From trauma to resilience: The resources that help individuals to thrive

Abigail Brown

Portfolio submitted in fulfilment of the requirements for the Professional Doctorate in Counselling Psychology (D.Psych)

City, University of London
Department of Psychology
March 2018

Table of Contents

City, University of London
Northampton Square
London
EC1V 0HB
United Kingdom

T +44 (0)20 7040 5060

THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED DUE TO THE SENSITIVITY OF ITS NATURE:
(a hard copy is available to view within the library)

Section B: case study.....121-132

THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR COPYRIGHT REASONS:

Section C: publishable paper.....137-159

VARIOUS SECTIONS FROM THE APPENDICIES OF THIS THESIS HAVE BEEN REDACTED TO COMPLY WITH DATA PROTECTION LEGISLATION:

Appendices A, B, C, F G,H, I.....161-181

THE FOLLOWING APPENDICIES OF THIS THESIS HAVE BEEN REDACTED DUE TO THE SENSITIVITY OF THEIR NATURE:
(a hard copy is available to view within the library)

Appendices L, M, N.....184-187

Acknowledgements

I would like to thank Dr Jessica Jones Nielsen for her support and belief that I could finish this thesis during the most challenging times of my life. I am grateful for her understanding and guidance throughout this research project. I would like to thank Dr Susan Strauss for her knowledge and support during points on this journey.

I would like to thank Dr Lisa Wilson and Dr Russel Ayling for their guidance and insight along the way. Thank you Dr Kate Russo, for your insightful guidance and encouragement, which has helped me to persevere when it felt impossible. To Dr Susan Cockett for her belief in me and in developing me as a practitioner over the last three years.

I would like to thank the eight women who shared their deeply moving and powerful stories with me. I commend all the women in this study for taking me on a journey where I had the privilege to hear about the most vulnerable time in their life and their journey towards resilience. I hope I have done justice to their stories and I hope this thesis will be a platform to help women who unexpectedly find themselves in this situation.

To Rhondda, Bridgette, Alexis and Anthony for listening, for providing inspiration, containment and laughter during the most difficult period of my life. I would like to thank Wayne for offering those most needed distractions. To Alan for his support when needed. Rhondda, a very special thank you to you for your unconditional support in helping me to continue with my studies without heavy worry.

Finally, I would like to dedicate the achievement of this doctorate to my mother and my children. To my beautiful children, thank you for being patient and understanding. To my mother, you have truly shown me what it means to give unconditional love and support. You have made sacrifices that are beyond what any human being should make for another, you have been a strong force in keeping me together, focused and grounded. Your relentless support has allowed me the time and space to do what I am passionate about, and in turn I have fulfilled my dreams. You are one in a million and you truly are a woman of strength, my best friend, a selfless grandmother and role model.

Declaration of Powers of Discretion

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Introduction to the Portfolio

This portfolio begins with a thesis using grounded theory, which aims to understand the process of the journey towards resilience following a traumatic birth. I then present a case study of a complex-trauma client who was referred by her GP for psychotherapy. The last section of the portfolio is comprised of a publishable piece based on the findings of the thesis, and this will be submitted to the journal *Midwifery*.

My journey began from my own experience of a traumatic childbirth. This personal journey made me curious about human behaviour. People are very complex, and deciphering why we act the way we do is a fascinating arena. This learning journey started with a degree in Social Psychology, which contributed to my healing and also directed me towards becoming a counselling psychologist.

When I started my counselling psychology training, I was keen to work with people who had experienced complex trauma. I was intrigued by how people made sense of their struggles and how they coped when faced with adversities in life. I hold a special interest in the area of trauma and how it can affect a person's sense of self, their identities, relationships with close others and how they relate to or view the world. In my quest to understand and know more about trauma I also embarked on clinical placements that would give me further insight into the challenges clients face in coping with and overcoming their traumatic experiences. I was also fascinated to learn more about other women's experience of traumatic birth and how they became resilient: hence my thesis in this specialist area.

This led me to clinical placements at specialist trauma units and secondary care within the community (NHS) where I continue to work in providing psychotherapy and cognitive behavioural therapy (CBT) for trauma. At the beginning of my placements, I felt overwhelmed by some of the complex trauma presentations, and inexperienced when building therapeutic relationships with clients.

Now that I am more experienced, I see that this work has been rewarding in providing me with insight into the importance of building a supportive therapeutic relationship with my clients. Continuing to work in this clinical context has placed me in a fortunate position, as part of and witness to how some of my clients can become -resilient with support, care and the use of their own inner resources. My experience so far has reinforced my belief that the adoption of a warm, respectful, non-judgemental attitude can not only help clients to feel empowered, but also begin the process of healing. This way of working is not only important with complex trauma presentations but also congruent with my own personality, and in line with the ethos of counselling psychology in building the therapeutic relationship. My exposure to this phenomenon has also made me reflect on what I could add to the field of traumatic birth and resilience.

Part of my professional practice and development is to conduct research that can bring forth knowledge, which in turn benefits the wider world beyond the therapeutic environment (Milton, 2010). In addition, my own experience of traumatic birth has influenced my decision to research this area further. Research into traumatic childbirth tends to focus on the experience and possible development of PTSD. I felt that as a counselling psychologist my research needed to be geared towards empowering individuals to enhance their lives by providing the knowledge needed to understand, cope with, grow and maximise their own potential (Kasket, 2013). It is my hope that my research topic will not only produce new knowledge, but will contribute to improving professional practice with this particular population of women. I am excited to contribute to the research on traumatic births and resilience, and also to contribute to clinical practice by sharing these findings across the UK. I hope my research will give voice to women to speak up about their trauma whilst promoting resilience.

Finally, the concept of resilience when faced with adversity has been consistently experienced in my personal and professional life. As a trainee, I persevered through many challenges even though at times I considered discontinuing my training. I made the choice to work through those challenges by utilising my own inner resources, being guided by supervisors and relying on supportive relationships. These have all helped me to own my journey of transitioning from a trainee into a counselling psychologist.

The threads that run through my thesis – and my development as a counselling psychologist – are challenges, trauma, and resilience. I plan to continue my work in promoting resilience after a traumatic childbirth and build my practice within this area.

Section A: Doctoral Research

This section presents the doctoral research entitled, 'The Journey towards Resilience following a Traumatic Birth: A Grounded Theory study'. The research aim was to develop a theory of the process of fostering resilience following a traumatic birth. Eight semi-structured interviews were conducted with women who had experienced traumatic birth, which gave insight into the process of becoming resilient. A constructivist approach to grounded theory was utilised in analysing the data, and a model of resilience following traumatic childbirth was co-constructed and described. The findings of the analysis built upon existing theory of traumatic birth and resilience. The study highlights the subjective experience of a traumatic birth and the resources women utilise to build resilience. The study concludes with implications for practice for counselling psychologists and health professionals who work with this group of women.

Section B: Client Case Study

This section begins with a clinical case study of a client who was referred by her GP for therapy for help with her depression and anxiety. It became apparent after the first session that my client's struggle was her difficulty in maintaining meaningful supportive relationships in her life. The case study presents the use of supportive psychodynamic therapy over the course of 12 sessions for complex trauma. It presents some of the challenges encountered in working with complex trauma, and gives insight into the importance of having a supportive therapeutic relationship in providing a safe, containing environment where the client can begin to explore and process the emotional conflicts that bring them to therapy. It has been noted that a secure attachment can help individuals to become resilient and cope with the worst effects of trauma (Herman, 1992; Kagan, 2004). This case study also gave me the opportunity to link my research topic of trauma and the importance of supportive therapeutic relationships in building resilience.

Section C: Publishable Paper

This section presents the findings from my thesis in journal-ready form. The core category was 'The Journey towards Resilience following a Traumatic Birth', and the five central categories that emerged from the data were: Category 1: Traumatic birth: To be cared for – who's accountable?; Category 2: Moving towards faith and spirituality; Category 3: Motherhood becomes you; Category 4: Supportive relationships; Category 5: Self-care – as a way of owning my journey.

Midwifery journal seemed to be very appropriate for publishing my research, as its focus is on informing clinical practice about the safety and quality of care, as well as exploring new theoretical evidence. Publishing in this journal will present health professionals with emergent theory in the area of traumatic birth and resilience, and this can inform clinical practice on ways of working with this group of women pre- and post-labour.

Summary

This portfolio presents a grounded theory study on the topic of traumatic childbirth. The study provides insight into the internal and external resources women utilise to cope with their trauma and provides suggestions and insights for working with this particular presentation. This is followed by a psychodynamic clinical case study involving a client who had experienced complex trauma and the importance of a supportive relationship. Similar themes run through both pieces of work and showcase the incredible capacity for people to develop resilience in the face of adversity. Throughout the portfolio the themes of trauma, the process of becoming resilient, and the human capacity to cope are presented through the use of supportive others.

One key finding common across the work in this portfolio is the importance of supportive relationships in the process of developing resilience. Being able to present this in depth in both the clinical case study and research highlights the value of counselling psychology training, and the potential role we can play as educators to improve the experiences of others.

References

Herman, J. (1992). *Trauma and recovery*. New York, NY: Basic Books.

Kagan, R. (2004). *Rebuilding attachments with traumatized children*. New York, NY: Haworth Press.

Kasket, E. (2013). The counselling psychologist researcher. In G. Davey (Ed.). *Applied psychology, supplementary chapters* (pp. 1-20). West Sussex: Blackwell Publishing.

Milton, M. (Ed.). (2010). *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues*. London: Wiley-Blackwell.

Section A:
Doctoral Research

The Journey towards Resilience following a Traumatic Birth: A Grounded Theory

Abigail Brown

Supervised by Dr Jessica Jones Nielsen

Abstract

Statistics have shown that 30% of women in the UK experience childbirth as traumatising, and some may as a consequence go on to experience symptoms of anxiety, depression or post-traumatic stress disorder (PTSD). However, some women do not go on to develop PTSD. As this is a relatively common occurrence, an important question is: How do women who experience a difficult birth develop resilience? Research has mainly focused on the development of PTSD in such women and researchers have therefore recently tried to shift the focus to positive outcomes following a traumatic birth. The focus of positive outcomes has mainly been around post-traumatic growth and researchers have called for more investigations into the area of resilience. At present, research is still sparse in the area of traumatic birth and resilience.

Objectives: The aim of this study was to understand the process of fostering resilience after a traumatic birth.

Method: Semi-structured interviews were conducted with eight female participants aged 30 to 50 years who experienced a traumatic childbirth. A constructivist grounded theory was used to analyse interviews.

Results: A new model of the process of resilience following a traumatic birth was devised, which emerged from the data. The core category of 'The Journey towards Resilience following a Traumatic Birth' was described and connected to the five following categories: Category 1: Traumatic birth: To be cared for – who's accountable?; Category 2: Moving towards faith and spirituality; Category 3: Motherhood becomes you; Category 4: Supportive relationships; Category 5: Self-care – as a way of owning my journey.

Discussion: The model suggests that the journey towards resilience is a process whereby women move towards internal or external resources or both at different points on their journey. This study brings new findings to the area of traumatic birth and resilience which will help guide counselling psychologists and health professionals on how to promote resilience in birthing mothers.

Chapter 1: Introduction and Literature Review

The birth of a child is a key life event for many women, and with support and care during labour this can be described as a moment of great success, joy and fulfilment (Nelson, 2003). A 'normal birth' has been defined as encompassing the psychological and social aspects of labour and birth, which includes mothers being informed about these aspects and having a choice and the opportunity to give consent, having a supportive environment, support in labour, respectful care, non-pharmacological methods of pain relief, being able to refrain from routine interventions, having access to evidenced-based information and practice, midwives providing hands on care, a focus on mother and baby bonding, and having a choice to have their baby at home or in a medical setting (WHO, 2018; The Royal College of Midwives, 2007). Women themselves define a 'normal' or 'great birth' as exceeding their expectations, not experiencing complications or unexpected events, feeling safe and accepted by medical staff, having a sense of freedom to not be fearful or experience suffering from emotional trauma, experiencing a sense of achievement from giving birth, and receiving care individualised to their needs (Simpkin, 2006).

However, many women experience their delivery as deeply distressing. Statistics have shown that 30% of women in the UK experience childbirth as traumatising, and some may as a consequence go on to experience symptoms of anxiety, depression or post-traumatic stress disorder (PTSD) (Slade, 2006; Ayers, 2014). The experience of childbirth as distressing has been emphasised as an event which gives rise to poorer psychological outcomes for mothers (Greenfield, Jomeen & Glover, 2016). Ayers and Pickering (2001) found that for some women, PTSD can manifest from six weeks to six months postpartum. As this is a relatively common occurrence, an important question is: How do women who experience a difficult birth develop resilience?

This thesis aims to provide an understanding of birth trauma and resilience. In this introduction, the definition, conceptualisation and theories of traumatic birth and resilience will be discussed in terms of the historical developments of this phenomenon. Empirical studies on resilience following traumatic childbirth will be critically reviewed. Gaps in knowledge and practice will be highlighted, providing a rationale for the current study, and the contribution it will add to the field of counselling psychology.

1.1 Traumatic Birth: Current Debates

1.1.1 Definition and defining attributes

Ask any woman whether she has experienced a traumatic birth, and she is likely to understand what this means. However, there is no consistent definition of traumatic birth and no systematic way to assess birth trauma: the terms *birth trauma* and *traumatic birth* are often used interchangeably (Greenfield et al., 2016). Adding to the definitional debate, a variety of other terms are also used interchangeably, such as birth trauma, traumatic birth, difficult birth, traumatic experience of childbirth, post-traumatic stress disorder resulting from childbirth, etc. However, the medical definition of a traumatic birth is connected to the mode of birth (operative birth) and the event of the birth only, although the literature suggests that not all women are traumatised by operative births (Bahl, Strachan & Murphy, 2004). One may argue that the interchangeable definitions of traumatic birth challenge the medical model as being specifically related to the mode of delivery.

In their seminal work on traumatic birth, Ayers, Joseph, McKenzie-McHarg, Slade and Wijma (2008) widened the definition of traumatic birth to include the psychological distress that could be experienced without women encountering physical trauma or an operative birth. They also explicitly acknowledged that the experience of psychological distress does not necessarily result in a diagnosis of PTSD. Similarly, Thomson and Downe (2010) found that physical trauma during childbirth did not always lead to PTSD. In this study various terms will be used interchangeably when referring to the studied phenomenon, such as ‘traumatic childbirth’, ‘birth trauma’, ‘difficult birth’, ‘traumatic birth’ and ‘traumatic experience of childbirth’.

1.1.2 Assessing the impact: PTSD

Some risk factors for developing PTSD have been identified (Simpson & Catling, 2016), including poor care from health professionals, pre-existing maternal psychological disorders (including prior diagnosis of PTSD), perception of social support (Grekin & O’Hara, 2014), a history of sexual trauma (Verreault et al., 2012), unplanned pregnancies, feeling pressured to have labour induced, and experiencing an unplanned caesarean section (Beck et al., 2011). A proportion of women develop PTSD after giving birth and for some women, their traumatic birth experience leads to ongoing trauma symptoms.

The DSM-5 has provided a psychiatric model of traumatic birth in relation to childbirth PTSD (American Psychiatric Association, 2013). According to the DSM-5 manual the first criterion for diagnosis of PTSD is that the person has had a traumatic experience where they felt their life was at risk, or they witnessed another person who was at risk of actual or threatened death and serious injury. According to the criteria of PTSD, diagnosis must include a specific number of symptoms from each of their criteria. For example, in

criterion (B) the individual will experience repetitive intrusive memories, flashbacks and nightmares, in criterion (C) they will avoid any stimuli that reminds them of the trauma (e.g., hospitals), and in criterion (D) they may experience symptoms of hyperarousal, become hypervigilant and experience difficulties sleeping. Criterion (E) requires that the symptoms are present for over a month in the patient and these symptoms must cause substantial distress or difficulty in their social, occupational or other significant areas of functioning. The DSM-5 has recently added negative alterations in mood to their PTSD criteria, which may influence how trauma is reported and impact prevalence rates.

For some women a traumatic birth has an impact on their family relationships and their bond with their infants (McKenzie-McHarg et al., 2015). The course of PTSD following childbirth is still poorly understood and research needs to focus on incidence, severity, duration and recovery phases utilising longitudinal methods (McKenzie-McHarg et al.). A longitudinal meta-analysis conducted by Morina, Wicherts, Lobbrecht, and Priebe (2014) looked at spontaneous long-term remission rates in adults with post-traumatic stress disorder, who did not receive psychological intervention. They found that 44% of adults recover spontaneously in the first 10 or more months after the event. It would appear that the difficulties related to traumatic birth are overcome naturally over a period of time for many women. The focus of this thesis is not to explore diagnosis or symptomology of PTSD, but to explore the trauma experience and then the process of resilience.

1.1.3 Challenges of using a positivist paradigm

In my review of the current literature it is noticeable that the field of trauma generally is dominated by the quantitative paradigm and based upon the diagnosis of PTSD. Moyzakitis (2004) has argued that there is a need for more qualitative research that presents the lived experience of traumatic birth, rather than simply categorising and pathologising these women's experiences. Greenfield et al. (2016) suggest that their research challenges the concept that traumatic birth results in a diagnosis of PTSD or postnatal depression. Theorists are beginning to recognise that a group of women exist who experience a traumatic childbirth but do not go on to develop a diagnosable psychological condition (Coates, Ayers & De Visser, 2014; Greenfield et al., 2016). This raises the question as to why some women do not experience ongoing distress, whilst for others the distress continues. It can be argued that the existing medical and psychiatric definitions do not explain perceptions of traumatic births or what they mean for mothers.

For us to understand these concepts further, we need clear definitions that make sense to the people experiencing these events, rather than definitions that are identified by arbitrary categories or diagnostic criteria. For the purpose of this study, the term 'traumatic childbirth' is defined as the subjective judgement of a woman's birth experience in relation

to her personal satisfaction with the process and outcome of birth (Sorenson & Tschetter, 2010) and care (Garthus-Niegel, von Soest, Vollrath, & Eberhard-Gran, 2013).

To fully research the impact of traumatic childbirth, we need a much more detailed understanding of the experience that these women go through. Several researchers have already argued this point – to fully understand, address and improve on the experience of traumatic birth, we need to listen to those who have experienced it.

In the next section, I will review the qualitative research into the subjective experience of traumatic birth in order to explore what is known about this topic.

1.1.4 Qualitative research on traumatic birth

To understand what makes the experience of childbirth traumatic, it is worth reviewing the factors that comprise and influence women's perceptions of their birthing experiences (Simpson & Catling, 2016). Sorenson and Tschetter (2010) have described a traumatic birth as the subjective judgement of a woman's birth experience in terms of personal satisfaction with the process and outcome. They argue that women can perceive their birth experience to be traumatic based on numerous factors, such as fear for their life and that of their infant, type of delivery, perception of personal performance, medical intervention during birth, perception of control, ability to achieve their expectations of birth, adapting to unmet expectations, cultural expectations and environmental factors. Garthus-Niegel et al. (2013) argue that a mother's subjective experience of care is more important than the objective description of the birth. Greenfield et al. (2016) also propose that the most expert description of a traumatic birth is a mother's understanding and perception of their own experience and feelings.

1.1.5 The subjective experience of traumatic birth

Research suggests that the subjective experience of traumatic birth may be related to the woman's perception of the event (Beck, 2004a) or how she subsequently processed the event of childbirth (Ayers et al., 2015).

Beck (2004b) explored the meaning women gave to their experience of traumatic childbirth in a descriptive phenomenology study with 40 mothers from New Zealand, USA, Australia and the UK. After analysing written accounts of traumatic childbirth, four themes emerged: 'To care for me: was that too much to ask?', 'To communicate with me: why was this neglected?', 'To provide safe care: you betrayed my trust and I felt powerless', and, 'The end justifies the means: at whose expense? And at what price?'. The themes are suggestive of the participants' experiences of not feeling cared for by their health professionals, experiencing the health professionals as not communicating with them, and an overall sense of powerlessness in relation to their interactions with the medical

profession. The study highlights adjectives such as “cold” and “mechanical” in relation to the care the women received during traumatic labour. As a result of this type of care, women felt alone, abandoned and stripped of their dignity. A recurrent feeling was that they felt invisible to medical staff, and loss of control and powerlessness were recurrent thoughts and emotions experienced by women during their “terrifying” labour. The authors summarised that healthcare professionals played a significant role in whether women feel their childbirth was traumatic or not. The authors also comment that birth trauma is perceived in the “eye of the beholder” (Beck, 2004b). The strength of this study and one noted by the authors is that although elements of their four themes had been reported in previous studies, they were the first to report the full depth of the experience. A limitation of the study was that recruitment was undertaken via one organisation that had specific views on birth trauma, so the organisational views may have influenced the participants’ descriptions of their experiences. Nevertheless, this study offers valuable insight into women’s subjective experience of traumatic birth.

A qualitative study conducted by Moyzakitis (2004) in the UK presented an exploratory and descriptive feminist perspective of how women describe or make sense of their distress or trauma in childbirth, and also considered the appraisal of the birth as “awful” in changing these women forever. Four major themes emerged: the role of the caregiver, impact on self-image, impact on relationships, and severity of experience. Additional features noted within the subcategories were lack of information, sensing professionals were being unfair, experiencing a lack of care, and feeling betrayed. It was noted that participants felt alienated during the birth and expressed feeling a sense of loss and grief for themselves, whilst others reported a desire to preserve their integrity. Another finding was that all the women reported problems in their relationships with their infant or partner, and five women developed postnatal depression. The author suggests that there are many-layered meanings entrenched in women’s memories of childbirth. In addition, health professionals should be mindful of the life experience and the memories we help to create for those in our care. A strength of the feminist approach is that it aims to empower women by placing them as experts on their own lives.

Ayers (2007) examined thoughts and emotions during traumatic birth, cognitive processing after the birth, and memories of the birth that may contribute to the development of PTSD. This UK study was based on a sample of twenty-five women with post-traumatic stress symptoms and twenty-five women without. The prevalent themes were: wanting labour to end, poor understanding of procedures, mental coping strategies, and mental defeat. The women described experiencing more negative emotions, such as fear and upset. The results showed that women found it difficult to remember certain aspects of the birth and wished to forget their negative experiences of birth. They also found that postnatal

cognitive processing included a retrospective appraisal, and this was related to fear of death or to a focus on caring for their baby. Women with PTSD symptoms also experienced more anger, thoughts of death, mental defeat and experienced dissociation during birth. Post-natally these women reported experiencing painful and intrusive memories, ruminating thoughts and a tendency to focus less on the present compared to women without symptoms.

Ayres (2007) suggested that it was important to recognise that although all women experienced severe distress during labour, not all developed symptoms of PTSD. The author also highlighted that those women who did not develop post-traumatic symptoms might have had particular strengths that helped them to cope with or respond to distress in different ways. A notable finding was that women without symptoms of PTSD were focused on getting on with their lives: they focused on their baby and on their own health, which suggests that certain strategies may help women to recover from a traumatic birth and decrease the risk of developing post-traumatic symptoms. Ayres's study offers valuable insight into some of the strategies women can use to cope and move forward with their lives. These results provide a useful insight into those aspects of birth and postnatal processing that affect whether women will develop symptoms of PTSD. A significant limitation of the study, and one acknowledged by the author, is that it did not provide a measure of whether births fulfilled criterion (A) of the DSM-5 criteria for PTSD, which would have given a clear analysis of whether the women felt their life or their infant's life were threatened, and whether they reacted with hopelessness, fear or horror. However, it could be argued that fulfilling a criterion for a diagnosis does not change the experience, so it may not have altered the findings of the study.

Elmir, Schmied, Wilkes and Jackson (2010) undertook a qualitative meta-ethnography review of ten studies, with samples from the UK, New Zealand, Australia and Canada. The aim of the review was to give insight into women's perceptions and experiences of traumatic birth, and the impact this can have on the physical and emotional well-being of the woman, her infant, and family. The qualitative review included three of the studies mentioned in the above section – those by Ayers (2007), Beck (2004b) and Moyzakitis (2004). Six major themes were found of women's perception of their traumatic birth. These were: 'feeling invisible and out of control', 'being treated humanely', 'feeling trapped: experiencing recurring nightmares of childbirth', 'a rollercoaster of emotions', 'disrupted relationships', and 'strength of purpose: a way to succeed as a mother'. The women in this study described feeling angry, distressed, let down and experiencing a sense of loss due to lack of care from medical professionals during birth.

The subjective experience of what makes a childbirth traumatic is an important starting point in understanding these women. But also important is the care they receive during this time. This will now be explored.

1.1.6 The role of healthcare professionals during traumatic birth

Some of the research discussed above has indicated that the quality of care received by women during childbirth can influence the extent to which they perceive their experience as traumatic.

Sorenson and Tschetter (2010) argue that the Quality of the Provider Interactions (QPI) largely affect the birth experience due to the verbal and non-verbal behaviours of the care providers in meeting the stated or implied needs as perceived by the childbearing mothers. It is also pertinent to note that although the birth experience may appear uncomplicated to healthcare professionals, such as midwives and doctors, women may still experience their birth as traumatic if they feel they have lost control or dignity, whilst experiencing their interactions with care providers as hostile or disrespectful (Ford, Ayers & Bradley, 2010).

Harris and Ayers (2012) support the idea that interpersonal interactions with care providers during labour and birth can have a significant impact on women's birthing experience. The authors also identified peri-traumatic hotspots associated with a traumatic birth which included difficult interactions with care providers, feeling ignored, unsupported or abandoned. Their study also found that mothers who experienced interpersonal difficulties with medical staff expressed feelings of anger and conflict, resulting in symptoms of PTSD, distress, impairment and avoidance. In addition, other intrapartum hotspots were reported as a traumatic experience, such as obstetric complications, neonatal complications, emergency caesarean section or intrapartum disassociation.

These findings are supported by a similar study conducted in France which found that a mother's experience of care providers as projecting negative attitudes affected the birth experience, and the perceived levels of post-traumatic stress (Denis, Parant & Callahan, 2011). Factors that make care good or bad in terms of a traumatic birth need further exploration, but the emergent themes are connected to the interactions between the midwife and mother, and whether the mother feels in control of decisions being made and/or feels that her needs are being taking into account (Elmir et al., 2010).

The ethnographic review by Elmir et al. (2010) suggests that healthcare professionals need to communicate effectively and provide supportive relationships and continuity of care, both pre- and post-labour, which will help women to experience their birth as positive. The authors suggest that health professionals can identify risk in the antenatal period, acknowledging these risks whilst providing a positive interaction with expectant mothers.

We can now further explore the qualitative research that looks at the impact of a traumatic birth upon the mother, her infant and her family.

1.1.7 The impact of traumatic birth

The impact of the traumatic birth was explored in the qualitative ethnographic study by Elmir et al. (2010), with women describing a noticeable breakdown in their relationships with their partners and infants. These women also experienced symptoms of depression which sometimes led to suicidal ideation. The key findings in this meta-review were all concerned with women feeling overwhelmed after their traumatic birth. They continued to feel anger, disappointment and loss for a number of years, and this in turn affected the care they provided for their infants and their ability to be close. However, the women in these studies acknowledged that the support of their partner was fundamental in helping them to process their feelings. A noteworthy finding was evidence of positive adjustment after a traumatic birth in the theme entitled 'strength of purpose: a way to succeed as a mother'. This theme found that breastfeeding helped women to overcome their traumatic birth and proved that they could be good mothers. Some women described feeling like failures because they did not have a normal birth, and being able to breastfeed provided a compensatory experience where the symbolic and interconnected act of breastfeeding helped them to heal and recover from their trauma, and lift their confidence as mothers. This finding was identified as the only area of difference amongst the studies, with some women experiencing breastfeeding as a positive factor and others as a burden which added to their trauma. One might suggest that breastfeeding was not the only factor that helped women to cope and positively adjust, since the support of their partners may have aided their healing and recovery.

Much has been learnt about the experience and impact of traumatic birth. There is consistency in the findings, and these articles are describing the practical lessons we can learn from existing research. These recommendations are still not finding their way into clinical practice, as research continues to highlight issues with communication and continuity of care. Also, there are wider psychosocial implications that can occur from the trauma.

Fenech and Thomson (2014) conducted a meta-synthesis to focus on the maternal psychosocial implications of a traumatic birth on women, providing further insight into the wider psychosocial impact of traumatic births in the postnatal period. Thirteen papers were included in their final synthesis with 292 women from the UK, New Zealand/Australia, Norway and Sweden. The review included three studies mentioned in the above sections – those by Ayers (2007), Moyzakitis (2004) and Beck (2004b). Three constructs were found: women being 'consumed by demons' (experiencing strong negative emotions and utilising

unhelpful ways of coping), 'embodied sense of self' (a loss of self and family beliefs), and 'shattered relationships' (experiencing difficulties with partner and infant).

The meta-review found that the experience of traumatic birth can have a pronounced emotional impact on women, and may result in women holding negative feelings about themselves and others. Some women also developed unhelpful ways of coping with nightmares and flashbacks. Women who had a traumatic birth carried with them a sense of loss in connection to their birthing experience, their view of an ideal family, motherhood, and their sense of self. The authors also identified other symptoms, such as sexual dysfunction and difficulties in being intimate, difficulty bonding with their infant, breakdown in family relationships and suicidal ideation. In addition, a significant theme in their study was women reporting a fear of future childbirth or a conscious decision to have elective caesarean for future births. The authors suggested that their findings give insight into how traumatic birth experiences can have enduring consequences for a woman's identity and her relationships with loved ones.

What remains unknown is how women are able to rebuild their identities as women/mothers, and reconnect with loved ones, whilst nurturing and caring for their infants. In addition, questions remain about which factors help women to feel empowered and regain their sense of self after a traumatic birth.

This section has presented an overview of the subjective experience of traumatic births, the role of healthcare professionals, and the psychological and psychosocial impact on the women and their loved ones. The research in the area of traumatic birth has mainly focused on the development of PTSD, but there is a lack of focus on those women who do not go on to develop PTSD or psychological disorders. These women are currently under-represented in research on traumatic birth. The aim of this present study is to fill a gap in our understanding by exploring what helps the majority of women who positively adapt following a traumatic childbirth.

1.2 Theoretical Considerations for Trauma

1.2.1 Trauma models

A number of models have been put forward to explain and understand the experience of the human stress response, seen through biological, physiological and psychosocial lenses. These theories will be discussed further in the next two subsections.

Theorists have concluded that human beings will experience at least one traumatic life event over the course of their lifetime (Fletcher & Sarkar, 2013; Bonanno & Mancini, 2008). Trauma theories provide us with an understanding of human adaptation to traumatic stress. Careful consideration of these trauma theories can give us greater clarity in our understanding of difficulties in adjustment following childbirth. The trauma models that have

been put forward to explain the complex process of trauma adaptation include the following: the Transactional Theory of Stress and Coping (Lazarus, 1966; Lazarus & Folkman, 1984), which focuses on the individual's appraisal of threat, their cognitive appraisal and coping behaviours; Information Processing Theories (Foa & Rothbaum, 1998; Horowitz, 1976; Janoff-Bulmann, 1992; Ehlers & Clark, 2000), which focus on how individuals adapt to trauma through a cognitive process; and the diathesis-stress model (Rabkin, 1982), which focuses on identifying risk and resilience factors that exposes the individual to trauma.

However, for this research only two models of trauma will be discussed – the Transactional Theory of Stress (Lazarus, 1966; Lazarus & Folkman, 1984) and the Cognitive Model of PTSD (Ehlers & Clark, 2000) – as they have been widely used to understand the impact of the subjective experience and the subjective appraisal on post-traumatic stress symptoms and they help us to understand the development and persistence of PTSD in birthing mothers. We will now look briefly at these two models.

1.2.2 Transactional Model of Stress and Coping

The Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) highlights an individual's appraisal of threat, challenges and harm, and the process of coping with stressful experiences. This model outlines how a person responds to a traumatic or stressful environment. It looks at the use of cognitive appraisals and coping behaviours and examines biopsychosocial reactions. The authors suggest that cognitive appraisal is a process whereby the person evaluates their situation by giving attention to the implications, meaning or significance of the interactive process between the environment and the individual.

Lazarus and Folkman (1984) explain that cognitive appraisal can be split into two categories, primary and secondary, when explaining responses to stressful environments. Primary appraisal is the individual's assessment of the stressor in relation to their own well-being, whereby they judge it to be irrelevant, benign-positive (produces positive and pleasurable emotions), or stressful (harm, threat or challenge). The authors suggest that there will be no emotional reaction if the primary appraisal of the event is perceived as irrelevant. However, if the encounter is deemed relevant and stressful or traumatic, it is possible for some individuals to view the stressor as a challenge to overcome. Research suggests that this may be a factor of resilience which requires further research (Benight, 2012). Secondary appraisal cannot be considered without linking it to primary appraisal in terms of an individual's assessment of the available social, physical, psychological and material resources that can be utilised to control or improve the current environment (Folkman, 1984).

Coping within this model has been conceptualised as the individual's appraisal of their personal resources in response to harm or threat (Lazarus & Folkman, 1987). The theory suggests that coping behaviours can be divided into problem-focused, emotion-focused, or avoidant coping. Research on coping suggests that problem-focused coping is typically linked with positive outcomes (Taylor & Stanton, 2007). However, researchers have argued that attempts to alter the environment when conditions are uncontrollable can lead to negative responses (Taylor & Stanton). In light of these findings, recent studies not connected to the trauma field suggest that disengagement from uncontrollable goals is highly adaptive (Wrosch, Scheier, Carver, & Schulz, 2003).

Benight (2012) suggests that these findings raise important considerations for those within the trauma field in relation to the definition of trauma and its link to extreme uncontrollability. The author argues that the main issue here is the evaluation of how individuals cope with what cannot be reversed or how they work towards their recovery process, which can be controlled (e.g., seeking support). Furthermore, a recent meta-analysis of coping behaviours and outcomes in trauma studies found no effect for approach in coping behaviours and outcomes in trauma studies (Littleton, Horsley, John, & Nelson, 2007). It has been suggested that future studies should focus on the interactions between cognitive appraisal of coping self-efficacy and approach-oriented coping after trauma as this may help clarify the processes that help individuals to adapt and successfully recover (Benight, 2012).

In contrast, emotion-focused coping or avoidant coping has been linked to negative outcomes (Taylor & Stanton, 2007). Research in the area of trauma indicates that avoidant coping has been consistently linked to negative outcomes of PTSD symptoms (Littleton et al., 2007). It has been argued that researchers should consider dynamically analysing coping as a process (Folkman & Moskowitz, 2004).

Garthus-Niegel et al. (2013) used the Transactional Theory of Stress and Coping in their study to understand the impact of the subjective experience on post-traumatic stress symptoms. This model is useful in exploring the subjective experience of childbirth because the subjective appraisal of threat is at the core of the theory. An event that is perceived as threatening or harmful to an individual can cause negative psychological distress. Some birthing mothers perceive childbirth as a life-threatening event and can develop symptoms of PTSD in the absence of any unexpected birth complications.

In summary, although the Transactional Theory of Stress and Coping is comprised of a complex assessment of the coping process in relation to person and environment interactions that encompass cognitive appraisals process and biopsychosocial outcomes. One shortcoming of this theory is that it has not been adequately tested within the traumatic

stress context (Benight, 2012). Researchers are calling for more research that will focus on testing this theory's applicability within trauma.

1.2.3 Cognitive Model of PTSD

One of the models that has been widely used and which is supported by empirical evidence is the Ehlers and Clark Cognitive model of PTSD (2000). This emphasises the role of cognitive appraisals during adverse experiences and in the aftermath of the experience. The model highlights the paradox of PTSD whereby an individual may hold anxieties about the future even though the traumatic experience occurred in the past. The authors propose that some individuals may experience difficulty in processing the autobiographical memory of the trauma which produces a sense of external threat to their safety or of internal threat to themselves and their future.

These pathological responses arise from the individual's negative appraisal of the adverse event and the autobiographical memory of the trauma (Brewin & Holmes, 2003). Ehlers and Clark (2000) expanded on the work of Foa and Rothbaum (1998) and Jones and Barlow (1990) in highlighting a vast range of negative appraisals. They note that some individuals may focus on the traumatic event and look for signs of danger, or maybe negatively judge their own actions. Others may focus on symptoms of PTSD, such as numbing, having a negative outlook on life or viewing others' reactions towards them as negative. These negative appraisals are linked to a combination of thought processes experienced during the trauma, prior beliefs and experiences. They suggest that the individual's appraisal of threat can produce powerful emotions, such as shame, anger, anxiety, guilt and symptoms of arousal.

Ehlers and Clark (2000) also suggest that the individual holds a specific frame of mind defined as 'mental defeat', whereby the individual perceives themselves as being weak, ineffective or unable to protect themselves. They propose that prior memories of trauma or helplessness can increase the risk of the individual viewing themselves as vulnerable to danger or to being a victim of hostility. They suggest that the traumatic memory has not been integrated adequately into the individual's autobiographical knowledge, which will then cause them to recall biased appraisals of the trauma. They further suggest that the individual may experience problems in recalling information and forming connections to other relevant information. Ehlers and Clark also describe maladaptive behavioural strategies and coping styles that sustain symptoms of the disorder. Coping strategies include thought suppression, avoidance of trauma reminders, distraction, use of alcohol or medication to control anxiety, and adopting safety behaviours that keep the individual from merging adverse events with their autobiographical memory.

Ehlers and Clark's cognitive model provides insight into the maintenance and treatment of PTSD (Brewin & Holmes, 2003). Their theory has provided an understanding of a vast range of negative appraisals and cognitive coping styles that affect the disorder. This model has brought to attention certain features of peri-traumatic processing and mental defeat which act as risk factors in precipitating the disorder. A limitation of this theory is the difficulty of assessing cognitive processing and memory disorganisation as it is complex and self-report measures do not provide consistent relations to each other or other variables (Murray, Ehlers & Mayou, 2002).

The cognitive model of PTSD has been applied to PTSD following childbirth and has been found to give good prognosis of postnatal PTSD. A small number of researchers have begun to explore this model's applicability to postnatal symptoms and the development of PTSD following childbirth. A study conducted by Ford, Ayers and Bradley (2010) using structural modelling found that the cognitive model explained post-traumatic symptoms and that the model was a good predictor of PTSD symptoms after childbirth. Their results suggested that the Ehlers and Clark model can be used to provide insight to postnatal symptoms, although other factors will need to be considered (Iles and Pote, 2015).

Another study utilising this model was conducted by Vossbeck-Elsebusch, Freisfeld and Ehring (2014) in Germany, and looked at predictors of post-traumatic stress symptoms following childbirth. One of the aims of the study was to specifically test variables from the Ehlers and Clark model, such as dissociation during childbirth, negative appraisal related to childbirth, levels of thought suppression and rumination following childbirth, and to test whether a theoretically derived cognitive variable would predict PTSD symptom levels when established predictors of PTSD following childbirth had been controlled for. Vossbeck-Elsebusch et al. found that negative appraisal of the trauma, thought suppression, rumination/repetitive thinking and peri-traumatic dissociation had a strong positive link with PTSD symptom severity. These findings suggest that cognitive variables and PTSD following childbirth are connected. In addition, they also found that theoretically derived cognitive variables could enhance the analytical prediction of PTSD in terms of established risks. The authors suggest that these findings help us to understand how cognitive variables play a significant role in a mother's development or sustenance of postpartum PTSD.

However, the cognitive model is not without limitation, and recent research suggests that other factors need to be considered. For example, Iles and Pote (2015) conducted a grounded theory analysis of 11 first-time mothers in the UK who viewed their labour as traumatic, and who experienced trauma symptoms. This study aimed to address a gap in how we understand maternal postnatal post-traumatic stress by developing a theoretical model for PTSD following childbirth, exploring experiences of pregnancy, childbirth and the postpartum period. Five themes emerged from the analysis, including 'fear and pre-existing

anxieties', 'coping and processing (needing support)', 'a lack of choice, control', 'their narratives/stories about their traumatic labour as first time mothers' and 'the power of their experience in terms of the impact on them and others'. These themes were constructed into a theoretical model that showed factors very unique to postnatal trauma symptoms. Many of Iles and Pote's findings are in line with Ehlers and Clark's cognitive model of post-traumatic stress (2000), such as the impact of past experiences and beliefs and how these new mothers processed their trauma and post-event recollection.

However, the new model extended the cognitive model of trauma in this population by highlighting specific areas linked to the perinatal period, and some new event-specific factors about the traumatic birth. Also, the Ehlers and Clark (2000) model suggests that trauma memories are recalled with a biased appraisal of the trauma, whereas the Iles and Pote (2015) study challenges this idea. Some women in their study who experienced full symptoms of childbirth-related post-traumatic stress were able to provide detailed appraisals of when they experienced fear, and the impact this had on them as first-time mothers. The findings suggest that cognitive models of PTSD need to consider other factors to help us understand and formulate treatments for maternal post-traumatic stress.

In summary, there is a considerable gap in the trauma models with regard to consideration of how individuals overcome trauma, or examination of the concept of resilience. We need to understand why given the large number of individuals exposed to trauma, the majority show exceptional resilience, either experiencing limited symptoms over a period of time or even being symptom free (Alim et al., 2008; Ozer, Best, Lipsey & Weiss, 2003; Southwick & Charney, 2012). Through the study of psychological resilience we can gain an understanding of how individuals withstand or thrive in response to the most testing experiences (Fletcher & Sarkar, 2013).

1.3 Exploring Resilience

Exploring human resilience and the factors that help individuals to thrive provides a more balanced view of how we as practitioners can promote individual strengths and assets rather than focusing only on what is broken. This view is supported by positive psychology in promoting human potential to thrive (Park, 2012). The following section will define resilience, provide an overview of current models and theories of resilience and end with a discussion of empirical literature that looks at traumatic childbirth and resilience.

1.3.1 Defining 'resilience'

In an attempt to gain clarity on the concept of resilience, Aburn, Gott and Hoare (2016) conducted a systematic literature review of the various definitions of the term. They concluded that there is no universally accepted definition of resilience to date, but highlight

five key themes associated with the concept. The first theme defined resilience as 'rising above to overcome adversity'. This suggests that resilience as a process is aided by the way in which individual interacts with others in their surrounding environment. The notion of 'rising above' a traumatic experience was associated with words such as 'flourishing', 'thriving' and 'succeeding' in the literature. These words suggest that such resilience enables an individual to function at a higher level than before or during their adversity.

The second theme identified was 'adaptation and adjustment', which suggests that an individual who can successfully adapt or adjust to new challenges has shown a mark of real resilience. The third theme, originally conceived by Masten (2001), was described as "ordinary magic": an everyday characteristic inherent in all people. This theme suggests that resilience is developed through family, love and close relationships which can be fostered by positive interactions within work and education environments. It also suggests that resilience can be built from previous experiences and supportive relationships during stressful or traumatic periods. It is pertinent to note that 'magic' is difficult to measure or quantify (Aburn et al., 2016).

Another theme identified was good mental health as a proxy of resilience, which suggests that an individual's resilience is proportional to their state of mental health. The final theme defined resilience as the ability to bounce back, and many studies in Aburn et al.'s review saw this as a key attribute of resilience. As a result, authors have made clear connections between 'recovery' and 'bouncing back' as way of recovering from trauma (Felten, 2001; Edward, Welch & Chater, 2009).

Although many authors have used recovery and resilience interchangeably, some have argued that they are distinct concepts. For example, Bonanno (2004) argues that resilience is a distinct outcome trajectory, different to recovery, in which symptoms (PTSD) are experienced and then recovery evolves over time. A limitation with Bonanno's definition is the lack of clarity in the timescale to recovery (days or weeks) or how much symptom reduction is needed to perceive the individual as resilient, which suggests that resilience is dependent on self-report measures (Wald et al., 2006).

A number of authors suggest that resilience is an evolving phenomenon (Mullin & Arce, 2008). For instance, an individual can show courage, strength and adaptability in their work life, but may struggle with overcoming hurdles in their personal life (Aburn et al., 2016). Some authors argue that resilience is not a static state but a dynamic process within the context of time (Gartland, Bond, Olsson, Buzwell & Sawyer, 2011). This has been attributed to the environment or support network that is available to the individual during their lifespan (Luthar & Cicchetti, 2000; Masten, 2001). Fletcher and Sarkar (2013) suggest that despite the lack of agreement on an operational definition of resilience, there is agreement that adversity and positive adaptation are its core ingredients. They also highlight the importance

of addressing the confusion in definitional concerns to provide some understanding of the different approaches that have emerged in relation to theoretical explanations of the core concepts of resilience.

1.3.2 Debates on conceptualisation

Alongside definitional debates on resilience, there are co-existing debates on the conceptualisation of resilience. Theorists have put forward an important discussion with regard to conceptualising resilience as a personality trait or process (Windle, 2011). The concept of a trait implies that the individual has certain characteristics that help them to adapt to stressful events (Connor & Davidson, 2003). This concept was first proposed by Block and Block (1980), who used the term 'ego resilience' to explain traits such as strength of character, flexible responses to the environment, and resourcefulness. The authors also suggest that resilient individuals show traits which are optimistic, inquisitive, and that they have the ability to detach from and conceptualise problems. These characteristics have been referred to as protective factors that aid the individual to adapt or modify their responses to stressful environments (Rutter, 1985). Since the identification of protective factors by Rutter, numerous other protective factors in resilience research have emerged, such as hardiness (Bonanno, 2004), positive emotions (Tugade & Fredrickson, 2004), spirituality (Bogar & Hulse-Killacky, 2006), self-esteem (Kidd & Shahar, 2008) and positive affect (Zautra, Johnson & Davis, 2005).

Alongside conceptualisations of personality traits in relation to psychological resilience, resilience has also been described as a process that develops over time and can be learned (Fletcher & Sarkar, 2013). For example, Luthar and Cicchetti referred to it as a "dynamic process encompassing positive adaptation within the context of significant adversity" (Luthar & Cicchetti, 2000, p. 543). The conceptualisation of resilience as a process takes into consideration protective and promotive factors, which will change according to the context in which situations occur, and the point at which the person is in their lifespan (Fletcher & Sarkar, 2013). Theorists who promote resilience as a process argue that resilience is not a static way of being (Mahoney & Bergman, 2002; Ungar, 2008).

For the purpose of this study, the term 'resilience' is defined as a "dynamic process that involves positive adaptation in the context of adversity" (Luthar & Cicchetti, 2000). The process takes into consideration assets within the individual or resources external to the individual (Zimmerman et al., 2013).

A number of theories on resilience have been put forward to explain the human ability to become resilient following adversity. The theories discussed in the following section provide a different perspective on the trauma model and help explain the process of resilience.

1.4 Theoretical Considerations for Resilience

Fletcher and Sarkar (2013) have identified over a dozen theories of resilience that have been put forward by researchers over the past three decades, all with similar features. Among these are the following: the adolescent resilience model (Haase, 2004), which is geared towards adolescents and considers three factors – protective factors, risk and outcome (resilience); the conceptual model of sport resilience (Galli & Vealey, 2008), which focuses on the adversity, sociocultural influences, and personal resources of an athlete as the main elements of the resilience process; the family adjustment and adaptation response model (Patterson, 1988), which describes the process of families managing demands and the outcome leading to adjustment or adaptation; and the stress shield model of resilience (Paton et al., 2008), which considers the person (police officer), their team and their organisation in building resilience and gaining empowerment. Fletcher and Sarkar (2013) note that the majority of theories proposed are focused towards specific populations (adolescents, families, police officers), and they highlight a need for a generic theory of resilience that can be used across groups of people, and settings.

In line with this need, the researcher has chosen to discuss three broader theories of resilience: the meta-theory of resilience (Richardson, 2002), which focuses on cognitive reintegration returning to baseline homeostasis; the generic theory of resilience (Agaibi & Wilson, 2005), an integrative model which focuses on person-environment and its interaction with five variables; and the adult personal resilience model (Taormina, 2015), which presents a theory from the positive psychology perspective where resilience is described as a multidimensional construct that consist of four domains of adult personal resilience. I have chosen to focus on these three theories of resilience because the meta-theory and the generic theory can both be applied to various adversities, different types of stressors, and life events when considering the person and the community. This is important given the lack of research on resilience following a traumatic birth; these theories offer flexibility in helping us to understand the factors that aid resilience in a niche area. In addition, it was also important to incorporate the theory on adult personal resilience as this specifically focuses on the internal resources and exact ingredients that help individuals to thrive. There is also a need to consider where theory currently stands in relation to childbirth.

1.4.1 Meta-theory of resilience

Richardson's (2002) meta-theory of resilience has been viewed as a generic theory that can be applied to adversities, life events and various stressful situations at different levels of analysis in relation to the individual, family or community. This theory has been conceptualised as encompassing a range of theoretical ideas derived from the area of medicine, psychology and physics (White, Driver & Warren, 2008). Richardson suggests

that the historical development of resilience can be grouped into three sub-areas, which he refers to as 'first wave', 'second wave' and 'third wave'. He suggests that the first wave of research identified individual qualities, such as protective factors, in helping individuals to respond positively to adversity. He proposes that the second wave focused on resilience as a process in relation to how individuals cope with stress, change, adversity or opportunity. The third wave of research sought to identify motivational forces within the person or group that would lead them to self-actualisation in certain circumstances.

This model suggests that the resilience process begins with the individual state of mind being of a bio-psycho-spiritual balance or a sense of homeostasis/comfort zone. This enables an individual to balance physically, spiritually and mentally how they adapt to life circumstances. According to the model, there are certain points at which individuals experience disruption from their homeostatic state due to a lack of protective factors to shield them from stressors in life. The model also proposes that with the passage of time, an individual will adjust and begin the process of reintegration. This process can lead to one of four possible outcomes: resilient reintegration (where protective factors are relied upon), homeostatic reintegration (where some individuals retreat to their comfort zone when they encounter stressors, until the disruption has passed), reintegration with loss (where stressors lead to loss of protective factors and lower levels of homeostasis), and dysfunctional reintegration (where stressors can lead some individuals to rely upon destructive behaviours, such as abusing substances) (Fletcher & Sarkar, 2013). A potential limitation of this model is that it is linear in only taking into account one event in an individual's experience. The model has been viewed as biased towards the process of coping, and it has been suggest that resilience can be viewed as an individual's capacity to cope with stressors (Connor & Davidson, 2003).

1.4.2 Generic theory of resilience

Another generic model of resilience has been proposed by Agaibi and Wilson (2005). It has established key factors that determine resilient behaviours caused by traumatic events, and is based around the person-environment paradigm, emphasising how individuals perceive, process and adapt to trauma. It looks at the interaction between many variables, such as personality, ego-defences, coping styles and mobilisation/utilisation of protective factors. These variables have been identified within the model as the allostatic load/stress response. This model brings together earlier models (Richardson, 2002; Wilson, Friedman & Lindy, 2001; Green, Wilson & Lindy, 1985; Wilson, 1989; Maddi, 1999) to help identify and consider all the factors that work together to help an individual adapt psychologically to traumatic events.

It is essential to consider the various ways in which individuals can respond to traumatic events. Traumatic events will have various levels of impact on the psyche, and vary greatly in the levels of stress imposed (Wilson, 1989, 2004; Wilson & Lindy, 1994). Secondly, individuals will respond subjectively based on their internal psychological processes. Another consideration is the variation in the type of traumatic event that can occur, and the differing levels of impact or severity, and resultant states of allostatic load (McEwen, 1998, 2002; Wilson et al., 2001). The complexities of allostatic load suggest that there are various degrees of affect dysregulation connected to how individuals cognitively process trauma (Schore, 2002). It has been noted that traumatic events influence current personality states, such as structure, defences and dynamics. This model suggests that trauma should be viewed from a holistic perspective, taking into consideration the affect it has on personality and self-processes, which then activate allostatic stress response patterns in the individual that are connected to their sensory nervous system (Wilson, 2004; Agaibi & Wilson, 2005).

When the allostatic stress response pattern has been activated, it connects to five areas of functioning, such as coping styles, personality characteristics (e.g., assertiveness, hardiness, locus of control etc.) and affect modulation and degrees of affect balance and mobilisation and utilisation as protective factors that are in the list of coping behaviours (Agaibi & Wilson, 2005). The individual's response to trauma will lie on a continuum depending on how they adapt and become resilient. This suggests that they will eventually find a positive way of coping with the trauma, and also that they will master how to cope with excessive stress and show resilience by relying upon specific personality traits (e.g., hardiness). The individual can aim to maintain a positive outlook and create meaning from the traumatic experience to ease the effect of trauma (Agaibi & Wilson).

The generic model of resilience seems to focus heavily on personality traits as a way of adapting to and coping with trauma. This model seems limited to considering aspects of spirituality and community support as contributing factors in helping individuals to gain a positive outlook and positive meaning as a way of moving forward with their lives.

1.4.3 Adult personal resilience model

This is a relatively recent theory of (Taormina, 2015) and its title suggests that it is applicable to any society. The author suggests that this theory is unique in comparison to previous theories which traditionally focus on helping victims find ways to live with trauma. Taormina presents this theory from a positive-psychology perspective, and it considers those features of a person that can help them become stronger in order to prevent personal problems and also work through traumatic experiences. He argues that despite the existence of several theories of personal resilience, there has been a lack of focus on the internal characteristics

and the exact ingredients that make up adult personal resilience. He stresses that this theory focuses only on adult resilience, in contrast with some previous research in the area of resilience which has been dedicated to the study of children (Howard, Dryden & Johnson, 1999). Luthar, Cicchetti and Becker (2000) note that resilience is not restricted to children but is personally constructed throughout a person's life span, which highlights a need for the study of adult resilience. It is further proposed that personal resilience is not restricted to internal characteristics, but is a multifaceted construct that is related to a determination to survive (Bandura, 1989), having the ability to endure hardships (Rutter, 1987), being able to adapt to changing conditions (Bonanno, 2004), or to recover from adversity (Tugade & Fredrickson, 2004).

In considering the various definitions of personal resilience, Taormina (2015) defines adult personal resilience as a multifaceted construct that is comprised of a person's determination and ability to endure, adapt and recover from adverse situations. He puts forward four dimensions of adult personal resilience: being determined, having endurance, being adaptable, and being able to recuperate. The author defines determination as a person's willpower and resolve to focus on succeeding, which relates to a conscious or cognitive effort of personal resilience. He suggests that the dimension of endurance can be cognitive or physical, and is focused on personal strength and courage to overcome stressful situations without giving up. For example, a person may be able to survive trauma inflicted to his or her body, thus bearing physical suffering.

