A QUALITATIVE STUDY EXPLORING BRITISH PAKISTANI WOMEN'S EXPERIENCES OF RECEIVING SUPPORT FOLLOWING A PERINATAL LOSS WITHIN THE UNITED KINGDOM

By

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A thesis submitted to the university of Birmingham for the degree of DOCTOR OF CLINICAL PSYCHOLOGY

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July 2022

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Thesis Overview

This thesis compromises three chapters, which have been submitted as per the requirements for the degree of Doctor of Clinical Psychology at the University of Birmingham. The first chapter is a Meta-Analysis exploring the effectiveness of brief psychological interventions in reducing maternal morbidity following a traumatic birth. Fifteen papers were reviewed and included within the analysis. The second chapter is a qualitative research study exploring British-Pakistani women's experiences of accessing and receiving support from healthcare professionals, family, friends, and their wider community following perinatal loss. Six women were interviewed about how the intersections of race, religion, culture, and societal factors influenced their experiences of accessing support following the loss of their babies. The first theme relates to how dominant medicalised and sociocultural narratives strengthened a cycle of silence surrounding perinatal loss, where the second theme refers to professionals' responsibility to advocate for women's needs, though women's experiences of poor and occasionally clinically negligent care, and the harmful implications of their experiences upon future help-seeking behaviour. The final theme relates to the significance of compassionate support, alongside women finding connection through shared experiences of loss and to their religious and spiritual identity. The final chapter is a press release providing a summary of the two prior chapters and is suitable for a public audience.

All names and identifying features have been removed to ensure confidentiality.

Dedication

This thesis is dedicated to the courageous women who lived and shared their stories with me and to their beautiful babies waiting in heaven for them. Zara, Alayna, Sofia, Amira, Leila, and Sara, I am eternally grateful for you putting your trust in me, in the understanding that sharing your stories may support other women to receive the support that you so deserved to receive following the loss of your babies.

Acknowledgments

To my beautiful family, Mum, Dad, James, and Dom. I cannot thank you enough for always believing in me, especially when I didn't, and for being there for me every step of the way. Mum, I am eternally grateful for your kindness and encouragement, and for always checking in on me.

Dom, you've put up with endless nights of me showing more attention to my beloved Mac. Thank you for reminding ("nagging") me to take a much-needed break to spend time with you and Luna!

To all my friends, thank you for just being you, for providing me with endless love and laughter, and for keeping me balanced when I needed it the most. Chloe, thank you for always being my biggest cheer leader, your support means everything to me.

I would like to say a huge thank you to all of my supervisors who have supported me to grow over the past three years. Sam, your passion and encouragement has been instrumental in my interest for working within perinatal mental health, thank you for helping me to shape this research so thoughtfully. George, thank you for holding onto hope that I would get there in the end, even when I had no idea how it would all come together! Rukhsana, your guidance in supporting me to reflect on racial equality and anti-racist perspectives has been integral to this research, I am so appreciative of your honesty, time, and patience in supporting me to make sense of women's stories. Chris, thank you for all your meta-analysis guidance along the way.

To all the women that helped to carefully shape this research, thank you for your time, I am so grateful for your guidance. A special thank you to Asia, for always only being a text or phone call away.

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Chapter One Meta-Analysis Review: 'Effectiveness of brief psychological interventions following a traumatic childbirth to reduce maternal psychological distress'.

Abstract

Introduction

Within the maternity context, many interventions exist with the intention of preventing maternal psychological morbidity following childbirth, with one intervention commonly known as debriefing. However, the current utility of debriefing interventions to reduce maternal psychological morbidity following traumatic childbirth is unclear and inconclusive, with research reporting little or no evidence to support either positive or adverse effects (Bastos et al., 2015). Other low-cost and brief interventions include structured self-help psychoeducational material and self-directed expressive writing tasks, though these have been less researched within the maternity context.

Methodology

A search was conducted on three databases, which identified 15 papers. The meta-analysis included a range of brief psychological interventions which had the intention of supporting women following childbirth to reduce experiences of maternal morbidity, including post-traumatic stress, depression, and anxiety symptoms.

Results

When comparing all interventions, the findings revealed that interventions only reduced the severity of post-traumatic stress in the short term up to 3 months, though did not sustain

longer-term recovery in the medium to long term. Debriefing interventions mainly revealed non-significant effects, whilst self-directive expressive writing tasks showed effectiveness in reducing post-traumatic stress and depressive symptoms.

Discussion

The review adds to the existing mixed to unclear evidence about the effectiveness of debriefing interventions in reducing maternal morbidity and does not support the routine use following a traumatic childbirth. The utility of self-expressive writing tasks in reducing psychological morbidity within the maternity context, alongside the impact of variability within the studies and recommendations for future research are discussed.

Introduction

For most women and their families, giving birth to a baby is a happy occasion filled with joy and relief, with many women experiencing a positive birth. However, for a significant number of women there can be stark differences between the idealised birthing journey and the reality of giving birth, with many women encountering complications throughout their birth and experiencing it as psychologically traumatic, leading to psychological distress, known as birth trauma (Delicate et al., 2020). The experience of birth trauma has been described as *"An event that occurs during the labor and delivery process that involves actual or threatened serious injury or death to the women or her infant. The birthing woman experiences intense fear, helplessness, loss of control and horror"* (Beck, 2004, pg28), with one in three women reporting their childbirth as traumatic (Creedy et al., 2000; Soet et al., 2003).

Birth trauma can lead to harmful effects upon women's psychological wellbeing, and whilst most women do not go on to develop post-traumatic stress disorder (PTSD), it is estimated that 1-9% of women do meet the criteria for acute PTSD (Bastos et al., 2015). The causes of birth trauma are unique to each woman and seen to be *"…in the eye of the beholder*" (Beck, 2004, pg23), though, several factors are evidenced as important predictors of PTSD including previous traumatic experiences, psychological problems during pregnancy, women's subjective distress during labour, low support from healthcare staff during labour and delivery, pregnancy complications and obstetric intervention during birth (Andersen et al., 2012; Ayers et al., 2016). A traumatic childbirth can also influence women's relationships, including a lack of understanding, loss of intimacy and increased strain within intimate relationships (Delicate et al., 2018), and difficulties with the parent-infant relationship, including difficulties breast-feeding, reduced bonding, and attachment (Elmir et al., 2010; Garthus-Niegel et al., 2018).

Maternal psychological problems following birth may arise due to inadequate or incomplete processing of the birth, therefore interventions assisting women to normalise and

emotionally process their births may help to avoid the development of such morbidities (Ayers et al., 2006). Following childbirth, many interventions exist with the intention of preventing maternal psychological morbidity, with one intervention commonly known as debriefing. The term debriefing refers to a broad intervention that typically comprises a one-off session originating from Mitchell's (1983) Critical Incident Stress Debriefing (CISD), in which individuals are encouraged to talk about a stressful or traumatic event to promote emotional processing and prevent the development of acute psychological morbidity, such as PTSD (Rose et al., 2002). However, research exploring its efficacy in non-obstetric populations indicates limited effectiveness and some indication that it may increase the risk of developing PTSD (Rose et al., 2002). Within the maternity context there is great variability in how debriefing interventions have been defined and applied, with post-birth interventions employing a variety of structured and unstructured approaches, leading to confusion about their purpose and effectiveness (Rowen et al., 2007). Two main types of debriefing include psychological debriefing and postnatal debriefing (Bastos et al., 2015). Maternity debriefing provision was originally based upon psychological debriefing involving a highly structured protocol (e.g., CISD) (Mitchell, 1983) and aimed at preventing maternity morbidity. Whereas other commonly used midwife or obstetrician-led postnatal debriefing interventions are less structured and provide women with the opportunity to retell their birth story, go through their birth notes and ask questions in the days and weeks following childbirth (Meades et al., 2011). The current utility of debriefing interventions to reduce psychological morbidity following traumatic childbirth is unclear and inconclusive, with research reporting little or no evidence to support either positive or adverse effects (Bastos et al., 2015), whilst other research indicates increased symptoms and possible harm (Rowan et al., 2007). In a survey of UK hospitals, 94% reported using formal or informal services for women following a difficult birth, with 78% of these being debriefing type services (Ayers et al., 2006). Despite insufficient evidence

regarding its utility in reducing maternal morbidity, women report valuing the opportunity to have their birth story heard and validated by a midwife (Baxter et al., 2014; Rowen et al., 2017).

The inconclusive evidence appears mainly due to poor quality evidence and heterogeneity between studies (Bastos et al., 2015), with several methodological factors identified, including, unclear and unstandardised definition of the purpose of debriefing, what exactly they entail, who they are for, by whom they should be delivered and when they should be delivered. Debriefing also differs in terms of whether it's offered universally to all women experiencing a 'normal' childbirth, or targeted, to women at increased risk of maternal psychological distress (e.g., traumatic, instrumental, or emergency birth) (Sheen & Slade, 2015). Targeted debriefing following a traumatic birth may be more effective, though variability in how debriefing is offered causes confusion and poses limitations when attempting to inform practice within maternity settings (Sheen & Slade, 2015). Research specifies routine psychological debriefing after childbirth isn't supported, though other forms of unstructured postnatal discussions and listening services should continue (Bastos et al., 2015; Baxter, 2019). This is in line with the National Institute for Health and Care Excellence (NICE, 2007; 2014) maternity guidelines that do not recommend single-session high-intensity psychological interventions with an explicit focus on re-living the traumatic birth, though recommend other unstructured postnatal discussions with a maternity professional.

There may also be remit for other brief psychological interventions with the intent to prevent psychological morbidity following childbirth that differ from the traditionally used debriefing interventions, these being, structured self-help psychoeducational material and self-directed expressive writing tasks. Whilst these interventions are typically less used, researched or recognised within the maternity context, there may be a place for their use, as NICE (2014) antenatal and postnatal mental health guidelines recommend the development of cost-effective adapted psychological interventions for women in the perinatal period. Whilst these

interventions appear in their infancy, low-cost prevention packages such as psychoeducation and self-help material (on how to manage early psychological responses following childbirth) and self-directive expressive writing tasks (asking women to write about their birthing experiences) have shown advantageous findings in reducing psychological distress following childbirth (Di Blasio et al., 2015; Horsch et al., 2016; Slade et al., 2020).

Several systematic and meta-analytic reviews have assessed the effectiveness of formal debriefing interventions in the prevention of maternal psychological trauma following childbirth, focusing primarily upon Randomised Control Trials (RCT) due to their methodological high-quality (Bastos et al., 2015; Shorey et al., 2021). Whilst RCT's are classified as the gold standard, by including both randomised and non-randomised studies, the current meta-analysis extends the existing literature base by evaluating a greater variation of quality studies and including other non-traditional psychological interventions following childbirth. The primary aim of this meta-analysis was to systematically evaluate and update the literature base following Bastos et al. (2015) Cochrane review, by exploring how varying afterbirth interventions have been implemented to reduce maternal psychological morbidity following a traumatic childbirth.

To understand the effectiveness of afterbirth interventions in reducing maternal psychological morbidity, as compared to standard postnatal treatment as usual, the below questions were asked through subgroup analyses. These being:

1. The effectiveness of the different types of intervention procedures (cognitive-behavioural counselling, group counselling, postnatal debriefing, psychological debriefing, self-directive task).
2. The effectiveness of the study design (randomised or non-randomised).
3. The effectiveness of either structured or unstructured intervention procedures.
4. The effectiveness of the selected trial population (targeted or universal).

5. The effectiveness of the intervention delivery mode (individual, group or self-directed).
6. The effectiveness of the intervention frequency (multiple or single session).
7. The effectiveness of different active intervention elements (re-experiencing the birth, re-evaluating the birth, normalising the birth, and enhancing support systems).

Method

Identifying primary studies

Search of Electronic Databases

A systematic search of the literature was carried out on the 7th December 2021 using PsychINFO, Web of Science and MEDLINE[1]. The aim of the search was to obtain a comprehensive overview of the existing literature into the effectiveness of psychological interventions following childbirth to reduce psychological morbidity (post-traumatic stress, depression, and anxiety). The search terms used to identify these studies are outlined in Table 1 below.

Table 1
Search Criteria

Construct	Free Text Search Terms	Method of Search	Limits
Population	"childbirth", "postnatal", "postpartum", "perinatal", "parturition", "antenatal", "pregnan*", "labour", "birth trauma", "traumatic birth", "distressing birth",	Free search terms Each of the three category search terms are combined with *OR*. The three categories are then combined with *AND*.	Peer reviewed articles before December 2021
Phenomena of interest (debriefing terms)	"midwife-led debriefing", "midwife intervention", "debriefing", "labour debriefing", "maternal debriefing", "psychological debriefing", "post-partum debriefing", "postnatal debriefing", "stress debriefing", "obstetric debriefing", "debriefing intervention", "crisis intervention", "childbirth review", "birth review", "birth discussion", "postnatal care", "postpartum care", "postnatal support", "postpartum support", "postnatal counselling", "postpartum counselling", "birth counselling", "birth listening", "birth reflections", "afterbirth support", "cognitive behavioural therapy", "CBT", "cognitive therapy", "psychological therapy", "trauma focused"		

[1] These databases were selected to give a good coverage of both the clinical and academic literature describing psychological debriefing interventions. A brief scoping search using CINEA was completed whilst developing the research question, though was not used in the actual analysis as it reported a minimal number of papers that were included elsewhere within the other databases

Content / disorder	"PTSD", "post-traumatic stress disorder", "depression", "psychology*", "anxiety*", "postpartum stress", "stress", "emotional distress", "mental health problems", "mental health"

Inclusion and Exclusion Criteria

In accordance with the diversity of clinical procedures that would be included within psychological interventions delivered within the maternity context, any intervention meeting the inclusion and exclusion criteria below was permitted (table 2).

Table 2

Inclusion and Exclusion Criteria

Inclusion criteria	**Exclusion criteria**	**Justification**
Type of articles:		
Articles published in English language before December 2021.	Articles published in a foreign language (i.e. not in English).	No restrictions on date were applied to the search. Time constraints and resources prevented non-English articles being translated.
Original articles reporting original empirical data. Not the following: Review articles, study protocols, systematic-reviews, meta-analysis', theoretical papers/, reviews/commentaries, clinical guidance, non-outcome focused studies.	Review articles, study protocols, critique papers and books/book chapters.	The focus is on studies including original data, these articles do not provide the data needed for this meta-analysis.
Participant focus		

Inclusion criteria	Exclusion criteria	Justification
Studies that include interventions for postnatal women following childbirth, who have given birth to a living baby, through any birthing experience.	Articles that do not provide an intervention for postnatal women following childbirth.	The focus is on addressing the effectiveness of psychological interventions delivered postnatally to reduce psychological distress.
Women who either have or haven't experienced their birth as traumatic.	Women who have not experienced childbirth	
Nature of intervention:		
Psychological intervention delivered to postnatal women following childbirth, with the aim of preventing psychological morbidity (post-traumatic stress, depression, anxiety).	Psychological interventions that do not measure at least one psychological morbidity of post-traumatic stress, depression, or anxiety	Due to the unclear definition of what exactly debriefing is, a range of psychological interventions, in different formats were included.
Interventions were not reliant upon being labelled as "debriefing" and could have been described as psychological debriefing, postnatal debriefing, critical incident stress debriefing, counselling, or cognitive therapy.	Interventions that did not have a focus upon reducing psychological morbidity following childbirth.	As above.
Other forms of psychological interventions, such as self-directive tasks, that have a focus upon reducing maternal psychological morbidity following childbirth.	As above.	As above.
Either interventions delivered to women by a facilitator or self-directed via an expressive writing task or self-help material.	No intervention delivered to women.	As above.
Psychological intervention employing various formats, including structured or unstructured protocols, different delivery modes (individual, group, self-directed) and through different facilitators (mid-wife, other obstetric professionals or self-directed by the women herself).	As above.	As above.

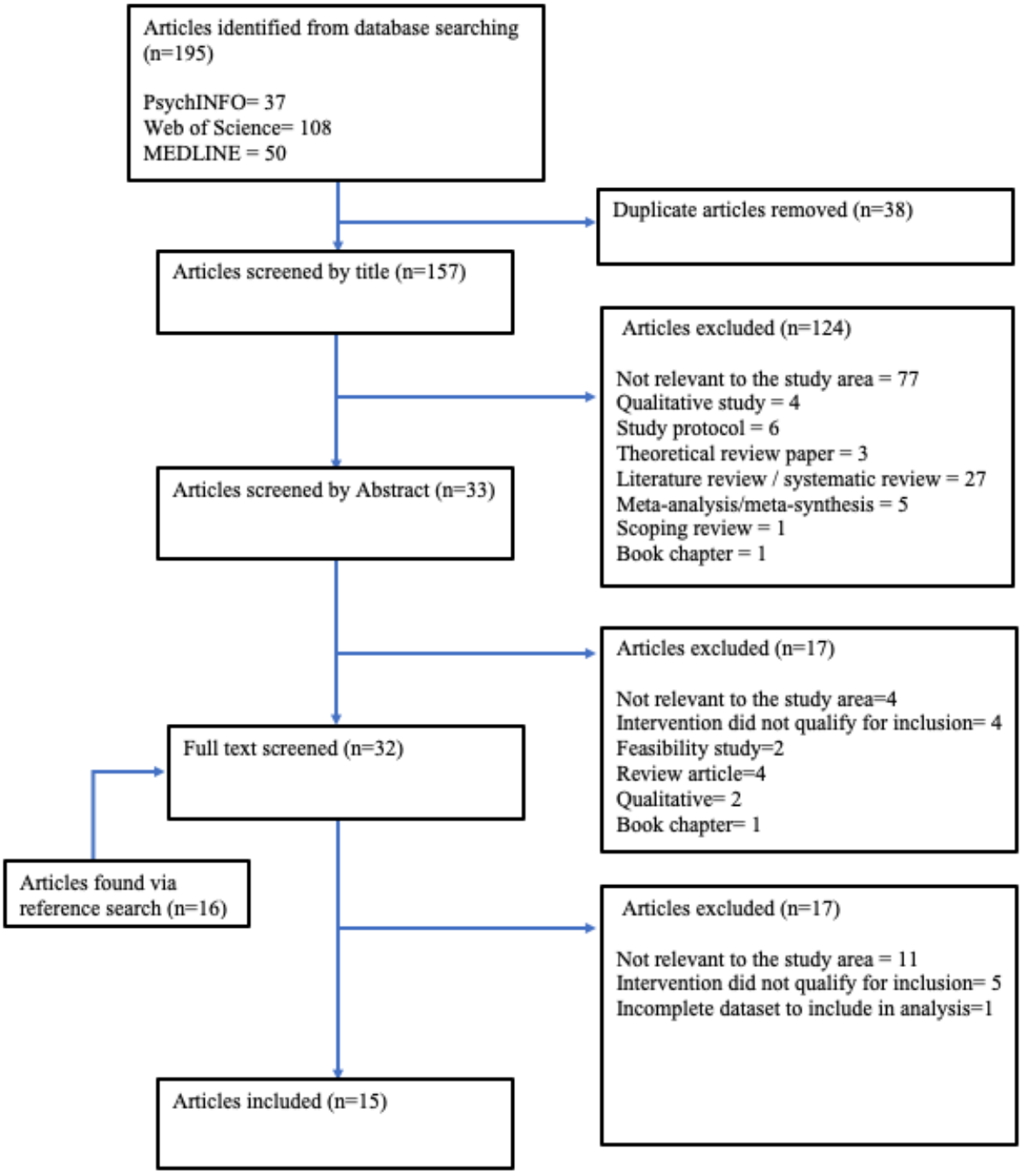
Inclusion criteria	Exclusion criteria	Justification
Studies providing a psychological intervention, consisting of 1 to 2 sessions.	Interventions that include more than 2 sessions.	Maximum of 2 sessions were included, to reflect an intervention that obstetric staff could employ within a busy job role.
The intervention must be compared to another comparator, which could be another intervention or treatment as usual.	Psychological interventions that are not compared to another intervention or treatment as usual.	Articles must include a control group to compare effectiveness.
Outcome data		
Studies that measure psychological components of distress, including post-traumatic stress, depression, and different constructs of anxiety (e.g., anxiety, fear of childbirth).	Articles that do not measure one of the following psychological components of distress: post-traumatic stress, depression, and different constructs of anxiety (e.g., anxiety, fear of childbirth).	These are the common psychological constructs that are evaluated and have been included to allow comparison across different studies.
The studies are required to report either Means and Standard Deviations, or F- Test statistics, Cohen's d effect size or an r effect size.		To ensure that outcomes can be calculated into an effect size.
Timing of outcome assessment		
Timing of the outcome assessments postpartum were categorised as short term (up to three months), medium term (three to six months) and long term (more than six months).	Articles that do not provide the assessment time period.	Timings reflect the onset and duration of clinical features of PTSD symptoms and reflect those used in within two Cochrane systematic reviews of psychological debriefing, one for the general population (Rose, 2002) and another for postnatal women (Bastos et al., 2015).
Outcome Data and study design		
Studies that are either: randomised controlled trial/experiment, non-randomised controlled trial/experiment, or a before and after study.	Studies that are not randomised controlled trial/experiment, non-randomised controlled trial/experiment, or a before and after study.	This is to ensure that an effect size can be calculated and increases methodological rigour of studies included.

Inclusion criteria	Exclusion criteria	Justification
Findings presented as group data	Articles that do not present group data and only provides individual scores.	As above.

A PRISMA chart showing the results of the systematic search are presented in Figure 1**Error! Reference source not found.**. The search yielded a total of 195 articles reducing to 1 57 once duplications were removed. These articles were initially screened by title against the inclusion and exclusion criteria, with 33 then screened by the abstracts. The two most common exclusion reasons were: not offering a psychological intervention following birth (n=81) and either being a literature or systematic review article on the study area (n=27). A remainder of 16 articles were left, where following a grey literature search of the article's references, an additional 16 articles were identified for review. The full text of 32 articles were then reviewed, with 15 meeting the full inclusion/exclusion criteria and included within the review.

Figure 1

Results of the systematic search and the application of the inclusion criteria



Data extraction

All data were extracted by the author. Treatment outcome will be reported as a mean or mean difference, a standard deviation and sample-size for each of a treatment and control groups. If standard deviations for each group are not reported individually then the pooled

standard deviation may be substituted. If means, standard deviation and n-sizes are not reported then Student t or F statistics may be transformed into estimates of Cohen's d if the sample sizes are reported. Finally, if neither summary statistics nor t or F statistics are reported then effect sizes as calculated within the primary studies will be considered. Effects sizes reported in primary studies are frequently calculated from data that has been adjusted for the association with one or more covariates. Such adjustments emphasise the idiosyncratic character of the reported effect and may result in dissimilarity with the effects reported within the other primary studies. The contribution of adjusted effect size to overall heterogeneity will be examined empirically if problematic heterogeneity is identified in the random effects model.

Multiple reporting of outcomes can result from primary studies reporting multiple measures of the same outcome or reporting the same outcome measure in multiple subgroups. Where possible multiple outcomes will be combined in a single quantitative outcome using the procedures described by Borenstein et al. (2009). If this is not possible, the multiple effects will be included. Including multiple reporting of outcomes from that same study may result in a slight reduction in confidence intervals for the random effects model as the sample size of that study will be included twice.

Defining problematic variance

A study level effect is considered heterogeneous if it presents with variation from the meta-analysis synthesis that cannot be attributed to true variation in the distribution of effect in the population. Heterogeneity can result from methodological variation in the studies, measurement error or uncontrolled individual difference factors. Higgins I^2 is a commonly used measure of heterogeneity, with greater values of I^2 indicating variation in effect that cannot be attributed to true variation in the distribution of effect in the population. Intervention studies may show considerable heterogeneity in reported outcomes due to the lack of consistency in

the intervention definition and absence of standardised methods of assessment fidelity, as well as diversity of research designs used to assess efficacy. As there was considerable variation in the methodologies of the primary studies used to calculate the meta-analytic synthesis, problematic heterogeneity was defined as a Higgins I^2 value greater than 75%. This figure was chosen as intervention studies may show considerable heterogeneity in reported outcomes as stated for the above reasons. Where unacceptable or problematic heterogeneity is observed, the focus of the subsequent analyses will be upon the identification of the sources of heterogeneity between the estimates of standardised mean difference in the primary studies.

Risk of Bias Assessment

A set of quality criteria were developed to assess any risk of bias within the literature and were adapted from existing frameworks, including The Cochrane Collaboration Risk of Bias Tool (Higgins et al., 2011), and the Risk of Bias Assessment Tool for Nonrandomised Studies (Kim et al., 2013). The current framework assesses risk of bias in seven domains: selection bias, performance bias, treatment fidelity, detection bias, statistical bias, reporting bias and generalisation. The risk of bias criteria is described in Table 3 .

