**Background**

Postnatal women may experience a variety of psychological difficulties that can be distressing. It is increasingly recognised that although childbirth is a safe and satisfying experience for the majority of women, the event itself can be experienced as traumatic and may result in posttraumatic stress disorder following childbirth(Yildiz et al., 2017)(Grekin and O’Hara, 2014) ). Post-traumatic stress disorder (PTSDFC) after childbirth creates significant psychological distress, with 3% of women suffering at full diagnostic levels and 5-9% when sub-diagnostic levels are included. When considering those known to be at risk for experiencing birth as traumatic (for example those experiencing obstetric emergencies) the prevalence of PTSDFC has been estimated to be higher ranging between 15.7% and 18.5% (Grekin and O’Hara, 2014).

PTSD is classified as a trauma and stressor-related disorder in the Diagnostic and Statistical Manual (DSM)-5 (American Psychiatric Association, 2013) and characterised by intrusions typically involving reliving, avoidance of associated stimuli, hyperarousal and change in cognitions and mood. If symptoms have not resolved in the first few months and are left untreated, they have the potential to become long lasting (Ayers, Eagle, & Waring, 2006; Nicholls & Ayers, 2007). The impact of PTSDFC on maternal psychological wellbeing can include feelings of low self-worth, an increased risk of experiencing symptoms of postnatal depression (Söderquist et al., 2009), and developing a fear of subsequent pregnancies/births (Lapp et al., 2010). It can also have an impact on intimate relationships, relationships with other family members and infant feeding/bonding (McDonald, Slade, Spiby, & Iles, 2011; Cook, Ayers, & Horsch, 2018).

Although characterised by the same cluster of symptoms, the context of traumatic birth differs from that of other events leading to PTSD . For example, giving birth is *generally* regarded as a positive event which is in contrast to the perception of other traumatic events (James, 2015). It is also a predictable event in the sense that following pregnancy a birth is expected, with variability existing in the birth events themselves. It also takes place in the context of a care system and caregivers. There may also be further differences with regards to the manifestation of symptoms. For example, hyperarousal symptoms are a common reaction postnatally probably because of the new responsibility for a vulnerable infant and may not be indicative of PTSD. They should not be considered in isolation when assessing symptoms of PTSDFC (Ayers et al., 2015).

The recognition that women can experience PTSDFC has led to a need for effective interventions to reduce symptoms of distress. However, there is still some uncertainty surrounding the guidance for providing specific treatment for PTSDFC (National Institute for Health and Care Excellence [NICE], 2016). Given the contextual differences and the importance of women’s mental health in the postnatal period, determining which interventions are effective in treating PTSDFC is extremely important and should not be assumed on the basis of simple extrapolation from existing guidance on PTSD more generally (NICE, 2019)

Reviews/syntheses on the effectiveness of interventions that could provide specific guidance for interventions for PTSDFC have been relatively neglected. One early review investigating the management of PTSDFC identified that there are inconsistencies regarding the effectiveness of some interventions such as debriefing and counselling (Lapp et al., 2010). Furthermore, a review of the efficacy of debriefing interventions for reducing PTSDFC found that the majority of studies reported that debriefing is ineffective, although a handful of studies showed it could be useful if targeted specifically at those who have experienced a traumatic birth (Sheen and Slade, 2015).

A systematic review and meta-analysis considering trauma focussed psychological therapies for post traumatic stress disorder symptoms has been reported (Furuta et al., 2018). Some studies included though were actually prevention studies as there was no measure of pre-existing symptoms and the interventions were from 6 hours postpartum. It is critical that if interventions for a condition are being evaluated then studies must have established that preintervention condition is actually present. Post traumatic stress symptoms by definition can only occur 4 weeks postnatally as this is the minimum duration to meet criterion.

Studies including women who had had a still birth and therefore incorporating complex bereavement responses were also included. In terms of quantitative evidence there was therefore a need for a more targeted review specifically considering only studies with pre and post measures of posttraumatic stress symptoms initially identified at least post 4 weeks postnatally, where there is a live infant. Such an approach ensures clinicians can access the key information about effective interventions in a rapid and accessible way. This review also provides the potential for available evidence in relation to the effectiveness of psychosocial as well as psychological interventions for PTSDFC to be considered.

In addition, if services are to be effective in engaging women in need, then there needs to be a clear understanding of what factors may act as barriers what may facilitate uptake of psychological care. Hence a met synthesis of qualitative evidence concerning women’s experiences of and how psychological care following birth experienced as traumatic should be provided is also required.

