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The impact of birth trauma on the couple relationship and related support requirements; a framework analysis of parents' perspectives

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ABSTRACT

Background: Ongoing distress following a traumatic birth experience, commonly known as birth trauma, can lead to post-traumatic stress symptoms. Experiencing birth trauma can affect personal well-being and impact the couple relationship.
Objective: The present study aimed to explore the lived experience of the impact of birth trauma on the couple relationship and related support requirements.
Methods: A purposive sample of men and women in the UK who had experienced birth as traumatic were recruited and interviewed remotely in 2021. Data were analysed using framework analysis in NVivo 12.
Results: The sample (N=18) contained 9 women who were first time parents and 9 men; 5 of which were first time parents and 4 who had two children. Twelve themes are reported related to the impact of birth trauma on the couple relationship. Findings suggest the impact of birth trauma on the couple relationship can be negative and distressing, or for some lead to a strengthened relationship. Fourteen themes are reported related to associated birth trauma support. Negative aspects of support were reported in themes: unavailability of help from friends and family; unhelpful birth debriefing services; no personal awareness of birth trauma; absence of trauma validation from health care professionals; lack of awareness of the emotional needs of men; and barriers to accessing psychological services. Potential improvements to support included: supporting parents to understand the traumatic events; birth trauma informed antenatal preparation; improving access to specialist psychological services; and compassionate parent centred maternity services.
Conclusions: The impact of birth trauma on the couple relationship appears complex with both positive and negative affects reported. Current support for the impact of birth trauma on the couple relationship has perceived inadequacies for which improvements are proposed.

Introduction

In the UK, traumatic childbirth has been defined as "births, whether preterm or full term, which are physically traumatic…and births that are experienced as traumatic, even when the delivery is obstetrically straightforward" (NICE, 2014, p14). Ongoing distress following a traumatic birth experience, commonly known as birth trauma, can lead to post-traumatic stress symptoms (PTSS) and may result in diagnosis of post-traumatic stress disorder (PTSD) (Simpson et al., 2018). Birth trauma related distress such as re-experiencing and/or avoidance PTSS is seen in 10 to 12.5% of women (Ayers, 2004; White et al., 2006) and the prevalence of birth related PTSD in women is 4% (Yildiz et al., 2017). Witnessing a traumatic birth can cause distress in partners (Hinton et al., 2014) and lead to anxiety (Bradley et al., 2008) and PTSS (Elmir and Schmied, 2016).

In addition to negative impact on personal health (Beck, 2011) birth trauma can impact upon the couple relationship, with the potential to cause relationship distress (Campbell and Renshaw, 2018) and decline in relationship satisfaction (Garthus-Niegel et al., 2018). Appreciating the impact of birth trauma on the couple relationship is important as good relationships are associated with improved personal health (Figueiredo et al., 2008; Robles et al., 2014). The quality of the couple relationship between parents can also impact on infant wellbeing (Sroufe, 2005).

There is limited research on the impact of birth trauma on a couple relationship with discrepancies between quantitative and

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qualitative studies (Delicate et al., 2018a). Quantitative research has reported that birth related PTSD is not associated with negative impacts on the couple relationship (Ayers et al., 2007; Parfitt and Ayers, 2009). However, meta-synthesis of qualitative studies of the impact of birth trauma reported four negative themes of strain on relationship; negative emotions; lack of understanding and support; loss of intimacy; and one positive theme of strengthened relationship (Delicate et al., 2018a). Furthermore, the transition to parenthood is a major life event with its own stresses (Ayers et al., 2019) and potential to effect relationships (Delicate et al., 2018b).

Evidence based treatment for PTSD is either trauma focused cognitive behaviour therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) (NICE, 2018). Though this guidance is not specific to birth related PTSD and would not apply to parents experiencing birth trauma related PTSS in the absence of a PTSD diagnosis. Parents indicate that they want support with birth trauma (Etheridge and Slade, 2017; Watson et al., 2020) and despite lack of evidence for effectiveness in progression of trauma symptoms (Bastos et al., 2015) referral to midwifery led debriefing is commonplace in some countries (Ayers et al., 2006a; Baxter, 2019). Such birth debriefing is often semi-structured in format and focused on a woman's need to discuss their feelings around birth and gain information about management of care (Thomson and Garrett, 2019).