Table 3

Domains of risk of bias and the criteria for ratings of low, unclear, or high risk

Domain	Details	Risk of Bias
Selection Bias	Bias can emerge in the selection period of research through unrepresentative or idiosyncratic sampling or through assigning participants to intervention or control group without randomisation. Randomisation can be random, pseudo-randomised or not randomised. Participant characteristics should be reported, and representative of the population being assessed. For example, recruiting from low-risk mothers who have not experienced birth trauma, when wanting to generalise the findings to women who have experienced birth trauma. Randomisation procedure should be reported and clearly described (e.g., allocation concealment / random sequence generation).	High Risk Participants are not randomised to groups. Participant characteristics are not reported or are highly idiosyncratic. Includes an unacceptable level of non-response rate (reporting less than 30% of the data). Unclear Risk Recruitment process / Randomisation procedure Is unclear or not reported. Participants are pseudo-randomised, or convenience sampling was used. Participant characteristics are reported but are idiosyncratic. OR the participant characteristics are not clearly reported (e.g., country, setting, location, population demographics). Non-response rate is not reported Low Risk

Domain	Details	Risk of Bias
		Participants are randomised to groups and randomisation process is reported. Participant characteristics are reported and representative of the target population. There may be some reassurance that there is no evidence of selection bias. Non-response rate is reported and of an acceptable level (set at 50%).
Performance Bias	Refers to systematic differences between/within groups in the participants motivation to complete the study. Participants' or facilitators' awareness of participant experimental allocation may bias the findings. 'Blinding' participants/facilitators to the experimental allocation can help to control for this. However, due to the nature of the type of psychological intervention offered, it is not possible to blind women or the facilitators delivering the intervention in all studies.	High Risk: Blinding is absent or not reported. Participants were told which intervention group/what questionnaires they were completing and why, along with any proposed hypotheses for the research. Participants were rewarded for their participation in the study. Responses are not confidential or anonymous. Unclear Risk: Either participants or facilitators are not blinded. It is unclear how much information was provided to the participant prior to taking part in the study. It is not clear if participants were rewarded for their participation (e.g., motivation to respond in a certain way). The study does not report levels of confidentiality and anonymity. Low Risk: Participants & facilitators are blinded to the experimental allocation. Information and procedures are provided in a way that does not differentially motivate women's involvement. For example, women were not rewarded for their participation in the study. Study reports levels of confidentiality and anonymity.
Treatment Fidelity	Poor treatment fidelity can affect the generalisability of research findings. The researchers must report that they have attempted to ensure that the intervention procedure is representative of a form of psychological intervention following birth. The content and procedure of the intervention should be reported. The researchers should also make efforts to measure and report the treatment fidelity e.g., through independent assessment of the interventions. Facilitators should be appropriately trained in the psychological intervention. Was the intervention sufficiently well described that it could be replicated? Did the actual intervention delivered correspond to intended treatment? Were procedures in place to assess the fidelity of the administered intervention? Is it reasonable to consider that the intervention (or exposure or experimental manipulation) would obtain the intended result?	High Risk: Psychological intervention procedure is not reported. Treatment fidelity is not reported. Professionals facilitating the intervention are not reported or their training is not reported/inappropriate. Unclear Risk: Psychological intervention procedure may be reported, but procedure may be unclear or not detailed enough. Treatment fidelity is undertaken but not described. Training of facilitators is not reported. Low Risk: Psychological intervention procedure is clearly reported. Indication that the intervention was delivered as described in the protocol. Treatment fidelity is assessed and reported. Facilitators are appropriately trained in the form of psychological intervention offered.
Detection Bias	Detection bias refers to whether the design of the study is optimised to detect the effectiveness of interventions reducing psychological distress following childbirth. The researchers' processing/reviewing participant outcomes and awareness of experimental condition may lead to bias. 'Blinding' of these researchers can control for this. There is a hierarchy of study designs based on the likelihood that the null hypothesis can be	High Risk: Researchers are not blinded, or blinding is not reported. The study design was cohort analytic or weaker. Information regarding the outcome measures are not reported. The outcome measures were implemented differently across participants. The outcome measures used had poor reliability and validity reported e.g., Cronbach's Alpha < 0.6. and/or test/retest reliability < 0.6. Only using one dimension/ subscale of the scale or separating the subscales/ dimensions in the analysis. Unclear Risk: The research question is unclear. Blinding is not reported or unclear. The study design is controlled clinical trial.

Domain	Details	Risk of Bias
	rejected. For this review only the following designs will be considered (in order of their place in the hierarchy): 1. Randomised controlled trials, 2. Controlled clinical trial. 3. Cohort analytic (two groups pre/post). Are the scales included reliable?	Information regarding the outcome measures is either not reported or not clearly reported e.g., definition, validity, reliability. Cronbach's Alpha for outcome measures is between 0.6 and 0.7. Test-retest reliability for outcome measures is between .6 and .7 It is not clear if the measures were implemented consistently across all participants. Low Risk: Outcomes are blindly rated. Individuals are blinded to the experimental condition. The study design is randomised controlled trial. The outcomes are clearly defined, valid and reliable, and are implemented consistently across all participants.
Statistical Bias	Bias resulting from the (inappropriate) statistical treatment of the data. Appropriate analyses selected to analyse data and to manage impact of attrition. Intention-to-treat (ITT) analysis is used. If ITT has not been used, methods for inputting missing data are made clear. Bias may also result from completer only analysis. Completer analysis refers to treatment outcome analyses in which only individuals who completed the debriefing intervention are included. Assuming that people who drop out of treatment early do not respond as well as those who remain in treatment, completer analyses may overestimate the efficacy of a particular treatment. Has the data been reported raw or has it been corrected/manipulated/transformed in some way before reporting? For example, regression, covariate techniques to control for nuisances.	High Risk: Statistics were not reported. Wrong statistical test was used and not appropriate for the study design. Attrition rate – data loss is reported at analysis at an unacceptable level (30%). Completer analysis used, instead of intent to treat. Unclear Risk: Attrition rate – either low attrition rate or data loss is not reported at analysis and is therefore unclear. Not clear if completer analysis or intent to treat was used. Unclear what statistical test was used. OR Appropriate statistical test was used, but the statistic cannot be transformed into a Pearson's value. Confidence intervals or exact p-values for effect estimates were not reported and could not be calculated. Low Risk: Appropriate statistical testing was used. Intent to treat analysis has been used. The study has reported a Pearson's value, or the statistic can be transformed into a statistical equivalent. Confidence intervals or exact p-values for effect estimates were given or possible to calculate. No, or very low attrition rate – data loss is reported at analysis at an acceptable level (50%).
Reporting Bias	Selective reporting of findings can lead to bias favouring the experimental condition. Good quality studies should report all findings reported in the study's method. Lower quality studies reporting of data requires some manipulation/translation before getting it into the review, where important information is not reported, or where reporting obscures the meaning of it. This should include outcome data for each main outcome, including attrition and exclusions from the analysis (and reasons reported), the numbers in each intervention group (compared with total randomised participants), and any reinclusions in analyses for the review.	High Risk: Not reported full outcome measures that are stated in the method section/ reported only a subsample of results/only significant results/ not reported the measure as it should be (e.g., HAD should report separate subscale not total them). Attrition rates is not reported. Unclear Risk: Not all descriptive and/or summary statistics are presented. There is a description (narrative) in the results but do not record statistics. Reported more than one correlation. Attribution rates are reported, but reason of attrition/exclusion is unclear/not reported. Low Risk: Reported all results of measures as outlined in the method. Attrition/exclusion rates are reported, along with reasons
Generalisation	The generalisability of the study refers to how confident we can be that the results of the research are applicable to the wider population they are meant to represent. Small samples and participants taken from an unrepresentative group (e.g., students) can create bias. Generalisability describes the extent to which research findings can be applied to settings	High Risk: High percentage (over 80%) of sample is from an unrepresentative population or not reported, so cannot be generalised to the wider population. The sample size (n<20) is not adequate to detect an effect. A sample size justification, estimate and power analysis are not reported. Unclear Risk:

Domain	Details	Risk of Bias
	other than that in which they were originally tested. This can relate to any differences between the study participants and those persons to whom the review is applicable.	Sufficient sample for generalisation (n> 20) but with some idiosyncratic features. A sample size justification, estimate and power analysis are not provided. Low Risk: Sufficient sample for generalisation and representative of target population. Women who have experienced a high-risk birth (e.g., traumatic birth). A sample size justification, estimate and power analysis was provided. The sample size is adequate to detect an effect. Sample n> 20 with no idiosyncratic features.

The application of these criteria are reported in Figure 2, with each study rated low, unclear, or high risk across the seven domains. Figure 2 also contains the "quality score"[2].

Figure 2

Ratings of risk of bias

Study.name	Selection.Bias	Performance.Bias	Treatment.Fidelity	Detection.Bias	Statistical.Bias	Reporting.Bias	Generalisability	Overall.Quality.Score	Overall.Quality.Index
Addollahpour et al (2019)	Unclear risk	High risk	High risk	Low risk	Unclear risk	Unclear risk	Unclear risk	36	82%
Addollahpour et al (2019)	Unclear risk	High risk	High risk	Low risk	Unclear risk	Unclear risk	Unclear risk	36	82%
Asadzadeh et al (2020)	Low risk	High risk	Unclear risk	Unclear risk	Unclear risk	Low risk	Unclear risk	38	86%
Asadzadeh et al (2020)	Low risk	High risk	Unclear risk	Unclear risk	Unclear risk	Low risk	Unclear risk	38	86%
Asadzadeh et al (2020)	Low risk	High risk	Unclear risk	Unclear risk	Unclear risk	Low risk	Unclear risk	38	86%
Di Blasio & Ionio (2002)	High risk	High risk	High risk	High risk	Unclear risk	High risk	High risk	21	48%
Di Blasio et al (2015a)	High risk	High risk	Unclear risk	Unclear risk	Unclear risk	Unclear risk	High risk	24	55%
Di Blasio et al (2015a)	High risk	High risk	Unclear risk	Unclear risk	Unclear risk	Unclear risk	High risk	24	55%
Di Blasio et al (2015b)	High risk	High risk	High risk	High risk	Unclear risk	Unclear risk	High risk	22	50%
Di Blasio et al (2015b)	High risk	High risk	High risk	High risk	Unclear risk	Unclear risk	High risk	22	50%
Gamble et al (2005)	Low risk	High risk	Unclear risk	Unclear risk	Unclear risk	Low risk	Unclear risk	38	86%
Horsch et al (2016)	Unclear risk	High risk	Unclear risk	Unclear risk	Unclear risk	Low risk	Unclear risk	37	84%
Horsch et al (2016)	Unclear risk	High risk	Unclear risk	Unclear risk	Unclear risk	Low risk	Unclear risk	37	84%
Horsch et al (2016)	Unclear risk	High risk	Unclear risk	Unclear risk	Unclear risk	Low risk	Unclear risk	37	84%
Horsch et al (2016)	Unclear risk	High risk	Unclear risk	Unclear risk	Unclear risk	Low risk	Unclear risk	37	84%
Kershaw et al (2005)	Unclear risk	High risk	High risk	High risk	Unclear risk	High risk	Unclear risk	33	75%
Kershaw et al (2005)	Unclear risk	High risk	High risk	High risk	Unclear risk	High risk	Unclear risk	33	75%
Kershaw et al (2005)	Unclear risk	High risk	High risk	High risk	Unclear risk	High risk	Unclear risk	33	75%
Kershaw et al (2005)	Unclear risk	High risk	High risk	High risk	Unclear risk	High risk	Unclear risk	33	75%
Lavender et al (1998)	High risk	High risk	High risk	High risk	Unclear risk	Unclear risk	High risk	32	73%
Lavender et al (1998)	High risk	High risk	High risk	High risk	Unclear risk	Unclear risk	High risk	32	73%
Meades et al (2011)	High risk	High risk	High risk	Unclear risk	High risk	High risk	Unclear risk	22	50%
Meades et al (2011)	High risk	High risk	High risk	Unclear risk	High risk	High risk	Unclear risk	22	50%
Ryding et al (2004)	High risk	High risk	High risk	High risk	Unclear risk	Unclear risk	Unclear risk	33	75%
Ryding et al (2004)	High risk	High risk	High risk	High risk	Unclear risk	Unclear risk	Unclear risk	33	75%
Ryding et al (2004)	High risk	High risk	High risk	High risk	Unclear risk	Unclear risk	Unclear risk	33	75%
Selkirk et al (2006)	High risk	High risk	High risk	Unclear risk	Unclear risk	High risk	High risk	22	50%
Selkirk et al (2006)	High risk	High risk	High risk	Unclear risk	Unclear risk	High risk	High risk	22	50%
Selkirk et al (2006)	High risk	High risk	High risk	Unclear risk	Unclear risk	High risk	High risk	22	50%
Slade et al (2020)	Unclear risk	High risk	Unclear risk	Unclear risk	High risk	Unclear risk	Unclear risk	35	80%
Slade et al (2020)	Unclear risk	High risk	Unclear risk	Unclear risk	High risk	Unclear risk	Unclear risk	35	80%
Slade et al (2020)	Unclear risk	High risk	Unclear risk	Unclear risk	High risk	Unclear risk	Unclear risk	35	80%
Small et al (2000)	Unclear risk	High risk	High risk	High risk	Low risk	Unclear risk	Unclear risk	35	80%
Small et al (2006)	Unclear risk	High risk	High risk	High risk	Unclear risk	Unclear risk	Unclear risk	34	77%

Note. Red indicates high risk of bias, amber marks an unclear risk of bias and green is a low risk of bias.

Selection Bias

Two studies were rated as low, five as unclear and eight as high risk. Low-risk studies were both RCT's, included women experiencing a traumatic birth, detailed participant

[2] Calculated by awarding two points for each area of bias rated as "low risk" and one point for each area of bias rated as "unclear risk". The sum of points awarded for risk of bias is then expressed as a percentage of the maximum number of points a study could have scored.

characteristics and outlined a suitable randomization method (Asadzadeh et al., 2020; Gamble et al., 2005). For unclear risk studies, participant characteristics were either incomplete or not reported, there were noticeable participant characteristic differences across the treatment and control group, vague explanations of the randomization process, alongside birthing experiences not explicitly classified as traumatic (preterm babies within the NICU or operatively delivered by caesarean section, forceps, vacuum). High-risk studies included women with unclear birthing experiences or no evident experience of trauma, unclear or unreported participant characteristics and either a non-randomized sample or randomization by an unclear or flawed method.

Performance Bias

Performance bias was overwhelmingly poor, with all studies rated as high-risk. Due to the nature of the psychological interventions being delivered following birth, blinding women and/or facilitators to the intervention group was either not possible, or there was no reference to whether blinding was implemented.

Treatment Fidelity

Five studies were rated as unclear, and ten studies rated as high. High-risk studies either did not provide the treatment protocol, or provided a vague treatment outline or therapeutic approach preventing accurate replication, with none assessing treatment fidelity, and only two detailing appropriate training and/or supervision of the facilitators (Addollahpour et al., 2019; Kershaw et al., 2005). Unclear-risk studies reported key elements of the intervention and reference to appropriate facilitator training and/or supervision, and whilst two reported methods to monitor women's adherence to the intervention, approaches did not appear reliable in monitoring task fidelity (Di Blasio et al., 2015a; Horsch et al., 2016).

Detection Bias

One study was rated as low, seven rated as unclear and seven were rated as high. The low-risk study reported double blinding of the outcome assessor and data analyser of the intervention, and adequate reliability and validity ratings of outcome measures (Addollahpour et al., 2019). For unclear studies, single or double blinding was either not used or not reported, or the reliability and validity of outcomes were not reported, whilst for high-risk studies, there was no mention of blinding and no reliability or validity provided for outcome measures.

Statistical Bias

One study was rated as low, twelve studies as unclear and two studies as high. For the low-risk study, an intent-to-treat (ITT) analysis was used (Small et al., 2000). For unclear-risk studies it was unclear whether completer analysis or ITT analysis was used, why women dropped out of the study and how missing data was dealt with, whilst for one study, ITT analysis was used though reported an unacceptable attrition rate higher than 30% (Kershaw et al., 2005). For the first high-risk study, it was unclear what the attrition rate was, whether completer analysis or ITT had been used and what participant number was used in the analysis (Meades et al., 2011), whereas for the second, the attrition rate was 30% and whilst ITT was used, there was inappropriate randomization handling (Slade et al., 2020).

Reporting Bias

The full reporting of the outcomes was mixed, with three studies rated as low, eight as unclear and four as high-risk. The attrition rate, associated reason for data loss, and full outcome data was reported for low-risk studies, whilst for unclear studies, the attrition rate was reported, though the associated reason and how missing data was dealt with was either unclear

or not reported. For high-risk studies there was no reporting of missing data, unclear or no reason for attrition rates, unclear how missing data was dealt with, unclear how many women were in each arm of the treatment group, or what sample size had been used for analysis, in addition to insignificant findings presented and key findings omitted.

Generalisability

Ten studies were rated as unclear and five rated as high, with all studies recruiting adequate sample sizes to detect treatment effects. High-risk studies included women who had either a 'healthy' and/or 'normal' vaginal labour, a non-traumatic birth or unclear birthing experience, and may include idiosyncratic features when compared to a traumatic birth, therefore caution should be taken when generalising findings from these articles. Unclear-risk studies included women reporting either a traumatic birth or birthing experience that the author classified as including a distressing element, despite explicit reference to a traumatic birth. Studies also either didn't report sample size justification, estimates or power analysis or idiosyncratic features were reported within the participant characteristics, limiting accurate generalisation to other populations (e.g., differences in treatment/control group characteristics, an entirely Italian, French, or British sample).

Summary

Overall, there was an exceptionally high level of bias across the studies included in the meta-analysis. All studies reported at least one high-risk area of bias, with many reporting multiple areas. There was a notable high-risk of bias across studies in performance bias and treatment fidelity. Due to the low number of studies in this field, studies with medium to high-risk of bias were included. Consequently, whilst the results should be interpreted with caution, the meta-analysis offers a valuable review of the research literature as it stands currently.

Results

Post-Traumatic Stress, Depression and Anxiety

The psychological outcome measures included within this meta-analysis relate to post-traumatic stress symptoms, depression, and anxiety. Studies have commonly included these psychological constructs when evaluating how psychological interventions prevent the development of maternal psychological morbidity following a traumatic childbirth.

Post-traumatic stress, depression and anxiety were measured using a variety of outcome measures presented in table 4. Included within the anxiety outcome, are studies reporting general anxiety and fear of childbirth[3].

Table 4

Outcome measures used for post-traumatic stress, depression, and anxiety symptoms

Post-traumatic stress	Depression	Anxiety
IES-R (Creamer et al., 2003), IES (Horowitz, Wilner & Alvarez, 1979), PCL-5 (Weathers et al., 2013), PPQ (DeMier et al., 1996), MINI-PTSD (Sheehan et al., 1998), PSS-SR (Foa et al., 1993) and CAP-5 (Weathers et al., 2013).	EPDS (Cox et al., 1987), BDI (Beck et al., 1996) and HADS (Zigmond & Snaith, 1983).	HAM-A (Hamilton, 1959), HADS (Zigmond & Snaith, 1983), STAI (Spielberger, 1983) and WDEQ (Wijma et al., 1998).

Separate results are presented for post-traumatic stress, depression, and anxiety symptoms. For each outcome, an assessment of heterogeneity, influential studies and reporting biases are presented, in addition to the below subgroup analyses:

1. Impact of the study design (randomised or non-randomised),
2. Impact of the intervention procedure (cognitive-behavioural counselling, group counselling, postnatal debriefing, psychological debriefing or self-directive task),
3. Impact of either a structured or unstructured intervention,
4. Impact of the selected population type (targeted or universal),
5. Impact of the delivery mode (individual, group or self-directed),

[3] This was justified as there were not enough studies to solely analyse fear of childbirth and as this construct can be considered a type of anxiety, anxiety and fear of childbirth were combined into one anxiety outcome

6. Impact of the session frequency (multiple or single session),
7. Impact of the different active elements of the intervention (re-experiencing the birth, re-evaluating the birth, normalising the birth, and enhancing support systems).

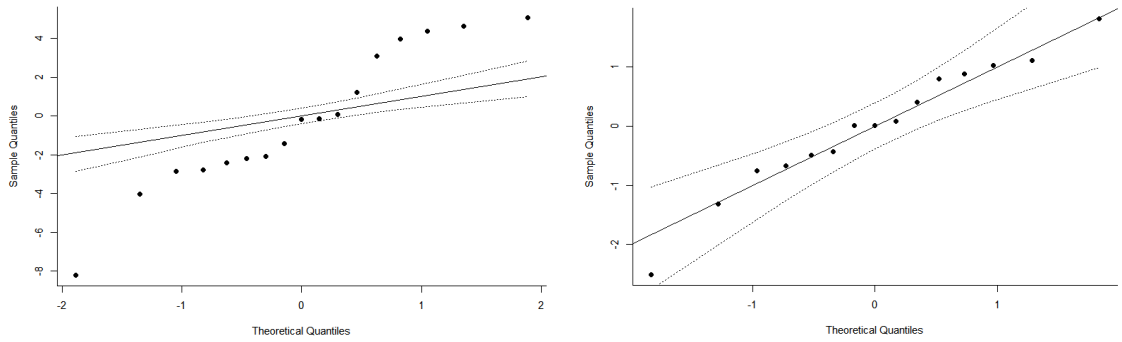
Post-Traumatic Stress symptoms

Selection of the meta-analytic model

The distribution of primary study effects is shown in Figure 3. The between studies variance (tau^2) was calculated using the DerSimonian and Laird estimator.

Figure 3

QQ plot of the distribution of efficacy of interventions within the primary post-traumatic stress studies



A B

Note. The fixed effect model is shown in panel A and the random effects model calculated using the DerSimonian and Laird estimator is shown in panel B.

Figure 3 shows clear evidence of non-linearity in the distribution of the standardised mean differences within fixed effects model; however, this nonlinearity was not apparent when using the random effects model calculated using the DerSimonian and Laird estimator. It was therefore deemed an appropriate method for the meta-analysis.

The omnibus test

The effect of psychological interventions described in the primary studies are reported in Table 5. There were 12 studies reporting a total of 1861 participants from several countries (England, Italy, France, Sweden, Iran) and whilst not all studies reported participant characteristics, the sample can be considered a cross-cultural population. Participants included women with varying birthing experiences: typical and healthy births, traumatic births, operative births, births with high levels of medical intervention and births where babies requiring time in the Neonatal intensive care unit (NICU). Studies included varying afterbirth interventions, including, cognitive-behavioural counselling, psychological debriefing (abiding to or adopting Mitchell's (1983) critical-incident stress debriefing protocol), postnatal debriefing (less structured approach providing women with the opportunity to go through birth experience and ask questions), group counselling (a group setting for women to share their birthing experiences) or self-directive tasks (expressive writing task or psychoeducation and self-help material).

Table 5

Effect of the psychological interventions in the included post-traumatic stress studies[4]

	SMD	Lower 95-CI	Upper 95%-CI	% Weight in REM
Addollahpour et al. (2019)	-2.1258	-2.5496	-1.702	6.6
Addollahpour et al. (2019)	-0.8749	-1.2303	-0.5195	6.8
Asadzadeh et al. (2020)	-1.3244	-1.7885	-0.8603	6.5
Di Blasio & Ionio (2002)	-0.7686	-1.3047	-0.2326	6.2
Di Blasio et al. (2015[a])	-0.9364	-1.3249	-0.5479	6.7
Gamble et al. (2005)	-0.4203	-0.8109	-0.0296	6.7
Horsch et al. (2016)	-0.3693	-0.8597	0.1211	6.4
Horsch et al. (2016)	-0.4212	-0.9129	0.0704	6.4
Kershaw et al. (2005)	0.2441	-0.0377	0.526	7
Kershaw et al. (2005)	0.1521	-0.1293	0.4335	7
Meades et al. (2011)	0.8161	0.3426	1.2896	6.4
Slade et al. (2020)	-0.1579	-0.5347	0.2189	6.7
Di Blasio et al. (2015b)	-0.7128	-1.0176	-0.4081	6.9

[4] There are two study entries for Addollahpour et al. (2019), Horsch et al. (2016) and Kershaw et al. (2005) as they either compared two different intervention approaches or analysed outcomes at different timings.

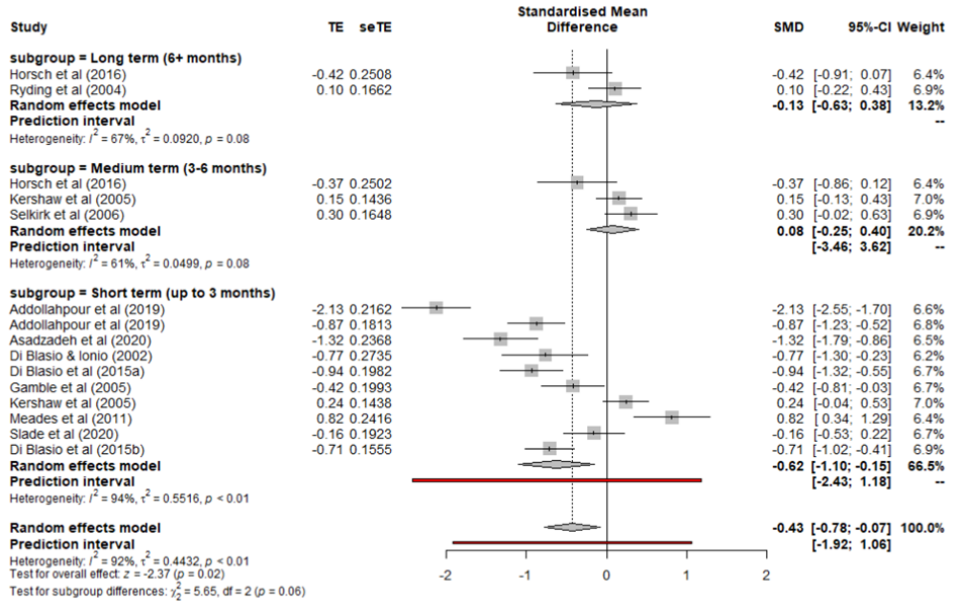
Ryding et al. (2004)	0.1028	-0.2229	0.4285	6.9
Selkirk et al. (2006)	0.3029	-0.0201	0.6258	6.9

Severity of post-traumatic stress symptoms: psychological intervention versus control group

When analysing for differences in post-traumatic stress severity between the psychological intervention and control group, a random effects models was calculated using the generic inverse variance method (figure 4). Post-traumatic stress symptom outcomes were separated into the short-term (up to 3 months from start the start of the intervention), medium (3 to 6 months after the start of the intervention) and long term (>6 months after the start of the intervention).

