



Article

Post-traumatic stress disorder following childbirth: an update of current issues and recommendations for future research

McKenzie-Harg, K, Ayers, S, Ford, E, Horsch, A, Jomeen, J, Sawyer, A, Thomson, Gillian and Slade, Pauline

Available at <http://clock.uclan.ac.uk/12211/>

McKenzie-Harg, K, Ayers, S, Ford, E, Horsch, A, Jomeen, J, Sawyer, A, Thomson, Gillian ORCID: 0000-0003-3392-8182 and Slade, Pauline (2015) Post-traumatic stress disorder following childbirth: an update of current issues and recommendations for future research. Journal of Reproductive & Infant Psychology, 33 (3). pp. 219-237.

It is advisable to refer to the publisher's version if you intend to cite from the work.
<http://dx.doi.org/10.1080/02646838.2015.1031646>

For more information about UCLan's research in this area go to <http://www.uclan.ac.uk/researchgroups/> and search for <name of research Group>.

For information about Research generally at UCLan please go to <http://www.uclan.ac.uk/research/>

All outputs in CLoK are protected by Intellectual Property Rights law, including Copyright law. Copyright, IPR and Moral Rights for the works on this site are retained by the individual authors and/or other copyright owners. Terms and conditions for use of this material are defined in the [policies](#) page.



Post-traumatic stress disorder following childbirth: an update of current issues and recommendations for future research

Journal:	<i>Journal of Reproductive and Infant Psychology</i>
Manuscript ID:	Draft
Manuscript Type:	Review
Keywords:	Childbirth, Pregnancy, Follow-up

SCHOLARONE™
Manuscripts

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Post-traumatic stress disorder following childbirth: an update of current issues and recommendations for future research

For Peer Review Only

This work was supported by the Society for Reproductive and Infant Psychology, Research Developmental Workshop Grant.

Abstract

Objective: This paper aimed to report the current status of research in the field of post-traumatic stress disorder following childbirth (PTSD FC), and to update the findings of an earlier 2008 paper. **Background:** A group of international researchers, clinicians and service users met in 2006 to establish the state of clinical and academic knowledge relating to PTSD FC. A paper identified four key areas of research knowledge at that time. **Methods:** Fourteen clinicians and researchers met in Oxford, UK to update the previously published paper relating to PTSD FC. The first part of the meeting focused on updating the four key areas identified previously, and the second part on discussing new and emerging areas of research within the field. **Results:** A number of advances have been made in research within the area of PTSD FC. Prevalence is well established within mothers, several intervention studies have been published, and there is growing interest in new areas: staff and pathways; prevention and early intervention; impact on families and children; special populations; and post-traumatic growth. **Conclusion:** Despite progress, significant gaps remain within the PTSD FC knowledge base. Further research continues to be needed across all areas identified in 2006, and five areas were identified which can be seen as 'new and emerging'. All of these new areas require further extensive research. Relatively little is still known about PTSD FC.

Keywords:

PTSD; childbirth; review; theory; research

Introduction

There is now substantial empirical work showing that a proportion of women develop post traumatic stress disorder (PTSD) following childbirth, with potentially wide ranging consequences for them and their families (Fenech & Thomson, 2014). To date, research has focused on the proportion of women affected, risk factors for the development of PTSD following childbirth, and its impact on women. In contrast, there has been relatively little research into prevention, assessment and intervention. In 2006 an international group of researchers, clinicians and user-group representatives met to discuss the status of knowledge and formulate recommendations for research into PTSD following childbirth. Recommendations were made for research into (1) prevalence and comorbidity of PTSD after birth; (2) screening and treatment; (3) diagnostic and conceptual issues and (4) theoretical issues (Ayers, Joseph, McKenzie-McHarg, Slade & Wijma, 2008).

1
2
3
4 Research and understanding of PTSD following childbirth has increased considerably
5 since that time. In 2014 a small meeting of researchers and clinicians from the UK
6 and Europe was held with the aims of discussing progress in research, and
7 considering key gaps in current understanding (see Appendix for a list of
8 participants). The meeting focused on updating the four primary areas discussed in
9 2006 and identifying promising areas of developing knowledge.
10
11
12
13

14
15 This paper provides a summary of discussions at this meeting and aims to update
16 our understanding of PTSD following childbirth and recommendations for research.
17 The paper is in two sections. The first considers how research has developed in the
18 areas originally considered in 2006. The second considers emerging areas for
19 research identified as: (1) staff and pathways; (2) prevention and early intervention;
20 (3) impact on families and children; (4) special populations; and (5) post-traumatic
21 growth. As in the previous paper, discussions were based on the knowledge of
22 individuals attending, and the multidisciplinary nature of the group means a variety of
23 views were represented. This paper is not a systematic review but represents the
24 discussions on the day, and an overview of issues raised by participants.
25
26
27
28
29
30
31

32 A number of themes arose in most discussions. It was acknowledged that childbirth,
33 when experienced as traumatic, may differ from other potentially traumatic events
34 due to its socially positive connotations, the need to consider at least two individuals
35 at all times (mother and baby), the liminal nature of pregnancy and birth, that the
36 event takes place within the context of formal care, and the potential issues for the
37 mother of caring for a baby who may be a reminder of the trauma. This has
38 implications for labelling, measurement, comparability with other populations with
39 PTSD, and applicability of PTSD research into the context of traumatic birth. Another
40 issue commonly arising was whether traumatic experiences of childbirth should be
41 conceptualised as a diagnostic category or a continuum of distress. These issues are
42 considered further in the sections on conceptual issues and theory.
43
44
45
46
47
48
49

50 **Section 1: Update on research areas outlined by Ayers et al., 2008**

51
52

53 This section presents the groups' discussions on the four topics considered in the
54 previous paper (Ayers et al, 2008), updating the current knowledge base and
55 identifying ongoing research where applicable.
56
57
58
59
60

Prevalence and Comorbidity

The 2008 paper identified three issues within this topic: prevalence; course of PTSD; and methodological issues to be considered. The prevalence of PTSD following childbirth has been widely examined and meta-analyses of this research suggest it is 3.1% in all postnatal women and 15.7% in high risk groups (Grekin & O'Hara, 2014). Since 2006, there has been an increase in research examining prevalence in other groups, such as fathers, specific populations (such as those experiencing stillbirth), and staff, all of which provide some evidence that PTSD following childbirth (PTSD FC) can occur within these groups. Because of the relatively smaller numbers of studies that focus on these groups, reported prevalence rates vary and more research is needed. The implications of the new diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, APA, 2013) are unknown at present as all published research thus far has been conducted using DSM-IV criteria.

The natural course of PTSD FC is still poorly understood, and research needs to chart incidence, severity, duration and recovery phases utilising longitudinal methods. Comorbidity with depression is known to be high, with reported rates from 20-75% (Stramrood et al., 2011; White, Matthey, Boyd & Barnett, 2006). However, comorbidity with other mental health problems is unknown. Differentiating between PTSD FC and postnatal depression (PND) is not straightforward as several symptoms overlap.

Methodological issues in this area remain largely unchanged. Robust measures are needed, adapted to the perinatal period, to ensure that women are being appropriately identified as having PTSD FC. Research using clinical interviews remains rare and usually reports lower prevalence rates (Grekin & O'Hara, 2014). There are very few studies looking at long-term outcomes after the first year.