There are no interventions for birth trauma specifically developed for couples. However, there is evidence from PTSD research in other populations that couple-based trauma counselling can reduce trauma symptoms and prevent decline in relationship satisfaction (Greenman and Johnson 2012; Monson et al., 2015). Therefore, the present study aimed to explore the lived experience of the impact of birth trauma on the couple relationship and related support requirements.

Methods

A qualitative approach was adopted to answer four research questions: 1) How do parents experience the impact of birth trauma on their couple relationship?; 2) How do couples deal with the impact of birth trauma on the couple relationship?; 3) Where do couples obtain birth trauma support, and how effective do they perceive such support?; and 4) What would facilitate more acceptable birth trauma support for couples?

Participants

Purposive sampling was used to recruit men and women with a lived experience of birth trauma. Participants were eligible if they or their partner had experienced self-reported birth trauma defined as 'emotionally traumatic childbirth causing ongoing distress'. The birth took place in the UK, after 37 weeks of gestation, and resulted in a live infant who was between six months and five years old at time of interview. Interviewing participants within the first six months postpartum was deemed inappropriate as any impact of birth trauma on the couple relationship would take time to develop. Whilst being mindful of accurate recall declining with time, to gain a range of couple relationship experiences over short to longer term, the upper limit of five years postpartum was decided.

Recruitment

Ethical approval was obtained from the School of Health Sciences Research Ethics Committee at City, University of London. Recruitment took place between January and June 2021 and to reach parents across the UK, recruitment was conducted via social media, predominantly Facebook and Twitter, using parenting and birth trauma networks such as: the Birth Trauma Association; Make Birth Better; Fatherhood Institute; NCT; and Dads Matter. All potential participants enquiring about the study were sent the participant information sheet, consent form, and support information on birth trauma.

Data collection

Participants completed demographic information and consent using an online survey platform Qualtrics. Individual semi-structured interviews were conducted remotely due to the Covid-19 pandemic using Microsoft Teams or telephone. The interview topic guide (supplementary file 1) asked participants about their experience of birth trauma; about their relationship with their partner since birth; and about any support they or their partner had received for birth trauma. The primary author conducted interviews in English and audio recorded. Average length of interviews was 59 minutes (range 29 to 119 minutes). Participants were not required to answer all questions, and conversely responses were not restricted to the interview guide.

Audio files were anonymously transcribed verbatim by the primary author. Transcripts were not returned to participants as the interview involved discussing the traumatic experience and had potential to cause distress.

Data analysis

Demographic data were analysed using descriptive statistics. Interview data were analysed using framework analysis to ensure systematic treatment of all data and acknowledgement of the depth and breadth of experiences in the sample (Hackett and Strickland, 2018).

The primary author read each transcript several times and concepts were noted. Initially data for women and men were analysed separately to enable any similarities or differences of experiences in the data sets to be clear. However, due to initial concepts within the two data sets being homogenous it was agreed by the authors that data be combined for final analysis. Using the research questions as a guide, inductive concepts from the data, and deductive concepts from prior research (Delicate et al., 2018a; 2020a; 2020b) were used to create an analysis framework.

In NVivo 12, data from each transcript were assigned to relevant framework codes. Functionality within NVivo was used for charting of data; recalling and summarising data coded to a concept at participant and sample level. Concepts sharing key characteristics were combined to create emergent themes which were compared across the data set to establish relationships between research questions. Emerging themes and relationships were discussed and rationalised by both authors to produce final themes (Hackett and Strickland, 2018; Parkinson et al., 2016).

Themes were mapped for negative and positive aspects of the impact of birth trauma on the couple relationship and birth trauma support. Supporting data for each theme were interrogated to ensure appropriate representation of the sample. Consideration was given to the influence that Covid-19 may have had on experiences and resulting themes. Data for participants whose perinatal phase was affected by Covid-19 were examined within the context of thematic results and were found to be similar to the remainder of the sample. Therefore, no specific Covid-19 findings are reported.