Figure 4

Forest plot of the standardised mean difference between interventions and treatment as usual



Note. Negative SMD scores indicates reduced psychological distress.

In the short-term (up to 3 months after the intervention), the random effects model suggested a statistically significant weighted average standardised mean difference of -0.62

and a 95% confidence interval of between -1.10 to -0.15, favouring afterbirth interventions. A treatment effect of this magnitude would be considered moderate. The following studies reported favourable differences in post-traumatic stress symptoms up to 3 months (Addollahpour et al., 2019; Asadzadeh et al., 2020; Di Blasio & Ionio, 2002; Di Blasio et al., 2015a; Di Blasio et al., 2015b; Gamble et al., 2005).

There were statistically non-significant differences in post-traumatic stress symptoms in the medium term at 3 to 6 months (SMD 0.08; 95% CI -0.25 to 0.40) and in the long-term at 6 months (SMD 0.13; 95% CI -0.63 to 0.38) after the start of the intervention.

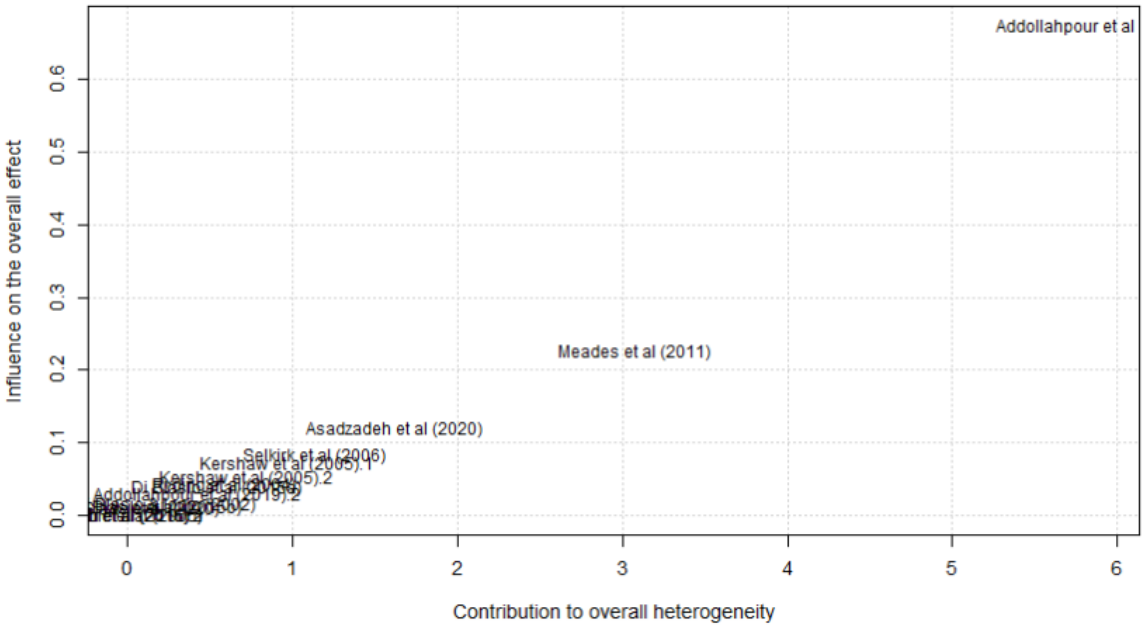
There is a high level of heterogeneity in the short-term outcomes ($tau^2 = 0.5516$, $p < 0.01$ Higgin's $I^2 = 94\%$;), suggesting that the estimates of the treatment effect within the primary studies may be biased by the presence of uncontrolled or confounding factors. Therefore, the focus of the subsequent analyses will be upon the identification of the sources of heterogeneity between the estimates of treatment effect within the primary studies.

The impact of influential primary studies

The impact of disproportionately influential studies was assessed using a "leave-one-out" analysis, in which the random effects model was calculated with each of the primary studies removed in turn and change in weighted average effect size (i.e., influence) and the change in heterogeneity (i.e., discrepancy) was recorded. The result of this "leave-one-out" analysis is presented on the Baujat plot (Baujat et al., 2002) in figure 5.

Figure 5

Baujat diagnostic plot of sources of heterogeneity



Note. The vertical axis reports the influence of the study on the overall effect and the horizontal axis reports the discrepancy of the study to the rest of the literature.

Two influential and discrepant studies were identified (Addollahpour et al., 2019; Meades et al., 2011). The random effects model was recalculated with the two studies showing disproportionate influence removed. The corrected random effects model reported a statistically significant SMD = -0.5667 (95% CI -0.975 to -0.159). The corrected random effects model evidences an approximately 8% decrease in the treatment effect relative to the uncorrected estimate, however, it should be noted that the removal of these two influential and discrepant studies does not change the substantive conclusions of the meta-analysis.

The two influential and discrepant studies were re-examined to identify risks of bias or other methodological issues that would warrant their removal from analysis, though they were retained as no issues were identified.

The effect of risk of bias in the primary studies

To assess the impact of study level risk of bias upon heterogeneity, a series of subgroup analyses were conducted on the standardised mean difference for the risk of bias ratings of "low risk" and "any risk" (i.e., unclear risk and high risk of bias combined) for each of the seven types of methodological bias. This can be seen in table 6.

Table 6

Effect of risk of bias in the primary post-traumatic stress studies

	Low Risk			Any Risk				
	EFFECT	**95% CI**	**k**	**EFFECT**	**95% CI**	**k**	**X^2**	**P**
Selection bias	-0.8633	-1.7492 to 0.0225	2	-0.3600	-0.7411 to 0.0210	13	1.05	0.3064
Performance bias	-	-	-	-0.4462	-0.8237 to -0.0688	15	-	-
Treatment fidelity	-	-	-	-0.4462	-0.8237 to -0.0688	15	-	-
Detection bias	-1.4948	-2.7206 to -0.2690	2	-0.2578	-0.5570 to 0.0414	13	3.69	0.0547
Statistical bias	-	-	-	-0.4462	-0.8237 to -0.0688	15	-	-
Reporting bias	-0.6330	-1.0800 to -0.1860	4	-0.3747	-0.8520 to 0.1026	11	0.60	0.4389
Generalisability bias	-	-	-	-0.4462	-0.8237 to -0.0688	15	-	-

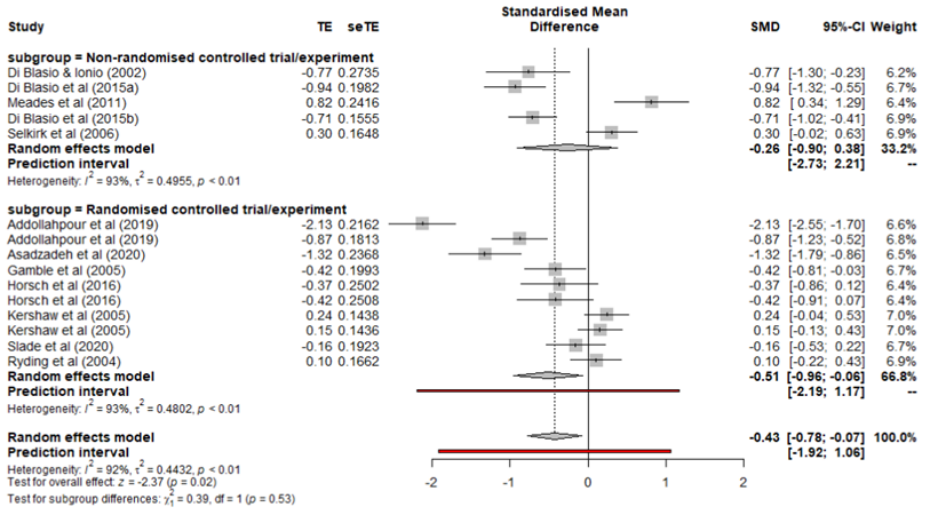
All included studies were rated as having some risk of performance bias, treatment fidelity bias, statistical bias, and generalisability bias. Therefore, the impact of these areas of risk of bias could not be evaluated. However, selection bias, detection bias and reporting bias did not evidence statistically reliable differences between risk categories.

Subgroup analyses

To further explore the impact of study level characteristics and better understand how underlying intervention components might influence the efficacy of brief psychological interventions in reducing maternal psychological morbidity, a series of subgroup analyses were conducted.

Figure 6

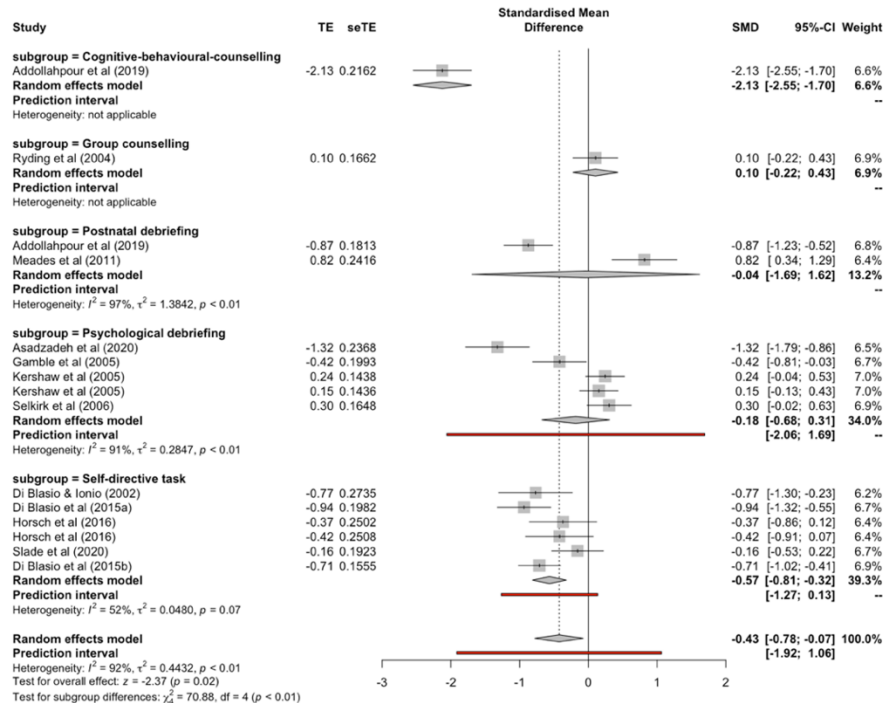
Subgroup plot of the impact of the study design (non-randomised control trial, randomised control trial) for post-traumatic stress studies



When analysing for differences in post-traumatic stress symptoms based upon the study design, there were no statistically reliable difference between randomised or non-randomised design ($X^2 = 0.39$, $p = 0.53$).

Figure 7

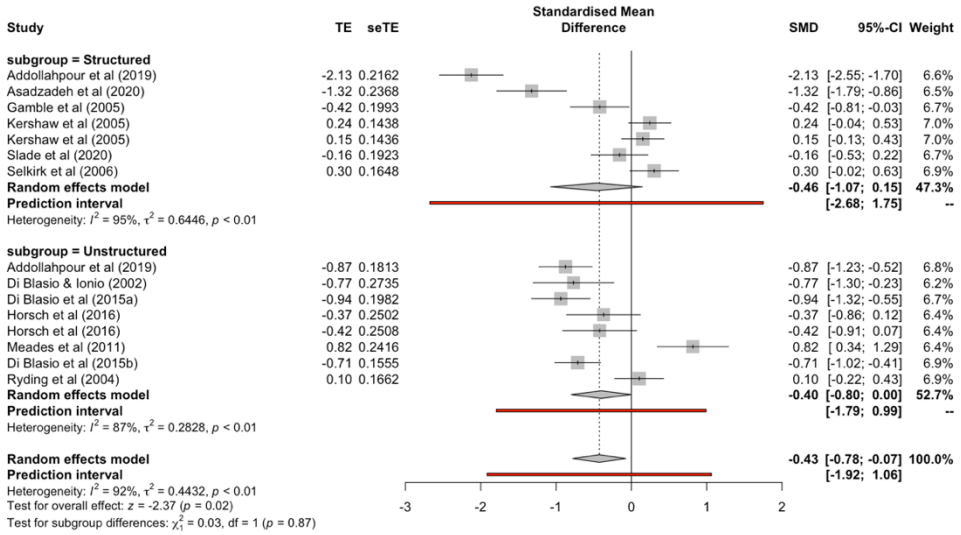
Subgroup plot of differences in intervention procedures (cognitive-behavioural counselling, group counselling, postnatal debriefing, psychological debriefing, self-directive task) for post-traumatic stress studies



A significant difference (X^2=70.88, p<0.01) was reported when comparing the different therapeutic procedures (as seen in figure 7). Nonsignificant effects were observed for group counselling, postnatal debriefing, and psychological debriefing, however, some self-directed tasks and brief cognitive behavioural counselling showed statistically reliable therapeutic gains. It should be noted that the cognitive behavioural counselling outcome is derived from a single study, which reports an extremely large effect size (SMD = 2.13). It is likely that the statistical significance and/or the size of this effect will change following the publication of new studies reporting this therapeutic procedure.

Figure 8

Subgroup plot of the intervention split by structured or unstructured approaches for post-traumatic stress studies



When analysing for differences in post-traumatic stress symptoms across structured and unstructured approaches to the intervention, there were no statistically reliable difference (X^2 = 0.03, p = 0.87; see figure 8). Structured interventions were those that followed a specific model or detailed protocol (critical-stress incident debriefing), whereas with unstructured interventions, there was no protocol and women were encouraged to freely discuss or write

about their birthing experiences and concerns, thus shaping the context of the psychological intervention.

Figure 9

Subgroup plot of differences in the trial population (targeted or universal debriefing) for post-traumatic stress studies

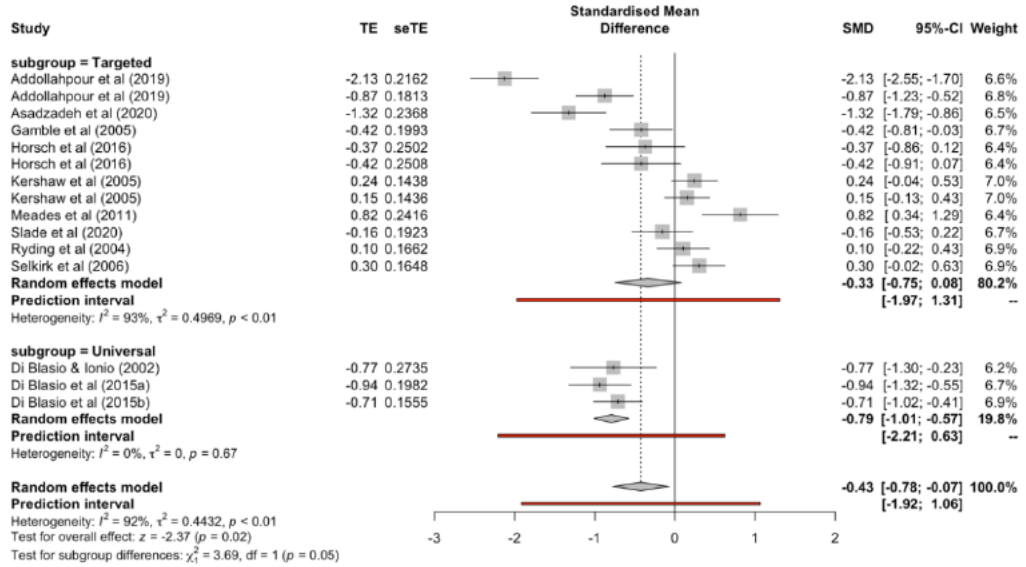


Figure 9 indicates a significant difference (X^2=3.69, p=0.05) when examining for whether the intervention was offered universally (to women who experienced a 'normal/healthy' childbirth) or targeted (to women thought to be at increased risk of maternal distress). Nonsignificant effects were observed for targeted interventions, whilst interventions offered universally showed statistically reliable therapeutic gains.

Figure 10

Subgroup plot of intervention delivery mode (individual, group, or self-directed) for post-traumatic stress studies

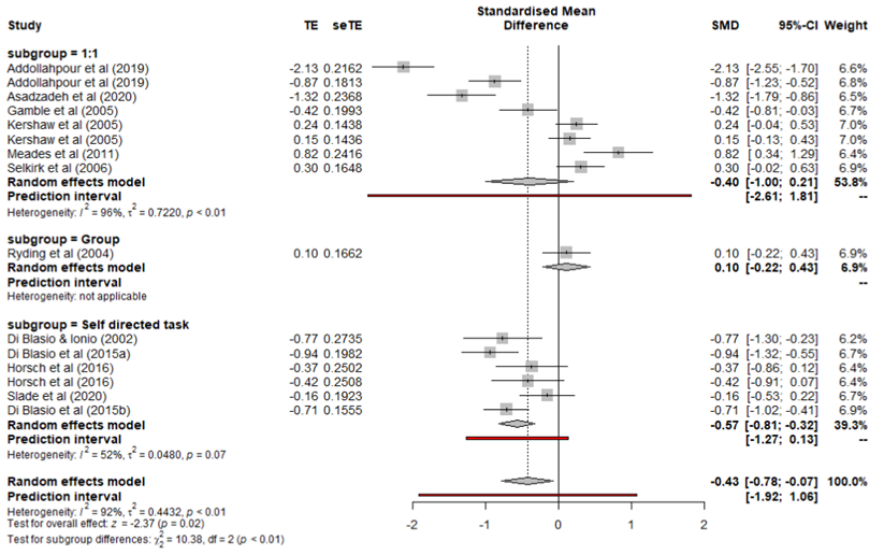


Figure 10 shows a significant difference (X^2=10.38, p<0.01) when analysing for the intervention mode of delivery. Nonsignificant effects were observed for individual (i.e., 1:1) and group debriefing delivery modes, whilst self-directed tasks showed statistically reliable therapeutic gains.

Figure 11

Subgroup plot of the frequency of debriefing sessions (multiple or single session) for post-traumatic stress studies

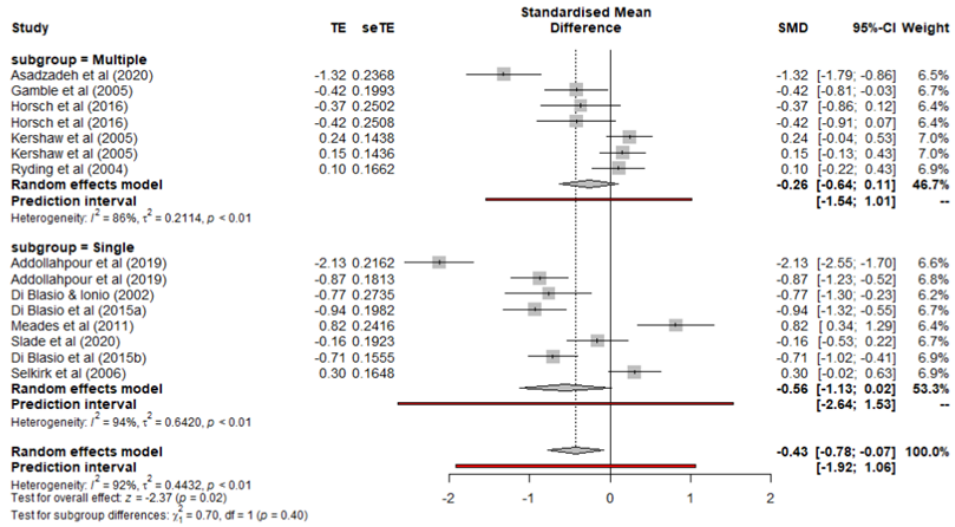


Figure 11 indicates that when analysing for the frequency of sessions, there were no statistically reliable difference between single or multiple sessions ($X^2 = 0.70$, $p = 0.40$).

To analyse whether specific intervention components had an impact upon reducing post-traumatic stress symptoms, the author grouped together and labelled common intervention components outlined in the intervention description, these were re-experiencing the birth, re-evaluating the birth, normalising the birth, and enhancing support systems. Table 7 presents effect size estimates and significance of subgroup differences, with no statistically significant differences between the active intervention elements observed.

Table 7

Effect size estimates and significance of subgroup differences for active elements of the psychological interventions for post-traumatic stress studies

	Present			Absent				
	EFFECT	**95% CI**	**k**	**EFFECT**	**95% CI**	**k**	**X^2**	**p**
Re-experiencing the birth	-0.4462	-0.8237 to -0.0688	14	-0.1579	-0.5347 to 0.2189	1	1.12	0.29
Re-evaluating the birth	-0.8855	-1.9641 to 0.1930	4	-0.2615	-0.5787 to 0.0558	11	1.18	0.28
Normalising the birth	-0.1764	-0.5882 to 0.2355	6	-0.5903	-1.0891 to -0.0915	9	1.57	0.21
Enhancing support systems	-0.2085	-0.6024 to 0.1854	6	-0.5671	-1.0914 to -0.0427	9	1.15	0.28

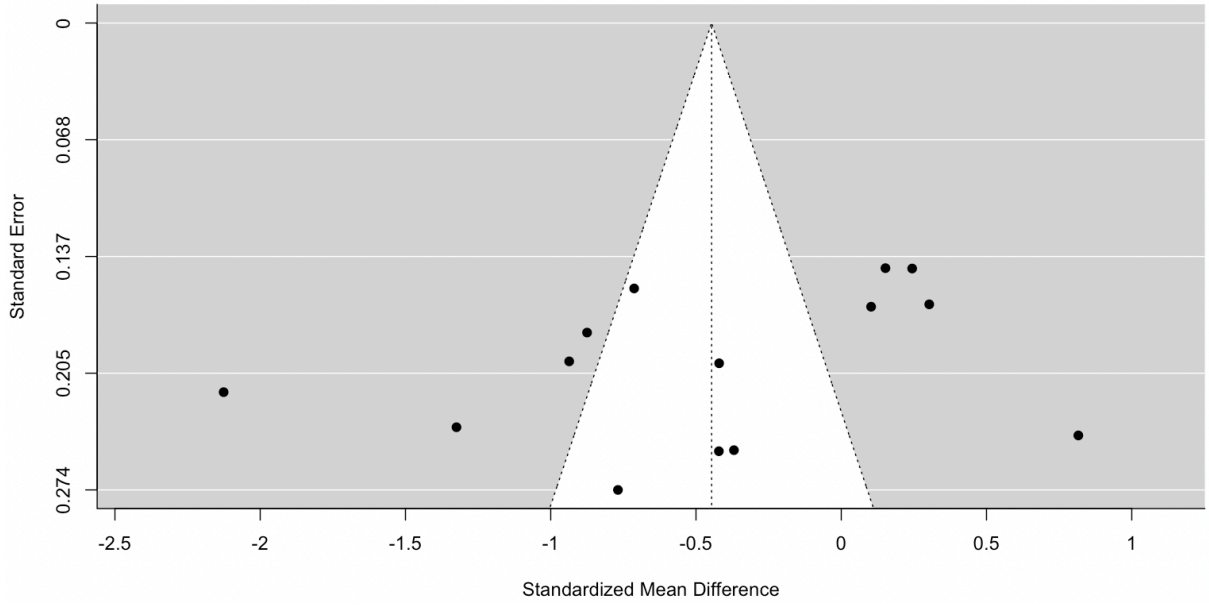
The impact of publication and small study biases

Publication bias is caused by the tendency for statistically significant results to be published and the reticence to publish papers with non-significant results. Small study bias is the tendency for studies with smaller sample sizes to show greater variability in their measurement of treatment efficacy. These biases can be identified in a funnel plot, which plots the magnitude of the study's standardised mean difference against the studies sample size (usually presented as the standard error). If there is an absence of publication bias, the effects from the studies with small sample sizes which show greater variability will scatter more widely at the bottom of the plot compared to studies with larger samples at the top which will

lie closer to the overall meta-analytic effect, creating a symmetrical funnel shape. If there is an absence of studies in the area of the plot associated with small sample sizes and non-significant results, then it is likely there is some publication bias leading to an overestimation of the true effect. The funnel plot is presented in figure 12.

Figure 12

Funnel plot of the standardised mean effect for post-traumatic stress studies



Note. The 95% confidence interval of the expected distribution of the standardised mean effect is shown as an inverted "funnel".

As can be seen from figure 12, there is clear evidence of publication bias in the distribution of treatment effects. The effect of publication bias was simulated using a trim and fill procedure (Duval & Tweedle, 2000). The trim and fill procedure builds on the assumption that publication bias would lead to an asymmetrical funnel plot. Trim and fill procedure uses an iteratively removes the most extreme small studies from the side of the funnel plot associated with positive effects, re-computing the effect size at each iteration until the funnel plot is symmetric about the (corrected) effect size. While this trimming yields the adjusted effect size, it also reduces the variance of the effects, resulting in biased and narrow confidence interval.