**Objectives**

1. To evaluate the literature on psychological interventions for PTSD following childbirth in terms of clinical effectiveness.
2. To synthesise the qualitative literature on the barriers and facilitators to uptake of interventions/care for PTSDFC.

**Method**

**Review and Metasynthesis Protocol**

The combined review and metasynthesis protocol was registered on PROSPERO (International Prospective Register of Systematic Reviews) (CRD 112728). Quantitative reporting was guided by Preferred Reporting Items for Systematic Reviews and Metaanalyses (PRISMA)(Liberati et al., 2009).

**Search Strategy**

Web of Knowledge, CINAHL, MEDLINE, PSYCINFO, the Cochrane Central Register of Controlled Trials (CENTRAL), OpenGrey, UKCTG, and the ISRCTN were consulted to include refereed journal articles published in English up to 30th April 2019 and updated on 21st October 2020. Following consultation within a multi-disciplinary team which included a consultant clinical psychologist in perinatal mental health, a general practitioner and a consultant obstetrician, a series of search terms were devised and consisted of the following: ((PTSD OR Posttraumatic OR Trauma\* OR 'Post traumatic' OR post-traumatic) AND (Childbirth OR birth OR labour OR labor OR Delivery OR postnatal OR Perinatal OR postpartum) AND (Intervention OR Psycho\* OR EMDR OR 'eye movement' OR counselling OR counseling OR CBT OR cognitive OR therapy OR Debrief\*)). References lists were hand searched for any relevant papers. This process was checked with another researcher (PS).

**Inclusion and Exclusion Criteria**

For the first objective, quantitative papers were included according to the following criteria organised according to PICO headings.

Participants: Women who had given birth to a live baby and showed symptoms of post traumatic stress disorder as measured at four or more weeks after childbirth. To be included, it was also essential that baseline PTSD symptoms (on or after 4 weeks since the birth) prior to the intervention. It was also essential that the study sample overall was symptomatic prior to intervention.

Intervention: Studies that investigated the use of a psychological or psychosocial intervention for PTSDFC. Acceptable interventions were defined as follows: Non-pharmacological interventions targeting reduction of PTSD symptoms and based on a psychological method including but not limited to:

1. Trauma focused cognitive behavioural therapy (TFCBT)

2. Exposure (therapy)

3. Eye Movement Desensitisation Reprocessing (EMDR)

4. Psychological debriefing (if provided for symptom management rather than prevention)

5. Counselling and Psychosocial interventions based on social interaction, for example enhancing/creating supportive relationships (e.g. peer support).

Comparator: The comparator could be any other intervention or none

Outcome: PTSD symptoms assessed using a validated assessment tool.

All study designs were included.

For the second objective qualitative papers were included if they contained women’s accounts of any psychological care received or discussed a need for psychological care following a traumatic birth. Papers investigating interventions for distress following a stillbirth, or following preterm birth where the birth itself was not experienced as traumatic were excluded. This stage was completed by RM with reference to the research team for discussion and resolution through consensus for issues of uncertainty

**Search Outcome**

A total of 5355 papers were identified by the search method previously outlined. Figure 1 depicts the screening and selection process. Following the application of the inclusion and exclusion criteria, 5 quantitative and 13 qualitative papers remained. Papers were hand searched for references and none were found that would be considered relevant for this review. (Tables 1 and 2 for overview of papers included).

**Quality appraisal and Risk of Bias**

All papers were appraised for quality and risk of bias using the Mixed Methods Appraisal Tool (MMAT: Pluye, Robert, Cargo, & Bartlett, 2011). The MMAT was used in this review as it considers a diverse range of study designs and has been shown to be a reliable tool. Although a numerical score can be obtained for each screening outcome, this feature was not utilised by the present review as it is not regarded to be overly informative in practice (Pace et al., 2012). Details of the appraisal can be found in Tables 3 and 4. This was completed by RM with reference to the research team for discussion and resolution through consensus for issues of uncertainty Specific details relating to quality appraisal and risk of bias are discussed in relation to the findings of each paper where applicable.

**Data Extraction and Synthesis**

Studies were first segregated based on their relation to the two objectives (quantitative and qualitative) and data was extracted using separate data extraction tools designed for this review. Due to the small number of studies and the differences in the types of intervention/treatment, a meta-analysis was not thought to be useful for addressing the first objective. Instead, findings of each of the studies is described and appraised in relation to the first objective (clinical effectiveness).