Results

Interviews were conducted with 20 participants (9 women and 11 men). Prior to analysis two men were removed from the sample because their experiences of trauma were not related to birth.

Table 1
Sample demographics.

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

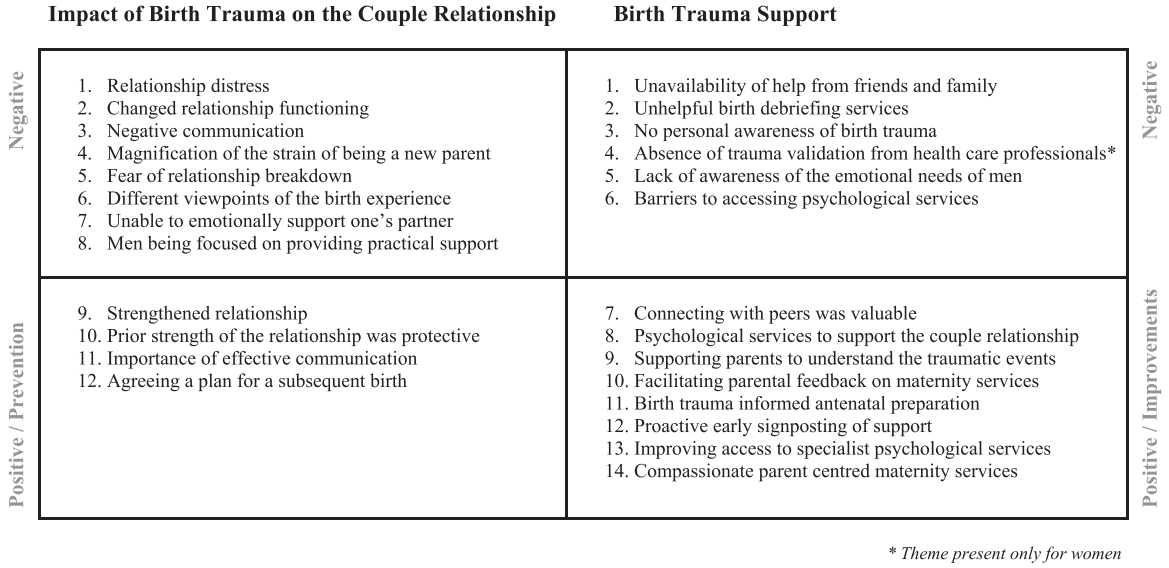

Fig. 1. Overview of Themes
*Theme present only for women.

Sample

Eighteen participants were included in analysis (9 women and 9 men). All participants were currently in married, heterosexual relationships. One married couple are included in the sample; other participants had no connection. All participants were resident in England when the traumatic birth took place and stated English as their first language. Table 1 provides further demographic information.

Thematic findings

Data synthesis identified 12 themes relating to the impact of birth trauma on the couple relationship and 14 themes relating to birth trauma support. Fig. 1 maps themes against positive and negative aspects of the impact of birth trauma on the couple relationship and associated birth trauma support. Thematic results are presented with examples of indicative data and indicating which participants, male or female or both, supported each theme. Participants are numbered M1 to M9 for men, and W1 to W9 for women.

Impact of birth trauma on the couple relationship themes

Themes 1 to 8 illustrate the negative aspects of parents' perspectives of the impact of birth trauma on the couple relationship. Themes 9 to 12 describe positive impacts of birth trauma on the couple relationship or potential ways in which the impact of birth trauma could be curtailed.

Theme 1 - Relationship distress was reported as being created by having to deal with the impact of birth trauma on an individual and relationship level. Distress was also reported as resulting in strain on the relationship, which for some resulted in heightened reactions between partners or apparent disconnect from the relationship (M1, M8, M9, W2, W3, W4, W8).

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

Theme 2 - Changed relationship functioning was reported negatively in terms of relationship roles being altered due to the impact of birth trauma. For example, the practical and emotional roles once customary for the relationship were now disordered. In addition, negative effect on sexual functioning was reported (M2, M3, M5, M7, M8, W2, W3, W4, W5, W8).