Screening and Treatment

The 2008 paper considered screening, treatment and impact of PTSD on women and their families. Many of the issues outlined in 2008 remain. Screening for PTSD FC is not common in maternity care, and the disorder remains largely unrecognised outside specialist perinatal and/or maternity services. Research is needed to examine the context and process of screening as well as identifying appropriate tools. For example there are questions around when screening should take place, by

1
2
3 whom, and what the best method might be of raising staff and patient awareness.
4 The process of screening can raise anxiety and hence it is important to administer
5 screening in an appropriate manner, and ensure that referral routes exist. The
6 course and onset of comorbid PTSD and depression is also unclear, although
7 clinicians in the group suggested PND is usually secondary to PTSD FC. It is also
8 important to consider symptom overlap with comorbid mental health issues, such as
9 depression or generalised anxiety, and how best to assess for these.
10
11
12
13

14
15 Since 2008, a few studies have looked at interventions for women with PTSD FC.
16 These predominantly comprise case studies but suggest that PTSD treatments such
17 as CBT and EMDR are effective (Ayers, McKenzie-McHarg & Eagle, 2007;
18 Sandstrom, Wiberg, Wikman, Willman & Hogberg, 2008; Stramrood et al, 2012).
19
20
21

22
23 The role of charities, service user groups and advocacy groups has gained
24 prominence in supporting the development of quality services providing input to
25 women and their families. For example, in the UK, the Maternal Mental Health
26 Alliance was set up as an umbrella advocacy group for organisations working within
27 the perinatal period. Their campaign for improved recognition and services was
28 launched in 2014 (see www.everyonesbusiness.org.uk). Internationally, there are
29 calls for maternal mental health to be fully integrated into maternity care (Rahman et
30 al., 2013). These and other initiatives provide an opportunity for PTSD FC to be
31 appropriately recognised.
32
33
34
35
36
37

38 Diagnostic and Conceptual Issues

39

40
41 The 2008 paper considered whether PTSD FC is the same as PTSD following other
42 events, and whether focus should be broadened to include other forms of distress.
43 Diagnostic issues remain paramount. To date, all published research utilises DSM-IV
44 criteria, which included somatic symptoms common in the postnatal population such
45 as 'difficulty falling or staying asleep', 'difficulty concentrating' and 'hypervigilance'.
46 This has issues for how we conceptualise, diagnose and screen for postnatal PTSD.
47 DSM-5 has changed how PTSD is classified and it is now a 'trauma and stressor-
48 related disorder' rather than an anxiety disorder. Event criteria have changed,
49 including the removal of the previous criterion A2 which specified that individuals
50 must respond to the traumatic event with intense fear, helplessness or horror. In
51 DSM-5 a cluster of symptoms has been added to include 'negative alterations in
52 cognitions and mood associated with the traumatic event(s)'. Symptoms such as loss
53
54
55
56
57
58
59
60

1
2
3 of interest or participation in significant activities, persistent negative emotional state,
4 and inability to experience positive emotions could also be attributed to depression.
5
6

7
8 These changes are critical and impact on the prevalence, conceptualisation and
9 diagnosis of PTSD FC. For example, two large studies (UK and Australia) suggest
10 the removal of A2 will increase prevalence rates of PTSD FC because many women
11 perceive a threat of injury or death during birth (Ayers, Harris, Sawyer, Parfitt, & Ford,
12 2009; Boorman, Devilly, Gamble, Creedy, & Fenwick, 2014). Research is therefore
13 needed to examine the implications and utility of DSM-5 criteria in comparison to
14 other diagnostic criteria, such as DSM-IV or ICD-10 (World Health Organisation,
15 2010).
16
17
18
19

20
21 Another issue is the importance of recognising the impact of sub-threshold
22 symptomatology, particularly when broadening the focus on the full range of distress
23 rather than just diagnosis. Many women may not meet full caseness for a diagnosis
24 of PTSD, but clinically group members reported that this may still negatively impact
25 on their functioning, particularly if they are experiencing symptoms of re-
26 experiencing. Given the potential impact of PTSD on women and their families,
27 intervention remains important even where a diagnosis cannot be given if there is a
28 clear impact on levels of distress or functioning.
29
30
31
32
33

34 35 Theoretical Issues 36

37
38 Research in PTSD FC has been predominantly atheoretical, in that it has rarely been
39 explicitly based on theory. Careful consideration of relevant theories can contribute to
40 greater clarity of concepts and understanding of different explanations for PTSD
41 following childbirth. Theories of PTSD, stress, and specifically about PTSD FC are all
42 relevant. Theoretical mechanisms proposed to perpetuate symptoms of PTSD after
43 traumatic events include dysfunctional cognitions (Ehlers & Clark, 2000), memory
44 processes (Brewin, 2001; Ehlers & Clark, 2000), and negative social phenomena
45 (Charuvastra & Cloitre, 2008). Ehlers & Clark's (2000) theory proposes that PTSD
46 occurs if individuals process the event or its sequelae in a way which produces a
47 *sense of current threat*, with negative thoughts and cognitions about the event, and a
48 disturbance or block in memory processing (Ehlers & Clark, 2000). This model has
49 been applied to PTSD FC and found to be a good predictor of PTSD FC symptoms
50 (Ford, Ayers & Bradley, 2010; Vossbeck-Elsebusch, Freisfeld & Ehling, 2014).
51
52
53
54
55
56
57
58
59
60

1
2
3 Relevant stress theories include those by Lazarus and Folkman (1984), who
4 emphasised the importance of appraisal in stress responses. Stress arises when
5 events are appraised as high threat and coping ability is perceived to be low.
6 Diathesis-stress frameworks account for the interaction between individual
7 vulnerability and events to determine outcome. Specific conceptual frameworks using
8 stress theories for perinatal populations have been proposed. Ayers (Ayers, 2004;
9 Ayers & Ford, in press) used a diathesis–stress framework to propose a model of
10 vulnerability and risk factors for PTSD following childbirth, and to summarise factors
11 that might be involved in the aetiology of the condition. Slade (2006) provided a
12 detailed conceptual framework which includes predisposing, precipitating, and
13 maintaining factors which relate to internal, external and interactional influences.
14
15
16
17
18
19

20
21 Whilst the application of theory is increasing, there is still much to be done to
22 evaluate theoretical frameworks for PTSD FC. Greater application and testing of
23 existing PTSD theories to PTSD FC is needed, including exploration of proposed
24 mediating factors, such as memory processes involved in trauma memories, and how
25 they differ in women with and without PTSD following birth. Research is also needed
26 to extend the theories applied to childbirth. Theories thus far are mainly
27 psychological; however social theories and those from other disciplines may also be
28 relevant. For example, liminality theories, which understand birth as a rite of passage
29 (Kenworthy Teather, 2005; Parratt, 2008) may provide a different perspective.
30 Research should also examine the role of social bonds within the development of
31 PTSD between the woman, her caregivers, her partner and her infant as well as her
32 family and personal networks and the impact of these. A major role for attachment
33 theory in terms of adult attachment patterns as predisposing vulnerability factor is
34 also emerging (Iles et al 2011). Additionally, it would be valuable to see research on
35 high risk subgroups, such as stillbirth, being informed by theoretical frameworks.
36
37
38
39
40
41
42
43
44
45

46 **Section 2: Important or emerging areas of research in PTSD FC**

47 Five important or emerging areas of research are focused on here: staff and
48 pathways, prevention and early intervention, impact on families and infant, special
49 populations, and post-traumatic growth.
50
51

52 Staff and Care Pathways

53
54 Evidence indicates that one significant cause of a woman's perception of birth as
55 traumatic is the actions/inactions of maternity staff, which can result in care being
56 experienced as dehumanising, disrespectful or uncaring (Elmir, Schmeid, Wilkes &
57
58
59
60

1
2
3 Jackson, 2010; Goldbort 2009). Professionals' manner and communication can
4 significantly affect women's feelings of control during their delivery (Salter 2009) and
5 their ability to make informed decisions (Eliasson, Kainz & Von Post, 2008). Yet
6 choice, information and involvement in decisions are potentially protective against a
7 traumatic birth experience (Goodall, McVittie & Magill 2009). Therefore, professionals
8 need to understand that childbirth can be traumatic for women (Elmir et al., 2010);
9 acknowledge the role they may play and recognise the signs of psychological trauma
10 (Beck 2004). There is also evidence that increased empathy in staff can increase
11 their own risk of PTSD symptoms after witnessing traumatic childbirth events (Sheen,
12 Spiby & Slade, 2014).
13
14
15
16
17
18

19
20 In some international contexts, there is a firm policy remit for the assessment of
21 psychological health and identification of perinatal mental health disorder in its
22 broadest sense (eg NICE, 2007; Beyond Blue 2011; Rahman et al., 2013) which
23 assumes that improved detection and assessment leads to improved outcomes. At
24 present this relationship is neither proven nor likely to be linear. Across the spectrum,
25 perinatal mental health detection, treatment and referral remains seriously lacking, is
26 inconsistent and requires attention (Goodman & Tyler-Viola 2010; NSPCC 2013;
27 Jomeen & Martin 2014).
28
29
30
31
32

33 Routine questioning in clinical practice to elicit trauma symptoms requires
34 appropriate and available measures (Alderdice et al., 2013). However, these are
35 often not consistently utilised or applied (Rowan, McCourt & Bick 2010). Several
36 authors propose flexible questioning to facilitate broader consideration of the
37 comorbidities of psychological and complex psychosocial factors (Dennis, Janssen &
38 Singer, 2004; Robertson, Grace, Wallington & Stuart 2004), which might be more
39 relevant to the PTSD FC context.
40
41
42
43
44