The meta-synthesis approach used in this review was based on the seven-phase process described by Noblit & Hare, 1988. The first phase involved extracting data from the included studies relevant to the area of interest (potential barriers and facilitators to uptake of psychological care). Data relating to women’s experiences of or need for psychological/emotional care following a traumatic birth were first extracted and coded in a process similar to phenomenological analysis. Codes were then combined thematically (using reciprocal translation and refutational investigation) by comparing themes across studies and combing codes that are similar in content. Simultaneously, it was important to ensure that each key theme was captured by the extracted data, and descriptive themes from the synthesis remained close to those in the original papers. This stage was completed by RM.

Generated themes and subthemes were then presented by RM and discussed and checked for evidence by the multidisciplinary research team which consisted of a consultant clinical psychologist (PS) who specialises in perinatal mental health, a general practitioner with experience of treating postnatal distress (AW) (agreed results can be found in table 5). Once a consensus was reached, a final analytical process considering the relationships between the themes was generated by the team (Figure 2).

**Results**

***Clinical effectiveness of psychological/Psychosocial interventions for PTSDFC***

Of the 55 full text articles assessed for this section of the review, only 5 studies from 4 countries (UK, Sweden, Switzerland and USA) met the inclusion criteria. Although there were other studies identified by the search process that investigated psychological interventions for PTSDFC, they failed to meet some of the pre-specified criteria. For example, some did not assess PTSDFC using validated measures (e.g. Ayers, McKenzie-McHarg, & Eagle, 2007; Stramrood et al., 2012) or did not include a baseline assessment prior to intervention (e.g. Borghini et al., 2014; Brecht, 2014; Madrid, Skolek, & Shapiro, 2006). Some only measured acute symptoms of PTSD prior to 4 weeks post-birth and therefore the intervention would not be treating PTSDFC (e.g. Bernard et al., 2011; SmithBattle, Chantamit-o-pas, Freed, McLaughlin, & Schneider, 2017). In comparison, the small number of included papers assessed an intervention targeting PTSD symptoms following childbirth, used validated assessment tools to measure baseline symptoms (on or after 4 weeks following the birth) and post-intervention symptoms. Overviews of included studies can be found in tables 1 (quantitative) and table 2 (qualitative).

One study used an expressive writing paradigm (Horsch et al., 2016), the remaining four implemented a psychological intervention based on psychological theory, such as Eye-Movement Desensitisation and Reprocessing (Sandström et al., 2008), trauma focussed cognitive behavioural therapy one study being an internet intervention (TF-ICBT: Nieminen et al., 2016) and the other involving in person therapy or a midwife led debriefing session (Meades et al., 2011). Three of the studies were RCTs one a quantitative case series descriptive study and the other an individual case study (Reina et al., 2019). Methodological quality was generally satisfactory with one RCT not including details regarding missing outcome data (Horsch et al., 2016) and two studies not including details of sample representativeness relative to the study population (Meades et al., 2011; Sandström et al., 2008). Case study data clearly provided only weak evidence (Table 3). As the interventions were quite diverse, brief descriptions are provided prior to findings.

***Eye movement desensitisation and reprocessing (EMDR)***

Only one study assessing the use of EMDR to treat PTSDFC was identified by this review (Sandström et al., 2008). This paper presented a series of four case studies of women aged 24-31 identified as having symptoms of PTSD following a traumatic birth 3 months to 7 years prior to receiving treatment. The intervention was carried out by a licensed EMDR therapist according to the protocol outlined by Shapiro (Shapiro and Forrest, 1997). To assess symptoms, the Traumatic Event Scale was used (TES: Wijma, Söderquist, & Wijma, 1997). All participants fulfilled criteria for PTSD according to DSM-IV (APA, 1994) and scored close to the maximum score (16) on the TES for criterion A prior to receiving treatment. The sum score for B, C and D can vary between 17 and 68 and for the score for B, C and D when scored ‘often disturbing’ can vary between 0 and 17. A score ≥ 30 is considered to indicate a PTSD diagnosis (Wijma et al., 1997). Before treatment the mean score for criterion A was 15.3, and for criterion B, C and D was 52.7. After treatment, mean score for criterion B, C and D was reduced to 33.5 and when followed up at 1-3 years post treatment this had further reduced to 22.7.

***Trauma focussed cognitive behavioural therapy (TF-CBT).***

One study developed an internet TF-CBT treatment derived from previous studies (Ivarsson et al., 2014), based on prolonged exposure (Foa et al., 1999) and was completed using components of narrative exposure (Robjant and Fazel, 2010). The treatment comprised of 8 modules of written text (involving psychoeducation, anxiety coping methods and skill training, imaginary and in vivo exposure and cognitive restructuring) and lasted 8 weeks (one module presented each week). This was guided by post-graduate students under supervision and via a secure management network (computer based). Women who were demonstrating PTSD symptoms relating to a traumatic birth, which took place at least 3 months prior to their inclusion (*N*=56), were randomly allocated using an online random-number service to receive the treatment (*n*=28) or be placed on a waiting list (control: *n*=28).