The cognitive aspect focuses on a person's ability to adjust their thinking in times of hardship or oppression. Taormina defines adaptability as a person's ability to be flexible and quick-witted whilst adjusting to adverse environments. This concept is more cognitive than physical because it relies on the individual making a conscious effort to adapt their thinking to the changing environment. The final dimension, recuperability, focuses on the cognitive and physical dimensions a person uses to recover from adverse situations. The author notes that cognitive recuperability relates to the individual having positive thoughts about their situation. He further suggests that counsellors and psychotherapists within the field depend on the client's cognitions as a way of helping them to work through and recover from traumatic experiences, hence the use of cognitive behavioural therapy in treating trauma victims (Gaudiano, 2008).

Taormina argues that the adult personal resilience model has an advantage over previous theories in that it excludes external factors, such as social support. He notes that social support is an important aspect of resilience. It is, however, external to the person, which contradicts the concept of personal resilience. He proposes that another advantage of a personal resilience model is the issue of measurement. It has been noted that earlier measures only observed one dimension of resilience (Campbell-Sills & Stein, 2007), while

Taormina's new theory measures four domains. Although the author points out the advantage of excluding external factors, he also acknowledges that this is a limitation. Arguably, we cannot exclude the premise that as humans we are constantly interacting with our environment, which includes interactions with loved ones and friends. I would argue that it is important to consider internal and external resources that strengthen an individual's capacity to thrive when talking about personal resilience. In conclusion, Taormina's theory of adult personal resilience has implications for definitions of what constitutes resilience in future research and practice across various settings.

This concept of adult personal resilience has ingredients of the positive psychology movement, in that it takes into consideration the scientific study of human strength and virtues (Sheldon & King, 2001). Gable and Haidt (2005) argue that although the field of psychology focuses on what is wrong and has made significant advances in understanding pathology in terms of diagnosis and treatment of mental illness, there needs to be more work in the area of understanding of personal strengths that can withstand illness and negative life events. The authors highlight the aim of positive psychology to build on what we already know about human resilience, strength and growth.

The concept of positive psychology is particularly appealing to the ethos of counselling psychology since as counselling psychologists we also focus on the positives in psychology (Magyar-Moe & Lopez, 2008). In addition, a unique feature and a unifying theme of counselling psychology is the focus on a client's potential to strive, and their personal resources, regardless of their psychopathology (American Psychological Association, 1999). Similarly, the field of midwifery highlights a need for a 'salutogenic' approach to health instead of a focus on pathology (Magistretti, Downe, Lindstrøm, Berg, & Schwarz, 2016). Theorists that adopt this approach to health focus on factors that promote positive well-being and positive functioning and which individuals can understand, manage and find meaningful (Antonovsky, 1987).

1.5 Resilience and Traumatic Childbirth

Researchers have called for more qualitative research in the area of resilience to further our understanding of this phenomenon (Luthar et al., 2000; Rutter, 2006). Theorists argue that qualitative research would allow researchers to grapple with methodological issues such as being able to consider the context and subjective experience of resilience (Massey, Cameron, Ouellette & Fine, 1998). Ungar (2008) suggests that qualitative methods can provide a deeper understanding of resilience in various contexts and address the challenges encountered by quantitative resilience researchers in terms of providing thick descriptions. Most importantly, qualitative methods give voice to those in marginalised sectors, allowing for multiple truths to emerge through the co-construction of experiences.

Resilience has been explored in a number of challenging contexts, including criminal victimisation (Kilpatricrek, Saunders, Veronen, Best & Von, 1987), trafficking and prostitution (Farley, 2003), child abuse and incest (Briere & Elliott, 2003; Herman, 1981), terrorism and torture (Goldfield, Mollica, Pesavento & Farone, 1988; Turner, 2004), disaster (Barron, 2004; Norris et al., 2002) and health (DeSheilds, Heiland, Kracen & Dua, 2015; Wang, Zhou, Gao, Xu & Yang, 2018). Generally, these studies suggest that women who have experienced trauma are capable of developing resilience and that there are many pathways towards resilience.

The following studies give some insight into how women become resilient in a particular population. I decided to focus only on women because traumatic birth is specific to women and I believe these studies closely match the clinical sample in this study. For example, a qualitative study conducted by Liu and Mishna (2014) investigated resilience in the cultural context of Taiwanese female earthquake survivors. They found that the women used coping strategies influenced by female gender roles in the family, which included - putting their children as a first priority in their role as a mother, accepting the role of working within the home while the men were the providers, and taking over this role when the men were not able to provide. Additionally, a study conducted by López-Fuentes and Calvete (2015) explored the resilience process of women who experienced Intimate Partner Violence within a Spanish population. The findings revealed that the women used individual and external factors in building resilience. Individual factors included spirituality, altruism, rediscovering oneself, gaining control over one's life, creativity, focusing on the present, humour, introspection, optimism, and projects and goals. External factors included informal and formal social support.

While we can learn from the existing literature on resilience, it remains difficult to generalise to the unique area of traumatic childbirth. As there is little research that focuses on resilience in the perinatal population (Ayers, 2017), it remains difficult to know how to fully support women in this position. I want to address this gap by introducing resilience to a niche area because of the scale of the problem - 30% of women in the UK experience traumatic childbirth (Ayers, 2014).

To gain a deeper understanding, the focus of the next section will be on qualitative methodologies that allow for a fuller appreciation of positive outcomes and resilience following traumatic childbirth.

1.5.1 Positive adjustment and resilience after traumatic birth

1.5.2 Post-traumatic growth (PTG)

The area of traumatic birth has mainly focused on negative psychological outcomes and the development of PTSD. In addressing this gap a small number of researchers have

attempted to shift the focus away from negative outcomes to positive adjustment after a traumatic birth, and have presented research in the area of post-traumatic growth and resilience (McKenzie-McHarg et al., 2015). Research on positive outcomes has focused on personal growth where the individual experiences a positive change from a distressing and challenging event, and this can be conceptualised as 'post-traumatic growth' (PTG), 'thriving' and 'benefit-finding'. Tedeschi and Calhoun (1996) have put forward the post-traumatic growth inventory (PTGI), a scale that measures five dimensions of growth: Appreciation of Life, Relating to Others, Personal Strength, New Possibilities, and Spiritual Change. The area of post-traumatic growth gives us some insight into how women experience a positive change or thrive following a traumatic childbirth (Henderson & Redshaw, 2013).

Research in the area of perinatal post-traumatic growth (PTG) is sparse, and only three studies have examined it following birth trauma (Beck & Watson, 2016). Firstly, Black and Sandelowski (2010) interviewed 15 women who had been told pre-natally that they had severe foetal anomalies. They used a qualitative content analysis (Hsieh & Shannon, 2005), and Tedeschi and Calhoun's five dimensions of the post-traumatic growth inventory (PTGI) to code their data. Their findings revealed that over a period of time the most lasting change was on the dimension of Relating to Others.

The next two studies were conducted in the UK with participants who did not specify whether they viewed their childbirth as traumatic. The first of these was conducted by Sawyer and Ayers (2009) using an online questionnaire on a sample of 219 women who had given birth. The aim of the study was to explore possible links between growth, support and control during birth, coping after birth, and PTSD symptoms using the PTGI (Tedeschi & Calhoun, 1996), the Posttraumatic Diagnostic Scale (PDS; Foa, Cashman, Jaycox & Perry, 1997), the Coping Response Inventory (CRI; Moos, 1990), and the Support and Control during Birth questionnaire. The authors found in relation to PTGI that women scored highly on the Appreciation of Life domain (80%), followed by Personal Strength (63%), Relating to Others (52%), New Possibilities (48%) and Spiritual Change (16%). The third study, conducted by Sawyer, Ayers, Young, Bradley and Smith (2012), was a longitudinal study in the UK with 125 women who completed the PTGI (Calhoun & Tedeschi, 1998) during their third trimester of pregnancy and 8 weeks postpartum. In this study 23% of their participants perceived their childbirth as traumatic in line with the DSM-5 criterion for PTSD. The study found that 48% of women experienced a small degree of positive change that was linked to having an operative delivery, as they scored over 41% on the PTGI. Their results were similar to those of Sawyer and Ayers (2009) and showed Appreciation of Life to be rated highly (68%) followed by Personal Strength (52%), Relating to Others (51%), New Possibilities (45%), and lastly Spiritual Change (22%).

Beck and Watson (2016) suggest that further research is needed in the area of perinatal post-traumatic growth as the only two quantitative studies of PTG in mothers are the ones mentioned above, and the studies are limited by not specifically assessing PTG in mothers who viewed their childbirth as traumatic. The authors also suggest a need for more qualitative studies that do not use the PTGI dimensions to guide analysis. In an attempt to address this gap, Beck and Watson investigated women's experiences of PTG following a traumatic birth using a phenomenological methodology on a sample of 15 women in the UK. They found four themes of post-traumatic growth: 'opening oneself up to a new present', 'achieving a new level of relationship', 'fortifying spiritual-mindedness', and 'forging new paths'. The women in this study described PTG as a process. For example, one participant in the theme 'opening oneself up to a new present' described the process as being shattered into pieces and then a transition where she became more open to being transformed into this new person that she believed could survive any adversity. Participants also described PTG in the theme 'achieving a new level of relationship nakedness', in the context of forging deeper connections with partners and friends. The theme 'fortifying spiritual-mindedness' described how participants' faith became stronger and they were able to gain clarity on religious and spiritual matters in their daily lives A notable strength of this study was the descriptive phenomenological approach, which gave deep insight into the lived experience of traumatic birth.

To summarise, the above studies give some insight into how women positively adjust following childbirth. Furthermore, the PTG literature is heavily reliant on the PTGI to conceptualise positive change, and only one study in this area has directly assessed growth after a traumatic childbirth. Research on positive growth following childbirth is limited and the relationship between growth and resilience needs further exploration (Westphal & Bonanno, 2007) and resilience as a whole in relation to childbirth. Collicutt-McGrath and Linley (2006) argue that PTG involves increased psychological change, and should be viewed as a separate concept from coping and resilience, which focus on enduring stress or returning to prior ways of functioning. Ayers (2017) suggests that there is a need to understand resilience and PTG in the perinatal population, which could give more insight into the experiences of those women who do not develop postpartum PTSD. In addition, PTG does not give insight into the process of women becoming resilient after a traumatic childbirth. One might suggest that insight into these factors can help health professionals to identify ways to enable women to adapt and thrive as a means of increasing their resilience and reducing risk.

Although a number of theorists have attempted to further our understanding of positive adjustment in perinatal populations, there remains a critical gap in understanding

how women become resilient following a traumatic childbirth. The resilience literature related to childbirth will be explored in more detail below.

1.5.3 Resilience after traumatic birth

Mautner et al. (2013) used a quantitative study of 67 women in Austria who experienced mild, severe and superimposed pre-eclampsia, to explore the differences in resilience in terms of quality of life, depression and post-traumatic-stress symptoms. The authors investigated resilience as a protective personal resource in relation to psychological outcomes using four scales and questionnaires: Medical Outcome Study Short-Form (SF12), Edinburgh Postnatal Depression Scale (EPDS), Resilience Scale (RS13), and Impact of Event Scale (IES-R). Their results showed that highly resilient women had low symptoms of depression in comparison to the less resilient women. They concluded that resilience is a protective factor which shields women from experiencing psychological distress, such as depression, and aids in improving mental health. A notable strength of the study, and one noted by the authors, is that they were the first to assess resilience in relation to adverse pregnancy outcomes and to offer some insight into our knowledge of resilience as a protective factor after pre-eclampsia. Although the study mentions the support of the partner as a protective factor, a significant limitation of this study is that the methodology does not provide further insight into other protective factors, or the women's subjective experience of how or which resilient resources helped them to experience a better quality of life, reduce depression and minimise post-traumatic stress symptoms. As we have mentioned, resilience has been described as a process (Connor & Davidson, 2003; Bonanno, 2004; Ungar, 2008), and the use of a quantitative methodology and the Resilience Scale (RS13) limits our understanding of this process over time.

A Ugandan study undertaken by Kaye et al. (2014) used a qualitative phenomenological approach to examine how obstetric complications affect birthing mothers' understanding of their vulnerability and resilience in a sample of 36 women. They found that participants' ability to recover and become resilient from acute obstetric crises was dependent on their social capital, which included support they received from social networks such as friends and family who helped ease their financial burdens, gave emotional support and provided assistance with housework. They also found that factors that aided recovery were having a positive attitude, having the ability to regulate their emotions through lack of worry, and optimism. The authors also found social capital to be an essential resource with regard to women's resilience. However, they noted that social capital (neighbourhood, work connections, friends, family connections) and body capital (a resource connected to physical health, beauty and physical productivity) could serve as an asset or a liability, depending on whether their expectations of childbirth had been met. The

authors concluded that women's expectations prior to delivery can influence their perception of childbirth, their vulnerability and resilience. They also concluded that context is important with regard to whether these women become vulnerable or resilient.

This study gives us some insight into the factors that can influence whether and how women oscillate between vulnerability and resilience in terms of their body and social capital as a means of support after experiencing a traumatic birth. Although the study gives us some insight into the resources that aid resilience after an obstetric complication, it is limited to providing resilience from one particular adverse event (obstetric) and neglects insights into how the process of resilience evolves after various perceptions of a traumatic birth. Another limitation of the study is its definition of resilience as referring to 'quick recovery' from illness or hardship which is connected to cultural values, primary survival values and recovery assets for one's livelihood and its focus on body and social capital as contributors to resilience. The authors also suggested that resilience and vulnerability can be viewed as static and dynamic dimensions in which women respond to adverse events. Their definition of resilience does not take into consideration that resilience is a dynamic process which can evolve over time. A further limitation of this research is the sample of women whose economic resources are limited, and this may influence how these women define resilience which may not be transferable to more developed countries. Further research is needed on understanding the process of resilience in order to not only promote maternal well-being but also to give women hope and ideas of how they can move forward with their lives following a traumatic birth.

In summary, researchers have attempted to address the gap in the literature that heavily focuses on pathology and negative outcomes with a shift towards positive change and resilience. However, research in this area is limited, and quantitative measures continue to dominate existing literature. Further research is needed to understand the process of resilience after a traumatic childbirth.

What is left unknown is the process of women becoming resilient, and there is a clear need for research that gives us insight into the resources women rely upon to become resilient following a traumatic childbirth. This research study aims to contribute towards closing the gap.

1.6 Research Contribution to Counselling Psychology and Rationale for Research

A defining goal for conducting research in this area is to add new knowledge and theory to the discipline of counselling psychology. As counselling psychologists, our core value is to ease our clients' distress and encourage healthy functioning by researching and listening to their subjective experience in relation to the environments in which they are embedded

(Jones Nielsen & Nicholas, 2016). This study will bring a new understanding to counselling psychologists and mental health workers within the field with regard to the process of the journey to resilience following a traumatic birth. Fouad (2013) suggests that within counselling psychology there is a strong focus on well-being, prevention and individual differences. She also suggests that clinical research within the field promotes resilience, healthy development, career development and a strengths perspective in treatment. This means that the field of counselling psychology tends to focus on positive ways of coping rather than the deficit-oriented aspect of the problem. Fouad (2013) advocates that focusing on strengths, resilience and the cultural aspects of healthy functioning enables counselling psychologists to make a unique contribution to the field.

This study brings new theory and insight to counselling psychology in a number of ways. In terms of clinical practice, resilience has been viewed as a process that can occur over an individual's lifetime (Luthar & Zigler, 1991; Rutter, 1987). This research will help scientist-practitioners to be mindful that resilience is a lifelong process when working with this particular client group (Bogar & Hulse-Killacky, 2006), and by doing so will give clients hope and a belief that they can cope with and potentially recover from their trauma. It is hoped that the results of this study will serve as a guide for midwives and health professionals in their work with this group of women. The findings from this study also have important clinical implications.

In terms of the wider stakeholders, NHS England (2016) recognises that there is a substantial need to focus on perinatal mental illness, since it affects up to 20% of women, and has implications for these mothers' bond with their infants and loved ones. The NHS has recently invested in perinatal mental health within the community with a view to promoting and developing services within this area. The focus is to improve the quality of care for women and their families (NHS England, 2016). It is hoped that the results of this study will help guide interventions and inform policy whilst making a significant difference to perinatal mental health and to those who need access to these services (see Discussion section).

In summary, studies in the area of resilience and traumatic childbirth have mainly focused on resilience in terms of quality of life, depression and PTSD (Mautner et al., 2013), or on coping with maternal near-miss obstetric events in terms of social and body capital (Kaye et al., 2014). By developing an understanding of the processes of resilience following childbirth, psychologists and the medical profession will gain an understanding of how to encourage better psychological health and functioning pre- and post-labour. Beyond the clinical setting, if clients are aware that resilience is a dynamic personal process, this may encourage them to be open to, and actively embrace, different pathways to resilience (Crann & Barata, 2016).

Given that this area of research is an understudied phenomenon, the rationale for this study is to explore and explain what women believe has fostered their resilience after experiencing a traumatic birth. This knowledge will guide counselling psychologists in working with this group of women in terms of treatment and prevention. By extending research in this area we will gain further insight into the resources that birthing mothers use as a way of building and developing their resilience. This in turn will help provide hope for some women struggling with the aftermath of a traumatic childbirth (Beck & Watson, 2016) and contribute to informing clinical practice and policy.

Chapter 2: Methodology

2

2.1 Overview and Aim of the Research

In this chapter I outline a rationale for the chosen methodology, which uses the constructivist grounded theory approach outlined by Charmaz (2014). In addition, this chapter presents methodological considerations, the analytic process, the research design and ethical considerations. It concludes with reflections on the research process and my own personal reflexivity, which is also interwoven at points in my analysis in the form of a reflexive space (presented in *italics*).

2.2 Rationale for Using a Qualitative Approach

A qualitative rather than quantitative methodology was undertaken, as it was best suited to the research question. Adopting a qualitative approach afforded me the opportunity to explore, construct and interpret the lived experience of participants as described and embodied within the data (Ponterotto, 2002). This is in contrast to a quantitative research approach, where the focus is on quantifying experiences in terms of statistical analysis, observational statements and predictions (Ryan-Nicholl & Will, 2009). Ponterotto further suggests that an advantage of using a qualitative methodology is that the focus is on theory generation, in contrast to hypothesis testing and the quantifying of data.

Researchers have argued that qualitative methods fit with the research and practice ethos in counselling psychology (Morrow, 2007; Rafalin, 2010; Ponterotto, 2005). Rennie (1994) also suggests that qualitative research aids in closing the gap between research and practice, which is fundamental to the philosophy of counselling psychology. Accordingly, McLeod (2011) further suggests that qualitative researchers actively seek to understand how participants construct and make sense of their social world, which is congruent with the aim of therapy. Adopting a qualitative methodology gave me the opportunity to cultivate an empathic understanding of the participants' experiences whilst gaining a deeper understanding of their emotional and cognitive experience.

I was drawn to the potential of a qualitative study as it afforded me the opportunity to gain an in-depth understanding of participants' experiences of a traumatic birth, their struggles and how they coped. Utilising this paradigm allowed me to consider the complex, multifaceted-nature of human phenomena (Morrow, 2007) when a group of women each individually construct their experience of resilience after a traumatic birth.

2.3 Research Paradigm, Theoretical and Philosophical Influences

A research paradigm defines the researcher's philosophical assumptions about the social world, and in turn guides the choice of research design. The researcher selects the paradigm that most closely matches their beliefs and assumptions about the nature of reality (Mills, Bonner, & Francis, 2006), and then decides the relationship between researcher and participant in obtaining that knowledge (Hall, Griffiths, & McKenna, 2013). Guba and Lincoln (1994) have discussed the numerous paradigms in which grounded theory has evolved; the most frequently mentioned of the paradigms are positivism, post-positivism and constructivism.

The post-modern era has also influenced the direction in which grounded theory has developed as a research paradigm. Post-modern interpretations suggest that reality is there to be uncovered through individuals' social constructs of their reality (Hall et al., 2013).

Positivists assume that hypotheses can be created by deductive reasoning and a true objective, and that a rational reality is waiting to be discovered (Hall et al., 2013). Therefore, the positivist researcher's aim is to produce objective knowledge whilst remaining independent in order to avoid contaminating the results with their personal values (Charmaz, 2014). From this perspective, a positivist researcher would measure the validity of their research design and findings on the basis of producing facts that are impartial and objective, whilst separating their personal values from the research (Charmaz). Researchers employing a post-positivist philosophy adopt a critical-realist ontology where there is a belief that although reality exists, it is not fully apprehensible (Hall et al.). Hall et al. further suggest that positivist researchers cannot be truly objective in their discovery of knowledge. Nevertheless, knowledge of the world is there to be discovered, and that knowledge represents a separate reality to our minds.

Constructivists, on the other hand, reject the existence of an objective reality, and assume a relativist ontology which believes that many realties exist as constructions of the mind (Ghezeljeh & Emami, 2009). The relativist concepts of truth, reality and rationality should be understood "as relative to a specific conceptual scheme, theoretical framework, paradigm, form of life, society or culture… there is non-reducible plurality of such conceptual schemes" (Bernstein, 1983, p. 8). Relativist ontology suggests that because many multiple realities exist, the purpose of science is to comprehend the participants' subjective experiences of reality and multiple truths (Levers, 2013).

Epistemologically, constructivists highlight the subjective relationship between the interviewer and the interviewed in the construction of meaning (Pidgeon & Henwood, 1997). The chosen research ontology for this study is relativist, and the epistemological stance will be constructivist as it is in line with my personal views on the study of being and the nature of knowledge. Constructivism is based on the interaction of the researcher and the

researched in constructing reality through deep reflection. Only through this interaction can hidden meaning be discovered (Ponterotto, 2005). Kant (1966) argues that a central tenet of constructivist thinking is that we cannot separate an objective reality from the research participant who is processing, labelling and experiencing that reality (Sciarra, 1999). The philosophical underpinnings of constructivism suggest that participants construct their reality which is then interpreted by the researcher.

2.4 Rationale for Use of Grounded Theory

The ultimate aim of grounded theory is to construct theory where little is known about the researched phenomenon. In my interest to explore the time period of resilience after a traumatic birth, a constructivist grounded theory approach was utilised (Charmaz, 2014). The use of the Charmaz's (2014) version of grounded theory afforded me a number of unique features in terms of interpreting complex social phenomena whilst utilising a flexible and practical approach. Another compelling feature that drew me to this methodology was its emphasis on keeping the participants' voices at the forefront of the research (Charmaz, 2006). In addition, grounded theory allows the researcher to construct theory from a shared understanding between the researcher and the participant (Gardner, McCutcheon, & Fedoruk, 2012).

In line with the study aim, a grounded theory approach is particularly useful in aiding the researcher to identify issues of importance to women in their understanding of their recovery from a traumatic birth. The phenomenon of the process of recovery from childbirth, and which resilient factors influenced their recovery, has been scarcely researched. As a result, grounded theory allowed me to discover and develop theory regarding this under-researched phenomenon.

2.5 Origins of Grounded Theory

Grounded theory was originally developed by Glaser and Strauss (1967), and has its roots in sociology as a research methodology. Its aim is to generate new theory grounded in the data, but also positioned alongside existing theory (McGhee, Marland & Atkinson, 2007). Glaser and Strauss developed a research methodology based on a theoretical perspective of symbolic interactionism, which utilises an ontology that humans construct their realities through engaging with others, and that it is through this engagement that meaning is communicated (Fassinger, 2005). After the publication of 'The Discovery of Grounded Theory', a methodological split occurred between Glaser and Strauss in 1967 where differences in their ontological, epistemological and methodological viewpoints positioned their research in a range of different paradigms (Hall et al., 2013).

The split developed separate schools of thought, resulting in Glaserian Grounded Theory and Straussian Grounded Theory. Strauss went on to merge his theories with those of Juliet Corbin (Richards & Morse, 2007). Glaser continued the development of classic grounded theory which focused on methods, and his was considered a 'critical-realist' and 'modified-objectivist' approach (Annells, 1997). According to objectivists, theory emerges from the data and the researcher remains objective throughout the analytical process (Hall et al., 2013). However, Strauss and Corbin (1994) demonstrated a shift towards relativist and subjectivist positions, and rejected the objectivist view that theory is there to be discovered (Hall et al.). They proposed that reality is there to be interpreted and constructed by the researcher and suggested that analysis is based on interpretation (Hall et al.).

Constructivist grounded theory emerged as an alternative to classic (Glaser, 1978, 2011) and Straussian grounded theory (Strauss & Corbin, 1990, 1998). Charmaz (2003) suggests that her constructivist stance steers qualitative research towards the 21st century by providing an accessible method, whilst resting between postmodernism and positivism (Breckenridge, Jones, Elliott & Nicol, 2012). As constructivists, grounded theorists believe that data and analysis are socially constructed within their context of culture, place, time and situation (Ghezeljeh & Emami, 2009). The researcher will also aim to interpret and understand participants' meaning (Guba & Lincoln, 1994). The ongoing process between the researcher and the researched presents an interpretation of how individuals create their meaning and understanding of reality (Charmaz, 2000, 2006).

2.6 Methodological Considerations

A number of qualitative research methods were considered for the current research project, such as Discourse Analysis and Interpretative Phenomenological Analysis. I will briefly compare and contrast the differences in methodological fit.

2.7 Grounded Theory versus Interpretative Phenomenological Analysis

Historically, grounded theory originates from a sociological perspective, which aims to understand the meaning of interactions and others in social processes (Blumer, 1986; Jeon, 2004). In contrast, Interpretative Phenomenological Analysis (IPA) has historically originated from phenomenology and symbolic interactionism, which involves a substantial description and close examination of lived experiences with the aim of understanding how participants create meaning through their own perception (Sokolowski, 2000). Another difference between IPA and grounded theory is their theoretical underpinning, whereby IPA fundamentally describes the lived experience of phenomena, whilst the goal of the grounded theorist is to generate new theory (McGhee et al., 2007).

Furthermore, a personal preference for using constructivist grounded theory is the focus on the underlying social processes that may arise through the constant analysis of data, which may not be apparent at the beginning but emerge over time. Therefore, taking into consideration the need to understand what influences women's recovery and resilience after experiencing a traumatic birth and the need to develop theory where little is known about the researched phenomenon, grounded theory was considered the best methodological fit.

2.8 Grounded Theory versus Discourse Analysis

A distinct difference between grounded theory and discourse analysis is that the latter's goal is to understand how individuals use language to create and enact relationships, identities and activities (Starks & Trinidad, 2007). In contrast, the aim of grounded theory is to understand, interpret and create theory that is consistent with the intention of this research. Another key difference is in how research questions are developed and investigated (Starks & Trinidad). For example, discourse analysts aim to discover how identities, knowledge and meaning are agreed upon and constructed through the use of language, whereas grounded theorists look at the process and enquire about how social structures are negotiated through interactions with others (Starks & Trinidad), which is fundamental to the development of the research topic.

Constructivist grounded theorists also emphasise the importance of keeping the participants' words intact during the process of analysis. In contrast, discourse analysts aim to dissect participants' use of language and examine how they account for themselves and make sense of their social worlds. In view of the research question, constructivist grounded theory was seen as enabling the researcher to draw out the voices of participants and acknowledge the researcher as co-constructor of the developed theory in exploring participants' constructions of their multiple realities (Gardner et al., 2012).

2.9 Research Design

2.9.1 Sampling inclusion and exclusion criteria

Participants were selected on the basis that they were over 18 and classified themselves as having overcome the experience of a traumatic childbirth. Specifically, the inclusion criteria were defined as the participant's perception of a traumatic childbirth, and this included feeling uncared for by nurses or medical staff, experiencing unexpected medical intervention, feeling unbearable pain beyond their ability to cope, feeling unsafe and inhuman, and perceiving their life and the life of their infant as at risk of death, which could have led to psychological effects after the birth (Sawyer & Ayers, 2009).

Participants were excluded if they had given birth within the last year and viewed themselves as experiencing postnatal depression. To minimise risk, the researcher also excluded participants who viewed themselves as still in a recovery process and currently experiencing nightmares, flashbacks, hyperarousal, or still distressed about their childbirth experience.

In setting the inclusion criteria, some ethical implications arose via the City University ethics department, and were considered in relation to the exclusion criteria and participants' well-being. The first area of concern was whether there should be a cut-off point in relation to the time period in which a participant had experienced a traumatic childbirth. The ethics committee suggested that there should be a cut-off point of a year since the trauma was experienced. The issue concerning cut-off points is debateable and only one study in the UK has reported longitudinal results on the duration of post-traumatic stress symptoms following childbirth. This study was conducted by Ayers and Pickering (2001) who found that 2.8% of women at 6 weeks postpartum reported experiencing PTSD and 1.5% of women at 6 months postpartum, which indicated that symptoms improved over time.

The second area of concern was my procedure for responding to a participant who disclosed that she was in the recovery process and experiencing postnatal depression from her traumatic childbirth. It was decided that the research would come to an end and the researcher would provide a list of resources from which the participant could seek further help (Appendices F and G).

2.9.2 Recruitment strategy

All participants in the study were women who viewed themselves as resilient from their experience of a traumatic birth. Women were recruited using a snowballing technique where friends and work colleagues circulated the recruitment poster (Appendix A) and recruitment letter (Appendix B), whereby interested individuals could make contact with the researcher. The recruitment letter outlined the purpose of the study and the inclusion/exclusion criteria, and what taking part in the study involved. The second approach for recruiting participants was to place the same advertisement and recruitment letter on the website of the National Childbirth Trust, a voluntary organisation. Theoretical sampling was employed with participants from this organisation so as to capture gaps in the data, in order to answer questions and address under-developed ideas as theory emerged (Fassinger, 2005) during the interview process.

2.9.3 Procedure

Women interested in taking part in the research contacted me by phone or email. Potential participants who contacted me were then screened over the telephone to determine whether they met the exclusion criteria. If participants met the inclusion criteria, then a face-to-face meeting was arranged at a location convenient to the participant.

Participants were given the choice of having the interviews at City University premises or in their home. I ensured confidentiality by choosing a private space in all instances. As participants in the study were mothers who had constraints on their time due to childcare commitments, the majority of the interviews were conducted in participants' homes. In conducting a constructivist interview the researcher is encouraged to create an atmosphere of equal sharing of power by giving the participant the choice of time and location by which the interview will be held (Mills et al., 2006).

I began each meeting by giving the participant an information sheet (Appendix C) and consent form (Appendix D) to read, and participants were encouraged to discuss any issues or concerns they might have in taking part in this study. When concerns were raised I would reassure participants and make them aware of their freedom to withdraw from the research at any time and their right to not answer any of the questions. All participants chose to be interviewed and their interviews were recorded on a digital recorder.

At the end of each interview, participants were given a copy of their signed consent form and a debrief sheet (Appendices D and F), and a verbal debrief took place to ensure they were not distressed. Participants were given the opportunity to ask any further questions with regard to the research and to feed back their experience of the interview. As part of the debrief process participants were asked how the interview was for them and how they felt once it was complete. A resource list of potential support was given to all participants at the end of each interview as a guide should any distress arise (Appendices F and G). A financial reward of £10 in the form of an M & S voucher was offered to participants for taking part in the study. The researcher also offered participants the opportunity to receive the findings of the study on completion.

2.9.4 Participants

Eight participants were included in this study and their ages ranged from 30 to 50. The women were all UK residents who self-identified as having experienced a traumatic birth.

Pseudonym	Age	Ethnic Group	Employment Status	Traumatic Experience	Number of children	Relevant child's age
Deidre	42	White British	Employed	Still birth	1	8
Jenny	50	White British	Employed	Pancreatitis	1	15
Vivian	45	White British	Employed	Pre-eclampsia	1	8
Marva	45	White British	Housewife	Placenta-abruption	2	10
Lorna	35	Black British	Housewife	Haemorrhaging	4	6
Onika	44	Black British	Employed	Haemorrhaging	3	10
Laura	40	White British	Employed	Feeling violated	1	6
Rhianna	30	White British	Housewife	Lack of Care	2	7

Table 1: Demographics of participants

2.10 Interviews

2.10.1 Design of the interview

This study was designed to explore and offer potential explanations of what women believe helped them to be resilient after experiencing a traumatic childbirth. Therefore, semi-structured interviews were used in order to understand how these women constructed and interpreted their experience of a difficult birth (see Appendix E). In addition, semi-structured interviews afforded me the opportunity to learn about participants' worlds whilst constructing theory.

Intensive interviewing has been recommended by Charmaz (2014) as a good fit for grounded theory because "it facilitates conducting an open-ended, in-depth exploration of an area in which the interviewee has substantial experience" (p. 85). The traditional perspective on interviews has encouraged researchers to convey "sympathetic understanding" towards participants, to attentively listen to them (which in turn builds trust and rapport), and to show respect for their views, beliefs and perspectives (Berg, 2001; Dexter, 1956; Lavin & Maynard, 2001; Weiss, 1994).

In contrast to the traditional model of interviewing, constructivists have placed an emphasis on the reciprocal interchange between the interviewer and the interviewee (Denzin, 2001). Traditional models have positioned the role of the participant as a mechanistic source of information to be transmitted to the researcher. Constructivists, however, view the interview process as an experience that brings meaning to participants' stories through the collaborative interaction of the interviewer and the interviewee (Hiller & DiLuzio, 2004).

In considering the constructivist approach to interviewing it was hoped that the design of the interview would enable the researcher to gain access to participants' implicit meanings, whilst providing a defined understanding of their constructed reality.

2.10.2 Interview process

The majority of the interviews were conducted in participants' homes and lasted 60 to 90 minutes, unless the participant felt they needed to share more of their story. A digital voice recorder was used to record the interview, the debrief and any questions or concerns raised by participants. Notes were not taken during the session so as not to interrupt the flow of questions, and to preserve the empathic flow of entering my participant's world. After each interview I typed up my reflections so as to consciously reflect on the process of the interview, consider where I was in relation to the research and to openly acknowledge how my prior life-experience could impact upon the participants' viewpoints (Charmaz, 2000).

Time was allowed at the end of each interview to give participants the opportunity to ask any further questions with regard to the research, and to feed back their experience of the interview. In addition, participants were asked to share their overall feelings about the interview. Some participants told me that the interview helped them to process their thoughts and feelings about their journey towards resilience, whilst others expressed concerns about whether they provided sufficient information.

2.11 Ethical Considerations

The research gained ethical approval from the Psychology Department Standard Ethics Committee at City University (Appendices H and I). I aimed to comply with the Code of human research, Ethical Principles & Guidelines of the British Psychological Society (2009). The following ethical considerations were discussed:

- **Informed consent.** Participants were informed about the aims and objectives of the research study and were given details regarding procedures and purpose. I gave all participants a copy of their signed consent form. Participants were asked if they had any questions or concerns before proceeding with the interview.
- **Deception.** I made all participants aware that there was no intention to use deception within the procedure of the study. I discussed openly the aims of the study at the beginning of the interview.
- **Confidentiality.** Participants were made aware that the content of their interviews would be kept confidential from all but myself, and that participants' and family members' names would be anonymised in the final report. Participants were told that should I suspect them or anyone else of being in danger, then confidentiality might be breached, although this would be discussed with participants first. I kept all written and printed notes in a locked cupboard at my home address. I also kept all computer files, audio recordings, transcripts, addresses and phone numbers of participants password protected.

- **Right to withdraw.** Participants were made aware that they had the freedom to withdraw from participating in the study at any time, and they were reassured that they did not have to answer any questions they did not want to.
- **Risk to researcher.** The researcher informed a family member of her interview schedule and supplied them with the address and time of the interview. The researcher carried her mobile phone with her at all times and called the family members at the end of each interview. The family member was instructed to call the researcher at 90 minutes after the start of the interview if they had not heard from her.
- **Risk to participants.** The researcher monitored risk at all times during the interview process. None of the participants disclosed experiencing postnatal depression or any distress during the course of the interview.
- **Debriefing.** Time was allowed to debrief all participants at the end of the interview. Participants were asked as part of the debrief about their overall experience of the interview process. I made contact with participants three days after the interview to ensure that there had been no negative effects. Where there was a concern of negative impact, participants were advised to contact their GP and organisations with psychologists who specialised in traumatic birth (Appendix G). This entailed providing written advice of telephone helplines and email addresses of organisations geared towards women who had experienced a difficult birth. I also provided a list of therapists should the participant require further support.

2.12 Analytic Process

Charmaz (2014) proposes that grounded theory as a method provides the researcher with analytic control during data collection and more ideas for theory construction. Charmaz suggests that the researcher enters an analytic space where they become immersed in the data in reconstructing their participants' experience. This analytic space leads the researcher to new analytic questions where comparisons are made between the data and coding, with progression towards theoretical categories and theory development. In the following sections I will discuss the steps taken in the analytic process, which include the process of transcriptions, line-by-line coding, focused coding, memo writing, constant comparison and theoretical coding.

2.12.1 Transcription

All interviews were transcribed verbatim by the researcher at the end of each interview to allow for the development of codes and emerging categories. Transcribing individual interviews was time-consuming, however, it allowed the researcher to gain intimate

familiarity with participants' experience of the researched phenomena. Once the transcript was completed, the typed transcript was re-read and checked for errors.

2.12.2 Line-by-line coding

The first phase of data collection was line-by-line coding, where analytical questions opened the analysis. Charmaz (2014, p. 116), suggests that researchers should consider the following: "(1) what do the data suggest? (2) From whose point of view? (3) What theoretical category does this specific datum indicate". This gave me more directions to consider and led to emergent links within the data (Charmaz, 2014). There were some advantages to using line-by-line coding in the initial process. For example, I was able to dissect participants' experiences and analyse their understanding of their experience as it occurred. Line-by-line coding also allowed me to identify participants' implicit and explicit statements which directed the focus of later interviews (Charmaz). Line-by-line coding enabled me to gain distance from my own and my participants' preconceptions about their experience so that my findings could produce new insights (Charmaz). This was of particular importance to me since I had experienced the studied phenomenon. An example of line-by-line coding can be seen in Figure 1 and is further expanded upon in Appendix J.

TRANSCRIPT	**LINE-BY-LINE CODING**
P:526 … and I'd say to someone, "*Had a really bad birth*." "*But you're alright now*!" [Laughs]. You know, they… they don't want to know what happened! I:527 Yes. P:527 And you're thinking, "*It could happen to you*." I:528 Mm hmm. P:528 You know, if you don't… I:529 Mm hmm. P:529 … if you don't share that experience, how would you know, you know?	P.526 Wanting to share experience of bad birth. P.526 Being told she is alright. P.526 Not being listened to by others. P.527 Thinking it could happen to them. P.529 Questioning how others will know.

Figure 1: Line-by-line coding of Onika's interview

2.12.3 Focused coding

The second phase of coding was focused coding, which develops the path towards theory. As defined by Charmaz (2014), focused coding uses the codes to "sift, sort, synthesize, and analyse large amounts of data" (p. 138). In developing focus codes, I made a decision about which line-by-line codes were analytically significant in order to form categories and subcategories in the data (Charmaz) whilst simultaneously referring to my memos. This steered the analysis into a comparative process where I compared codes with other codes and the data, which enhanced the direction in which the theory was built. After each interview I would start the process of identifying focus codes. I also reviewed previous

transcripts and made comparisons. Once the process of analysing all interviews was completed, all focus codes were then logged onto a table and grouped into subcategories and categories. The analytic process for developing categories and subcategories can be seen in Appendices J, K, L, M & N. Throughout the analysis, memos were used to capture thoughts and help guide the research direction. Memo writing provided me with the opportunity to develop new ideas whilst engaging in critical reflexivity (Charmaz).

2.12.4 Memo writing

Memos constitute a major phase of the entire analytic journey (Charmaz, 2014). In the early phase, writing focuses on codes and data, which evolves towards the creation of theoretical categories throughout the research process. Memos play many roles, although their main purpose is to construct theoretical categories. According to Charmaz, memo writing serves a variety of purposes: "it prompts you to analyse your data and codes early in the research process … keeps you involved in the research process … memos catch your thoughts, capture the comparisons and connections you make, and crystallize questions and directions for you to pursue" (p. 162). Figure 2 (below) shows an example of a memo.

P.526 SHARING EXPERIENCES vs NOT SHARING EXPERIENCES.
- This participant gives reasons for not sharing her traumatic birth.
- Perhaps she felt others did not want to hear about her traumatic birth.
- It seems she felt closed down from talking???
- I think she now wants others to be aware that difficult childbirth can occur.
- She explains there is an impact on others for not sharing their experience.
- Maybe less traumatising if women were aware that trauma can occur.

Figure 2: Example of a memo

Memo writing allowed me to critically reflect upon and dissect participants' codes and data whilst considering links between codes and categories. In addition, this analytic method helped me to analyse codes and construct categories, which gave me new a understanding of and insight into the studied phenomenon (Charmaz, 2014). It also provided a reflexive tool for me to gain clarity about the data (Ghezeljeh & Emami, 2009). I found this process useful in defining and developing the core category and it helped me to select my categories and subcategories whilst determining how they were related (Charmaz). Memo writing helped guide the shape and formation of my analysis, as seen in Figure 2. Memos were used during the analysis and my personal reflections, which helped me to make discoveries about the data and about myself during the process.

2.12.5 Constant comparison and theoretical coding

Grounded theory uses a constant comparative process where the researcher refers to what has been previously said in earlier transcripts. This process is done by moving back and forth between the data looking for similarities and differences between emerging categories (Willig, 2008).

The approach to the analysis was to consecutively interview participants and code interviews with regard to the development of emerging theory. For example, midway through the study the theoretical category 'Moving towards Faith and Spirituality' was developed from the focus codes of *'religion'* and *'spirituality'*. These often appeared linked to ideas of faith as helping participants to endure their trauma during labour, or to help them move forward with their life. The focus code of 'religion' additionally incorporated interim codes of thanking God, being given answers, and the external higher power as helper, which pointed to the importance of faith and spirituality in helping participants to be resilient after their trauma (Appendix O).

In addition, following coding of the first six interviews and category development, it became apparent that more in-depth questioning was required into specific aspects concerning participants' perception of trauma ('To be cared for – who's accountable?'). Therefore, a question was added about whether participants had any private thoughts or feelings about their traumatic birth. This question was addressed to only two participants (See Appendix E), due to time constraints.

2.12.6 Theoretical saturation

Saturation for a grounded theorist is the point at which data replicates itself, and no new theoretical insights emerge from the core theoretical categories (Charmaz, 2014). The meaning of saturation has been the subject of much contention amongst authors in the field. Weiner (2007) suggests that saturation is a judgement based on the researcher's resources, timescale and finances. In contrast, Morse (1995) argues that researchers assert saturation without providing recognisable characteristics. For the purposes of this study, saturation will be defined as 'theoretical sufficiency' (Dey, 1999), in the context of the limited timescale and resources available to complete this study.

It has been acknowledged that "theoretical saturation functions as a goal rather than a reality" (Willig, 2008 p. 37) because the research goal, category generation and time constraints may change the direction of the studied phenomenon. Mason (2010) has suggested that the researcher should consider the research aim and quality of data when considering sample size and saturation. In support of this claim, Charmaz (2006) has further suggested that a "small study with modest claims might allow proclaiming saturation early"

(p. 214). I will consider whether full saturation was achieved in the present study in the discussion section.

2.13 Preconceptions and Recognising Bias

Classic grounded theorists have disagreed strongly as to the necessity of the initial review of literature before the researcher codes and categories their data (Glaser, 1992). Strauss and Corbin (1990) have asserted that an early review of the literature has some importance for various reasons: it helps with the construction of research questions; it provides a secondary source of data; it provides theoretical sensitivity to the researcher; and it may guide theoretical sampling. In support of Glaser (1992), Hickey (1997) argues that researchers' review of the literature poses a risk in the researcher developing assumptions about the particular phenomenon which may hinder the grounding of the emerging theory in the data.

Most researchers entering the field are in the position of needing a credible research area to present to the ethics committee (Strauss & Corbin, 1998). In a study undertaken by Marland and Cash (2005), the authors advised conducting an initial literature review as this can provide the researcher with a theory free of methodological problems, whilst aiding in closing the perceived gap in existing knowledge and creating a unique addition.

Within the constructivist framework, Charmaz (2014) asserts that "we must also guard against forcing preconceptions on the data we code during every phase of coding" (p. 155). In addition, researchers are advised to engage in reflexivity throughout the research process, so as to keep awareness of the potential impact prior preconceptions can have. In other words, my experience and personal view of the importance of resilience and prior review of the literature inevitably had an impact on the research study. From a personal perspective, and as a constructivist grounded theorist, I was aware that I needed to consistently draw out participants' voices throughout the analytic process as I co-constructed the meaning that signified their experience, and it was essential that I kept in mind the potential influence my history might have had upon the process of analysis by keeping a reflective memo (Mills et al., 2006).

2.14 Rigour and Trustworthiness

The criteria for rigour and trustworthiness can vary across research designs and encompass multiple standards. Lincoln and Guba's (1985) criteria proposed a model of trustworthiness as consisting of credibility, transferability, dependability and confirmability. Credibility allows participants to recognise the experiences contained within the research as their own experience. Transferability is the ability to transfer findings of a particular phenomenon to other participants in other contexts. Dependability enhances the trustworthiness of the

research project when the researcher is able to provide an audit trail that another researcher can follow by describing, for example, the aim of the study, discussing the inclusion and exclusion criteria of participant selection, describing how data was collected, how data was analysed and so on. Confirmability/neutrality is established when transferability, credibility and dependability exist (Thomas & Magilvy, 2011).

Morrow (2005) states that qualitative researchers should ground their research solidly in the paradigm that is suited to their research question, as well as consider the criteria of trustworthiness. Morrow also recommends that qualitative researchers assess the quality of their work by including subjectivity, reflexivity, adequacy of the data, and adequacy of interpretation. Adequacy of data is not solely based on the number of interviewed participants that will ensure its quality, but on the rigor of the analysis. In meeting this criteria, the representativeness of the final categories across all participants can be seen in Table 2 (see Appendix P). Erickson (1986) suggested that researchers consider five types of evidence of adequacy, such as the researcher providing a sufficient amount of evidence, by showing a variety in kinds of evidence, providing sufficient disconfirming evidence, by providing faulty interpretive status of evidence and ample amount of discrepant case analysis. In order to meet the criteria of adequacy of data for the present study, I used a snowball recruitment technique and theoretical sampling procedures which should have helped to identify good participants for the studied phenomenon. Also, I considered that a possible weakness of the study might be the lack of variety of sources of data gathering. The criteria of rigour will be reviewed further in the discussion section.

2.15 Ensuring Standards of Rigour in Constructivist Grounded Theory Research

Charmaz (2014) asserts that grounded theory researchers should consider the following standards of rigour when evaluating constructivist grounded theory research: credibility, originality, resonance and usefulness. Credibility requires the researcher to have engaged closely with the topic by providing sufficient data for the reader to agree with the findings of the study. In considering originality and usefulness, this study will provide fresh insights into the process of resilience following a traumatic birth. Previous research has explored traumatic births using quantitative measures, and one aspect of trauma (pre-eclampsia or obstetric complications) in relation to resilience.

There is a gap in the literature where more qualitative research is needed on various type of trauma and the process of resilience. The findings from this study would extend current ideas in helping women to understand the resources they rely upon to become resilient. In fulfilling the criterion of resonance, I sent the results to at least two participants to gain feedback on their interpretation of the analysis. In addition, this study will be useful

and resonate with other women as well as all health professionals who work within the public sector. I provide further reflections on whether the criteria of credibility, originality, resonance and usefulness were achieved throughout the research process in the discussion section.

2.16 Personal Reflexivity

2.16.1 Reflections on the research process

I acknowledge that the very selection of the research topic is based upon my own experience of a traumatic childbirth, and that this contains a host of values, beliefs and judgements. To minimise the potential impact of my beliefs on the research process, I wrote memos and used reflexivity within my analysis as tools to help me remain reflexive and self-aware. During these times it was helpful to position myself as an 'outsider' on the research topic, which helped me to remain as neutral as possible. As suggested by Robson (2002), reflexivity is "an awareness of the way in which the researcher as an individual with a particular social identity and background has an impact on the research process" (p. 22).

During the process of the interviews and transcriptions I paid particular attention to any of my own preconceptions that might have affected my ability to be open and flexible in understanding each participant's construction of their experience. Although I was in a privileged position to hear participants' stories, I was also involved in a mutual relationship where I co-created a shared reality of the researched phenomenon.

I was aware that participants' stories resonated with me and shared some aspects of my own story. There were points where I chose to self-disclose, which prompted two participants to be more open and at ease in discussing a delicate experience. Traditionally, researchers were expected to be a silent witness in the interview process (Holstein & Gubrium, 1995). My decision to share varied from participant to participant, bearing in mind the difficulty in pre-empting the natural flow of the interview process. However, my decision to self-disclose when I did was in the interest of helping the participant to be more forthcoming during the interview. Eder and Fingerson (2003) suggest that interviewer self-disclosure can be an empowering experience for the participant, where the researcher is positioned as an 'insider' with similar experiences (Merton, 1972).

The impact of this research upon me has been informative in terms of my own experience and my role as a counselling psychologist. This area of research has brought new insights and development, not only to other researchers, but also to me and my understanding of other women's experiences of traumatic births and resilience.

2.16.2 Reflections on the data analysis

During the research process I initially struggled to separate my own experience from that of my participants. The use of constant reflection and meetings with my supervisor helped me to recognise when my own experiences and feelings were influencing the data analysis. In addition, it was useful to discuss boundaries, my role during the interview and the importance of remaining objective.

Another difficulty I encountered was choosing categories and subcategories. I was aware that some parts of the interview transcript resonated with me more than others because I could identify with some of the participants' experiences. Therefore, I continuously reviewed my transcripts, line-by-line coding, focus codes and memos to ensure that my categories were grounded in the data. I continued to gain distance from my participants' preconceptions and experiences by recording/noting my personal feelings in my memo/journal. The next section presents the findings of the study.

Chapter 3: Analysis

3

3.1 Overview

In this chapter I will present the emergent theory based on eight interviews with women who experienced a journey towards resilience after a traumatic childbirth. I will then discuss and explain the five main categories that emerged from the analysis. All quotations were taken from participants' interviews, which are presented in italics along with participants' pseudonyms and the line number (e.g., Jenny 25-28). Three dots (...) have been used to indicate pauses in speech or where data has been omitted.

The Charmaz (2014) version of grounded theory was used to allow the researcher to interpret complex social phenomena whilst keeping the participants' experiences and voices at the forefront of the research. The analysis presents the ongoing process between the researcher and the researched with regard to how participants interpret and create meaning from their understanding of their reality (Charmaz, 2000, 2006). Through this approach, an emergent theory was developed which uncovered the process of fostering resilience amongst women following traumatic birth.

My initial question explored women's experience of traumatic birth and resilience, with a particular interest in exploring the process of resilience. During the final stages of the analysis it became apparent that women would rely upon a range of resources to build resilience at various points during their journey. A core connecting category of *'The Journey towards Resilience following a Traumatic Birth'* was described and linked to the five central categories: Category 1: Traumatic birth: To be cared for – who's accountable?; Category 2: Moving towards faith and spirituality; Category 3: Motherhood becomes you; Category 4: Supportive relationships; Category 5: Self-care – as a way of owning my journey.

3.2 The Proposed Model of the Journey towards Resilience following a Traumatic Birth

Findings suggest that following a traumatic birth, women embark on a journey towards resilience. This process is outlined in Figure 3. All the participants in this study described their trauma as stemming from unexpected complications or lack of care from health professionals which left some of them feeling they had no control, had lost their voice, felt powerless or not worthy of care.

The constructs within the model (see Figure 3 below) highlight the process of the journey towards resilience following a traumatic childbirth. The model also suggests that to understand the process of how women become resilient one should consider the external

and internal resources that help them to feel empowered, experience self-growth, gain clarity about their trauma and regain their identities as women, as well as how they adjust, thrive and find ways to move forward with their lives. The model suggests that women move towards internal and external resources with regard to themselves or others at different points during their journey, depending on their needs. The drawing upon internal and external resources in the model do not occur in a specific order. The participants also described the various resources they relied upon to help them feel protected, comforted, regain their confidence and rebuild their identities and gain support. A notable finding in the analysis was that all participants advised that self-care was an important ingredient for women in owning their journey towards resilience after a traumatic birth.

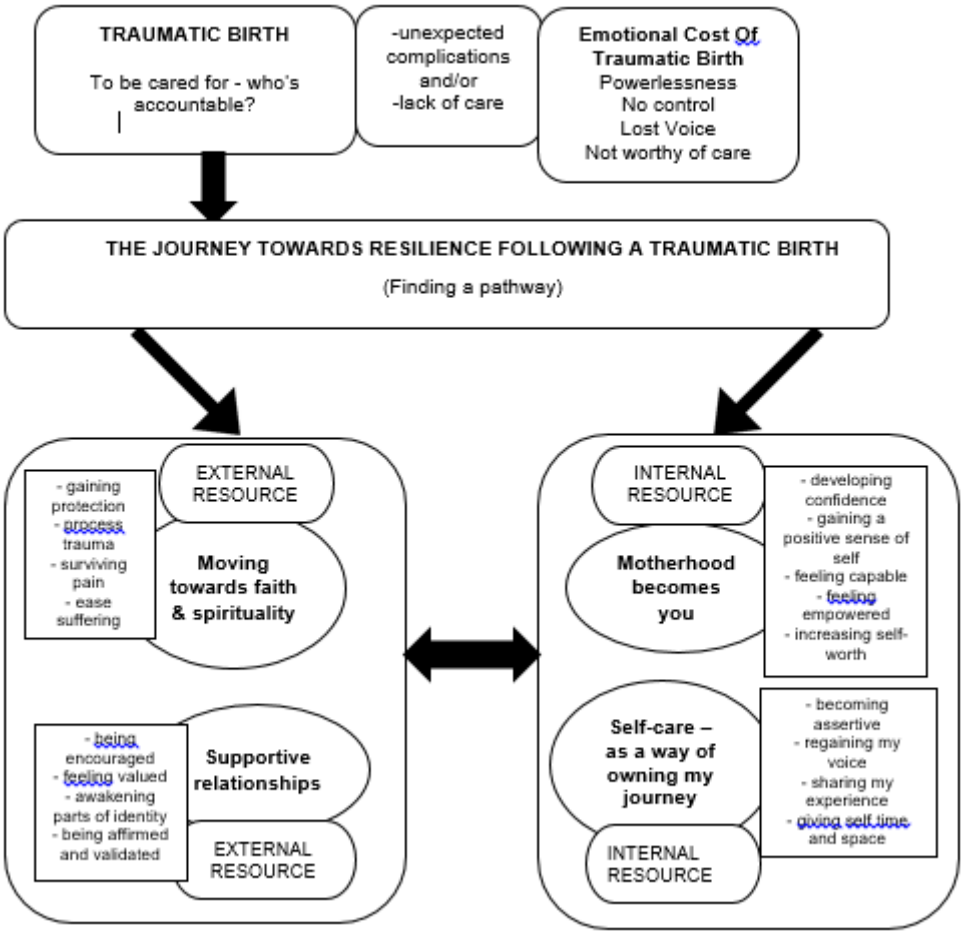


Figure 3. A model of the process of resilience following a traumatic birth

3.3 Core Category: The Journey towards Resilience following a Traumatic Birth

3.3.1 Presentation of the five main categories

- **Category 1: Traumatic birth: To be cared for – who's accountable?**

  The findings suggest that participants' socially constructed expectations of how childbirth should be experienced, and the care they should receive during labour, had a significant effect on their experience of childbirth as traumatic. The

majority described their trauma as rooted in the unexpected complications that occurred, or in relation to the lack of care they received from health professionals. During childbirth, most participants described their distress as due to needing and wanting more care and attention when complications occurred. They wanted to be consulted about procedures being conducted on them or their babies. Perceived lack of care led to them feeling powerless, hopeless, helpless, unheard, lacking control, and at points as if they had lost their voice as they questioned whether they were worthy of care. Participants went on to describe their journey towards resilience after experiencing traumatic childbirth. The following categories present the internal and external resources participants used to move towards building and developing resilience, as outlined in Figure 3.