> *The experience which left me, really very vulnerable, not in a particularly good place…I was usually the strong one, the very practical pragmatic keeping everything going, keep being the one to keep us safe…I wasn't able to do that anymore and you know things got very, very difficult. W2*

Theme 3 - Negative communication was reported within the relationship which was attributed to the impact of the traumatic birth. Such as conflict and arguments or conversely, not communi-

cating due the levels of distress being experienced by one or both parents. For some couples, whilst difficult, negative communication was a transient experience. For others it was ongoing and led to other negative impacts such as distress or fear of relationship breakdown (M1, M6, M7, M8, M9, W1, W2, W3, W4, W5, W6).

So we argued quite a lot at that point…we'd sort of been occupying the same space and doing a lot of the functional but we'd not really seen each other. M9

Theme 4 - Magnification of the strain of being a new parent was reported due to the additional physical demands that came from dealing with birth trauma. In addition, dealing with the emotional impact of birth trauma also added to the strain of being new parents; a period of adjustment already fraught with potential stressors (M2, M6, M8, M9, W2, W3).

It was obviously trying to learn to be new parents, whilst also dealing with, the fact that, I mean I didn't cope well at all afterwards understandably I completely shut down…it made our first few months of being parents really, really difficult. W3

Theme 5 - Fear of relationship breakdown was reported due to high levels of emotions and distress in the relationship caused by the impact of birth trauma, i.e. this fear was not present prior to the birth (M6, M7, W1, W2, W3).

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

Theme 6 - Different viewpoints of the birth experience was reported as creating difficulties between some partners. Typically, one partner having a non-traumatic view of the birth, which made it difficult to recognise the distress of the traumatised partner, emphasise or facilitate support (M1, M4, W1, W2, W3, W4, W6, W7, W8, W9).

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

Theme 7 - Unable to emotionally support one's partner regarding the birth trauma or unrelated emotional issues was reported as a negative effect on the couple relationship. Due to their own personal level of distress owing to the birth trauma, participants reported that they were unable to support their partner as they would have done prior to the birth. (M6, M8, W1, W2, W3).

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

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

He's very good for the sort of on the ground support and you know, doing things, task-based things but then I guess the emotional side he's just not…I do feel the burden on myself to process this further. W7

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

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

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

It's taken us a long time but like now we can talk about it…we are very fortunate that we have a very incredibly strong relationship…, so thankfully having that foundation I think saved us... W3

Theme 11 - Importance of effective communication between partners was reported as key to enabling mutual support regarding birth trauma. Participants reported having regular open and honest conversations and not being afraid to discuss difficult topics to be useful in their lived experience. For some women feeling that their partner really listened and understood their distress limited the impact of birth trauma on their relationship with their partner (M4, M7, W1, W3, W4, W5, W9).

[struggling with addiction] made me bring up the way I was feeling about the PTSD and the traumatic birth, and then since then we have spoken about it quite a lot this year…I do think talking more is making it better. M4

Theme 12 - Agreeing a plan for a subsequent birth to limit anxiety and risk of further trauma was reported as positive emotional support. This included being more informed and assertive around options for maternity and intrapartum care; but for some participants this meant deciding not to have any more children (M1, M2, M3, M7, M8, W1, W2, W3, W4, W5, W8, W9).

We've already decided…I would just have a planned caesarean next time so it will be a completely different experience…I just wouldn't want either of us to have to go through [labour] again. W3

Birth trauma support themes

Themes 1 to 6 detail parents' experiences of negative aspects pertaining to current birth trauma support. Themes 7 to 14 report positive aspects of current birth trauma support parents experienced or their perspectives on how birth trauma support could be improved.

Theme 1 - Unavailability of help from friends and family added to the difficulties some parents had coping with birth trauma. Some participants reported that having more practical help with household and baby tasks would have supported them to deal with the impact of the traumatic birth. Others wanted more emotional support and understanding from friends and family to help them with their birth trauma distress (M2, M4, M6, M9, W2, W6, W7).

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

Theme 2 - Unhelpful birth debriefing services. All 9 of the women participants engaged in some form of birth debrief service and 3 men accompanied their partner to such a service. Feedback on debriefing was on balance negative and reported as unhelpful for dealing with the trauma. Indeed, some participants reported that attending a debriefing service added to their distress (M3, M6, W1, W2, W4, W5, W6, W7, W8, W9).