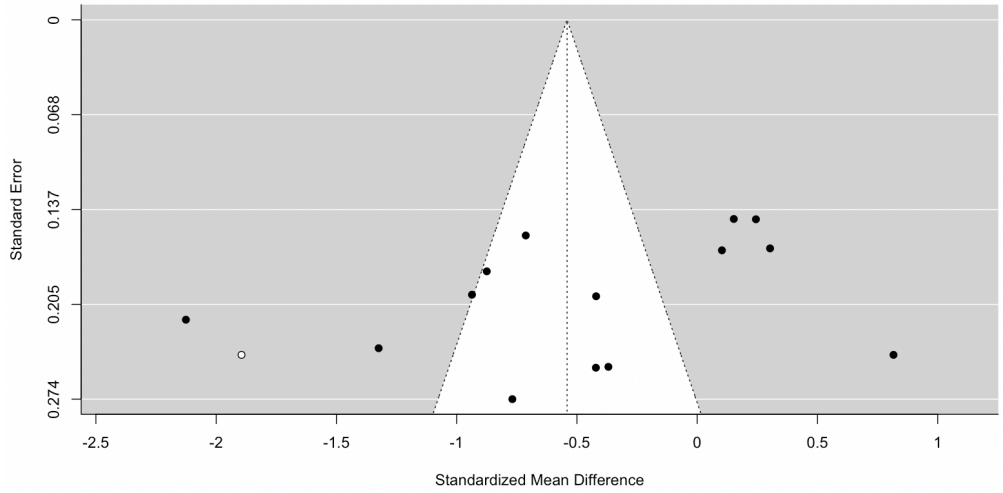
Therefore, the original studies are returned into the analysis, and the procedure imputes a mirror image for each on the side of the funnel plot associated with negative effects.

The trim and fill procedure yielded a corrected random effects model of the standardised mean effect = -0.5412 (95% CI -0.9331 to -0.1493). The corrected random effects model evidences an approximately 21.28% decrease relative to the uncorrected estimate (figure 13).

Rosenthal (1979) describes the calculation of a failsafe number; this method calculates the number of with non-significant results which would need to be included in the meta-analysis for the overall effect to be non-significant ($p > .05$). This procedure suggests that 298 studies would be required to reduce the observed standardised mean effect = -0.5412 to non-significance, suggesting that the observed standardised mean effect = -0.5412 is robust to studies missing due to publication bias.

Figure 13

Funnel plot of the corrected random effects model for post-traumatic stress studies



In the above funnel plot the observed studies are shown as dark circles (Figure 13). The omnibus estimate of the effect is -0.4462 (95%CI -0.8237, -0.0688). The imputed studies are shown as white circles, and the imputed estimate is -0.5412 95%CI -0.9331, -0. 1493). The adjusted point estimate represents a 21.27% decrease relative to the original omnibus analysis.

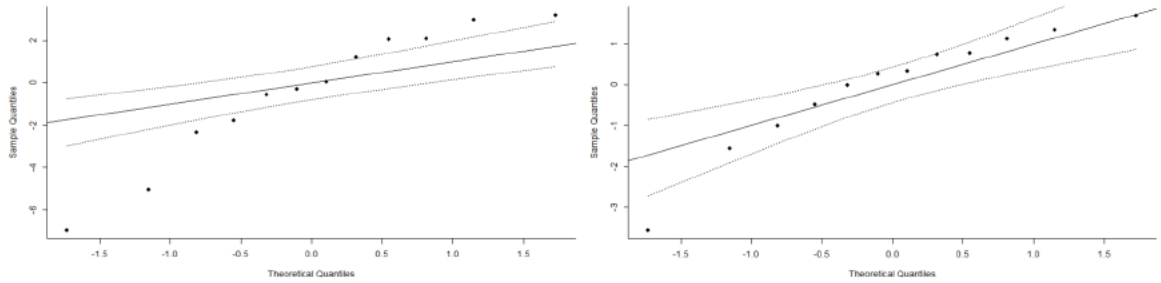
Depression

Selection of the meta-analytic model

The distribution of primary study effects is shown in Figure 13. The between studies variance (tau^2) was calculated using the DerSimonian and Laird estimator.

Figure 14

QQ plot of the distribution of efficacy of interventions within the primary depression studies



A B

Note. The fixed effect model is shown in panel A and the random effects model calculated using the DerSimonian and Laird estimator is shown in panel B.

Again, as seen from figure 14, there is clear evidence of non-linearity the distribution of the standardised mean differences within fixed effects model, however, this nonlinearity was not apparent when using the random effects model and was an appropriate method for the calculation of the meta-analysis.

The omnibus test

The effect of psychological interventions described in the primary studies are reported in table 8. There were 11 studies reporting a total of 2865 participants. Participants were recruited from several countries (Australia, England, Iran, Italy, France, Sweden) and again whilst not all studies reported participant characteristics, the sample can be considered a cross-cultural population. Women experienced varying birthing experiences, including a traumatic

birth, typical vaginal and healthy birth, operative delivery (routine or emergency), birth of a baby requiring time in the NICU, birth requiring high levels of medical intervention. Women also received a range of brief psychological interventions, including cognitive-behavioural counselling, group counselling, postnatal debriefing, psychological debriefing, or a self-directive task (expressive writing task or psychoeducation self-help material).

Table 8

Effect of the psychological interventions in the included depression studies[5]

	SMD	Lower 95-CI	Upper 95%-CI	% Weight in REM
Meades et al. (2011)	0.3913	-0.07	0.85	7.5
Small et al. (2000)	0.0787	-0.05	0.21	9.8
Small et al. (2006)	-0.0810	-0.25	0.09	9.6
Asadzadeh et al. (2020)	-1.8493	-2.35	-1.35	7.1
Di Blasio et al. (2015[a])	-0.4176	-0.79	-0.04	8.2
Horsch et al. (2016)	-0.2198	-0.71	0.27	7.2
Horsch et al. (2016)	-0.6711	-1.17	-0.17	7.1
Lavender et al. (1998)	0.5124	0.14	0.89	8.2
Ryding et al. (2004)	0.2558	-0.07	0.58	8.5
Selkirk et al. (2004)	0.1093	-0.21	0.43	8.6
Di Blasio et al. (2015b)	-0.8590	-1.17	-0.55	8.7
Slade et al. (2020)	-0.1081	-0.29	0.07	9.5

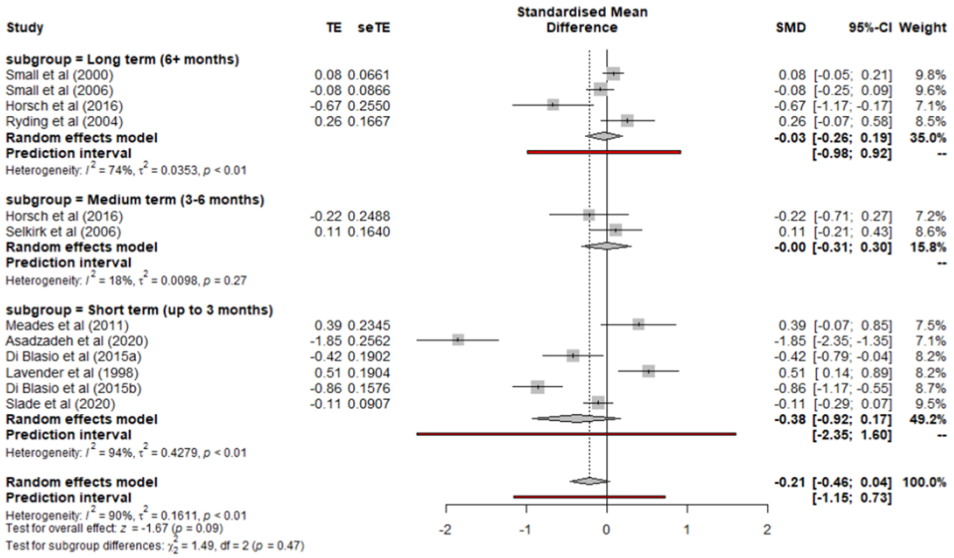
Severity of depression symptoms: psychological intervention versus control group

When analysing for differences in depression severity between the intervention and control group, a random effects models was calculated using the generic inverse variance method and is presented in figure 15. Depression outcomes were separated into short-term (up to 3 months from start the start of the intervention), medium (3 to 6 months after the start of the intervention) and long term (> 6 months after the start of the intervention).

[5] Horsch et al. (2016) is reported twice due to analysing depression at different timings.

Figure 15

Forest plot of the standardised mean difference between interventions and treatment as usual for depression studies



Note. Negative SMD scores indicates reduced depression

For the short-term outcomes, the random effects model suggested a statistically non-significant weighted average standardised mean difference of -0.38 (95%CI–0.92 to 0.17). In the medium-term outcomes there was non-significant differences in depressive symptoms (SMD -0.00; 95% CI -0.31 to 0.30), whilst in the long-term outcomes, there was a statistically non-significant difference (SMD -0.03; 95% CI -0.26 to 0.19).

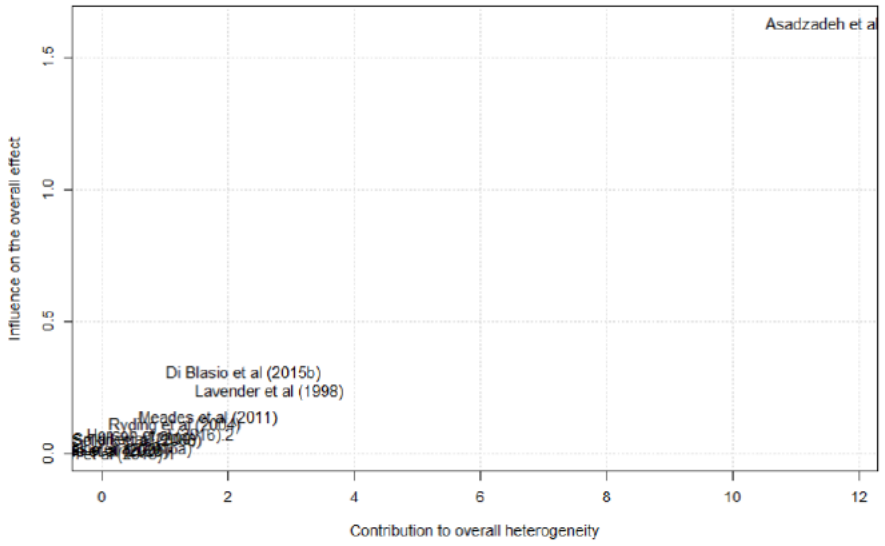
There is a high level of heterogeneity in the short-term outcomes (tau^2 = 0.4279, p < 0.01 Higgin's I^2 = 94%;), suggesting that the estimates of the treatment effect within the primary studies may be biased by the presence of uncontrolled or confounding factors. Therefore, the focus of the subsequent analyses will be upon the identification of the sources of heterogeneity between the estimates of treatment effect within the primary studies.

The impact of influential primary studies

Once again, the impact of disproportionately influential studies was assessed, with one influential and discrepant study identified, as seen in figure 16 (Asadzadeh et al., 2020). The random effects model was recalculated with the one study showing disproportionate influence removed.

Figure 16

Baujat diagnostic plot of sources of heterogeneity



Note. The vertical axis reports the influence of the study on the overall effect and the horizontal axis reports the discrepancy of the study to the rest of the literature.

The corrected random effects model reported a statistically significant SMD = -0.1096 (95% CI -0.56 50 0.34). The corrected random effects model evidences an approximately 5% decrease in the treatment effect relative to the uncorrected estimate, however, it should be noted that the removal of this influential and discrepant study does not change the substantive conclusions of the meta-analysis. The influential study was re-examined to identify issues that would warrant its removal, though it was retained as no issues were identified.

The effect of risk of bias in the primary studies

Again, a series of subgroup analyses were conducted on the standardised mean difference for the risk of bias for each of the seven types of methodological bias.

Table 9

Effect of risk of bias in the primary depression studies

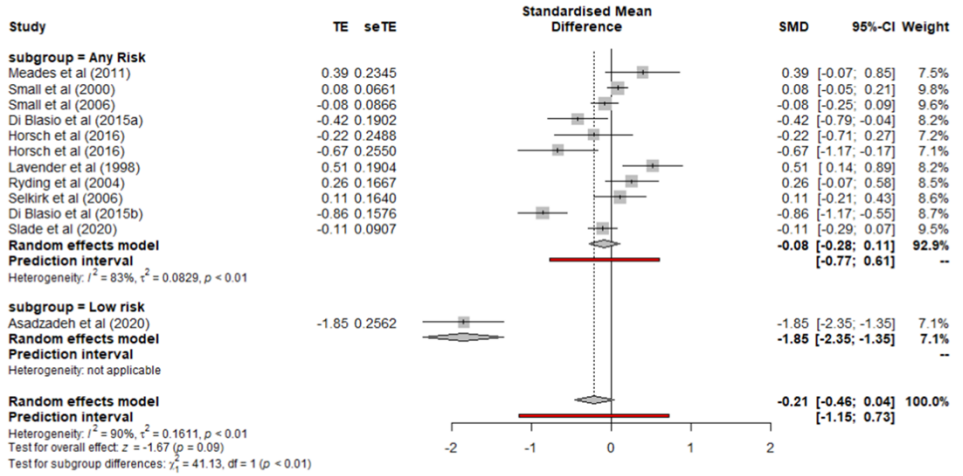
	Low Risk			Any Risk				
	EFFECT	**95% CI**	**k**	**EFFECT**	**95% CI**	**k**	**X^2**	**P**
Selection bias	-1.8493	-2.3515 to -1.3472	1	-0.0839	-0.2812 to 0.1135	11	41.13	<0.0001
Performance bias	-	-	-	-0.2122	-0.4612 to 0.0368	12	-	-
Treatment fidelity	-	-	-	-0.2122	-0.4612 to 0.0368	12	-	-
Detection bias	-	-	-	-0.2122	-0.4612 to 0.0368	12	-	-
Statistical bias	-0.0787	-0.0508 to 0.2082	1	-0.2482	-0.5436 to 0.0471	11	3.95	0.0469
Reporting bias	-0.9122	-1.8630 to 0.0387	3	-0.0264	-0.2357 to 0.1829	9	3.18	0.0746
Generalisability bias	-	-	-	-0.2122	-0.4612 to 0.0368	12	-	-

All included studies were rated as having some risk of performance bias, treatment fidelity bias, detection bias and generalisability bias (table 9). The impact of these areas of risk of bias could therefore not be evaluated.

Selection bias evidenced statistically significant different estimates of treatment efficacy, with lower levels of bias being associated with higher estimates of efficacy (figure 17). There was however only one study rated as low risk of selection bias, and as such, this difference cannot be considered robust and may likely change with the publication of future studies using improved methodological procedures.

Figure 17

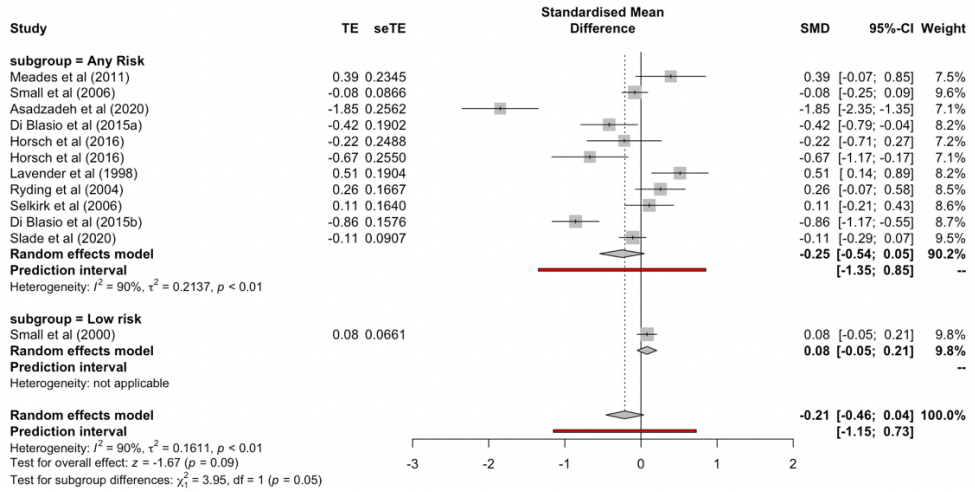
Subgroup forest plot of selection bias



Similarly, statistical bias evidenced statistically significant differences estimates of treatment efficacy, with lower levels of bias being associated with higher estimates of efficacy (figure 18). As above, only one study rated as low risk of statistical bias, and therefore this difference cannot be considered robust and may likely change with the publication of future studies using improved methodological procedures.

Figure 18

Subgroup forest plot of statistical bias



Reporting bias did not evidence statistically reliable differences between risk categories and is therefore not presented graphically.

Subgroup analyses

Again, several subgroup analyses were completed to further explore the influence of study level characteristics upon the efficacy of interventions.

Figure 19

Subgroup plot of the impact of the study design (non-randomised control trial, randomised control trial) for depression studies

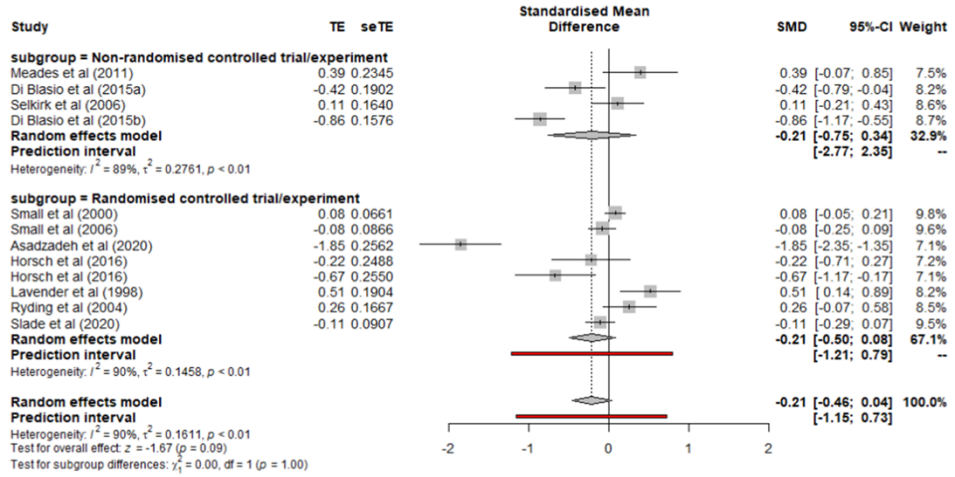
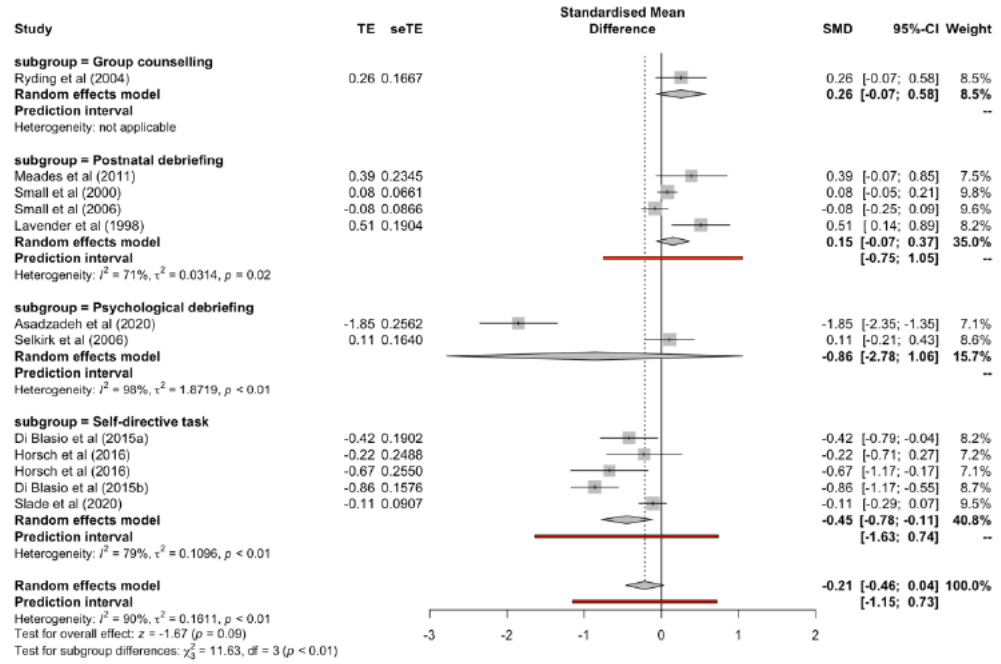


Figure 19 indicates that when evaluating for differences in study design, there were no statistically reliable difference between either randomised or non-randomised study designs ($X^2 = 0.00$, $p = 1.00$).

Figure 20

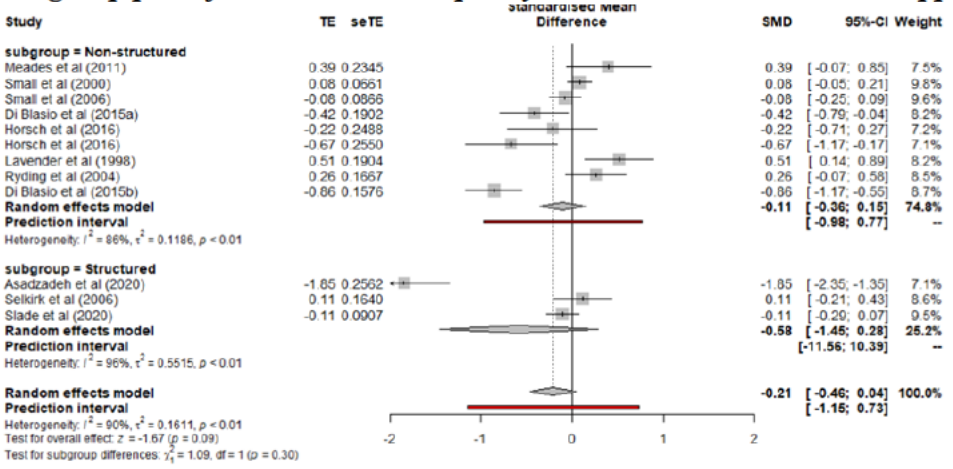
Subgroup plot of differences in intervention procedure (cognitive-behavioural counselling, group counselling, postnatal debriefing, psychological debriefing, self-directive task)



As seen in figure 20, there was a significant difference (X^2=11.63 p<0.01) between the different intervention therapeutic procedures. Nonsignificant effects were observed for group counselling, postnatal debriefing, and psychological debriefing. However, self-directed tasks showed statistically reliable therapeutic gains.

Figure 21

Subgroup plot of the intervention split by structured or unstructured approaches



When analysing for differences within the depression outcomes across structured and unstructured debriefing procedures, there was no statistically reliable difference (X2 = 1.09, p = 0.30) (figure 21).

Figure 22

Subgroup plot of differences in the trial population (targeted or universal intervention)

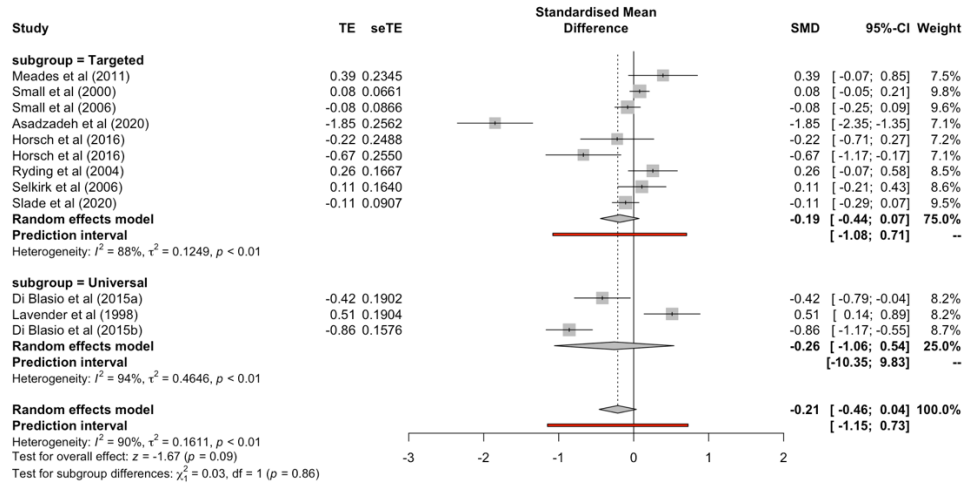
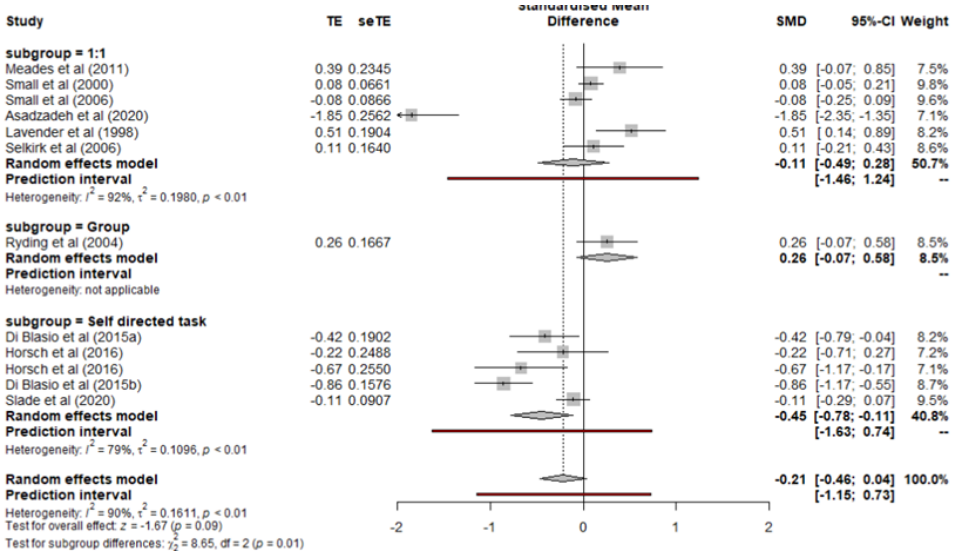


Figure 22 indicates that when examining for differences within targeted or universal intervention approaches, there was no statistically reliable difference between these types of designs (X^2 = 0.03, p = 0.86).