45 Clinical guidelines refer to PTSD FC pathways for care that appear to be outside the
46 maternity context. The result of this might be that practitioners feel less informed
47 about PTSD FC but also unclear about referral and management options. Lack of
48 training has been identified as a core barrier to addressing issues of perinatal mental
49 illness (Byatt, Moore-Simas, Lundquist Johnson, Ziedonis, 2012). Available and
50 accessible pathways for care and onward referral are also critical for confident
51 practitioner identification and assessment. Evidence highlights that midwives
52 (Jomeen, Glover & Davies 2009), health visitors (Jomeen, Glover, Jones, Garg &
53
54
55
56
57
58
59
60

1
2
3 Marshall 2013) and obstetricians (Leddy, Hagga, Gray, Schulkin, 2011) are reluctant
4 to ask women about psychological issues when pathways are not evident.
5
6

7
8 Deficient care may be a consequence of numerous factors, including
9 psychopathology, time, effective screening measures, referral options or lack of
10 knowledge (Matthey & Ross-Hamid 2011). Research is needed to evaluate care
11 pathways and training interventions, with reference to sensitive care, effective
12 identification, assessment and management of PTSD FC.
13
14

15 16 17 Prevention and Early Intervention 18

19
20 At present, published research on the prevention of PTSD FC is scarce. Most
21 available evidence is on midwife-led postnatal debriefing which suggests women
22 appreciate debriefing but there is inconsistent evidence on whether it reduces
23 symptoms of PTSD FC or depression (Baxter, McCourt & Jarrett, 2014; Borg Cunen,
24 McNeill & Murray, 2014; Peeler, Chunt, Stedmon & Skirton, 2012). A less
25 standardised “postnatal discussion”, in which a woman has the opportunity to
26 evaluate the course of labour and delivery, to ask questions and to voice her opinion
27 to a trained professional, is recommended for women who wish to talk about their
28 experiences (NICE, 2007).
29
30
31
32
33

34
35 A recent RCT of trauma-focused CBT for mothers of preterm infants found a
36 reduction in symptoms of PTSD, depression and anxiety at 1 and 6 months (Shaw,
37 St John, Lilo, Jo, Benitz, Stevenson & Horwitz, 2014). Ongoing research in this area
38 is examining a number of potential prevention strategies, such as a system of
39 identifying high risk women and training staff to provide empathic care (McKenzie-
40 McHarg, Crockett, Olander & Ayers, 2014).
41
42
43
44

45
46 Prevention can address a variety of factors, some of which are outlined in previous
47 sections, such as staff training and systemic interventions aimed at whole maternity
48 systems. Prevention strategies targeted at women could include early identification
49 of vulnerable women, additional targeted support from midwifery and psychological
50 services, ensuring compassionate care in labour and interventions early in the
51 postnatal period such as postnatal discussion which could encourage women to
52 process any traumatic experience and have the possibility of reducing later
53 symptoms. Any such interventions should also be aimed at changing factors that
54
55
56
57
58
59
60

1
2
3 play a role in women's appraisals, including the need for maternity staff to create
4 realistic expectations of delivery.
5
6

7
8 One example of an intervention which aims to address the need for realistic
9 expectations is that of a 'birth flow chart' rather than a 'birth plan', with different
10 pathways for 'what if labour starts with induction / preterm / ends with caesarean
11 section' etc. (Thomson & Downe, 2010). It is important that approaches to birth
12 consider a range of possible processes and outcomes, rather than focusing on a
13 single expected outcome which can result in women going into labour with an
14 idealistic picture of natural childbirth (Frost, Pope, Liebling & Murphy, 2006).
15
16
17

18
19
20 The group acknowledged the need to map current perinatal provision, in order to
21 understand the messages women are receiving antenatally, but also during and after
22 delivery. A number of researchers have explored the role of support antenatally and
23 in labour (Iles, Spiby & Slade, 2013) and this work is continuing.
24
25
26

27
28 Despite increasing knowledge of PTSD FC, very few professional support services
29 are available to help women postnatally or prior to a subsequent birth (Thomson &
30 Downe 2008). Limited fear of childbirth interventions exist within maternity services,
31 emerging from the premise that fear in childbirth is both a consequence of (Elmir et
32 al., 2010) and a risk factor for trauma symptoms (Otley, 2012; Fisher, Hauck &
33 Fenwick 2006). Despite a somewhat inconsistent evidence base (Otley, 2012) these
34 offer one pathway of care for PTSD FC.
35
36
37

38
39
40 For future clinical and research purposes, strategies for early intervention may be
41 adapted from studies in other trauma populations. The optimal timing of treatment
42 and intervention for PTSD FC remains a topic of debate. Intervening in the very early
43 postnatal period may have the potential to pathologise and disrupt normal cognitive
44 mechanisms of adjustment. It potentially disregards the fact that most women do *not*
45 develop long term trauma responses following a difficult delivery. However, as 9-14%
46 of women report labour as traumatic (Boorman et al., 2014; Stramrood et al., 2011) a
47 further approach could involve staff offering these women appropriate referral.
48
49
50
51

52 53 Impact on Families and Infants

54

55
56 Traumatic birth may have negative implications for maternal and infant health,
57 reproductive choices and relationships with infants and partners. Recent meta-
58
59
60

1
2
3 syntheses highlight the emotional impact on women, with reports of anger, self-
4 blame, suicidal ideation, loss of positive affect, isolation and dissociation from others
5 (Elmir et al., 2010; Fenech & Thomson, 2014). Future reproductive choices may be
6 affected, with women delaying or avoiding future pregnancies due to fear. In extreme
7 cases this can lead to women contemplating sterilisation (Fenech & Thomson, 2014).
8
9

10
11
12 Women's relationships may also be affected. Qualitative research suggests women
13 can struggle to form a positive relationship with their infant (Elmir et al., 2010; Fenech
14 & Thomson, 2014), although the role of comorbid depression is unclear (Davies,
15 Slade, Wright & Stewart, 2008; Parfitt & Ayers, 2009). PTSD FC can negatively
16 impact on relationships with partners; avoidance of sex and intimacy are common
17 due to fear of conception and triggering PTSD symptoms (Elmir et al., 2010; Fenech
18 & Thomson, 2014). Studies of male partners show high levels of co-morbidity within
19 couples and men's PTSD responses may affect the mental health of their partner
20 (Iles, Slade & Spiby, 2011). Men also report PTSD responses (Stramrood et al.,
21 2013; White, 2007), but evidence of the scope of these is mixed (Bradley and Slade
22 2008). Similarly impact is not clearcut. For example, Parfitt and colleagues found that
23 although PTSD was associated with a worse self-reported parent-baby bond (Parfitt
24 & Ayers, 2009) it was not associated with an observational measure of parent-infant
25 interaction (Parfitt, Pike & Ayers, 2013a).
26
27

28
29
30 The long-term impact on infants is not well evidenced. Qualitative research suggests
31 women might have difficulties bonding and/or avoid breastfeeding (Beck & Watson,
32 2008), which can have long-term health implications for infants (Horta, Bahl, Martines
33 & Victora, 2007; Ip et al., 2007). Longitudinal studies of the impact of PTSD on
34 infants suggest symptoms may be associated with parenting stress at two years, but
35 do not affect mothers' perceptions of their infant (McDonald, Slade, Spiby & Iles,
36 2011). A study of infant development found PTSD FC was associated with poor
37 cognitive development at 17 months of age (Parfitt, Pike & Ayers, 2013b).
38
39
40
41
42
43
44
45
46

47
48 Conclusions about the impact of PTSD on the mother-baby relationship, couple's
49 relationship and child development remain tentative because of the limited evidence
50 available. Whilst there is substantial qualitative research showing a traumatic birth
51 can have a wide-ranging impact on women and their families, more quantitative
52 research is needed to confirm and extend these findings. In particular, prospective
53 studies with larger, representative samples are needed to establish the extent and
54 nature of the impact of PTSD on the couple's relationship and infant development.
55
56
57
58
59
60 Studies are needed that examine gaps between index and subsequent children; the