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

Theme 3 - No personal awareness of birth trauma delayed acknowledgment of the traumatic birth and its impact for some participants. Lack of awareness also led to feelings of isolation and acted as a barrier to seeking support (M1, M4, M8, M9, W1, W3, W4, W5).

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

Theme 4 - Absence of trauma validation from health care professionals in acknowledging the experience of the traumatic birth and related impact added to distress for some women. Lack of validation added to feelings of isolation and led to a breakdown of trust between the woman and healthcare professional (W2, W3, W5, W7, W8, W9).

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

Theme 5 - Lack of awareness of the emotional needs of men from friends, family, employers, and health care professionals resulted in a lack of support and sense of needing to cope with birth trauma alone (M2, M3, M4, M6, M7, M8, M9, W2, W3).

I don't feel like anyone ever asked me how I was doing really…so again I resented that a little bit because I was feeling so awful and I'd spend a lot of time in the car by myself and I'd be thinking "why does no one care, why is no one asking me how I'm feeling? M4

Theme 6 - Barriers to accessing psychological services were reported. Barriers included own doubts about being worthy of receiving NHS resources and lack of availability of specialist services. Participants also reported difficulty finding the right therapist to meet their needs and complex referral processes as barriers to gaining support (M3, M4, M6, W1 W2, W3, W4, W5, W6, W7, W8).

So, we spoke to a consultant midwife, who diagnosed me with PTSD…but because we weren't based in [city], the people that she recommended [for counselling] I wasn't eligible to speak to, so then it was a case of okay well I've now got to go away and find someone to speak to and I never did that. M4

Theme 7 - Connecting with peers was valuable for gaining acknowledgement of current distress and removing the sense of being alone. Likewise, peers with a shared experience of birth trauma could highlight potential sources of support and give insight into its usefulness (M1, M7, M8, W3, W4, W5, W6, W7, W8, W9).

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

Theme 8 - Psychological services to support the couple relationship were reported as being required to enable partners to work through the birth trauma and impact together. In addition, the need for provision of services that tackle specific relationship functioning issues such as sexual health (M3, M4, M6, M7, M8, W1, W2, W3, W8).

I think honestly dealing with us as a couple would have been better for us than individual therapies…a lot of the stress that it put on our relationship could have been avoided if we were able to speak to somebody together rather than everything being done separately. M6

Theme 9 - Supporting parents to understand the traumatic events was reported as being important for overcoming birth trauma. Participants appeared to value and want opportunities to ask questions about what happened, why, and to explore any future ramifications (M2, M3, M4, M5, M6, M7, M8, W2, W5, W7, W8).

So we were fortunate…[the obstetrician] went through it with both [partner] and I and answered questions that we had…and then at my 6-week appointment he did the same thing again. W3

Theme 10 - Facilitating parental feedback on maternity services was reported as positive. Enabling participants to feel that their negative experience and concerns were acknowledged and that services would develop accordingly to benefit future care (M3, M5, M6, W1, W4, W5).

There's some feedback mechanisms as well but maybe make them more accessible to people so they can feedback on their experiences…I'd like peoples' outcomes both clinically and emotionally to be better than ours. M3

Theme 11 - Birth trauma informed antenatal preparation was reported by participants to be an area of potential improvement in parent support. To build parental awareness of the realities of birth and coping strategies for preventing or managing difficult experiences. In addition, the need for preparation that raises awareness of birth trauma, how to recognise it, and gain support to curtail the impact (M1, M8, M9, W4, W5, W6, W8).

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

Theme 12 - Proactive early signposting of support that is appropriate and accessible for both parents was reported as potentially being beneficial. Being given information about birth trauma and relevant signposts in the immediate postnatal period was highlighted as a potential improvement to support (M1, M4, M7, M8, W3, W5, W7).