- **Category 2: Moving towards faith and spirituality (external resource)**
  Faith and spirituality was placed in the model as an external resource, although arguably it has some elements of an internal resource. During points on the journey, moving towards faith helped some participants to regain a sense of control, process their loss and gain a new understanding of their trauma, whilst feeling comforted and strengthened. According to participant responses, meditative practices helped some women to detach from their pain, ease their suffering and reconnect to parts of themselves that may have been lost as a result of the trauma. Participant responses suggested that connecting to a higher spiritual power provided some of them with a supportive friend, confidante and healer and this helped them to feel protected at times.

- **Category 3: Motherhood becomes you (internal resource)**
  At another point on the journey, participants described their roles as mothers as a resource that helped them to regain their confidence and feel more capable, not only as mothers but also within themselves. Participants described a feeling of empowerment as they regained a belief in themselves as carrying a mindset of perseverance and determination. The findings suggest that as women positioned themselves as role models, they encouraged their children to adopt the values and beliefs needed to overcome adversity.

- **Category 4: Supportive relationships (external resource)**
  'Supportive relationships' presents findings that illustrate how other sources of support were found in family, friends, social media and support groups. The

findings highlight how supportive bonds with others can help women to feel cared for, encouraged and valued. Supportive relationships helped women to regain their identities and sense of self, and awaken parts of their identity that helped them to adjust after the trauma. According to participant responses, belonging to support groups provided women with a sense of unity and protection within a community that they felt understood their challenges.

- **Category 5: Self-care – as a way of owning my journey (internal resource)**
  In this final category, all participants suggested that women could demonstrate resilience by practising self-care as a way of owning their journey. Participants described a need for women to practise self-care by becoming assertive, talking about their struggles and looking after themselves. Participants' responses suggested that by adopting this position in life they could transition from powerless individuals to becoming assertive women who voiced their opinions. Participants noticed a transformation in their identities, and acknowledged a more developed and trusting sense of self. Demonstrating resilience was described by participants as recognising their need to take time for themselves as a way of 'self-preservation'. They also described a need to pamper themselves as a way of confirming that they were valuable and deserving. The findings suggest that demonstrating resilience would require women to practice self-care by knowing themselves enough to recognise when they needed to access or rely upon various resources to aid their recovery.

As mentioned above, the findings suggest that participants were traumatised through unexpected complications and/or the lack of care from health professionals. The process of resilience after a traumatic birth shows women moving towards external or internal resources as a way of building resilience. This process is discussed further in the next sections using extracts from and reflections upon the interviews to illustrate the development of the model.

3.4 Category 1: Traumatic Birth: To Be Cared For – Who's Accountable?

It was important to first gain insight into and understanding of which aspects of childbirth participants perceived as traumatic, and the severe impact this had on them. At the beginning of the interview, participants were asked to share their feelings and thoughts of when they had noticed that their labour had started to become difficult. Women constructed their birth experience as traumatic due to the various struggles they had to endure. The following subcategories: 1) 'Am I worthy of care – feeling neglected?'; 2) 'Who's

accountable?'; and 3) 'Do you have my consent – please give me a choice?' give insight into the way women perceived and interpreted their birth as traumatic.

3.4.1 Am I worthy of care … feeling neglected?

This experience highlights participants' perception of health professionals as being inattentive and unconcerned about their needs. Six participants described feeling unworthy of care by health professionals during and after labour, which they believed made their childbirth traumatic. Participants described health professionals as not reading critical warnings in their notes during labour, not being supportive and not listening to their concerns or their distress. This made them feel vulnerable. For example, Jenny explained that she was not seen by a doctor for two days, even though she had been violently sick. When she was finally checked by a doctor, she was diagnosed with acute pancreatitis, which is a rare and life-threatening condition:

> *Although I was in excruciating pain ... they didn't even bother to read my notes that the doctor had made me carry around They still sent me home again ... They still hadn't picked up that the womb wasn't reacting as it should do, and the doctor had written on my notes that if it went on for more than four hours ... that I was going to have a Caesarean ... (Jenny: 25-27)*

Similarly, Laura experienced her health professional as not referring to her notes when making decisions about her labour. Laura observed midwives not noting critical aspects of her labour, and assumed there was a culture that medical notes were not prioritised:

> *I think it's just the culture … culture of the … of the unit ... She [the midwife] actually said, "There's no point in me writing this, like, you know, no one will take any notice anyway," ... (Laura: 86).*

Lack of attention to their medical notes left participants feeling vulnerable and fearful about how their labour was progressing.

Another aspect contributing to the experience of trauma was women sensing something was wrong during labour. They had a strong intuition that their labour was not progressing as it should – and their concerns were valid. For example, Onika felt this a number of times:

> *Why am I still, you know … not not giving birth, and I thought, you know, something's wrong. (Onika: 16-17)*

Onika went on to explain that after she gave birth, she again sensed that something was wrong when she noticed she kept losing blood:

> *And I just thought to myself, "Something's not right" … I was bleeding and they looked alarmed ... I realised that something had really gone wrong*

> *was when they started saying, "Oh no, we've got to get her into theatre," … (Onika: 62-64)*

Women described trusting their 'inner voice' in knowing something was not normal or something was wrong. However, they were not able to voice their concerns.

> *I remember there being a point where I felt there was something not quite right and that I've … remember thinking, "I'm sure this is going to end in a C-Section. I'm sure this baby is stuck." … But I remember suddenly being hit by a very subjective feeling of, "This isn't … this isn't right," but I couldn't get anybody to take it seriously ... (Laura: 4-5)*

Another aspect of feeling unworthy of care was experiencing health professionals as not listening to their concerns. Below, Rhianna describes noticing and voicing her concerns about excrement from her body that seemed abnormal, and experiencing pain in her chest:

> *Erm so I hobbled over to the toilet and erm … I … my faecal matter was full of blood and I … I … I ... said to them "there's loads of blood in my stools. I'm really worried". Erm, and they said to me: [speaking louder] – "it's normal, get back into bed". (Rhianna: 14)*

Laura described experiencing herself as "screaming from within" because her frustrations were not acknowledged by medical staff. She recalled having numerous conversations with midwives where her request for her birthing plan were dismissed, which in turn made her feel her concerns for her labour would also be dismissed. Who could she trust?

> *I also felt a bit like I was screaming in a … in a void because I felt … I felt a bit like that we'd had a number of conversations ... The first time anyone had looked at the birth plan [laughs] only to go ... "you can't have that!" [Laughs] … So I felt like I was not um that I didn't suppose that would be heard either… (Laura: 14-15)*

Participants described a dynamic of openly voicing their concerns or "screaming" within themselves. Neither action appeared to be listened to. They desperately wanted staff to acknowledge their fears and discuss their concerns. This made them question whether they were in fact worthy of care. The most challenging experiences of not being listened to occurred during the birth process. However, such experiences also occurred during post-labour care too. For example, Lorna explained how her carers did not check her bleeding had stopped from her earlier complications where she haemorrhaged:

> *They did not check to make sure that I wasn't bleeding anymore, um but so luckily I wasn't. (Lorna: 260)*

Deidre also experienced her midwife as cold, "hardened" and inattentive, despite her delivering a still-born baby:

> *Without being needy ... I'm there on my own, because they're busy helping with the children that are living. … I didn't feel like ... they were very caring, and I think in their role they become very hardened … (Deidre: 432-433)*

Rhianna also experienced midwives as uncaring and inattentive to her distress during labour:

> *But no one was taking care. No one's … no one noticed. I'm … I'm vomiting, like re … erm, violently vomiting. No one comes to clean it up so I'm lying in vomit. (Rhianna: 18)*

Participants described a need to feel safe, to be checked on, and a need for more attention during their traumatic labour. These women desperately wanted the health professionals to provide care that was containing and warm, to convey that they were worthy of care during a vulnerable period of their life.

Difficulties with care were also experienced as a lack of communication from health professionals. A common experience amongst most participants was a feeling of "not knowing" or "not understanding" what was happening to them and their baby during labour. Deidre and Onika described their bewilderment at not knowing what was going on:

> *Not as informed as I should have been. But I felt under-informed, I really did. So I would have liked them to be more there with me more … (Deidre: 436)*

> *I was lying there by myself for about half an hour, and then someone came back, wheeled me into theatre and then they did the operation ... No one was explaining what was happening. (Onika: 68-69)*

The lack of communication during labour left them feeling vulnerable, insignificant and unworthy. This left them angry and frustrated.

In contrast, those who received care that was "supportive" were helped to not only feel held and contained, but also that they could recover from their traumatic birth. For example, praise was heard from Vivian and Marva, who both had premature babies, as they described the health professionals within the Special Care Baby Unit (SCBU) as "trusting", "supportive" and "good". Marva shared how having this support helped her get through:

> *And certainly the nurses in neonatal were … very, very supportive. Which actually got me through ... (Marva: 287-290)*

> *But I did trust the nurses, and I felt very supportive ... They were very good … And all the doctors were ... (Vivian: 18-20)*

Those who had care from the SCBU felt valued, which helped them to get through their difficult childbirth. Building friendships with health professionals, and the value of having supportive relationships during and after their labour, will be expanded upon in the following sections (see Section 3.7 Supportive Relationships).

3.4.2 Who's accountable?

Along with not feeling listened to, the questions remained – what was the impact of not being attended to? And who is responsible when things go wrong? Rhianna shared the consequences of her being left unattended by the midwives, where she delivered her son on her own, who was later identified as brain damaged:

> *I know something's wrong. And basically erm, they all leave the room. I'm still screaming ... She looks and she goes oh my God the baby's on the bed. I'd delivered by myself ... We were told he wasn't gonna last the week … (Rhianna: 24-25)*

Rhianna explains that her distress could have been avoided had the midwives been more attentive to her during the course of labour. Rhianna shares her thoughts:

> *Much more medical than I needed to go through … a laxative at the right time probably … an enema in the right moment … probably would have saved my son which is a basic, basic, basic, thing. If somebody had spoken to me. If ... someone had sat next to me and said Rhianna … why are you in pain? Where is it hurting? … Talked to me ... (Rhianna: 29-32)*

Rhianna recognises that she is untrusting of hospitals since the birth of her son and describes herself as feeling unworthy to be listened to:

> *The scars I got left w…with is that err, a big mistrust of…of…of…of hospitals. And the other thing is that erm, for a long ... I walked around feeling like I'm not worthy to be listened to … (Rhianna: 36)*

Rhianna went on to describe how her son being born brain damaged is now something she has to live with for the rest of her life:

> *And … and they can all walk away. And we couldn't walk away from it. We're living with it. (Rhianna: 64)*

Accounts suggests that the impact of a lack of communication and care can place women in a position of powerlessness as they question whether the complications they experienced could have been avoided. Onika also questioned who was accountable when she needed a blood transfusion following haemorrhage after giving birth. Onika explained how close she was to losing her life after she was left with a student nurse:

> *I was haemorrhaging, completely. So I'd lost about … quite a bit of blood … because they had to actually give me four units of blood ... (Onika: 77-78)*

> *You know, they could have been more careful, they could have checked, they could have not left me with a student nurse who didn't know what to do … Someone should have been there to take me in hand and say. "You know what? You're losing too much blood", and I should have been seen before I lost that amount of blood. (Onika: 90-91)*

Her use of the words “should” and “could” brings into focus her expectation of health professionals, her belief that it could have been avoided, and her expectation of health professionals to know their job. She shares a feeling of sadness, anger and blame that the health system has somehow let her down by not providing the care she hoped for or she felt she deserved. Participants described a need for health professionals to be more “careful” and to give more attention by “checking” up on them as a way of noticing their needs and lessening their distress. The use of the phrase “take me in hand” suggests that Rhianna wanted to be held – she wanted more care and needed support.

Unlike Onika and Rhianna, who directly attributed their trauma to the lack of care received from the health professionals, Lorna may have viewed the decisions made by the health professionals as causing her to haemorrhage. Lorna questioned and criticised the health professionals’ decisions to speed up her labour with a deep sweep to kick-start her labour whilst giving her two sleeping pills. As Lorna relayed her story, her anger was evident:

> *But you give me a deep … a very deep sweep, two sleeping pills, send my mum and my husband home and you didn’t expect any action until the morning! Come on now! I’m not even a nurse. And I… I know now that it’s just silly. (Lorna: 369-371)*

When asked what would have been different if those actions were not taken, she explains:

> *My body’s like, “Listen, I want you to give birth!” ... I am tired. Naturally you’re tired but now she’s given me this extra medication to go into my system to shut it down because that’s what sleeping pills are to do! To make you sleep! (Lorna: 425-426)*

These women described the loneliness and vulnerability they felt when they were not communicated with when complications occurred. There was a strong sense that their trauma could have been avoided had the health professionals involved them in their decisions about their labour. Their accounts suggest that it is difficult for participants to hold in mind that complications can occur in childbirth, but when they do they expect health professionals to be responsible for their distress.

Rhianna reflected on her experience following the birth of her brain-damaged son:

> *So I felt like a failure. I felt … often I felt this message in my head saying oh you’re such a failure because you couldn’t even give birth like a … safely. You let your baby down because you … I didn’t even give birth safely. Erm, so I often felt like that I’m dysfunctional as a woman ... because I didn’t give birth safely. Like it’s such a normal thing to do. Why couldn’t I just get it right? So didn’t … that’s something I thought about a lot. Erm, yeah, and … and … and then like you know the inadequacies of my body. (Rhianna: 663-671)*

Rhianna went a bit further to explain what she thought she could have done differently to get help:

> *Yeah, so sometimes I thought well you know I didn't shout loud enough to get help. [deep breath] … (Rhianna: 676)*

Rhianna's thoughts reveal that she views herself as faulty or broken as she did not deliver her baby safely, which is a common experience of other women. She refers to herself as a "failure" for not giving birth to her son "safely". The trauma of her son being born brain damaged has also caused her to turn her anger towards herself as she questions her self-worth, holding an image of herself as defective. There is a clear shift from her solely blaming the health professionals to now blaming herself for not delivering a healthy baby and not being more assertive. Laura also shares her thoughts about her birth becoming traumatic:

> *So in terms of an overall big reason, is it kind of the universe correct … re-correcting your path … In terms of were there reasons for what actually happened? Had I upset somebody in some way within that ward or whatever? … Yes, I think you look at kind of, "Well am I being punished for something that I've done …" (Laura: 925-927)*

Laura felt the universe was punishing her for having done something wrong in the past. Suffering a painful experience results in wanting to blame someone. Some women blamed the healthcare professional, focusing on lack of communication, or being abandoned. Most women also blamed themselves for not speaking up. For some, self-blame threatened their very core beliefs, resulting in them feeling a failure and inadequate as women and mothers. Further questioning provided deeper insight into the hidden thoughts women may not openly share with others about the reasons for their childbirth becoming difficult.

Reflective Space

As I listened to these women describe their feelings about the health professionals, I felt an overwhelming sadness. A sinking feeling came over me when I heard Rhianna say that she was living with their mistake. I felt anger because these women felt alone with little understanding of what was going to happen to them or their baby. I felt that the personal question on accountability revealed thoughts that these women may never have shared with others in terms of looking introspectively, as some of the women held themselves accountable for their traumatic childbirth. I could connect with the feelings of failure within Rhianna's body and Laura looking towards the universe as possibly punishing her for something she had done in her past. These revelations made me reflect on my personal thoughts when I experienced my still birth and traumatic birth. I blamed my midwife for not going to full term, and blamed myself – wondering what I had done to deserve the loss of my baby.

3.4.3 Do you have my consent – please give me a choice?

Another subcategory that was salient in representing participants' experience of a traumatic birth was lack of consent, and their feelings of helplessness and lack of control. There was a lack of consent and choice in relation to the procedures being carried out to their bodies, and what was happening inside their bodies. They experienced health professionals as not consulting them, which also removed their choices and made them feel invisible and powerless. Laura explained that her midwife did not have a discussion with her before breaking her waters:

> *I mean you're not supposed to say, "I'm going to break them anyway." You're supposed to say, "Right, we need to sit up and have a … have a discussion about this." And wait five minutes [laughs]. Not in the middle just get the hook out. I mean I looked away at that point because I knew what she was going to do ... Um and it was done without consent ... (Laura: 75-79)*

> *... because at that point I think I just felt completely violated. Because somebody had just done something without asking me and it's kind of … (Laura: 95-96)*

Above, Laura described feeling violated about the lack of consent for breaking her waters. She again felt violated when she was not told about the drugs being induced into her body:

> *... put me on a Synto drip that again, we hadn't really discussed. She just said that's what she was going to do and at that point, I wasn't really talking ... (Laura: 127)*

Laura tried telling her midwife that she did not want the Synto drip in her body, but her pleas were ignored and she was helpless. There was nothing she could do about the drug that was being released into her body:

> *I'd rather you'd turned it off," ... And she said, "But I turned it off," and I said, "No you haven't, I can see you haven't!" And she said, "Yes, I have!" And there's nothing I could do about it ... (Laura: 128-129)*

Like Laura, Rhianna also experienced the midwives as invading her body without having a discussion with her before carrying out intrusive interventions:

> *They never said what they were doing. They did a couple of sweeps but rather than saying … erm, one minute Rhianna, we're gonna do a sweep to try and bring it on. They just said, right we have to do this. Open your legs, put them up, stuff their fingers in … (Rhianna: 11-12)*

The lack of consent was experienced as a violation and lack of communication. The women described wanting to be consulted, and this lack of communication left them feeling powerless to express their needs. Their accounts suggest that not being communicated with, and having no say in the interventions, made them feel powerless and invisible.

Utter helplessness was also experienced when they realised that their death was a possibility – a permanent outcome they had no control over. Both Lorna and Onika felt helplessness when their bodies haemorrhaged after giving birth. Lorna explained her fears of dying upon realising she was haemorrhaging:

> *And then they were like, "I'm sorry Lorna, we have to take you into theatre. We've got to stop this bleed." ... literally raced me off into theatre … I just thought, "Right okay, if I'm going to die … Well there we go." There … there was nothing that I could do. (Lorna: 120-123)*

> *They said to me that, you know, it was very close to me, you know, probably losing my life. They … they … they said, you know, that basically it was, you know, I couldn't leave hospital without having blood because I was that low … (Onika: 79)*

Marva also shared the moment when she realised she had no choice but to deliver her baby immediately:

> *I was monitored um and when the baby's heart rate dropped a second time, they hit a button on the wall and the room was instantly full of professionals … instantly! They said – 15 minutes to get this baby out. Wheeled me down to the operating theatre flat on my back ... (Marva: 527-258)*

Lack of consent was experienced as a lack of communication, and also a lack of choice in what was happening to their bodies. There was a sense from the women that not only were their bodies failing them but so were the health professionals.

Unexpected complications can take away the freedom to have a normal delivery, as the process becomes heavily medicalised and choices are reduced. Participants felt invisible, and unworthy, and had no control over their voice or bodies. This made them question their whole worth as human beings, deeply affecting their self-identity.

Now that we have explored the impact and subjective experience of a traumatic birth, we will explore in more detail how these women moved into their journey towards resilience. As can be seen in Figure 3, the model suggests that to understand the process of the journey towards resilience one should consider the internal and external resources women draw upon along the way. We will start by exploring the external resources.

3.5 Category 2: Moving towards Faith and Spirituality

External resources were utilised during points on the journey where women moved towards faith and spirituality as a way of regaining control, to feel protected and gain a new understanding of their trauma through a higher spiritual source or through spiritual practices. They were able to draw upon their belief in a higher spiritual power, which helped them to distance themselves from their trauma. Participants perceived God as saviour and possible omnipotent rescuer who could get them through – given that they felt let down by their health

professionals. Participants also described God as a "friend" and a "spiritual being" they could turn to and rely upon to get them through adversity. Participants used spirituality to receive guidance, strength and protection. Moving towards faith and spirituality occurred in various ways: 1) Finding my faith, 2) Meditation, mindfulness and prayer, and 3) God, the giver – the helper.

3.5.1 Finding my faith

This theme seemed to serve a significant role in helping these mothers process their moments of pain and abandonment. For example, following Rhianna's experience of severe pain that was not acknowledged, she described how she was able to dissociate from her pain by focusing on God:

> *Absolutely feeling alone. That terrible, terrible feeling of alone, I turned to God ... I am not the most spiritual person I know. I'm not even the most orthodox person. And yet in that moment … I found my faith … In that moment and in the meditation … the pain was … I was almost like external from pain. I could disconnect my mind from my body almost … that's what I did to preserve myself. (Rhianna: 208-214)*

Finding her faith helped her to tolerate her pain during labour. As I listened to her describe how she felt, I noticed a discomfort in her tone in admitting that as a Jewish lady she was not "orthodox". Rhianna described being surprised that she focused on God because she never believed she was particularly spiritual. Her account suggests that extreme pain can transport women from not being spiritual to focusing on God as their key to survival and as a way of coping. Finding faith during difficult moments can help women survive their pain and regain a sense of control by focusing on a higher spiritual presence.

In contrast to Rhianna, Deidre describes faith as helping her to gain an understanding of her still birth, and to process the pain of her loss. She explains that faith provided her with comfort and strength in her time of loss, and she viewed faith as supporting her belief that her baby was living somewhere else in the spiritual realm:

> *I'm a firm believer in everything happens for a reason – traumatic or otherwise. Finding my faith was a way of dealing with why it happened and also understanding where that baby might be now – happy, healthy. Happy, healthy, but living somewhere else in the spiritual sense … taking that from my faith now makes you see it in a totally different way and makes you understand, and that gave me strength as well, um, because it gave me something to reflect upon ... But yeah, finding my faith was a huge support … But I did that on my own ... (Deidre: 460)*
>
> *So yeah, 100%. My faith has been a huge support and it's helped me build up the resilience ... (Deidre: 465)*

The analysis shows that trauma can lead women on a journey to find answers and gain a new perspective about their loss through their reconnection to their faith. Connecting to faith

allowed women to regain control during adverse situations, and also helped them process their feelings of loss and increase their sense of strength.

3.5.2 Meditation, mindfulness and prayer

The participants in this study viewed meditation, mindfulness and prayer as providing a higher spiritual power, or spiritual practices, that they could rely upon to cope with their trauma. Accounts suggested that this way of connecting and relating to a higher spiritual power could help women to cope, process, reconnect to themselves and improve their attention and concentration in their daily lives. As mentioned above (see. 3.5.1 Finding my faith), Rhianna found her faith by meditating on God during her traumatic birth. Rhianna expands further on how meditation helped her to feel protected and become detached from the pain within her body during her labour:

> *And I told our Rabbi … that was I meditating on … on God. I think I was meditating in the birth when the pain was … beyond, I kept meditating erm and saying there is only God and God will protect and that's how I … I kept meditating. And … I felt like I was my … I was floating. So the pain … was happening to my body but I was actually external of my body. (Rhianna: 197-201)*

Rhianna went on to explain that before the trauma she would not have meditated, although she would pray, and her experience of loneliness and suffering pushed her to meditate:

> *Erm, because I pushed myself ... I don't really meditate err in my daily life … that much. I mean like we pray, erm being Jewish we pray once a day. So … but I wasn't a big meditator … (Rhianna: 202-207)*

Meditation was described as easing suffering and loneliness whilst preventing women from sinking into the depths of their pain. By tapping into meditative practices, women were able to rise above their pain. The use of the word 'floating' captures an image of her becoming free, feeling calmness as she experiences an out of body experience.

Rhianna went on to explain how prayer and meditation continue to be beneficial in helping her and her husband to process the trauma and become more mindfully focused and present during therapy:

> *In the end we paid privately for all our care, all our treatment ... the test was not, didn't manifest like other people's. And I said to him, yeah I think it might be because I'm religious and erm … and I meditate … [tut] my attention ... good … at tuning our minds into focusing on the moment ... (Rhianna: 317 -318)*

Rhianna suggested that women should be offered some form of holistic or mindful therapy immediately after their trauma as a way of helping to build resilience:

> *I think that…that people should be offered, even if it's not formal therapy ... some kind of like relaxation hour ... You know an hour of yoga, an hour*

> *of meditating erm, erm, you know mindful meditating ... to let them have a space to eject the terrible experience as well as being validated for that experience. I think … natural resilience will start to kick in. It's a … I think resilience is a natural part of our fl…fight and flight… of our evolution. I think God created us to be resilient or ... I think if you wanna, if you're not Godly, but in evolutionary terms, I think we are resilient erm as … as a species ... I think that validation goes a long way to helping that ... (Rhianna: 548-552)*

Accounts suggested that the use of meditation and mindfulness practices was perceived as improving attention and concentration in their daily lives. Participants viewed meditative and mindfulness techniques as providing a space where they could let go and receive validation of their experience. Meditative practices were described as bringing forth 'natural' resilience, which suggests that the women could find resilience within themselves by drawing upon spiritual practices. Jenny shared her feelings about meditation:

> *I was in a meditation circle. That really helped. Just meditating and being who you want ... you know, being me ... (Jenny: 288-290)*

Being in a meditation 'circle' can provide a space for women to feel held and help them to reconnect to parts of themselves that may have been lost from the trauma. Trauma can alter one's self-perception and sense of self. One might suggest that meditation can help women reconnect to parts of their inner self or become more like their previous self. Participants described meditative practices as helping them to develop their sense of self and identity in the use of the phrases "being who you want" and "being me".

I asked Jenny if there was anything else that had been important through her process of resilience. She explained that her belief in prayer helped her to become stronger within herself, which led her to take on the role of a Sunday school teacher:

> *I really believe in prayer. You know, it's led me to be a Sunday school teacher ... just praying. (Jenny: 372-375)*

Similarly, Lorna viewed prayer as helpful, and she relied upon God to help her adjust from her traumatic birth:

> *I'd … I'd pray. So I'd talk to God. And said, "You know what God? You've got to help me get through this." (Lorna: 827-828)*

Meditation, mindfulness and prayer helped women to rise above their pain and connect to, and regain parts of, their inner self that may have been fragmented by their trauma. This belief of gaining spiritual support ties in with the next subcategory where a higher spiritual power is perceived as a giver and a helper.

3.5.3 God, the giver – the helper

The concept of God as 'giver' and 'helper' came up as a very prominent concept in the analysis as participants described an appreciation of life, having faced their own mortality. Participants shared the view that God was responsible for them surviving their traumatic childbirth, and provided relief from their burdens post-labour. The findings suggest that following the lack of care received from health professionals, participants found support in higher spiritual power. Further into the interview, Jenny recalled her gratitude to God for giving her life:

> *And during the whole time all I was thankful for was to God for giving me life ... (Jenny: 153)*

One may suggest that her practice of gratitude, in attributing her survival to God, helped her to process the possibility that she almost lost her life. Lorna, it seemed, held a similar view of God as giver or saviour as she recalled asking God to stop her haemorrhaging:

> *When I prayed to God, when I started haemorrhaging … I said, you know, "God, I don't want to die so you need to fix this. You need to make this blood stop and you need to get me well so that I can still be here for my kids." (Lorna: 195-196)*

One might think from her account that she is saying that if the health professionals are not listening, then I need to talk to someone who is listening. There appeared to be a desperation in her voice with her use of the words "you need to", and it felt as if she was demanding an action from God. This held within it an unshakeable belief that God would hear her pleas and save her life. Her account suggests that she holds determination that she has to survive this experience in order to be there for her children. Lorna went a bit further to explain that God gave her mother a premonitory dream of her being at risk of passing away during childbirth. Lorna shares her belief that God saved her life, and this suggests she holds a sure and definite feeling within her voice that God was responsible for her survival:

> *But I know who God is, and I know it was because of him … That I got through ... He gave my [mum] that dream and she was able to pray against it. And … Here I am today. (Lorna: 202-206)*

For some participants, spiritual beliefs seem to provide a unique dependability on a higher spiritual power as hearing their needs and serving as a protective factor. Positioning God as a helper and saviour highlighted a sense of gratitude to God for being alive. It appeared that some participants needed to hold God in their mind as the good doctor and omnipotent rescuer who is faithful in fixing any problem. Accounts suggest that holding a specific belief in God as a helper seems to serve a function whereby participants can comfort themselves from their disappointment in the health professionals, whilst having a

spiritual reason for their survival. Lorna described God as a friend she could rely upon to get her through difficult days:

> *"And you've got to pull me through this." Um he is my friend so I talk naturally to him. (Lorna: 832-833)*

Lorna went on during the interview to describe a belief in God as removing or taking care of her burdens:

> *But when I say, "You know what God? You know what? I'm feeling this." "Ah! God, that's a weight off my shoulder!" Because I know he's going to take care of it now for me … (Lorna: 853-855)*

Similar to Jenny and Lorna, Marva also shared similar feelings of God as saviour, fixer and rescuer. Marva recalls her thoughts and belief that only God could save her and her baby's life when complications occurred during labour:

> *In God's hands, absolutely. Um I mean bottom line … it wasn't meant to be and there's nothing … I could … I could or they could have done about it. (Marva: 612-614)*

Again, Marva echoes the belief that only God was able to save her life and not the medical procedures carried out by the health professionals that day. There is a sense that these women are actively surrendering all to God with a belief that their needs will be taken care of. It is interesting to note that Jenny, Lorna and Marva seem to hold a very strong expectation of what God can do and the type of support they can receive.

By holding on to faith, some participants held a belief that a spiritual power could be relied upon as a friend or a confidante to provide the precise support and care to help women overcome their difficult birth. Some participants held a belief that having a close personal relationship with a higher spiritual power saved their lives, their bodies were healed, and they were able to overcome their adversity. Resilience seems connected to and influenced by participants' belief in having a relationship with a higher spiritual power they can connect to when making sense of their traumatic experience. Deidre explained how her religious beliefs helped her to process her feelings, become "strong" and gain religious direction:

> *I think if it hadn't been for the church now ... I wouldn't probably be as strong ... I deal with mine by going to church and trying to understand why it happened or how it's going to happen ... I would say to anybody who was going through a traumatic experience ... go and sit in church and listen ... They've given a sermon and it was like – ... – "That's for you" – because the, the answers coming out of it … (Deidre: 463)*

Similar to Deidre, Lorna echoes a special relationship she has with God in "always" providing for her needs:

> *He has always been good to me. And um he is my number one. (Lorna: 870-871)*

Deidre and Lorna seem to share a view of holding a special relationship with God in either being given the answer that is needed or always being in receipt of good things. This view of God, again, holds a definite and precise belief that God will provide relief during adverse times in their lives.

The findings suggest that moving towards faith provided women with a great sense of trust, comfort, protection and containment in a higher spiritual power as helping them to survive and thrive after their trauma. There is also a sense that faith presents a process of women moving from fear of losing their life to thanking an external source for saving it. Moving towards faith and spirituality highlights the value of having a close personal relationship with another in overcoming and getting through adversities in life. The value of supportive relationships in helping women to become resilient will be discussed in Section 3.7.

Reflective Space

As I listened to participants' descriptions of a higher power (God) as helping them during their trauma and in aiding their recovery, I reflected upon my own experience of religion and birth. I reflected upon my first pregnancy where the experience of my still birth made me turn my back on religion and God. I was filled with anger and questioned how God could allow this to happen to me and my baby. I wondered whether if God did not meet these women's expectations and need to save them and their babies' lives, would their belief in this higher power be shattered or would they still find a way to make sense of their trauma? Looking back, I am aware how the trauma caused me to lose faith and hold God also accountable for my loss. I am aware that in my following pregnancy, which was also traumatic, I did ask God to save my son's life when I felt there was nothing the health professionals could do. I believe that my son's survival helped strengthened my faith in later years, and helped me to heal from the trauma.

3.6 Category 3: Motherhood Becomes You

This section presents the experience and process of resilience as being linked to internal resources women found in being a mother, which helped them to continue to move forward. Each of the subcategories: 1) 'Recognising achievement in oneself' 2) 'Admiration for one's child' and 3) 'Mothers as role models' were developed from participants' descriptions of how motherhood helped them to become stronger and more confident individuals.

3.6.1 Recognising achievement in oneself

This subcategory of achievement evolved from participants' roles as mothers in caring for their child. Recognising themselves as competent mothers helped women to regain confidence within themselves. For example, Vivian recognised that her role as a mother had helped her to feel capable in raising her premature baby who could have died during labour:

> *I realise that I am a lot stronger … than I thought I was ... I think, … I gonna be able to achieve something … I know I'm a lot more capable than I thought I was. And I think being a mother makes you very capable ... And that's, erm ... resilience, I think it's just a question of strength, I think ... Being made to think, well you're much more capable than, than you thought you were [laughing]. (Vivian: 150-155)*

There appeared to be a determination within Vivian of "I can" and "I will", which perhaps was not part of her former self. Her use of the words "I gonna be able to achieve something" and "I'm a lot more capable" suggests that holding a positive attitude and having a "can do" approach are important in her journey towards building resilience. There is a sense of growth in her gaining a belief in herself. Participants' accounts suggest that motherhood can shift women into viewing themselves as confident and capable as they gain a belief that they can be successful, not only as a mother but in other areas of their life. Being a maternal carer can help women to feel empowered and experience a growth in their sense of self or self-worth, which may heal any doubts they may have carried within themselves following their traumatic birth.

Vivian went on to say that her number one priority as a mother was to be available and "strong" for her daughter:

> *You've got to be there for her, and you've got to be strong … I think it's definitely made me a much stronger person ... (Vivian: 138-139)*

It is interesting to note the Vivian's use of the words "got to be there" and "got to be strong" suggest that having a sense of duty and responsibility as a mother may have strengthened her resolve and helped her to adjust to life following trauma.

Similarly, Rhianna gains a feeling of fulfilment and pride within herself in keeping her son alive at the end of every day:

> *But one doctor asked me a similar question. And I said to her because at the end of every day, I feel I've achieved something. I feel proud if my son is still alive ... So I am a success every day because he's alive. (Rhianna: 451-453)*

> *Resilience it's to tell myself every day you know, he is alive, well done. [laugh] And that's that … it sounds silly … (Rhianna: 507)*

Rhianna shared with me how building strength in her son also helped to build strength within her and "liberate" her from guilt that her son was born brain damaged:

> *And I started to help him on … on the edges of his abilities I started to try and push his Boundaries ... that built my strength … it allowed me to liberate myself from the guilt … that he was damaged. (Rhianna: 445-449)*

I am struck by her use of the words "liberate myself from guilt", as this suggests that she is able to free herself from thinking she played a part in her son being born brain damaged, as she criticised herself for not being able to deliver her baby safely (see Section 3.4 Who's accountable?) The findings suggest that successfully raising a child that could have been lost during childbirth may bring psychological healing where a transformation occurs from self-blaming to becoming more compassionate to oneself. One might think that trauma can bring women close to loss, but through the process of being mothers they regain a positive sense of self as an accomplished carer.

In contrast to Rhianna, Jenny shared a unique turning point when her health visitor praised her for being "a model parent":

> *The first turning point is when I went to see the health visitor when Kendra was having an arterial check … and she said to me, you're a model parent ... (Jenny: 272-273)*

> *She said [health visitor], you need to sort of like congratulate yourself after going through everything … to say, well done … and I suddenly walked away thinking, "God, yeah, I have got it right. I, I am doing a good job." (Jenny: 275).*

Being praised by her health visitor also helped Jenny to end the grief process she experienced from her traumatic birth, and gain confidence in her ability as a mother:

> *That was my turning point, I think. Everything came right. Now ... It's behind you now. And it was just dealing with it. It was almost like ... It was like a grief process. (Jenny: 279 – 280)*

Participants' accounts suggest that receiving praise from others for successful parenting can help women begin to let go of the burden they carry from their traumatic childbirth, and regain a feeling of accomplishment in being a mother. Jenny experienced a fundamental shift in her perspective as she confronted her feelings and freed herself of the weight she had been carrying. Her account suggests that by ridding herself of self-doubt she can begin the journey of moving forward with her life. There is a sense that by being successful mothers, women are able to show they are protective, caring and responsible for their child, which helps them to feel empowered and become more compassionate towards themselves. One may suggest that there is a development of self, and their identity as women seems to be evolving as they feel accomplished in their roles as mothers.

3.6.2 Admiration for one's child

This section focuses upon the experience and process of participants' admiration in observing their child physically thrive, which in turn helped them to value themselves as maternal carers as they took pride in their child's development. Four participants described their admiration of their children becoming healthy and strong. Both Marva and Vivian did not have a choice but to deliver their babies early due to pregnancy complications (see Section 3.4.3 Do you have my consent – please give me a choice). Marva explained that observing her daughter's development was part of the process of overcoming her trauma:

> *Um … I don't know. Just being able to see my little girl grow up and … know that she was meant to be. (Marva: 794-795)*

Similarly, Vivian explained her admiration in observing her daughter develop from a "tiny" baby into a "really strong" little girl:

> *But I think, and seeing Andrea every day. I sort of think, you know, wow, she's amazing. I think how tiny, tiny she was, when I first saw her ... and now she's like, really strong … (Vivian: 143-145)*

The word "amazing" resonates with a feeling within me of a mother not only admiring her daughter's growth, but also suggesting that she did an amazing job in raising a daughter who has transitioned from being "tiny" to "really strong". One might think that observing vulnerable children fight for their survival might in turn have stirred these women to push through with overcoming their own traumas.

Similarly to Vivian's experience of nurturing a healthy child, Jenny shared a moment where she admired her daughter's development and progression, although she had physical disabilities at birth. As an early years specialist, her confidence came from knowing that her daughter was ahead in her development:

> *I had no worries about Kendra's development and progression because I was ... I'd taught it for years, so I could see at the drop of a hat that she was actually ahead and keeping up ... and the only worry we had was the hip where it dislocated ... (Jenny: 180-183)*

Similar to Jenny, Rhianna shares her admiration for her son's development as she manages his care:

> *We do do physio every single day with him … we're managing to sort of maintain him very nicely and he hasn't … got any bedsores and his spine is still straight, his hips are lovely … because we've done a lot of work ... he's cared for really well. We're basically opting to give him, erm a happy and content life. So we're giving him quality of life ... (Rhianna: 480-486)*

By witnessing her child physically thrive, Rhianna gained a sense of pride in herself as a mother who is able to provide the type of care that brings 'contentment' to her son's life.

Admiration for one's child as physically thriving was significant in helping women to acknowledge their contribution in raising a healthy child. One might suggest that one's ability to raise a healthy child had the parallel process of helping women to gain a sense of pride and joy within themselves as competent mothers. Trauma can shatter the view of the self, and adopting a position of self-praise may allow women to begin the process of valuing themselves and rebuilding themselves as they move forward in their journey.

3.6.3 Mothers as role models

Another salient aspect of the process of becoming resilient was women wanting to be strong role models to their children. Onika and Lorna shared their motivation to teach their children how to overcome challenging situations, which they hoped would promote resilience within their children. This in turn seemed to reinforce their own capacity to improve their lives. Onika explained that part of her "strength" in overcoming her difficult birth was to show her children how to live their life in a "positive" and "enjoyful" way:

> *I want to set an example for them, a role model for them. You know, that's part of my strengths of something to show them that this is how you try … you try to live your life in a positive way and … enjoyful way. You get a life and you're given a life." (Onika: 330-331).*

Onika identified that she also does this by encouraging her children to try new things and by "promoting" the strength she sees within her children's characters:

> *Even my kids, I encourage them to do things. To live and to really enjoy, you know? If a child is able to show you that they have the strength within them, I promote the strength. (Onika: 398-400)*

Motherhood gave these women the opportunity to be positive role models where they could teach and "encourage" their children to adopt the behaviour and values needed to overcome adversity. The findings suggest that as women built resilience in their children, they were able to be resilient themselves.

Lorna came close to losing hers and her son's life during labour (see Section 3.4) and she described struggling with 'baby blues' afterwards. She explained the importance of her role as a mother, and how she wanted to live up to that role:

> *You cannot let these emotions get the better of you because you will crumble and you will not survive and my mother did not raise me not … you have to survive. We are survivors!... we have to hold the … the bull by the ... Mama is number one. When mama isn't there, the house crumbles! So I've got to keep my family intact. (Lorna: 663-666)*

> *So my kids need to see, "Yeah, mummy is strong, even things are going wrong, mummy is strong." (Lorna 674).*

Lorna also described her role as a mother as being able to 'pass on to' her children the inner personal strength and personal actions needed to overcome adversities:

> *I have to pass this on to my children! When my kids are grown, they know, right. You know, this is what mama taught us ... So then that when they have their kids, and they're in labour and anything goes traumatically wrong, they know, "Right, this is what you have to do." "You've got to pull yourself up." "And keep going." But we can't stay down! (Lorna: 690-969)*

The experience and process of being a role model gave women the opportunity to pass on to their children family values and beliefs about ways of overcoming adversities. Accounts suggest that being a role model also served to motivate and reinforce to these women the importance of adopting a mindset of perseverance and determination as a way of putting themselves back in control of their lives.

Reflective Space

Listening to these women describe how their roles as mothers built their resilience, I could connect with their feelings of joy, pride and admiration in seeing their children develop and progress well. Their accounts made me aware that I also take pride in raising a premature child that could have died during labour. As I reflect upon myself as a mother, I also realise that one of the ways my resilience was built was being strong for my son whilst he was in the special care unit. Lorna's descriptions of "mummy being strong", "pulling herself up", "you cannot stay down" continue to resonate with a feeling within me of the process I went through in building my resilience post-labour. I knew I was strong at that point in my life, but I could never put it into words. These interviews have helped me to realise more of my own process of building and developing resilience over the years.

3.7 Category 4: Supportive Relationships

This section presents the experience and process of the use of supportive relationships in helping women to build their strength from within and not feel isolated. Supportive relationships developed through the analysis as another external resource that women used during points on their journey. As described previously, participants accessed a supportive other by moving towards faith and spirituality (see Section 3.5). Participants also described their family as either lifting their negative emotions or helping them to feel cared for and encouraged. Friendships provided women with an opportunity to be sociable again, regain their identities and sense of self. Social media and support groups were described as providing a space where they could meet other women with similar struggles, which helped them to feel understood and not isolated on their journey towards resilience. Each of the following subcategories gives insight into supportive relationships as helping women to

receive care and support: 1) 'Family', 2) 'Friendships' and 3) 'Social media and support groups'.

3.7.1 Family

The family unit seems to provide a great source of external support and care in overcoming, coping with and processing participants' difficult births. Deidre recognised that the care she received from her family had helped keep her "spirits up". It is worth noting her use of "100%", which projects a strong conviction and certainty that the support of her family helped her to move forward after her still birth.

> *100% my family. The support of my family, Gordon's family and my parents, my brother, was immense ... – 100% wouldn't have got through it. And they were able to keep my spirits up and keep me going. I got through it through people caring ... (Deidre: 444)*

Like Deidre, Vivian described how she was fortunate to have a supportive family:

> *And I'm lucky to have my, my family, 'cause they've all been very supportive ... I, I'm very aware of the family structure being important to, to overcoming these things. (Vivian: 141-142)*

It was quite interesting to note Marva's use of the word "obviously", which might imply that she feels a person simply could not overcome their traumatic birth without the support of their family:

> *Having lots of support. Um… Oh family – obviously family … (Marva: 792 -793)*

The family was described as an essential source of strength in helping women to overcome adversity through their bonds with loved ones. Family relationships can also help women feel encouraged to be positive whilst weathering a crisis together and this in turn helps women to emerge stronger. The findings suggest that the family bonds influenced how women would view their ability to overcome their trauma. When I asked Onika how she coped, she described the symbolic gestures of her family in making sure she was fed, and that viewing her family as "happy" helped her to keep positive. Onika explained that her family unit helped her to cope by enabling her to not dwell on the complications she experienced during labour, which helped her to move forward and, it seemed, to look more positively towards the future:

> *I've got my family, you know, my mum came every day, she bought food. Tom came every day ... everyone was happy. We got so many visitors ... just having people around me. It helps you to cope. The support system. (Onika: 156-167)*

Onika went a bit further to explain that her family's acts of generosity, outpouring of gifts and checking on her all contributed to her keeping positive and helping her to be happy:

> *The little clothes that everyone then brings, the little presents ... all the things that you're then able to … to see and smile about. (Onika: 170-171)*

> *I had lots of family help ... people calling ... sending messages and cards … extended family support … with people, you know, calling up and saying, "Congratulations" ... (Onika: 277-283).*

These acts may have helped women to feel regenerated after such a degenerative experience. The warmth and care of these acts helped them to feel worthy and important. Similarly, Lorna viewed her family as the source that helped her to feel supported. Throughout the interview, Lorna expressed feeling unsupported by the nurses during labour (see Section 3.4), resulting in her calling her mother and husband back to the hospital. Lorna described her family as a "strong" support that helped her to cope after labour and to overcome her traumatic birth:

> *So just having the support of my family … we are strong family so … (Lorna: 207-208)*

> *You don't really get much support from nurses so that's why I said, you know, it's my family around me. (Lorna: 249)*

Family was described as helping women to feel worthy, important and cared for, which enabled them to move forward with their lives. It was notable in the analysis that fathers were hardly mentioned during the occurrence of the trauma. However, it was clear that they were seen as a strength in terms of the compensatory roles they played, such as looking after the house, or other children – taking on the roles the women were not able to, and thereby allowing the women to focus on the internal things that needed to happen.

The husbands of both Onika and Lorna took control of the home and carried out the necessary tasks when the women arrived back from the hospital. Onika described her husband as helping around the home and that having his support was a huge factor in helping her to regain her strength:

> *I didn't have to do very much, Tom took over. He cooks, he cleans. He took a paternity leave – so he took two weeks. (Onika: 247-252)*

> *Came home from the hospital, I was actually confined to upstairs for nine days … I … can't walk up and down stairs ... my husband had to do everything for me. (Lorna: 334-337)*

Onika went on to explain the importance of gaining support from family, husbands or partners:

> *I think it's been important to have family. Husband, family … if people have partners. That's the important thing, to keep them close. (Onika: 602-605)*

Gaining support from family members, husbands and partners was recognised by women as an important aspect in feeling cared for and building their resilience. The family unit provided participants with an important source of strength where women could feel held, contained and worthy of care. One might suggest that through the connection with family members women gained strength and courage to heal.

3.7.2 Friendships

Relationships with friends were another important source of external support for women. Not only were friends a practical source of support in terms of looking after older children, for example, Lorna appreciated her friend doing the school run so she could focus on herself, but friendships also provided an opportunity for these women to be sociable again and feel more like their previous selves, how they were before the traumatic birth. This was a role that was not seen to the same extent in family relationships.

> *I was so blessed that my friend who lived local to me did the school run for me for the first six weeks. So all I had to do was get up and get her ready. (Lorna: 634-635)*

Jenny experienced a significant change of heart when a friend with cancer described how she admired her ability to cope with her pregnancy complications and focus on her baby:

> *How, I just focused on Kendra when she was there and nobody else and, and that she wished ... she wished she had that resilience and then she told me about her story ... She's got nine different types of cancer ... ... she was admiring me and I thought I was being selfish. So, it made me sort of turn around, really, and when I came out of hospital decided ... I was just gonna [have] ... I had fantastic friends ... (Jenny: 144-147)*

Social comparison with how others coped with challenges in their lives seemed to help Jenny understand that she had a choice to get better when others had no choice. She went on to explain how the support of her friend helped her to have a social life by getting her out of the house, which helped her to feel more like herself:

> *Um, I think Louise came around once and she had said, right ... Get your lippy on, we're going out and actually getting up and going out and being sociable again and ... and being me. (Jenny: 187-188)*

The use of the words "getting up" and "going out" suggest that friendships can be a motivating force in getting women out of the house and being active again. The words "being me" suggest that friendships also provided women with the opportunity to awaken parts of

their identity and regain a sense of self that was beyond motherhood and their bonds with their family members.

When asked to describe anything else women thought had been important during the process of their resilience, Marva explained that being surrounded by good friends helped her to become stronger:

> *Um having really good friends around. (Marva: 791)*

She described a special friendship she formed with her midwife. This was in contrast to other women who were mainly angry towards the health professionals. Marva's resilience seemed contingent on the role and actions of her midwife as she uses such words as "followed me home", "found me" and "effort" in feeling she had a friend in her midwife. Marva explained that she interpreted the actions of the midwife as friendship, and that she was someone who followed through and did not let her down:

> *She just lost … lost my name and actually followed me up, rather than just ignoring it. She found me in the hospital ... Which was lovely that she had made that effort ... she followed me home. (Marva: 413-419)*

> *So that … that consistency was a huge thing ... she was more like a friend coming to visit. (Marva: 441-443)*

There is a sense that after Marva's traumatic experience life may have felt uncertain, and having a consistent friend may have helped her to feel safe and stable, and trust that she could move forward with her life. As women journey through the process of resilience, friendships provide a reliable alliance and source of emotional and physical support. Becoming sociable again through friends seems to have helped women to awaken and regain parts of their inner self and their identity. The findings suggest that supportive relationships with friends can put back together parts of the self that have been lost through their trauma. Women also gained support through social media and organised support groups by bonding with other women, which will be expanded upon in the next section.

3.7.3 Social media and support groups

Gaining support through social media and support groups was pivotal in helping some women connect with others who had similar struggles. Support networks occurred in formal group settings, or more informally through social media, which women experienced as very helpful. Laura, Marva and Jenny viewed this type of support system as helping them to build their resilience. A number of women reported that the support they received from support groups helped them to rebuild their confidence whilst providing a space where they felt others were thoughtful and understanding of their experience. Laura found ongoing feeding issues with her baby prevented her from moving forward from her traumatic birth

experience. The support group played a crucial role in helping put this issue into context, allowing her to move on.

> *Friends and kind of groups [helped]. But as the feeding thing got more complicated ... That then became quite isolating in itself. (Laura: 420-422)*

Laura went on to suggest that women should search for support within the community:

> *Just kind finding your tribe ... finding ... bunch of women locally… we all had the same sort of life view … That was supportive in that they were just there ... I think having the confidence to go to different place and think, "Okay these people are saying this" ... I'm not sure that's quite right for me but that's okay because I've taken something from it ... And recognising that you are also on a bit of a journey … And you … you might on a journey stop at different places. (Laura: 780-789)*

I am struck by her use of the words "finding your tribe", which suggest that women should go in search of support groups as part of an extended family. Belonging to a group can provide women with a sense of unity and protection in knowing that they are not alone on their journey towards becoming resilient from trauma related to childbirth. People within these groups, as Laura highlighted, often grow together and form friendships as they all move towards resilience.

> *Ante-natal groups [were helpful] ... I'm still friends … the three of us who stuck together. Yeah, close friends now. We still, we're going to meet up in a couple of weeks. Even though we've moved a little bit. So yeah, we still … and all the boys still play together and, you know, so that's really nice (Laura: 436-440)*

Similarly, Marva explains how those within these support groups would "compare notes", with Jenny adding they could actually "work through" their issues together:

> *Because we did have follow up groups ... Um so there were other mum … other parents that we'd met in … (Marva: 753-755)*

> *But if they can find people that have gone through similar experiences ... other parents that we'd met in … So we did sort of compare notes … about um how we'd coped since. (Marva: 749-759)*

> *Um, but it was a really good way of actually working through ... (Jenny: 271)*

Women described social media as a useful tool in gaining and sharing information. One might assume that to be informed brings empowerment. There were examples of the sharing of information within these informal networks which helped to identify ongoing issues. For example, Laura explained that it is important for women to keep searching for a group until they find one they are comfortable with:

> *To go wherever you feel comfortable, and that might not be the first place you go ... for example, AIMS* [Association for Improvements in the Maternity Services]*… I feel very comfortable with the women there … I know they've all had some difficult experiences ... They're a very positive bunch of people ... there's a lot of understanding there for what everyone there has been through. (Laura: 771-775)*

The women recognised the value of joining networks as providing a space where they could find others who had shared similar experiences and struggles. In this way, they were able to make sense of their trauma, regain confidence in caring for their children and end their isolation of carrying their burden on their own. The words "finding a tribe" continue to resonate within me as describing a provision of unity, and security in surviving adversities together. Support groups provided a community where women could heal in knowing that they were sharing a special journey together.

The next category expands more on the value of talking about trauma, where women described a proactive stance of becoming resilient by practising self-care as a way of owning their journey.

3.8 Category 5: Self-Care – As a Way of Owning my Journey

This section presents the experience and process of resilience as being linked to internal resources that women found through their practice of self-care as a way of owning their journey. After moving towards faith, feeling empowered in their roles as mothers and receiving much support from family, friends and social networks, participants described a renewed strength and desire to take back control of their life through the practice of self-care. They was this as a way of moving forward after their difficult birth. All women shared the importance of owning their journey through the practice of self-care as a way of building resilience. Participants provided examples of ways in which women could overcome their trauma and demonstrate resilience: 1) Becoming assertive (speaking up), 2) Talking about their struggles, and 3) Looking after self.