The TES and Impact of Events Scale Revised (IES-R: Weiss & Marmar, 1997) were used to assess PTSD symptoms at inclusion and weekly during treatment, followed by a final assessment post -treatment. At baseline, there were no significant differences between the groups with regards to the baseline proportions of full PTSD symptoms, although not all of the participants displayed full criteria for PTSD (detailed results can be found in Table 1). When assessed post treatment, the percentage of women fulfilling criteria for PTSD was reduced in both groups and on both measures. A proportion of those in the control group received delayed treatment following the waiting list period (n=23) of whom the 10 women reporting symptoms fulfilling PTSD criteria was reduced to 2 post delayed treatment. Within group analyses showed significant decreases in TES and IES-R scores post treatment for both the treatment and control groups. However, when assessing scores between groups over time, only the IES-R showed a significant effect with a large effect size favouring the treatment group.

The results from this study suggest that TF-CBT may be effective for treating women with PTSDFC. However, the study also highlights the importance of considering which measures to use when assessing symptoms. It should also be noted that the control group did show a reduction in symptoms whilst on the waiting list. However, as acknowledged by the authors, this may be due to the weekly measurement of symptoms which may have encouraged women to process and confront their trauma, inadvertently strengthening their coping strategies by means of exposure. Although natural recovery could also be the reason for the reduced symptoms displayed in the control group, as previously mentioned for the results of the EMDR study, this is unlikely given the length of time since the birth.

This study included women who were not displaying full diagnostic criteria for PTSD and as such this may explain the small to modest between-group effect sizes in comparison to previous studies using this method of treatment. The acceptability of this treatment for women should also be considered as although 92.3% of the women reported finding the modules easy to understand, novel symptoms in the form of stress appeared during the study as women felt burdened by the time required to complete the homework (reported by 9 women in the treatment group and 11 women in the control group). It was also observed that on average, only 53% of the treatment group completed all 8 weeks of treatment with 67% of those managing at least four modules and hence participant demand should not be overlooked.

The other TF-CBT study was an individual case study with a 28 year old woman(Reina et al., 2019), two and a half years after a traumatic birth and who fulfilled clinical diagnosis for PTSD (Diagnostic and Statistical Manual-5) and reported clinical level scores on both the Posttraumatic Stress

Disorder Checklist for Civilians, *DSM-5* (PCL5:(Blevins et al., 2015; Weathers, 2008)), and the Impact of Event Scale Revised (Weiss and Marmar, 1997) at baseline. As well as preparatory and ending sessions 12 sessions of prolonged exposure were followed by five of cognitive behaviour therapy sessions focussing on thoughts, events and feelings. The intervention was provided by a master’s level clinician on a doctoral programme who was supported with weekly clinical supervision. By the end of the active sessions the woman was no longer fulfilling clinical diagnosis either by clinical assessment or the self-report scales. She was unable to be contacted for a three-month post treatment follow up. The findings whilst supportive of the approach, clearly relate to a single individual receiving extensive input and cannot take account of the role of time or attention and support and can by definition provide only weak evidence.

To truly assess the effectiveness of TF-CBT whether via the internet or in person, further larger scale studies would be needed measuring the long-term effects with consideration given to the measurement tools used whilst being mindful that women may find this method of treatment laborious and may not fully adhere.

***One to one midwife- led debriefing***

Psychological debriefing was originally used as a method of facilitating the processing of a traumatic event in emergency personnel to reduce psychological distress and is still used for this purpose (Schmidt and Haglund, 2017). It has also been adapted for use in a maternity setting to prevent the development of PTSDFC symptoms, providing women with the opportunity to discuss their birth experience with a midwife or obstetrician (Selkirk et al., 2006). A recent review found 9 studies using debriefing interventions to reduce PTSDFC (Sheen and Slade, 2014). The findings suggested that the use of debriefing in this context is ineffective, unless the intervention is targeted at treating those who have reported experiencing their birth as traumatic. Of the two studies using targeted interventions for women who have experienced their birth as traumatic (Gamble et al., 2005; Meades et al., 2011) one fulfilled the inclusion criteria for this review.