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

Theme 13 - Improving access to specialist psychological services was reported as being a potential enhancement to birth trauma support. Services which are available to both parents in a straightforward, timely, and affordable way. It is notable that 6 participants mentioned that they or their partner had accessed NHS therapeutic services, yet 11 said that they or their partner had accessed private services (M3, M4, M6, W1, W2, W3, W4, W5, W6, W7, W8).

I think I would definitely benefit from speaking to someone about it in detail…just talk it through with someone who maybe had a bit of experience, who was a professional counsellor would have been great or would be great in the future. M3

Theme 14 - Compassionate parent centred maternity services were reported as being required to support both parents to have a positive experience of birth or to provide physical and emotional support for those experiencing birth as traumatic. Some participants perceived the care they received during the birth or postnatal period to be focused on the physical health of the baby

at the detriment of parental emotional well-being (M2, M3, M5, M7, M9, W1, W2, W3, W4, W5, W6, W7, W8, W9).

> *In terms of support…afterwards it's been really bad, we literally had nothing…not once did the midwife say to [partner] "how are you feeling?, how is your mental well-being?...and I think that really put her off reaching out for the support. M7*

Discussion

The present article reported the findings of a study exploring the lived experience of the impact of birth trauma on the couple relationship and related support requirements. Twenty-six themes which are summarised in Fig. 1, describe both positive and negative aspects of the phenomena.

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

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

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

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

The present study substantiates birth trauma debriefing being commonplace (Ayers et al., 2006a) and something women utilise (Baxter, 2019). Lack of understanding about what happened during the traumatic birth appears to magnify distress and be the motivation for attending debriefing type services. However, as previously found, the effectiveness of debriefing for helping deal with the impact of trauma appears variable (Meades et al., 2011). Findings provides further evidence for the need to develop safe and effective opportunities for couples to explore and understand a traumatic birth experience (Baxter, 2019; Daniels et al., 2020). Furthermore, parents want the process of understanding birth trauma to be two-way, and for mechanisms to be in place to facilitate feedback of their experiences to services to improve quality.

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

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

In the present study parents, particularly men, encountered barriers in accessing individual psychological services. Barriers were apparent at the parent level, such as lack of awareness of birth trauma, and at an organisational level such as inadequate supply of support resources (Smith et al., 2019). A pertinent issue being that most participants in the study accessed privately sourced and funded support. As well as a financial burden, private services could also be problematic due to lack of regulation and validation of some providers. Findings further illustrating the need to improve access to evidence based (Ayers, 2004) specialist psychological services for birth trauma (Delicate at al., 2020b).

As previously reported, a lack of awareness of the emotional needs of men following birth (Baldwin et al., 2018; Daniels et al., 2020) was highlighted. Which for some men leads to distress being undisclosed (Elmir and Schmied, 2021) and coping alone with limited support (Etheridge and Slade, 2017). Furthermore, the study presented a theme that some men focused on providing practical help at home to the detriment of emotional support in the relationship. These findings suggest that a dyadic approach to emotional support is required for birth trauma; both within the relationship and from external sources.

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

The present study provides clear insight into the impact of birth trauma on heterosexual, highly educated people in married relationships in England and acts as further impetus for primary and secondary prevention of birth trauma. Furthermore, the study provides parent perspectives on the efficacy of current birth trauma services including valuable insight into potential improvements pertinent to the continued commitment to developing perinatal mental health pathways in the UK (NHS, 2019).

However, it is acknowledged that the impact of birth trauma and resulting need for support may be different for diverse groups. There are further limitations of the study that need to be acknowledged. Not least the lack of a formal, standardised measure of birth trauma guiding inclusion in the study meaning a range of severity of birth trauma may be represented in the sample. Recall of experiences may have been impacted by the amount of time between the birth and taking part in the research interview. Likewise, participant experiences may differ depending on whether they are first time parents or had other children.

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

Ethical approval

School of Health Sciences Research Ethics Committee, City University of London.

Declaration of Competing Interest

None.

CRediT authorship contribution statement

Amy Delicate: Conceptualization, Data curation, Formal analysis, Investigation, Validation, Visualization, Project administration, Software, Writing – original draft, Writing – review & editing. **Susan Ayers:** Funding acquisition, Investigation, Methodology, Supervision, Writing – review & editing.

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Supplementary materials

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