b>
	Arab <input type="checkbox"/>
	Any other ethnic group (write in) <input type="checkbox"/>

<b>ABOUT YOU</b>	
19. How old were you when your baby was born?	Please tick one box
Under 20 years	<input type="checkbox"/>
20 – 24 years	<input type="checkbox"/>
25 – 29 years	<input type="checkbox"/>
30 – 34 years	<input type="checkbox"/>
35 - 39 years	<input type="checkbox"/>
40 years or over	<input type="checkbox"/>

20. What is your highest level educational qualification? (e.g. GCSE, A level, Degree)	
21. What is your postcode?	

<b>YOUR PREVIOUS PREGNANCIES</b>		
	Yes	No
22. Have you had any previous pregnancies?	<input type="checkbox"/>	<input type="checkbox"/>
If so how many babies have you had?	.....babies	
<p><b>Thank you very much for your help with this study by completing this questionnaire</b></p> <p>23. Would you be interested in participating in another part of this research by attending an interview with the researcher? If your answer is "Yes" please give your name and telephone number below. The researcher may call you on this number to make arrangements.</p> <p>Name:.....Address:.....  .....  .....Postcode:.....</p> <p>Telephone:.....</p> <p>24. If you would like a copy of the final report of this study please give your name and address below and this will be sent to you in the future.</p> <p>Name:.....Address:.....  .....  .....Postcode:.....</p> <p><b>IN ORDER TO PROTECT YOUR PERSONAL INFORMATION THIS LAST PAGE WILL BE DETACHED AND STORED IN A LOCKED CUPBOARD FOR THE DURATION OF THE RESEARCH STUDY. IT WILL BE DESTROYED WHEN THE RESEARCH IS COMPLETED.</b></p>		

## **Appendix G: Interview guide for research study**

**“Why do women attend a postnatal discussion meeting?”**

- 1. Discuss confidentiality**
- 2. Sign consent form**
- 3. No right/wrong answers**

**Semi-structured interview using the following open-ended questions to guide discussion (not all questions will be necessary for use with all participants – this is meant as a guide to prompt discussion):**

.  
(Firstly, need opportunity to warm up)

### **Pregnancy**

Was this your first baby?

Can you start by telling me how you felt when you first found out that you were pregnant?

(If 1<sup>st</sup> baby) What did you know about having a baby and becoming a mother?  
(If >1 baby) What do you think about labour and actually giving birth to a baby?

### **Labour**

How well do you feel you managed during labour?

Did it meet your expectations?

Do you feel you were sufficiently prepared?

Did you experience a latent phase of labour?

Was your labour long?

Did you feel supported?

Who provided that support to you?

How do you rate the care provided during labour? Was the midwife/midwives supportive?

### **Your birth**

What type of birth did you have?

Did your birth meet with your expectations?

How do you feel about your birth experience overall?

What are your lasting memories of your labour and birth?

### **Soon after birth when at home**

How did you feel when you arrived home and during the first few weeks following the birth? (e.g. happy, sad, tearful, upset)

If feeling unhappy, sad, etc what was the cause, i.e what was it about the birth that left you feeling this way.

Do you feel you understood everything that happened to you during your labour and your birth?

Did you ever think about what happened to you during labour and the birth itself?

Did you ever feel the need to discuss your birth experience with anyone?

If so did you do so and who did you speak with?

If not do you have a view why some other women may wish to do so?

### **Speaking with a health professional**

Did you ever feel the need to discuss your birth experience with a health professional?

Yes/no – what was the reason for your answer to this question?

### **Birth Reflections service**

Did you attend the Birth Reflections service?

If you did not attend why not?

If no, did you know of its existence and would you have liked to have attended?

What is your understanding of a Birth Reflections service?

If yes, and you did attend the BR service, how did you know about this service/who referred you?

If yes, and you did attend the BR service, what were your expectations and were they met?

Please describe what happened during this meeting?

Was this meeting helpful? Please elaborate your thoughts on this experience?

Please describe the good aspects of the BR meeting with the midwife?

Was anything not so good about this meeting?

**(Prompts)**

“How did that make you feel?”, “Can you tell me a bit more about that?”