Meades et al. (2005) evaluated the use of a one to one debriefing session provided by one of two midwives with specialist training. Women were offered the opportunity to discuss their feelings, emotions and concerns relating to their birth and any future births. Medical notes were made available for clarification. Sessions took place 1.3 to 72 months following to the birth, lasted 1-1.5 hours and were provided on request or by referral. Symptoms of PTSDFC were measured by the PTSD symptom self-report scale (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993) and negative appraisals measured using the Posttraumatic Cognitions Inventory (PTCI; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999). Measurements took place before debriefing and one month following debriefing (on entry to the study and one month later for the control group). Women who met criteria for a traumatic birth and attended debriefing (*n*=46) were compared to a group of women who also met criteria but did not want debriefing (*n*=34). A significant reduction in PTSD symptoms was found in the debriefing group compared to the control group, in which the effect appeared to be due to a reduction in re-experiencing symptoms, rather than avoidance or arousal symptoms (Table 1). Although this study found an overall reduction in negative appraisals over time irrespective of group, there was a significant interaction between group and time whereby those in the debrief group had a greater reduction in negative appraisals. It is however worth noting that the debriefing group had significantly more negative appraisals overall irrespective of time.

As this study used patient preference as a means of group allocation, the results suggest that a debrief may be effective for those women who wish to have one, which is in-keeping with previous findings (Sheen and Slade, 2015). The evidence presented however is relatively weak in suggesting debriefing as an efficacious treatment option. The structure of the debrief itself may have also varied from one midwife to the next. Although both groups reported their birth as traumatic at inclusion to the study, only 17% of women in the comparison group (*n*=6) were experiencing symptoms fulfilling criteria A-D on inclusion into the study. To assess the true efficacy of debriefing within a maternity setting, the effects should be investigated within an RCT design with those who are symptomatic and randomly allocated to receive the treatment or care as usual/delayed treatment.

***Expressive Writing Paradigm***

One study investigating the use of an expressive writing paradigm as a means of reducing PTSDFC symptoms was identified and fulfilled criteria for this review (Horsch et al., 2016). Mothers of 67 very preterm infants were randomly allocated using a random number system to the intervention group to take part in the expressive writing task (*n*=33) or control group (treatment as usual, *n*=32) when their infant was 3 months old. Symptoms of PTSD were measured using the perinatal PTSD questionnaire (PPQ; DeMier, Hynan, Harris, & Manniello, 1996) pre-intervention (3 months after the birth), one month following the intervention and 2 months following the intervention.

Women were asked to write for 15 minutes for three consecutive days about their ‘*deepest thoughts and feelings about the most traumatic experience relating to the birth and hospitalisation of your premature baby’*. The first set of measures were completed by 67 women (71.2%) 3 months following their birth, of whom 54 (80.6%) completed all three time points. A significant effect of time was observed with reductions in symptoms found in both groups. There were no significant differences in symptoms between the groups, or between the groups over time. However, exploratory post-hoc tests revealed a significant decrease in PTSD symptoms between baseline and 1-month post intervention in the intervention group but not in the control group (*p*=0.013 vs. control *p*=ns). As not all of the women in each group displayed clinically relevant symptoms of PTSDFC, further analyses were carried out comparing those in both groups scoring 6 or more on the PPQ. No significant differences were found 1-month post intervention although a trend towards a lower score in the intervention group was found at 6 months that did not quite reach significance (*p*=0.07).

The results from this sole study do not provide evidence that expressive writing is an effective treatment for PTSDFC, and further work is needed. Comparing proportions of participants of both groups who were above the clinical cut-off for PTSD symptoms revealed no significant differences, although there were almost twice as many PTSD cases in the control group at the 3-month follow-up. However, the majority of women reported finding the intervention useful and hence there may be some benefits for its use aside from reduction in PTSDFC symptoms. Clinically significant symptoms of PTSD were not present in the entire sample of women prior to the intervention and therefore it is difficult to know if the intervention would be effective for those displaying more severe symptoms of PTSD. It is also important to note that the women in this sample were asked about their traumatic birth experiences *and* their experiences of being in the neonatal intensive care unit. Future research would need to consider the effectiveness of this method of treatment in a sample of mothers who have experienced a traumatic birth specifically, and not in addition to experiencing a distressing time following the birth due to their infant’s hospitalisation, as this may warrant separate exploration.