3.8.1 Becoming assertive (speaking up)

Participants recognised that their journey towards resilience went from powerless, helpless and without a voice to feeling assertive and empowered. Over time they recognised that they had to discover ways to find their voice when they were vulnerable – something they were not able to do during their traumatic birth. Rhianna described this beautifully when she noticed that she felt she could rely on herself and her own abilities, and that she no longer idealised health professionals and undervalued herself. She was now assertive, no longer being afraid to speak up and stand her ground:

> *Erm, we [partner] became assertive people ... no longer take it for granted. We no longer see a professional and think because they're a professional they're next to God. We use our common sense. We're both very, very, very bright so why we let them get away with what they did to us in the birth, I don't know? But now, we stand our ground. And we're not scared (Rhianna: 365)*

Rhianna described a time in her life when she was compared to a mother who, like herself, had a disabled child, and who others viewed as coping well. She recognised the difference in her past self as being someone who tried to live up to others' expectations, and her new assertive self who was insistent in finding out how this mother was coping. Rhianna explained that in the past she would have "eaten up" herself to "breaking point" but that her "new assertive" self was persistent in finding out how this mother was coping:

> *I came more assertive ... Someone said to me "oh Rhianna you look terrible. So and so had a disabled child and she's coping amazingly. Why can't you be more like her?" ... I picked up the phone to so and so and I said to her, "I heard you're coping amazingly, I want to know how." And she just started to cry ... But old me would have eaten myself up ... the new assertive me. I picked up the phone and said, well if she's coping better I want to know how she's doing it. (Rhianna: 637-639)*

Rhianna showed awareness of the transformation within herself, with her being open to acknowledging shortfalls, and with a willingness to become a better self. Similarly, Onika recognised the difference within her old and new self as no longer taking things for granted. She explained how she was in her first pregnancy, and the conscious changes she would make to prevent possible trauma in a subsequent pregnancy:

> *From having that first experience … of having a child and I tell you now, if I was in that position again, I would be a completely different person. I would ask more questions. I wouldn't be as easy to just brush over things that I thought were wrong ... (Onika: 344-346)*

Onika further explained how she approached her subsequent pregnancy by feeling more assertive and asking staff more questions, as well as standing up for herself and her family more generally:

> *This time I screamed the whole ward down ... I made sure that people were aware of what was happening to me. No more to suffer in silence. And that's the difference between me then and now. I will stand up for myself and family, and… and others if I need to … no merit in being quiet. (Onika: 349-352)*

Onika was able to find meaning in her previous suffering and it propelled her to become more confident and more vocal about having her needs met. Becoming assertive encompassed women taking back control of their lives by standing their ground, "no longer taking things for granted", and speaking up for what they believed others should know in terms of having their own needs met.

Onika explains below that she now carries a belief of "you don't ask, you don't get", which implies that if she is not assertive in asking for what she needs then she can only hold herself responsible. I am struck by her use of the words "I have to be the voice" (see below) and how it's her responsibility as a mother to speak out. This demonstrates how she has positioned herself within the family as a strong role model (see Section 3.6.3 Mothers as role models) and the strength she has gained within herself. She is also reflective about what she could have done differently during her traumatic labour where she haemorrhaged heavily and almost died:

> *And you don't ask, you don't get ... if I'd have asked that first time, maybe someone would have done something sooner ... I have to be the voice ... I have to speak out and if I don't speak out then if anything happens, I can only hold myself responsible. So now I speak out. So it makes me want to be that person and it's changed me … I'm more confident ... (Onika: 354-360)*

I am struck by her recognition that she felt responsible for speaking up during her traumatic birth and let the medical team know her needs. This shows a shift from blaming the junior midwife for the amount of blood she lost, to taking some responsibility for not telling the nurses her concerns (see Section 3.4 To Be Cared For – Who's Accountable?). Her reflection about using her past experiences to direct future behaviours is a great example of how she has become resilient. She showed how she used this learning during her subsequent pregnancy and delivery – no longer would she suffer in silence:

> *"Where are the midwives? Why am I giving birth alone?" And I shouted it over and over again.There was no way I was going to sit in silence. Because I just can't … I thought for someone to take my life at … at that pace and say, "Her life doesn't matter, her pain doesn't matter," it matters, and I make sure that people know it matters. For me that's a very powerful thing – to have a voice. (Onika: 369-374)*

This suggests a real determination from within and that Onika will not allow herself to become helpless in childbirth – or perhaps in any area of her life – again. Lorna, who almost died during delivery from haemorrhaging, found her strength arose from wanting to live for her children, and she made a conscious decision to speak up in her subsequent pregnancies. She explained that there was no way she was going to stop communicating her needs:

> *Yeah, that when it comes to your children, you're so resilient, you want to live. I didn't want to die ... It made me go into my last pregnancy differently ... With my last child I said, "Listen, I know what childbirth is like. I am going to get the epidural." If I have to sit on the floor and get it!" (Lorna: 452-456)*

Their accounts suggest that these women all clearly have emerged with a fighting spirit, having found their voice, recognising that they no longer have to be silenced. In some

cases, these women have gone on to communicate this to others in similar situations, highlighting the importance of speaking up to minimise the impact of traumatic experience:

> *So all my friends who are pregnant, I just say, "Listen, when you get into that hospital, you make sure …" "If … if you're not comfortable with something or you don't like what's happening, open your mouth and say something, yeah?" (Lorna: 504-505)*

Lorna suggested that women should be assertive during labour and "fight" for their needs to be met as a way of stopping the possibility of them experiencing a traumatic birth:

> *"If … if you're in pain, you … you let them know. You have to fight for what you want." … But when it's traumatic … you don't forget it ... (Laura: 509-511)*
>
> *Let other mums know. This is what happened to me. Don't let it happen to you. Don't ever be afraid to speak out. (Lorna: 515-517)*

One might suggest that passing on knowledge and experience of a traumatic birth can be a restorative process that helps women to feel empowered and triumphant that they can make a positive difference in other women's lives. The findings suggest that feeling unheard by health professionals during a difficult childbirth propelled women to gain empowerment by speaking up and owning their voice as a means of preventing further trauma in future child births. Their accounts suggest that they are empowered by their desire to protect themselves and their families. It seems that part of their transformation also encompasses a desire to protect other women from experiencing trauma.

Becoming assertive was described as "standing our ground", noticing changes from the old shy self to the new assertive self, having a "voice", speaking up and "asking for help". It was apparent that these women recognised significant changes within themselves after experiencing their traumatic birth. The value of having a "voice" and talking about their experiences is developed further in the following section.

Reflective Space

The words "very powerful thing – to have a voice" continue to resonate within me. I also found my voice in subsequent pregnancies and I became very assertive in preventing another traumatic experience. I recalled being assertive in telling the consultant that I would not take a tablet to speed up my labour as I remembered how my body felt in my last pregnancy just as I was about to deliver. I remember that a family friend who was a midwife came in the room and reattached the plugs to the machine that was monitoring my labour pains. We then realised that the junior midwife had attached the plugs wrongly and so the readings were inaccurate. In hindsight, had I not been assertive and had instead taken the tablet to speed up labour then my womb could have ruptured. My knowledge and intuition

of my body, my ability to speak up, helped to save our lives. I am now aware how powerful it was for me to be assertive and have a voice.

3.8.2 Talk about your struggles

Talking about their struggles helped women to find their voice – and empowered them, which in turn allowed them to feel supported and less isolated. Lorna suggested that women should talk to friends and health professionals about how they are feeling so they can receive help:

> *Good friends around you, you know, talk to your Health Visitor. Your midwife. You say, "Listen, this is how I'm feeling." … But you just let them know so that then they can … they can help. (Lorna: 772-780)*

Similarly, Marva reported that talking to friends, relatives or other women that had experienced a traumatic childbirth would help build resilience in women:

> *I mean talking to friends. And talking to relatives ... if they can find people that have gone through similar experiences to … to compare notes with ... (Marva: 747-750)*

The act of sharing one's struggles with another can also serve as a channel for developing or strengthening bonds with significant others, as can hearing other people's stories. The women's voices seem to undergo a transition over the course of their journey, where in the early part of it they are silent and in the latter part they use their voices to bring attention, to be listened to and understood.

Lorna explains below that talking would help women to feel supported and to process their feelings and move forward with their lives:

> *Find someone, talk to someone about it. Um your friend might say, "Oh! I've been through that too" … Because it is that knowing that you are not alone. When you're going through things … You always think it is just you and when you feel it's just you, it seems ten times harder. (Lorna: 745–755)*

Jenny recognised that knowing her friend's story provided her with a source of comfort in realising she was not alone on her journey towards becoming resilient. She recognised that it changed her perception of feeling that her life was challenging in comparison with others, which made her path towards resilience easier:

> *So, it's not just one thing, is it, that makes you a stronger person. It's a lot … knowing Lisa's story ... But together, knowing each other's stories, it made it easier because you know you're not walking that pathway on your own. (Jenny: 347-352)*

Later in the interview, she described the core process of talking as providing a way of moving forward with her life:

'Cause the more you share ... the more you let go. (Jenny: 361)

Talking provided women with an outlet to receive help, share their stories and let go of the weight of the trauma. It struck me that talking was very therapeutic in helping women feel supported in knowing that they were not walking alone on their journey. The findings suggest that through the process of talking, women could begin to process and let go of the baggage and the pain they were carrying by finding their voice again, and making a conscious effort to move away from anger and make sense of their traumatic childbirth. One might think that it was also therapeutic for these women to share their experience of trauma and their journey to resilience with me.

3.8.3 Looking after self

This final subcategory pulls together a salient part of becoming resilient and reflects the indication by some women that they had to take responsibility for meeting their own needs. Deidre recognised the need for "time" to mourn, reflect, process and understand why she had a still birth. This seemed to help her to put back together the pieces of her life that seemed shattered:

> *Take that time out, because I know through other experiences, you throw yourself back into life and you just bottle it all up and you pop it away in this little box ... You need to take that time to recover, understand, discover, explore, and to be able to understand why it happened, how it happened, and to take that time for you as a family ... to take that time to get over it ... Take that time for, for you, and that – that was a huge thing for me. I took quite a lot of time, I re-evaluated my life ... what I felt I needed to change …. So I think you need to take that time to yourself to heal, mentally and physically and get over it. (Deidre: 456)*

Similarly, Vivian described the need for "time" and "space" to recuperate:

> *Don't neglect your, your own needs ... You're a mum, you're always sort of thinking about other people, and I think you need to, erm, give yourself a bit of space and time occasionally, because that's important … If you constantly wear yourself out, you're not gonna be a hundred per cent for your children. (Vivian: 164-165)*

Lorna described that common maternal conflict around who to put first – the kids or yourself:

> *You have to put yourself first because we always say, "Put the kids first." You cannot put the kids first because if you put the kids first and you don't look after yourself and something happens to you, what then happens to the kids?...There's nothing wrong with ten minutes …You have to look after yourself ... (Lorna: 961-973)*
>
> *Don't feel guilty about putting yourself first (Lorna: 992)*

The women recognised that giving themselves time and space would not only help them to become resilient, but would also reinforce the practice of self-care and allow them

to fulfil their roles as mothers. They recognised that women who look after themselves can look after their children better. Allowing themselves time and space were important ingredients of self-care.

Rhianna gave more detail of how guilt can manifest among women who feel pressure to conform to society's expectation of motherhood. Rhianna explained the importance of women using "self-preservation" as a means of taking care of themselves, which then enables them to continue caring for others. She described "self-preservation" as women knowing their limits and not letting guilt be a driving force in them neglecting their own needs:

> *You haven't got that energy for yourself, never mind feeding the baby. So it's like realising that and not caring that people are judging ... But [with] self-preservation and then you can … take care of yourself and you can care for others. You can't care for a baby if you're a wreck. Because if you don't know your limit ... guilt's a huge thing. (Rhianna: 595-602)*

Following on from Rhianna's advice that women should know their limits as another aspect of looking after themselves, Laura suggests similar advice about women knowing themselves enough to support themselves as part of their recovery:

> *So I think we have these incredible reserves that we just … use up. The problem is you … if you're doing that, you've also got to be supporting yourself to notice when that's happening … the tricky balance … (Laura: 368)*

There was a sense that societal expectations of motherhood had a huge effect on women feeling guilty about taking time out for themselves. Guilt played an important part in women neglecting their own needs and not nurturing themselves. The process of owning their journey through the practice of self-care required women to know their limits, and recognise the importance of looking after themselves first, which meant they would manage better in caring for their children. Further examples were given of ways in which women could look after themselves and build resilience. Both Lorna and Onika suggested that women needed to pamper themselves as a form of self-care:

> *Everything [is] about the baby and sometimes we think, "Oh, if I indulge, I'm being a bad mum." No, you're not. If you don't look after yourself, then you can't look after your baby. So if you want to go get your nails done for half an hour, quickly make sure baby's fed and ... just feel good about yourself. (Lorna: 935-936)*

> *You've got to spruce … yourself. You've got to get back into it … You've got to feel good about yourself! For me, feeling good about myself is having decent clean clothes on. (Onika: 578-581)*

Taking time to nurture themselves was part of rebuilding their identities and this in turn helped them to regain a sense of who they were before their traumatic childbirth. There is

a sense that owning one's journey is not only about nurturing oneself as a mother, but as an individual. Jenny similarly recognised the need to look after herself:

> *Do things for yourself, go out with your friends, let the child work around you rather than you work around the child all of the time. Of course her needs were paramount but she didn't just have me. But I needed to have me. So, I needed to understand me. I needed to have things for myself. I put a plan in motion about what I wanted to do, where I wanted to be ... (Jenny: 299-304)*

Jenny's use of the phrases "I needed to have me", "I needed to understand me", "I needed to have things for myself" resonated with me as a very powerful description of what she had to do to rebuild herself. This sense of taking back control of one's life and owning one's journey seemed to be also echoed by Rhianna (see below), with strong words that captured her self-responsibility:

> *This is my baby, this is my birth, this is my journey. Only I know how to look after myself … (Rhianna: 620)*

There is a sense in the above quote that Rhianna holds pride, self-control and an intimate connection with herself in owning her journey. It is a way of looking after herself and demonstrating resilience. I believe that Rhianna's and Jenny's quotes above beautifully capture the overall essence of how women can demonstrate resilience after a traumatic childbirth.

These women were broken and shattered from their traumatic birth and through their journey towards becoming resilient they relied on various resources to help them cope with or overcome their trauma. The process of becoming resilient has shifted women from being powerless to powerful, and they appear to have more control of their lives. These women recognised that they are not the same individuals they were before, and whilst some are still putting the pieces back together, others continue to strive. I noticed a distinct transformation in these women's use of language, where the first part of their journey was about them surviving their struggle, loss of self and endurance, and in the second part they transitioned to a place of self-love, empowerment, confidence and pride. There appeared to be a development of the self as women felt more able to manage their trauma, and some of them no longer felt fragile and defenceless. The accounts of participants suggest that demonstrating resilience requires women to own their journey by knowing their needs and knowing which resources they need to access at different points in their life. This is a notable finding in the model. The findings from this study suggest that internal processes are important, but these cannot happen in isolation. Women also need to utilise external resources that provide support around them.

Chapter 4: Discussion

This study is focused on the process of becoming resilient following a traumatic birth. The literature review explored the likelihood of developing PTSD after a traumatic birth, and resilience in childbirth. The dearth of studies exploring how women become resilient after a traumatic childbirth highlighted the importance of generating new theory and knowledge in this area. A constructivist grounded theory approach was used to give voice to these participants' stories of their journey towards resilience following their traumatic birth experiences. Eight semi-structured interviews were conducted, and transcripts analysed using Charmaz's (2014) grounded theory. A new model of the process of resilience following a traumatic birth was devised, which emerged from the data.

The model consists of the following stages: Category 1: To be cared for – who's accountable?; Category 2: Motherhood becomes you; Category 3: Moving towards faith and spirituality; Category 4: Supportive relationships; Category 5: Self-care – as a way of owning my journey. These stages describe the trauma each participant endured, and explored the process of resilience development in each of their journeys. A core connecting category of 'The Journey towards Resilience following a Traumatic Birth' was identified, which applied to all categories and which linked all the constructs within the model. The model shows a pathway (see Figure 3) which illustrates that for women to build resilience they utilise either internal or external resources or both at different points on their journey.

In this chapter, I will discuss the five main stages of the model, and relate these findings to existing theory and the relevant literature. The strengths, limitations and suggestions for future research will also be presented. I will then evaluate the implications and suggestions for counselling psychology practice. I hope to present a new understanding of how to facilitate resilience following a traumatic birth.

4.1 Key Findings

4.1.1 Traumatic birth: To be cared for – who's accountable?

The participants described their experience as being traumatic due to unexpected complications and this was further compounded by the lack of care they received from health professionals.

Participants in this study described losing their voice – not being listened to – and this was a key part of their traumatic experience. Lewis, Hauck, Ronchi, Crichton and Waller (2016) similarly found that women described their dissatisfaction with care in terms of their caregivers' inability to listen to their needs and the experience of being ignored. Dennett (2003) has found that women value a listening approach by health professionals and suggests that women should be given a chance to discuss their needs during the birthing

process. The NHS Constitution (NHS England, 2017) states that one of its key principles and values is to give women choice and personalised care. However, emergency birth situations appear to challenge this right.

The women in the current study also described that another distressing aspect of care during childbirth was not being aware or informed of the complications that were occurring at the time. The lack of communication had a profound effect on the women feeling "invisible", and also placed them in a position of vulnerability. Beck (2004) similarly identified that failure to communicate can influence a mother's perception of their childbirth as traumatic. Lewis et al. (2016) suggested that uncertainty can raise anxiety and disappointment in the birthing mother. It is clear that essential communication with mothers is not happening as it should.

So what makes a 'good birth' experience, Talbot (2014) found that the experience of respectful care, including supportive and reassuring communication with healthcare professionals, can have a profound effect on mothers, giving them a positive experience, even in challenging situations. In the current study, the two participants who experienced premature births described the health professionals as trusting, supportive and good. It is interesting that both of these women received care provided by the SCBU, which provides support and care for families, tailored to the needs of the mother and baby. This suggests that both these women benefited from these supportive resources, reducing the impact of their traumatic birth experience. Those without this specialist support continued to struggle with their experiences.

Several women in this study expressed anger and helplessness due to their lack of choice and control over procedures being performed on their bodies. The lack of choice made women feel insignificant. This echoes the findings of previous studies where women reported feeling distress from lack of care (Elmir et al., 2010) and non-existent from lack of acknowledgement (Thomson & Downe, 2008). In this study, women were traumatised by the interactions they had with the medical profession when they experienced their care as unsupportive.

The women also described health professionals as not explaining what interventions they would carry out on their body. This in turn hindered women's feelings of control, as they were not involved in decisions about their care, leaving them feeling violated, powerless and vulnerable. They felt let down by their midwives. Silver (1985) described these feelings of betrayal as "sanctuary trauma", as previous assumptions of caregivers as empathic and caring were not what was experienced. This then led to "shattered assumptions" as a result of the negative attitudes and inactions of caregivers (Elmir et al., 2010). The findings of this study suggest that there is a clear need for women to feel

empowered during childbirth through the conscious effort of midwives actively seeking to understand the wishes and feelings of women in their care.

The provision of effective maternity care is important to not only lower mortality and morbidity rates (World Health Organisation, 2018) but to ensure that the well-being of the mother and child are prioritised (Symon et al., 2016). The focus on empowering the service user has been of particular importance for maternity providers in the UK (Department of Health, 2007). The idea behind this drive is to give women the option to negotiate their care options with their health professionals, once the women have had time to look at these options (Symon et al., 2016). Despite the provision of women-centred care across the UK, Australia and Canada (Sandall, Soltani, Gates, Shennan & Devane, 2013), women still experience the birthing process in ways that are not congruent or aligned with this approach. When there are unexpected issues, it seems this approach is not occurring. It has been recommended that future research should explore the various models of care in terms of implementation and effectiveness (Symon et al., 2016).

The women in this study expected a 'normal' birth with no complications, and that health professionals would be competent, attentive, and include them in decision making during labour. However, their actual experience was far from what they expected, heightening their experience of trauma. This mismatch in expectation appears to be common – numerous studies have found women's expectations and their actual experience of childbirth are often different (Gibbins & Thomson, 2001; Newton, 1991; Green, 1993). The difference between expectation and experience can produce adverse emotional outcomes, such as guilt, failure, and disappointment (Crowe & Baeyer, 1989; Fridh & Gaston-Johansson, 1990), as well as anger, frustration and helplessness (Mozingo, Davis, Thomas & Droppleman, 2002). The experiences of the women in this study closely echo those cited by Denham and Bulteemeier (1993) who found that anger can be triggered by labouring women when they feel powerless and perceive the medical profession to have not fulfilled their expectations. A number of participants within this study described feeling powerless as they had no control over their birthing experience. They also experienced anger in relation to the lack of information, or the withholding of information, which is consistent with studies that found that women desire information at every stage of their delivery (Green, Coupland & Kitzinger, 1990; Fowles, 1998).

The subjective experiences of the participants mirror those in previous studies (Beck, 2004b; Ayers, 2007; Moyzakitis, 2004). However, their sense of being abandoned was very strong, which elicited a fear of lack of accountability. The experience of not being heard, not being communicated with, and having no control resulted in intense feelings of terror and abandonment in these women at a time when they were most vulnerable. It was a common feeling that their life was at risk, and that they were invisible. The subjective

appraisal of threat for these women supports the Transactional Theory of Stress and Coping (Lazarus & Folkman, 1984), which highlights their primary appraisal of the event. These women were not in control, but also felt others were not in control either.

Using the Ehlers and Clark (2000) model as a guide to understand the experience of a traumatic birth gives us insight into how the women in this study mentally processed their trauma as they found themselves unable to protect themselves, experiencing themselves as vulnerable and in danger of losing their lives. These intense emotions of anger, anxiety and guilt all contributed strongly to their experience of trauma, and it would be some time before they were able to resolve these feelings. This has huge implications for clinical practice.

This first stage of the model presents findings from the subjective experience of traumatic childbirth. I will now discuss the findings of the experience and process of resilience, and connect my findings to existing theory and the relevant literature.

4.1.2 Moving towards faith and spirituality

Moving towards faith and spirituality is the first stage in the model, where women start their journey towards gaining resilience. This is an external resource that helps women to regain a sense of control at a time when they feel so out of control – and are at risk of losing their lives. Being unable to put their trust in the health professional, these women turn to a higher spiritual power, which helps them endure pain, suffering, and abandonment during labour. In this way, the journey towards resilience commences during the traumatic birth. This belief in a higher power enables women to feel protected and cared for, which helps them to get through their difficult birth – a finding that others have also noted in the literature.

Southwick and Charney (2012) highlighted that suffering can motivate women to focus on a higher spiritual power as a source of strength. Díaz-Gilbert (2014) also found that faith can help participants to “transcend suffering”, and if participants can find meaning in their suffering then they can begin the process of healing. This echoes some of findings in this study where faith built one participant’s resilience by helping her to process the pain of losing a child, and gain comfort in her belief that her child was spiritually alive in the universe. The findings of this study would suggest that finding faith both during and following a traumatic birth can be a source of comfort and strength in helping women to reframe their loss.

It is important to note that although the stage represented by faith and spirituality is labelled as an external resource in the model, there are elements of faith and spirituality that cross over into internal resources, such as connecting with inner parts of the self through meditation. Meditation was described by some participants in the study as helping them to connect to parts of their inner self that may have been lost from the trauma. For

example, one participant described meditation as helping her to be who she wanted to be, or giving her the courage to just be herself. Spiritual resources, such as having deep faith, practising prayer, and meditation, have been recognised as factors that aid resilience (Werner & Smith 1992). The findings, therefore, support the literature that meditative practices allow individuals to discover their internal and personal resources (Lee, Zaharlick & Akers, 2011). They suggest that meditation can help women to develop their sense of self and identity, which may have been lost due to their trauma.

Another source of faith was these participants' description of gaining or having a close supportive relationship with a higher spiritual power as something that saved their lives, healed their bodies when they were haemorrhaging, and helped them to get through difficult days after their traumatic childbirth. For these women, faith seemed to provide a sense of being cared for – something they were not experiencing with their health professional. These findings are in line with Drumm et al. (2013), who found that resilience was built through a unique dependence on a higher spiritual power as being central to survival. Some researchers have found that faith promotes effective healing and recovery (Undermann, 2002). What is clear is that when there was no one else listening, and when these women felt totally abandoned and that their lives were at risk, turning to faith allowed them to put their hope in something.

4.1.3 Motherhood becomes you

One of the key ways in which these mothers moved through their journey towards resilience was by claiming their role as a mother. Within this role, they were able to become more confident within themselves as women, deriving a sense of achievement. They drew upon the strength they found in that role to regain their confidence in other areas of their lives. In this study, being a mother empowered women, allowing them to experience growth in their sense of self as being worthy and capable. These findings are supported by a study conducted by Weinzimmer, Bach and Bhandari (2013), who also found that motherhood helped women to develop a positive sense of self and, that by having children, women developed a good self-image and conveyed to others their confidence in being successful mothers. Other studies on motherhood and resilience suggest that transitioning into motherhood, or the process of becoming a mother, can transform women's sense of self and produce a more valued identity (Nelson, 2003).

Another process that contributed towards resilience was having admiration for their child growing into healthy human being. As mothers, they were able to nurture and protect their child who might have died during labour. Seeing their child alive and thriving allowed them to experience a parallel process for themselves. These findings have been supported by Weinzimmer et al. (2013) who found that becoming a mother can help women to feel

more in control of their lives as they become maternal protectors. In addition, they suggest that successfully raising children can produce a sense of achievement. An interesting example from this current research is Rhianna, whose son was born brain damaged. Despite disabilities, Rhianna described her admiration for her son's development. To summarise, a traumatic birth experience can shatter the view of one's self. However, the role of the mother can have a positive effect in helping women to rebuild their identities and move forward with their lives.

The current model shows how being a mother helps foster resilience in women by giving them the opportunity to be positive role models. The women in this study explained that living positively and enjoying life fully encouraged their children to emulate the behaviours needed to overcome adversity. The women also described a need to put on a brave face during difficult times as a way of instilling the values and the character needed to survive adversities. These findings are in line with a study that looked at the components of resilience among African-American single mothers. In this study, women described a need to teach their children the values required to overcome adversities, which also motivated them to improve their lives (Brodsky, 1999). As women positioned themselves as role models, this had the parallel process of not only building resilience within their children but also within themselves.

The findings of this study support some of the dimensions of the theory of adult personal resilience, as women relied upon their internal characteristics or resources as a way of becoming stronger and able to work through their trauma. There was a clear sense from the participants that they were determined to raise healthy children and be the best mothers they could be. Elements of cognitive recuperability also manifested in women wanting to show their children how to live their lives in a positive way.

4.1.4 Supportive relationships

Supportive relationships were another external resource in the model that helped women in their journey towards resilience. Participants described family members as lifting their negative emotions, and helping them to feel cared for and encouraged. In addition, supportive relationships can be an important source of strength for women as they develop bonds or connections with others. There is much research to suggest that support from others is a key protective factor following trauma – for example, Walsh (2003) found that connections with loved ones represented the most important source of strength following the trauma of the 9/11 terrorist attacks.

Participants explained that through close connections with family members they were able to 'get through' their traumatic loss or 'overcome' their traumatic birth. The participants explained that after their traumatic birth, family members would bring presents

or food which in turn helped them to feel cared for, valued and regenerated, especially after feeling abandoned and unworthy. This is in line with Black and Lobo (2008) who found that support from family members can help individuals feel good about the family and feel nurtured when their needs are being met. Other theorists have also viewed the family as a source of comfort and strength (DeFrain, 1999; Parke, 2000). Abboud and Liamputtong (2005) similarly identified that family bonds that were positive and encouraging can help women cope when they experience a traumatic loss. The findings suggest that family connections or bonds are important sources of support that help women feel cared for and worthy again.

Abboud and Liamputtong (2005) explained that the support and encouragement of partners and husbands is an important factor in women coping and getting through a traumatic childbirth. However, in the current study, it was noticeable that partners were hardly mentioned pre- or post-trauma. When asked specifically about the roles their partners played, some described the practical support, including helping with chores and caring for other children, as especially helpful, giving them a chance to regain their strength and heal from physical complications.

Another aspect of the journey to resilience following a traumatic birth was regaining a sense of a social self. Friendships with other women helped reduce the isolation following childbirth, and helped them get back on their feet socially again. The women explained that through the support and encouragement of friendships, they were motivated to have a social life, helping them to be active again. This also had the effect of enabling women to awaken and regain parts of themselves that were beyond motherhood and their bonds with family members, and which may have been fragmented by the trauma. Previous studies support these findings that developing and regaining a sense of self and identity through friendships is an important factor for resilience (Muraco, 2012). Shepherd, Reynolds and Moran (2010) conducted a qualitative study looking at how a single close supportive friendship may facilitate psychological resilience in adolescents, finding that friendships can be a source of emotional and motivational support.

At points during their journey some women connected to social media and support groups, providing a sense of community, connection and empowerment. Social media gave them a way of connecting with other women who had experienced difficulties with childbirth. The use of social media suggests that women do not need to feel isolated with their struggles but can reach out in different ways if it is physically difficult to get out socially. For example, Laura described the use of social media as helping her to identify ongoing feeding issues she had with her son. The findings of this study suggest that this type of support is very important and different in nature to the support received from family and friends. This is a significant, and perhaps overlooked, aspect of resilience. It is generally well known that

contact with others who have experienced similar things is a really important source of social comparison, which helps coping. These sources of support can be found in formal support groups, or via social media. It seems that it may be easier to access social media following birth, when one is recovering physically or feeling isolated. Those who reach out and seek this contact may experience it as a protective factor.

Participants described joining formal support groups as like belonging to a "tribe" of women who were walking similar paths. They explained that forming connections with women with similar experiences helped them feel understood, enabling them to rebuild their confidence in a space where they could share their stories.

The findings of my study are consistent with a study on resilience in women who viewed their relationship with other women as a strong network which helped them to know that others experienced similar struggles (Shanthakakumari, Chandra, Riazantseva & Stewart (2014). Support from others in similar circumstances provided a sense of unity, protection, normalisation, and understanding. These findings are similar to those of Walstrom et al. (2013) who found that women can cope better by strengthening their interpersonal connections with others through uniting with other women who are experiencing the same life transition. Studies have suggested that support groups provide women with a space where they can connect with other women who understand the challenges they are facing whilst learning how these women cope (Southwick & Charney, 2012).

Overall, this study has highlighted that many forms of social support – family members, partners, friends, and others who have experienced similar things – all play a role in helping women recover from their traumatic experience. This scaffold of support is a major protective factor for women, and is consistent with the literature on other forms of trauma such as building resilience in women who have suffered intimate partner violence (López-Fuentes & Calvete, 2015).

4.1.5 Self-care – as a way of owning my journey

All participants shared a belief that women needed to practise self-care as way of owning their journey towards becoming resilient. Self-care evolved as another internal resource in the model, which would require women to become assertive (speaking up), talk about their struggles and look after themselves.

The women in this study expressed a desire to take back control of their life by becoming assertive. Participants described their journey towards resilience as taking them from being powerless, where they had no voice, to being assertive and empowered. The accounts of participants suggested that they transformed themselves from shy individuals to women who were confident to vocalise their needs as a way of preventing future trauma.

The women described a determination to voice their needs in subsequent pregnancies as a way of regaining control of their labour, and they expressed a strong conviction that they would not suffer in silence any longer.

In line with these findings, Lynch, Keasler, Reaves, Channer and Bukowski (2007) found in their study of survivors of trauma that participants conveyed a special interest in taking care of themselves, and that this would require them to assert that their rights be respected so that their needs could be met. Vocalising these needs meant that women would speak without hesitation as a way of coping with stress, and speak up for what they believed others should know. They viewed this as making a difference to what happened in their lives. According to Lazarus and Folkman (1984) – see Section 1.2.1 – a person's cognitive appraisal of challenges and threat will determine how they respond to traumatic or stressful environment, and the coping behaviours they will use. The authors also suggest that what may have been viewed as a stressor now becomes a challenge to overcome. Theorists have highlighted that this may be a factor of resilience (Benight, 2012). The participants in this study became assertive by utilising their personal resources, which helped them to feel in control of their lives and meant that they would not suffer in silence again when faced with adversity.

A number of studies support the findings that assertiveness reduces psychological stress (Lee & Crockett, 1994; Massong, Dickson, Ritzler & Layne, 1982). The women in this study noticed transformations within themselves in developing a fighting spirit and a more trusting and secure sense of self over time. One may argue that there is a restorative change where women have lost their voice during their traumatic birth and now feel empowered to voice their concerns as a way of preventing further trauma in the future. The literature suggests that individuals who have an internalised sense of self and power and put their needs first are able to cope better with adversities (Dale, Pierre-Louis, Bogart, O'Cleirigh & Safren, 2017).

The women in this study also highlighted the value of talking about their struggles, which helped them to find their voice and empowered them. This had the effect of helping them feel supported and not isolated. The women explained that talking about their struggles allowed them to receive help and tell their stories, which in turn, helped them to know that others had similar struggles. They also explained that this knowledge made life easier for them as they realised that they were not alone on their journey towards recovery. Talking also enabled them to let go of the struggles they were carrying within, whilst feeling they were listened to and understood – something they did not experience during their traumatic birth experience. The act of confiding our deepest thoughts and feelings about trauma in others can decrease physical and mental health symptoms over time (Pennebaker, 1993). Silver and Wortman (1980) found in their study that survivors of trauma

described a need to talk about their trauma and express their feelings as a way of receiving social support. Talking about adverse events can help the individual gain knowledge that others are also experiencing similar feelings (Valins & Nisbett, 1972), and confiding in others can help the individual to find meaning or reorganise their experience (Silver & Wortman, 1980). Having supportive others that listen to their struggles has been found to help individuals recover from trauma (Pennebaker; Stroebe, Stroebe, Abakoumkin & Schut, 1996).

Another salient part of self-care was taking responsibility for meeting one's own needs. Looking after themselves required women to take time and space to reflect, to pamper themselves and take pride in their appearance as a way of rebuilding themselves. For example, the participants explained that women need to make an active decision to put themselves first by giving themselves time and space so they can provide better care for their children. In support of these findings is a study conducted by Gardner and Harmon (2002), who researched resilient parents, finding that women recognised that self-care would require them to acknowledge their needs and act upon them as a way of coping. In addition, the authors found that women recognised that when they practised self-care they had more enthusiasm and energy to look after their children, which was necessary for them to cope.

The women in this study also explained that pampering helped them to feel good about themselves, and this meant that they were taking the time to nurture themselves as a way of rebuilding their identities. The literature suggests that when women recognise their needs and how to meet them constructively, it can give them a sense of achievement and help them to develop a more solid sense of self (Williams, Lindsey, Kurtz & Jarvis, 2001). There was a clear sense that the participants believed that pampering themselves meant they were treating themselves as valuable and deserving. The women used phrases such as "needing to have me", "needing to understand me", and "needing to have things for myself", which suggest an awareness of what is required to rebuild one's sense of self.

It was interesting to note that the women also expressed that societal expectations affected their decision to put their needs first, before those of their children. One might argue that female roles in society have reinforced to women that their duty as maternal carers is to prioritise their children. The women in this study described how the overall essence of becoming resilient requires women to own their journey by knowing which resources (internal or external) they need at various points. As one participant beautifully stated, "this is my baby", "this is my birth" and "this is my journey", suggesting that women need to not only take responsibility but hold an intimate connection with themselves in developing resilience.

4.2 Evaluation of the Study

Because of the severe impact a traumatic birth can have on women, it is important for us to understand what happens to them, and how they overcome their traumatic experiences. This has not been widely covered in the literature. This study has offered a model developed from in-depth interviews, allowing us to understand the experiences of these women and the journey they go through to develop resilience following their traumatic birth. The model brings new insights into the process, highlighting the two dimensions (internal and external) birthing mothers utilise to build resilience. To my knowledge a theory of resilience for traumatic childbirth has not been proposed.

This research has also provided insight into the resources women rely upon to foster resilience. The findings of this study illustrate how at the beginning of the journey these women are left feeling hopeless, powerless, abandoned, unheard and fearful. Over time, by relying upon their faith and supportive relationships to find security and protection, they are able to process their feelings about their traumatic childbirth. They continue to find strength in their role as mothers, regaining their voice and reawakening their sense of self. A notable finding is that all participants described self-care as an important ingredient for resilience.

The current study contributes to our theoretical understanding of developing resilience in a number of ways. Existing theories have mainly developed from at-risk children and have now shifted to adult trauma survivors (Agaibi & Wilson, 2005). The development of the new theory of adult personal resilience (Taormina, 2015) brings new insight into the internal resources adults can use to become stronger and cope with trauma. However, it does not consider the external resources that help individuals to adjust positively. This current proposed model give us in-depth insight of the process of how utilising internal and external factors helps to build resilience.

As mentioned above (see Section 1.4), researchers have put forward theories of resilience such as the meta-theory and the generic theory of resilience that can be applied to various populations. The meta-theory offers the process of resilient reintegration, where protective factors are relied upon; and the generic model focuses on reliance on personality traits. However, these existing theories are difficult to apply to this niche group of women in terms of how resilience is developed in both models. The dimensions within this current give personalised insight into the resources women rely upon in their journey towards resilience. The personalised nature of the dimensions within this model are easily transferable within clinical practice and the wider community.

One may argue that traumatic birth is a very unique type of trauma, in that not only are the usual trauma issues experienced (hopelessness, violation, loss of control) but there is the added dimension that you are not just one person but a mother responsible for

someone else – yet you have no power to do anything. Taking these factors into consideration highlights the need for more research and resilience models in the area of traumatic birth.

The dimensions within this model have implications for how birthing mothers conceptualise their resilience from a subjective experience. The two dimensions have four constructs within them: 'Moving towards faith and spirituality', 'Motherhood becomes you', 'Supportive relationships' and 'Self-care', which can help practitioners gain insight into the very personalised nature of sources women rely upon in adjusting after a traumatic birth.

It is hoped that this research will guide health professionals in their interactions with this particular group of women pre- and post-birth. I feel honoured that the participants shared deeply personal and private experiences of a traumatic birth with me, and how they moved on from their lowest moments. The constructs within the model can provide a useful framework that allows health professionals to promote resilience by exploring their interactions, communications, and support, both at the time and following delivery as a routine part of perinatal mental health.

4.3 Strengths and Limitations of the Current Study

It has been suggested that qualitative methods provide many advantages in the study of resilience (Ungar, 2003). To date, the process of developing resilience in relation to traumatic births has not been investigated. The qualitative nature of this research provides rich insights into the process of resilience that are difficult to achieve with quantitative measures. The strength of this study is that it has produced a novel area of research, an area that is clinically relevant, using a grounded theory methodology which has allowed a model to be developed, and the model gives some practical guidance for preventive approaches and interventions.

This study has contributed to our understanding of resilience, and may be transferable to other areas of trauma. It has also given women a voice when theirs was silenced, which in itself is a reparative process for them. This study offers the potential to provide new insights on ways to structure intervention and clinical practice with this group of women.

Another particular strength of this study is that it gave women a voice to provide compelling narratives of the way in which motherhood and other resources were used in building resilience. According to the women in this study, motherhood can help them to feel empowered and gain belief in themselves as being capable and confident.

One might consider the sample size of participants in this study to be a possible limitation. However, as mentioned above (see Section 2.12.6), saturation will be defined in this study as 'theoretical sufficiency' (Dey, 1999), whereby the researcher considered the

research aim and the quality of the data when establishing sample size (Mason, 2010). The sample size in this study was eight participants, although the size recommended for grounded theory is 10 to 60 participants (Starks & Trinidad, 2007). Charmaz argues that a small sample size with modest claims can justify claiming saturation early (2006, p. 214). The women in this study were a small sample from a limited geographical location, which may prevent the findings from being generalised across a wider group of women.

A potential limitation of the study is that women were not asked at the beginning of the study to give a definitional construct of resilience. This would have given us further insight into whether current constructs and concepts of resilience were applicable to women who experience traumatic birth. In addition, a definitional construct from participants would have captured the diverse meanings this niche group of women negotiated in their personal constructions of resilience.

Another limitation of the present study was that only one interview was conducted with each participant due to time constraints and the availability of the women as busy mothers. This may have hindered our understanding of how resilience can evolve over time, and of how this group of women define their experience of resilience. In addition, the retrospective nature of this study may have influenced these women's accounts of their traumatic birth experience. Despite this, it was important to ethically exclude women who had given birth in the last year and viewed themselves as experiencing postnatal depression or symptoms of PTSD.

In addition, the use of grounded theory is limited to providing thick descriptions of participants' lived experiences of the studied phenomenon (Sokolowski, 2000; Stewart & Mickunas, 1974). The use of a phenomenological methodology could have provided the researcher with the opportunity to understand the embodied perception of participants' trauma, and how they captured the meaning and experience of becoming resilient. However, it is important to consider that the aim of grounded theory is to develop emergent theory on the social processes of the studied phenomenon (Starks & Trinidad, 2007). In line with the research aim and objective, grounded theory was the best methodological fit.

4.4 Future Research

The women in this study gave voice to factors that made their childbirth traumatic, and the majority of grievances were centred on the type of care they received or their expectation of care. Future studies should continue to explore how expectations can impact women's perception of their birthing experience as being traumatic. In addition, practitioners need more knowledge of the internal and external resources women utilise in developing or building resilience, and which help guide clinical practice.

A noteworthy finding in this study came from the two women who had premature births and described the health professionals in the special care units as “supportive”, “trusting” and “good”. One might argue that the health professionals in the SCBU are required to be more attentive to the needs of the mother and baby. Thus, future research is needed to give further insight into how women who have experienced traumatic premature births become resilient and potentially recover in comparison with full-term births.

Future research should also interview women from a variety of cultures in order to give a more diverse exploration of what factors women rely upon in becoming resilient. Due to the timescale of this study, it was impossible to look further into cultural and socio-economic differences and resilience. Further exploration is also needed on samples of women with a specific focus on how they become resilient after the loss of a baby (still birth) or following the birth of a baby with severe developmental/physical disabilities, as the findings indicate that women may have different needs in terms of becoming resilient.

Future research is needed on the processes of motherhood and resilience, and the implications of motherhood in improving women’s health, as the literature is sparse in this area (Zraly, Rubin & Mukamana, 2013).

Spirituality enabled women to feel supported, protected and comforted. More advanced understanding is needed on the role of religion and spirituality in building resilience in women who have experienced traumatic births, and this may bring forth new theory on how women adapt to trauma.

Support groups and networks in this study gave the women the opportunity to share their traumatic birth and their emotions with others whom they perceived as being of the same “tribe”. Further research could examine how the perception of belonging to a “tribe” of women can help foster resilience.

A further area of challenge is the use of the word “resilience” during the interview process. Although it was important to orient the participants to the specific phenomenon being studied, this could have steered women to put forward socially acceptable preconceived ideas of resilience. Future research could ask women to give a definitional construct of resilience, which would give further insight into their own interpretation of the term.

This study provided new insight into the process of resilience, and it is hoped that it will highlight possible areas for future research.

4.5 Ensuring Standards of Rigour and Credibility

Charmaz (2014) asserts that the following criteria should be considered in evaluating constructivist grounded theory research: credibility, originality, resonance and usefulness

(see previous reflections in Methodology – Section 2.1). Table 3 (below) presents an overview of the criteria used to ensure standards of quality.

Ensuring standards of quality	**Researcher's response**
Credibility "Research should achieve intimate familiarity with the topic; has enough evidence been provided for the reader to agree with claims and form an independent assessment."	• Through the analysis of transcripts, coding, memos and reflexive practice, the researcher achieved intimate familiarity with the research topic. • The researcher provided participant quotes and links within the data to allow for an independent assessment to be conducted. • The researcher positioned herself as co-constructor of meaning in the data analysis and monitored herself by being reflexive through the analysis and through the use of memos.
Originality "The researcher should provide fresh insights on the studied phenomenon; provide new concepts in data; the researcher should provide social and theoretical significance."	• A new model was derived from the data, showing a process of building resilience after a traumatic birth. • The researcher provided social and theoretical significance in the implications for counselling psychologists and suggestions for health professionals. (Section 4.6)
Resonance "The methodology should make sense to the participants who shared their experience and provide these women with deeper insights into their life."	• Two participants were contacted and both women agreed that the methodology made sense and captured the process of their journey to resilience. • All participants shared their reflections of their experience as helping them to process their feelings and gain deeper insight into how they became resilient.

Usefulness "Analysis should offer interpretations that others can use in their everyday world. Analysis should contribute to knowledge and warrant further research in this area."	• The analysis presented quotes and interpretations that both participants and health professionals can use in their everyday world and in clinical practice. • The results from this study have contributed to knowledge in the development of emergent theory and suggestions for future research have been given. Contribution to knowledge can be found in the evaluation of the study section (Section 4.6)

Table 3: Ensuring standards of rigour and trustworthiness using Charmaz's (2014) criteria

In addition, I also considered Morrow's (2005) criteria as these relate specifically to the ethos of counselling psychologists in assessing the standards of work. It has been recommended by Morrow that counselling psychologists should produce research that aims to be educative and transformative, which will in turn invite other researchers in the field to engage with the research problem. Morrow also highlights the importance of integration of theory into practice, and suggests that counselling psychologists should have this as one of the main features or guiding principles in their research. These principles have informed the development and construction of this research, and are discussed further in the implications for practice section below.

4.6 Implications for Counselling Psychology Practice

The findings of the present study and the emergent model show how women rely upon internal and external resources at various points on their journey in developing resilience after a traumatic childbirth. The external and internal resources women utilised were faith and spirituality, motherhood, supportive relationships and self-care. As mentioned at the outset of this thesis, literature on resilience after a traumatic birth is limited to quantitative measures, which does not take into consideration that resilience is a process and that the use of scales is limited to capturing the deeper experiences of resilient functioning (Aburn et al., 2016). In addition, the birth and resilience literature is limited to examining resilience from one traumatic birth event, and neglects insights into how the process of resilience evolves after time following a traumatic birth. This study has provided insight into the process of resilience and the internal and external resources women rely upon in fostering resilience.

One of the ways in which the women in this study experienced trauma was from unexpected complications during labour. Thomson and Downe (2010) suggest that a possible form of intervention is for health professionals to use a 'birth flow chart' instead of a 'birth plan'. This would present various pathways in which labour could start in terms of induction/normal labour, pre-term or caesarean section. Utilising this approach would give the birthing mother some insight into the various ways in which childbirth can progress, and lessen the impact of an unexpected outcome (Frost, Pope, Liebling & Murphy, 2006).

This study draws attention to the role that healthcare professionals play in providing comfort and support during and after labour. Healthcare professionals need to ensure that consent and communication are adequate even in emergency situations to avoid adding to the trauma of birth complications. Counselling psychologists can also highlight the issues of violation, helplessness and dissociation that can occur if communication and consent are not clear. The recent government initiatives invested in specialist perinatal community support in order to improve access to – and experience of – care, early diagnosis and intervention with women during pregnancy and postnatally (NHS England, 2016) should help with this.

Another aspect that contributed to participants' trauma in this study was a lack of care, which was experienced in some instances as a lack of communication between them and the health professionals. This had the effect of making them feel invisible, not worthy of care, neglected and helpless in experiencing their childbirth as traumatic. The recent changes in policy regarding intrapartum care have stressed the importance of good, clear communication between health professionals and birthing mothers (NICE, 2015). A new guide for midwives and obstetricians has been published in the *British Medical Journal* where the authors propose that health professionals should avoid the use of certain terms when communicating with the birthing woman as a way of promoting a "culture of respect" (Mobbs, Williams & Weeks, 2018). In addition, the use of 'alternative' language will give women the respect and empowerment needed to make decisions, which in turn should promote respectful practice.

These new guidelines also provide counselling psychologists with knowledge of changes within societal norms and expectations in respecting the care and autonomy of the birthing mother. My study strongly supports the new guidelines and suggests that there is a clear need to train health professionals in the importance of communication, choice, control, listening and their use of language when caring for the birthing mother pre- and post-labour. Health professionals need to be mindful that how they communicate during traumatic and emergency situations will have a huge impact upon how these women perceive their birthing experience. Evidence has shown that positive communication and interactions during pregnancy can change one's view of pregnancy as being positive, which

in turn can affect the mother's mental and physical health, and interactions with her baby (Harris and Ayers, 2012; Reed, Sharman & Inglis, 2017).

As health professionals, it is imperative that we give women the best possible chance of building resilience by considering the very personalised nature of it. The women in this study reported that receiving praise for successful parenting from the health professional helped restore their confidence that they were great mothers, which in turn built their resilience. Being recognised by health professionals for doing well in motherhood can promote resilience in women.

Another finding that was important for the participants was the use of supportive relationships. One would suggest that practitioners can promote resilience by discussing with birthing mothers the internal and external resources pre- and post-labour that can help build resilience, so that they do not need to feel in the dark if they experience a traumatic birth. For example, they can communicate to birthing mothers the value of having a strong support network pre- and post-labour as a way of promoting resilience and reducing risk. Ayers (2017) suggests that identifying ways to increase resilience in women can be informative in guiding maternity care services on the resources that increase resilience and lessen risk. It is hoped the findings of this study will help guide health professionals and maternity care services on how to enhance resilience in this group of women.

The findings from the category 'faith and spirituality' also serve to guide clinicians on how religion and spirituality can foster resilience. Goldberg (1996) suggests that it would be useful for healthcare professionals to view faith and spirituality as part of their client's cultural value structure, and as a resource that helps the client to cope. Clinicians working with this group of women should ask specific questions about the client's belief systems, and how this influences their ability to cope after trauma. Drumm et al. (2013) advise that clinicians should be wary of labelling a client's beliefs as superstitious or magical thinking, potentially leading to a pathological diagnosis. The authors suggests that clinicians should help their client identify how their spiritual beliefs help them to foster resilience and persevere in the face of adversity. Shafranske (1996) also suggests that clinicians need to respect their client's religious or spiritual beliefs, whether or not they accept their client's reality.

The subcategory of 'talking about their struggles' highlighted the importance of discussing a difficult birth, which helped women to own their voice, feel empowered, access support and share their experience with other women. In the UK, clinical guidelines recommend that women should be offered a 'postnatal discussion', where they can reflect and process their labour and delivery, ask questions and voice their concerns to a health professional (NICE, 2007). This brings into focus the importance of health professionals giving this group of women the knowledge of and insight into how they can build their

resilience when the clinical resources are not readily available. This study, I believe, will bring more attention to, and focus on, the importance of promoting resilience in birthing mothers.

4.7 Personal Reflexivity

I was driven to explore this research area because of my own experience of traumatic childbirth. This brought with it a host of preconceptions. Participants' stories of their trauma resonated with me and I found myself in the early stages of the research interview process struggling to remain objective when listening to their wants and needs for care from their health professionals. To minimise the impact of my beliefs, I used reflexivity and memo writing throughout the research process to help me remain self-aware. Supervision also helped me to recognise when my own feelings and beliefs might be influencing the research process.

I have been fortunate to have the opportunity to listen to their feelings of fear, powerlessness, suffering, and their experience of emotional turmoil and pain. I am aware that it required immense courage and strength for these women to share with me a very traumatic time in their life. It was inspiring to see how they went from a time in their life where they felt powerless to a position of empowerment as they found various resources to build their resilience. What resonated with me was the importance of looking within or externally for the help needed to withstand adverse times in our lives. I can only hope I did justice to their stories.

Several moments on this research journey have really resonated with me. For example, after leaving the home of one participant's house, I needed a few hours of solitude to process her story, and the impact it had on me. I understood what resilience was. Writing on the very topic of resilience also helped me personally to stay strong and focused in completing such a challenging but rewarding area of study. Also, the words 'having a voice' continue to resonate with me, reminding me of how these women felt silenced during their traumatic experience and how in subsequent births they found their voice as they remained determined not be placed in a position of vulnerability again. On reflection, I believe that this study also helped these women to find their voice through the writing of this project, and I hope that this study has played a reparative role in their journey too. It was challenging to sit through some interviews where women talked about difficulties with health professionals, and I had to remain neutral – despite my anger – so as not to collude with my participants. Constantly, I had to monitor my reactions and remain objective.

I was also struck by the participants' comments on faith and spirituality in helping to build resilience. My own experience after my still birth was to turn away from God. I blamed God for the loss of my baby. Deidre's experience of a still birth continues to resonate with

me in relation to how she processed and made sense of her loss through religion and spirituality. She held a positive belief that her baby was living happy and healthy somewhere in the spiritual realm. This made me think of how soothing and comforting it must be to find meaning and connect positive beliefs to the trauma of one's loss and in living with that loss.

As I reflect on my own process, I am aware that I will never be the same person I was at the beginning of this journey as a lot has changed in my life and I have experienced major changes and challenges. The very write-up of my research topic on resilience has reinforced to me that although challenging situations may enter our lives, we can look towards various resources within ourselves or others in weathering the storms. Plus we must make the ultimate decision to own our journey in life as a means to our survival, regardless of the adversities we may face along the way. I believe this research has helped to strengthen my belief that we can all become resilient and eventually overcome or recover from traumatic experiences. The process has not only built upon who I am as an individual but also as a practitioner.

4.8 Conclusion

The aim of this study was to gain an understanding of how women become resilient and potentially recover or heal. The study contributes to the gap in the field through the use of qualitative methodology and by giving these women the opportunity to voice and share their understanding of what factors they believed fostered their resilience. This will help further our knowledge as healthcare professionals about the various resources that allow women to develop and build their resilience.

Conducting research in the area of resilience following trauma felt congruent with my ethos as a counselling psychologist, since as a profession we tend to focus on the individual's ability to thrive and the resources available to them in aiding that process. It is hoped that the findings from this research will empower other women and convince them that they too can overcome adversity following a traumatic birth, and hopefully highlight the importance of this area for future research. Most importantly, this study has helped women give voice to their experiences, as they described a time when they felt they had no voice. I hope this study has also given women a voice to continue sharing their experiences as a way of helping other women to overcome a traumatic birthing experience.

References

Abboud, L., & Liamputtong, P. (2005). When pregnancy fails: Coping strategies, support networks and experiences with health care of ethnic women and their partners. *Journal of Reproductive and Infant Psychology*, *23*(1), 3-18.

Aburn, G., Gott, M., & Hoare, K. (2016). What is resilience? An integrative review of the empirical literature. *Journal of Advanced Nursing*, *72*(5), 980-1000.