1
2
3 impact of trauma on infant's developmental outcomes within term, pre-term and
4 vulnerable population groups (e.g. bereaved or abused mothers); the course and
5 impact of male partners' PTSD responses; the combined effect of co-morbidity
6 (particularly depression) on familial relationships; other birth partners (i.e
7 grandparents, sisters); as well as the intergenerational implications of trauma.
8
9

10 11 12 Special Populations

13
14
15 High-risk populations are increasingly focused on, including women with pre-
16 eclampsia, preterm or stillbirth. Here we consider stillbirth and preterm birth.
17
18

19 20 *Stillbirth*

21
22
23 The global prevalence rate of stillbirths (in the UK, a baby born after 24 weeks with
24 no signs of life) is 2.64 million (Cousens et al., 2011). Most research has focused on
25 the psychological impact of stillbirth on parents and the wider family system,
26 highlighting grief, loss of self-esteem, and feelings of worthlessness, isolation, shame
27 and guilt (Cacciatore, 2010). Depression, anxiety, PTSD and traumatic grief have
28 also been reported (Campbell-Jackson & Horsch, 2014).
29
30
31

32
33
34 As understanding about care after stillbirth has developed, there is a need to
35 disentangle traumatic grief and post traumatic stress at a conceptual level. The
36 International Society for Traumatic Stress Studies describes traumatic grief as the
37 sudden and unexpected death of a significant other – usually a close family member.
38 While many of the symptoms of traumatic grief overlap with PTSD, the core
39 symptoms of traumatic grief are an unquenchable yearning or longing for the dead
40 person that preoccupies much of a person's waking life. It is not typical to
41 experience reliving or avoidance phenomena in the way that those experiencing
42 PTSD do. There is very little research which aims to disentangle the two, and only a
43 small number of studies examine both PTSD and traumatic grief within the same
44 cohort (Campbell-Jackson & Horsch, 2014; Horsch, McKenzie-McHarg & Jacob, in
45 press)
46
47
48
49
50
51

52
53
54 Guidelines surrounding maternal contact with the stillborn infant have been
55 contradictory (NICE, 2007) and evidence as to whether seeing and holding the
56 stillborn baby is associated with maternal anxiety and depressive symptoms has
57 been inconclusive. A recent study on the maternal experience of this contact found
58
59
60

1
2
3 that the majority felt satisfied with their decision to see or hold their stillborn (Ryninks,
4 Collins, McKenzie-McHarg & Horsch, 2014) and another emphasised the importance
5 of sharing memories of the stillborn baby to aid psychological adjustment (Crawley,
6 Lomax & Ayers, 2013). Efforts have increased to better understand the risk factors
7 and predictors of traumatic grief after stillbirth (Crispus-Jones, McKenzie-McHarg &
8 Horsch, under review), but more are needed. Recent studies have focused on the
9 impact of stillbirth on antenatal attachment during the subsequent pregnancy and on
10 parenting a subsequent child (Campbell-Jackson, Bezance & Horsch, under review;
11 Lee & Horsch, under review).

12
13
14
15
16
17
18 Most research to date has grouped together all forms of perinatal loss and the
19 psychological impact of early versus late loss requires further clarification. More
20 longitudinal studies and those using validated measures and incorporating diverse
21 samples are needed. More research examining the impact of changes in guidelines
22 and care offered to bereaved parents linked with psychological theory should be
23 encouraged.

24 25 26 27 28 29 *Preterm Birth*

30
31
32 Preterm birth (prior to 37 weeks gestation) is the most important determinant of
33 adverse outcome in terms of survival, quality of life, psychosocial and emotional
34 impact on the family and costs for health services. In Europe the preterm birth rate
35 for live births ranges from approximately 5% to 11% (Zeitlin et al., 2013). PTSD and
36 depression in pregnancy are also associated with an increased risk of preterm birth
37 (Yonkers, Smith, Forray, Epperson, Costello, Lin & Belanger, 2014).

38
39
40
41
42 Preterm birth and hospitalisation of the baby can be a distressing time for parents.
43 Research on psychological adjustment following preterm birth has focused on
44 depression and anxiety. Fewer studies have explored maternal trauma reactions.
45 Studies report high and persistent rates of PTSD (Elkit, Hartvig, & Christiansen,
46 2007; Forcada-Guex, Borghini, Pierrehumbert, Anserment, & Muller-Nix, 2011; Jotzo
47 & Poets, 2005; Misund, Nerdrum, Bratten, Pipp, & Diseth, 2013). Associations
48 between PTSD symptoms, a poor mother-infant relationship, and adverse infant
49 outcomes have also been reported (Feeley et al., 2011; Forcada-Guex et al., 2011;
50 Pierrehumbert, Nicole, Muller-Nix, Forcada-Guex & Anserment, 2003).

1
2
3 More studies are needed to identify risk factors for traumatic stress responses
4 following preterm birth. Current research suggests a higher level of prematurity, low
5 social support, dysfunctional coping, preeclampsia, bleeding in pregnancy, and
6 intraventricular hemorrhage in babies associated with higher levels of PTSD
7 symptoms (Misund et al., 2013; Shaw, Bernard, Storfer-Isser, Rhine, & Horwitz,
8 2013; Suttora, Spinelli, & Monzani, 2014). There is a higher incidence of preterm
9 birth in certain ethnic groups and in women from very deprived areas (Aveyard,
10 Cheng, Manaseki, & Gardosi, 2002; Smith, Draper, Manktelow, Dorling & Field,
11 2007). However, most research exploring PTSD has been conducted with White,
12 married, highly educated mothers and research is needed with more diverse groups.
13 Finally, guidelines for screening for trauma symptoms in mothers of preterm infants
14 are absent. As there are currently no clear maternal or infant predictors, one option is
15 to screen all mothers of preterm infants (Shaw et al., 2014).
16
17
18
19
20
21
22
23

24 **Post-Traumatic Growth**

25
26 Research on psychological adjustment following childbirth has predominantly
27 focused on negative outcomes, and positive outcomes have been relatively ignored.
28 A positive outcome that may be particularly relevant to birth is personal growth.
29 Growth is defined as positive change resulting from struggle with challenging events
30 (Tedeschi & Calhoun, 1996) and has been variously conceptualised as 'benefit-
31 finding', 'thriving' and 'posttraumatic growth' (PTG).
32 Evidence that positive outcomes and growth occur after birth is increasing. A
33 population survey of 5333 women found that approximately one third reported a
34 positive outcome after birth (Henderson & Redshaw, 2013). Qualitative research on
35 women's experiences following traumatic births supports this with positive outcomes
36 such as a sense of strength or purpose being reported (Beck & Watson, 2010;
37 Thomson & Downe, 2010; Thomson & Downe, 2013; Elmir et al., 2010).
38
39
40
41
42
43
44
45

46 Very few studies have examined growth directly using validated instruments such as
47 the posttraumatic growth inventory (PTGI). The PTGI measures five areas: New
48 Possibilities, Relating to Others, Personal Strength, Spiritual Change, and
49 Appreciation of Life. Studies confirm that approximately 50% of women report at least
50 moderate levels of growth, and scores are broadly comparable to other samples e.g.
51 after accidents (Sawyer & Ayers, 2009). Women report most growth in the
52 Appreciation of Life and Personal Strength domains, and the least in the Spiritual
53 Change domain (Sawyer & Ayers, 2009; Sawyer, Ayers, Young, Bradley, & Smith,
54
55
56
57
58
59
60

1
2
3 2012; Taubman-Ben-Ari, Findler, & Sharon, 2011). More growth is reported by
4 women with more difficult circumstances e.g. mothers of preterm babies (Spielman &
5 Taubman-Ben-Ari, 2009), women who have PTSD in pregnancy or caesarean
6 section births (Sawyer et al., 2012).
7
8
9

10
11 However, research on growth following childbirth is limited and important gaps
12 remain around conceptualisation and measurement, predictors, and how growth can
13 be incorporated into clinical interventions. Conceptually, the relationship between
14 growth and resilience is unclear (Westphal & Bonanno, 2007). The applicability and
15 validity of measures of growth with postnatal women needs to be explored further
16 (Taubman-Ben-Ari et al., 2011). More qualitative research is needed to provide
17 insights into the nature of positive changes following childbirth.
18
19
20
21