***Discussion: Which treatments are effective in treating PTSDFC?***

This review is notable for the absence of robust evidence for effectiveness of psychological/psychosocial interventions in relation to PTSD following childbirth***.*** Four types of intervention were identified with one study for each type, and for this reason it is difficult to draw conclusions from such tentative evidence. In addition, the inclusion of women who are not symptomatic cloud the results and hence conclusions on clinical effectiveness are also difficult to draw. Based on the evidence identified by this section of the review the following recommendations are suggested:

1. EMDR needs to be tested more thoroughly, in a larger sample of women and with a comparison group to assess true effects. In addition, the context in which treatment is offered should be considered. Previous mental health history and personal circumstances (i.e. whether a woman is pregnant) would need to be taken into consideration and treatment provided with caution
2. TF-CBT via the internet and in person needs to be assessed in large groups of women and longitudinally to assess longevity. This method of treatment can be time consuming for women and this should be considered when exploring as a treatment option. Women who have recently given birth or have young children, may not have the time to complete such a demanding method of treatment and this may have a negative effect on stress levels.
3. The use of debriefing in a maternity setting should be used following careful consideration of target population. In addition, the most effective structure of a debrief in this context should be identified and, following robust evidence, consolidated guidance produced on its application in a maternity setting.
4. The evidence for the efficacy of the expressive writing paradigm is lacking and this should be investigated within a sample of symptomatic women who report experiencing their birth as traumatic. This task may however have the same caveats as TF-ICBT, in that women with a young infant or other children may find it difficult to find to the time to complete the treatment, and this may affect adherence and create added stress. These issues would need to be considered carefully in the context of the intervention’s efficacy at reducing symptoms.

***Meta-synthesis of facilitators and barriers to uptake of psychological care for PTSDFC***

**Results**

Thirteen studies met the inclusion criteria for this review. Half of the studies originated from the UK (*n*=6), the remaining half originated from Australia (*n*=2), the USA (*n*=2), South Africa (*n*=1), France (*n*=1) and Iceland (*n=*1). An overview of the included studies and their quality appraisal can be found in tables 2 and 4 respectively.

Seven themes emerged from the meta-synthesis. Table 5 shows how these are evidenced in the original papers. Three themes relate to barriers are initially presented followed by four identifying facilitators enabling access of care. Barriers covered the difficulty for women of firstly even *Realising there is a problem* and then needing validation of their concern but the fear of judgment getting in the *way (Needing to validate or disclose distress without fear of being judged)* and the perception of lack of real engagement of staff with emotional needs issues as in *No one addressed my emotional needs.* Only ifwomen were actively asked could they obtain helpas in *Ask me how I am feeling and I can get help*. Following on from active askingto facilitate care women needed willing empathic listening and reassurance (*Someone who willingly listens and reassures me)* and who would spend the time to help them make sense of their experiences (*Putting all of the pieces together to understand and make sense of experiences*). To do this the person needed to know and be known to them *(The importance of continuous and personalised support)*These themes are brought together under an overarching theme of ‘*Towards facilitating good emotional support’*. These themes emerging from synthesis and the proposed relationships between themes are presented in Figure 2 and are now considered in turn.

***Realising there is a problem***

This theme contains data from 10 of the included studies (table 5) and contained two subthemes; *‘avoiding the problem’* and *‘I was at breaking point’.* The former subtheme describes how women find it hard to acknowledge their distress and may initially try to downplay or avoid it because they expected their distress to fade with time (Garel et al., 2007), they ‘blocked out their feelings’ (Bailey and Price, 2008) or because they found thinking/talking about the birth too distressing ‘*cried a lot – very upset – avoided talking/felt like I couldn’t talk about the birth*’ (Thomson and Downe, 2016). Four of the studies described how women felt they had to reach ‘*breaking point’* where their distress would rise to a high level before they would try to source support, which was captured by the subtheme ‘I *was at breaking point’*.

***Needing to validate or disclose distress without fear of being judged***

Linked to avoidance of distress and delay in sourcing support was the need to obtain validation of their distress, as women struggle to decide if their distress is normal before risking disclosure. This theme contains three subthemes, the first *‘is my distress normal and can I ask for help?’* contains data from 11 of the included studies (Table 5). Within this subtheme, women describe their difficulty in understanding whether their distress in relation to their traumatic birth is ‘normal’. This was particularly salient for first time mothers lacking a point of reference (Coates et al., 2014). Women also described feeling as if they did not deserve help as they grapple with the concept of ‘trauma’ in the context of birth (Iles and Pote, 2015). Closely associated with this experience of struggling to know what is normal, are the social norms and pressures of ‘*trying to be the perfect mother and the fear of being judged*’ which became the second subtheme. This subtheme contains data from 7 studies where women describe how they feel they cannot disclose their distress and how they ‘*put on a brave face’* for fear of their disclosure being seen as an ‘*inability to cope*’ (Coates et al., 2014; Hinton, Locock, & Knight, 2015; H. Priddis, Dahlen, & Schmied, 2013; . Priddis, Keedle, & Dahlen, 2018a). Similarly, women describe avoiding disclosure of their distress for fear of being labelled or judged by other mothers or by health professionals (Iles and Pote, 2015; Thomson and Downe, 2016). Again, closely associated with this notion of feeling judged was the feeling that women cannot disclose their distress to, or in the presence of other mothers who seemingly did not share their experiences. Women described feeling ‘*like a black cloud over everyone else*’ (Coates et al., 2014). However, when women felt as if the individual they were speaking with could identify with their experiences, this facilitated the sharing of their own experiences. For example, women spoke of the value of talking in a group of other mothers who had similar experiences (Coates et al., 2014; Rossman et al., 2017) or talking with health professionals who may have been at the birth or had experienced a similar event (Coates et al., 2014; de la Cruz et al., 2013).