Figure 23

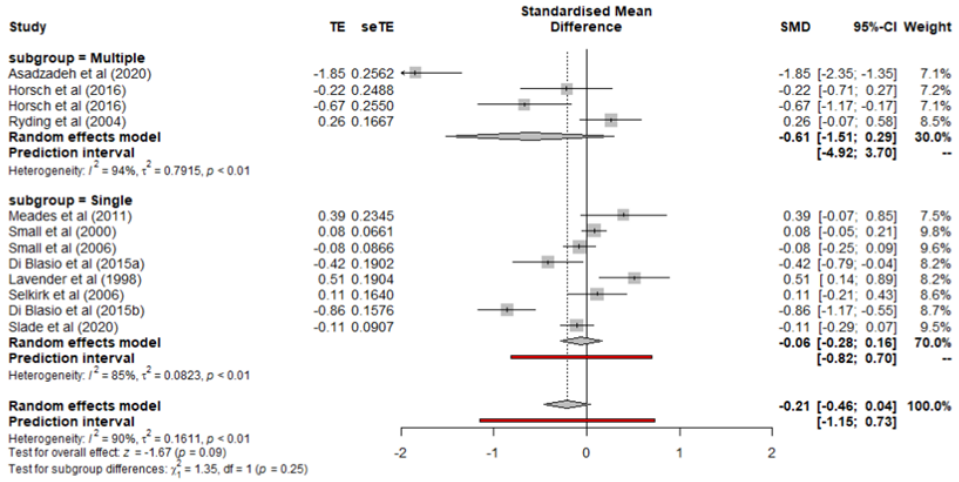
Subgroup plot of intervention delivery mode (individual, group, or self-directed task)



There was a significant difference (X^2=8.65, p=0.01) between the delivery mode of interventions (figure 23). Nonsignificant effects were observed for individual (1:1) and group debriefing approaches, however, self-directed tasks showed statistically reliable therapeutic gains.

Figure 24

Subgroup plot of the frequency of sessions (multiple or single session)



When separating for the frequency of intervention sessions, figure 24 indicates that there was no statistically reliable difference between whether single or multiple sessions were offered (X^2 = 1.35, p = 0.25).

Effect size estimates and significance of subgroup differences for active elements of the debriefing intervention are presented in Table 10. No statistically significant differences between the active elements of the psychological intervention were observed.

Table 10

Effect size estimates and significance of subgroup differences for active elements of the intervention

	Present			Absent				
	EFFECT	**95% CI**	**k**	**EFFECT**	**95% CI**	**k**	**X^2**	**p**
Re-experiencing the birth	-0.2279	-0.5180 to 0.0622	11	-0.1081	-0.2858 to 0.0697	1	0.48	0.4901
Re-evaluating the birth	-0.8601	-2.7794 to 1.0592	2	-0.1040	-0.3175 to 0.1095	10	0.59	0.4428
Normalising the birth	-0.5843	-1.4491 to 0.2806	3	-0.1050	-0.3591 to 0.1490	9	1.09	0.2974

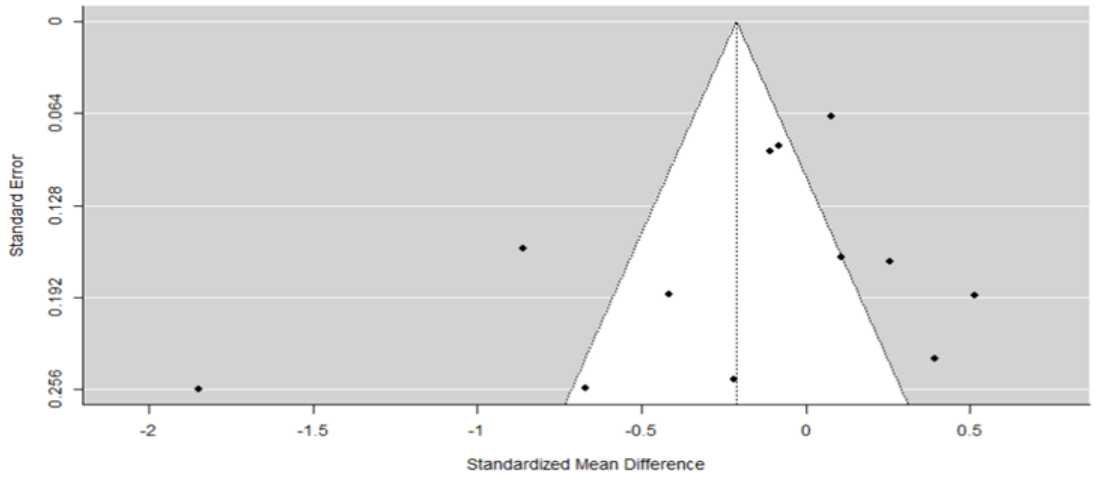
	Present			Absent				
	EFFECT	**95% CI**	**k**	**EFFECT**	**95% CI**	**k**	**X^2**	**p**
Enhancing support systems	-0.5382	-1.4464 to 0.3700	3	-0.1214	-0.3699 to 0.1272	9	0.75	0.3856

The impact of publication and small study biases

Once again, the publication bias of the included studies was analysed and presented in a funnel plot. As can be seen from Figure 25, there is clear evidence of publication bias in the distribution of treatment effects.

Figure 25

Funnel plot of the SMD



Note. The 95% confidence interval of the expected distribution of SMS is shown as an inverted "funnel".

The effect of publication bias was again simulated using a trim and fill procedure (Duval & Tweedle, 2000), yielding a corrected random effects model of SMD = -0.3419 (95% CI -0.6059 to -0.0780). The corrected random effects model evidences an approximate of 61.14% decrease relative to the uncorrected estimate.

Based upon Rosenthal (1979) procedure as previously described, 49 studies would be required to reduce the observed SMD = -0.3419 to non-significance, suggesting that the observed SMD = -0.3419 is vulnerable to publication bias and the conclusions of this meta-analysis may change with the publication of future studies.

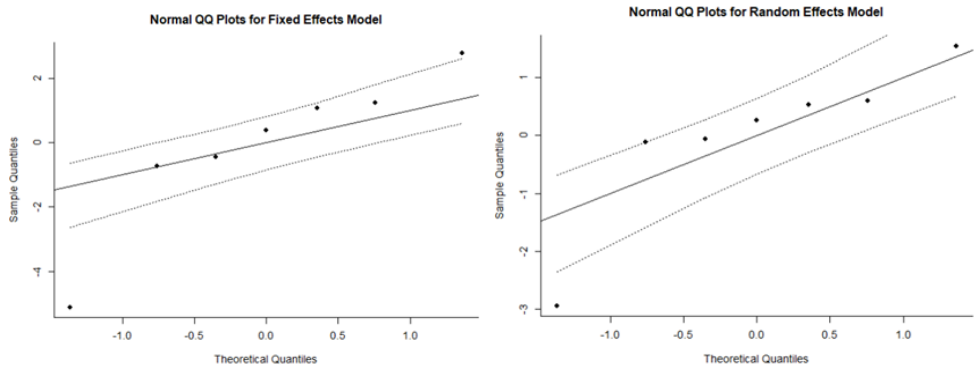
Anxiety

Selection of the meta-analytic model

The distribution of primary study effects is shown in Figure 26. The between studies variance (tau^2) was calculated using the DerSimonian and Laird estimator.

Figure 26

QQ plot of the distribution of efficacy of interventions within the primary anxiety studies



A B

Note. The fixed effect model is shown in panel A and the random effects model calculated using the DerSimonian and Laird estimator is shown in panel B.

There is little or no evidence of non-linearity in the distribution of the standardised mean difference within the primary studies (figure 26). However, 95% of the primary study standardised mean difference falls within the 95% confidence intervals for the expected normal values and therefore, the random effects model is an appropriate method for the calculation of the meta-analysis.

The omnibus test

The effect of psychological interventions described in the primary studies are reported in table 11. There were 6 studies reporting a total of 1183 participants. Women were recruited

from several countries (England, Iran, Sweden) and had experienced varying birthing experiences, including traumatic birth, typical vaginal and healthy birth, operative delivery (routine or emergency) or a labour requiring high levels of medical intervention. Women received one of the following interventions: psychological debriefing, postnatal debriefing, group counselling or engaged in a self-directive task (psychoeducation and self-help material).

Table 11

Effect of risk of bias in the primary anxiety studies

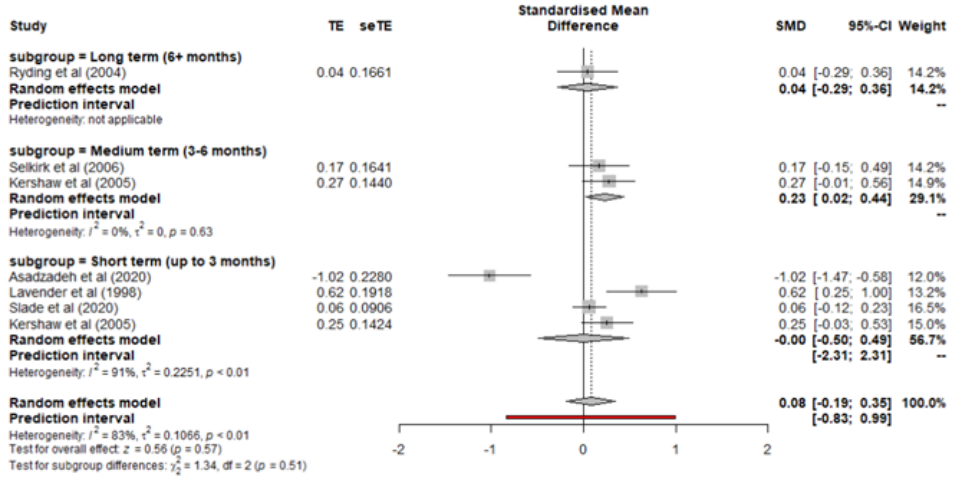
	SMD	Lower 95-CI	Upper 95%-CI	% Weight in REM
Asadzadeh et al. (2020)	-1.0224	-1.47	-0.58	12
Lavender et al. (1998)	0.6232	0.25	1.00	13.2
Selkirk et al. (2006)	0.1682	-0.15	0.49	14.2
Slade et al. (2020)	0.0567	-0.12	0.23	16.5
Kershaw et al. (2005)	0.2531	-0.03	0.53	15
Kershaw et al. (2005)	0.2745	-0.01	0.56	14.9
Ryding et al. (2004)	0.0387	-0.29	0.36	14.2

Severity of anxiety symptoms: psychological intervention versus control group

As seen in figure 27, a random effects model was calculated using the generic inverse variance method. As with the other psychological components, Anxiety outcomes were separated into the short-term, medium, and long term.

Figure 27

Forest plot of the standardised mean difference between interventions and treatment as usual



Note. Negative SMD scores indicates reduced levels of anxiety.

In the short-term, the random effects model suggested a non-significant weighted average standardised mean difference of -0.00 and a 95% confidence interval of between -0.50 to 0.49. Similarly, there were statistically non-significant differences in anxiety symptoms in the medium-term at 3 to 6 months (SMD 0.23; 95% CI 0.02 to 0.44) and in the long-term at 6 months (SMD 0.04; 95% CI -0.29 to 0.36) after the start of the intervention.

Due to the small number of six studies evaluating the anxiety outcome, a more detailed meta-analysis of this outcome measure could not be reliably completed.

Discussion

Research findings in context

This meta-analytic review aimed to evaluate whether brief psychological interventions reduced maternal psychological morbidity (post-traumatic stress symptoms, depression, anxiety) following childbirth. The analysis included 15 studies, comprising of 10 randomised and 5 non-randomised control trials from 6 countries (Australia, England, Italy, France, Sweden, Iran) and involved 3365 women in total.

When separating the findings and analysing for the impact of interventions upon reducing post-traumatic stress symptoms, analysis across time revealed that the severity was statistically lower up to 3 months after the start of the interventions. The following interventions contributed towards these significant effects: cognitive behavioural counselling, psychological debriefing, and self-expressive writing tasks (Addollahpour et al., 2019; Asadzadeh et al., 2020; Di Blasio & Ionio, 2002; Di Blasio et al., 2015a; Gamble et al., 2005; Di Blasio et al., 2015b). However, interventions did not have any significant effect upon reducing the severity of post-traumatic stress symptoms when measured in the medium (3 to 6 months) and long-term (6+ months) after the interventions. This may suggest that whilst certain psychological interventions have a favourable impact in reducing psychological trauma in the immediate term, they do not facilitate longer-term recovery beyond 3 months postpartum. When controlling for the impact of the intervention procedure, results indicated that, overall, group counselling, postnatal debriefing, and psychological debriefing did not have a significant effect upon reducing post-traumatic stress symptoms, whilst brief cognitive behavioural counselling and self-directed tasks in the form of an expressive writing tasks showed statistically favourable impacts. The self-directed expressive writing tasks (Di Blasio & Ionio, 2002: Di Blasio et al., 2015a: Di Blasio et al., 2015b: Horsch et al., 2016) were based upon Pennebaker (1997) approach, and asked women to write a brief and meaningful account of

their childbirth experiences. Whilst Slade et al. (2020) self-help psychoeducation intervention was grouped together with the self-directed interventions, which overall showed effectiveness in reducing post-traumatic stress symptoms, though when examined closer, the psychoeducation package was ineffective in reducing incidences of post-traumatic stress disorder. In line with the above result, when controlling for the delivery mode of interventions, tasks delivered on a self-directed basis (in comparison to individual and group setting tasks) showed statistically significant effects in reducing the severity of post-traumatic stress symptoms. When controlling for whether the intervention was offered universally (women experiencing a 'normal/healthy' childbirth) or targeted (women thought to be at increased risk of maternal distress), significant effects were observed for universal interventions. The results did not indicate any significant effects upon the severity of post-traumatic stress when controlling for the impact of the psychological approach (structured or unstructured), study design (randomised or non-randomised), intervention frequency (single or multiple sessions) and active elements of the intervention (re-experiencing the birth, re-evaluating the birth, normalising the birth, and enhancing support systems).

When examining the effectiveness of different therapeutic interventions in reducing depressive symptoms, the severity of depressive symptoms statistically reduced for self-directive tasks (expressive writing tasks and psychoeducation self-help material), whilst there was no impact for group counselling, postnatal debriefing, and psychological debriefing. In line with this, when controlling for the delivery mode (individual, group or self-directed), only self-directive tasks indicated statistically significant improvements within depressive symptoms. Again, when looking closer for which self-directive tasks contributed towards reducing depressive symptoms, it was solely expressive writing tasks that contributed towards this and not the self-help interventional package. The results indicated non-significant findings when separating the depression outcome and analysing for impact across time, across study

designs (randomised or non-randomised), intervention approach (structured or unstructured), target population (targeted or universal), frequency of sessions (single or multiple sessions), or active elements of the intervention.

Given the small number of six studies contributing towards the anxiety outcome measure, in-depth subgroup analyses could not reliably be conducted for anxiety.

Several main insights can be drawn from this review. Firstly, although women generally find postnatal debriefing a valuable process, in that it provides an opportunity for their experiences to be validated and to be provided with information (Baxter et al., 2014), the current review adds to the mixed to unclear evidence that debriefing interventions are ineffective in reducing maternal morbidity following a traumatic birth and that where offered, they should be offered universally to all women, not as a targeted intervention following a traumatic childbirth. Aligning with Bastos et al. (2015), the current meta-analysis does not support the routine use of postnatal debriefing interventions for women experiencing a traumatic birth. The review highlighted the utility of brief cognitive behavioural counselling in reducing post-traumatic stress symptoms, though, only one study (Addollahpour et al., 2019) contributed to this finding and a clear intervention protocol was not included, thus it is unclear exactly how the intervention was delivered, and caution should be given when interpreting the results. Uniquely however, the current meta-analysis provided interesting findings through extension of the literature base on the utility of low-cost and brief psychological interventions, highlighting the utility of expressive writing tasks in reducing post-traumatic stress and depressive symptoms. Furthermore, when separating for the effects across time, the review indicated that the interventions may only have a time-limited impact upon reducing post-traumatic stress in the short-term and thus may not promote longer term recovery. This finding is in contrast with other reviews, as when comparing just debriefing Interventions (Bastos et al., 2015) across time, no significance was found in the short, medium, or longer-term. The

current review also revealed that when interventions were offered universally to women who experienced a 'normal/healthy' childbirth, significant effects were evident in the reduction of the severity of post-traumatic stress symptoms. As described within other reviews (Bastos et al., 2015; Cunen et al., 2014; Gamble et al., 2002), the methodological quality of studies was variable and often of low quality, with the descriptions of interventions often generalized, unspecific and lacking sufficient detail for accurate replication.

Comparison to other reviews

A Cochrane review (Bastos et al., 2015) evaluating the effectiveness of debriefing interventions in the prevention of psychological trauma following childbirth found little to no evidence to support either a positive or negative effect of psychological debriefing in preventing maternal psychological trauma following childbirth. As with this review, Bastos et al. (2015) found high heterogeneity within included studies and concluded that the psychological intervention protocols were not well-defined, limiting accurate understanding the included intervention components and therefore difficulty replicating in future studies. The current review is however not entirely comparable to Bastos et al. (2015), as it included broader psychological self-directed interventions (self-help material and expressive writing tasks).

Strengths and limitations of the current review

The current review included a wider variety of post-birth interventions and included both randomised and non-randomised studies, thus extending the evidence base into the utility of how a broad range of psychological interventions could be applied within the maternity context to reduce maternal distress. There were several study limitations, including the methodological low quality of research papers, for instance variability in the interventions and

the way the studies were conducted led to high, or unclear risk of bias in multiple domains, thus reducing the reviews scientific rigour in accurately interpreting the interventions effects.

Implications for clinical practice

As indicated in Bastos et al. (2015), the current meta-analysis does not support the routine use of postnatal debriefing interventions for women who experience their birth as traumatic. The review has highlighted the possible utility of maternity services asking women to write a brief and meaningful account of their childbirth based upon Pennebaker's (1997) approach, in reducing post-traumatic stress and depressive symptoms following childbirth. It's possible that self-expressive tasks may have a similar function of assisting women's emotional processing through supporting them to develop insight into their emotional experiences following childbirth. Considering clinical practice and given that NICE (2014) guidelines indicate the need for cost-effective adaptive psychological interventions within the perinatal period, midwifery staff could promote this writing intervention to women after their childbirth at no additional cost and with minimal time restraints as an additional intervention to aid women's emotional processing. Given that women report valuing debriefing interventions despite lack of evidence into their effectiveness, these writing interventions could be promoted to women prior to their debriefing session to support their early emotional processing and be used within their debriefing session as a reference to discuss their insights.

Future research

Methodological weaknesses and a high degree of heterogeneity within included studies demonstrates the importance of future studies developing and delivering high quality interventions and subsequent reviews to accurately inform clinical practice. To account for this, it is essential that intervention studies report the intervention protocol and both complete and

provide an assessment of fidelity, thus enabling clearer interpretation of the reliability and validity of interventions. Whilst effects were noted in the short-term, they were not present in the longer-term, thus highlighting the necessity for future research to ensure that a follow up with women beyond 3 months is completed to draw conclusions about their utility in promoting longer-term recovery. There is a paucity of research into the utility of expressive writing tasks and self-help psychoeducation material in reducing maternal morbidity following childbirth, where based upon the advantageous findings in this review, future research should endeavour to provide further conclusive evidence about their effectiveness.

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Chapter Two Empirical Research Paper: 'A qualitative study exploring British-Pakistani women's experiences of receiving support following perinatal loss within the United Kingdom'

Abstract

Introduction

Ethnic minority women experience racial inequities in maternity outcomes, including being more likely to have worse care, die and experience baby loss during pregnancy and childbirth, as compared to White women. Despite disproportionate rates of perinatal loss for British-Pakistani women, there is a paucity of research exploring their experiences of receiving support. It is essential for healthcare and community providers, family, and friends to develop insight into British-Pakistani women's support needs and the influencing intersections of race, religion, culture, and societal factors.

Methodology

Six British-Pakistani women were interviewed regarding their experiences of receiving and accessing support. Interviews were analysed using Interpretative Phenomenological Analysis.

Results

Three superordinate themes relating to British-Pakistani women's experiences of support were identified through the analysis, these were '*The cycle of silence', 'Power of professional support'* and *'Connection after loss'.* Findings illustrated how medicalised narratives misunderstanding or not advocating for women's emotional support needs, and socio-cultural narratives existed around perinatal loss, influencing how women made sense of

their loss and accessed support. Women reflected on poor, misaligned and occasionally clinically negligent care from healthcare professionals, despite their power and responsibility to advocate for their support needs, and the harmful implications of their experiences upon seeking and receiving professional support in the future. The significance of compassionate support, connecting through shared experiences of loss and to their religious and spiritual identity was highlighted.

Discussion

Several recommendations for improving maternity care offered to British-Pakistani women are illustrated, with particular emphasis upon the importance of women's race, culture, community, and religious-cultural beliefs.

Introduction

Research in context

The current research and how British-Pakistani women make sense of their experiences of support following perinatal loss are understood and interpreted firstly within the historical context of structural issues affecting the United Kingdom (UK) maternity and healthcare services, For instance, significant underfunding and staff shortages have devastating implications on the human rights of those using maternity service, whilst disproportionately impacting those belonging to already marginalized groups (Birthrights, 2022). Secondly, the research exists within the current maternity climate, of which it has long been recognised that Black, Asian, and other ethnic minority women[6] continue to experience disproportionate racial inequities in maternity outcomes, including being more likely to have worse care, die and experience baby loss during pregnancy and childbirth, as compared to White women (Birthrights, 2022; Draper et al., 2021; Knight et al., 2021). Thirdly, the Coronavirus pandemic has increased rates of maternal deaths and perinatal loss (Chmielewska et al., 2021), significantly reduced access to maternity, neonatal and bereavement care services for bereaved parents (Silverio et al., 2021), and likely exacerbated and widened existing ethnic disparities across poorer maternal outcomes and experiences of maternity care for ethnic minority women (John et al., 2021; Knight et al., 2020).

Perinatal loss context

Perinatal loss is an umbrella term used to describe the death of a baby during the perinatal period, due to early (less than 20 weeks) or late miscarriage (20 to 24 weeks), stillbirth (born from 24 weeks onwards, with no sign of life), and neonatal death (babies which die within

[6] See Appendix A for a glossary of terminology and definitions

the first 28 days of life). Rates of stillbirth and infant mortality are much higher in the UK, as compared to other high-income countries where rates are slowly decreasing (Flenady et al., 2011a, 2011b). In 2019 in Birmingham, rates of infant mortality (early neonatal, late neonatal and post-neonatal) were even higher when compared to average UK rates, with respective rates of 7 and 3.9 deaths per 1,000 births (Health and Social Care Overview and Scrutiny Committee, 2021). However, such inequalities are much greater for ethnic minority women, with disproportionately high rates of perinatal loss reported for Black and Asian Pakistani women, as compared to the wider population and to White women. For instance, in 2019 stillbirth rates were 3.22 per 1,000 total births for White women, as compared to 5.05 per 1,000 total births for Asian and Asian British women (Draper et al., 2021). The MBRRACE report further highlights the impact of ethnicity, deprivation, and mother's age, with rates of stillbirth increasing to 6.91 per 1,000 total births for babies of Asian and Asian British women, when born to mothers aged 35 years and living in the most deprived areas (Draper et al., 2021). Worryingly, whilst rates of stillbirth and neonatal mortality have reduced respectively by 16% and 11% between 2013 and 2018, rates are declining slower among Black and Asian babies, as compared to White babies (Draper et al., 2021). Disparity rates remain somewhat unclear, though minority ethnic groups in the UK are typically more socioeconomically disadvantaged and likely to have poorer health outcomes, with increased rates of perinatal loss reported for Pakistani mothers living in deprived areas, as compared to White British mothers (Matthews et al., 2022). The primary cause of death for Pakistani stillbirths is reported to be due to unknown causes, placental related and congenital anomaly related (Matthews et al., 2022). Pakistani women are also less likely to be referred to and use the most specialist mental health services, where despite rates of perinatal loss being far greater for Pakistani women in Birmingham (as compared to White women), referral rates to a Birmingham maternal mental

health service[7] that provide specialist care to women experiencing complex mental health difficulties following perinatal loss are considerably lower for Pakistani women, as compared to White women (respective referral rates of 11% and 56% of the total referrals) (Health and Social Care Overview and Scrutiny Committee, 2021; Kapadia et al., 2017; Whittaker & Day, 2022). However, levels of social deprivation, age and other socioeconomic factors cannot solely explain racial inequalities within maternal and infant deaths, with research highlighting the influence of systemic and environment factors upon birth outcomes, and disparities across maternity care experiences and support for Black, Asian, and other ethnic minority women (Birthrights, 2022). A recent inquiry into racial injustice and human rights in UK maternity care demonstrated how systemic racism exists in maternity settings and threatens women's basic human rights to safety, dignity, autonomy, and equality (Birthrights, 2022).

The perinatal period is a complex time for women's psychological well-being, with the intensity of this period further effected by perinatal loss and associated with increased risk of anxiety, depression and post-traumatic stress disorder (Gausia et al., 2011; Heazell et al., 2016). Implications of perinatal loss upon minority ethnic women include poorer relationships with husbands and family members, not feeling as valued within the marital family, increased emotional vulnerability due to social isolation, heightened feelings of guilt over the loss of their babies, and anxiety over subsequent pregnancies (Gausai et al., 2011; Sutan & Miskam, 2012). Although grief is a common and universal experience, the way in which grief is manifested and how individuals are supported following bereavement can vary greatly due to the influence of community, culture, and religious-spiritual beliefs, and how grief is socially acknowledged (Allahdadian & Irajpour, 2015; Suhail et al., 2011).