Agaibi, C. E., & Wilson, J. P. (2005). Trauma, PTSD, and resilience. *Trauma, Violence, & Abuse*, *6*(3), 195-216.

Alim, T. N., Feder, A., Graves, R. E., Wang, Y., Weaver, J., Westphal, M., & Charney, D. S. (2008). Trauma, resilience, and recovery in a high-risk African-American population. *American Journal of Psychiatry*, *165*(12), 1566-1575.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association (1999). Archival description of counseling psychology. *The Counseling Psychologist*, *27*(4), 589-592.

Annells, M. (1997). Grounded theory method, part I: Within the five moments of qualitative research. *Nursing Inquiry*, *4*(2), 120-129.

Antonovsky, A. (1987). *Unraveling the mystery of health: How people manage stress and stay well*. San Francisco/California, CA: Jossey-Bass.

Ayers, S. (2007). Thoughts and emotions during traumatic birth: A qualitative study. *Birth*, *34*(3), 253-263.

Ayers, S. (2014). Fear of childbirth, postnatal post-traumatic stress disorder and midwifery care. *Midwifery*, *30*(2), 145-148.

Ayers, S. (2017). Birth trauma and post-traumatic stress disorder: The importance of risk and resilience. *Journal of Reproductive and Infant Psychology*, *35*(5), 427-430.

Ayers, S., Joseph, S., McKenzie-McHarg, K., Slade, P., & Wijma, K. (2008). Post-traumatic stress disorder following childbirth: Current issues and recommendations for future research. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*(4), 240-250.

Ayers, S., McKenzie-McHarg, K., & Slade, P. (2015). Post-traumatic stress disorder after birth. *Journal of Reproductive and Infant Psychology*, *33*(3), 215-218.

Ayers, S., & Pickering, A. D. (2001). Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. *Birth*, *28*(2), 111-118.

Bahl, R., Strachan, B., & Murphy, D. J. (2004). Outcome of subsequent pregnancy three years after previous operative delivery in the second stage of labour: Cohort study. *BMJ*, *328*(7435), 311-315.

Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist*, *44*(9), 1175-1184.

Barron, R. A. (2004). International disaster mental health. *Psychiatric Clinics of North America*, *27*(3), 505-519.

Beck, C. T. (2004a). Birth trauma. *Nursing Research*, *53*(1), 28-35.

Beck, C. T. (2004b). Post-traumatic stress disorder due to childbirth: The aftermath. *Nursing Research*, *53*(4), 216-224.

Beck, C. T., Gable, R. K., Sakala, C., & Declercq, E. R. (2011). Posttraumatic stress disorder in new mothers: Results from a two-stage U.S. national survey. *Birth*, *38*(3), 216-227.

Beck, C. T., & Watson, S. (2016). Posttraumatic growth after birth trauma: "I was broken, now I am unbreakable." *MCN, The American Journal of Maternal/Child Nursing*, *41*(5), 265-271.

Benight, C. C. (2012). Understanding human adaptation to traumatic stress exposure: Beyond the medical model. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(1), 1-8.

Berg, B. L. (2001). *Qualitative research methods for the social sciences* (4th ed.). Boston, MA: Allyn and Bacon.

Bernstein, R. (1983). *Beyond objectivism and relativism: Science, hermeneutics, and praxis*. Philadelphia, PA: University of Pennsylvania Press.

Black, B., & Sandelowski, M. (2010). Personal growth after severe fetal diagnosis. *Western Journal of Nursing Research*, *32*(8), 1011-1030.

Black, K., & Lobo, M. (2008). A conceptual review of family resilience factors. *Journal of Family Nursing*, *14*(1), 33-55.

Block, J. H., & Block, J. (1980). The role of ego-control and ego resiliency in the organization of behaviour. In W. A. Collins (Ed.), *Minnesota symposium on child psychology* (pp. 39-101). Hillsdale, NJ: Erlbaum.

Blumer, H. (1986). *Symbolic interactionism: Perspective and method*. Berkeley, CA: University of California Press.

Bogar, C. B., & Hulse-Killacky, D. (2006). Resiliency determinants and resiliency processes among female adult survivors of childhood sexual abuse. *Journal of Counseling & Development*, *84*(3), 318-327.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, *59*(1), 20-28.

Bonanno, G. A., & Mancini, A. D. (2008). The human capacity to thrive in the face of potential trauma. *Pediatrics*, *121*(2), 369-375.

Breckenridge, J. N., Jones, D., Elliott, I., & Nichol M. (2012). Choosing a methodological path: Reflections on the constructivist turn. *The Grounded Theory Review*, *11*(1), 64-71.

Brewin, C. R., & Dalgleish, T., & Joseph, S. (1996). A dual representation theory of posttraumatic stress disorder. *Psychological Review, 103*(4), 670-686.

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review*, *23*(3), 339-376.

British Psychological Society (2014). Code of human research ethics. Leicester: BPS. Retrieved from https://www1.bps.org.uk/system/files/Public%20files/inf180_web.pdf

Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect*, *27*(10), 1205-1222.

Brodsky, A. E. (1999). "Making It". The components and process of resilience among urban, African-American single mothers. *American Journal of Orthopsychiatry*, *69*(2), 148-160.

Calhoun, L.G., & Tedeschi, R.G. (1998). Posttraumatic growth: Future directions. In R.G. Tedeschi, C.L. Park, & L.G. Calhoun (Eds.). *Post-traumatic growth: Positive change in the aftermath of crisis* (pp.215-238). Mahwah, NJ; Lawrence Erlbaum Associates.

Campbell-Sills, L., & Stein, M. B. (2007). Psychometric analysis and refinement of the Connor–Davidson Resilience Scale (CD-RISC): Validation of a 10-item measure of resilience. *Journal of Traumatic Stress*, *20*(6), 1019-1028.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 249-291). Thousand Oaks, CA: Sage.

Charmaz, K. (2003). Grounded theory: In J.F. Holstein & J.F. Gubrium (Eds.), *Qualitative psychology: a practical guide to research methods* (pp. 81-110). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.

Charmaz, K. (2014).*Constructing grounded theory (2nd ed).* London: Sage.

Coates, R., Ayers, S., & De Visser, R. (2014). Women's experiences of postnatal distress: a qualitative study. *BMC Pregnancy and Childbirth*, *14(1),* 1471-2393.

Collicutt-McGrath, J., & Linley, P. A. (2006). Post-traumatic growth in acquired brain injury: A preliminary small scale study. *Brain Injury*, *20*(7), 767-773.

Connor, K. M., & Davidson, J. R. (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety*, *18*(2), 76-82.

Crann, S. E., & Barata, P. C. (2016). The experience of resilience for adult female survivors of intimate partner violence. *Violence Against Women*, *22*(7), 853-875.

Crowe, K., & Baeyer, C. (1989). Predictors of a positive childbirth experience. *Birth*, *16*(2), 59-63.

Dale, S. K., Pierre-Louis, C., Bogart, L. M., O'Cleirigh, C., & Safren, S. A. (2018). Still I rise: The need for self-validation and self-care in the midst of adversities faced by Black women with HIV. *Cultural Diversity and Ethnic Minority Psychology*, *24(1),* 15-25.

DeFrain, J. (1999). Strong families around the world. *Family Matters*, *53*, 6-13.

Denham, G., & Bultemeier, K. (1993). Anger: Targets and Triggers. In S.Thomas (Ed.), *Women and anger* (pp.68-90). New York: Springer Publishing Company.

Denis, A., Parant, O., & Callahan, S. (2011). Post-traumatic stress disorder related to birth: A prospective longitudinal study in a French population. *Journal of Reproductive and Infant Psychology*, *29*(2), 125-135.

Dennett, S. (2003). Talking about the birth with a midwife. *British Journal of Midwifery*, *11*(1), 24-27.

Denzin, N. (2001). The reflexive interview and a performative social science. *Qualitative Research*, *1*(1), 23-46.

Department of Health (2007). Maternity Matters: Choice, access and continuity of care in a safe service. Retrieved from http://webarchive.nationalarchives.gov.uk/20130103035958/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074199.pdf

Deshields, T. L., Heiland, M. F., Kracen, A. C., & Dua, P. (2015). Resilience in adults with cancer: development of a conceptual model. *Psycho-Oncology*, *25(1),* 11-18.

Dexter, L.A. (1956). Role of relationships and conceptions of neutrality in interviewing. *American Journal of Sociology*, *62*(2), 153-157.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. San Diego, CA: Academic Press.

Díaz-Gilbert, M. (2014). Spirituality, suffering, meaning, resiliency, and healing: Research findings and a patient's story of overcoming a medical challenge. *International Journal for Human Caring*, *18*(4), 45-51.

Drumm, R., Popescu, M., Cooper, L., Trecartin, S., Seifert, M., Foster, T., & Kilcher, C. (2013). "God just brought me through it": Spiritual coping strategies for resilience among intimate partner violence survivors. *Clinical Social Work Journal*, *42*(4), 385-394.

Eder, D., & Fingerson, L. (2003). Interviewing children and adolescents. In J. A. Holstein and J. F. Gubrium (Eds.), *Inside interviewing: New lenses, new concerns* (pp. 33-35). London: Sage.

Edward, K., Welch, A., & Chater, K. (2009). The phenomenon of resilience as described by adults who have experienced mental illness. *Journal of Advanced Nursing*, *65*(3), 587-595.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319-345.

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: A meta-ethnography. *Journal of Advanced Nursing*, *66*(10), 2142-2153.

Erickson, F. (1986). Qualitative methods in research on teaching. In M. Wittrock (Ed.), *Handbook of research and teaching* (pp.119-161). New York, NY: Macmillan.

Farley, P. D. (2003). *Prostitution, trafficking, and traumatic stress*. Hoboken, NJ: Taylor and Francis.

Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counselling psychology research. *Journal of Counselling Psychology*, *52*, 156-166.

Felten, B. S. (2001). Conceptualizing resilience in women older than 85. *Journal of Gerontological Nursing*, *27*(11), 46-50.

Fenech, G., & Thomson, G. (2014). "Tormented by ghosts from their past": A meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery*, *30*(2), 185-193.

Figley, C. R. (1985). *Trauma and its wake: Vol.1*. New York, NY: Brunner/Mazel.

Fletcher, D., & Sarkar, M. (2013). Psychological resilience: A review and critique of definitions, concepts and theory. *European Psychologist*, *18*(1), 12-23.

Foa, E. B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment*, *9*(4), 445-451.

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioural therapy for PTSD*. New York, NY: New American Library.

Folkman, S. (1984). Personal control and stress and coping processes; a theoretical analysis. *Journal of Personality and Social Psychology*, *46*, 839-852.

Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annual Review of Psychology*, *55*(1), 745-774.

Ford, E., Ayers, S., & Bradley, R. (2010). Exploration of a cognitive model to predict post-traumatic stress symptoms following childbirth. *Journal of Anxiety Disorders*, *24*(3), 353-359.

Fouad, N. A. (2013). Future of counseling psychology research. *Counselling Psychology Quarterly*, *26*(3-4), 227-237.

Fowles, E. R. (1998). Labor concerns of women 2 months after delivery. *Birth, 25*, 235-240.

Fridh, G., & Gaston-Johansson, F. (1990). Do primiparas and multiparas have realistic expectations of childbirth? *Acta Obstetricia et Gynecologica Scandinavica*, *69*(2), 103-109.

Frost, J., Pope, C., Liebling, R., & Murphy, D. (2006). Utopian Theory and the discourse of natural birth. *Social Theory & Health*, *4*(4), 299-318.

Gable, S. L., & Haidt, J. (2005). What (and why) is positive psychology? *Review of General Psychology*, *9*(2), 103-110.

Galli, N., & Vealey, R. S. (2008). "Bouncing back" from adversity: Athletes' experiences of resilience. *The Sport Psychologists*, *22*(3), 316-335.

Garber, J., & Seligman, M. E. (1980). *Human helplessness: Theory and applications*. New York, NY: Academic Press.

Gardner, J., & Harmon, T. (2002). Exploring resilience from a parent's perspective: A qualitative study of six resilient mothers of children with an intellectual disability. *Australian Social Work*, *55*(1), 60-68.

Gardner, M., McCutcheon, H., & Fedoruk, M. (2012). Discovering Constructivist Grounded Theory's fit and relevance to researching contemporary mental health nursing practice. *Australian Journal of Advanced Nursing*, *30*(2), 66-74.

Garthus-Niegel, S., von Soest, T., Vollrath, M. E., & Eberhard-Gran, M. (2013). The impact of subjective birth experiences on post-traumatic stress symptoms: A longitudinal study. *Archives of Women's Mental Health*, *16(1),* 1-10.

Gartland, D., Bond, L., Olsson, C. A., Buzwell, S., & Sawyer, S. M. (2011). Development of a multi-dimensional measure of resilience in adolescents: The Adolescent Resilience Questionnaire. *BMC Medical Research Methodology*, *11(1)*, 1471-2288.

Gaudiano, B. A. (2008). Cognitive-behavioural therapies: Achievements and challenges. *Evidence-Based Mental Health*, *11*(1), 5-7.

Ghezeljeh, T. N., & Emami, A. (2009). Grounded theory: Methodology and philosophical perspective: Tahereh Najafji Ghezeljeh and Azita Emami explore aspects of grounded theory and constructivist grounded theory using examples from research. *Nurse Researcher*, *17*(1), 15.

Gibbins, J., & Thomson, A. M. (2001). Women's expectations and experiences of childbirth. *Midwifery*, *17*(4), 302-313.

Glaser, B.G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, California: Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (2011). *Getting out of the data: Grounded theory conceptualisation*. Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York, NY: Aldine.

Goldberg, C. (1996). The privileged position of religion in the clinical dialogue. *Clinical Social Work Journal*, *24*(2), 125-136.

Goldfield, A. E., Mollica, R. F., Pesavento, B. H., & Farone, S. V. (1988). The physical and psychological sequelae of torture. *Journal of the American Medical Association*, *259*(18), 2725-2729.

Green, B. l., Wilson, J. P., & Lindy, J. (1985). Conceptualizing post-traumatic stress disorder: A psychosocial framework. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 53-69). New York, NY: Brunner/Mazel.

Green, J. M. (1993). Expectations and experiences of pain in labor: Findings from a large prospective study. *Birth*, *20*(2), 65-72.

Green, J. M., Coupland, V. A., & Kitzinger, J. V. (1990). Expectations, experiences, and psychological outcomes of childbirth: A prospective study of 825 women. *Birth*, *17*(1), 15-24.

Greenfield, M., Jomeen, J., & Glover, L. (2016). What is a traumatic birth? A concept analysis and literature review. *British Journal of Midwifery*, *24*(4), 254-267.

Grekin, R., & O'Hara, M. W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: A meta-analysis. *Clinical Psychology Review*, *34*(5), 389-401.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigm in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage.

Haase, J. E. (2004). The adolescent resilience model as a guide to intervention. *Journal of Pediatric Oncology Nursing*, *21(5),* 289-99.

Hall, H., Griffiths, D., & McKenna, L. (2013). From Darwin to constructivism: The evolution of grounded theory. *Nurse Researcher*, *20*(3), 17.

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

Henderson, J., & Redshaw, M. (2013). Who is well after childbirth? Factors related to positive outcome. *Birth*, *40*(1), 1-9.

Herman, J. (1981). Father-daughter incest. *Professional Psychology*, *12*(1), 76-80.

Hickey, G. (1997). The use of literature in grounded theory. *NT Research*, 2(5), 371-379.

Hiller, H. H., & DiLuzio, L. (2003). The interviewee and the research interview: Analysing a neglected dimension in research. *Canadian Review of Sociology & Anthropology*, *41*(1), 1-26.

Holstein, J. A., & Gubrium, J. F. (1995). *The active interview*. Thousand Oaks, CA: Sage.

Horowitz, M. J. (1976). *Stress response syndrome*. New York, NY: Aronson.

Howard, S., Dryden, J., & Johnson, B. (1999). Childhood resilience: Review and critique of literature. *Oxford Review of Education*, *25*(3), 307-323.

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277-1288.

Iles, J., & Pote, H. (2015). Postnatal posttraumatic stress: A Grounded theory model of first-time mothers' experiences. *Journal of Reproductive and Infant Psychology, 33*(3), 238-255.

Janoff-Bullman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York, NY: Free Press.

Jeon, Y. H. (2004). The application of grounded theory and symbolic interactionism. *Scandinavian Journal of Caring Sciences*, *18*(3), 249-256.

Jones, J., & Barlow, D. H. (1990). The etiology of posttraumatic stress disorder. *Clinical Psychology Review*, *10*(3), 299-328.

Jones Nielsen, J. D., & Nicholas, H. (2016). Counselling psychology in the United Kingdom. *Counselling Psychology Quarterly*, *29*(2), 206-215.

Kant, I. (1966). *Critique of pure reason*. Garden City, NY: Doubleday.

Kasket, E. (2012).The counselling psychologist researcher. *Counselling Psychology Review*, *27*(2), 64-73.

Kaye, D. K., Kakaire, O., Nakimuli, A., Mbalinda, S. N., Osinde, M. O., & Kakande, N. (2014). Survivors' understanding of vulnerability and resilience to maternal near-miss obstetric events in Uganda. *International Journal of Gynecology & Obstetrics*, *127*(3), 265-268.

Kidd, S., & Shahar, G. (2008). Resilience in homeless youth: The key role of self-esteem. *American Journal of Orthopsychiatry*, *78(2),* 163-172.

Kilpatrick, D. G., Saunders, B. E., Veronen, L. J., Best, C. L., & Von, J. M. (1987). Criminal victimization: Lifetime prevalence, reporting to police, and psychological impact. *Crime & Delinquency*, *33*(4), 479-489.

Lavin, D., & Maynard, D. W. (2001). Standardization vs rapport: Respondent laughter and interviewer reaction during telephone surveys. *American Sociological Review*, *66*(3), 453-479.

Lazarus, R. S. (1966). Psychological stress and the coping process. New York, NY: Springer.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York, NY: Springer.

Lazarus, R. S., & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality*, *1*(3), 141-169.

Lee, M. Y., Zaharlick, A., & Akers, D. (2011). Meditation and treatment of female trauma survivors of interpersonal abuses: Utilizing clients' strengths. *Families in Society: The Journal of Contemporary Social Services*, *92*(1), 41-49.

Lee, S., & Crockett, M. S. (1994). Effect of assertiveness training on levels of stress and assertiveness experienced by nurses in Taiwan, Republic of China. *Issues in Mental Health Nursing*, *15*(4), 419-432.

Lewis, L., Hauck, Y. L., Ronchi, F., Crichton, C., & Waller, L. (2016). Gaining insight into how women conceptualize satisfaction: Western Australian women's perception of their maternity care experiences. *BMC Pregnancy and Childbirth*, *16*(1).

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Littleton, H., Horsley, S., John, S., & Nelson, D. V. (2007). Trauma coping strategies and psychological distress: A meta-analysis. *Journal of Traumatic Stress*, *20*(6), 977-988.

Liu, C. J., & Mishna, F. (2014). Resilience in a cultural context: Taiwanese female earthquake survivors. *Qualitative Social Work: Research and Practice*, *13*(2), 288-303.

López-Fuentes, I., & Calvete, E. (2015). Building resilience: A qualitative study of Spanish women who have suffered intimate partner violence. *American Journal of Orthopsychiatry*, *85(4),* 339-351.

Luthar, S. S., & Cicchetti, D. (2000). The construct of resilience: Implications for interventions and social policies. *Development and Psychopathology*, *12*(4), 857-885.

Luthar, S.S., Cichetti, D., & Becker (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, *71*(3), 543-562.

Luthar, S. S., & Zigler, E. (1991). Vulnerability and competence: A review of research on resilience in childhood. *American Journal of Orthopsychiatry*, *61*(1), 6-22.

Lynch, S. M., Keasler, A. L., Reaves, R. C., Channer, E. G., & Bukowski, L. T. (2007). The story of my strength. *Journal of Aggression, Maltreatment & Trauma*, *14*(1-2), 75-97.

Maddi, S. R. (1999). The personality construct of hardiness: I. Effects on experiencing, coping, and strain. *Consulting Psychology Journal: Practice and Research*, *51*(2), 83-94.

Magistretti, C. M., Downe, S., Lindstrøm, B., Berg, M., & Schwarz, K. T. (2016). Setting the stage for health: Salutogenesis in midwifery professional knowledge in three European countries. *International Journal of Qualitative Studies on Health and Well-being*, *11*(1), 1-12.

Magyar-Moe, J. L., & Lopez, S. J. (2008). Human agency, strengths-based development, and psychological well-being. In W. B. Walsh (Ed.), *Biennial review of counseling psychology* (pp. 157-177). New York, NY: Routledge.

Mahoney, J. L., & Bergman, L. R. (2002). Conceptual and methodological considerations in a developmental approach to the study of positive adaptation. *Journal of Applied Developmental Psychology*, *23*(2), 195-217.

Marland, G., & Cash, K. (2005). Medicine taking decisions: Schizophrenia in comparison to asthma and epilepsy. *Journal of Psychiatric and Mental Health Nursing*, *12*, 163-172.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research*, *11*(3): Article 8.

Massey, S., Cameron, A., Ouellette, S., & Fine, M. (1998). Qualitative approaches to the study of thriving: What can be learned? *Journal of Social Issues*, *54(2),* 337-355.

Massong, S. R., Dickson, A. L., Ritzler, B. A., & Layne, C. C. (1982). Assertion and defense mechanism preference. *Journal of Counseling Psychology*, *29*(6), 591-596.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227-238.

Mautner, E., Stern, C., Deutsch, M., Nagele, E., Greimel, E., Lang, U., & Cervar-Zivkovic, M. (2013). The impact of resilience on psychological outcomes in women after preeclampsia: An observational cohort study. *Health and Quality of Life Outcomes*, *11*(1), 194.

McEwen, B. S. (1998). Protective and damaging effects of stress mediators. *New England Journal of Medicine*, *338*(3), 171-179.

McEwen, B. S. (2002). *The end of stress as we know it*. Washington, DC: Dana Press.

McGhee, G., Marland, G. R., & Atkinson, J. (2007). Grounded theory research: Literature reviewing and reflexivity. *Journal of Advance Nursing*, *60*(3), 334-342.

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

McLeod, J. (2011). *Qualitative research in counselling psychology*. London: Sage.

Merton, R. K. (1972). Insiders and outsiders. *American Journal of Sociology*, *78*(1), 9-47.

Mills, J., Bonner, A., & Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice*, *12(1)*, 8-13.

Mobbs, N., Williams, C., & Weeks, A. (2018, February 8). Humanising birth: Does the language we use matter? – The BMJ [Web log post]. Retrieved from http://blogs.bmj.com/bmj/2018/02/08/humanising-birth-does-the-language-we-use-matter/

Moos, R. (1990). *Coping responses inventory manual*. California: Center for Health Care Evaluation, Stanford University.

Morina, N., Wicherts, J. M., Lobbrecht, J., & Priebe, S. (2014). Remission from post-traumatic stress disorder in adults: A systematic review and meta-analysis of long term outcome studies. *Clinical Psychology Review*, *34(3)*, 249-255.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counselling psychology. *Journal of Counseling Psychology*, *52*(2), 250-260.

Morrow, S. L. (2007). Qualitative research in counselling psychology. *The Counselling Psychologist*, *35*(2), 209-235.

Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research*, *5*(2), 147-149.

Moyzakitis, W. (2004). Exploring women's descriptions of distress and/or trauma in childbirth from a feminist perspective. *Evidence Based Midwifery*, *2*(1), 8-14.

Mozingo, J. N., Davis, M. W., Thomas, S. P., & Droppleman, P. G. (2002). "I felt violated." *MCN, The American Journal of Maternal/Child Nursing*, *27*(6), 342-348.

Mullin, W. J., & Arce, M. (2008). Resilience of families living in poverty. *Journal of Family Social Work*, *11*(4), 424-440.

Muraco, A., (2012). *Odd couples: Friendships at the intersection of gender and sexual orientation*. Durham, NC: Duke University Press.

Murray, J., Ehlers, A., & Mayou, R. A. (2002). Dissociation and post-traumatic stress disorder: Two prospective studies of road traffic accident survivors. *British Journal of Psychiatry*, *180*(4), 363-368.

National Institute for Health and Care Excellence (NICE) (2017). Intrapartum care for healthy women and babies. Clinical guideline CG190, Retrieved from https://www.nice.org.uk/guidance/cg190/ifp/chapter/care-during-labour

Nelson, A. M. (2003). Transition to motherhood. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *32*(4), 465-477.

Newton, C. (1991). Patient's knowledge of aspects of labour. *Nursing Times*, *87*(12), 50.

NHS England (2016). Perinatal mental health community services development fund. Retrieved from https://www.england.nhs.uk/mental-health/perinatal/community-services

NHS England (2017). Better choice for a better birth. Retrieved from https://www.england.nhs.uk/blog/better-choice-for-a-better-birth

NICE (2015). Intrapartum care for healthy women and babies: Guidance and guidelines. Retrieved from https://www.nice.org.uk/guidance/cg190

Norris, F. H., Friedman, M. J., Watson, P. J., Byrne, C. M., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. *Psychiatry: Interpersonal and Biological Processes*, *65(3),* 240-260.

Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin*, *129*(1), 52-73.

Park, N. (2012). Adversity, resilience, and thriving: A positive psychology perspective on research and practices. In R. A. McMackin, E. Newman, J. M. Fogler, & M. Terrence (Eds.). *Trauma therapy in context: The science and craft of evidence-based practice* (pp. 121-140). Washington, DC: American Psychological Association.

Parke, R. D. (2000). Beyond White and middle class: Cultural variations in families: Assessments, processes, and policies. *Journal of Family Psychology*, *14*(3), 331-333.

Paton, D., Johnston, P., Clarke, J., Violanti, J. M., Burke, K. J., & Keenan, D. (2008). Stress shield: A model of police resiliency. *International Journal of Emergency Mental Health*, *10(2),* 95-108.

Patterson, J. (1988). Families experiencing stress: The family adjustment and adaptation response model: II. Applying the FAAR Model to health issues for intervention and research. *Family Systems Medicine*, *6(2)*, 202-237.

Pennebaker, J. W. (1993). Putting stress into words: Health, linguistic, and therapeutic implications. *Behaviour Research and Therapy*, *31*(6), 539-548.

Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 245-273). Hove, UK: Psychology Press.

Ponterotto, J. G. (2002). Qualitative research methods: The fifth force in psychology. *The Counselling Psychologist*, *30(3),* 394-406.

Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology*, *52*(2), 126-136.

Rabkin, J. G. (1982). Stress and psychiatric disorders. In L. Goldberg & S. Breznitz (Eds.), *Handbook of stress: Theoretical and clinical aspects* (pp. 566-584). New York, NY: Free Press.

Rafalin, D. L. (2010). Counselling psychology and research: Revisiting the relationship in the light of our 'mission'. In M. Milton (Ed.) *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 41-55). Malden, MA & Chichester, West Sussex: Wiley-Blackwell.

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth*, *17(21), 1-10*.

Rennie, D. L. (1994). Human science and counselling psychology: Closing the gap between research and practice. *Counselling Psychology Quarterly*, *7*(3), 235-250.

Richards, L., & Morse, J. M. (2007). *Readme first for a User's Guide to Qualitative Methods* (2nd ed.). Thousand Oaks, CA: Sage

Richardson, G. E. (2002). The metatheory of resilience and resiliency. *Journal of Clinical Psychology*, *58*(3), 307-321.

Robson, C. (2002). *Real World Research* (2nd ed.). Oxford: Blackwell.

Royal College of Midwives (2007). *Normal childbirth*. London: Royal College of Midwives.

Rutter, M. (1985). Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder. *The British Journal of Psychiatry*, *147*(6), 598-611.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *The American Journal of Orthopsychiatry*, *57*(3), 316-331.

Rutter, M. (2006). Implications of Resilience Concepts for Scientific Understanding. *Annals of the New York Academy of Sciences*, *1094(1),* 1-12.

Ryan-Nicholl, K. D., & Will, C. I. (2009). Rigour in qualitative research: Mechanisms for control. *Nurse Researcher*, *16*(3), 70-85.

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2013). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*. doi:10.1002/14651858.cd004667.pub5

Sawyer, A., & Ayers, S. (2009). Post-traumatic growth in women after childbirth. *Psychology & Health*, *24*(4), 457-471.

Sawyer, A., Ayers, S., Young, D., Bradley, R., & Smith, H. (2012). Posttraumatic growth after childbirth: A prospective study. *Psychology & Health*, *27*(3), 362-377.

Schore, A. N. (2002). *Affect dysregulation & disorders of the self: Affect regulation & the repair of the self*. New York, NY: W.W. Norton.

Sciarra, D. (1999). The role of the qualitative researcher. In M. Kopala & L. A. Suzki (Eds.), *Using qualitative methods in psychology* (pp. 37-48). Thousand Oaks, CA: Sage.

Shafranske, E. P. (1996). *Religion and the clinical practice of psychology*. Washington, DC: American Psychological Association.

Shanthakumari, R. S., Chandra, P. S., Riazantseva, E., & Stewart, D. E. (2013). "Difficulties come to humans and not trees and they need to be faced": A study on resilience among Indian women experiencing intimate partner violence. *International Journal of Social Psychiatry*, *60(7),* 703-710.

Sheldon, K. M., & King, L. (2001). Why positive psychology is necessary. *American Psychologist*, *56*(3), 216-217.

Shepherd, C., Reynolds, F. A., & Moran, J. (2010). "They're battle scars, I wear them well": A phenomenological exploration of young women's experiences of building resilience following adversity in adolescence. *Journal of Youth Studies*, *13*(3), 273-290.

Silver, S. M. (1985). An inpatient program for post-traumatic stress disorder: Context as treatment. In C. R. Figley, *Trauma and its wake: Traumatic stress theory, research and intervention* (pp. 213-231). New York: Brunner/Mazel.

Silver, R. L., & Wortman, C. B. (1980). Coping with undesirable life events. In J. Garber & M. E. P. Seligman (Eds.), *Human helplessness: Theory and applications* (pp. 279-340). New York, NY: Academic Press.

Simkin, P. (2006). What makes a good birth and why does it matter? *International Journal of Childbirth Education*, *21*(3), 4-6.

Simpson, M., & Catling, C. (2016). Understanding psychological traumatic birth experiences: A literature review. *Women and Birth*, *29*(3), 203-207.

Slade, P. (2006). Towards a conceptual framework for understanding post-traumatic stress symptoms following childbirth and implications for further research. *Journal of Psychosomatic Obstetrics & Gynecology*, *27*(2), 99-105.

Sokolowski, R. (2000). *Introduction to phenomenology*. Cambridge, UK: Cambridge University Press.

Sorenson, D. S., & Tschetter, L. (2010). Prevalence of negative birth perception, disaffirmation, perinatal trauma symptoms, and depression among postpartum women. *Perspectives in Psychiatric Care*, *46*(1), 14-25.

Southwick, S. M., & Charney, D. S. (2012). *Resilience: The science of mastering life's greatest challenges*. Cambridge: Cambridge University Press.

Starks, H., & Trinidad, S.B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*(10), 1372-1380.

Stewart, D., & Mickunas, A. (1974). *Exploring phenomenology: A guide to its field and its literature*. Chicago, IL: American Library Association.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). Thousand Oaks, CA: Sage.

Strauss, A., & Corbin, J. (1998*). Basics of qualitative research: Techniques and procedure for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Stroebe, W., Stroebe, M., Abakoumkin, G., & Schut, H. (1996). The role of loneliness and social support in adjustment to loss: A test of attachment versus stress theory. *Journal of Personality and Social Psychology*, *70*(6), 1241-1249.

Symon, A., Pringle, J., Cheyne, H., Downe, S., Hundley, V., Lee, E., ... Alderdice, F. (2016). Midwifery-led antenatal care models: Mapping a systematic review to an evidence-based quality framework to identify key components and characteristics of care. *BMC Pregnancy and Childbirth*, *16*(1), 1-15.

Talbot, D. (2014). Exploring the 'good' birth: What is it and why does it matter? *British Journal of Midwifery*, *22*(12), 854-860. doi:10.12968/bjom.2014.22.12.854

Taormina, R. J. (2015). Adult personal resilience: A new theory, new measure, and practical implications. *Psychological Thought*, *8*(1), 35-46.

Taylor, S. E., & Stanton, A. L. (2007). Coping resources, coping processes, and mental health. *Annual Review of Clinical Psychology*, *3*(1), 377-401.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, *9*(3), 455-472.

Tedeschi, R. G., & Calhoun, L. G. (1998). *Posttraumatic Growth: Positive changes in the aftermath of crisis*. Mahwah, NJ: Erlbaum.

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal of Specialists in Paediatric Nursing*, *16(2),* 151-155.

Thomas, S. (1993). *Women and anger*. New York, NY: Springer: Publishing Company.

Thomson, G. M., & Downe, S. (2008). Widening the trauma discourse: The link between childbirth and experiences of abuse. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*(4), 268-273.

Thomson, G. M., & Downe, S. (2010). Changing the future to change the past: Women's experiences of a positive birth following a traumatic birth experience. *Journal of Reproductive and Infant Psychology*, *28*(1), 102-112.

Tugade, M. M., & Fredrickson, B. L. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. *Journal of Personality and Social Psychology*, *86*(2), 320-333.

Turner, S. (2004). Emotional reactions to torture and organized state violence. *PTSD Research Quarterly, 15*(2), 2–7.

Undermann, B. E. (2002). The effect of spirituality on health and healing: A critical review of athletic trainers. *Journal of Athletic Training*, *35(2)*, 194-197.

Ungar, M. (2003). Qualitative contributions to resilience research. *Qualitative Social Work: Research and Practice*, *2*(1), 85-102.

Ungar, M. (2008). Resilience across cultures. *British Journal of Social Work*, *38*(2), 218-235.

Valins, S., & Nisbett, R. E. (1972). Attribution processes in the development and treatment of emotional disorders. In E. E. Jones, D. E. Kanouse, H.H. Kelley, R. E. Nisbett, S. Valins, & B. Weiner (Eds.), *Attribution: Perceiving the causes of behaviour (pp.137-150)*. Morristown, NJ: General learning Press.

Verreault, N., Da Costa, D., Marchand, A., Ireland, K., Banack, H., Dritsa, M., & Khalifé, S. (2012). PTSD following childbirth: A prospective study of incidence and risk factors in Canadian women. *Journal of Psychosomatic Research*, *73*(4), 257-263.

Vossbeck-Elsebusch, A. N., Freisfeld, C., & Ehring, T. (2014). Predictors of posttraumatic stress symptoms following childbirth. *BMC Psychiatry*, *14*(1).

Wald, J., Taylor, S., Asmundson, G. J., Jang, K. L., Stapleton, J., & British Columbia University Vancouver. (2006). *Literature review of concepts: Psychological resiliency*. Ft. Belvoir: Defense Technical Information Center.

Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process*, *42(1),* 1-18.

Walstrom, P., Operario, D., Zlotnick, C., Mutimura, E., Benekigeri, C., & Cohen, M. H. (2013). 'I think my future will be better than my past': Examining support group influence on the mental health of HIV-infected Rwandan women. *Global Public Health*, *8*(1), 90-105.

Wang, Q., Zhou, T., Gao, J., Xu, K., Qu, W., & Yang, Y. (2018). Attachment, Social Support, Resilience and Posttraumatic Stress Disorder Symptoms in Chinese Adults Living with HIV/AIDS. *Journal of Loss and Trauma*, *23(2),* 113-127.

Weiner, C. L. (2007). Making teams work in conducting grounded theory. In A. Bryant & K. Charmaz (Eds.), *Handbook of grounded theory* (pp. 293-310). London: Sage.

Weinzimmer, S., Bach, R., & Bhandari, S. (2013). Motherhood, empowerment and resilience within the context of intimate partner Violence. *Sociation Today*, *11*(2), 63-80.

Weiss, R. S. (1994). *Learning from strangers: The art and method of qualitative interview studies*. New York, NY: Free Press.

Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds*. New York, NY: Cornell University Press.

Westphal, M., & Bonanno, G. A. (2007). Posttraumatic growth and resilience to trauma: Different sides of the same coin or different coins? *Applied Psychology*, *56*(3), 417-427.

White, B., Driver, S., & Warren, A. (2008). Considering resilience in the rehabilitation of people with traumatic disabilities. *Rehabilitation Psychology*, *53*(1), 9-17.

Williams, N. R., Lindsey, E. W., Kurtz, P. D., & Jarvis, S. (2001). From trauma to resiliency: Lessons from former runaway and homeless youth. *Journal of Youth Studies*, *4*(2), 233-253.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Maidenhead: McGare Hill/ Open University Press.

Wilson, J. P. (1989). *Trauma, transformation and healing: An integration approval to theory, research and posttraumatic theory*. New York, NY: Brunner/Mazel.

Wilson, J. P. (2004). The broken spirit: Posttraumatic damage of the self. In J. P. Wilson & B. Drožđek, *Broken spirits: The treatment of traumatized asylum seekers, refugees, war, and torture victims (pp.109-159)*. New York, NY: Brunner/Routledge.

Wilson, J. P., Friedman, M. J., & Lindy, J. D. (2001). An overview of clinical consideration and principles in the treatment of PTSD. In J. P. Wilson, M. J. Friedman, & J. D. Lindy (Eds.), *Treating psychological trauma and PTSD* (pp. 59-94). New York, NY: Guilford Press.

Wilson, J. P., Friedman, M. J., & Lindy, J. D. (2001). *Treating psychological trauma and PTSD*. New York, NY: Guilford Press.

Wilson, J. P., & Lindy, J. D. (1994). *Countertransference in the treatment of PTSD*. New York, NY: Guilford Press.

Windle, G. (2011). What is resilience? A review and concept analysis. *Reviews in Clinical Gerontology*, *21*(02), 152-169.

World Health Organization (2018, February 15). Making childbirth a positive experience. Retrieved from http://www.who.int/reproductivehealth/topics/maternal_perinatal/en

Wrosch, C., Scheier, M. F., Carver, C. S., & Schulz, R. (2003). The importance of goal disengagement in adaptive self-regulation: When giving up is beneficial. *Self and Identity*, *2*(1), 1-20.

Zautra, A. J., Johnson, L. M., & Davis, M. C. (2005). Positive affect as a source of resilience for women in chronic pain. *Journal of Consulting and Clinical Psychology*, *73*(2), 212-220.

Zimmerman, M. A., Stoddard, S. A., Eisman, A. B., Caldwell, C. H., Aiyer, S. M., & Miller, A. (2013). Adolescent resilience: Promotive factors that inform prevention. *Child Development Perspectives*, *7*(4), 215-220.

Zraly, M., Rubin, S. E., & Mukamana, D. (2013). Motherhood and resilience among Rwandan genocide-rape survivors. *Ethos*, *41*(4), 411-439.

Section B: Case Study

Working with Complex Trauma: the importance of support in building the therapeutic relationship

Note: In order to preserve anonymity, the names of the client and members of her family, along with other identifying features, have been omitted or changed.

Abigail Brown

Introduction

Choice of case

I chose this case because of the challenges encountered in working with a complex trauma presentation, which afforded me the opportunity to use supportive psychodynamic therapy with a client with a borderline personality presentation. The work presented here shows the importance of the therapeutic relationship in providing a containing environment, where the client felt safe to begin exploring the emotional difficulties that brought her to therapy. I believe the work also highlights the transferential processes and experiences of working with complex trauma and attachment issues, and my commitment to supporting and understanding my client, which proved to be a great learning experience.

Theoretical orientation

Psychodynamic therapy has been recommended as an approach that can be helpful in working with underlying personality factors that are the result of trauma and is especially helpful for clients who have experienced complex trauma or have an insecure attachment style (Plakun & Shapiro, 2000). Complex trauma is a particular clinical presentation that usually occurs when the client has experienced multiple traumas, such as prolonged childhood abuse (Schottenbauer, Glass, Arnkoff & Gray, 2008) and intimate partner violence, which have had a significant effect on a client's personality and ability to function (Khan & Masud, 1963). In addition, the trauma will usually have had a negative impact on the person's ability to develop and maintain relationships (van der Kolk & Courtois, 2005). This is reciprocal, making it difficult for others to relate to them, and resulting in considerable isolation and alienation (Bowlby, 1969). In considering the clinical implication of complex trauma for an individual, psychodynamic therapy has been recommended as an effective treatment for complex presentations for a wide range of interpersonal problems resulting from trauma (American Psychological Association, 2004).

Attachment theory has important implications for informing the practice of psychodynamic therapy in working with complex presentations (Schottenbauer et al., 2008). Research evidence suggests that clinicians should consider attachment style when working therapeutically with clients as this may improve treatment outcomes (Meyer & Pilkinson, 2002). Attachment styles have also been shown to have an effect on building the therapeutic relationship (Diamond, Stovall-McClough, Clarkin & Levy, 2003) and the outcome of therapy (Fonagy et al., 1996). Bowlby (1969) showed the critical importance of secure attachment, when provided by one's caregivers, in offering protection and in helping

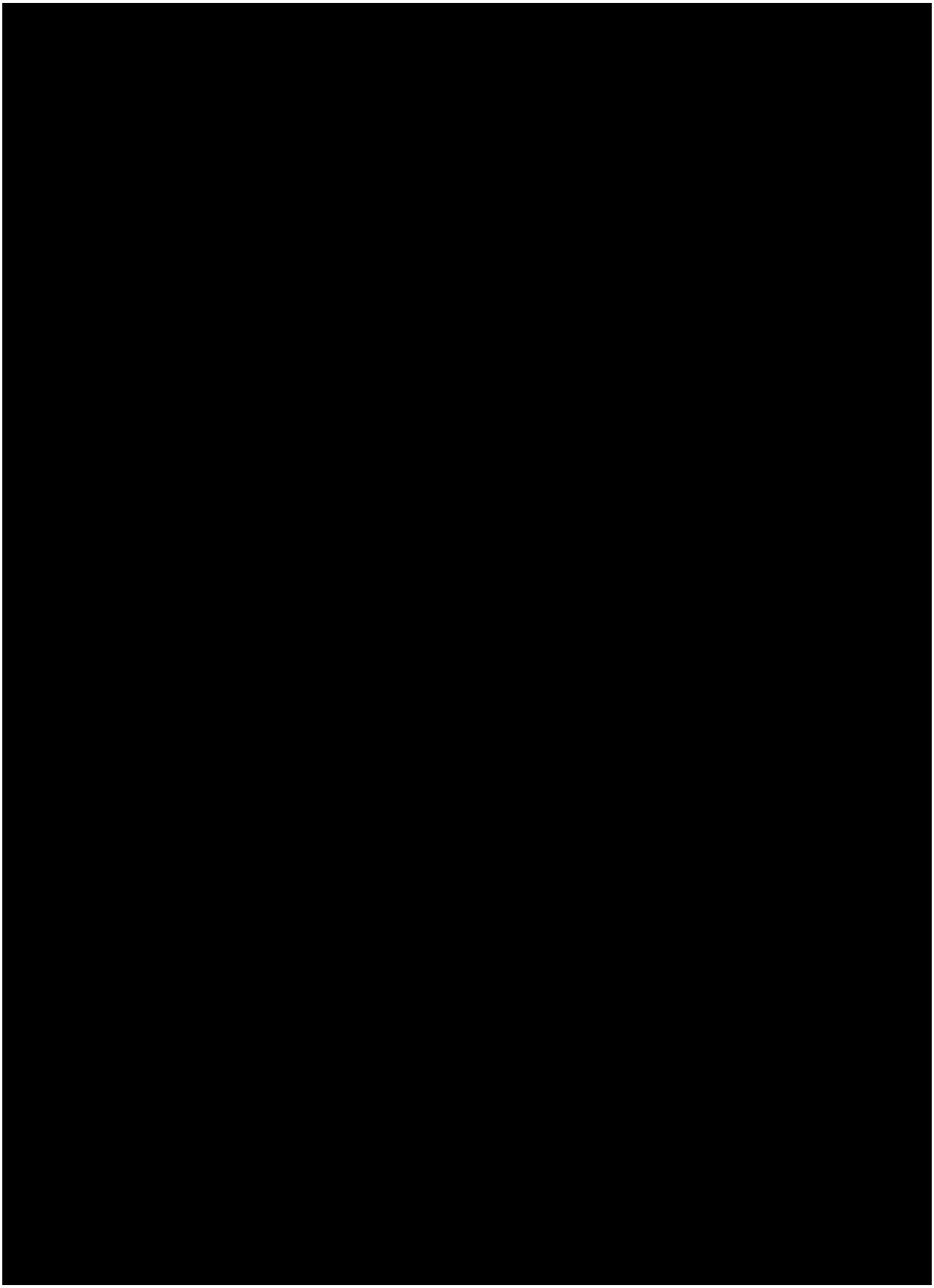
with social interaction with others, which enables healthy psychological development. A child who is provided with a secure base is able to feel confident in exploring the world and able return home when feeling overwhelmed (Pearlman & Courtois, 2005). A negative experience with one's caregivers, such as loss, abuse or violence, can lead to psychological difficulties, including anxiety and depression, and result in difficulties in relating to others in social situations (van der Kolk & Courtois, 2005). Bowlby (1969) introduced the idea of internal working models, which is based on early childhood relationships: these early relationships allow for the development of inner representations of the self and others that subsequently influence future relationships in adulthood, including the therapeutic bond (Woodhouse, Schlosser, Crook, Ligiero & Gelso, 2003).

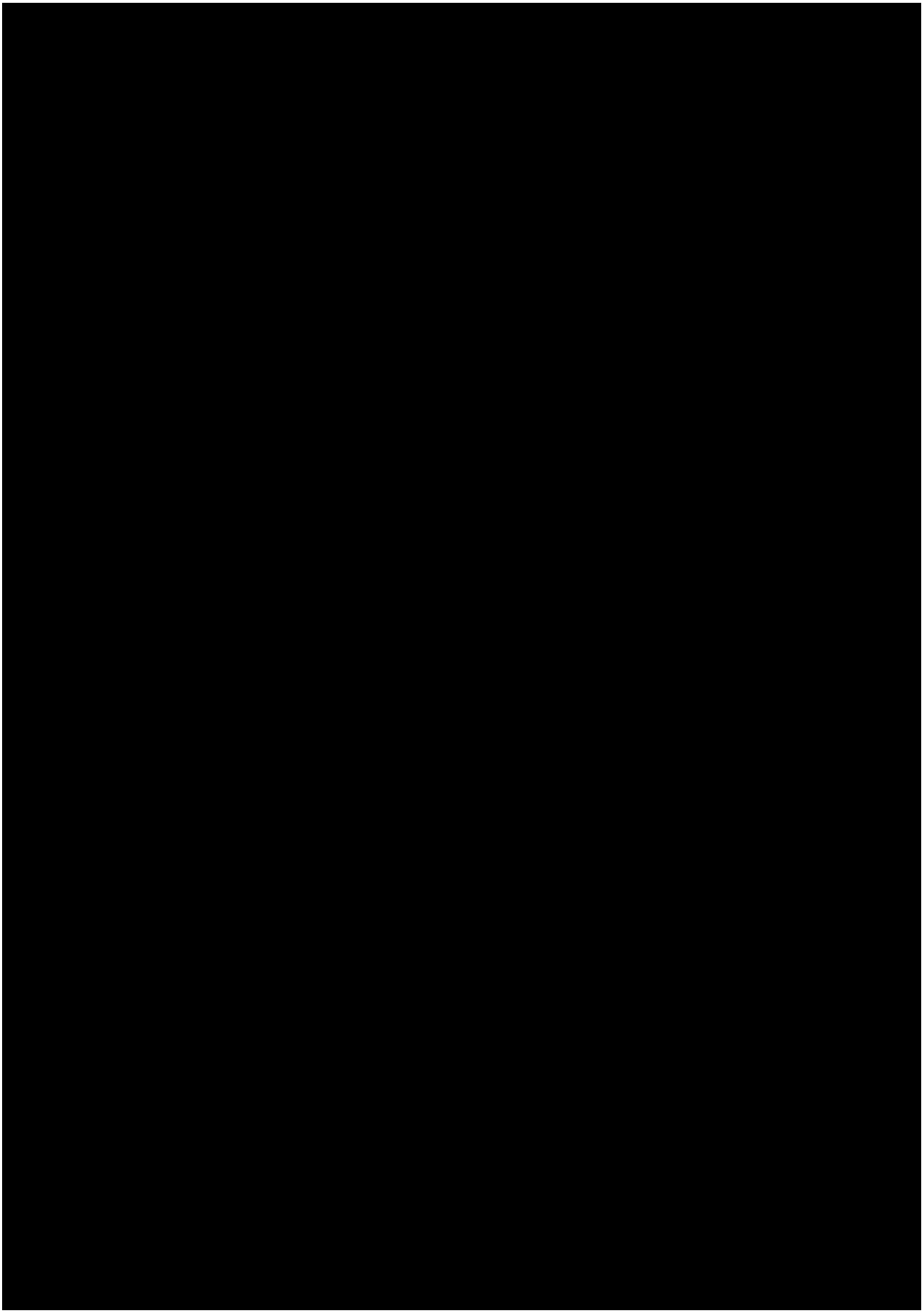
Attachment to significant others in childhood can affect later attachments in adulthood because childhood experiences become internalised and processed as inner working models of themselves (Woodhouse et al., 2003). This results in individuals believing that they are either worthy of care or neglect, and consequently viewing others as trustworthy of responding sensitively to their needs or not. The internal working model of individuals who have been traumatised in their early life tends to involve a defensive pattern of relating as a way of coping when experiencing distress (Knox, 2003). Internal working models play an important role in the individual's perception of threat in surviving in the world; the process of evaluation may consciously and unconsciously play a major part in their unconscious fantasy (Knox). Eagle (1995) suggests that the client's unconscious expectations can shape the relational experience within therapy, thus evoking certain predictable responses from others and the therapist. The therapist needs to recognise when their own countertransference has been evoked as a way of interpreting the client's unconscious fantasy and the effect it may have on the responses to the client (Knox).

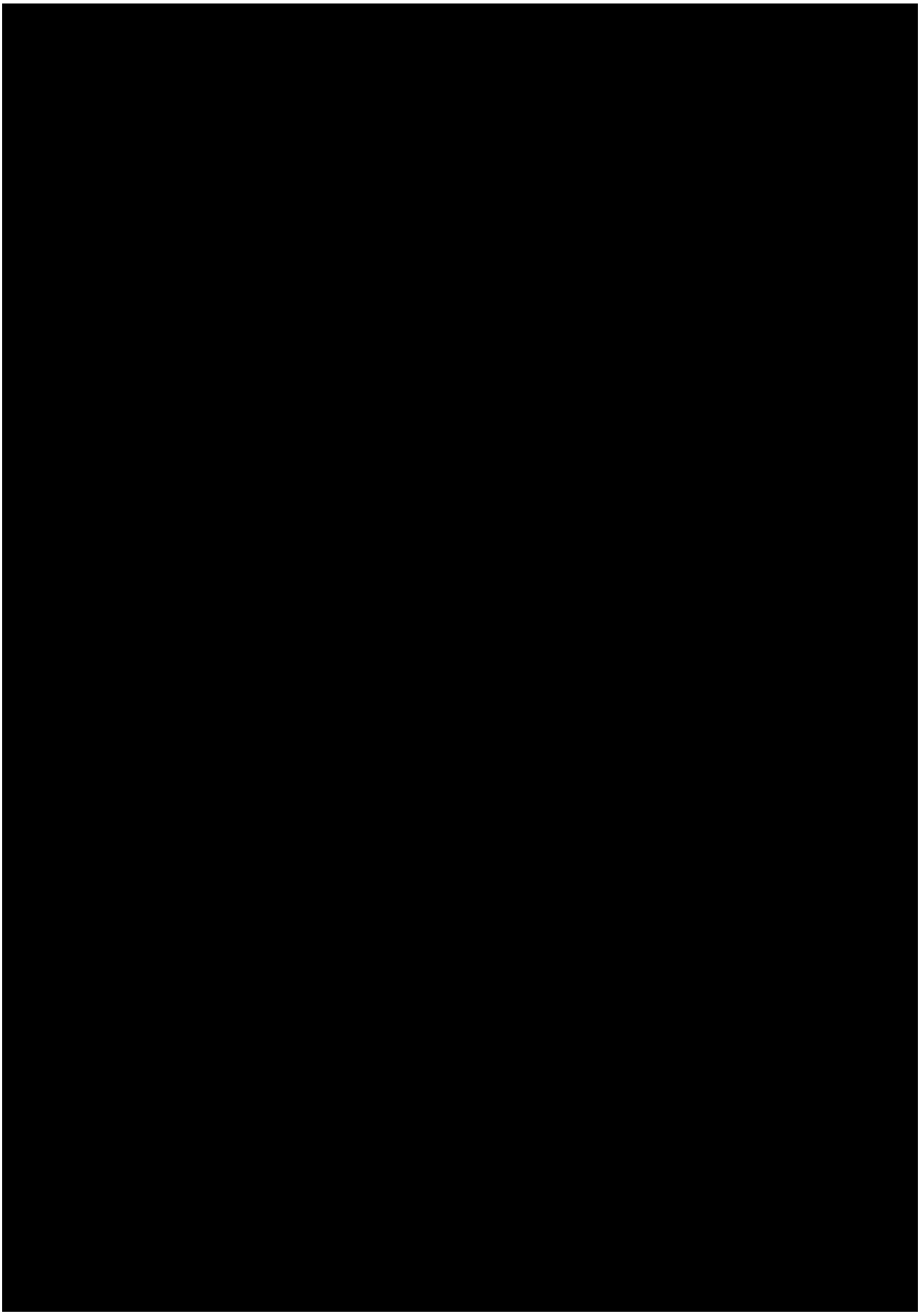
The therapeutic relationship can also be influenced by the client's attachment style and interpersonal problems (Schottenbauer et al., 2008). The therapist's knowledge of attachment theory can help them to empathise with the client, rather than take for granted difficult relational interchanges (Pearlman & Courtois, 2005). The primary function of attachment is the provision of a safe base where an individual feels confident to explore the world (Pistole, 1989). The therapist's fundamental task is to provide the therapeutic conditions that create a sense of safety, and therefore be experienced as a safe haven where the client can begin to explore aspects of their inner world (Pistole). The therapist's empathic mirroring and understanding of the client's difficulties can be reflective of a mother, providing a safe base where the client can experience comfort and containment. My intention with Laura was to create a haven of safety and a secure base within the therapeutic relationship (Cortina, 2013). Such a haven may eventually allow for gradual modulation of

Due to its sensitive nature some of this content has been removed

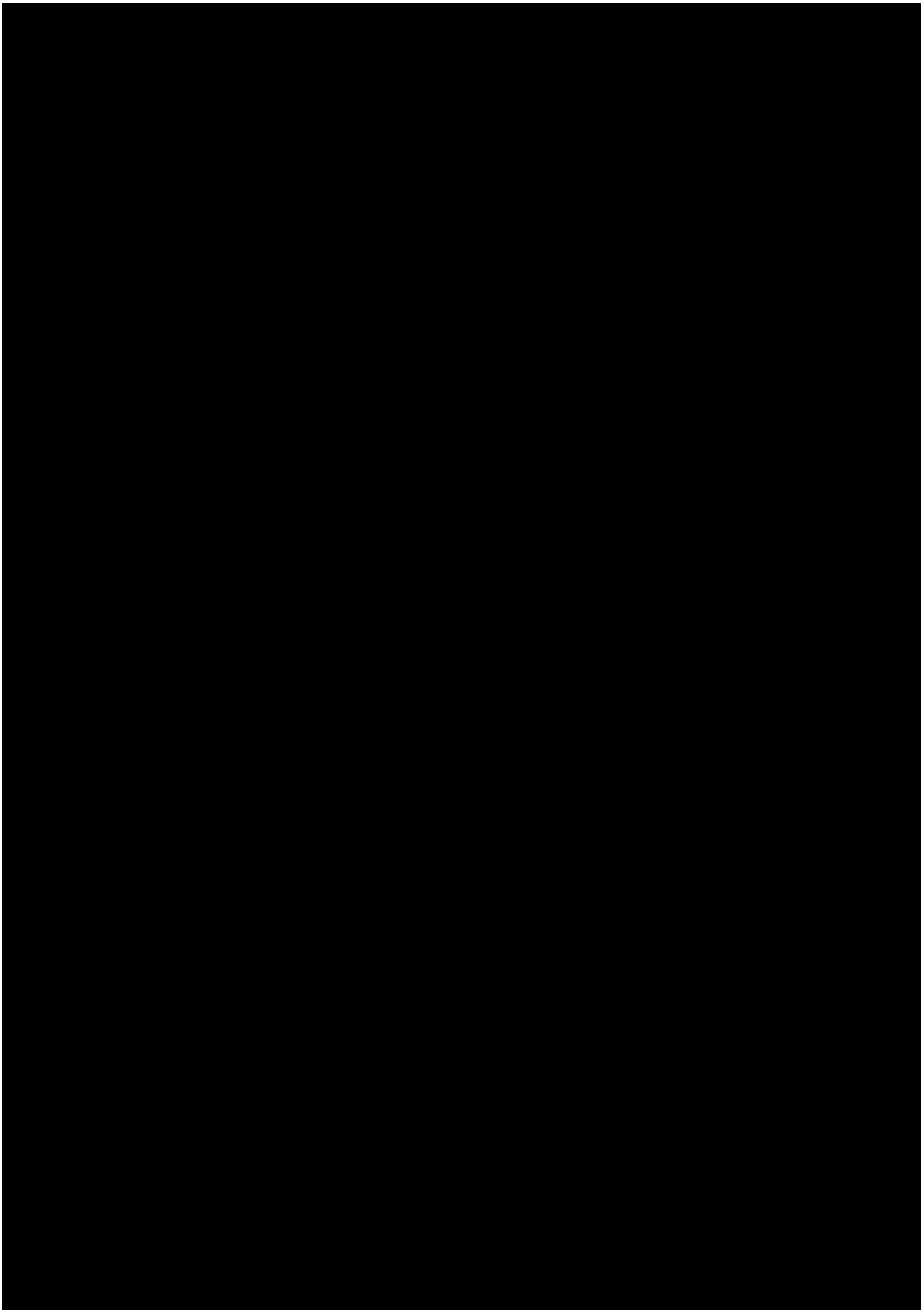
unbearable mental states associated with disorganised attachment styles (Allen, Fonagy & Bateman, 2008).