22
23 Finally, although the literature is equivocal regarding the relationship between growth
24 and distress, a number of notable longitudinal studies in non-obstetric populations
25 have found that growth following a stressful event is predictive of better emotional
26 adjustment in the long term (e.g. Danoff-Burg & Revenson, 2005; Frazier, Conlon &
27 Glaser, 2001), and there are promising studies integrating growth into clinical
28 interventions (Roepke, 2014). However, before growth can be recommended as a
29 viable therapeutic option for women with PTSD FC more prospective and longitudinal
30 studies are needed to understand the relationship between growth and distress.
31
32
33
34
35

36 **Summary**

37
38 This paper provides an update of Ayers et al. (2008) and reports on the four primary
39 areas identified then. In addition, five further areas of research are discussed which
40 we consider important in PTSD FC research. This paper highlights areas in which our
41 understanding of PTSD has increased, as well as those where more research is
42 needed. These include a wide range of issues, such as the development of robust
43 measures for the identification of risk factors and PTSD FC, as well as consideration
44 of sub-threshold symptomatology. The evaluation of theoretically informed insights
45 into PTSD FC are needed, as well as exploration into the potential for positive
46 outcomes. Longitudinal studies are required to assess prevalence, intensity and
47 severity of PTSD as well as impact on mothers, infants, fathers and others within
48 diverse population groups. Further areas that require consideration concern the
49 integration of PTSD FC within maternity care pathways together with suitable training
50 for maternity professionals, alternative approaches to prepare mothers for childbirth
51
52
53
54
55
56
57
58
59
60

and further testing to identify the timing of and suitable and effective intervention approaches.

For Peer Review Only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

References

Alderdice, F., Ayers, S., Darwin, Z., Green, J., Jomeen, J., Kenyon, S., Martin, C.R., Morrell, C.J., Newham, J.J., Redshaw, M., Savage-McGlynn, E., & Walsh, J. (2013). Measuring psychological health in the perinatal period: workshop consensus statement. *Journal of Reproductive and Infant Psychology*, 31(5), 431-438. DOI: 10.1080/02646838.2013.835039

American Psychiatric Association, (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington: APA.

Aveyard, P., Cheng, K. K., Manaseki, S., & Gardosi, J. (2002). The risk of preterm delivery in women from different ethnic groups. *British Journal of Obstetrics and Gynaecology*, 109, 894-899. DOI: 10.1111/j.1471-0528.2002.01197.x

Ayers, S. (2004). Delivery as a Traumatic Event: Prevalence, Risk Factors and Treatment for Postnatal Posttraumatic Stress Disorder. *Clinical Obstetrics and Gynecology*, 47(3), 552-567. DOI: 10.1097/01.grf.0000129919.00756.9c

Ayers, S., Harris, R., Sawyer, A., Parfitt, Y., & Ford, E. (2009). Posttraumatic stress disorder after childbirth: Analysis of symptom presentation and sampling. *Journal of Affective Disorders* 119: 200–204. doi:10.1016/j.jad.2009.02.029

Ayers, S. & Ford E. *Posttraumatic stress during pregnancy and the postpartum period*. , in *Oxford Handbook of Perinatal Psychology*, A. Wenzel and S. Stuart, Editors. in press, Oxford University Press: New York.

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. DOI:10.1080/01674820802034631

Ayers, S., McKenzie-McHarg, K., Eagle, A. (2007). Cognitive behaviour therapy for postnatal post-traumatic stress disorder: case studies. *Journal of Psychosomatic Obstetrics & Gynaecology*; 28, 177-184. DOI:10.1080/01674820601142957

- 1
2
3 Baxter, J.D., McCourt, C., & Jarrett, P.M. (2014). What is current practice in
4 offering debriefing services to post partum women and what are the perceptions of
5 women in accessing these services: a critical review of the literature.
6 *Midwifery*. 30(2),194-219. DOI: 10.1016/j.midw.2013.12.013. Epub 2013 Dec 27.
7
8
9
10
11 Beck T.C. (2004). Birth trauma: in the eye of the beholder. *Nursing Research*. 53(1),
12 28–35. DOI: 10.1097/00006199-200401000-00005
13
14
15 Beck, C. T., & Watson, S. (2008). Impact of birth trauma on breastfeeding. A tale of
16 two pathways. *Nursing Research*, 57, 228-236.
17
18 DOI: 10.1097/01.NNR.0000313494.87282.90
19
20
21 Beck, C. T., & Watson, S. (2010). Subsequent childbirth after a previous traumatic
22 birth. *Nursing Research*, 59, 241-249. DOI: 10.1097/NNR.0b013e3181e501fd
23
24
25
26 Beyond Blue (2011). *Clinical practice guidelines for depression and related disorders*
27 *– anxiety, bipolar disorder and puerperal psychoses – in the perinatal period. A*
28 *guideline for primary care professionals*. Melbourne, beyondblue: the national
29 depression initiative
30
31
32
33 Boorman, R.J., Devilly, G.J., Gamble, J., Creedy, D.K., & Fenwick, J. (2014).
34 Childbirth and criteria for traumatic events. *Midwifery*; 30:255-261.
35
36 doi:10.1016/j.midw.2013.03.001
37
38
39
40 Borg Cunen, N., McNeill, J., & Murray, K. (2014). A systematic review of midwife-
41 led interventions to address post partum post-traumatic stress. *Midwifery*. 30(2),170-
42 84. DOI: 10.1016/j.midw.2013.09.003. Epub 2013 Sep 21.
43
44
45
46 Bradley, R., Slade, P. & Leviston, A. (2008). Low rates of PTSD in men attending
47 childbirth: preliminary study. *British Journal of Clinical Psychology*, 47, 295-302.
48
49 DOI: 10.1348/014466508X279495
50
51
52 Brewin, C.R. (2001). A cognitive neuroscience account of posttraumatic stress
53 disorder and its treatment. *Behaviour Research and Therapy*, 39, 373-393.
54
55 DOI: 10.1016/S0005-7967(00)00087-5
56
57
58
59
60

1
2
3 Byatt, N., Moore Simas, T.A., Lundquist, R.S., Johnson, J.V., & Ziedonis, D.M.,
4 (2012) Strategies for improving perinatal depression treatment in North American
5 outpatient obstetric settings. *Journal of Psychosomatic Obstetrics & Gynecology*. 33
6 (4), 143-161. DOI:10.3109/0167482X.2012.728649
7
8

9
10 Cacciatore, J. (2010). The unique experiences of women and their families after the
11 death of a baby. *Social Work and Health Care*, 49, 134-48.
12 DOI: 10.1080/00981380903158078
13
14

15
16 Campbell-Jackson, L. & Horsch, A. (2014). The psychological impact of stillbirth: A
17 systematic review. *Illness, Crisis and Loss*, 22, 237-256.
18
19

20
21 Campbell-Jackson, L., Bezance, J., & Horsch, A. "A renewed sense of purpose":
22 Mothers' and fathers' experience of having a child following a recent stillbirth. Under
23 review.
24
25

26
27 Charuvastra, A., & Cloitre, M. (2008). Social Bonds and Posttraumatic Stress
28 Disorder. *Annual Review of Psychology*. 59: 301-328.
29 DOI: 10.1146/annurev.psych.58.110405.085650
30
31

32
33 Cousens, S., Blencowe, H., Stanton, C., Chou, D., Ahmed, S., Steinhardt, L., ... &
34 Lawn, J.E. (2011). National, regional, and worldwide estimates of stillbirth rates in
35 2009 with trends since 1995: a systematic analysis. *Lancet*, 377, 1319-1330.
36 DOI: 10.1016/S0140-6736(10)62310-0
37
38

39
40 Crawley, R., Lomax, S., & Ayers, S. (2013). Recovering from stillbirth: the effects of
41 making and sharing memories on maternal mental health. *Journal of Reproductive*
42 *and Infant Psychology*, 31, 195-207. DOI:10.1080/02646838.2013.795216.
43
44

45
46 Crispus-Jones, H., McKenzie-McHarg, K., & Horsch, A. Psychological and obstetric
47 predictors of complicated grief following stillbirth. *Journal of Reproductive and Infant*
48 *Psychology*. Under review.
49
50

51
52 Danoff-Burg, S., & Revenson, T. A. (2005). Benefit-finding among patients with
53 rheumatoid arthritis: Positive effects on interpersonal relationships. *Journal of*
54 *Behavioral Medicine*, 28, 91-103. DOI: 10.1007/s10865-005-2720-3
55
56
57
58
59
60

1
2
3 Davies, J., Slade, P., Wright, I., & Stewart, P. (2008). Posttraumatic stress symptoms
4 following childbirth and mothers' perceptions of their infant. *Infant Mental Health*
5 *Journal*, 29, 537–554. DOI: 10.1002/imhj.20197
6
7