Each culture and community have their own unique set of beliefs about the meaning and purpose of life and death, which influences how individuals experience and express grief

[7] Birmingham and Solihull (BSOL) Maternal Mental Health Service

following death, how the bereaved are supported and how the dead are remembered. Islamic perspectives on life, death and the afterlife hold significance in understanding how British-Pakistani women may make sense of perinatal loss and turn to religious and cultural beliefs to cope with their loss. In Islam, the birth and death of an individual are considered sacred, with only God having the ability to bestow life and take it away, whereby death marks the transition to the afterlife and a promise that separation is only temporary, with loved ones reunited in the afterlife after God's Day of judgement (Kristiansen & Sheikh, 2012; Rubin & Yasien-Esmael, 2004). Belief in the afterlife and viewing death as God's will can bring comfort to the bereaved and help cope with experiences of grief through externalization (Rubin & Yasien-Esmael, 2004). A collectivist community within Pakistani culture also influences how the bereaved are supported following loss, with the wider family and community being the primary support network and taking responsibility for providing emotional and practical support to the bereaved family, such as, offering condolences, preparing food, and supporting with caring for children (Kristiansen & Sheikh, 2012; Suhail et al., 2011). However, when death occurs during pregnancy or at the beginning of a life, this influences the way in which the Pakistani community make sense of this loss and provide support to the bereaved.

Research undertaken with British-Pakistani Muslim women highlighted how Islamic scriptures recognising the personhood of pregnancy and life beginning when the '*ruh'* (spirit) has been breathed into the baby at 120 days or at the start of the second trimester may influence whether a miscarriage or stillbirth is recognised as a baby or with any significance, and whether the baby can be named or receive a Muslim burial, ultimately influencing how perinatal loss is recognised, grieved, and remembered (Shaw, 2014). Similarly, recognition of Islamic personhood is constructed through having a Muslim burial, with public acknowledgement of the infant's life influencing the social and religious identity of a baby, with a burial announcing that the bereaved parents have lost a baby and allowing for community condolences.

Conversely, early miscarriages may not yet be recognised as a baby and thus influence societies recognition of the baby's personhood in which bereaved parents' grief may be dismissed, internalized and unexpressed (Roberts et al., 2012; Shaw, 2014). However, research also references a move towards challenging prevailing customary practices and adopting new practices of remembrance (Shaw, 2014; Qureshi, 2013).

Despite British Pakistani women experiencing disproportionately greater rates of perinatal loss and being less likely to be referred for specialist mental health support following the loss of their babies, there is a paucity of research directly exploring their unique experiences of receiving and accessing support. This leads to challenges with healthcare professionals and community services not adequately understanding women's unique support needs and providing inclusive, anti-racist, culturally safe and tailored care throughout their experiences of perinatal loss. Where research has explored Pakistani women's experiences of support following perinatal loss, minimal research has focused upon UK experiences (Farooq, 2015) and has largely been conducted with Pakistani women in Pakistan (Ahmed et al., 2020; Asim et al., 2022), or with women broadly grouped together and classified as Muslim or South Asian women (Garcia, 2017; Garcia et al., 2020), without discerning key differences within women's ethnicity. Previous research into Pakistani women's bereavement experiences following perinatal loss in the UK reflects negative healthcare experiences including women experiencing racist attitudes from professionals, feeling powerless and having no control within the healthcare system, feeling that their positions as mothers and pregnancy concerns were not taken seriously (Farooq, 2015). Pakistani women also reported having limited prior knowledge of perinatal mortality, a desire for more information on adverse pregnancy outcomes and being left without information as to why their babies had died, leading to undue experiences of distress, and feeling unprepared for the experiences of perinatal loss (Farooq, 2015; Garcia, 2015; Garcia et al., 2020). Where positive healthcare experiences were described, Pakistani

women associated this with professionals treating *"their babies as more than just 'statistics'"* (Farooq, 2015, p. 69), and viewing midwives as attentive, personal, and supportive (Garcia, 2015; Garcia et al., 2020). Contrasting experiences of support from Pakistani women's family and community are also reported, including good experiences of care, compared to women's difficulties in discussing experiences of loss and grief due to societal sensitivity surrounding perinatal loss, pregnancy not being openly spoken about and family members either not acknowledging or disapproving of expressions of grief (Farooq, 2015; Garcia, 2015; Garcia et al., 2020). Research also indicates British-Pakistani women's cultural support needs following perinatal loss as including modesty and need for privacy, and preference for female professionals due to marital couples' experiences of distress at medical interventions being completed by male professionals (Garcia, 2015; Garcia et al., 2020).

Research rational and aims

As perinatal loss research within the British-Pakistani community is limited, more research is needed to explore the influence that racial, religious, cultural, and societal factors have upon the ways in which British-Pakistani women make sense of their unique experiences of support following perinatal loss. Previous research also highlights the need for future studies to explore culturally diverse populations that have higher rates of perinatal loss and discern differences between South Asian communities (Garcia et al., 2020; Pollock et al., 2020). To date, no studies have researched British-Pakistani women's multifaceted experiences of receiving and accessing support from healthcare professionals, family, friends, and their wider community, and how the intersections of race, religion, culture, and societal factors may influence women's support needs following perinatal loss. Providing a homogenous model of maternity and community care following perinatal loss is unlikely to meet the diverse needs of British-Pakistani women, however with a paucity of published research to inform service

change and delivery, this research is therefore essential for healthcare and wider community services to better advocate for and support women's needs.

Reflections on being a white researcher

As a white, middle-class female, growing up within a white family, and living within a majority white area, the researcher has had to acknowledge and understand the ways in which her own whiteness has remained mostly invisible to her throughout childhood and into her early adult life. Prior to starting her Clinical Psychology training, the researcher had limited experience working therapeutically with ethnic minority communities, where alongside not being a mother, and not having experienced perinatal loss, she was very aware of the stark differences between herself and the British-Pakistani women that she was interviewing, in terms of individual life experiences, race, culture, and religion, and how these factors may influence how she and the women make sense of experiences. Commitment to acknowledging these differences and embedding anti-racist practices throughout the research was fundamental, and this was achieved through the researcher practicing self-reflexivity, alongside the research being developed through consultation with members of the British-Pakistani community to ensure that it was completed in a sensitive, useful, and culturally appropriate way. It was essential for the researcher to engage in reflexive practice, be vulnerable and open to reflecting on her own values, racial biases, and privileges, and how these interacted throughout her relationship with the British-Pakistani women taking part in the research, and upon her ability to understand their experiences. In recognising these differences, the researcher acknowledges the power that she held within her position as a researcher to provide a platform for typically socially oppressed stories to be heard. Consultation with British-Pakistani women who had lived experiences of perinatal loss enabled their voices to be heard and integrated into the research through the continual process of seeking guidance and feedback through all stages of

the research, from shaping the research idea and research question, to discussing themes within the analysis stage. The researcher also received consultation and supervision from a British-Pakistani Clinical Psychologist working within perinatal mental health to reflect on, critically examine and embed perinatal, cultural, and anti-racism perspectives throughout the research, particularly during the analysis of the findings.

Methodology

Interpretative Phenomenological Analysis (IPA)

The present study used Interpretative Phenomenological Analysis (IPA). IPA is a structured approach that allows for the examination of individuals lived experiences, by exploring the meanings attached to their experiences. This approach uses three key areas, these being phenomenology, analysing hermeneutics and idiographic aspects of the lived experiences (Smith et al., 2009). This approach was chosen as it allows for in-depth and meaningful interpretation of how events have been understood and made sense of by those that have lived through them (Smith et al., 2009). For this reason, IPA was selected as it provided a qualitative framework for a rich and in-depth understanding of British Pakistani women's experiences of support following perinatal loss. In terms of the researcher's epistemological and ontological stance, the researcher took a critical realist position, which asserts that there are features of reality which exist independently of human conceptualisation, however, the observed reality can only be truly understood through the individuals' experiences and perceptions of the reality (Bhaskar, 1989). Employing this position allowed the researcher to acknowledge the context in which women's experiences of perinatal loss took place, whilst providing a curious and sensitive framework to understand subjugated narratives.

Design

Ethical approval

The research received sponsorship from the University of Birmingham (Appendix B). Ethical approval was obtained from the NHS Research Ethics Committee (Appendix C), in addition to the Research and Development departments of the two participating NHS Trusts (Birmingham and Solihull Mental Health Foundation NHS Trust and University Hospital Birmingham) and a local third sector organisation in West Midlands.

Participant recruitment

Participants were recruited using a purposive sampling method to identify British Pakistani women who had experienced perinatal loss. To ensure homogeneity within the participant sample, an important factor for IPA, the following inclusion and exclusion criteria (Table 12 – 13) were employed to assess the suitability of participants for the study. For the participating NHS sites, potential participants were identified and assessed for suitability using the inclusion and exclusion criteria by local clinical collaborators (clinicians) within the participating NHS Trusts. Once they were deemed eligible for the research, local clinical collaborators provided the women with initial details about the research via a telephone call, where following an expression of interest and providing consent, their names and details were passed to the Chief Investigator. *The Chief Investigator then contacted potential participants via email to provide the Participant Information Sheet (Appendix D), confirm the inclusion and exclusion criteria, and provide an opportunity to ask further questions about the research and their potential involvement. Participants were all given a week to consider their involvement, where following this period of time and participants confirming their interest in the research, they were provided with the Consent Form (Appendix E) and an interview date was arranged. For the local third sector organisation, the research poster (Appendix F) was advertised on the organisations social media platforms (Instagram and Facebook), which included the inclusion criteria and the email address of the Chief Investigator. Women who were interested in the research were asked to contact the Chief Investigator to discuss the research further, where after this process, women followed the same research procedures indicated above*.

Table 12

Inclusion Criteria

Number	Inclusion Criteria
1	British Pakistani women (either born and raised in the UK, or Pakistani-born and migrated to the UK)
2	Aged 18 years or above
3	Able to speak fluent English (the study was unable to include non-English speaking women due to lack of resources for an interpreter)
4	Experienced perinatal loss (miscarriage, stillbirth, neonatal loss) within the United Kingdom healthcare service
5	Able to give informed consent
6	Deemed to not be experiencing acute or unmanageable distress

Table 13

Exclusion Criteria

Number	Exclusion Criteria
1	Males
2	Non-British Pakistani women
3	Below 18 years of age
4	Non-fluent in English
5	Not experienced a perinatal loss within the United Kingdom Healthcare Service.
6	Unable to provide informed consent
7	Experiencing acute or unmanageable distress

Participants

The research was conducted in the West Midlands, in Birmingham. In total, six British-Pakistani women were interviewed as part of the research, with five women living within Birmingham and the surrounding area, and one woman living in Bedfordshire[8]. The sample

[8] This participant was recruited through the local third sector organisations social media platform

size adhered to the range of participants recommended in IPA and was deemed appropriate for in-depth qualitative analysis (Smith et al., 2009).

Five women were recruited through a local third sector organisation in West Midlands rooted within the Birmingham Muslim community, whilst one woman was recruited through Bereavement midwives at a local maternity hospital (Heartlands–Hospital - University Hospital Birmingham NHS Foundation Trust). Table 14 presents participants demographics. At the time of interviewing, women's ages ranged from 29 to 46 years, with a mean age of 37 years. Women's experiences of perinatal loss ranged from between 14 years to 6 months ago.

Table 14

Participant demographics

Participant number	Participant pseudonym	Age	Ethnicity	Perinatal loss experiences discussed and years since loss
1	Zara	46	British Pakistani	Miscarriage at 12 weeks 14 years ago (2008) Miscarriage at 8 weeks 11 years ago (2011)
2	Alayna	34	British Pakistani	Stillbirth at 35 weeks 1 year ago (2021)
3	Sofia	39	British Pakistani	Multiple early miscarriages and miscarriages at 8 weeks Stillbirth at 31 weeks 12 years ago (2010)
4	Amira	36	British Pakistani	Miscarriage at 23 weeks 5 years ago (2017)
5	Leila	29	British Pakistani	Miscarriage at 11 weeks 5 years ago (2017) Miscarriage at 10 weeks 4 years ago (2018)
6	Sara	38	British Pakistani	Miscarriage at 8 weeks 3 years ago (2019) Miscarriage at 12 weeks 2 years ago (2020)

Data collection

The interviews took place between January and February 2022 during the Coronavirus-19 pandemic and abided to the government's social restrictions at the time. One interview was

completed face-to-face at the participants home, with five interviews completed remotely using the University of Birmingham's secure video-conferencing platform Zoom. Dependent on the women's preference and mode of interview, informed consent was gained either electronically, verbally or in person. At the beginning of the interview women were reminded of their right to withdraw from the study and their consent to participate in the research was revisited.

Interviews followed a semi-structured interview guide, exploring how British Pakistani women made sense of their experiences of receiving support from healthcare services, their family, friends and their community following perinatal loss. To ensure the appropriateness and sensitivity of the research questions, the interview guide was developed in consultation with a British Pakistani Peer support worker with lived experience of perinatal loss. Whilst the interview guide was used to structure the interview, it was used flexibly as the content of the interview was guided by the women.

Interviews varied in duration, ranging from 52 to 92 minutes, with an average interview time of 77 minutes. To enable transcription, interviews were audio recorded through either the Zoom recording function or an encrypted Dictaphone. At the end of the interview, the women were debriefed, and their emotional well-being was checked. All women were asked if they would like to receive a summary of the research results following analysis, which they all consented to.

Data analysis

The recordings were transcribed verbatim, with identifiable information altered to ensure anonymity. The IPA data analysis steps described by Smith et al. (2009) were followed and are detailed in Table 15.

Table 15

Overview of data analysis stages of IPA

Step	Description
1	**Reading and re-reading** All transcripts were read and re-read enabling the researcher to become familiar with the participant data. Initial notes were also made during this step.
2	**Initial coding** The researcher made detailed line by line coding on the transcripts, relating to descriptive comments (describing what the participant has said), linguistic comments (exploring the participants use of language) and conceptual comments (describing the meaning and interpretation of what was being said). (Appendix G)
3	**Developing emergent themes** The researcher brought together connections within the exploratory comments, through identifying and grouping together similar conceptual comments into emergent themes.
4	**Identifying connections across emergent themes** Connections between emergent themes were then identified to create superordinate and subordinate themes, creating a thematic structure. (Appendix G)
Steps 1 – 4 are repeated for each transcript	
5	**Looking for patterns and connections across transcripts** Each participant's thematic structure was collated into a single table (Appendix I), which was then printed out, with connections made between similar themes (Appendix J). These were then used to create the final superordinate and subordinate themes.

Reflexive statement

Due to the double hermeneutic nature of IPA, in that the researcher is making sense of the participants own sense making, it was important for the researcher to engage in reflexive processes to understand the influence of the researcher's own thoughts and feelings upon the interpretation of the data. Different processes were employed to enable reflexivity and consideration of how different factors might influence the research.

Throughout the researcher's training in Clinical Psychology, she developed an interest in perinatal mental health through working within a specialist maternal mental health service

specialising in supporting women and their families from various ethnicities following baby loss. This experience was crucial in supporting the researcher's awareness of the devastating implications following baby loss and provided insight into the differences within women's support needs from varying ethnic communities. The researcher engaged in processes of self-reflexivity, through reflections and reflective journaling, through which she recorded initial thoughts and questions about her own response to the interview material, and what feelings this brought up within her, to enable self-examination of internal biases and assumptions that could be explored in supervision. Throughout coding and within her reflective journal the researcher ensured she bracketed off any assumptions and understandings that were not clearly grounded within women's lived experiences.

Credibility and reflexivity

To ensure the credibility and validity of the research, throughout the analysis phase methods of triangulation were used to check the sense making of the qualitative claims and to ensure accuracy, fidelity, and rigour within the themes. The coding of transcripts, emerging themes and final themes were discussed in supervision with the researcher's Clinical Supervisors, with final themes discussed and feedback received from a British-Pakistani woman with lived experience of perinatal loss. Coding of transcripts and themes were also taken to an IPA support workshop with qualitative researchers in IPA and fellow colleagues completing IPA for review and to gain feedback.

Results

Following analysis of the data, three superordinate themes emerged relating to Pakistani women's experiences of support, these were '*The cycle of silence', 'Power of professional support'* and *'Connection after loss'*. Within each superordinate theme, three subordinate themes were identified, with a total of nine subordinate themes overall. Table 16 presents an overview of these themes, with each theme then described in detail with selection of participant quotes to illustrate them.

Table 16

Summary of superordinate and subordinate themes

Superordinate themes	Subordinate themes	Participants contributed
The cycle of silence	*Medicalised and socio-cultural influences*	1,2,3,4,5,6 (all)
	Silence of baby loss	2,3,4,5,6
	Internalised blame	1,2,3,5,6
Power of professional support	*Power and responsibility of professionals*	1,2,3,5,6
	Inequalities in provision of care	1,2,3,4,5,6 (all)
	Lasting and harmful implications	1,3,5,6
Connection after loss	*Everlasting support*	2,3,4
	"I am not alone"	2,3,4,5,6
	Connecting with spiritual and religious beliefs	1,2,4,6

Theme 1: The cycle of silence

This superordinate theme reflects British-Pakistani women's experiences of a cycle of silence that existed around their experiences of perinatal loss and that was influenced by dominant medical and socio-cultural narratives. Women discussed the influence of these

narratives upon their subsequent grief journey, leading to exacerbated feelings of blame, and impacting upon their ability to receive and access support. Reflected within this theme, is how the cycle of silence is perpetuated through the subordinate themes: '*Socio-cultural and medical influences', 'Silence of baby loss'* and *'Internalised blame'.*

Medicalised and socio-cultural influences

The theme '*Medicalised and Socio-cultural influences'* reflects how medicalised and socio-cultural narratives influenced women's experiences of feeling misunderstood, judged, and ultimately not supported following the loss of their babies. Women described their emotional needs as being dismissed due to commonly held medicalised perspectives, whilst socio-cultural ideals, beliefs and expectations surrounding motherhood, marriage, and perinatal loss further constrained how others understood women's support needs.

Women described a disparity of healthcare support, in which their physical and medical health needs were predominantly acknowledged, whilst their emotional needs were less easily recognised and thus advocated for. well-being. Here Sara reflects upon healthcare professionals medicalised understanding of her miscarriage, in which her psychological support needs appear dismissed and instead her miscarriage is seen largely through a "*medical(ised)"* perspective:

> *"…and not just seeing it (miscarriage) as just a medical thing really. That you know, it wasn't just a case of you've come in and this baby's gone. But yeah just go home and deal with the physical stuff, because that's it. There is so much more to it, and I felt like, from the medical side of things, when medical practitioners, there wasn't any acknowledgement of that at all"*

Within Amira's quote she refers to an Asian doctor minimising her emotional support needs and imposing an expectation to go back to work, in which she appears to understand his

difficulty in understanding her support needs as being located within the interaction between socio-cultural and medicalised narratives which dismiss expressions of grief:

> *"It's funny that I even went to the GP because I just wasn't ready to go back to work, and he was an Asian doctor. I spoke about how I felt … And I felt like he had this sort of attitude that, 'Oh here you go, have some antidepressants and that should help, and then you can go back to work'. But actually, I just wanted someone to talk to and say, 'You probably need a longer time, you're still grieving', you know, here you go. I just felt like maybe, stereotypical, maybe because he was Asian, he just didn't understand how, even being a doctor, I just felt like maybe he didn't understand then I needed a bit more time"*

Judgement and misunderstanding surrounding women's experiences of perinatal loss and their subsequent support needs also existed within women's societies and culture. Sara described how cultural expectations to marry and to conceive quickly after marriage contributed towards a sense of pressure to fall pregnant again after her miscarriage. She also reflected on felt expectations to resume household chores and to "*pull (her)self together*" after her miscarriage, with this appearing to reflect her family's difficulties in recognising her support needs and influencing her to minimise her own needs to avoid further judgement:

> *"…especially when it's your first baby, you know, oh there's a lot of pressure on women within Pakistani community to get married. And I didn't get married until I was 34. And then it's like, oh, 'When are you gonna' have a baby?' And then this baby comes along, and then it's not happening, and then it's like, oh, 'Will this ever happen?' and 'What will they think of me?', 'What would they think?'. There's a certain shame with it as well."*

> *"…there was a certain.. and it was never said, but there's a certain expectation that, 'Oh, you must get up now and help with the housework' and the rest of it. So I think culturally, there's, there's that pressure as well. So it was like, so I was trying to pull myself together. So I wasn't seen to be all lazy, or she's trying to play this out or whatever. So that was that was another challenge."*

Alayna, Sofia and Amira discussed members of their community paid condolences to their homes following the loss of their babies, and whilst Amira recognised this as an important

cultural practice offered "*in any situation, whether it's a happy occasion or a sad*", she described feeling "*bombarded*", reflecting that constant visits reduced the time that she could spend with her close family and delayed her initial grieving process: "*Because that's our culture, where you come and visit, and you give your condolences. But there's no stop to it. It's just continuous visitors, where you don't get time to grieve".*

Women described narratives about their extended family and wider communities holding cultural beliefs about the causes and implications of their perinatal loss, leading women to experience exacerbated judgement and isolation within their community. Alayna's quote illustrates societal judgement about the causes of perinatal loss "*They'll just come out with comments like, 'These lot used to be very outgoing and going out all the time, and maybe that's why it's (perinatal loss) happened'",* whilst Sofia's quote reflects how community narratives around supernatural explanations and the implications of perinatal loss lead to a reduction in women's support networks as they are avoided and socially isolated within their community: *"...a belief in our culture when you've had a miscarriage, you're not supposed to walk past a pregnant woman because your shadow, if it falls, if it passes her, then it curses her baby, so people keep their distance from you".*

This theme illustrates the negative influence that some medicalised and socio-cultural beliefs and discourses have upon women's experiences of perinatal loss and grief, and their subsequent support needs. These discourses appeared to lay the foundation for the cycle of silence that existed around perinatal loss, with a discussion of how British-Pakistani women understood and made sense of this silence presented in the next theme.

Silence of baby loss

The theme *'Silence of baby loss'* arose from five women's personal narratives of the social taboos surrounding perinatal loss and the felt silence that they experienced from others

(family, friends, extended community, and healthcare professionals) in relation to the loss of their baby and their experiences of grief. There was a sense that the silence surrounding perinatal loss wasn't a unique experience within the Pakistani community, though experienced universally, as illustrated by Sara: *"I'd say generally people don't talk about baby loss, universally".* Women described perinatal loss as not being openly spoken about and appeared to make sense of this silence within the context of it being a sensitive topic and others not understanding women's support needs and/or not knowing what to say, alongside others disapproval in acknowledging or talking about the death of a baby and women's expressions of grief. There was a sense that women experienced this silence as others discounting or dismissing the loss of their baby and their grief reactions, adding to feelings of being judged, misunderstood, and feeling they must *"get on with it" (Amira),* thus causing difficulties in seeking and receiving support.

Women reflected on baby loss not being openly spoken about within their community and how this created difficulties for them in expressing their feelings of loss and grief with others, contributing to feelings of loneliness, as illustrated by Sara: "…*it's (baby loss) not talked about, it's not mentioned*" and *"...if it's so common, why is nobody talking about it? You know, why do I feel so alone?".* For Alayna, she recognised others difficulty in not knowing what to say, though emphasised how others not acknowledging the death of her baby led to her experiences of loss and grief being dismissed:

> *"...people just didn't know what to say, or whether to ask about the baby or not, and I think just being silent on someone and not talking to them at all, I think that's really difficult as well. I think that's more upsetting more than anything, if someone doesn't want to acknowledge what happened."*

Women appeared to understand this silence within the context of dominant community narratives disapproving the expressions of emotions, particularly grief following perinatal loss.

These narratives and the impact upon women's difficulties in talking about their loss is illustrated here by Amira and Sofia's quote:

> *Amira: "I feel like in our community, they kind of brush the emotions of people under the carpet, like you're not able to express how you feel about loss, especially about baby loss or in pregnancy, miscarriaging', or anything like that. I feel like they expect you to carry on and get on with it, kind of thing".*
>
> *Sofia: "So you get that vibe of people, that they're not comfortable with you speaking out about everything that you've been through, in their eyes it's supposed to be something that's really secretive".*

A felt sense of disapproval and secrecy surrounding the topic of perinatal loss appeared to reinforce the cycle of silence and led women to feel that they must conceal their loss and subsequent expressions of grief, as illustrated here by Leila: *"...it's still considered kind of taboo of losing a baby. So first one (miscarriage), I did tell them, but the second one (miscarriage), I was like, oh don't tell anybody just hide it, just hide it, what if you have it again?".*

Women reflected on societies preference for discourses around healthy and living babies, as opposed to stories involving the death of a baby, and a desire to be asked about their babies, as illustrated by Alayna's quotes: "...*general questions that you'd probably ask someone who's just had a normal healthy child"* and: *"...you want people to still talk to you, as you would talk to someone who's had a healthy child. Still mention the babies name, because I'd like to speak about my child as well, just as a normal one".*

There was a particular emphasis on how women made sense of and internalised existing medicalised and socio-cultural beliefs that favoured silence surrounding perinatal loss, leading to increased feelings of blame, judgement, and isolation, further strengthening the cycle of silence. This will now be explored within the next subordinate theme.

Internalised blame

Women described blaming themselves for the loss of their babies, however for five women, medicalised and socio-cultural narratives strengthening narratives of silence surrounding perinatal loss appeared to influence how they made sense of their experiences of loss and grief. Alongside these narratives, due to an absence of any known causes for four women's miscarriages and/or stillbirths, women experienced exacerbated feelings of blame and judgement for the loss of their babies, with these feelings initiated by both themselves and their interactions with others.