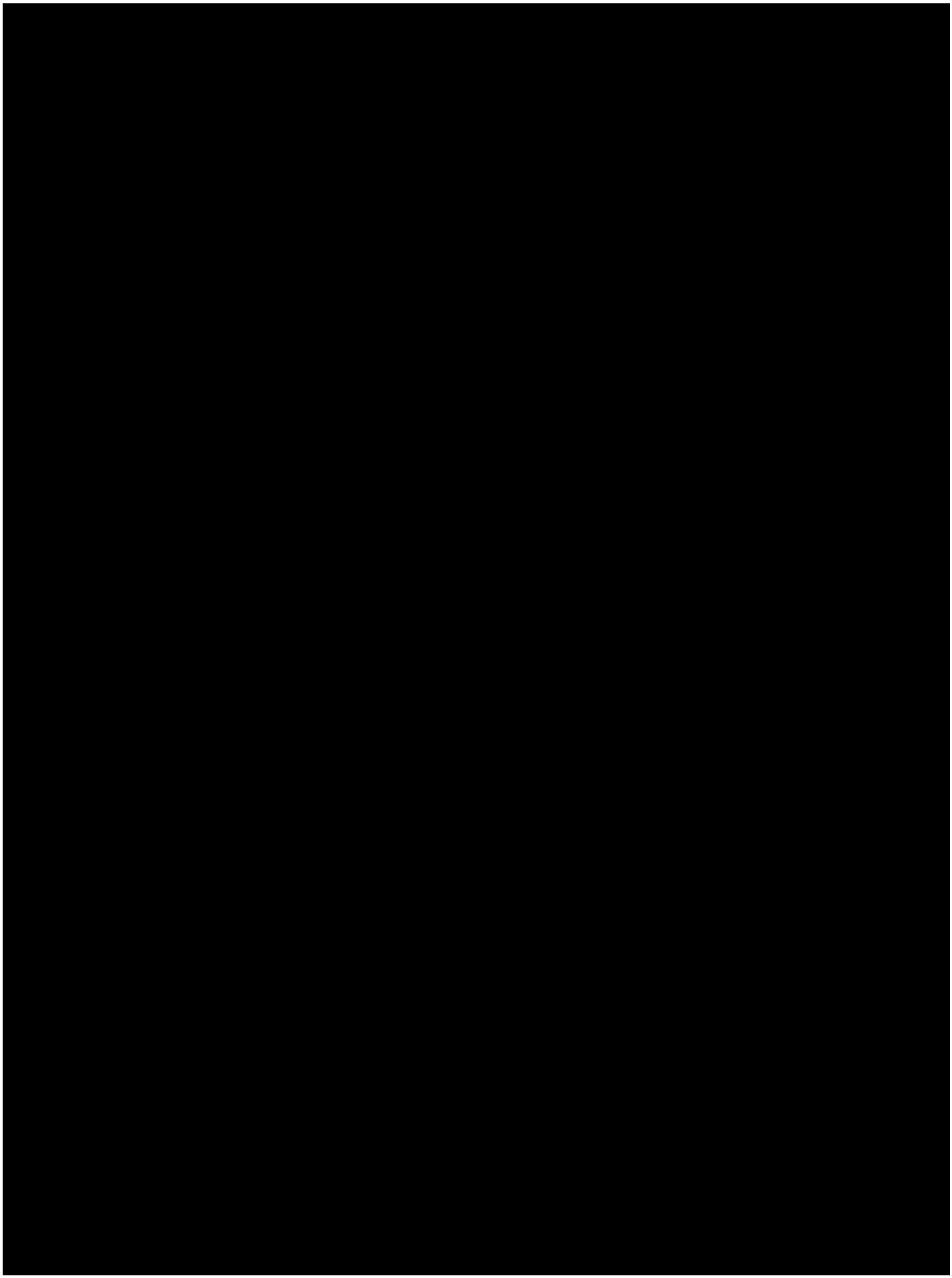


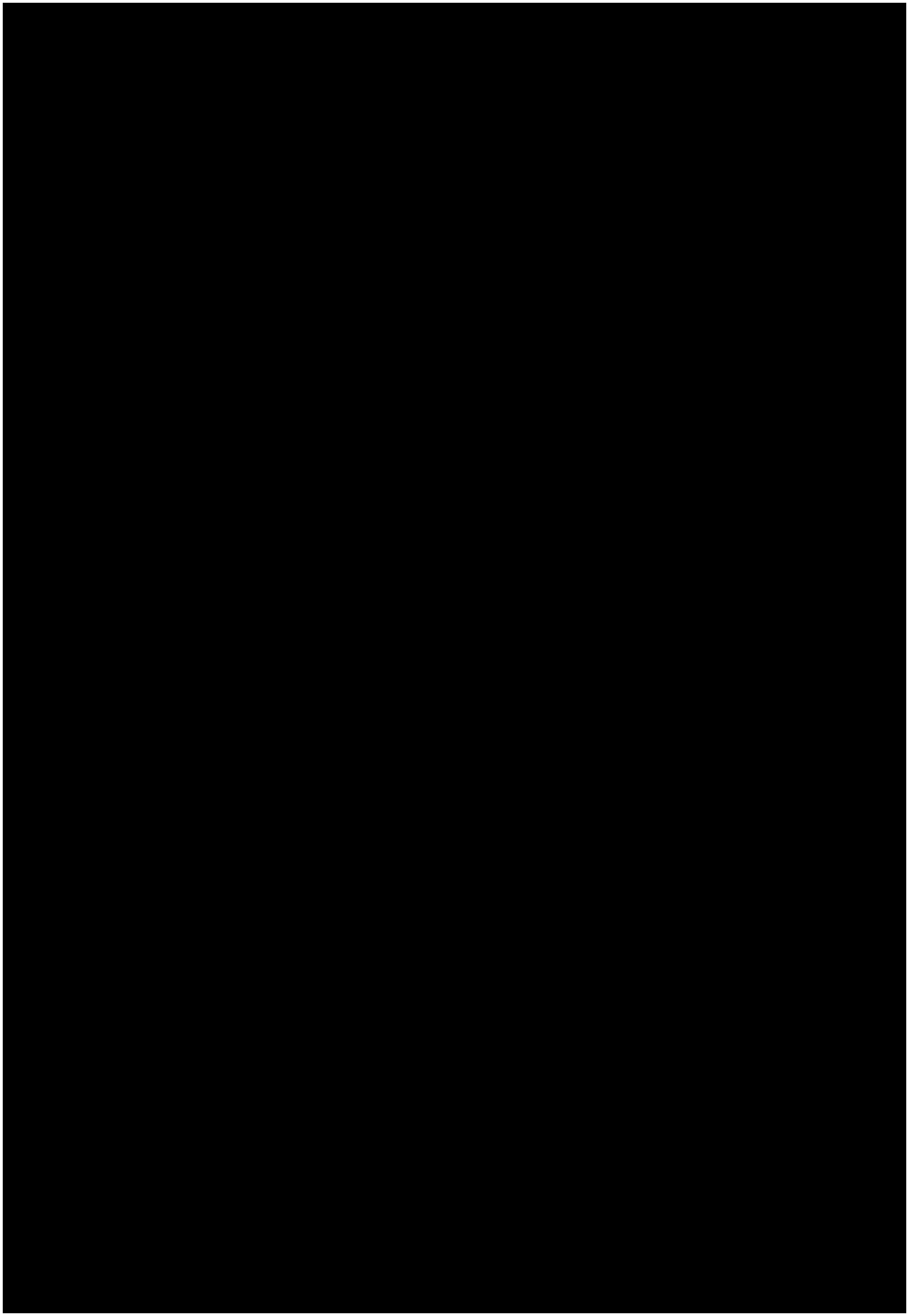


Section B – Case Study: Working with complex trauma

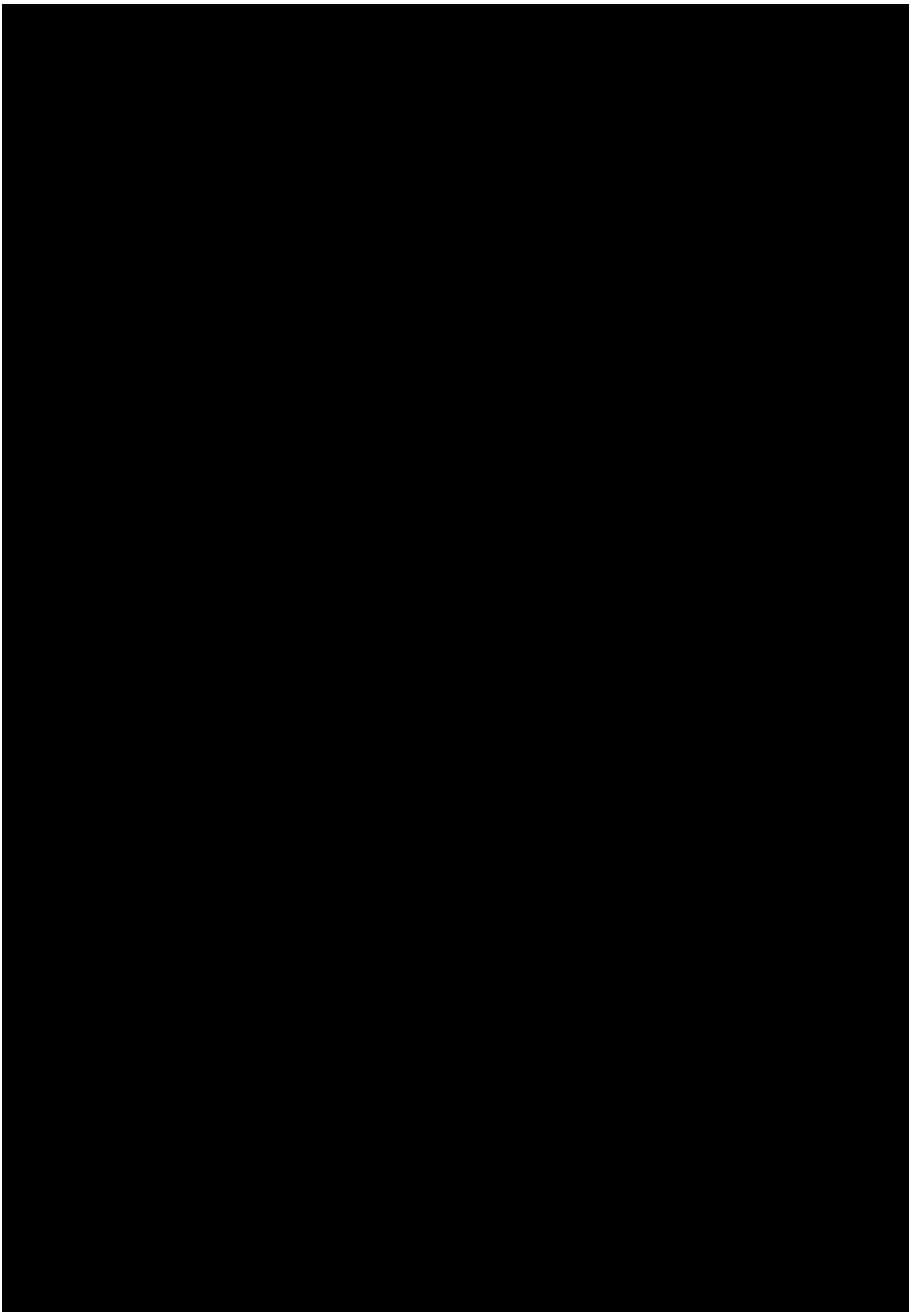


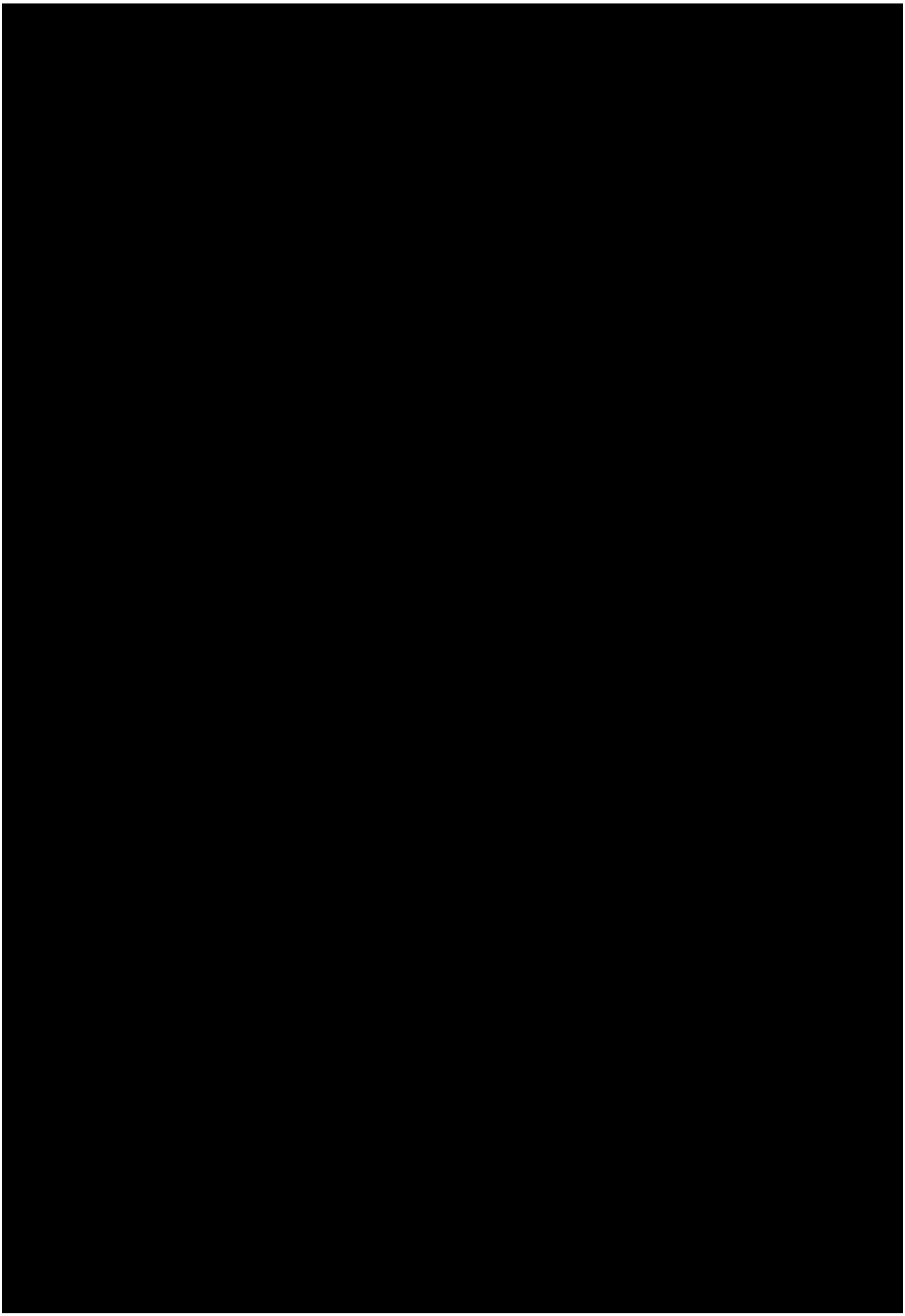
Section B – Case Study: Working with complex trauma

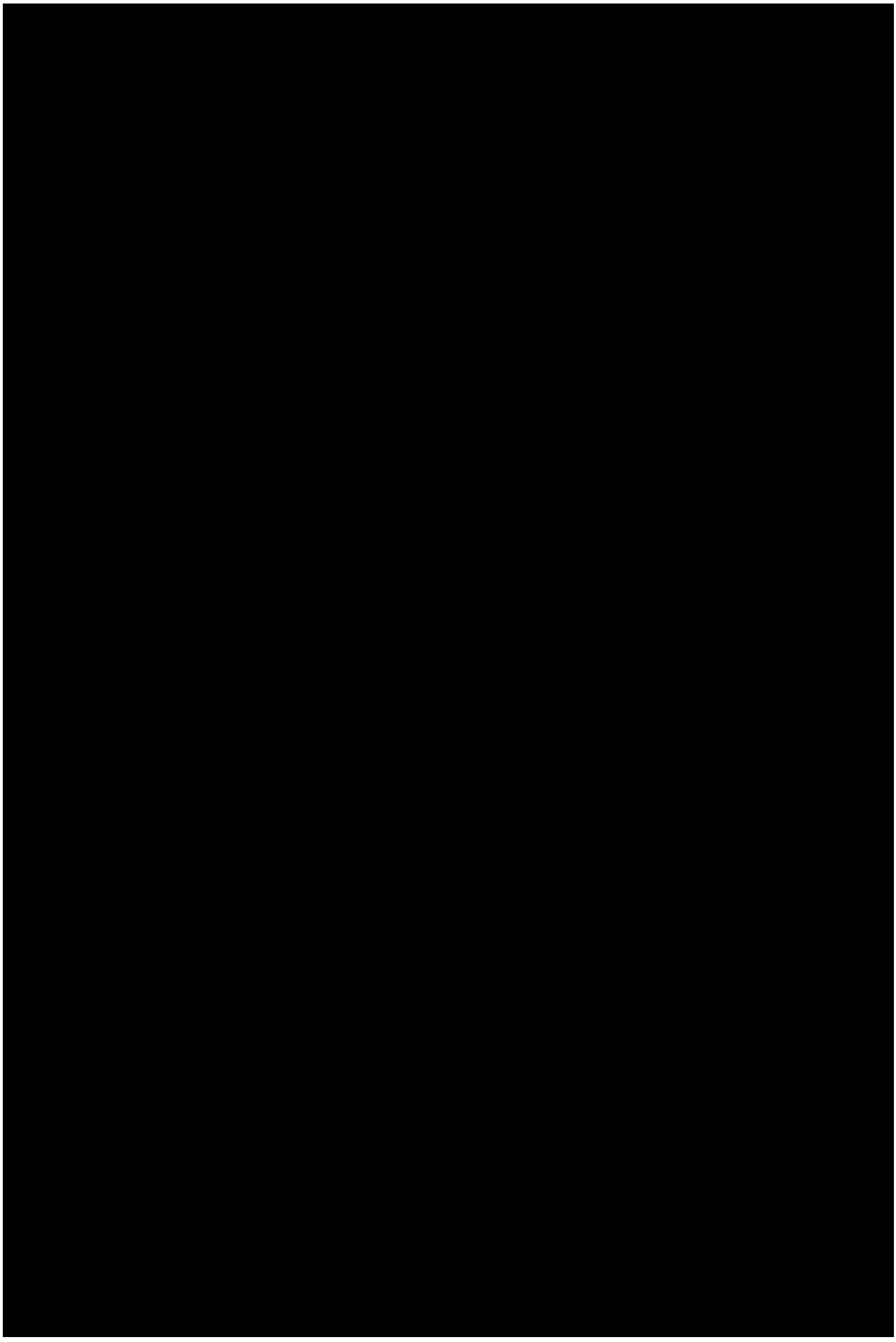


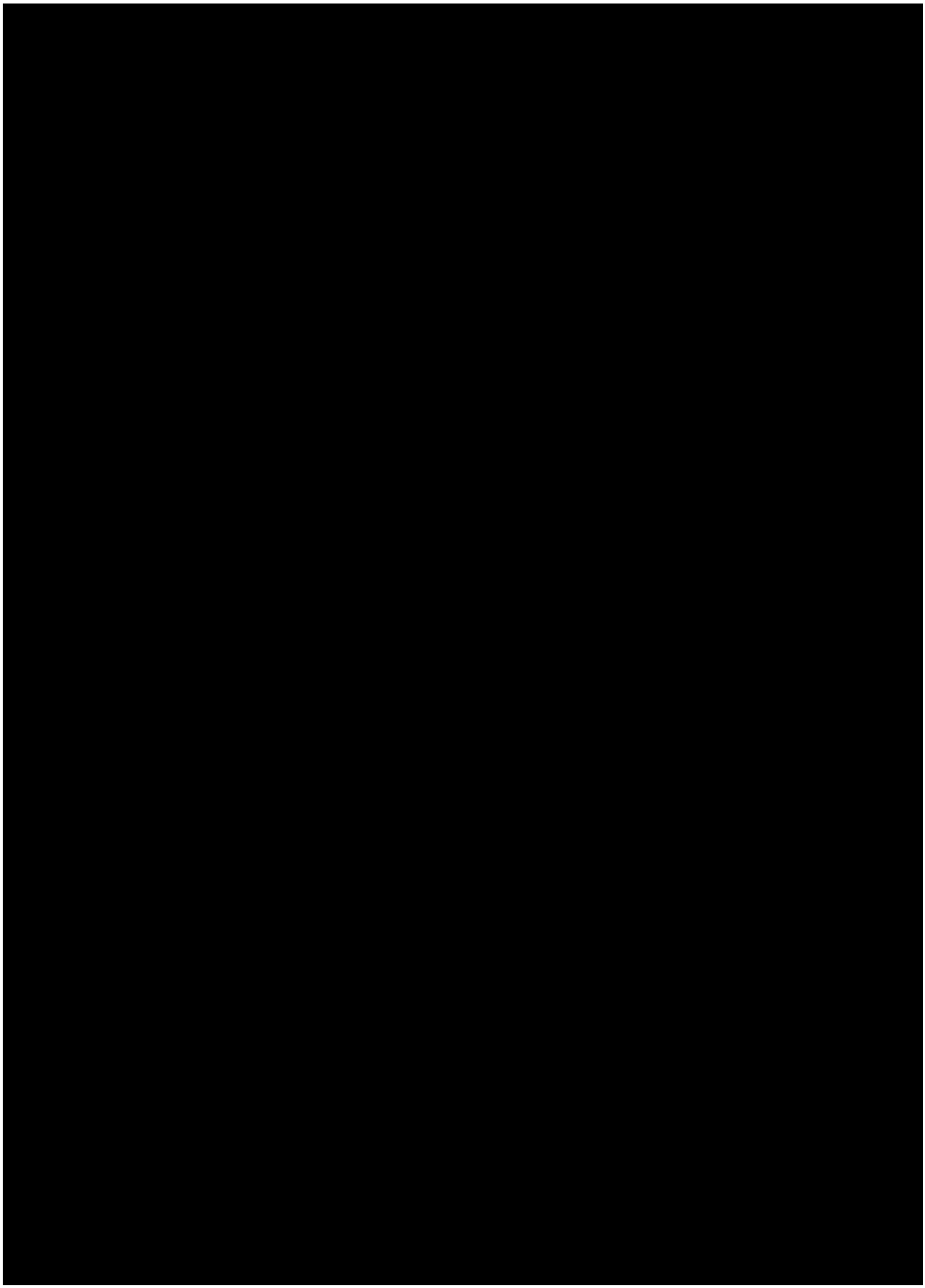


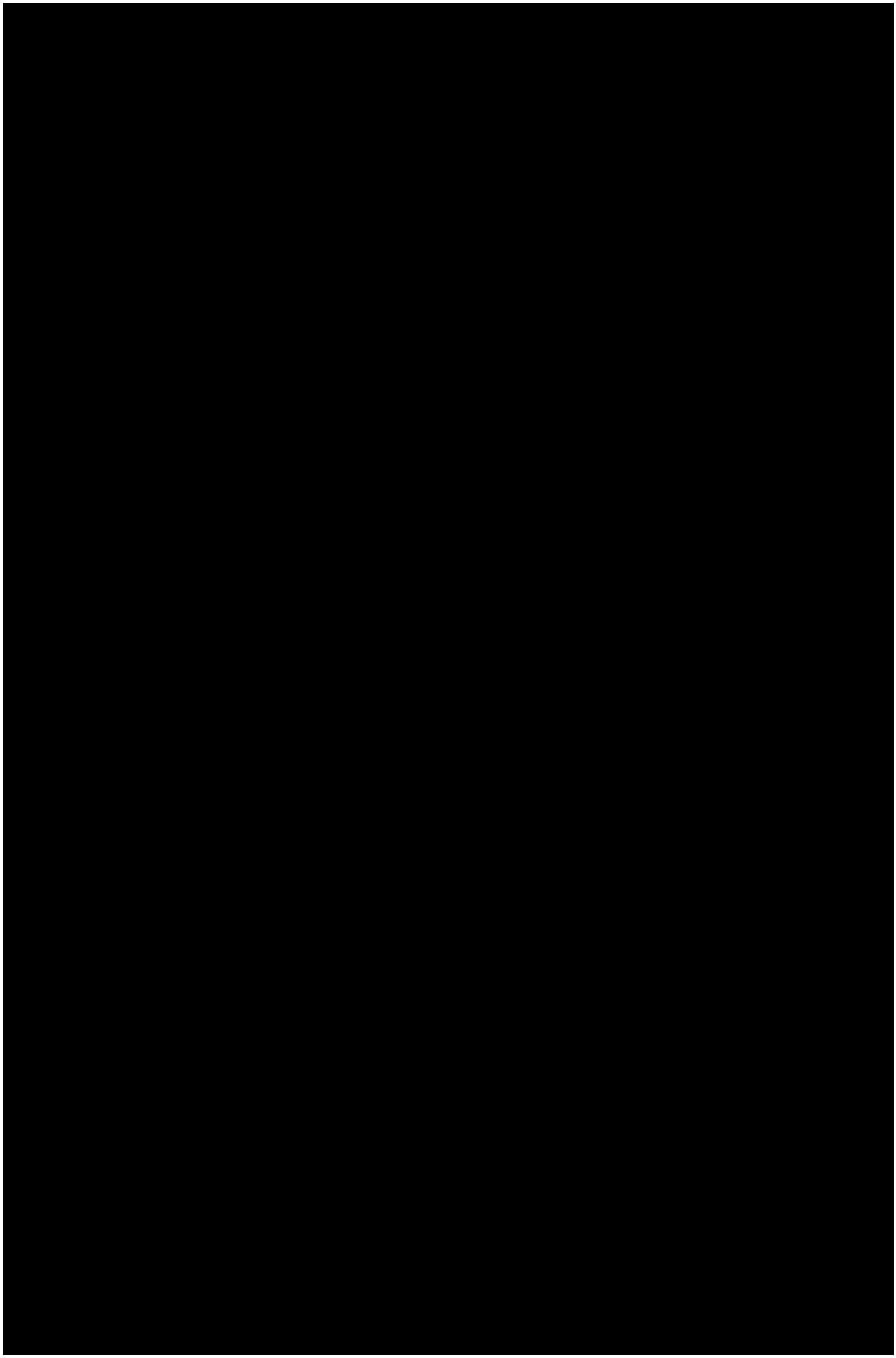
Section B – Case Study: Working with complex trauma

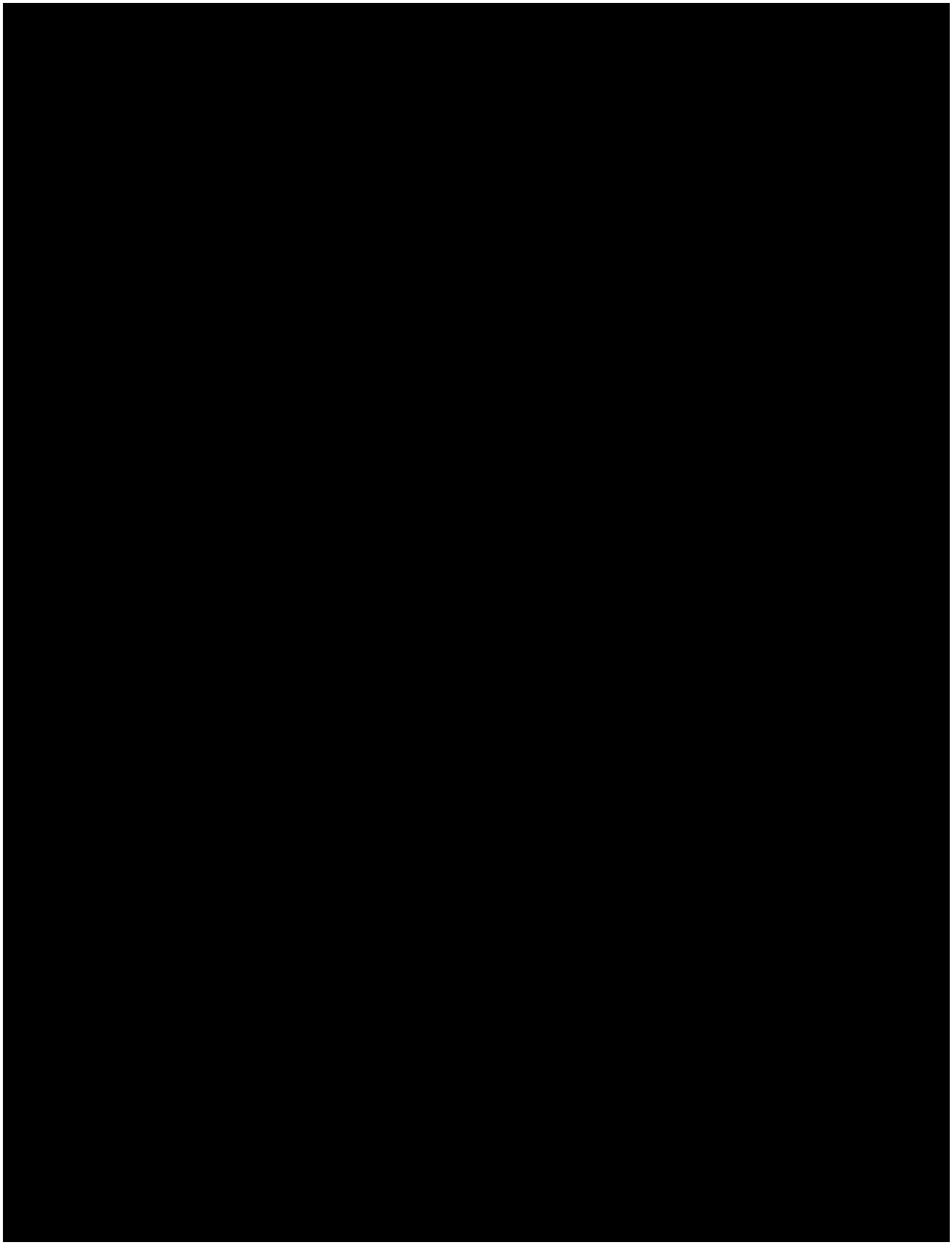












References

Allen, G. J., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in clinical practice*. Washington, DC: American Psychiatric Publishing.

American Psychiatric Association. (2004). Practice guidelines for the treatment of patients with acute stress disorders and posttraumatic stress disorder. *American Journal of Psychiatry*, *161(11),* 3-31.

Applebaum, A. (1989). Supportive therapy: A developmental view. In L. H. Rockland (Ed.). *Supportive therapy: A psychodynamic approach (pp. 40-57)*. New York, NY: Basic Books.

Baker, R. (1993). Some reflections on humour in psychoanalysis. *International Journal of Psychoanalysis*, *74(5*), 951-960.

Bateman, A., & Holmes, J., (1995[1943]). *Introduction to psychoanalysis: Contemporary theory and practice*. London: Routledge.

Bedi, N., & Vassiliadis, H. (2010). Supervised case experience in supportive psychotherapy suggestions for trainers. *Advances in psychiatric treatment*, *16(3*), 184-192.

Bowlby, J. (1969). *Attachment and loss: Vol 1*. New York, NY: Basic Books.

Bowlby, J. (1988). *A secure base*. New York, NY: Basic Books.

Casement, P. (1994). *On learning from the patient*. Hove: Routledge.

Cortina, M. (2013). The use of attachment theory in the clinical dialogue with patients. *Psychodynamic Psychiatry*, *41(3),* 397–418.

Diamond, D., Stovall-McClough, C., Clarkin, J. F., & Levy, K. N. (2003). Patient-therapist attachment in the treatment of borderline personality disorder. *Bulletin of the Menninger Clinic*, *67 (3),* 227-259.

DiRoso, A. C., Colli, A., Chessa, C.M., Marogna, C., Condino, V., Lis, A., & Mannarini, S. (2011). A supportive approach in psychodynamic-oriented psychotherapy. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *14*(1), 49-89.

Eagle, M. (1995). 'The developmental perspectives of attachment and psychoanalytic theory'. In S. Goldberg, R. Muir & J. Kerr (Eds.), *Attachment theory: Social, developmental and clinical perspectives* (pp.123-150). Hillsdale, NJ: Analytic Press.

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Matton, G., & Gerber, A. (1996). The relation of attachment status, psychiatric classification and response to psychotherapy. *Journal of Consulting and Clinical Psychology*, *64(1),* 22-31.

Gabbard, G. O. (2009). *Textbook of psychotherapeutic treatments*. Arlington, VA: American Psychiatric Publishing, Inc.

Gelso, C. J., Palma, B., & Bhatia, A. (2013). Attachment theory as a guide to understanding and working with transference and the real relationship in psychotherapy. *Journal of Clinical Psychology*, *69*(11), 1160-1171.

Gomez, L. (1997). *An introduction to object relations*. London: Free Association Books Ltd.

Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York, NY: Basic Books.

Hingley, S. (2001). Psychodynamic theory and narcissistically related personality problems: Support from case study research. *British Journal of Medical Psychology*, *74*, 57-72.

Horowitz, M. (2015). Effects of trauma on the sense of self. *Journal of Loss and Trauma*, *20*(2), 189-193.

Holmes, J. (1997). 'Too early, too late?" Endings in psychotherapy – An attachment perspective. *British Journal of Psychotherapy*, *14*(2), 159-171.

Khan, M., & Masud, R. (1963). The concept of cumulative trauma. In R. S. Eissler, A. Freud, H. Hartman, & M. Kris (Eds.), *The psychoanalytic study of the child*: XVIII (pp. 286-306). Oxford: International Universities.

Knox, J. (2003). Trauma and defences: Their roots in relationship. *Journal of Analytical Psychology*, *48*(2), 207-233.

Lemma, A., Target, M., & Fonagy, P. (2011). *Brief dynamic interpersonal therapy: A clinician's guide*. Oxford: Oxford University Press.

Levy, S., & Lemma, A. (Eds.). (2004). *The perversion of loss: Psychoanalytic perspectives on trauma*. New York, NY: Brunner Routledge.

Lyons-Ruth, K., & Jacobvitz, D. (2008). Attachment disorganization, genetic factors, parenting contexts and developmental transformation from infancy to adulthood. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (2nd ed.) (pp. 666-697). New York, NY: The Guildford Press.

Lyons-Ruth, K., Yellin, C., Melnick, S., & Atwood, G. (2003). Childhood experiences of trauma and loss have different relations to maternal unresolved and Hostile-Helpless states of mind on the AAI. *Attachment & Human Development*, *5*(4), 330-352.

Masterson, J. F. (1993). *The emerging self: A developmental, self and object relations approach to the treatment of the closet narcissistic disorder of the self*. New York: Brunner/Mazel.

Meyer, B., & Pilkinson, P. A. (2002). Attachment style. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients (pp. 112-141)*. New York, NY: Oxford University Press.

Misch, D. (2000). Basic strategies of dynamic supportive therapy. *The Journal of Psychotherapy Practice and Research*, *9*(4), 173-189.

Pagano, C. J. (2012). Exploring the therapist's use of self: Enactments, improvisation and affect in psychodynamic psychotherapy. *American Journal of Psychotherapy*, *66*(3), 205-226.

Pearlman, L. A., & Courtois, C. A., (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress*, *18*(5), 449-459.

Pistole, M. C. (1989). Attachment: Implications for counsellors. *Journal of Counselling & Development*, *68*(2), 190-193.

Plakun, E. M., & Shapiro, E. R. (2000). Psychodynamic psychotherapy for PTSD. *Journal of Clinical Psychiatry*, *61(10),* 787-788.

Rockland, L. (1989). *Supportive therapy: A psychodynamic approach*. New York, NY: Basic Books.

Shapiro, R. (1992). Discussion. *Contemporary Psychoanalysis*, *28(2*), 286-294.

Schottenbauer, M. A., Glass, C. R., Arnkoff, D. B., & Gray, S. H. (2008). Contributions of psychodynamic approaches to treatment of PTSD and trauma: A review of the empirical treatment and psychopathology literature. *Psychiatry*, *71*(1), 13.

Smith, P. V. (1997). Secret friends: Borderline symptomology and post-traumatic stress disorder in a case of reported sexual abuse. *British Journal of Psychotherapy*, *14(1),* 18-32.

van der Kolk, B. A., & Courtois, C. A. (2005). Complex developmental trauma. Journal of Traumatic Stress, 18 (5), 385-390.

Williams, W. (2006). Complex trauma: Approaches to theory and treatment. *Journal of Loss and Trauma, 11*(4), 321-335.

Winnicott, D. (1958). *Collected papers: Through paediatrics to psycho-analysis*. London. Tavistock Publications.

Winnicott, D. (1960). The theory of the parent-infant relationship. *International Journal of Psychoanalysis*, *41*, 585-595.

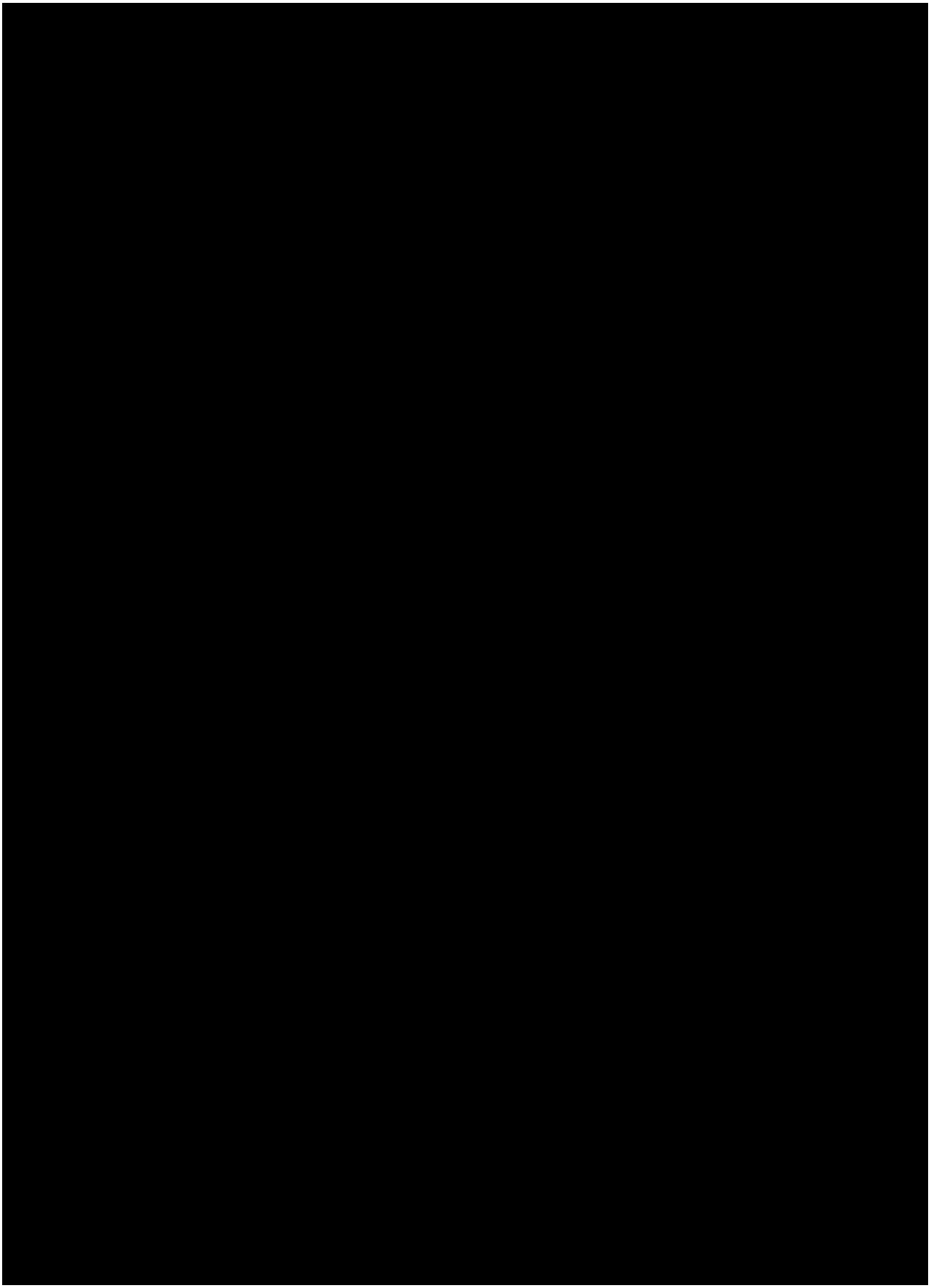
Winnicott, D. (1965). *The maturational processes and the facilitating environment*. London: Tavistock.

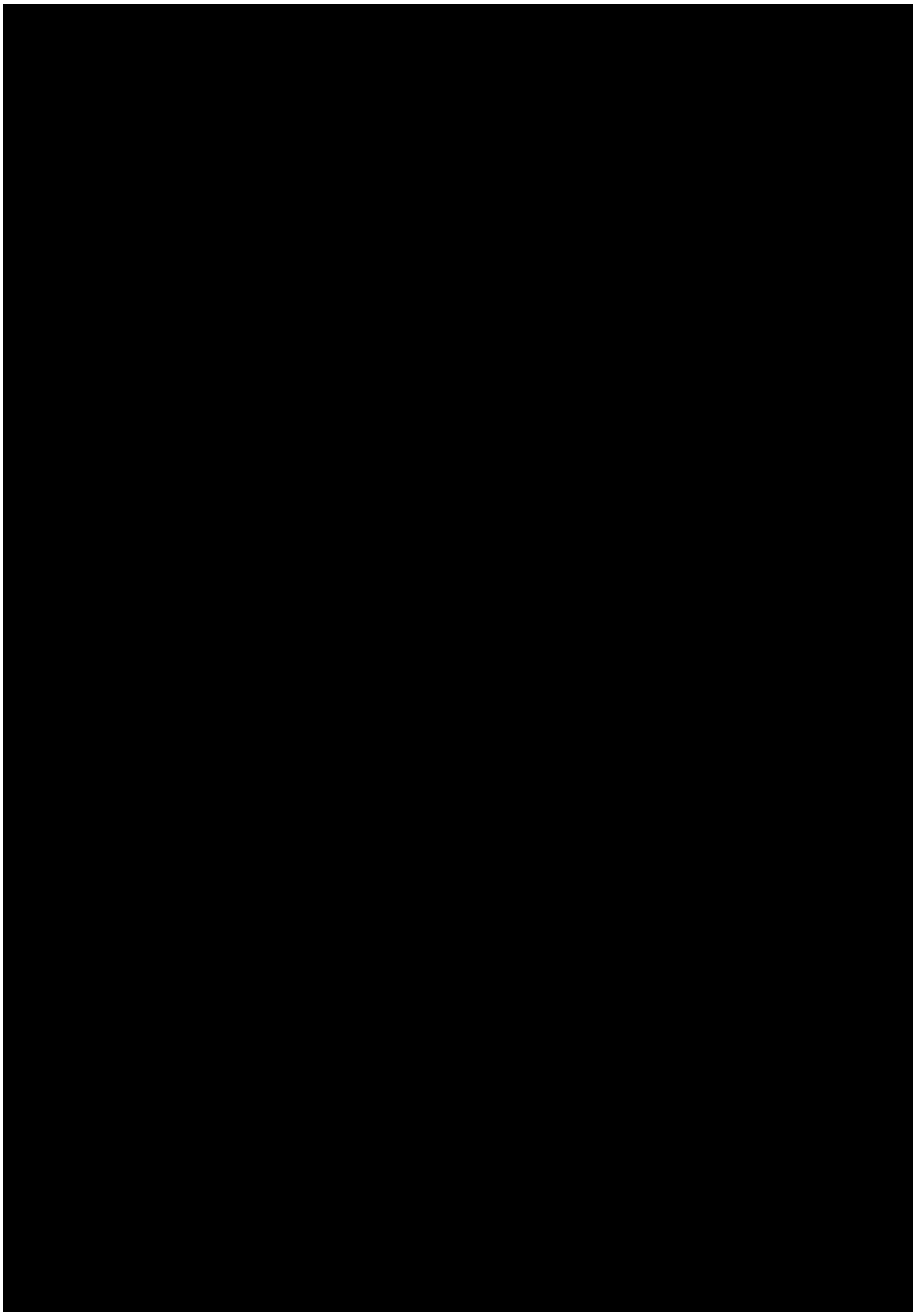
Winston, A., Rosenthal, R., & Pinsker, H. (2012). *Learning supportive psychotherapy: An illustrated guide*. Washington, DC & London: American Psychiatric Publishing.

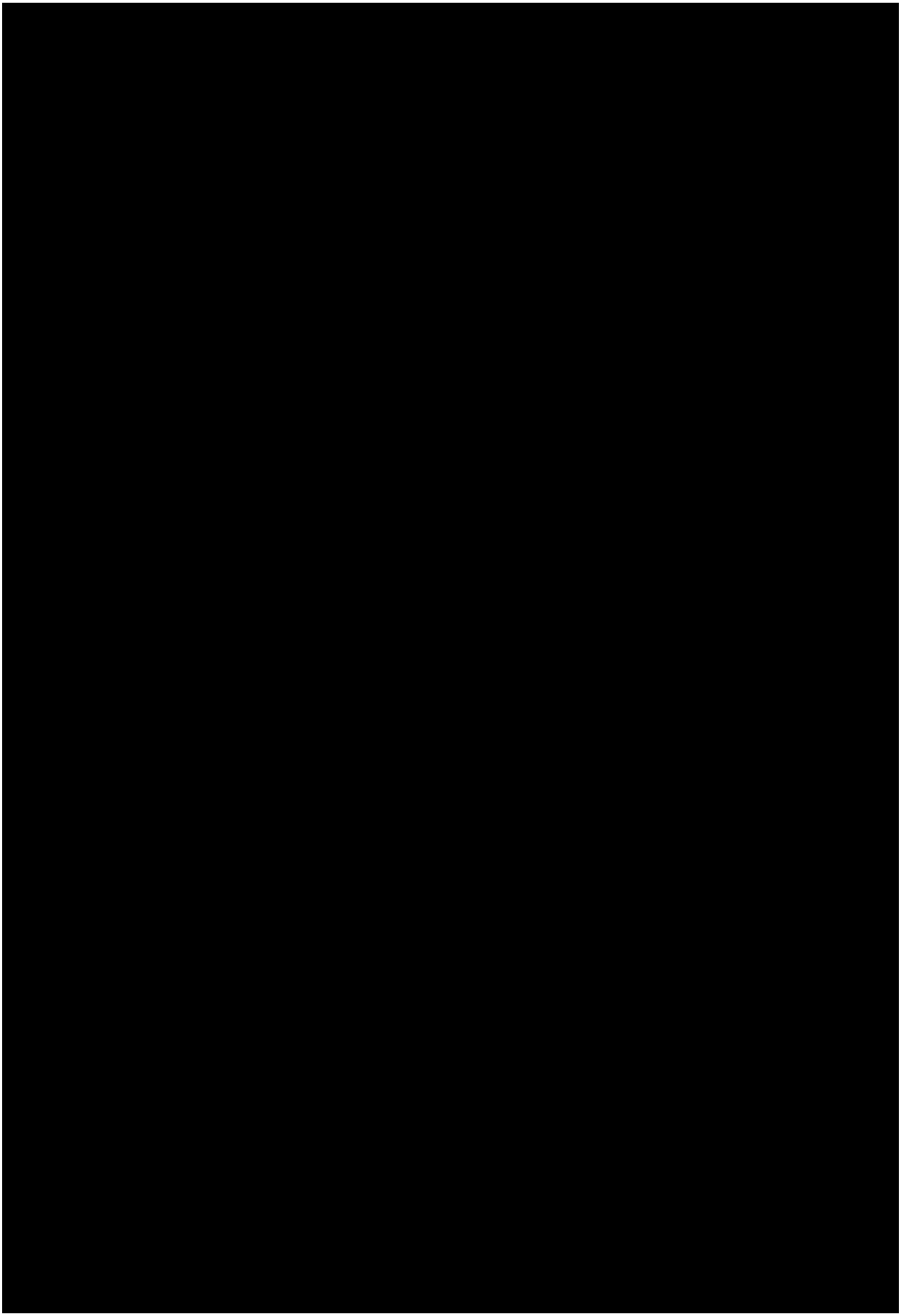
Woodhouse, S. S., Schlosser, L. Z., Crook, R. E., Ligiero, D. P., & Gelso, C. J. (2003). Client attachment to therapist: Relations to transference and client recollections of parental caregiving. *Journal of Counselling Psychology*, *50*(4), 395-408.