8
9 Dennis, C-L., Janssen, P., & Singer, J. (2004). Identifying women at-risk for
10 postpartum depression in the immediate postpartum period. *Acta Psychiatrica*
11 *Scandinavica*, 110, 338-346. DOI: 10.1111/j.1600-0447.2004.00337.x
12
13

14
15 Ehlers, A. & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder.
16 *Behaviour Research and Therapy*. 38(4): 319-345.
17 DOI: 10.1016/S0005-7967(99)00123-0
18
19

20
21 Eliasson, M., Kainz, G. & Von Post, I. (2008). Uncaring midwives. *Nursing Ethics*.
22 15(4), 501–511. DOI: 10.1177/0969733008090521
23
24

25
26 Elklit, A., Hartvig, T., & Christiansen, M. (2007). Psychological sequelae in parents of
27 extreme low and very low birth weight infants. *Journal of Clinical Psychology in*
28 *Medical Settings*, 14, 238–47. DOI: 10.1007/s10880-007-9077-4
29
30

31
32 Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and
33 experiences of a traumatic birth: A meta-ethnography. *Journal of Advanced Nursing*,
34 66, 2142-2153. DOI: 10.1111/j.1365-2648.2010.05391.x
35
36

37
38 Feeley, N., Zekowitz, P., Cormier, C., Charbonneau, L., Lacroix, A., & Papageorgiou,
39 A. (2011). Posttraumatic stress among mothers of very low birthweight infants at 6
40 months after discharge from the neonatal intensive care unit. *Applied Nursing*
41 *Research*, 24, 114-117. DOI: <http://dx.doi.org/10.1016/j.apnr.2009.04.004>
42
43
44

45
46 Fenech, G., & Thomson, G. (2014). 'Tormented by Ghosts of their Past': A meta-
47 synthesis to explore the psychosocial implications of a traumatic birth on maternal
48 wellbeing. *Midwifery*, 30, 185–193. DOI:10.1016/j.midw.2013.12.004
49
50

51
52 Fisher, C., Hauck, Y., & Fenwick, J. (2006). How social context impacts on women's
53 fears of childbirth: a Western Australian example. *Social Science and Medicine*,
54 63(1), 64–75. DOI: 10.1016/j.socscimed.2005.11.065
55
56
57
58
59
60

1
2
3 Forcada-Guex, M., Borghini, A., Pierrehumbert, B., Ansermet, F., & Muller-Nix, C.
4 (2011). Prematurity, maternal posttraumatic stress and consequences on the
5 mother–infant relationship. *Early Human Development*, 87, 21–6.
6
7 DOI: <http://dx.doi.org/10.1016/j.earlhumdev.2010.09.006>
8
9

10
11 Ford, E., Ayers, S., & Bradley, R. (2010). Exploration of a cognitive model to predict
12 post-traumatic stress symptoms following childbirth. *Journal of Anxiety Disorders*,
13 24(3): 353-359. DOI: 10.1016/j.janxdis.2010.01.008
14
15

16
17 Frazier, P., Conlon, A., & Glaser, T. (2001). Positive and negative life changes
18 following sexual assault. *Journal of Consulting and Clinical Psychology*, 69, 1048-
19 1055. DOI: 10.1037/0022-006X.69.6.1048
20
21

22
23 Frost, J., Pope, C., Liebling, R., & Murphy, D.J. (2006). Utopian Theory and the
24 Discourse of Natural Birth. *Social Theory & Health*; 4(4); 299-318.
25
26 DOI: <http://dx.doi.org/10.1057/palgrave.sth.8700076>
27
28

29
30 Gamble, J., & Creedy, D. (2004). Content and processes of postpartum counseling
31 after a distressing birth experience: a review. *Birth*;31:213-218. DOI: 10.1111/j.0730-
32 7659.2004.00307.x
33
34

35
36 Gamble, J., Creedy, D., Moyle, W., Webster, J., McAllister, M., & Dickson, P. (2005).
37 Effectiveness of a counseling intervention after a traumatic childbirth: a randomized
38 controlled trial. *Birth*; 32:11-19. DOI: 10.1111/j.0730-7659.2005.00340.x
39
40

41
42 Gamble, J.A., Creedy, D.K., Webster, J., & Moyle, W. (2002). A review of the
43 literature on debriefing or non-directive counselling to prevent postpartum emotional
44 distress. *Midwifery*;18:72-79. DOI: 10.1054/midw.2001.0287
45
46
47

48
49 Goldbort J.G. (2009). Women's lived experience of their unexpected birthing process.
50 *The American Journal of Maternal / Child Nursing*. 34(1), 57–62.
51
52 DOI: 10.1097/01.NMC.0000343867.95108.b3
53

54
55 Goodall E.K., McVittie C., & Magill M. (2009). Birth choice following primary
56 caesarean section: mothers' perceptions of the influence of health professionals on
57 decision making. *Journal of Reproductive and Infant Psychology*. 27(1), 4–14.
58
59
60

1
2
3 DOI: 10.1080/02646830801918430
4

5
6 Goodman, J.H., & Tyer-Viola, L. (2010). Detection, Treatment, and Referral of
7 Perinatal Depression and Anxiety by Obstetrical Providers. *Journal of Women's*
8 *Health*. 19(3), 477-490. DOI:10.1089/jwh.2008.1352.
9

10
11 Grekin, R., & O'Hara, M.W. (2014). Prevalence and risk factors of postpartum
12 posttraumatic stress disorder: a meta-analysis. *Clinical Psychology Review*, 34(5),
13 389-401. DOI: 10.1016/j.cpr.2014.05.003
14
15

16
17 Henderson, J., & Redshaw, M. (2013). Who is well after childbirth? Factors related to
18 positive outcome. *Birth*, 40, 1-9. DOI: 10.1111/birt.12022
19
20

21
22 Horowitz, M.J., *Psychological response to serious life events*. In *Human Stress and*
23 *Cognition: An Information Processing Approach.*, V. Hamilton and D.M. Warburton,
24 Editors. 1979, Wiley: New York.
25
26

27
28 Horsch, A., Jacobs, I., & McKenzie-McHarg, K. (under review). Cognitive predictors
29 and risk factors of PTSD and its relationship with perinatal grief following stillbirth: A
30 longitudinal study. *Journal of Traumatic Stress*
31
32

33
34 Horta, B. L., Bahl, R., Martinés, J. C. & Victora, C. G. (2007). *Evidence on the long-*
35 *term effects of breastfeeding: Systematic reviews and meta-analysis*. World Health
36 Organization: Geneva.
37
38

39
40 Iles, J., Slade, P., & Spiby, H. (2011). Posttraumatic stress symptoms and
41 postpartum depression in couples after childbirth: The role of partner support and
42 attachment. *Journal of Anxiety Disorders*, 25(4), 520–530.
43
44

45
46 DOI: 10.1016/j.janxdis.2010.12.006
47

48
49 Iles, J., Slade, P., & Spiby, H. (in press). Modification and preliminary use of the five-
50 minute speech sample in the postpartum: associations with postnatal depression and
51 posttraumatic stress. *Archives of Women's Mental Health*.
52

53
54 DOI: 10.1007/s00737-014-0414-y
55
56
57
58
59
60

1
2
3 Ip, S., Chung, M., Raman, G., Chew, P., Magula, N. ... & Lau, J. (2007).
4 Breastfeeding and maternal and infant health outcomes in developed countries.
5 *Evidence Report – Technology Assessment. 153*, 1-186.
6
7

8
9 Janoff-Bulman, R. (1992). *Shattered assumptions : towards a new psychology of*
10 *trauma*. New York: Free Press.
11

12
13 Jomeen, J., Glover, L., & Davies, S. (2009). Midwives' illness perceptions of
14 antenatal depression. *British Journal of Midwifery. 17(5)*, 296-303.
15
16 DOI: <http://dx.doi.org/10.12968/bjom.2009.17.5.42221>
17
18

19
20 Jomeen, J., Glover, L., Jones, C., Garg, D. & Marshall, C. (2013). Assessing
21 women's perinatal psychological health: exploring the experiences of health visitors.
22 *Journal of Reproductive and Infant Psychology. 31 (5)*, 479-489.
23
24 DOI: 10.1080/02646838.2013.835038
25
26