Following Zara's miscarriage, she was viewed as "*a bad aura for other pregnant women*" in that pregnant family members distanced themselves from her, leading Zara to withdraw herself from others and feel a heightened sense of blame, questioning whether she caused her miscarriage: *"For me, it was just like, oh my God, I have let my husband down, I've let myself down, I bet it was something I did. I bet it's me running down the stairs really quickly".* As for Sara, following her miscarriages she feared judgement from others and began to question her mothering ability: *"If you have a baby loss and you think, what will my in-laws say? Will they think that I can't have babies? And you know, I'm not, I'm not like, a full woman or whatever. You know?".* For several women, feelings of blame and judgement appeared to strengthen the cycle of silence and impacted upon their ability to seek support for their emotional wellbeing from friends, family, their wider community, and health professionals. For Sofia, due to being within a Consanguine marriage and her daughter being diagnosed with a "*lethal ... condition that's incompatible with life"*, she felt an increased amount of judgement from healthcare professionals and others outside of her family, with this influencing her support needs, as she "*was looking for an outsider, or an anonymous form online or something where you don't have to see that person again".* However, despite using online and anonymous social

forums, Sofia continued to feel judged and less worthy of support, leading her to disconnect from an online support forum:

> *"...but it felt like there was this hierarchy of judgement (on online support forums), this hierarchy where you're being judged because you've had a loss of a stillbirth. But, okay, there's others who have had stillbirths, but their babies didn't have any condition. So you know, their stillbirth is more justified than yours is. And then when they find out it has a genetic condition, and then the fact that you're cousin's, okay then you caused that, so there's no sympathy there. I kind of got a little bit of that, so that just put me off."*

Similarly for Sara, she reflected on difficulties talking about her grief to others as she *"didn't want to feel like (she) was burdening (her) family and friends, and (her) husband, with the same thing over and over again"*. Feeling a burden and at fault for her miscarriage contributed towards Sara questioning other's ability to be able to support her, hindering how able she felt to reach out for support:

> *"But at the time, it still made me even think, oh gosh, what if it is my fault and ah, I can't talk about this, and maybe I shouldn't mention it to anybody ever again in a public setting or whatever, because they might think is my fault … So it's just accepted, really, that it's one's own fault. And I guess if you just kind of accept it, oh it's my fault, then, what's the point of talking to anybody about it? Because they're not going to make me feel any better about it, or what can they do about it? Because it's my fault anyway. Potentially."*

This subordinate theme highlights the complexity of women's relationships with others and how they understand or value their own support needs, with internalised feelings of blame appearing to influence their experience of receiving and/or seeking support.

Overall, the superordinate theme illustrates how medicalised and socio-cultural narratives exist and strengthen the cycle of silence around perinatal loss, whilst contributing towards women's difficulty in receiving and accessing support. The next superordinate theme focuses on the power and responsibility of professionals to provide equitable support to

women, women's experiences of inequalities within their provision of care, and the lasting influence of this upon their engagement with healthcare professionals.

Theme 2: Power of professional support

British-Pakistani women reflected on the power and clinical responsibility that healthcare professionals held to provide and advocate for their needs and provide them with compassionate and appropriate support. However, women describe their experiences of poor and uncompassionate care, and on occasion reference clinical negligence, leading to undue experiences of secondary distress and trauma. As a result of women's negative interactions with healthcare professionals, several women described a shift in how they viewed healthcare professionals, and ultimately their relationship to receiving or seeking professional support.

Power and responsibility of professionals

Within this theme, five women emphasise the power and responsibility that professionals held to support and advocate for their ongoing support needs, and to provide them with clear and transparent information. In the absence of being provided with compassionate care and clear information, women reflect upon the devastating impact, leading to undue experiences of distress. Despite women feeling that in some instances professionals did not advocate for their needs, they described the significance that was placed upon professionals' authority, expert knowledge, and impartiality, with this seen as being superior to what they, their family or friends could offer. Some women more clearly reflected on the power imbalance within their relationships with professionals, whilst for others this was implied within their reflections. Here Sofia reflects upon a hierarchy of professional status and how she navigated this power imbalance, placing reliance upon a midwife's authority above her own ability to advocate for her and ensure that her and her unborn daughters needs were heard:

> *"She was a midwife, but she had authority in a way. So, if I wanted to question the Consultants, she'd do it for me on my behalf. So I didn't have to deal with that kind of ego of the Consultant, and she understood the Consultant because she works with them. And then she could put my question in a better way, kind of advocated for me, which really helped."*

For Zara, despite not receiving compassionate support from professionals following her two miscarriages, she signifies the value of what their support could have provided her with due to their professional knowledge and experience, with this seen as above and beyond what friends and family could offer her:

> *"I think for me at that moment, because she was a professional, I thought her being a professional has got so much experience. So she knows, she'll tell me, you know, she'll validate for me that it's actually okay for you to go through that. I mean, my friends and my family were telling me this, but I'm like, you just say that because you know, you're family and friends"*

Women referred to healthcare professionals' clinical responsibility to provide them with clear and transparent information, and how this could have helped them to prepare for the loss of their babies and limited unnecessary experiences of secondary distress and trauma. Despite professionals having access to this information and knowledge, women describe professionals holding onto this information, and reflect upon the devastating impact of this. For both Alayna and Leila, their prior knowledge about adverse complications throughout pregnancy was extremely limited, and so they felt entirely reliant upon needing to be informed by professionals. They reflected on how crucial it would have been for them to have been provided with complete and transparent information, both warning them about adverse outcomes throughout pregnancy and what to expect after their stillbirth and miscarriages, as they both relied upon professionals' knowledge, though felt uninformed: This is illustrated by Alayna's quote:

> *"But for me, it was such a shock because I didn't ever know that this could happen, I'd never heard of stillborn before. Maybe I was a bit naive as well, but I don't think there*

> *was a lot of awareness of it and wherever, like any of these books or anything you read about pregnancy. So I got these books on pregnancy and no one mentions anything about the complications that you can have or, or anything that could go wrong"*

Alayna continues to reflect upon the difficulty that professionals experience in providing women with complete and transparent information throughout their maternity care:

> *"But then also, I think they feel that they don't need to mention that (adverse outcomes), because when I mentioned that to the midwives, they were like, 'There was no reason to tell you because everything was fine with you. So what's the point of us telling you stuff, when it doesn't apply to you'?"*

For Leila, she had moved from Pakistan and had only been living within the United Kingdom for 6 months prior to her first miscarriage. Her quotes further illustrate healthcare professionals' clinical responsibility to provide women with clear and complete information about perinatal loss: *"I didn't know the system about here and I didn't even know about miscarriages"* and *"So, if the doctors don't tell us like, there's somethings that we will never know".* Leila's quote reflects clinical negligence and the potential impact of professionals not providing clear information, which contribute towards women feeling unprepared and experiencing further undue trauma during and after the experiences of birth:

> *"No, they didn't tell me the foetus will come out. You know, they didn't tell me. And like, obviously, you know, I was a bit naive to think that, you know. Like they said something like we'll check you after 10 days to see if you're completely clear, or otherwise we have to do, I think a D and C (Dilation and curettage) on you. But they didn't tell me what the clearing means. I just thought, you know, it would be just blood coming out. I wasn't ready for the foetus and it was grey colour, so I really got scared because, you know, if I had imagined something, I would have imagined something red coming out of me"*

Leila again refers to a felt power imbalance, relating to the clinical responsibility and value of professional's expert positions to provide factual and complete information. In her quotes she describes how her husband dismissed her physical and emotional distress, due to the significance that he placed upon professionals' words, in which the seriousness of her

miscarriage and subsequent support needs were dismissed: *"because you're just another person, whereas the doctors, they're professional and everything, your husband wants to believe them more than you".* She further illustrates how having transparent information would have enabled her husband to understand her support needs:

> *"And it actually made my relationship really bad with my husband as well, because they told me that everything's normal and my husband went straight back to work. And like, if they had told my husband like look, stay with her, she'll have a lot of blood loss, or you know, she'll be really bad. He would have stayed home. My husband thought everything's going to go back to normal because the doctors were really cool about it, like 'Oh, it's really fine, you know, one in four women do suffer from it'. And so I thought that's how it's supposed to be, and that's what my husband's thought. You know, we had a lot of clashes, he was like 'how am I supposed to know that you're going to suffer so much'.*

Across women's narratives, there was a sense of how easy women felt that it would have been for healthcare services to provide them with essential information that could have enabled them to feel more prepared and supported their wellbeing:

> "*Like it's as easy as just simply posting a poster on the hospital walls and stuff, like they don't even have to tell me, just outside the pregnancy ward"* and *"...that (information) would have been really helpful, you know, just like a leaflet about what to expect, what is going to happen, when to go for support, when to discuss, you know?"*

Within this subordinate theme women described the power that professionals held in their capacity to advocate for their support needs, in addition to the expected responsibility and value that they and family members placed upon professionals to provide expert knowledge and compassionate care. This narrative is continued in the next subordinate theme, as women describe their experiences of inequalities within their provision of care, through often incompetent, misaligned and/or uncompassionate healthcare support.

Inequalities in provision of care

There was a consistent narrative that British-Pakistani women were exposed to inequalities within their provision of care during or following the loss of their babies, with all women experiencing some element of care that was incompetent, not aligned, or not appropriate for their needs. There were varying examples of women feeling dismissed, minimised, treated unfairly, and having their needs unmet at some point throughout their contact with healthcare services. Some women reflected on hospitals not having a private space within the Accident and Emergency department that was appropriate for women experiencing a miscarriage, as illustrated by Sara who had to sit in the waiting area whilst she was losing her baby: "*So, I had to sit there in the flippin' waiting rooms bleeding, and it was heavy bleeding".* For two other women, due to the hospital's bereavement suite being refurbished or needing constant monitoring due to the severity of her physical health needs, they received their aftercare within the delivery suite and could hear other birthing women and their babies, as illustrated here:

> *Alayna: "...and that was really tough for me, because obviously, you've just gone through a loss and then you're hearing people expecting, and people having their children (placed on the delivery ward for aftercare). And that's really tough on yourself as well to go through something like this."*

For all women, compassion was seen as a critical element of support, however within Zara's quotes she reflects upon experiencing secondary distress due to her experiences of care with maternity staff, whilst describing just how little she felt she needed to feel compassionately cared for:

> *"...I think that my initial hurt, was yes, I have had a miscarriage, but then it was like. Oh, my God, I was just treated like a piece of trash to be honest. So yeah, that was really hard to take on."* and *"...all I wanted was for that nurse to sit down with me, just all she had to do was just sit down, hold my hand, and just have a little talk, just physically show that emotion, that care on her face."*

Women's narratives implied that healthcare professionals struggled to recognise and advocate for women's emotional needs, as illustrated here by Leila's quotes which reflects on her experiences of distress being dismissed and minimised: "…*they (healthcare professionals) don't take you very seriously after your miscarriages"* and "*I was crying on the bed and she was like 'no it's okay one in four women go through it, it's actually very common'. Like, I don't care if it's common or not, I'm talking about me".* The following quotes from Sara further demonstrate her emotional needs not being supported: *"...I did experience a lot of anxiety, but I wasn't offered any support from my doctor, or anyone else. Really, it was just a case of 'Just go home and bleed it out and deal with it' in all honesty".* Women referred to a further disparity of support, in that they either didn't receive any follow-up support or had limited contact with their midwives following the loss of their babies, as compared to the extent of support that women giving birth to living babies would receive. Alayna refers to the disparity of support that she experienced following her stillbirth at 35 weeks: "*because you don't have a child it just feels as though they don't need to come to you now, as they don't need to give you any support anymore as you haven't a child",* and how she felt that she was left without support:

> *"But I just feel as though, when you've got a child they come in for the child, you know community midwives they come right until, like if a baby's underweight, they come till about eight weeks, don't they. And even the mother, they check the mother after certain times. Well, no one came to check me. I didn't go to any GP, I didn't have no appointments, just to see if the stitches were fine and if they're healing and everything. It was just like I was left alone then, if I had any problems, I would have to go to the GP myself."*

Further compounding women's difficulty in receiving support was that in addition to healthcare professionals not being attuned to women's emotional support needs and either not providing or signposting them to support, women struggled to recognise and articulate their own support needs after such a traumatic experience. This is illustrated here by Sara's initial quote: *"So, I didn't ask for any support and I wasn't offered any support, and didn't know that*

there was. I didn't know to ask", and within her second quote as she reflects upon her support needs, though her dilemma of not being offered or knowing that support was available:

> *"I just wanted someone to talk to, I definitely needed to see a counsellor. At that time, it was just so traumatic. Yeah, to know that there was somebody that I could talk to, some service, some support group. It was just like both times, no matter how far along I was, there was just no support whatsoever. Nothing was offered, I didn't know if anything was available."*

In some cases where women were not offered or signposted to support, whether that be a midwife follow-up appointment or mental health support, this led them to them seeking support for themselves. This is illustrated by the following quotes from Alayna and Zara:

> *Alayna: "…there was no support from that side at all. Even if I had an issue and I wanted to get myself checked out. I went to check myself (to hospital to have her stitches checked). And that's it, there was no additional support offered to me or anything."*

> *Zara: "I had nothing. I literally had nobody. And even this counsellor thing, that was all from my side. I was the one that took that first step. I was the one that thought okay, I need to go and see a doctor."*

For Zara, she reflected that when she sought support for her mental health, she experienced it as not aligning or sensitive to her religious values due to a focus on suicide within a questionnaire, with her individual conceptualisation of distress appearing to be minimised by a dominant discourse surrounding suicide:

> *"All the questions were literally based on suicide. And I was like, okay, I don't understand. Like, has she given me the wrong form? And I said, sorry have you given me the wrong form?"*

> *"And it's a shame, because she automatically by that question (questionnaire asking about suicide), and by looking at that questionnaire I feel that maybe they feel that the majority of people that come to them, have got suicide on their mind. And it's a very big shame, because you really need to broaden your, your variety of illnesses or whatever, you have to see a person for their individual need, you can't be painting everyone with the same brush … And it was a shame, because I had gone to her with high hopes"*

During the pandemic, whilst experiencing a miscarriage Sara attended A&E for a second time due to the severity of her bleeding and abdominal pains, though references a medical professional being rude to her, dismissing her pain and her questioning her attendance at A&E:

> *"And he'd said, 'Are you back again?' and I was like, 'Yeah'. He goes, 'What's the issue?'. I said, 'I've got abdominal pain' and he said, 'Why have you come back for that?'. And he was just so rude to me. And I said to him, 'Stop shouting at me, I'm not shouting at you'. And that's when he calmed down and looked around the room, he was like, 'I'm not shouting at you'. I said 'I'm in pain, I need to see someone, they told me to come back if I was bleeding so much'...And it was like I was wasting his time or something."*

When reflecting on the above experiences, in addition to feeling dismissed over the phone by a receptionist at her GP whilst trying to make an appointment to check if her cervix had closed, she refers to professional racism and questions whether she received rude and dismissive care due to her race:

> *"I just questioned whether it's (the care that she received) because what I looked like, effected or impacted on the service that I received. I don't know for sure. But it just did make me question as to whether you know.. *pause* ... And, I said to myself, 'I wonder if she'd (receptionist) spoken to me like that, if I was someone else? Or I looked different or was from a different background?' Because it's more than possible. So yeah, it does make me question. And again, you know, the fellow at the (hospital), and how he responded to me coming back for the second time (for pain and severe bleeding due to her miscarriage). Yeah, it just got me thinking, I don't know for sure, I can't say".*

Due to British-Pakistani women's experiences of healthcare inequalities and support not being appropriate or aligned to their needs, women described harmful implications upon how they viewed their support needs and their relationship to seeking professionals support in the future.

Lasting and harmful implications

Throughout five women's narratives, there was a strong sense that throughout women's journeys of losing their babies, their interactions with healthcare providers had harmfully altered how they viewed themselves and care needs, and their relationship to receiving or seeking professional support. The lasting effects and seriousness of women's negative interactions with healthcare professionals appear to be illustrated within expressions of submissive and subjugated internal narratives and/or behaviours, with these narratives appearing to reflect internalized racism and influencing women's engagement with maternal health services.

Several women felt partially responsible for their care and expressed self-doubt as to whether they should have done more for their needs to be met, as illustrated by Zara: "*... maybe I could have asked more questions. Or, you know, maybe I could have been the one to.. *pause* I think I could, but then I wasn't in the right state of mind, to be honest with you."*. Both Alayna and Leila described feeling "*naïve*" and responsible for not being aware of adverse pregnancy outcomes or what to expect following a miscarriage or stillbirth. Additionally, Zara reflects on the mistreatment she felt following her two miscarriages, in which she doubts herself as to whether she should have been provided with better care, or whether that was the normality of how women are treated following a miscarriage:

> *"I think the hurt that I had towards the hospital, I suppose from the first time. Because I had this, had this feeling, that maybe this is what they do when people have miscarriages? You know yeah... Yeah, it was just what happens. That's probably how they treat people *laughs*, you know, became like a normality for me at that time."*

After Zara's experiences of Counselling services feeling misaligned to her religious and individual needs, she reflects upon a higher level of questioning, in which she questions the appropriateness of support provided within the NHS following perinatal loss, beyond her own care: *"... I really did feel that and that started making me question. Okay, 'What, what is the*

NHS service? How do they do these things? How do they? How can they feel that what they're doing is right?'. Zara continues to describe the impact of the care that she received, reflecting on an emerging reliance upon herself to heal following her miscarriage:

> *"No, I felt that there was no such thing as support, and I think after my experience with the Counsellor. At that moment, I knew I said, 'I have to be my own healer'. I can't, I just literally can't go to this counsellor again. I didn't complete my sessions. And I just backed off."*

Within Sofia's quote, due to her diminishing trust of health professionals surrounding the circumstances of her daughter's death, she describes an adverse change in her relationship with healthcare providers and the influence of this upon her feeling sceptical and less open to receiving support:

> *"So that trust, it was already, that trust was kind of disappearing as it is when you go through that journey, but that just totally, you know, went, so I just wanted to distance myself from all healthcare providers."*

> *"And then it stops you from even, going there. And if they ask you about support, you're like 'yeah, I'm fine, I'm fine'. You don't even divulge any information to them, because you just straight away know that they're not going to think the same way as you. So it's like you just put a barrier up straightaway"*

For Sofia, Sara and Leila, the implications of their interactions with healthcare professionals extended beyond their perinatal losses and into their future engagement with healthcare services. For both Sara and Leila, fear of future judgement and dismissal from professionals throughout their perinatal loss impacted their confidence and apprehension in seeking support, leading to a sense of dread and reliance upon their faith to support them prior to their appointments:

> *Leila: "Because I was a high risk pregnancy (subsequent pregnancy) I had to see a lot of Consultants, and before going to every Consultant I used to pray, I used to be sweating and I used to be praying, 'I wish I don't see her (previous Consultant from second miscarriage), I wish I don't see her. What if she gets to be my consultant? She's going to bully me for nine months?' Thank God, I didn't get to see her."*

> *Sara: "...whenever I go to health professionals, I just pray that I'll get somebody good and understanding. And you think, so it does involve that trust, as well. So you just pray, 'oh I hope I get somebody good or understanding, or somebody who's nice or whatever', because I'm a little bit more apprehensive about who I might come across and how they might be towards me when seeking a service. Or, you know, I have to attend something. So that certainly, so yes, those past experiences certainly didn't support really in seeking help. And now I'm like, oh gosh, what if I seek help, and they don't understand or if I ask this question, what if I ask this question about something and they're like, Oh they just dismiss me and how I'm feeling or whatever"*

For both Sara and Leila, this subsequently impacted upon how they interacted with professionals and sought support, as they engaged in submissive and subjugated behaviour when expressing their support needs. For Sara, the harmful implications of expecting to be dismissed by professionals lead her to purposefully alter how she talks to professionals about her support needs to be "*taken seriously*":

> *"...if they don't listen to me, or they invalidate something that I'm saying, or are not taking me seriously, I prepare myself for that beforehand. So just in case, instead of expecting someone to take me seriously, or expecting somebody to listen. I expect them not to do *laughs*, and then be prepared to have to persuade them to a little bit, really." ... "I just have to be a bit more stronger in maybe the wording or language that I use in order to, perhaps, be taken seriously"*

Instances of subjugated and submissive behaviour are further illustrated in Leila's narrative, as she describes wanting to make a formal complaint against a Medical Consultant due to feeling "*bullied*" throughout her treatment, though she acquiesced and did not pursue the complaint due to feeling it would be "*just too much*" for her to manage:

> *"We did think we'd talk to somebody about it, but then my husband said 'Talking about it, obviously they'll want to come back to you again. Are you ready for it?' And I was like, 'Just let it go'. Because at that time, I didn't want to repeat everything. Obviously, if we had complained about her, they would want to get back to me for the whole investigation, and I wasn't ready for the investigation part".*

Leila's interactions with healthcare professionals resulted in her "*los(ing) a lot of self-confidence*" and taking her husband to subsequent maternity appointments for support: *"I*

didn't like going without my husband because I felt like, oh, 'what if they start judging me?', but slowly, slowly, because I took a lot of visits. So it did get better, but it was still very scary". The lasting effects and seriousness of women's negative interactions with healthcare professionals in contributing to subjugated behaviour is illustrated in Leila's subsequent quote, in which she describes how her fear of future judgement from professionals led to her being passive, dismissing her own needs and feeling less able to voice her pain in her subsequent labour:

> *"You know, even when my son was being born, I was in full labour and I wasn't calling the nurses, because I was like, 'What if they start screaming at me?' And I was in the hospital and I was in full term labour and I was just walking, and she was like, 'Oh, it's time to check your baby' and she's put her finger in and she was like, 'You're in labour, I can see the baby, you have to push in emergency room straight away'. And she's like, 'How come you didn't tell us? Like you're such a brave woman, how could you be walking?' And I was like, 'I did tell you I'm in pain'. She was like 'When you're in labour, you don't come to us and say, Oh, we are in pain. You have to come and scream to us and say look, I'm in pain'. But I was so scared of being judged, you know?"*

In summary, this superordinate theme reflects the lasting and harmful implications that women's interactions with professionals had upon their continued relationship with healthcare providers and their confidence in seeking support during the loss of their babies and beyond this, into their future engagement with professionals. Instances of women's submissive and subjugated narratives and behaviours are presented, which appear to reflect experiences of internalized racism and serve to maintain a self-perpetuating cycle of oppression.

The next superordinate theme describes women's ability to find connection and acceptance following their loss, towards a journey of healing.

Theme 3: Connecting after loss

This theme reflects women's experiences of meaningful support and enduring connections through and beyond their experiences of perinatal loss, and towards a journey of

acceptance and healing. Within all women's narratives, a shared dialogue emerged relating to the significance of connecting with others, alongside the importance of their Islamic-faith, and religious and spiritual beliefs. Through connection, women found acceptance, healing and attached new and higher meanings to their experiences of baby loss.

Everlasting support

Despite women describing aspects of their care that was insensitive and misaligned to their needs within the '*Inequalities in provision of care"* theme*,* three women recalled receiving *"above and beyond" (Sofia)* care from professionals that was meaningful and attuned to their emotional, practical, and religious needs. These experiences involved women receiving empathetic, compassionate, respectful, and reassuring care from healthcare professionals, with Amira demonstrating the meaningfulness of their compassionate support within her quote *"…because it's such a traumatic experience, they just made it that little bit easier"*. Women reflected on the significance of needing compassionate care at such a traumatic time after losing their babies, with Alayna illustrating the importance of "*kind words",* validation and reassurance that the loss of her baby was not her fault: "*…they (midwives and Consultant) kept reassuring me 'That there was nothing that you did, you couldn't have done anything to prevent what has happened'".* Alayna reflects upon the importance of receiving warmth and empathic care from professionals:

> *"…throughout she (Consultant) came back and she spoke to me and she talked to my husband. And she was really, really kind. She was really kind, the way she sat there and when she spoke, and even she had tears in her eyes and everyone, whoever would come, they (Consultant and midwives) would just really feel your pain"*

Within women's narratives there was a sense that throughout the trauma of losing their babies, women would forever hold onto and remember compassionate aspects of support. This

is illustrated here within Amira's quote, as she recalls the everlasting impact that professionals had upon creating lasting memories with her baby after she delivered him:

> *"...they took the baby, but they were very caring, towards like, 'What blanket would you like to use? What do you want him wrapped in? Have you got any clothes for him?'... you look back and you think, that meant so much because that is the only memory you sort of carry forward."*

> *"I remember holding my baby and she said to me, 'He is the most beautiful thing ever'. And you just remember the words that they say, and it just sticks with you. She said, it just wasn't meant to be, but he's the most beautiful angel and just those sort of touching words, that stays with you."*

The lasting impact of professional's support is also demonstrated within Sofia's quote, as she refers to "*one professional who still stands out, who was a Neonatologist"*, describing how he acknowledged and respected her religious and cultural beliefs throughout her journey of being advised that her daughter would not survive a lethal genetical condition:

> *"He understood the religious, in fact, he did at times even understand the religious side of it and tried to balance religion and science, which was really helpful to try and make us see, I think he was trying to prepare us to say that, 'You know miracles do happen, but sometimes we need to just look at the facts as well'."*

For four women, there was a shared narrative about their husbands, close family and friends providing them with invaluable emotional and practical support, that was validating, responsive and attuned to their changing needs. Women reflected on their close family caring for their needs in the days to weeks after their loss, ensuring that they ate and drank, whilst also spending time and listening to them throughout their physical and emotional recovery. Alayna recalls "*getting a lot of support from (her) family. Because Asian community is more like a close-knit family.",* with Zara reflecting how her husband went into "*parent mode"* caring for their other children and giving her "*that time to actually absorb it, and to actually just go with the flow".*

Alongside women's experiences of compassionate care from their family, friends and healthcare professionals, women valued opportunities which allowed them to connect with others and share their experiences of loss and grief. This will be explored within the next theme.