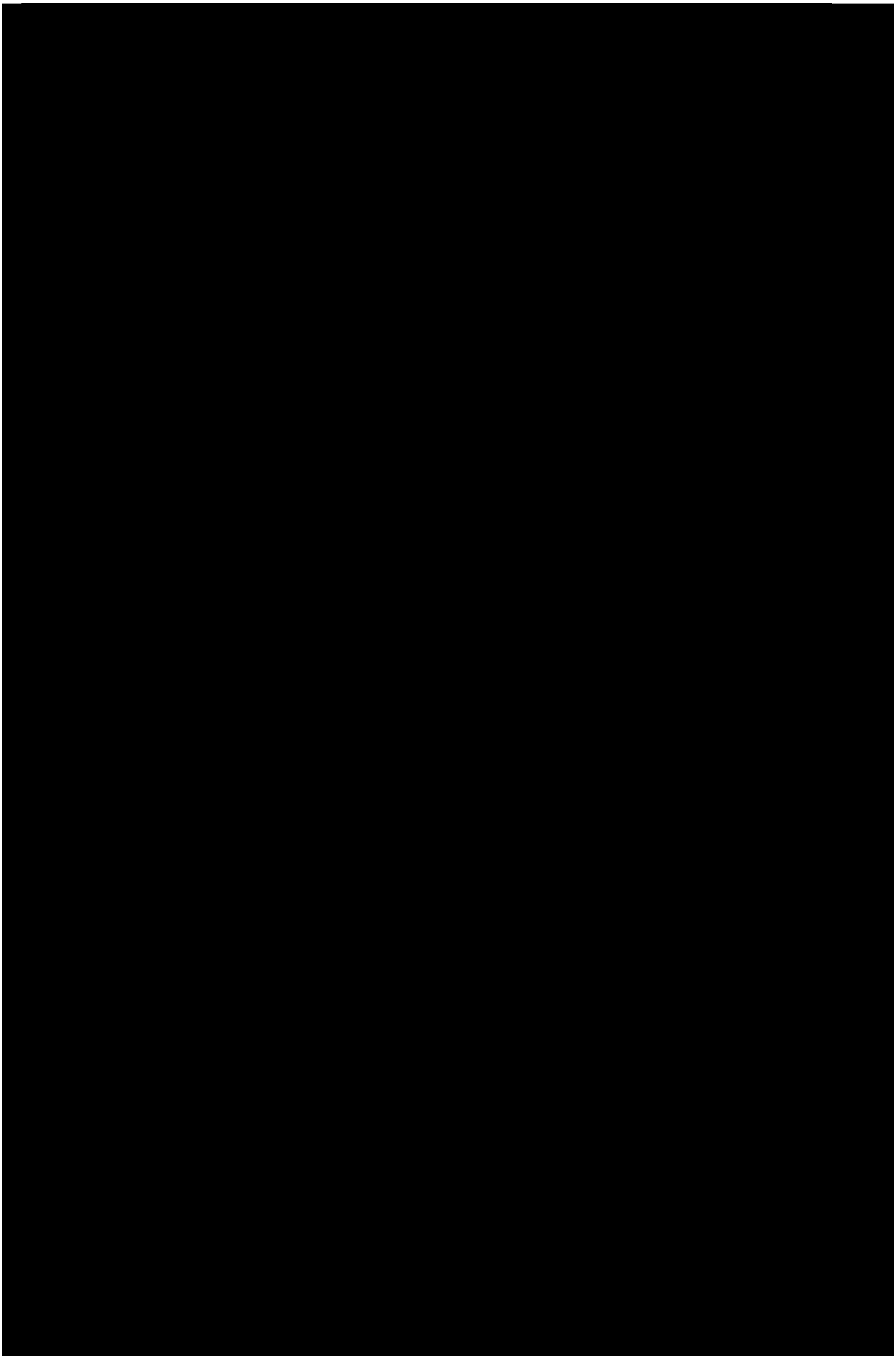
Wortman, C. B., Battle, E., & Lemkau, J. P. (1997). Coming to terms with sudden and traumatic death of a spouse or child. In A. J. Lurigio, W. G. Skogan, & R. C. Davis (Eds.), *Victims of crime* (pp.108-133). Thousand Oaks, CA: Sage Publications, Inc.

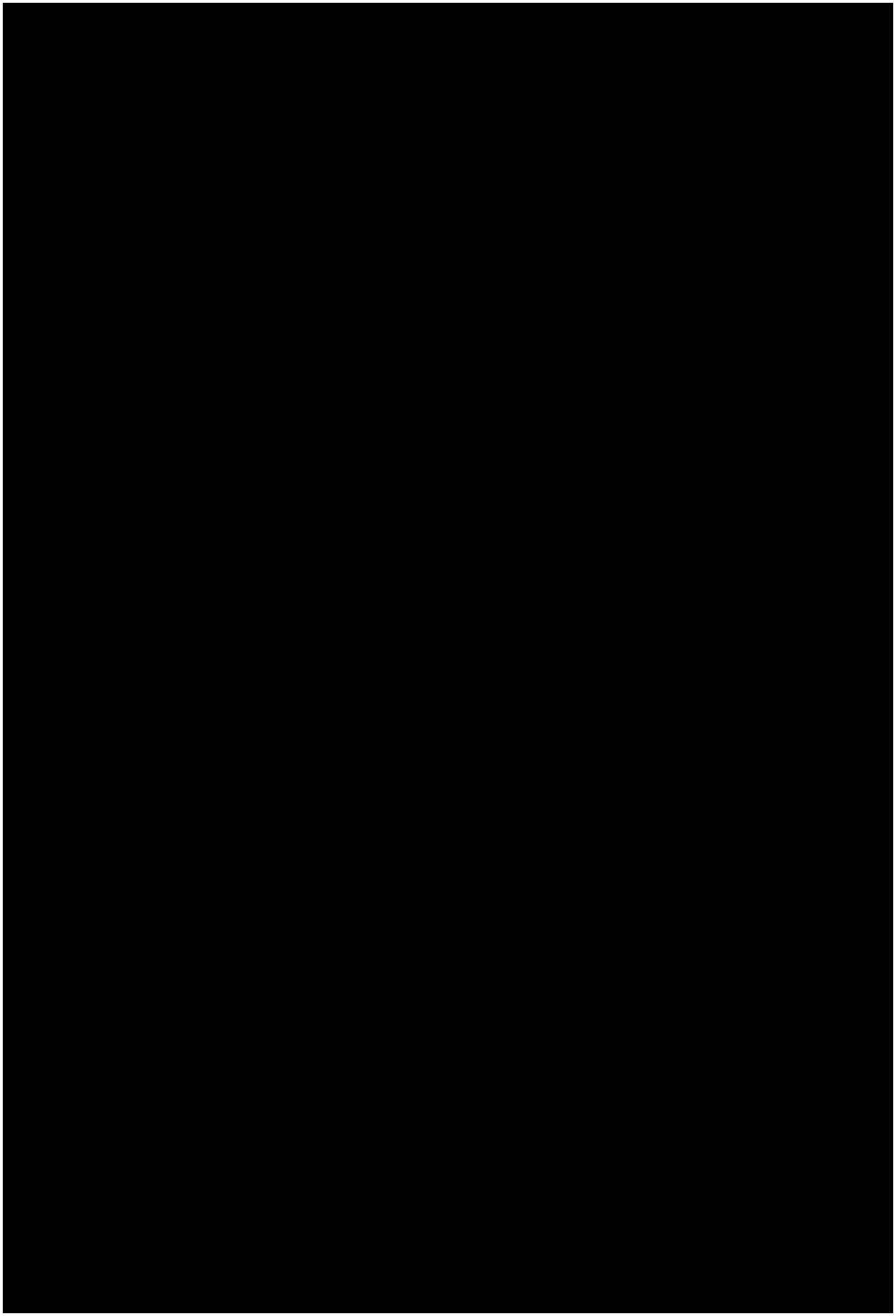
Section C: Publishable Paper

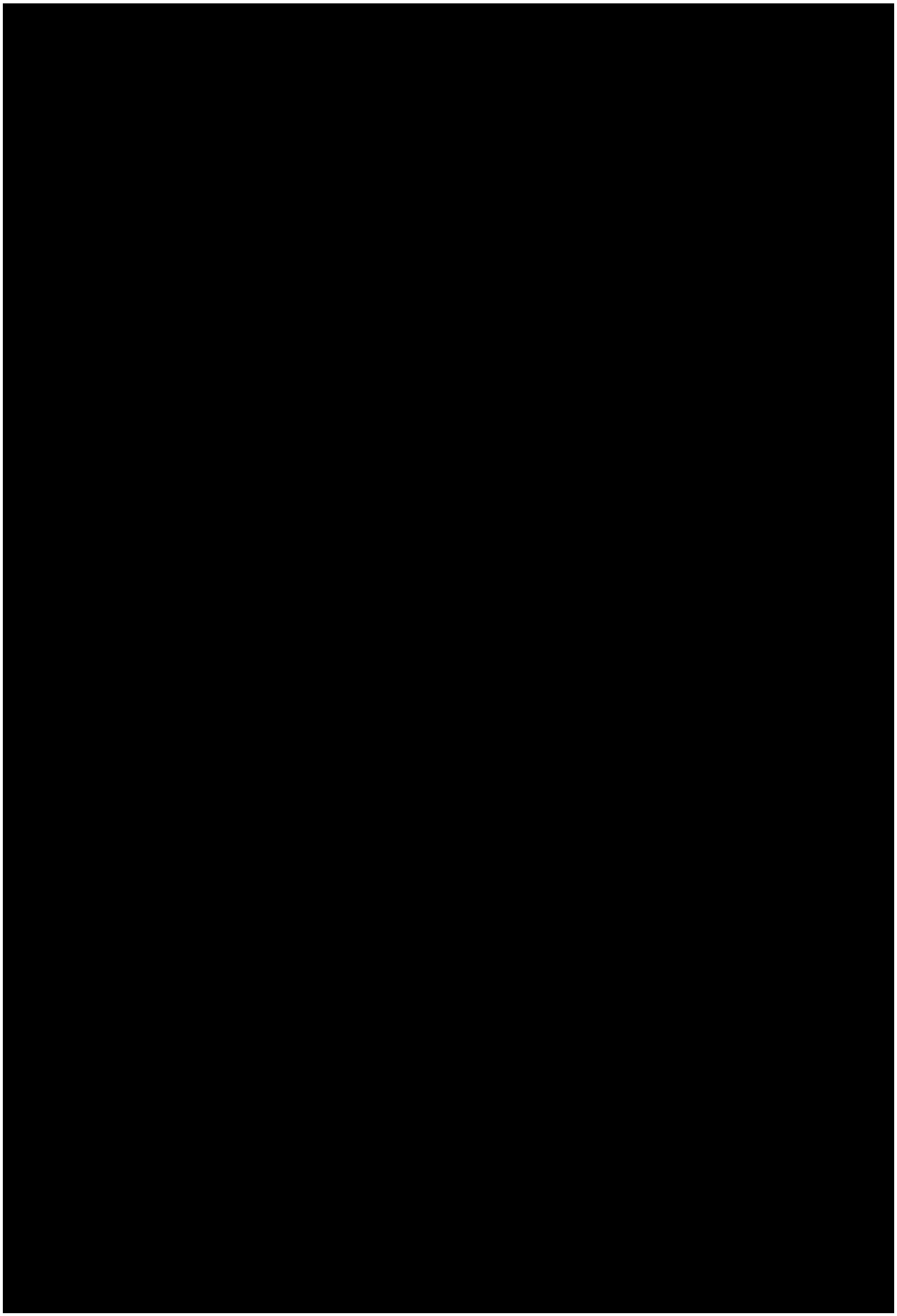


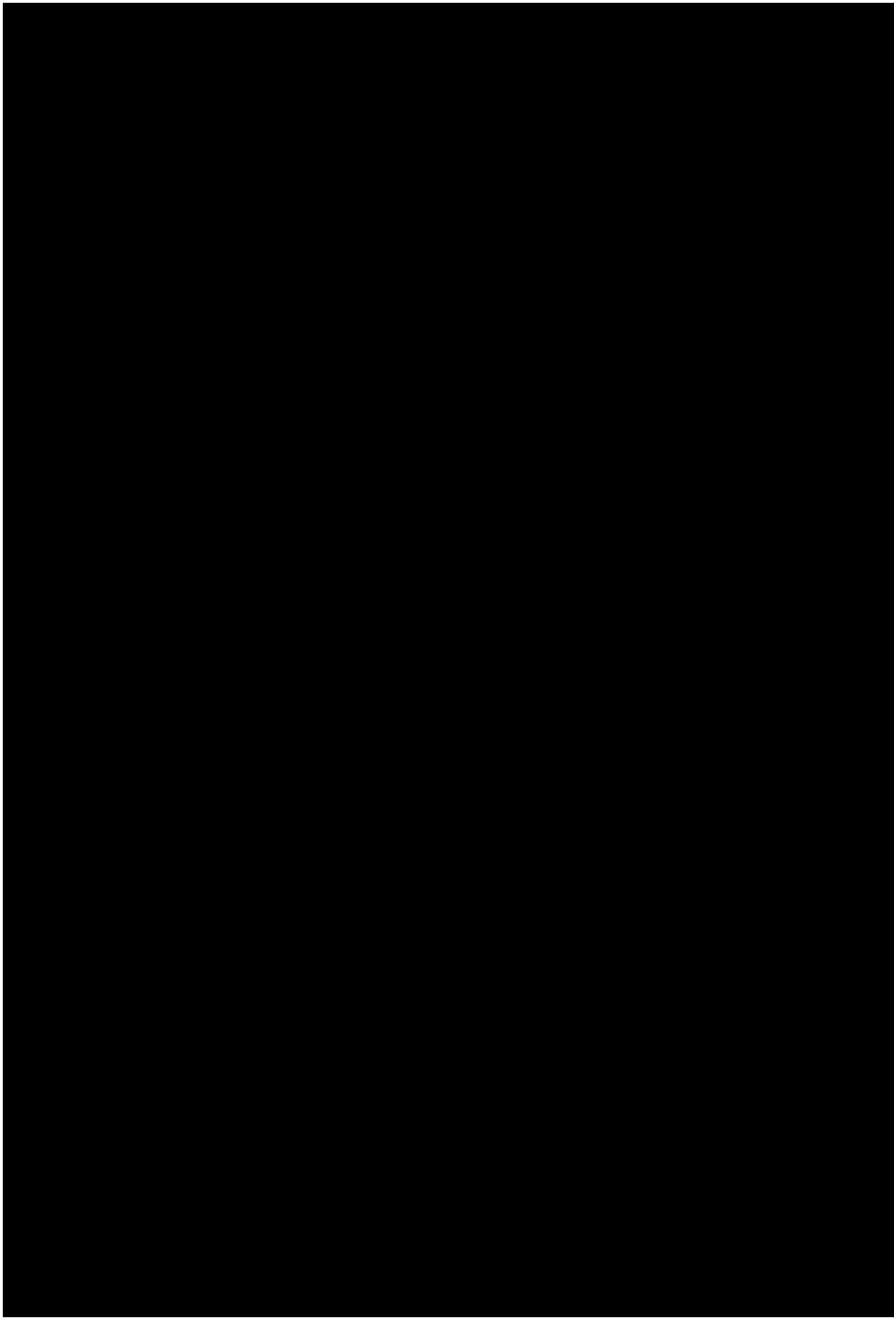


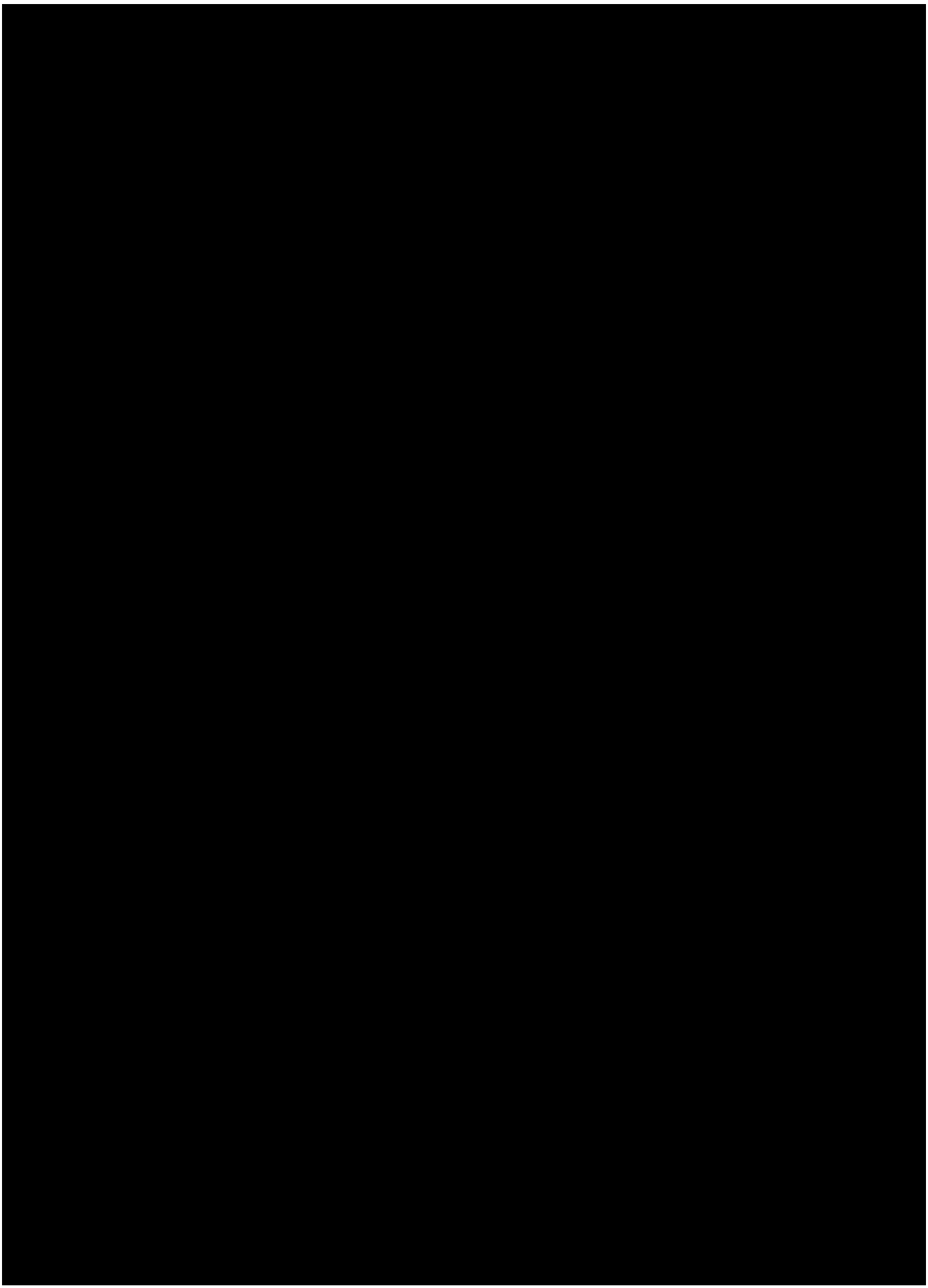


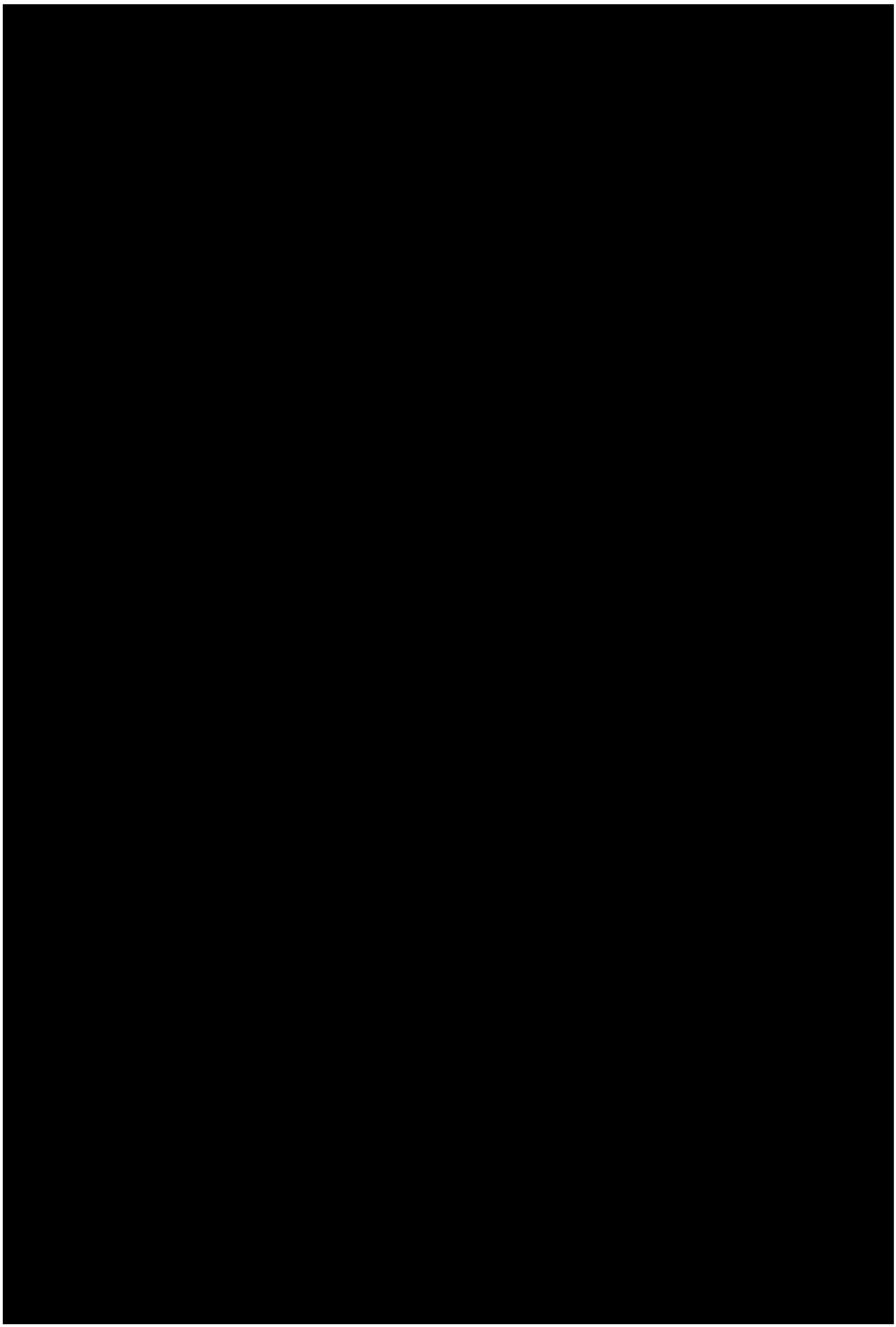


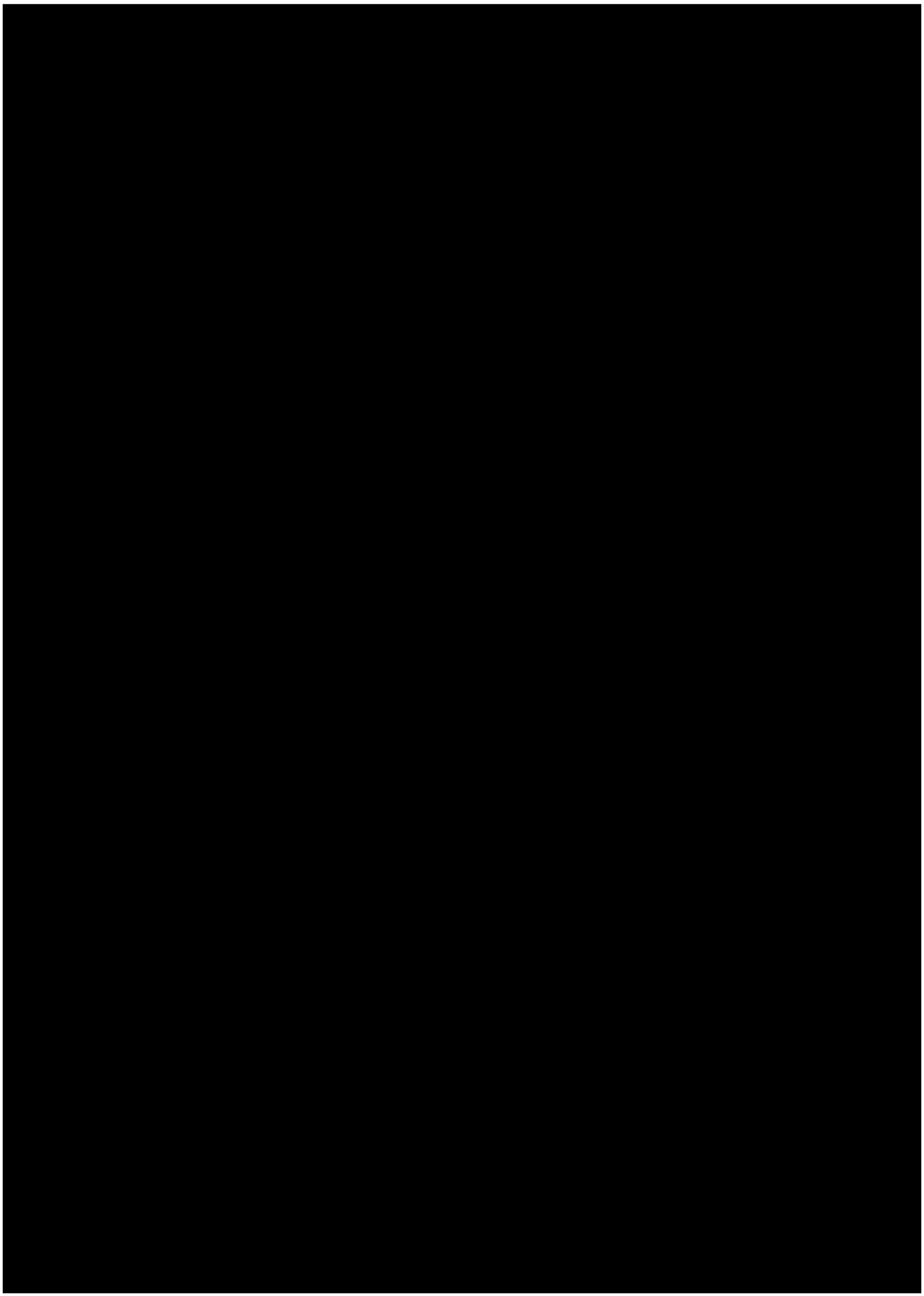


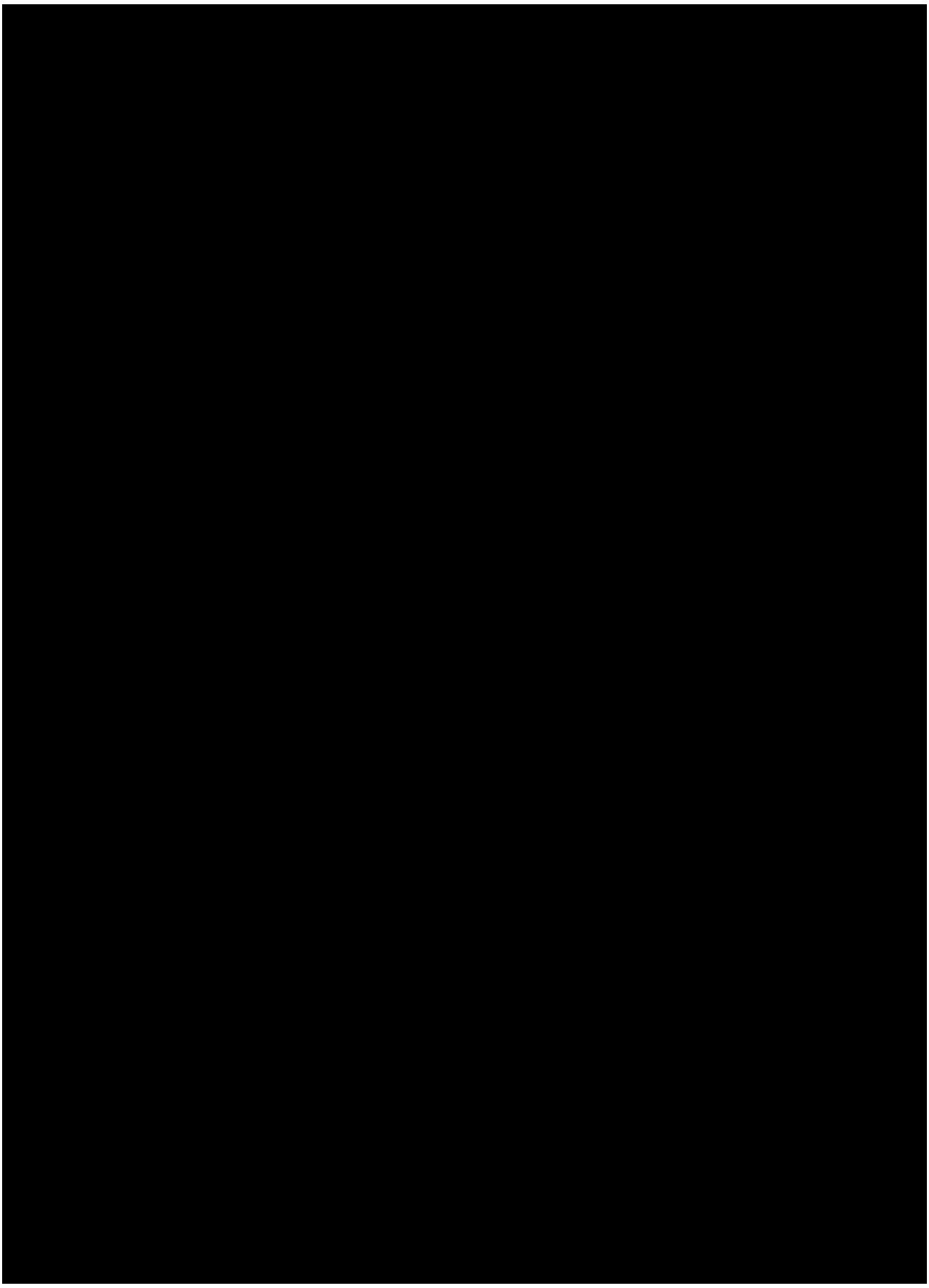


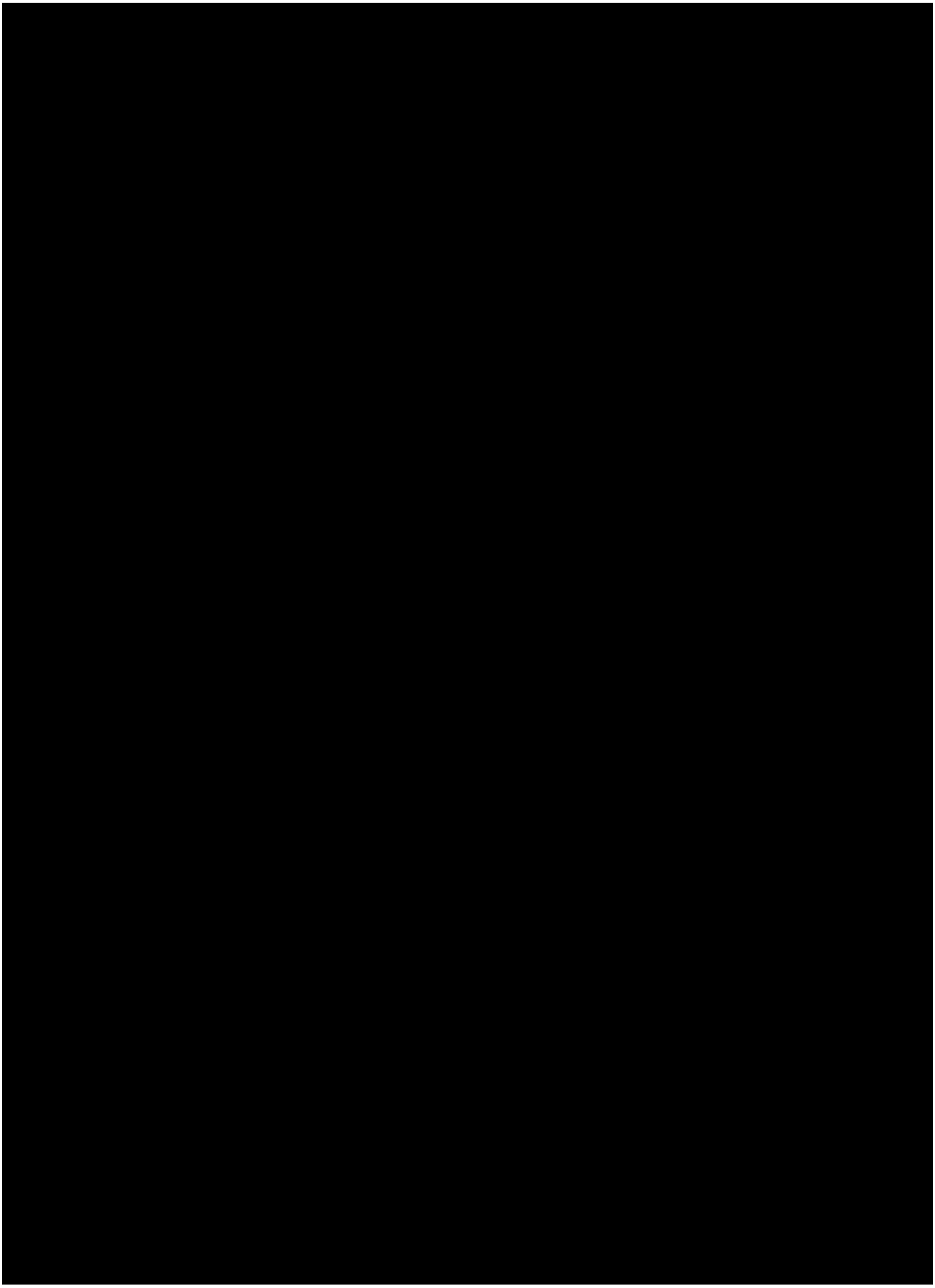


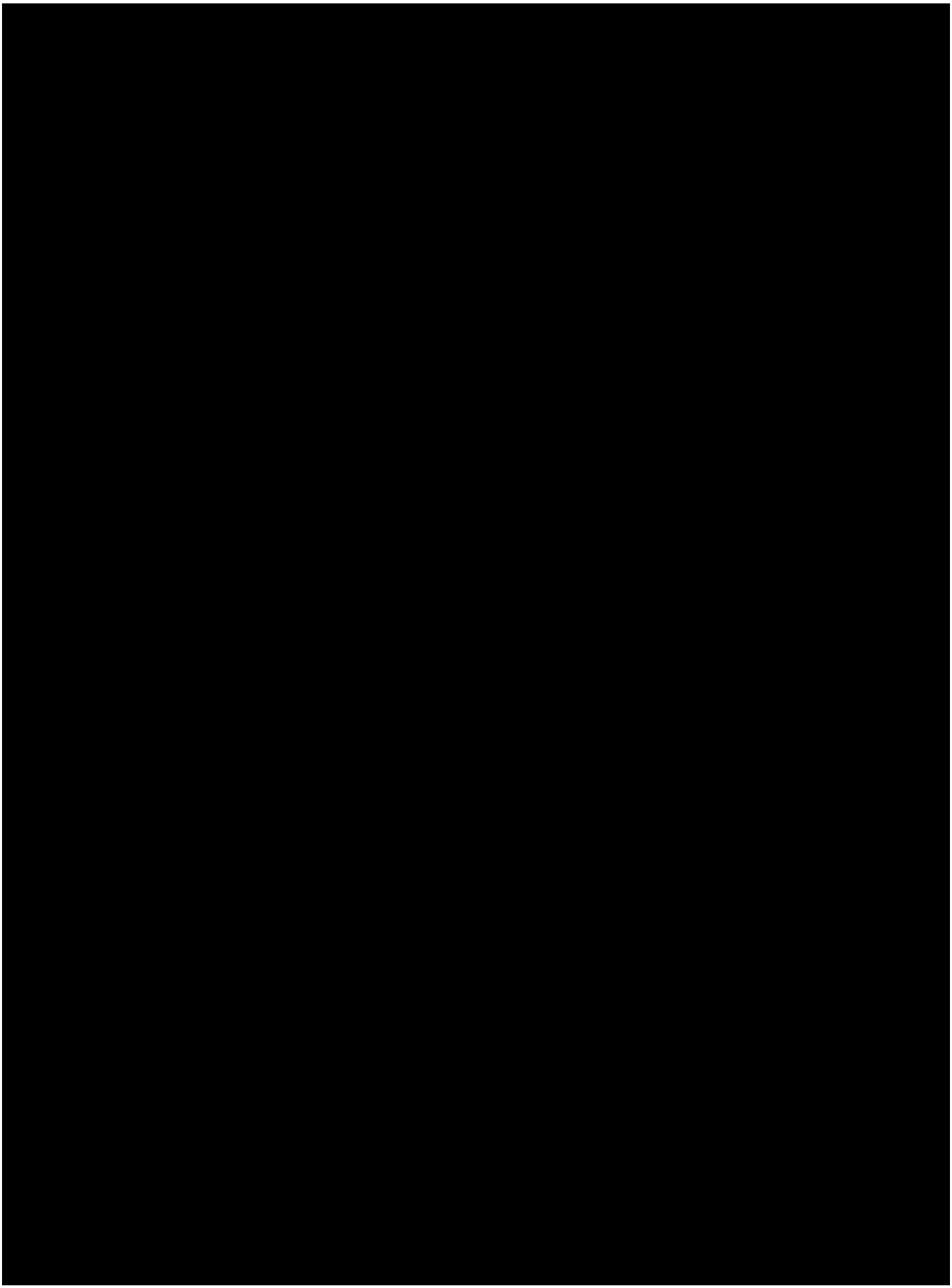


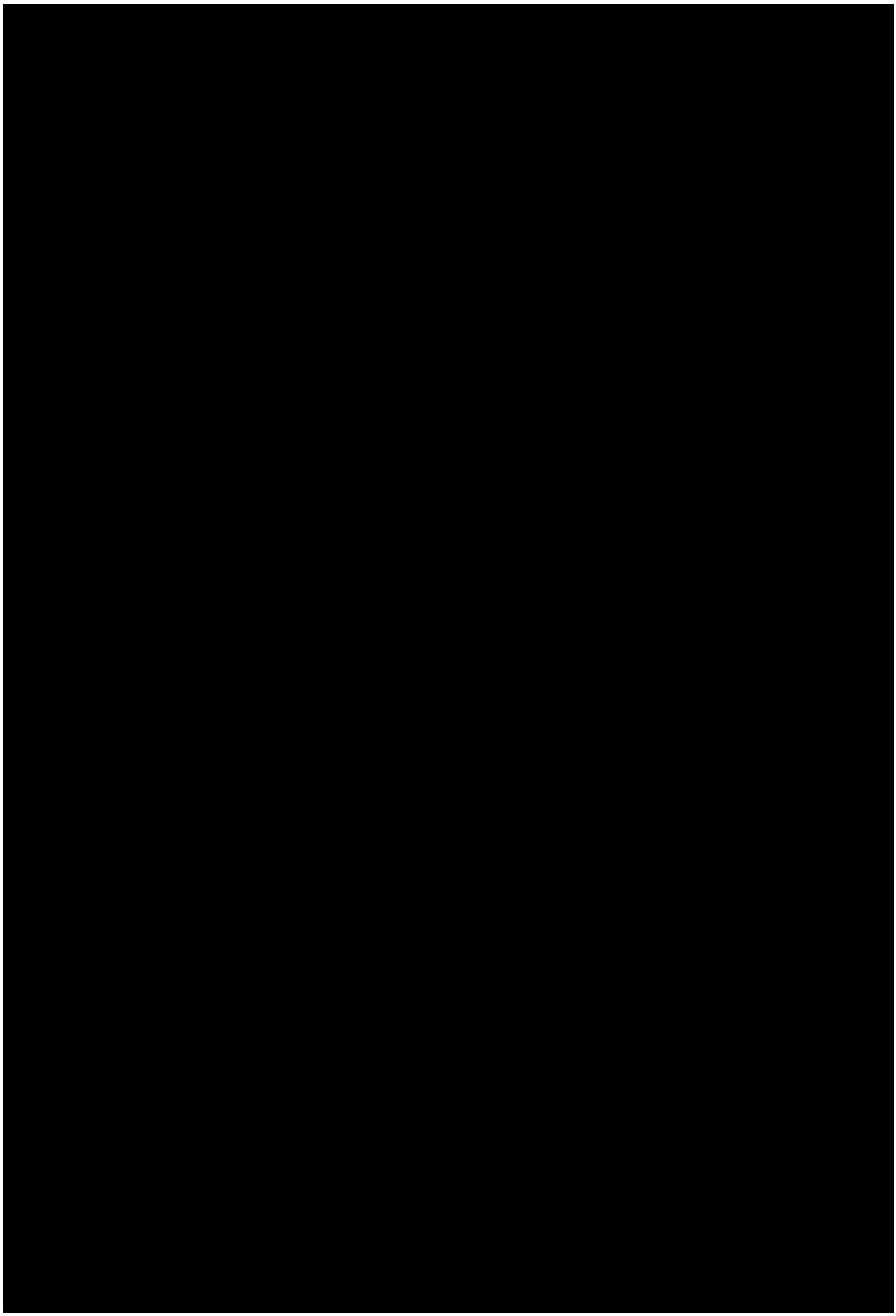


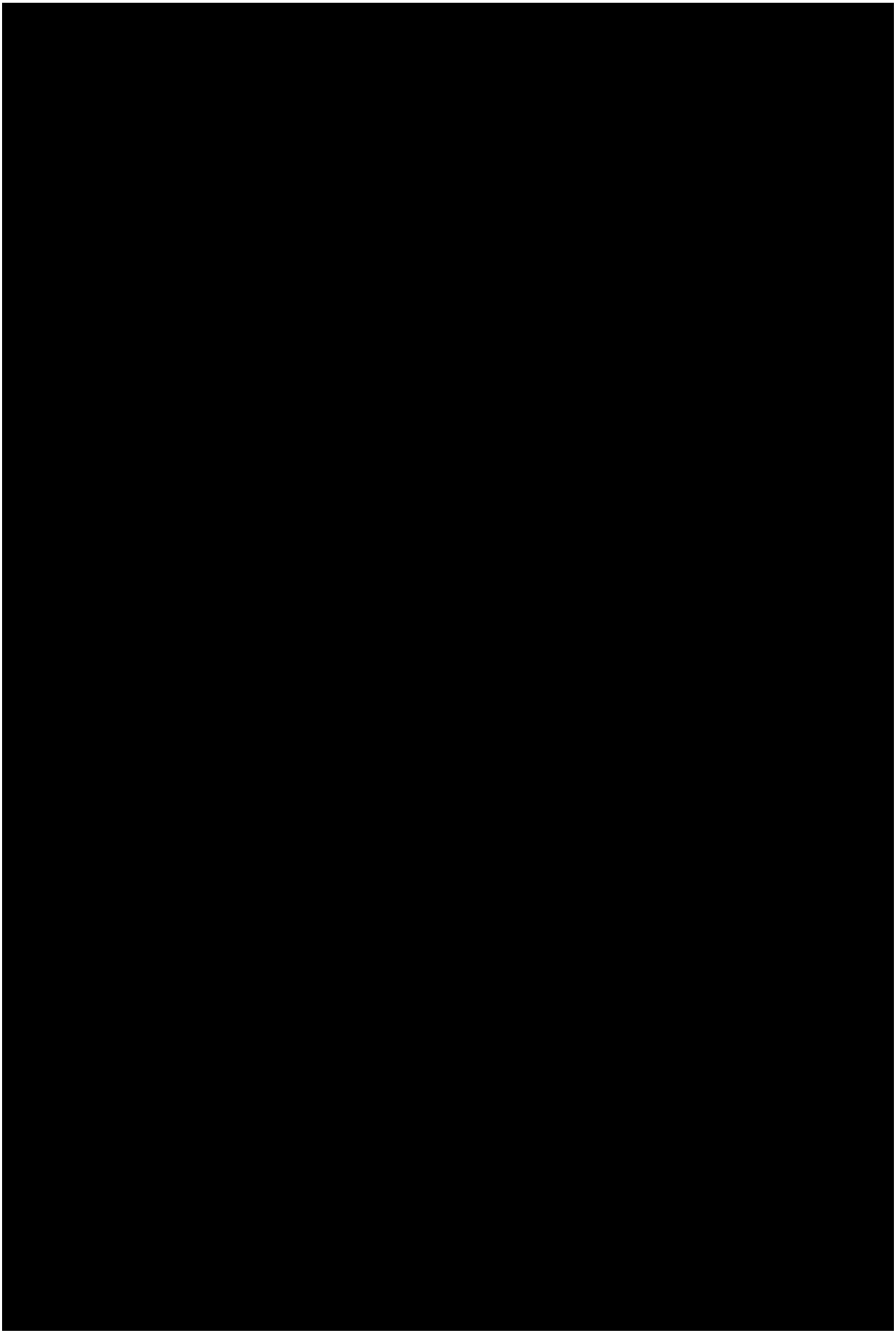


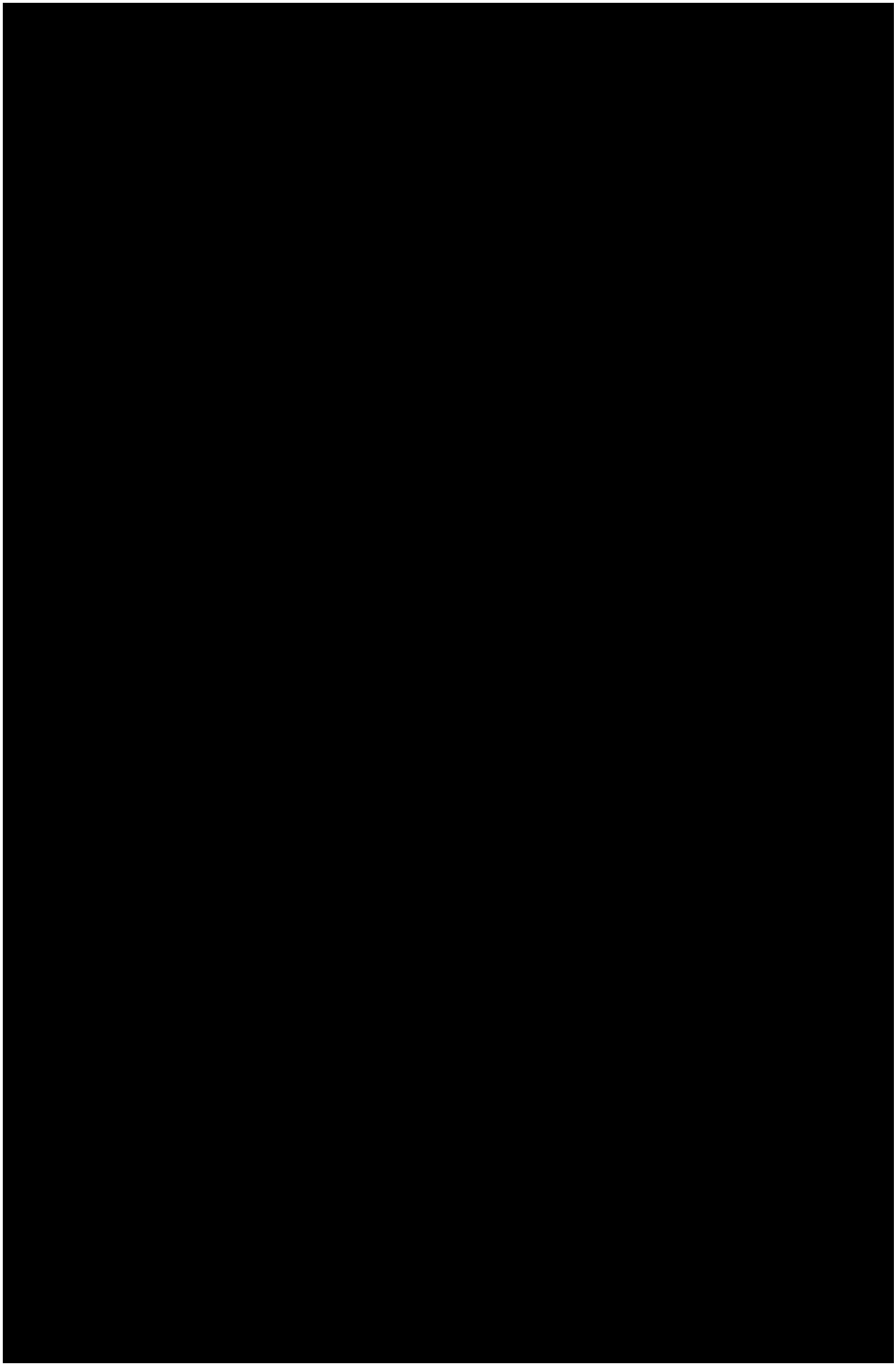


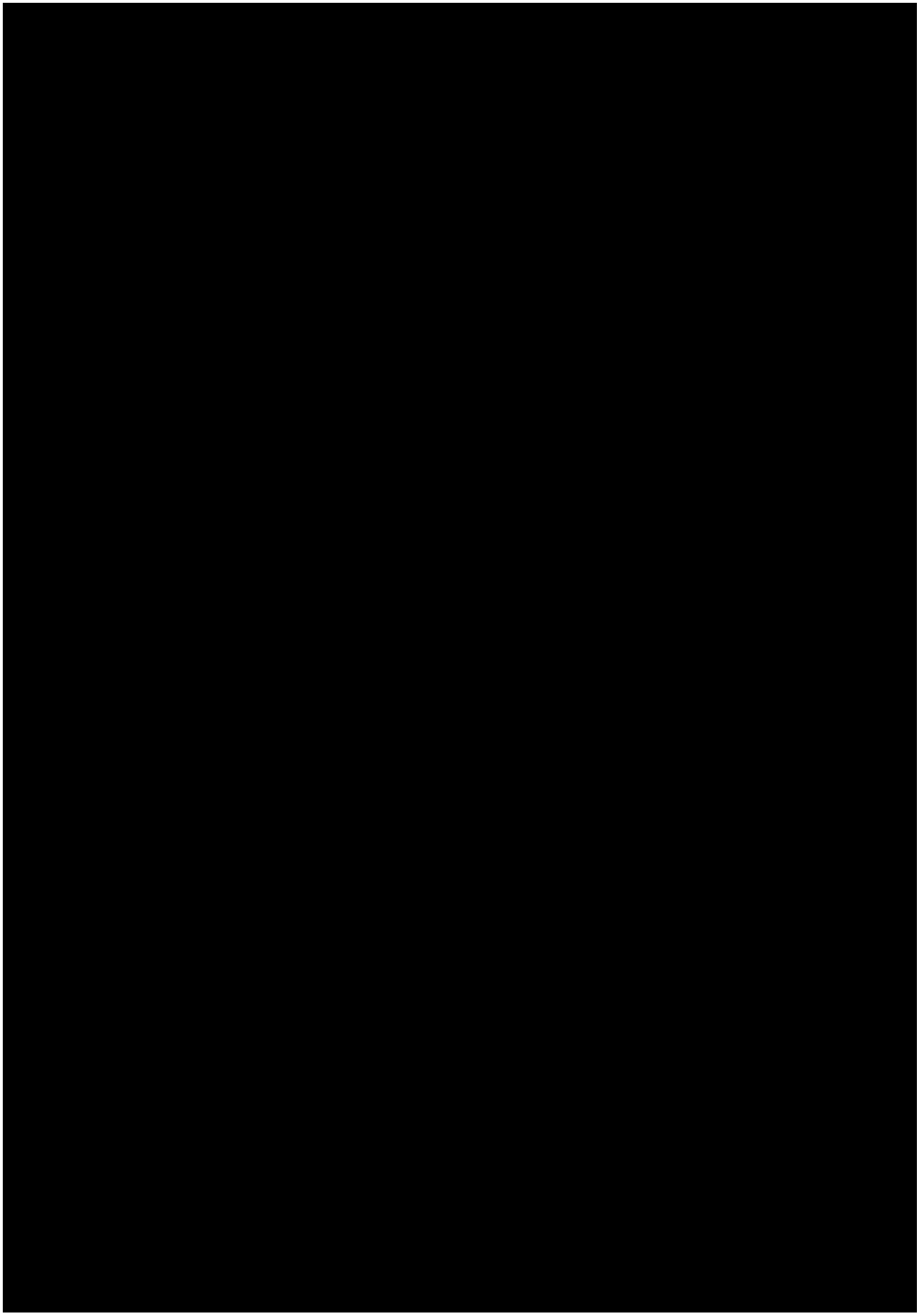


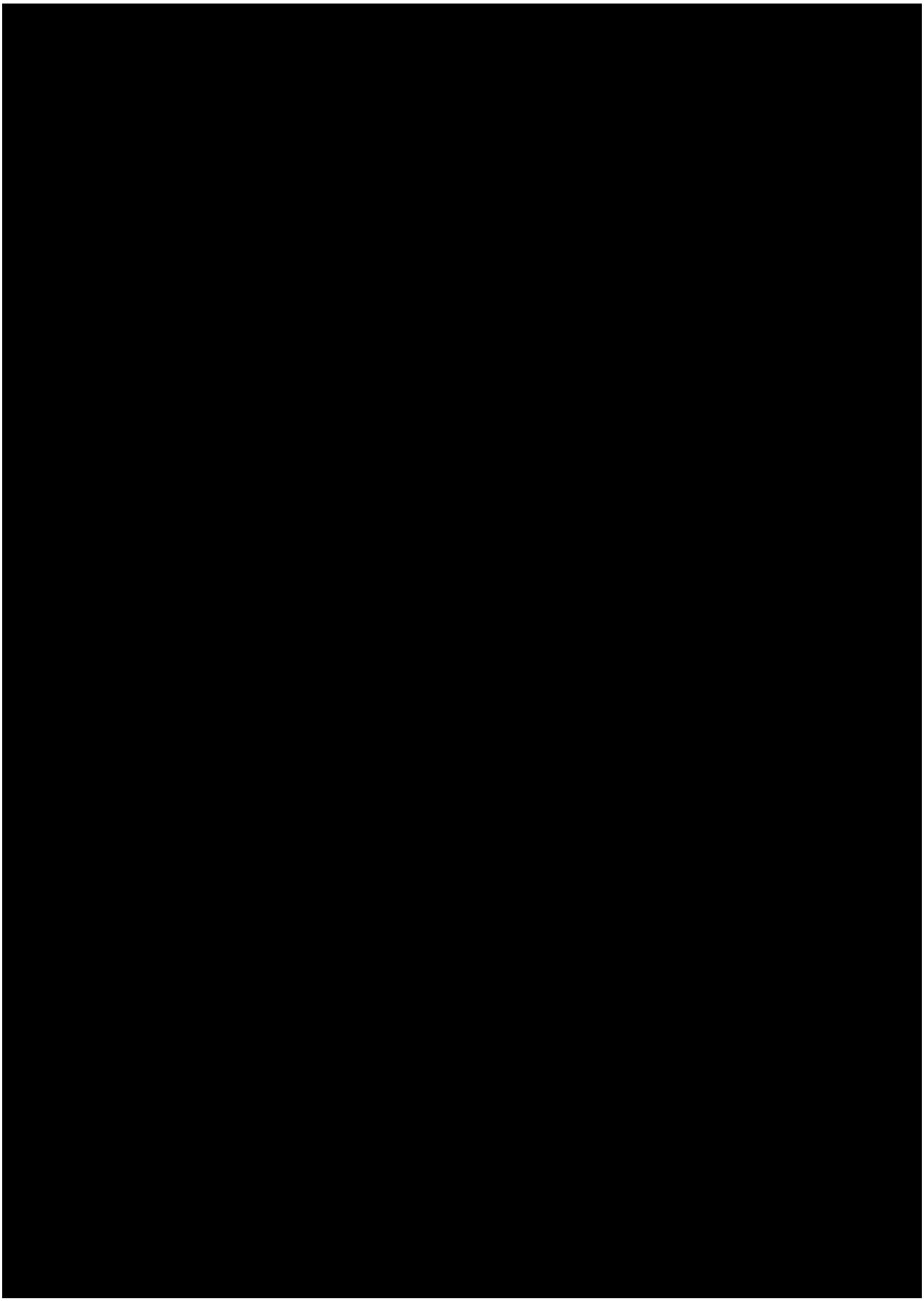


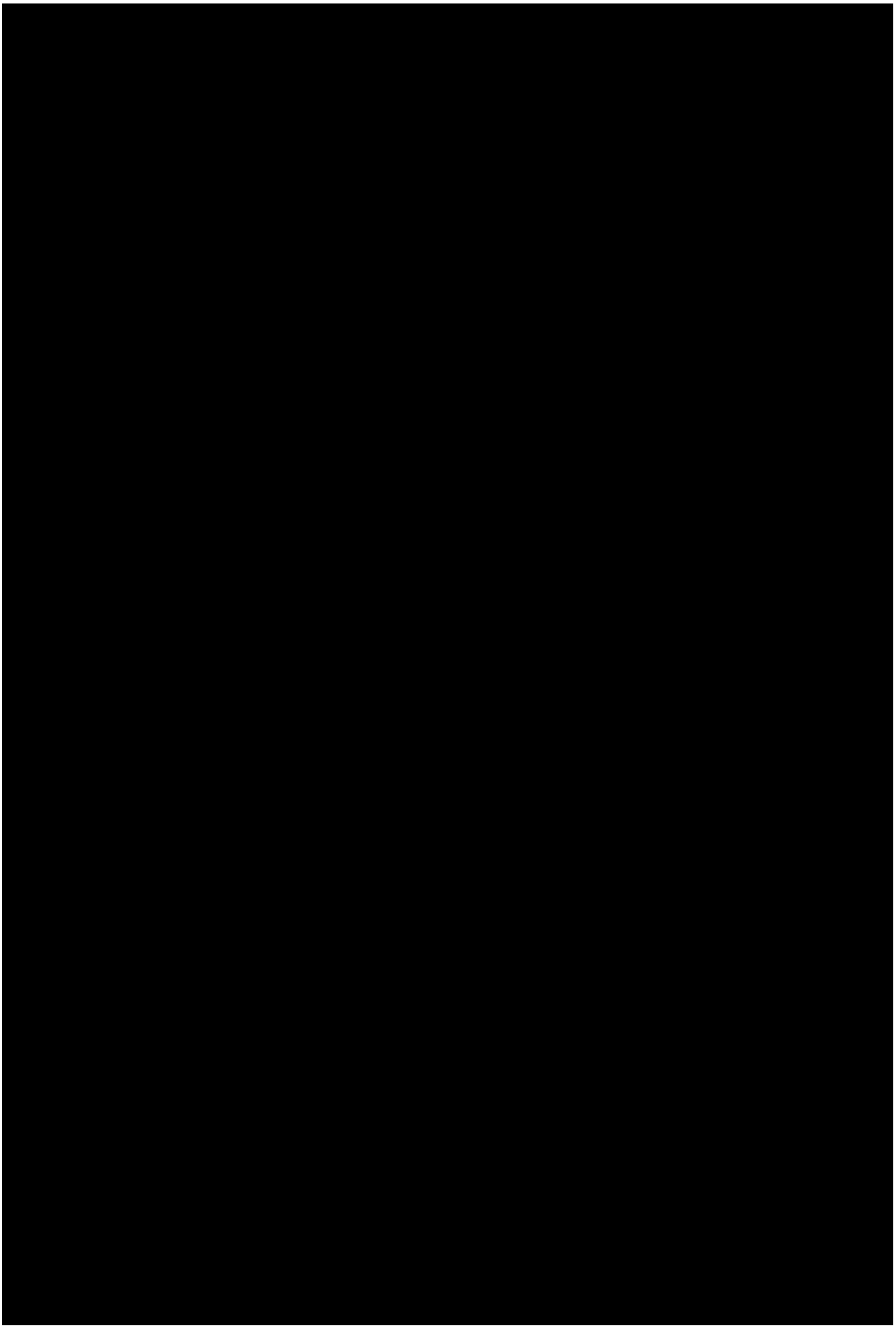


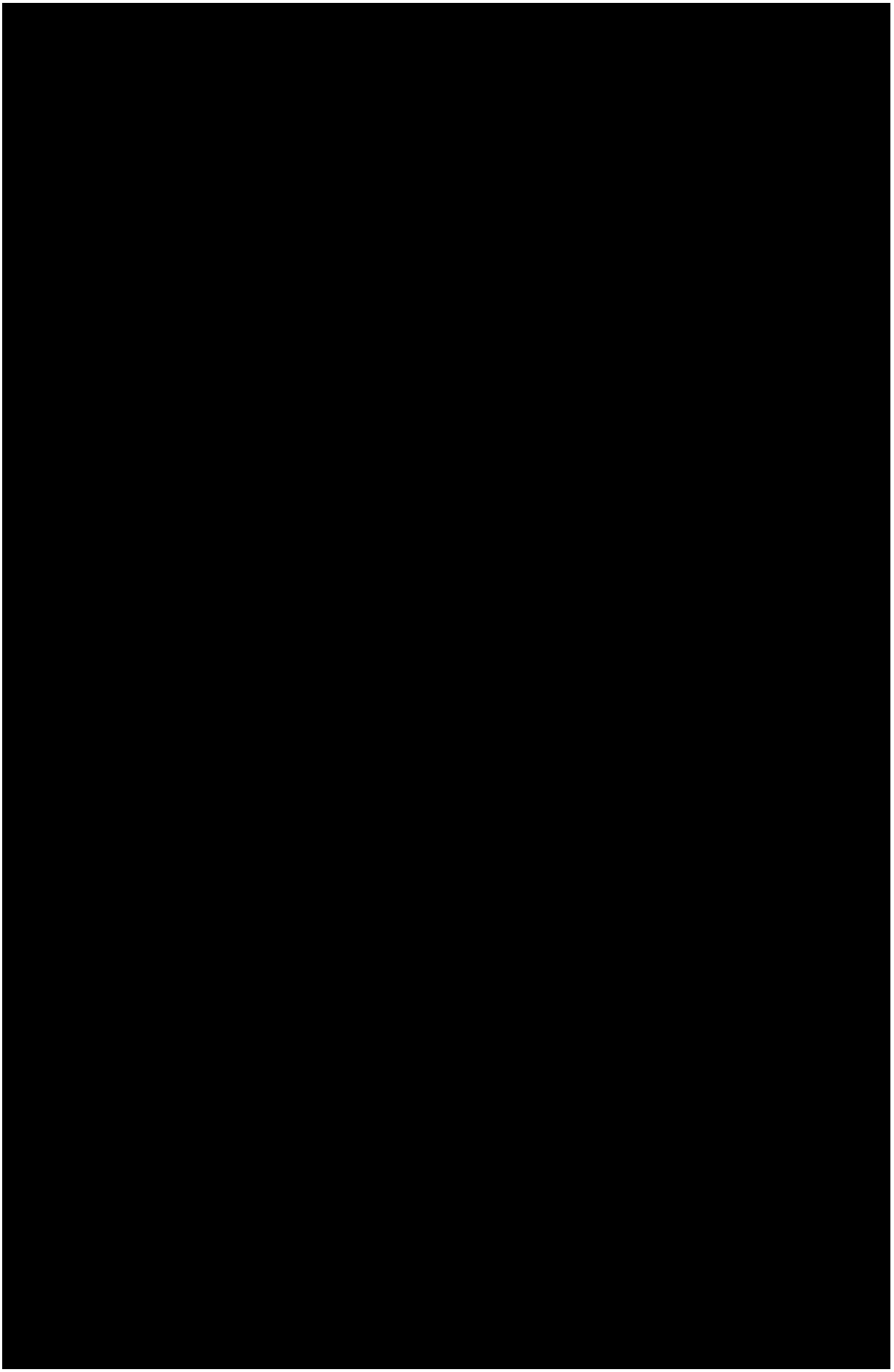












Some of this content has been removed for data protection reasons

List of Appendices

Appendix A: Recruitment poster

CITY UNIVERSITY LONDON

Department of Psychology

City University London

PARTICIPANTS NEEDED FOR RESEARCH IN: A DIFFICULT BIRTH STUDY.