27
28 Jomeen, J., & Martin C.R. (2014). Developing specialist perinatal mental health
29 services. *Practising Midwife. 17(3)*, 18-21.
30
31

32
33 Joseph, S., & Linley, P. A. (2008). Reflections on theory and practice in trauma,
34 recovery, and growth: A paradigm shift for the field of traumatic stress. In S. Joseph
35 & P. A. Linley (Eds.), *Trauma, recovery and growth: Positive psychological*
36 *perspectives on posttraumatic stress* (pp. 339-356). Hoboken, NJ: John Wiley &
37 Sons.
38
39

40
41 Jotzo, M., & Poets, C. F. (2005). Helping parents cope with the trauma of premature
42 birth: an evaluation of a trauma-preventive psychological intervention. *Pediatrics,*
43 *115*, 915–19. DOI: 10.1542/peds.2004-0370
44
45

46
47 Kenworthy Teather, E. (2005) *Embodied geographies*. Routledge.
48
49

50
51 Lazarus, R. & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer
52 Publishing.
53
54

55
56 Leddy, M., Hagga, D., Gray, J, & Schulkin, J. (2011). Postpartum mental health
57 screening and diagnosis by obstetrican-gynecologists. *Journal of Psychosomatic*
58 *Obstetrics and Gynaecology. 32(1)*, 27-34. DOI:10.3109/0167482X.2010.547639
59
60

1
2
3
4 Lee, L., & Horsch, A. The impact of miscarriage and stillbirth on the parent-foetal
5 bond. An integrative review. Under review.
6
7

8
9 Matthey, S. & Ross-Hamid, C. (2011). The validity of DSM symptoms for depression
10 and anxiety disorders during pregnancy. *Journal of Affective Disorders*. 133(3), 546-
11 552. DOI: 10.1016/j.jad.2011.05.004
12
13

14
15 McDonald, S., Slade, P., Spiby, H., & Iles, J. (2011). Post-traumatic stress
16 symptoms, parenting stress and mother-child relationships following childbirth and at
17 2 years postpartum. *Journal of Psychosomatic Obstetrics & Gynaecology*, 32(3),
18 141-146. DOI:10.3109/0167482X.2011.596962
19
20
21

22
23 McKenzie-McHarg, K., Crockett, M., Olander, E., & Ayers, S. (2014). Think Pink!: a
24 pink sticker alert system for women with psychological distress or vulnerability during
25 pregnancy. *British Journal of Midwifery*. In press.
26
27

28
29 Misund, A. R., Nerdrum, P., Braten, S., Pripp, A. H., & Diseth, T. H. (2013). Long-
30 term risk of mental health problems in women experiencing preterm birth: A
31 longitudinal study of 29 mothers. *Annals of General Psychiatry*, 12, 33-41.
32 Found at <http://www.annals-general-psychiatry.com/content/12/1/33>
33
34

35
36 National Institute for Health and Clinical Excellence (2005). *Post-traumatic stress*
37 *disorder (PTSD): The management of PTSD in adults and children in primary and*
38 *secondary care*. London: Department of Health
39
40
41

42
43 National Institute for Health and Clinical Excellence, (2007). *Antenatal and Postnatal*
44 *Mental Health; Clinical Management and Service Guidance*. London: Department of
45 Health.
46
47

48
49 NSPCC (2013). *Prevention in Mind*. Available from:
50 [http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/spotlight-](http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/spotlight-mental-health-landing_wda96578.html)
51 [mental-health-landing_wda96578.html](http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/spotlight-mental-health-landing_wda96578.html)
52
53

54
55 Oldea, E., van der Harta, O., Klebera, R., & van Sona, M. (2006). Posttraumatic
56 stress following childbirth: A review. *Clinical Psychology Review*, 26(1), 1–16.
57
58
59
60

1
2
3 Otle, H (2012). Fear of childbirth: understanding the causes, impact and treatment.
4 *British Journal of Midwifery*. 19(4). Available from <http://www.baby->
5 [birth.com/articles/54-antenatal/321-fear-of-childbirth-understanding-the-causes-](http://www.baby-birth.com/articles/54-antenatal/321-fear-of-childbirth-understanding-the-causes-)
6 [impact-and-treatment.html](http://www.baby-birth.com/articles/54-antenatal/321-fear-of-childbirth-understanding-the-causes-). DOI: 10.12968/bjom.2011.19.4.215
7
8

9
10 Parfitt, Y., & Ayers, S. (2009). The effect of post-natal symptoms of post-traumatic
11 stress and depression on the couple's relationship and parent-baby bond. *Journal of*
12 *Reproductive and Infant Psychology*, 27(2), 127-142.
13
14 DOI: 10.1080/02646830802350831
15
16

17
18 Parfitt, Y., Pike, A., & Ayers, S. (2013a). The impact of parents' mental health on
19 parent-baby interaction: A prospective study. *Infant Behavior and Development*, 36,
20 599 – 608. DOI: 10.1016/j.infbeh.2013.06.003
21
22

23
24 Parfitt, Y., Pike, A. & Ayers, S. (2013b). Infant developmental outcomes: a family
25 systems perspective. *Infant and Child Development*. DOI: 10.1002/icd.1830.
26
27

28 Parratt, J.A. (2008). *Territories of the self and spiritual practices during childbirth*.
29 Birth Territory and Midwifery Guardianship: Theory for practice, education and
30 research Edinburgh: Butterworth Heinemann Elsevier, pp 39-54.
31
32

33
34
35 Peeler, S., Chung, M.C., Stedmon, J., & Skirton, H. (2013). A review assessing the
36 current treatment strategies for postnatal psychological morbidity with a focus on
37 post-traumatic stress disorder. *Midwifery*. 29(4), 377-88.
38
39 DOI: 10.1016/j.midw.2012.03.004. Epub 2012 Nov 21.
40
41

42
43 Pierrehumbert, B., Nicole, A., Muller-Nix, C., Forcada-Guex, M., & Ansermet, F.
44 (2003). Parental post-traumatic reactions after premature birth: Implications for
45 sleeping and eating problems in the infant. *Archives of Disease in Childhood—Fetal*
46 *and Neonatal Edition*, 88, F400–F404. DOI:10.1136/fn.88.5.F400
47
48

49
50 Rahman A., Surkan, P.J., Cayetano, C.E., Rwagatare, P., & Dickson, K.E. (2013).
51 Grand Challenges: Integrating Maternal Mental Health into Maternal and Child Health
52 Programmes. *PLoS Med* 10(5): e1001442. DOI:10.1371/journal.pmed.1001442
53
54
55
56
57
58
59
60

1
2
3 Robertson, E., Grace, S., Wallington, T., & Stewart, D.E. (2004) Antenatal risk factors
4 for postpartum depression: A synthesis of recent literature. *General Hospital*
5 *Psychiatry*, 26, 289-295. DOI:10.1016/j.genhosppsy.2004.02.006
6
7

8
9 Roepke, A. M. (2014). Psychosocial interventions and posttraumatic growth: A meta-
10 analysis. *Journal of Consulting and Clinical Psychology*. Advance online publication.
11 <http://dx.doi.org/10.1037/a0036872>
12
13

14
15 Rowan, C., McCourt, C. & Bick, D. (2010). Provision of perinatal mental health
16 services in two strategic health authorities: views and perspectives of the multi-
17 professional team. *Evidence Based Midwifery*, 8(3), 98-106.
18
19

20
21 Ryninks, K., Collins, C., McKenzie-McHarg, K., & Horsch, A. (2014). Mothers'
22 experience of their contact with their stillborn infant. *BMC Pregnancy and Childbirth*,
23 14: 203. DOI: 10.1186/1471-2393-14-203.
24
25

26
27 Sandstrom, M., Wiberg, B., Wikman, M., Willman, A.K., & Hogberg, U. (2008). A pilot
28 study of eye movement desensitisation and reprocessing treatment (EMDR) for post-
29 traumatic stress after childbirth. *Midwifery*, 24, 62-73.
30
31

32
33 Salter, K. (2009). Beating the trauma of a bad birth experience. *Mental Health Today*,
34 *September*, 14–15.
35
36

37
38 Sawyer, A., & Ayers, S. (2009). Post-traumatic growth in women after childbirth.
39 *Psychology & Health*, 24, 457-471. DOI: 10.1080/08870440701864520
40
41