***No one addressed my emotional needs***

Women were often not offered emotional support following a distressing birth or were offered care that did not meet their needs. Information from eight studies contributed to this theme. Women described how their emotions were not addressed and how they wanted such needs to be acknowledged. Women described interactions with healthcare providers where they felt a ‘*tick box approach’* was applied to their care, and this did not facilitate a relationship in which they could disclose their distress (Coates et al., 2014). Similarly, women described ‘*always being referred to somebody else like they don’t want to* [talk]’ or feeling as if their healthcare professionals were in too much of a rush to talk about the mothers’ needs or emotions.

***Ask me how I am feeling, and I can get help***

Within the three themes relating to barriers, women described their avoidance of their distress and also needing validation to understand/recognise when their distress is normal or ‘severe enough’ to warrant asking for help and fearing judgement. and the lack of active engagement by staff in emotional issues. To facilitate care women in 6 studies describe a need for health professionals to **actively** ask about their emotional wellbeing and prompt an initial discussion. Only then could this lead to signposting to services, and the accessing of further support that they may not otherwise be able to source or ask for themselves (Sigurðardóttir et al., 2019). Those who were asked about their emotional wellbeing by a healthcare professional described the positive value of being asked (Fenwick et al., 2013; Sigurðardóttir et al., 2019). They suggested much greater active involvement from professionals in ‘*checking on*’ women at regular intervals (Priddis, Keedle, & Dahlen, 2018b), being aware that women may be ‘*too scared to ask for help’* (de la Cruz et al., 2013) or making women aware of available support options that they can access should they need to (Thomson and Downe, 2016). The next theme identifies how they wanted this input to be provided so that uptake would be facilitated.

***Someone who willingly listens and reassures me***

When prompting a conversation with women about their traumatic birth, feeling listened to and cared for enabled disclosure of distress and could also potentially reduce its level (Bailey and Price, 2008; Coates et al., 2014; Fenwick et al., 2013; Sigurðardóttir et al., 2019). Women described the need for a supportive, empathic listening ear, preferably from a healthcare professional with the experience or knowledge of what they have been through. For those women that experienced such care, they described the benefits of it in terms of ‘*off –loading’* their worrying thoughts (Fenwick et al., 2013) and having a ‘*shoulder to cry on’* (Rossman et al., 2017).

***Putting all of the pieces together to understand and make sense of their experiences***

Following on from realising there is a problem and discussing this with a healthcare professional, this theme with two subthemes describes how healthcare professionals can help women to ‘*piece together’ their experiences’* to process their distress and *fill in memory gaps* by *having their questions answered*. Eleven of the included studies provide data for this theme (Table 5). First, women describe the need to have the opportunity to discuss their birth experience with a someone who is knowledgeable and can explain the events to them in order for them to better understand what happened and potentially why. For those women that received this, they described how having their notes during the discussion and having someone explain these was helpful in understanding why their birth happened the way it did (Bailey and Price, 2008; Fenwick et al., 2013; Sigurðardóttir et al., 2019). It also helped them make sense of their situation which could provide closure (de la Cruz et al., 2013). For those that did not have the opportunity to do this, they described how it may have helped them piece together the puzzle, link their emotions to the events and *fill in memory gaps* by *having their questions answered* (Coates et al., 2014; de la Cruz et al., 2013; Iles and Pote, 2015; Roux and van Rensburg, 2011).