We are looking for volunteers to take part in a study on
A difficult birth: An analysis of Women's experience with traumatic birth and resilience.

You would be asked to: *take part in confidential in-depth interview.*

Your participation would involve *one* session,
each of which is approximately 60 to 90 minutes.

In appreciation for your time, you will receive
a £10 gift voucher.

For more information about this study, or to take part,
please contact:
Abigail Aleong
Psychology Department
at

[redacted]

or

[redacted]

This study has been reviewed by, and received ethics clearance through the *Psychology Department* Research Ethics Committee, City University London.
Ethics approval code is PSYCH (P/F) 14/15 77.

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on [redacted] or via email:
[redacted]

Appendix B: Recruitment letter

Hi,

My name is Abigail Aleong and I am a Counselling Psychology Doctoral student at City University, London. I would like to invite you to take part in a research project. The research project is about women who feel they have fostered resiliency and subsequently recovered from their experience of a traumatic childbirth. Through this research I hope to learn more about what is helpful in the recovery process.

This is an opportunity to give hope and ideas to other women who have experienced a traumatic birth. In addition, the research will inform healthcare professionals about what is helpful to women who have experienced trauma during pregnancy and how to offer suitable support. Before you decide if you want to take part, it is important that you read the inclusion and exclusion criteria.

INCLUSION CRITERIA
To take part in the research study you must see yourself as recovered from the traumatic experience of childbirth. A traumatic experience is defined as your perception of trauma child birth and this may include feeling uncared for by the nurses or medical staff, experiencing unexpected medical interventions, feeling unbearable pain beyond your ability to cope, feeling unsafe and inhumane, and perceiving your life and the life of your infant were at risk of death which can lead to psychological effects after the birth (Sawyer & Ayers, 2009).

EXCLUSION CRITERIA
Women who have recently given birth within the last year and view themselves as experiencing postnatal depression cannot take part in this study. Women who view themselves as still in the recovery process and are currently experiencing nightmares, flashbacks and hyperarousal about the childbirth experience will also be excluded from this study.

Please ask any questions if your are uncertain about the inclusion and exclusion criteria.
Taking part in this study involves being interviewed (for approximately 60/90 mins) so that I can learn about your experience. Before you decide if you want to take part, it is important to understand why the research is being done and what it will involve for you. More detailed information about the research will be provided on an 'Information Sheet': this includes details of how you can contact me if you have any questions. Please consider the information sheet carefully and talk about it with your family or friends.

You do not have to take part, it is your decision. If you do want to take part, you will be asked to sign a form giving consent. You will be given a copy of this information sheet and your signed form to keep. You are free to stop taking part at any time during the research without giving a reason.

If you take part and complete the session you will be given a £10 gift voucher as a thank you for your time and help.

Thanks for taking time to read this. I hope you will consider taking part and read the "Information sheet '.

Best wishes, Abigail Aleong

Appendix C: Information sheet

INFORMATION SHEET
Title of study: A difficult birth: An analysis of women's experience with traumatic birth and resiliency.

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
A primary purpose of this research is to explore and explain what you believe fostered your resiliency after experiencing a traumatic childbirth. This study will address your experience through the use of qualitative methods and explore in greater depth how you perceived, experienced and made sense of your birth experience.

Why have I been invited?
In this research project, I am looking for participants who feel they experienced a traumatic birth in the past. It is important that women who take part in this research feel they have made partial or complete recovery as the focus of this research is to understand what helped, which may include what things about themselves, other people and their environment that helped them in their recovery process.

Do I have to take part?
Participation in the project is voluntary, and you can choose not to participate in part or all of the project. You can withdraw at any stage of the project without being penalised or disadvantaged in any way.

You have the choice whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.
What will happen if I take part?
We will meet and I will ask you a few questions about how you fostered resiliency and subsequently recovered from your traumatic childbirth. The interview itself will last approximately 1 hour. You only say what you want to, there will be no intentionally difficult questions and you do not have to share anything that you do not want to. The research method being used looks at how participants construct and interpret their personal and social world, and the meanings they attach to particular experiences.

At the end of our meeting you will have the chance to ask me questions that you have and to say how you found talking about your experience. I will spend time talking about this whilst ensuring that you leave the interview feeling safe.
The interview will take place in a private and quiet environment, at a location convenient to you.

Expenses and Payments (if applicable)

- If you have travelled to the location of the interview, travel expenses will be reimbursed up to the value of £10 on the production of a travel receipts.
- You will be also be offered a £10 gift voucher, as a small thank you for your time.

What do I have to do?
If after reading this information sheet you would like to take part in the research, you will be given this sheet to keep and need to sign 2 consent forms. You will keep one copy of the signed consent form and the researchers will keep another copy. You will be asked to complete personal information sheet and take part in an in-depth interview, lasting approximately one hour. The interview will be recorded and as detailed above involve answering questions about your experience of childbirth.

What are the possible disadvantages and risks of taking part?
There are no foreseeable disadvantages or risk in taking part. However, reflecting on your birth experience may bring up some upsetting material. If so, you have the right to terminate the interview at any point.

What are the possible benefits of taking part?
Many people find talking and making sense of their experiences positive and helpful. It is also an opportunity to help healthcare professionals to understand how to offer suitable support to women who have experienced difficult deliveries. This in turn, would help guide therapists in how the carry out therapy. It is also hoped that this research will provide a better understanding amongst other women and families about difficult births and resiliency. A written summary of the results can be sent to you if you would like to be kept informed about the results of this research.

What will happen when the research study stops?
The records will be stored until the research has been successfully submitted and examined by the university. After complete examination all raw data will then be destroyed.

Will my taking part in the study be kept confidential?
Yes. If you decide to take part, we will keep your information in confidence. All information (i.e., your consent form, personal information sheet, interview audio-tape and transcript) will be kept at a secure location which will only be accessible by the researchers. The interview write up or transcript will not contain your name. The overall findings of the project may be published in a research paper, which may include direct quotes from interviews; however no individuals will be identifiable

The only time information from the interview would be shared with other professional, would be in exceptional circumstances if you revealed information about yourself that may indicate a risk of harm to yourself or others.

What will happen to the results of the research study?
The results of the study will form part of a Doctoral thesis and on completion it may be submitted to counselling psychology review. Anonymity will be maintained throughout the process and all participants can receive a copy of the publication or summary of results. Please email me if you would like a copy.

What will happen if I don't want to carry on with the study?
Participants are free to withdraw from the study at anytime without any penalty.

What if there is a problem?

If any problems occur after the research has been completed, please email me at [redacted]
If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to phone [redacted]. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is *[insert project title here]*

You could also write to the Secretary at:
[redacted]
Secretary to Senate Research Ethics Committee
Research Office, [redacted]
City University London
Northampton Square
London
EC1V 0HB
[redacted]

Who has reviewed the study?
This study has been approved by City University London Psychology Department Research Ethics Committee, approval number **PSYCH (P/F) 14/15 77.**

Further information and contact details:The research is being supervised by City University London.

Research Supervisor: [redacted] for further information:
[redacted]

Thank you for taking the time to read this information sheet.

Appendix D: Consent form

CITY UNIVERSITY LONDON

Title of Study: A difficult birth: An analysis of women's experience with traumatic birth and resiliency

Ethics approval number: **PSYCH (P/F) 14/15 77**

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will: • being interviewed by the researcher • allowing the interview to be audiotaped • making myself available for a further interview should that be required	
2.	This information will be held and processed for the following purpose(s): • To uncover how women fostered their resiliency and subsequently recovered from their experience of a traumatic birth. • To give women hope and ideas of overcoming the experience of a traumatic birth. • To guide counselling psychologist in their practice through the production of knowledge and theory that can be applied to helping individuals make sense of their experience. • To contribute knowledge to healthcare professionals on how to better support women professionally and psychologically. • To promote better psychological health and functioning in the aftermath of a traumatic childbirth. • I understand any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. BPS Ethics will be adhered to during the interviews. AND I understand that I will be given a transcript of data concerning me for my approval before it is included in the write-up of the research. AND I consent to audio tapes being used in future publications.	

3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Researcher	Signature	Date
Name of Participant	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix E: Interview schedule

1. Could you tell me about your thoughts and feelings when you noticed that you labour had started becoming difficult?
2. Can you tell me what made your birthing experience difficult?
   a. Prompt: Could you describe what was happening at the time? How it felt? What went through your mind?

3. Could you tell me what helped you to cope with the experience?

4. How do you feel you were able to overcome the difficult birth experience?

5. Is there anything else you think I should know or understand better?

6. Could you tell me if you discovered or developed any strengths having been through this experience?

7. How do you feel you were able to demonstrate resilience in overcoming that experience?

   a. How did you feel you were able to adapt having been through this experience?
   b. How do you feel you were able to build your strength after that experience.

8. In your opinion, what can/should women who have experienced difficult births do to overcome this and demonstrate resilience in their lives?

9. Could you describe anything else you think has been important through this process of recovery and resiliency (if appropriate)?

10. What private thoughts and feelings did you have after this experience?
    a. Prompt: What did you not want anybody else to know?
    b. Prompt: People search for reason as to why me? What did I do wrong?

11. Are there any questions you think I should have asked you that I did not, or is there any other information you would like to share with me that you feel might be helpful for this project that you did not share with me yet?

Appendix F: Debriefing sheet

Thank you for participating in this research by taking part in the interview.

The interview in which you participated was designed to explore how you fostered resiliency and subsequently recovered from your experience of a traumatic childbirth. In particular, I wanted to give you the opportunity to voice your experience which may help other mothers who have felt isolated by their experience. It is hoped that this will inform healthcare professionals about what is helpful to women who have experienced trauma during pregnancy and how to offer suitable support.

Please let me know if:

- You would like to add anything we discussed during the interview?
- You have any questions about this research and its aims.
- There was anything you found useful or not so useful about the interview.

If you are suffering from postnatal depression then please see the list of resources below (Birth Trauma Association, National Childbirth Trust and ASSIST). If anything discussed in this interview has caused you distress, you can contact myself or my research supervisor up until the research has been written up.

Please find below a list of support agencies should you need additional support:

Birth Trauma Association
Website: birthtraumassociation.org.uk
Email: support@birthtraumaassociation.org.uk

National Childbirth Trust
Website: www.nct.org.uk
Telephone: 0300 330 0700

Samaritans (24 hour helpline)
Telephone: 08457 90 90 90
Email: jo@samaritans.org

Assistance Support and Self-help in Surviving Trauma (ASSIST)
(a registered charity dedicated to offering confidential, emotional and practical support to individuals and families affected by any trauma
Helpline: 01788 560800
Website: www.traumatic-stress.freeserve.co.uk

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following: please contact me at [redacted] or my research supervisor, [redacted]

Ethics approval code:PSYCH (P/F) 14/15 77

Appendix G: List of therapists

THERAPIST ADVERTISED AT BIRTH TRAUMA ASSOCIATION:
[redacted], Clinical Psychologist,CPsychol, Psych D, BSc (Hons) Hove, East Sussex

Through working in both mental health and physical health services, I have developed a keen interest in working with people who have endured traumatic experiences. This includes working with women who are experiencing difficulties related to pregnancy and childbirth, such as:

- Symptoms related to and coming to terms with a difficult or traumatic birth experience (including thinking about possible future births and managing physical injury sustained during childbirth).
- Making decisions about and coping with fertility treatment
- Relationship and sexual difficulties
- Re-awakening of issues related to earlier sexual abuse

I am trained in both CBT (Cognitive Behaviour Therapy) and EMDR (Eye Movement De-sensitisation and Re-Processing) so am able to offer interventions recommended by NICE for women who have symptoms of Post-Traumatic Stress Disorder (PTSD), depression or anxiety. I use consulting rooms in Hove, and offer appointments on a range of days and times, including evenings and Saturday mornings. I am a chartered member of the British Psychological Society and am registered with the Health Professions Council.

For more information, please contact me on:
[redacted]

Zita Cox MBACP Accred; UKRCP; EMDR Europe Accredited Practitioner
I am accredited by the BACP (British Association of Counselling and Psychotherapy) and EMDR Accredited Practitioner, as a Psychotherapist and Counsellor. I have worked extensively in the NHS running a counselling service in a busy London GP surgery and in Hospitals in London and Gloucestershire. Alongside my NHS work I have maintained a Private Practice. I work in Gloucestershire near Cirencester and Stroud and in Harley Street Central London.

I specialise in working with Trauma and have helped many women recover from the effects of traumatic pregnancies and deliveries. My approach is a combination of Counselling – establishing a confidential and safe space – and specialist trauma approaches including TIR (Traumatic Incident Reduction) and EMDR (Eye Movement Desensitization and Reprocessing) the NICE recommended treatment for Trauma. I also use Hypnotherapy for relaxation and stress reduction where appropriate. I am accredited by the General Hypnotherapy Council.

Woman can suffer for years from the effects of traumatic pregnancies and deliveries, I feel passionately about this work, symptoms such as flashbacks, nightmares, insomnia completely invade everyday life and may deeply effect the Mother/child relationship whilst some women become frightened of future pregnancy; therapy can change this experience.

Appendix G: List of therapists

Appendix H: Ethics

CITY UNIVERSITY LONDON

Psychology Department Standard Ethics Application Form:
Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? For each item, please place a 'x' in the appropriate column	Yes	No
Persons under the age of 18		X
Vulnerable adults (e.g., with psychological difficulties)		X
Use of deception		X
Questions about potentially sensitive topics	X	
Potential for 'labelling' by the researcher or participant (e.g., 'I am stupid')		X
Potential for psychological stress, anxiety, humiliation or pain	X	
Questions about illegal activities		X
Invasive interventions that would not normally be encountered in everyday life (e.g., vigorous exercise, administration of drugs)		X
Potential for adverse impact on employment or social standing		X
The collection of human tissue, blood or other biological samples		X
Access to potentially sensitive data via a third party (e.g., employee data)		X
Access to personal records or confidential information		X
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		X

If you answered 'no' to <u>all</u> the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application they will submit it to psychology.ethics@city.ac.uk and you will be issued with an ethics approval code. <u>You cannot start your research until you have received this code.</u>

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review. You should send your application to your supervisor who will approve it and send it to psychology.ethics@city.ac.uk for review at the next Research Ethics Committee Meeting. These meetings are scheduled for the first Wednesday of every month. We aim to send you a response within 7 days of the meeting. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. <u>You cannot start your research until you have received this code.</u>

Which of the following describes the main applicant? Please place a 'x' in the appropriate space	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	X
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s).
Abigail Aleong
2. Email(s).
[redacted]
3. Project title.
A difficult birth: An analysis of women's experience with traumatic birth and resiliency.
4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)
Childbirth is a significant life event for most women and research has found between 1 and 6% of women develop symptoms of posttraumatic stress disorder (PTSD) after experiencing a traumatic birthing experience (Ayers, 2007). A traumatic or difficult birth is defined in this study as the mother's perception of trauma after the childbirth process. This may include feeling uncared for by the nurses or medical staff, experiencing unexpected medical interventions, feeling unbearable pain beyond her ability to cope, feeling unsafe and inhumane, and perceiving her life and the life of her infant were at risk of death which can lead to psychological effects after the birth (Beck, 2004b; Sawyer & Ayers, 2009). Researchers have found that traumatic childbirths can have adverse psychological and/or physical health consequences on women and their interactions with their baby and spouse (Ayers, 2007; Ayers, Eagle, & Waring, 2006; Allen, 1998). However, there is little research, focusing on the recovery process and resilience amongst women after a traumatic childbirth. The field of psychology has experienced a paradigm shift into the enquiry of examining resilience (Fletcher & Sarkar, 2013). This shift has moved the focus from examining risk factors to exploring individual strengths (Richardson, 2002). Increasingly, the thrust of early inquiry examined factors that protect individuals from stressful encounters, and differentiated between those individuals that give way to demands or adjust to adverse circumstances (Fletcher & Sarkar, 2013). Therefore, the proposed study will aim to explore and explain what women believe fostered and resiliency in their recovery process after experiencing a traumatic childbirth by addressing the following research question: What influences women's recovery and resiliency after experiencing a traumatic birth? This research will potentially uncover how women fostered their resiliency and subsequently recovered from their experience of a traumatic childbirth. This study has practice implications for Counselling psychologist in that it may produce knowledge and theory for better ways of working with this group of women (Kasket, 2012). In

addition, the research will inform healthcare professions how to better support women professionally, physically and psychologically after traumatic or difficult births occur.

5. Provide a summary of the design and methodology.

The research will be a qualitative study in both its design and analysis. The researcher will use semi-structured interviews to gather data from a sample of women who fostered resiliency in their recovery from a traumatic birth. The researcher will use a grounded theory approach (Charmaz, 2014) to analyse data whilst using a relativist – constructivist lens to examine the subjective experience of a traumatic birth and resiliency in the recovery process.

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

The researcher will recruit participants through the snowballing technique where participants will suggest a friend or work colleague by supplying them with the study advert (Appendix A) and recruitment letter (Appendix G), whereby interested individuals can contact the researcher.

The second approach for recruiting participants will be to meet with the service manager of National Childbirth Trust and the Birth Trauma Association to discuss the project and subsequent recruitment of participants. Study adverts (Appendix A) and recruitment letter (Appendix G) will be circulated via the coordinators of the National Childbirth Trust and the Birth Trauma Association who are both voluntary sector organisations.

Once potential participants make contact with the researcher, a phone meeting will be arranged to determine if they meet the inclusion criteria. If participants meet the research criteria, a face-to-face meeting that is conveniently located for them will be arranged. At the meeting they will be provided with an information sheet about the purpose of the study (Appendix B) and will be asked to sign a consent form (see Appendix C). Participants will be encouraged to discuss any concerns they might have in taking part in the study. If concerns are raised at the beginning the researcher will reassure participants and make them aware that they have the freedom to withdraw from the research at any time and they have the choice to not answer any questions.

A digital tape recorder will be used to collect data during semi-structured interviews that are open-ended to avoid leading participants' responses and to minimise response bias. Semi-structured interviews will also give participants the opportunity to provide in-depth information about their experiences.

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g., emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

If a participant becomes psychologically distressed as a result of the study interview, then the interview will be halted and the participant will be appropriately debriefed. Participants will be directed to a therapist or support network should any issues arise during the course of the research concerning their emotional, psychological or health needs. The researcher will also contact the participants within 2 to 3 days after the interview to ensure that there has been no negative effects. If the participant discloses that they are experiencing postnatal depression then the researcher will refer the participant to the list of resources (Appendix, E). Where there is concern about negative impact, participants will be given a list of names of therapist to contact (Appendix F). A debrief sheet will be provided to all participants with the list of information and contacts (Appendix, E).

8. Location of data collection. (If any part of your research takes place outside England/Wales please also describe how you have identified and complied with all local requirements concerning ethical approval and research governance.)
Interviews will be conducted in a location most convenient to the participants taking into consideration most women will be mothers and time commitments maybe constrained.
9. Details of participants (e.g., age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.
Inclusion criteria The inclusion criteria for participants will be women (over 18) who classify themselves as resilient or recovered after experiencing a traumatic childbirth. The inclusion criteria will be defined as the participants perception of a traumatic childbirth and this may include feeling uncared for by the nurses or medical staff, experiencing unexpected medical interventions, feeling unbearable pain beyond their ability to cope, feeling unsafe, inhumane and perceiving the life of her infant were at risk of death which can lead to psychological effects after birth (Sawyer & Ayers, 2009). Exclusion criteria Women who have recently given birth within the last year and view themselves as experiencing postnatal depression cannot take part in this study. Women who view themselves as still in the recovery process and are currently experiencing nightmares, flashbacks, hyperarousal will be excluded from the study to minimise any potential harm.
10. How will participants be selected and recruited? Who will select and recruit participants?
Women will be recruited using snowball technique where participants will suggest a friend or colleague who is willing or appropriate for the study via the recruitment advert (Appendix, A) and recruitment letter (Appendix, G) whereby interested individuals can make contact with the researcher. The researcher will not approach participants directly to participate in the study, only the voluntary organisations involved in the study (Birth Trauma Association and National Child Birth Trust) will directly approach participants. Theoretical sampling will also be used whereby the researcher will collect data based on the categories that have emerged from the earlier process of data analysis. The researcher will circulate the research advertisement sheet via the co-ordinators of the National Child Birth Trust and the Birth Trauma Association who are both voluntary organisations (see Appendix A). The researcher will then screen potential participants over the phone to see if they meet the inclusion criteria. If participants meet the inclusion criteria then a meeting will be arranged and participants will be provided with an information sheet about the purpose of the study (Appendix B). If participants are eligible to take part in the study then they will be asked to sign a consent form (Appendix, B). If a potential participant discloses that she is still in the recovery process and is experiencing postnatal depression from her traumatic birth the researcher will provide a list of resources via email or over the telephone where they can seek further help or support. The list of resources will include the contact details for Birth Trauma Association, National Childbirth Trust, Samaritans and Assistance Support and Self-help in Surviving Trauma (Appendix, E). Participants recommended from support agencies will not receive a sign post on further help as this will not be required.

11. Provide details of any incentives participants will receive for taking part.
Participants will be provided with a £10 gift voucher for taking part.
12. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)
Yes, informed consent will be obtained from all participants and one copy will be given to them and one will be kept for the researchers records (Appendix E).
13. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)
Participants will be briefed as follows: Informed consent. The participants for this study will be made aware about the aims and objectives of this study. Participants will be provided with full information to ensure understanding of the research as well as details regarding procedures and purpose. Participants consent will be collected before data collection (Appendix E). Deception. The researcher will make participants aware that there is no intention to use deception within the procedures. Confidentiality. Participants will be made aware that the content of their interviews will be kept confidential from all except the researcher and that participants names will be anonymised in the final report. Participants will be told that, should the researcher suspect them or anyone else of being in danger that confidentiality might be breached, although this will be discussed with participants first. Right to withdraw. Participants will be made aware at the beginning of the interview that they have the freedom to withdraw from participating in the study at any time and they do not have to answer any questions that they do not want to. Debriefing Time will be allowed to debrief all participants at the end of the interview. This will also give them the opportunity to ask any further questions with regard to the research and feed back their experience of the interview. I will as part of the debrief process ask participants, how has the interview been for them, how do they fell now and so on. A resource list of potential support will be given at the end of the interview as a guide for further support should any distress arise. Contact will made with the participants 3 days following the interview to ensure that there have been no negative effects. Where there is concern about the negative impact, participants will be advised to contact their GP and participants will be given the names of psychologist who specialise in traumatic births as a point of contact.
14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.
I am a trainee counselling psychologist and I will monitor risk that may arise. Risk Management. If a participant discloses that they are suicidal during the course of the interview, the researcher will have to stop the interview and contact her supervisor or the participant's GP. Participants may experience distress whilst recalling their experience of a traumatic birth. The researcher will provide participants with a debrief sheet where they can access further support (Appendix E). This will entail written advice of telephone help lines and email addresses of organisations that are geared towards women who have experienced a difficult birth. The researcher will also provide a list of therapist should the participant require further support (Appendix E).

15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.	
There are no foreseen potential risks to the researcher but as a precaution the researcher will make her supervisor aware of the location and times when interviewing. As most participants will be mothers it is foreseeable that interviews may take place in their homes. The researcher will also make family members aware of her interview schedule and supply them with the address and time, whereby the interview will be held. The researcher will carry her mobile phone with her at all times and call family members at the end of each interview.	
16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)	
Please place an 'X' in all appropriate spaces	
Complete anonymity of participants(i.e., researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	
Anonymised sample or data(i.e., an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	X
De-identified samples or data (i.e., a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	x
Participants being referred to by pseudonym in any publication arising from the research	X
Any other method of protecting the privacy of participants(e.g., use of direct quotes with specific permission only; use of real name with specific, written permission only.) ***Please provide further details below.***	x
17. Which of the following methods of data storage will you employ?	
Please place an 'X' in all appropriate spaces	
Data will be kept in a locked filing cabinet	X
Data and identifiers will be kept in separate, locked filing cabinets	X
Access to computer files will be available by password only	X
Hard data storage at City University London	X
Hard data storage at another site. Please provide further details below**.**	X
All data will be stored in a locked storage at the researcher's home address.	
18. Who will have access to the data?	
Please place an 'X' in the appropriate space	
Only researchers named in this application form	X
People other than those named in this application form. Please provide further details below of who will have access and for what purpose.	X
My university supervisor will access to the data. An audio typist may be used to type up participant interviews. To ensure confidentiality, the research will have the audio typist sign a confidentiality agreement in line with the ethical code of conduct.	

19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

Please place an 'X' in all appropriate spaces

	Attached	Not applicable
*Text for study advertisement	X	
*Participant information sheet	X	
*Participant consent form	X	
Questionnaires to be employed		X
Debrief	X	
Others (please specify, e.g., topic guide for interview, confirmation letter from external organisation)	X	

20. Information for insurance purposes.

(a) Please provide a brief abstract describing the project

The research project will investigate Women's experience of a traumatic Birth and their recovery process. The researcher is interested in finding out if there were any personal traits or strengths that helped these women in their recovery process. A grounded theory approach will be used and a relativist – constructivist position will be used to interpret participants meanings. Participants will be recruited through voluntary organisations and though friends and work colleagues. Participants that view themselves as still recovering from their traumatic experience will be excluded from the study.

Please place an 'X' in all appropriate spaces

(b) Does the research involve any of the following:	Yes	No
Children under the age of 5 years?		X
Pregnant women?		X
Clinical trials / intervention testing?		X
Over 5,000 participants?		X
(c) Is any part of the research taking place outside of the UK?		X

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to [redacted] before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name …….. Date……

21. Information for reporting purposes.		
Please place an 'X' in all appropriate spaces		
(a) Does the research involve any of the following:	Yes	No
Persons under the age of 18 years?		X
Vulnerable adults?		X
Participant recruitment outside England and Wales?		X
(b) Has the research received external funding?		X

22. Declarations by applicant(s)		
Please confirm each of the statements below by placing an 'X' in the appropriate space		
I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.		X
I accept the responsibility for the conduct of the procedures set out in the attached application.		X
I have attempted to identify all risks related to the research that may arise in conducting the project.		X
I understand that **no** research work involving human participants or data can commence until ethical approval has been given.		X
	Signature (Please type name)	Date
Student(s)	[redacted]	08.12.14
Supervisor	[redacted]	08.12.14

Appendix I: Ethics approval letter

CITY UNIVERSITY LONDON

Psychology Research Ethics Committee
School of Social Sciences
City University London
London EC1R 0JD

15 December 2014

Dear [redacted]

Reference: PSYCH(P/F) 14/15 77
Project title: A difficult birth: An analysis of women's experience with traumatic birth and resiliency.

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants
(b) Change, or add to, the research method employed
(c) Collect additional types of data
(d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [redacted] in the event of any of the following:

(a) Adverse events
(b) Breaches of confidentiality
(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

[redacted] [redacted]

Departmental Administrator Chair

[redacted]

Appendix J: Sample of transcript and line-by-line coding

TRANSCRIPT	LINE BY LINE
I:112 Right. Gosh.	
P:112 The Doctor came in. Obviously now I was so out of it. I… I can't remember the time when the Doctor came in but I remember they said, you know, "*Some people are going to come in so don't panic*," but I could feel them… I don't know, when your womb… You know after you've delivered the placenta, they press into your tummy to check that it's contracting? Every time they pressed, the blood was squirting out and I could see their faces, I'm tired and I literally got to the stage where I was like, "*God, there's nothing I can do now. This thing is out my hands. I don't want to die*," but I could see the panic on their faces, I am bleeding, it's not stopping and literally how they measured, they had the towel…	P.112 Feeling out of it. P.112 Being told by doctors not to panic P.112 Explaining her womb was not contracting. P.112 Explaining blood was squirting out. P.112 Looking at doctors faces P.112 Wanting God to help her. P.112 Not wanting to die. P.112 Seeing panic on doctors faces. P.112 Measuring blood loss.
I:113 Mm.	
P:113 And when the towel was filled with blood, you hear them put it on the scale and it just… it just went on the scale like a… like a five-kilogram sack of potatoes!	P.113 Explaining towel filled with blood. P.113 Explaining towel sounded like a sack of potatoes.
P:114 And… and I thought, "*All that can't be coming out of me*!" But every time they pressed, it was just squirting and squirting and I could see towel after towel going on the scale.	P.114 Experiencing loss of blood.
I:115 Mm.	
P:115 And I was just like, "Okay, this really isn't supposed to be happening!"	P.115 Not wanting blood loss.
I:116 Mm hmm.	
P:116 Doctor's coming, other people coming, my mum comes to me now and she's just holding my hand. She's like, "*Baby, it's going to be okay*," and but I'm quite clued into these things and I was like, "*Mum, I'm bleeding, I'm haemorrhaging, aren't I*?" And she doesn't want to panic me…	P.116 Witnessing doctors and others entering the room. P.116 Being consoled by mother. P.116 Telling her mother she is bleeding.
I:117 Mm hmm.	
P:117 But I'm thinking of my son. I'm thinking…	P.117 Thinking of her son.
I:118 Mm hmm.	

Appendix K: Sample of development from line-by-line coding to focused coding

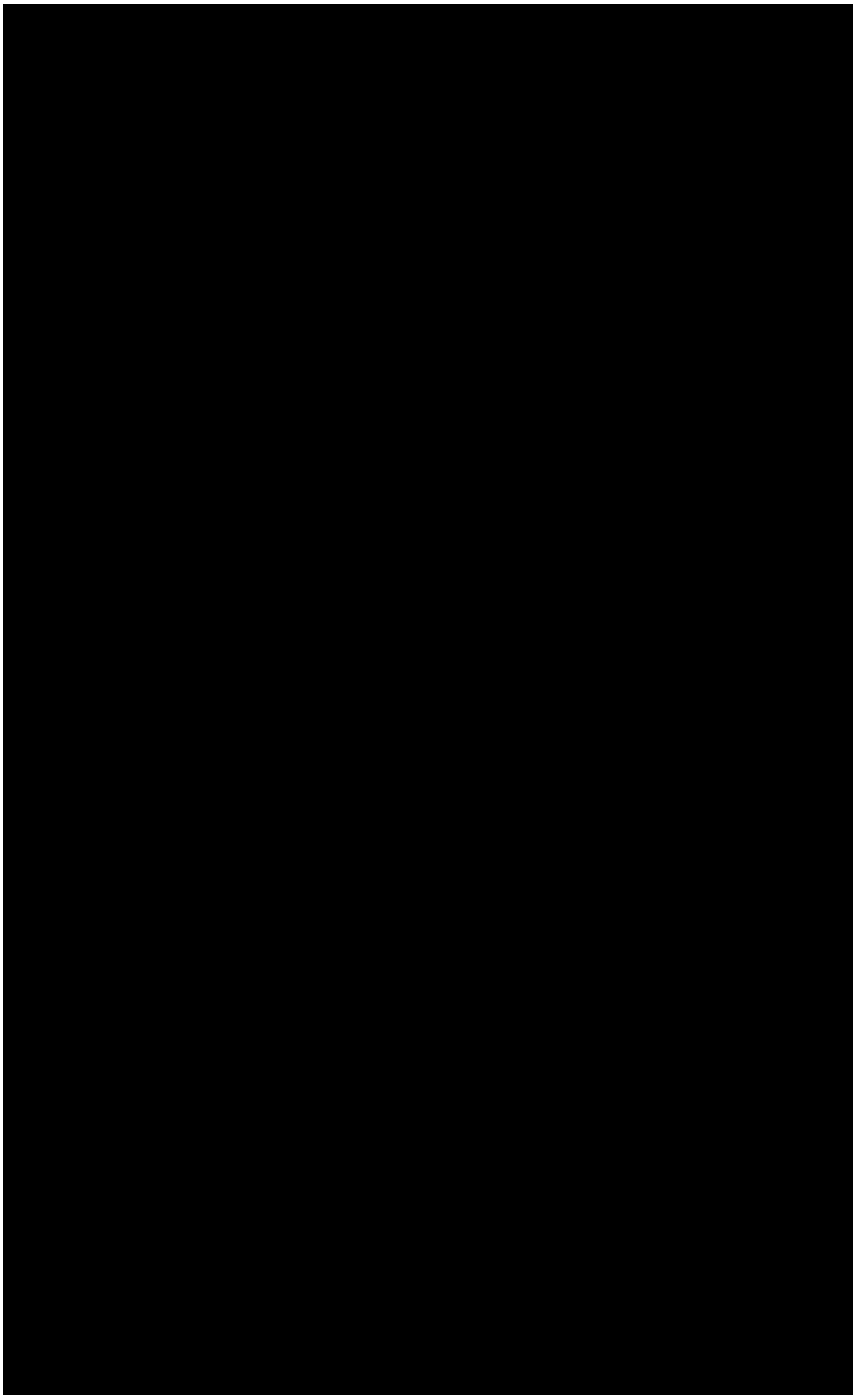
TRANSCRIPT	LINE BY LINE	FOCUS CODES
breath!" And then she was like, "*Come on! We have been coaching*!" And she was like, "*Breathe*!" And she was counting to ten and I would take that deep breath in and exhale. She was like, "*You are not going to be here kicking and carrying on because when you do that, the pain doesn't stop, it only becomes worse! You have to breathe through it*!"		
I:213 Mm hmm.		
P:213 Do you know what? Thank God for my mum! My mum is the one who keep… When I say, "*Mum! The pain! Oh no! I want to kick*!" No. She's like, "*No, I'm not allowing you to do it*!" And do you know what? The generation that I come from, we have to respect our parents! [Laughs]. So even [laughs] in the midst of childbirth – amidst the pain, I had to listen to her! So it was just, "*Okay, focus*," and she just kept me focused.	P.213 Being thankful for her mother. P.213 Remembering her mother's guidance through labour. P.213 Conveying respect for her parents' generation. P.213 Claiming she had to listen to mother during childbirth.	P.213 MATRIACH her MOTHER - thankful to mother - cultural respect for mother.
I:214 Mm.		
P:214 And… and I mean the secret is my mum. She is… she is my rock.	P.214 Claiming her mother is the secret rock. P.215 Wanting to scream.	P.214 MATRIACH MOTHER - secret rock

Due to its sensitive nature some of this content has been removed

Appendix L: Development of focused coding – Stage 2

Appendix M: Development of focus codes and mapping the journey – Stage 3

Development of Focus Codes and mapping the journey Stage 3



Appendix O: Constant comparison and theoretical coding

TRANSCRIPT	LINE BY LINE	FOCUS CODES	EMERGING CATEGORY	EMERGENT CATEGORY
And during the whole time all I was thankful for was to God for giving me life...	Feeling thankful to God for being alive.	RELIGION/ SPIRITUALITY - thanking God for giving her life.	FAITH SPIRITUALITY Faith in receiving help from God	
And I – if something's gone wrong – and we had a very traumatic experience at the weekend – I, I did not want to get up and go to church Sunday morning, but I knew I had to, because I needed to find an answer. I needed to find an answer and I found it.	Receiving answers in the church.	RELIGION/ SPIRITUALITY Being given answers by God in church and not given answers	FAITH SPIRITUALITY Faith in receiving answers from God	**FAITH/ SPIRITUALITY** God The Giver…. The Helper
In God's hands, yes. In God's hands, absolutely. Um I mean bottom line, if it wasn't meant to be, it wasn't meant <u>to be</u> and there's nothing… … I could… I could or they could have done about it.	Putting situation in God's hands. Seeing things in God's hands. Believing what is to be will be.	RELIGION/FAITH: God as Saviour, helper rescuer	FAITH SPRITUALITY External higher power as helper	

Appendix P: Number of participants in each category

Participants	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Traumatic Birth: To be cared for – who's accountable?								
Am I worthy of care… feeling neglected	√	√	√	√	√	√	√	√
Who's accountable?			√		√		√	√
Do you have my consent- please give me a choice?			√	√			√	√
Moving towards Faith and Spirituality								
Finding my faith		√					√	
Meditation, mindfulness and prayer	√				√		√	
God, the giver – The helper	√	√		√	√			
Motherhood becomes you								
Recognising achievement in oneself	√					√	√	
Admiration for one's child	√			√		√	√	
Mother as role models			√		√			
Supportive relationships								
Family		√	√	√	√	√		
Friendships	√			√	√			
Social Media and Support Groups	√			√				√
Self care – a way of owning my journey								
Becoming assertive (speaking up)			√		√		√	√
Talking about struggles	√			√	√			
Looking after self	√	√	√		√	√	√	√

Table 2.

Appendix Q: Midwifery journal – Guide for Authors

Article structure
Full length articles and reviews should be approximately 5,000 words in length, excluding references, tables and figures.
Double-blind peer review – This journal uses double-blind review, which means that both the reviewer and author name(s) are not allowed to be revealed to one another for a manuscript under review. The identities of the authors are concealed from the reviewers, and vice versa. To facilitate anonymity, the author's names and any reference to their addresses should only appear on the title page.
Blinded manuscript (no author details): The main body of the paper (including the references, figures and tables) should not include any identifying information, such as the authors' names or affiliations.
Authors should also ensure that the place of origin of the work or study, and/or the organization(s)
AUTHOR INFORMATION PACK 14 Mar 2018 www.elsevier.com/locate/midw 8
that have been involved in the study/development are not revealed in the manuscript – "X" can be used in the manuscript and details can be completed if the manuscript is processed further through the publication process.

Headings
Headings in the article should be appropriate to the nature of the paper. Research papers should follow the standard structure of: Introduction (including review of the literature), Methods, Findings and Discussion.
Introduction
State the objectives of the work and provide an adequate background, avoiding a detailed literature
survey or a summary of the results.
Methods
Provide sufficient detail to allow the work to be reproduced. Methods already published should be indicated by a reference: only relevant modifications should be described.
Results
Results should be clear and concise.
Discussion
This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.
Please note that the Title Page should be provided as a separate file.

Essential title page information
• ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.
• ***Author names and affiliations.*** Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. You can add your name between parentheses in your own script behind the English transliteration. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lowercase superscript letter immediately after the author's name and in front of the appropriate address.
Provide the full postal address of each affiliation, including the country name and, if available, thee-mail address of each author.

• ***Corresponding author.*** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. This responsibility includes answering any future queries about Methodology and Materials. **Ensure that the e-mail address is given and that contact details**
are kept up to date by the corresponding author.
• ***Present/permanent address.*** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as
a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.
•Authors are also encouraged to include their personal Twitter handles on the title page if they wish for these to be published.
Title page information and declarations. Authors are required to make certain declarations on their Title Page under the following mandatory headings 1-3, and in the order given here: (1) Conflict of Interest, (2) Ethical Approval, (3) Funding Sources. If some, or all three, do not apply, please still include the headings and state "None declared" / "Not applicable" next to them if necessary (for example "Conflict of Interest – None Declared"). Further headings may be used if applicable: (4) Clinical Trial Registry and Registration number (if applicable) and (5) Acknowledgments (if applicable).
Authors are also required to upload their completed Conflict of Interest checklist from the ICMJE website – http://icmje.org/conflicts-of-interest/ as a separate 'Supplementary Material' file entitled "Conflict of Interest Checklist".

Abstract
A summary should be in the 'Structured Summary Format' giving objective, design, setting, participants, interventions (if appropriate), measurements and findings, key conclusions and implications for practice (see http://www.elsevier.com/__data/promis_misc/midwifery-abstracts.pdf,
Vol 10, p58 for further information).
AUTHOR INFORMATION PACK 14 Mar 2018 www.elsevier.com/locate/midw 9

Highlights
Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). See http://www.elsevier.com/highlights for examples.
Keywords
Immediately after the abstract, provide a maximum of 6 keywords. The purpose of these is to increase the likely accessibility of your paper to potential readers searching the literature. Therefore, ensure keywords are descriptive of the study. Refer to a recognised thesaurus of keywords (e.g., CINAHL, Medline) wherever possible.
Abbreviations
As this is an international journal, please note that abbreviations can be used but the full name of the organisation must be included. No abbreviations should be used in abstracts.
Acknowledgements
For original submissions Acknowledgements should be included in the title page file to facilitate blinded review. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).
Formatting of funding sources
List funding sources in this standard way to facilitate compliance to funder's requirements:
Funding: This work was supported by the National Institutes of Health [grant numbers xxxx,

yyyy];the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].
It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding. If no funding has been provided for the research, please include the following sentence: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Artwork

Electronic artwork

General points

• Make sure you use uniform lettering and sizing of your original artwork.
• Embed the used fonts if the application provides that option.
• Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Provide captions to illustrations separately.
• Size the illustrations close to the desired dimensions of the published version.
• Submit each illustration as a separate file.

A detailed guide on electronic artwork is available.

You are urged to visit this site; some excerpts from the detailed information are given here.

Formats

If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is' in the native document format.
Regardless of the application used other than Microsoft Office, when your electronic artwork is finalized, please 'Save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
EPS (or PDF): Vector drawings, embed all used fonts.
TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of 300 dpi.
TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a minimum of 1000 dpi.
TIFF (or JPEG): Combinations bitmapped line/half-tone (color or grayscale), keep to a minimum of
500 dpi.
AUTHOR INFORMATION PACK 14 Mar 2018 www.elsevier.com/locate/midw 10

Please do not:

• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these typically have a low number of pixels and limited set of colors;
• Supply files that are too low in resolution;
• Submit graphics that are disproportionately large for the content.

Illustration services

Elsevier's Web Shop offers Illustration Services to authors preparing to submit a manuscript but concerned about the quality of the images accompanying their article. Elsevier's expert illustrators
can produce scientific, technical and medical-style images, as well as a full range of charts, tables and graphs. Image 'polishing' is also available, where our illustrators take your image(s) and improve them to a professional standard. Please visit the website to find out more.

Figure captions
Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables
Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in
accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References
Citation in Text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not permitted. Citations of a reference as 'in press' implies that the item has been accepted for publication.
The accuracy of the references is the responsibility of the author.
Text:
All citations in the text should refer to:
1. *Single author*: the author's name (without initials, unless there is ambiguity) and the year of publication;
2. *Two authors:* both authors' names and the year of publication;
3. *Three or more authors:* first author's name followed by 'et al.' and the year of publication.

Citations may be made directly (or parenthetically). Groups of references should be listed first chronologically, then alphabetically.
Examples: "as demonstrated (Allan, 1996a, 1996b, 1999; Allan and Jones, 1995). Kramer et al.(2000) have recently shown "
Reference list: References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication. Full journal titles must be used in the reference list.

Examples:
Reference to a journal publication:
Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T., 2015. Mortality data for Japanese oak wilt disease and surrounding forest compositions. Mendeley Data, v1. http://dx.doi.org/10.17632/xwj98nb39r.1.

References to a book:
Field, P. A., Morse, J. M., 1985. Nursing research: the application of qualitative approaches. Croom Helm, London.
AUTHOR INFORMATION PACK 14 Mar 2018 www.elsevier.com/locate/midw 11
Reference to a chapter in an edited book:
Mettam, G.R., Adams, L.B., 1999. How to prepare an electronic version of your article. In: Jones, B.S.,Smith , R.Z. (Eds.), Introduction to the Electronic Age. E-Publishing Inc., New York. pp. 281-304.

Citing and listing of Web references. As a minimum, the full URL should be given. Any further
information, if known (Author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references
This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.
Reference management software
Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles, such as Mendeley and Zotero, as well as EndNote. Using the word processor plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style.
If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide.

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:
http://open.mendeley.com/use-citation-style/midwifery
When preparing your manuscript, you will then be able to select this style using the Mendeley plugins for Microsoft Word or LibreOffice.

Audio Slides
The journal encourages authors to create an Audio Slides presentation with their published article. Audio Slides are brief, webinar-style presentations that are shown next to the online article on Science Direct. This gives authors the opportunity to summarize their research in their own words and to help readers understand what the paper is about. More information and examples are available. Authors of this journal will automatically receive an invitation e-mail to create an Audio Slides presentation after acceptance of their paper.

Data visualization
Include interactive data visualizations in your publication and let your readers interact and engage more closely with your research. Follow the instructions here to find out about available data visualization options and how to include them with your article.

Supplementary Data
Supplementary material can support and enhance your scientific research. Supplementary files offer the author additional possibilities to publish supporting applications, high-resolution images, background datasets, sound clips and more. Please note that such items are published online exactly as they are submitted; there is no typesetting involved (supplementary data supplied as an Excel file or as a PowerPoint slide will appear as such online). Please submit the material together with the
article and supply a concise and descriptive caption for each file. **All authors should have checked and approved the submission of each supplementary file.** Supplementary files will be subject to the journal's usual peer review process and all data included must meet ethical standards and approvals. If you wish to make any changes to supplementary data during any stage of the process, then please make sure to provide an updated file, and

do not annotate any corrections on a previous version. Please also make sure to switch off the 'Track Changes' option in any Microsoft Office files as these will appear in the published supplementary file(s). For more detailed instructions please visit
our artwork instruction pages.
AUTHOR INFORMATION PACK 14 Mar 2018 www.elsevier.com/locate/midw 12

Research data

This journal encourages and enables you to share data that supports your research publication where appropriate, and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings. To facilitate reproducibility and data reuse, this journal also encourages you to share your software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the research data page.

Data linking

If you have made your research data available in a data repository, you can link your article directly to the dataset. Elsevier collaborates with a number of repositories to link articles on Science Direct with relevant repositories, giving readers access to underlying data that gives them a better understanding of the research described.

There are different ways to link your datasets to your article. When available, you can directly link your dataset to your article by providing the relevant information in the submission system. For more information, visit the database linking page.

For supported data repositories a repository banner will automatically appear next to your published article on Science Direct.

In addition, you can link to relevant data or entities through identifiers within the text of your manuscript, using the following format: Database: xxxx (e.g., TAIR: AT1G01020; CCDC: 734053; PDB: 1XFN).

Mendeley Data

This journal supports Mendeley Data, enabling you to deposit any research data (including raw and processed data, video, code, software, algorithms, protocols, and methods) associated with your manuscript in a free-to-use, open access repository. During the submission process, after uploading your manuscript, you will have the opportunity to upload your relevant datasets directly to *Mendeley Data*. The datasets will be listed and directly accessible to readers next to your published article online.

For more information, visit the Mendeley Data for journals page.

Data statement

To foster transparency, we encourage you to state the availability of your data in your submission.

This may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you will have the opportunity to indicate why during the submission process, for example by stating that the research data is confidential. The statement will appear with your published article on Science Direct. For more information, visit the Data Statement page.