42
43 Sawyer, A., Ayers, S., Young, D., Bradley, R., & Smith, H. (2012). Posttraumatic
44 growth after childbirth: A prospective study. *Psychology and Health*, 27, 362-377.
45 DOI: 10.1080/08870446.2011.578745
46
47

48
49 Shaw, R. J., Lilo, E. A., Storfer-Isser, A., Ball, M. B., Proud, M. S. ... & Horwitz, S.
50 (2014). Screening for symptoms of postpartum traumatic stress in a sample of
51 mothers with preterm infants. *Issues in Mental Health Nursing*, 35, 198-207.
52 DOI: 10.3109/01612840.2013.85332
53
54
55
56
57
58
59
60

1
2
3 Shaw, R. J., Bernard, R. S., Storfer-Isser, A., Rhine, W., & Horwitz, S. M. (2013).
4 Parental coping in the neonatal intensive care unit. *Journal of Clinical Psychology in*
5 *Medical Settings*, 20, 135-142. DOI: 10.1007/s10880-012-9328-x
6
7

8
9 Shaw, R. J., Lilo, E.A., Storfer-Isser, A., Ball, M. B., Proud, M. S. ... & Horwitz S.M.
10 (2014). Screening for symptoms of postpartum traumatic stress in a sample of
11 mothers with preterm infants. *Issues in Mental Health Nursing*, 35, 198-206.
12 DOI:10.3109/01612840.2013.853332
13
14

15
16
17 Shaw, R.J., St John, N., Lilo, E., Jo, B., Benitz, W. ... & Horwitz, S.M. (2014).
18 Prevention of traumatic stress in mothers of preterms: 6-month outcomes.
19 *Pediatrics*. pii: peds.2014-0529. [Epub ahead of print]
20
21

22
23 Sheen, K., Spiby, H., & Slade, P. (2014). An integrative review of the impact of
24 indirect trauma exposure in health professionals and potential issues of salience for
25 midwives *Journal of Advanced Nursing*. 709(4), 729-743. DOI: 10.1111/jan.12274
26
27

28
29 Slade, P. (2006). Towards a conceptual framework for understanding post-traumatic
30 stress symptoms following childbirth and implications for further research. *Journal of*
31 *Psychosomatic Obstetrics and Gynecology*, 27(2): 99-105.
32 DOI:10.1080/01674820600714582
33
34

35
36
37 Smith, L. K., Draper, E. S., Manktelow, B. N., Dorling, J. S., & Field, D. J. (2007).
38 Socioeconomic inequalities in very preterm birth rates. *Archives of Disease in*
39 *Childhood: Fetal and Neonatal Edition*, 92, F11-F14. DOI:10.1136/adc.2005.090308
40
41

42
43 Soderquist, J. (2006). The longitudinal course of post-traumatic stress after
44 childbirth. *Journal of Psychosomatic Obstetrics & Gynaecology*;27(2),113-9
45
46

47
48 Spielman, V., & Taubman-Ben-Ari, O. (2009). Parental self-efficacy and stress-
49 related growth in the transition to parenthood: A comparison between parents of pre-
50 and full-term babies. *Health and Social Work*, 34, 201-212.
51 DOI: 10.1093/hsw/34.3.201
52
53

54
55 Stramrood, C.A., Doornbos, B., Wessel, I., van Geenen, M., Aarnoudse, J.G. ... &
56 van Pampus, M.G. (2013). Fathers with PTSD and depression in pregnancies
57
58
59
60

1
2
3 complicated by preterm preeclampsia or PPRM. *Archives of Gynecology and*
4 *Obstetrics*, 287(4), 653-61. DOI: 10.1007/s00404-012-2611-0
5
6

7
8 Stramrood, C.A., Paarlberg, K.M., Huis In 't Veld E.M., Berger, L.W., Vingerhoets,
9 A.J. ...& van Pampus, M.G. (2011). Posttraumatic stress following childbirth in
10 homelike- and hospital settings. *Journal of Psychosomatic Obstetrics and*
11 *Gynaecology*; 32, 88-97. DOI:10.3109/0167482X.2011.569801
12
13

14
15 Stramrood, C.A., van der Velde, J., Doornbos, B., Paarlberg, K.M., Weijmar Schultz,
16 W.C., & van Pampus, M.G. (2012). The patient observer: eye-movement
17 desensitization and reprocessing for the treatment of posttraumatic stress following
18 childbirth. *Birth*; 39, 70-76.
19
20
21

22
23 Stramrood, C.A.I., Wessel, I., Doornbos, B., Aarnoudse, J.G., van den Berg P.P. ... &
24 van Pampus, M.G. (2011). Posttraumatic stress disorder following preeclampsia and
25 PPRM: a prospective study with 15 months follow-up. *Reproductive Sciences*,
26 18(7): 645-653. DOI: 10.1177/19337191110395402
27
28
29

30
31 Suttora, C., Spinelli, M., & Monzani, D. (2014). From prematurity to parenting stress:
32 The mediating role of perinatal post-traumatic stress disorder. *European Journal of*
33 *Developmental Psychology*, 11, 478-493. DOI: 10.1080/17405629.2013.859574
34
35

36
37 Taubman-Ben-Ari, O., Findler, L., & Sharon, N. (2011). Personal growth in mothers:
38 examination of the suitability of the posttraumatic growth inventory as a
39 measurement tool. *Women and Health*, 51(6), 622.
40
41 DOI:10.1080/03630242.2011.614324
42
43

44
45 Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory:
46 Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9, 455-472.
47
48 DOI: 10.1007/BF02103658
49

50
51 Thomson, G., & Downe, S. (2008) Widening the trauma discourse: the link between
52 childbirth and experiences of abuse. *Journal of Psychosomatic Obstetrics and*
53 *Gynecology*. 29(4), 268-273. DOI:10.1080/01674820802545453
54
55
56
57
58
59
60

1
2
3 Thomson, G., & Downe, S. (2010). Changing the future to change the past: women's
4 experiences of a positive birth following a traumatic birth experience. *Journal of*
5 *Reproductive and Infant Psychology*, 28, 102-112.

6 DOI: 10.1080/02646830903295000
7
8
9

10 Thomson, G. & Downe, S. (2013). A hero's tale of childbirth. *Midwifery* 29(7), 765-
11 71. DOI: 10.1016/j.midw.2012.07.008.
12
13

14 Westphal, M., & Bonanno, G.A. (2007). Posttraumatic growth and resilience to
15 trauma: different sides of the same coin or different sides. *Applied Psychology: An*
16 *International Review*, 56, 417-427. DOI: 10.1111/j.1464-0597.2007.00298.x
17
18
19

20 White, G. (2007). You cope by breaking down in private: fathers and PTSD following
21 childbirth. *British Journal of Midwifery*, 15(1), 39-45.
22
23

24 DOI: <http://dx.doi.org/10.12968/bjom.2007.15.1.22679>
25
26

27 White, T., Matthey, S., Boyd, K., & Barnett, B. (2006). Postnatal depression and
28 post-traumatic stress after childbirth: Prevalence, course and co-occurrence.
29 *Journal of Reproductive and Infant Psychology*, 24(2); 107-120.
30
31

32 DOI: 10.1080/02646830600643874
33
34

35 World Health Organisation. (1992). ICD-10 Classifications of Mental and Behavioural
36 Disorder: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health
37 Organisation.
38
39

40 Yonkers, K.A., Smith, M.V., Forray, A., Epperson, C.N., Costello, D., Lin, H., &
41 Belanger, K. (2014). Pregnant women with posttraumatic stress disorder and risk of
42 preterm birth. *JAMA Psychiatry*. DOI: 10.1001/jamapsychiatry.2014.558. [Epub
43 ahead of print]
44
45
46
47

48 Zeitlin, J., Szamotulska, K., Drewniak, N., Mohangoo, A.D., Chalmers, J. ... & The
49 Euro-Peristat Preterm Study Group. (2013). Preterm birth time trends in Europe: a
50 study of 19 countries. *BJOG: An International Journal of Obstetrics and*
51 *Gynaecology*, 120, 1356-1365. DOI: 10.1111/1471-0528.12281
52
53
54
55
56
57
58
59
60

Appendix 1: participants

Susan Ayers

Ros Crawley

Elizabeth Ford

Antje Horsch

Jane Iles

Julie Jomeen

Kirstie McKenzie-McHarg

Aimee Poote

Alexandra Sawyer

Geraldine Scott-Heyes

Kayleigh Sheen

Pauline Slade

Claire Stramrood

Gill Thomson