***The importance of continuous and personalised support***

Women described how they need to be asked about their emotional health, the type of relationship which would facilitate disclosure of distress, and the types of discussions that would help them to move forward in processing their experiences. Linked to all three of these aspects is the idea of continuous and personalised emotional support. Within this theme, women from 8 studies describe the importance of both aspects of care (continuity and personalisation/woman-centred). The first subtheme ‘*the importance of continuity’* describes how women may prefer to speak with the same person i.e. *someone who they had already shared aspects of their childbirth experience’* (Fenwick et al., 2013; Sigurðardóttir et al., 2019). Similarly, women wished for a healthcare professional who was aware of their situation and described their frustration when feeling anonymous in the healthcare system where no one knows what they have been through (Coates et al., 2014; de la Cruz et al., 2013).

Women may also benefit from having care that is personally tailored to their needs. For example, the ideal time frame for talking about the birth may differ depending on individual circumstances and experiences as ‘*everyone is different’* (Sigurðardóttir et al., 2019; Thomson and Downe, 2016) and there may be a *‘great variation in when women feel ready to talk*’ (Hinton et al., 2015). Some women stated that talking about the birth 4-6 weeks afterwards was ‘*a good time to talk’* (Fenwick et al., 2013; Thomson and Downe, 2016). However for others, talking about the birth much later was preferred (de la Cruz et al., 2013). Talking about the birth quite soon after (i.e. in hospital) was generally regarded as not being particularly helpful. Similarly, although some women felt talking about the birth was beneficial, for others counselling or support from their general practitioner had not been experienced as helpful, suggesting a variation in how women perceive care as fulfilling their needs (Hinton et al., 2015).

**Discussion : Barriers and facilitators for uptake of care**

Clear barriers and facilitators of access to care emerged from the meta-synthesis. Following their traumatic experience women may initially try to avoid their distress and struggle to determine if their distress is ‘normal’ or justified. Women may be reluctant to disclose distress unprompted for fear of being judged or labelled. If women struggle to know if their distress is deserving of help and if subsequently, they encounter a healthcare provider who does not ask about their emotional distress then women are unlikely to access care.

Even if the issue of traumatic birth is raised by a health care professional, women are unlikely to engage unless they perceive the person to be reassuring, willing to listen and knowledgeable about their unique situation. Any feeling that their exchange with their healthcare provider is completed as a ‘tick box’ exercise will not encourage disclosure of distress.

In order to facilitate access to care women need to be routinely and actively asked about traumatic birth in an accepting and non-judgemental way by a health care professional with time, empathy, and genuine interest in their experiences. The person needs to be validating about their distress, knowledgeable about their experiences and enable women to put the pieces together and fill in gaps. It is of benefit if the person is someone with whom they are already familiar and comfortable speaking with, and this should occur at a time when the woman is ready (not a catch-all pre-specified time) so that care is personalised according to need.

**Limitation**s.

In terms of the quantitative aspect we were unable to extend the work to include non-English papers. Data extraction was conducted by a single researcher with processes checked at each stage in detail by the team and uncertainties resolved by discussion. In addition, the limited quantitative material available meant that it was not possible to disaggregate by timing of intervention or duration of follow-up.

**Clinical Implications**

Despite there being several encouraging approaches further studies are required to provide more robust evidence for psychological and psychosocial interventions of post traumatic stress disorder. There are very clear findings about the blocks to disclosure which services and staff need to be aware of and actively address. Only if traumatic birth is actively acknowledged, routinely addressed by staff skilled in sensitive conversations and allocated time will women disclose and have opportunity to engage in subsequent psychological interventions.

**Conclusion**

There are a very limited number of studies assessing interventions specifically for PTSDFC. Although a number of other studies were found during the search process, they did not meet the essential criteria required to assess the clinical effectiveness of the intervention (validated measures, baseline measures, measurement of symptoms on or after 4 weeks post event). Further research to address this gap in the literature should be a priority.

In terms of the barriers and facilitators to uptake of care, the scale of information available was more satisfactory. It is clear that women experience great difficulty in disclosing distress related to a traumatic birth. In terms of barriers women find it difficult to know when there is a problem, not knowing what is normal or abnormal after a birth and this may relate to the lack of public awareness of traumatic birth and post traumatic stress disorder. They try to avoid their distress and only actively seek help at breaking point. They often feel unjustified and require active validation as they fear they may be judged as failing as a mother. Beyond active inquiry, facilitating access to care requires genuine empathic unhurried interest from health professionals. Ideally this will be where there is a pre-existing relationship with a woman. When this occurs, it enables women to ‘put the pieces together’ and this can in itself reduce distress. What women need can vary and therefore professionals need to broach the subject always with care and warmth and at different time points. Providing care for women with PTSDFC requires not only information about effective interventions but also awareness of effective processes to enable women in need to access to available services.

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