"I am not alone"

Despite imposed narratives about not openly talking about their experiences of baby loss, women recognised the value and found resilience to share their stories of loss and connect with others as a helpful way of coping with their loss.

Five of the women found solace in listening to others and sharing their stories of loss, visiting their babies grave, and creating new and meaningful ways to connect with their babies, beyond their death. Women found comfort in connecting with others who had similar experiences of perinatal loss, as it helped them to recognise that they were not alone and that "*other women go through this (perinatal loss)" (Sara).* Connecting with other women (and their families) who understood their experiences appeared to provide validation for their traumatic experiences and enabled their grieving process, whilst providing hope, strength, and reassurance for their future. This is illustrated in the below quotes from Leila and Sara:

> *Leila: "...but those three or four times (attending midwife-led support group) were enough to make me understand, you know, it was just the feeling of being told that, you know, actual human beings go through it and you're just not going through nothing"*

> *Sara: "I think that the one thing that helped was to connect women that it had happened to, and understand that it's okay, it happens and you know, unfortunately it is common, but it's okay. You know, you're not special for having that experience. And we.. you know, we can move on from it. So I think that helps."*

For Sofia and Sara, they were both more receptive to receiving support from others who have lived experiences of perinatal loss, due to feeling that they better understood their experiences and support needs, as illustrated by Sofia: *"...so I valued their advice and their words, because they'd been through a loss".* In connecting with others through their

experiences of perinatal loss, women reflected upon a change in their relationships with others. Here Sara reflects how sharing stories of loss helped her to process her grief, whilst also strengthened her connections with friends who she came to realise had also experienced perinatal loss: *"…when I realised it happened to a couple of friends, I could talk to them about it and it helped us to connect and helped me to understand the process and just know that other people go through this, other women go through this".* Similarly, Amira reflected on a changed relationship with her husband "*And I saw a different side to my husband, I found that he's more supportive than I think *laughs*. But he just did all the right stuff as well".*

Whilst women primarily connected through shared experiences of loss, Amira and Alayna found connection in their continuing identities as mothers and to their babies, valuing the importance in "*keeping the memory alive" (Amira)* through making lasting memories with their babies and integrating their losses into their family life. This is illustrated here by Alayna *"So she's still my daughter, she will always be my daughter"* and Amira *"…I've cried about it (her son), and I now can go and do my normal day to day things. It's just, I'm keeping his memory alive, whether it means talking about him, crying about him, or it's one of those things".* Amira describes how she has integrated the loss of her baby son into her family life and the significance of the continuing bond that exist:

> *"…we always make sure we go on his due date, the day he would have been born or, and the day we lost him, so we always make an effort. And it's just lovely to see because my son will just run, he knows exactly where he is, and that's what I want. Because, he didn't have that brother, but he still has that connection with him and he will go and clean and tidy his grave up. And it's just things like that, that you kind of live for."*

In contrast for Sofia, due to finding out in her pregnancy that her daughter would not survive after birth, she recalled attempts to emotional detach herself and to limit her bonding with her daughter, though experienced difficulties in doing so after she was born:

> *"And I think throughout, you're kind of aware of your emotions, so you're kind of trying to be really sensible, and say, 'Okay, don't connect too much, don't bond too much to*

> *the baby', you're kind of trying to limit the amount of bonding you do throughout the pregnancy, because you know that you're going to be saying goodbye and this baby's not going to be here forever. So you kind of prepare yourself, and you're always doing that to yourself, that 'Don't get too emotionally attached'. But sometimes it's difficult, because after the birth, you can't help but get emotionally attached. It's kind of like you can't control it, it's just something that happens naturally. So no matter how much you try and prepare yourself, there's always things that you can't even think about dealing with, until you are in that time".*

As well as connecting to others who had shared experiences of perinatal loss and to their everlasting relationships with their babies, women also found comfort and healing in connecting with their religious and spiritual values, and to God.

Connecting with spiritual and religious beliefs

This subordinate theme reflects how British-Pakistani women's connection to their religious and spiritual beliefs enabled them to find meaning, comfort and a path towards healing following their perinatal loss. Women drew upon spiritual beliefs that their baby losses were apart of God's greater plan for them, in that their babies had become their saviours and would guide women into the spiritual afterlife for them to be reunited in heaven upon their day of judgement. In the absence of any known causes for the loss of their babies, women struggled to understand and accept their losses, with some women initially blaming themselves for the death of their baby and/or questioning God's intentions, as illustrated by Sara:

> *"I think spiritually, because I am a practising Muslim, I practise as much as I can, or I identify as being a Muslim. Or, you know, anybody really who's who's spiritual, you think, 'Well, why does God do this to me?' You know, 'Well, well am I a bad person or something?' You know, 'What did I do to deserve all this pain and trauma?'"*

However, in their search for meaning and acceptance, women found comfort in understanding the loss of their babies within the context of their religious beliefs surrounding life and death, in that women would be reunited with their babies again in the afterlife. Alayna

and Sara's quotes demonstrate how connecting with their faith allowed them to process their loss and provided the answers that they were previously seeking from healthcare professionals as to why their babies had died:

> *Alayna: "…what really helped me as well at the time, was reading some Islamic books as well. I think that really helped me as well, because I was just reading into my faith and what happens to the child when they pass away. 'Where do they go? And do we get to meet them again?' And I found all the answers to my questions, in my religion."*

> *Sara: "And I think that's the faith aspect really, that kind of pulls me through to know that, it's gonna' be okay at some point. And you kind of give it up, to think it's gonna', everything happens for a reason. And what that reason is, I don't know, and I may never know. But it's just giving it up to God, and I think dealing with it spiritually was the only way to, to move past it really, and to be able to process it."*

Women found comfort in reading Islamic verses and holding onto the belief that their babies had passed through to heaven and had become their saviours, in that they would lead women safety to heaven when they themselves passed away, to be reunited. This is illustrated here by Amira's quote: *"…if a mother has experienced a miscarriage or a loss, when she passes away the baby will hold her hand and lead her to heaven",* and further demonstrated here by Alayna: "*these children are there, they are like your saviours really, because they're gonna' help you on that day, no one can help anyone, but these will all be there".* There was an evolving narrative that women's connections to their religious beliefs provided them with inner strength and enabled them to cope better with the overwhelming effects of their grief, with Sara illustrating that her faith allowed her to be: "…*present in that moment, rather than thinking about the past and being sad and being anxious about the future, about whether it's going to happen again, and all of that stuff, and it just really helped to ground me*". This is also demonstrated by Alayna, as she reflected upon God giving her the "*patience to keep going"* and that she found reassurance in trusting that God wouldn't have bestowed the loss of her baby upon her, if God did not think that she had the strength to manage such a testament:

> *"We believe that God only gives people tests of how much they can bear. He will never give you a test that you can't bear, it would be too much for you. So when I was reading all that and I was thinking that God knows I can get through this, so I will get through this."*

For some women, they described their journey of faith and a changing connection to their religious beliefs and to God following their miscarriage or stillbirth. For Sofia, she described questioning: "*a lot of the things, a lot of the practices*", referencing her belief that Consanguineous marriages are a cultural practice, as opposed to a religious practice, describing her connection with her faith becoming more personal following her stillbirth: *"So religion to me became something personal, something that I'm not going to share with other people, and something that I'm not going to outwardly question".* Sofia also highlighted the importance of healthcare professionals not automatically assuming all British-Pakistani women hold strong religious beliefs and how this may influence their support needs:

> *"I'd like them to be aware of the religious sides, that not everyone is really religious. And so if someone said to me, 'Oh would you like to speak to a religious Imam or someone', I personally would shy away from that."*

For Amira she described religious offerings of support initially not aligning with her belief system or her stage of grieving, however, "*over time (she) gradually connect(ed) more*" and found comfort in *"verses from Islamic books":*

> *"Yeah, I could relate to that more later and find comfort in that later on. Because at the beginning, it's like, well I wanted this baby on earth with me, I wanted to hold this baby. So I wasn't even thinking about what he could do for me, or take me to heaven, but later, I found comfort in reading that and thinking it was God's way and he has better plans for me. And the better plan is that my baby will probably, is going to take me to Heaven, and it's going to be one of those, and then you sort of relate to it later"*

For Alayna she described getting *"closer to (her) religion"* following her stillbirth, and reflected upon a narrative of acceptance and growth, in how she attached meaning to her loss:

> *"She was my child and I just believe from now where I'm sitting now, six months on, I feel like it was a blessing that it happened to me. Because it happened to myself, and I've got so much trust now that it happened … there was no reason for it to happen, but it happened because our God wanted it to happen to me, I was chosen for it to happen"*

Within this subordinate theme women described how connecting to their religious and spiritual beliefs provided them with a higher level of meaning, acceptance and healing following their baby loss, something that appeared could only uniquely be provided by the strength of their faith.

Overall, this superordinate theme reflects women's journeys through and beyond their grief, through which they found connection, acceptance, and attached new and higher meanings associated with the spiritual afterlife and God's plan to their experiences of baby loss.

Discussion

Research findings in context

The study explored how British-Pakistani women made sense of their experiences of support from healthcare professionals, family, friends, and their wider community following perinatal loss. An Interpretative Phenomenological Analysis (APA) of interviews identified three superordinate themes: '*The cycle of silence', 'Power of professionals support'* and *'Connection after loss'*.

The first superordinate theme ***'The cycle of silence'*** reflected how medicalised and socio-cultural narratives existed and contributed towards a sense of silence surrounding perinatal loss, in that baby loss was rarely spoken about or acknowledged, despite women learning that it occurred quite frequently. This appeared to influence how women made sense of their loss and grief, and ultimately created difficulties in receiving and accessing support from both their close family, community, and healthcare practitioners. Narratives of silence and British-Pakistani women's emotional support needs being either misunderstood or dismissed in comparison to their medical needs was referenced throughout their experiences with healthcare professionals, with professionals not appropriately advocating for their psychological support needs and either not providing or signposting onto suitable support.

Congruent with previous research (Dyer et al., 2019; Garcia et al., 2020; Farooq, 2015), women experienced perinatal loss as an unspoken and "*taboo*" topic with expressions of grief being frowned upon or disapproved within their community. This contributed towards women's difficulties in openly talking about the loss of their babies and feeling a burden to others, leading to feelings of loneliness, isolation and being unsupported. As illustrated elsewhere with British-Pakistani women (Farooq, 2015), the findings illustrated women's desire to talk and be asked about their birth and babies, though the preference for dominant discussions about "*normal*" and "*healthy*" babies and birth outcomes, as opposed to narratives

involving grief and perinatal loss. Where perinatal loss and expressions of grief are not openly acknowledged, mourned, or culturally accepted by healthcare professionals, loved ones and societies, this can lead to experiences of disenfranchised grief (Hsu et al., 2002; Palmer & Murphey-Oikonen, 2019). For British-Pakistani women, the influence of the cycle of silence upon oppressing experiences of grief is therefore magnified.

The findings recognised the importance of British-Pakistani women's social support network, and the influencing role that culture played upon women receiving practical and emotional support from their close family and wider community following perinatal loss. As evidenced elsewhere, women reflected on their close family providing them with invaluable practical and emotional support that encouraged them to remain hopeful (Farooq, 2015), referencing the Asian community as being *"like a close-knit family".* However contrastingly and as discussed elsewhere (Asim et al., 2022; Farooq, 2015; Garcia et al., 2020), some women discussed their community holding supernatural explanations as to the causes and implications of their baby loss, leading women to be avoided and isolated within the community, and experience exacerbated feelings of self-blame and judgement.

The disparity of healthcare support surrounding perinatal loss is further demonstrated in the second superordinate theme ***'Power of professionals support',*** which reflects the power and clinical responsibility of healthcare professionals to advocate for British-Pakistani women's needs and provide appropriate and compassionate support. Reflected within this theme is women's experiences of poor, misaligned care and in some cases clinically negligent care, and the harmful implications of these experiences which may cause undue secondary distress and enduring difficulties in seeking healthcare support in the future. Women recalled healthcare support not being aligned or appropriate to their individual, emotional and/or religious needs, with common narratives of women feeling dismissed and reflecting on how little they felt they would have needed from professionals to feel compassionately cared for.

Dominant medical narratives of distress being associated with suicide may reflect the prioritising of Western models of distress, in which non-Western or spiritual conceptualisations of distress are disregarded by Western frameworks that do not respond to the varying diverse needs of Muslim populations (Fricker, 2007).

As illustrated elsewhere (Farooq, 2015), women appeared to express internalized racism about their support needs following perinatal loss, which is defined as "*the individual inculcation of the racist stereotypes, values, images, and ideologies perpetuated by the White dominant society about one's racial group, leading to feelings of self-doubt, disgust, and disrespect for one's race and/or oneself"* (Pyke, 2010, p. 553). For one woman, she explicitly questioned racism and whether professionals were rude and dismissive of her support needs due to her race, with this theme reported elsewhere in the literature, with Muslim and Pakistani women describing institutionalised racism, stereotypical, discriminatory, prejudice and insensitive attitudes and behaviours from maternity healthcare professionals (Birthrights, 2022; Farooq, 2015; Firdous et al., 2020).

Consistent with reports elsewhere in the literature (Farooq, 2015; Garcia et al., 2020; Smith et al., 2020), women reported poor communication and limited information being shared by professionals about risk factors associated with pregnancy, perinatal loss and what to expect during their birth experiences following their miscarriage or stillbirth. Evidenced elsewhere, women also described being left without answers following their perinatal loss and being sent home without any specific or appropriate support provided (Farooq, 2015; Garcia et al., 2020). Some women described feeling entirely reliant upon professionals to provide them with clear and complete information, though reflected upon not being given information that could have prepared them for the death or delivery of their babies and avoided unnecessary experiences of secondary trauma and distress. This has previously been evidenced with Pakistani, Bangladeshi, and White British women (Farooq, 2015; Garcia et al., 2020; Smith et al., 2020),

highlighting the clinical obligation and responsibility of healthcare professionals to provide clear and transparent information and use appropriate terminology to prepare women for the realities of pregnancy, labour and birth experiences following perinatal loss.

As a result of British-Pakistani women's negative interactions with healthcare professionals in which they felt judged, dismissed, and minimised, some women described harmful implications upon their relationship to receiving or seeking professional support in the future. For instance, women reported being more sceptical and less likely to be open about their support needs with professionals and described purposely altering how they engage with professionals since their perinatal loss, for example, displaying subjugated behaviour due to fear of judgement from professionals or expecting to be dismissed and therefore using stronger wording to be taken more seriously. Fear of being judged negatively by healthcare professionals has also been evidenced within Pakistani women's experiences of bereavement following perinatal loss (Garcia et al., 2020).

The last superordinate theme '***Connection after loss'*** reflects British-Pakistani women's experiences of receiving meaningful support from healthcare professionals, close family, and the significance of connecting to others with shared experiences of baby loss, and to their religious-spiritual beliefs. As evidenced elsewhere (Birthrights, 2022; Garcia et al., 2020), women described receiving empathetic and compassionate care from maternity and general healthcare professionals that was attuned to their individual needs, with this care enabling lasting positive memories that endured beyond the time of their loss. Also, consistent with previous research (Farooq, 2015), British-Pakistani women valued creating continuing bonds with their babies and sharing their experiences of loss with other bereaved mothers as fundamental in helping them to not feel alone and manage the psychological impact of perinatal loss. The significance of seeking out a support network and connecting with others who had similar experiences of loss may be even more central to their recovery, given the extent of

silence, medicalised and socio-cultural dominant narratives that appeared to prevent open discussions about loss and their emotional needs being appropriately met. There are many different models of coping with bereavement, though women's narratives appeared to relate to psychological concepts noted within the Continuing Bonds Theory (Klass et al., 1996), which demonstrates the importance of developing new relationships with loss and ongoing attachments with the deceased to cope with bereavement.

There was a strong narrative that as women moved throughout their grieving and healing journey, they came to rely less upon support from healthcare professionals and more upon themselves and their spiritual connection to God. As reported elsewhere (Allahdadian & Irajpour, 2015; Kalu, 2019), British-Pakistani women found courage, acceptance, and reassurance within their religious and spiritual beliefs, through which they came to accept and find comfort in the belief that their loss was part of God's greater plan and that they would be reunited again in the afterlife.

Strengths and limitations of the study

This is the first study to explore British-Pakistani women's unique and multifaceted experiences of receiving support from healthcare professionals, family, friends, and the wider community following perinatal loss, and therefore contributes new knowledge to the literature base. A further strength of the study is that it was thoughtfully developed through consultation with women from the British-Pakistani community, with women providing either guidance through their lived experiences of perinatal loss or through expertise working within a perinatal and anti-racist frame of reference.

It's important to consider how representative this studies sample of British-Pakistani women are, when compared to British-Pakistani women within the general population who have experienced perinatal loss. Firstly, recruitment into this study was on a voluntary basis

and relied upon women having existing connections with either the local NHS trust or third sector charitable support service to have been informed about the research. The sample may therefore only represent women who were in touch with support services and were willing to discuss their experiences of support following perinatal loss, possibly excluding British-Pakistani women that may face additional barriers and ethnic inequalities in accessing and receiving support. This is particularly relevant considering that British-Pakistani women within this study described diminishing trust with healthcare services, being more sceptical and less open to receiving or accessing healthcare services in the future. Additionally, due to unavailable funding for an interpreter, the study excluded women not fluent in English and therefore does not highlight the additional disadvantages that Pakistani women who cannot speak English experience in communicating and subsequently having their needs appropriately met by maternity services (Garcia, 2017; MacLellan et al., 2022).

Implications for clinical practice

The Equality Act 2010 states that NHS treatment and care, including that of maternal care, should be equitable, with no person experiencing discrimination based on their ethnicity. To reduce maternal inequalities experienced by ethnic minority women, urgent action must be taken by healthcare providers to provide maternity care that meets women's basic human rights to safety, dignity, autonomy, and equality. The research highlights several recommendations which could be implemented to improve the level of support that British-Pakistani women receive before, during and following a perinatal loss. Healthcare providers have a clinical duty to provide culturally safe, high quality and equitable care to all patients to meet their diverse values, beliefs, social and cultural needs, irrespective of ethnicity (Horvat et al., 2014). Considering British-Pakistani women's experiences of racial inequality within maternity care, it is paramount that healthcare services embed trauma-informed approaches that consider racial

trauma, take responsibility to provide racial equality in maternity care and make progress to implement the actions and steps identified within Birthrights (2022) inquiry into systemic racism. These including commitment to be an anti-racist organisation, decolonising maternity curriculums and guidance, making Black and Brown women and birthing people decision-makers in their care and wider maternity system, creating safe and inclusive workforce cultures, and dismantling structured barriers to racial equity through national policy change (Birthrights, 2022).

When working with clients who hold an Islamic-faith, Williams (2005) recommends that healthcare professionals must, identify and avoid making false assumptions concerning Islamic beliefs, values, and practices; be aware of and respect issues, practices, and belief systems that underly an Islamic client's frame of reference; and work within the boundaries of and incorporate client's religious belief sets. Delivering insensitive care that does not account for British-Pakistani women's race, values and belief systems may therefore lead women to feel misunderstood, insulted, disregarded, disempowered, or disrespected. Harmfully, this may result in therapy being incomplete or not fully valid, as key elements of their reflective processing and underlying frame of reference may be missing (Williams, 2005). It is essential for healthcare professionals to engage in continuous racial awareness training and appropriate ongoing supervision and continue to gain understanding and experience in working with women from diverse racial, cultural, and social backgrounds, such that they can better cater for the unique needs of British-Pakistani women.

The findings illustrated the role and function of British-Pakistani women's faith and religious-cultural belief systems as central in their healing journey, and therefore there is a need for more spiritually orientated methods of working with bereavement. This must be both acknowledged and included by healthcare professionals, within assessment frameworks, psychological models and interventions when supporting ethnic minority women who may rely

upon their faith following perinatal loss. Keshavarzi and Haque (2013) highlight the significance of psychological interventions involving client's identity to their Islamic faith, through acknowledging spiritual and cultural identity as powerful mechanisms towards change and healing. However, use of westernised psychological theories, ideals and worldviews may be incompatible or ineffective for women from a cultural minority, which could further marginalize ethnic minority communities from accessing and engaging meaningfully in mental health and maternity services (Ahmed & Amer, 2012; Keshavarzi & Haque, 2013). In providing culturally and religiously safe care to British-Pakistani women, healthcare professionals must ensure that they apply theoretical frameworks which take consideration women's unique and diverse racial, spiritual, religious, and cultural needs. One model that holds the spiritual self as fundamental to positive mental health and can support clients of Islamic-faith to build positive mental health is the Al-Ghazali model of the self (Keshavarzi & Haque, 2013). This model can be used by culturally competent non-Islamic mental health practitioners to support non-Muslim and Muslim clients in reaching change and overall positive health. However, barriers to embedding Islamic-informed models within healthcare services include the lack of recognition and policy surrounding the standardised need for the spiritual assessment of service users, despite the Department of Health (2009) and research evidencing the need for professionals to consider the impact of spirituality on service users mental health recovery as part of a holistic and all-inclusive assessment (Islam et al., 2021). More prominently however, fundamental factors contributing to health disparities and inequalities in the provision of maternity care, and acting as a barrier towards British-Pakistani Muslim women accessing healthcare services is structural and systemic racism, and Islamophobia (Bunglawala et al., 2021), with Islamophobic discrimination reportedly associated with poorer mental and physical health, in which fear of further discrimination acts as a barrier towards accessing healthcare services (Samari et al., 2018). Addressing these issues at a governmental

and policy level is essential to reduce racial inequalities and improve the healthcare experiences of Muslim clients to ensure no person experiences discrimination based upon their ethnicity.

Furthermore, the findings revealed that healthcare professionals did not provide sufficient or transparent information about adverse birth outcomes throughout pregnancy, what to expect when having a miscarriage or stillbirth, and information about emotional support services. The unintended consequences of providing insufficient information and using language or terminology that minimizes and/or dismisses women's experience of trauma is extremely harmful, as women felt unprepared for the realities of perinatal loss and labour, and subsequently experienced secondary distress and trauma. Healthcare professionals therefore have a clinical obligation to provide women with clear and transparent information that is easily accessible, and for this to be provided to women both verbally, and physically in the form of leaflets, posters, and within wider educational information. Ensuring British-Pakistani women have equal access to information is essential in reducing the power dynamics between healthcare professionals, whilst also promoting their ability to make informed decisions about their care, which could empower them to recognise their own support needs and seek support.

In supporting British-Pakistani women's bereavement and recovery needs, healthcare professionals should ensure that they inform and/or signpost women to support services in which they can connect with other women and families who have experienced perinatal loss. Where British-Pakistani women identify strongly with their faith, it is important for healthcare professionals and psychological models to acknowledge the importance of Islamic culture and collectivism, which emphasises the importance of strengthening one's social support network through their extended family, and interconnectedness with their community (Keshavarzi & Haque, 2013).

Additionally, improving wider societal and public awareness of the prevalence and psychological impact of perinatal loss, regardless of the length of pregnancy, is essential to

help break the misunderstanding, silence and stigma surrounding perinatal loss. If a greater understanding of perinatal loss exists within the public and particularly within the Pakistani community, this could contribute towards more open discussions between British-Pakistani women and others close to them, enhancing women's social support network and ability to talk more about their loss and grief. However, the challenges of this are recognised, though greater public awareness through national educational campaigns, TV broadcastings and the media could work support this endeavour.

Future research

The current study briefly highlighted additional disadvantages that newly arrived migrant Pakistani women to the UK experience in navigating maternity services and receiving support following perinatal loss. As noted elsewhere (Garcia et al., 2020; Pollock et al., 2020), research would benefit from exploring the additional inequalities of support that newly arrived migrant and non-English speaking Pakistani women experience following perinatal loss. Whilst not included within the main analysis of this study due to the small research scope and termination of pregnancy being conceptualized and experienced differently to natural baby loss, two women discussed the additional stigma attached to a termination of pregnancy within the Pakistani community due to religious and cultural beliefs. For instance, to avoid questioning from others, one woman socially referred to her termination as a miscarriage, where concealment led to difficulties seeking and accessing appropriate support tailored to the additional complexities associated with termination of pregnancy. Research exploring how British-Pakistani women make sense of their experiences of terminating a pregnancy, and their subsequent maternity and bereavement support needs is essential to help healthcare providers and the community understand the unique and complex factors influencing the provision of culturally and religiously responsive care.

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Chapter Three: Public Dissemination Document - Press Release

University of Birmingham News Release

Do brief psychological interventions following a traumatic childbirth reduce maternal psychological distress?

Within the maternity context many interventions intend to prevent the development of maternal psychological morbidity following childbirth, with one intervention commonly known as debriefing. However, the current utility of debriefing interventions to reduce maternal psychological morbidity following traumatic childbirth is unclear and inconclusive, with research reporting little or no evidence to support either positive or adverse effects (Bastos et al., 2015), whilst other research indicates increased symptoms and possible harm (Rose et al., 2002; Rowan et al., 2007). Despite insufficient evidence regarding its utility, women report valuing the opportunity to have their birth validated by a midwife (Baxter et al., 2014; Rowen et al., 2017). These interventions have been widely studied, however, relatively less researched brief interventions include structured self-help psychoeducational material and self-directed expressive writing tasks (Di Blasio et al., 2015; Horsch et al., 2016; Slade et al., 2020). These low-cost interventions may have a place within the maternity context to reduce maternal morbidity and appear in line with NICE (2014) antenatal and postnatal mental health guidelines recommending the development of cost-effective adapted psychological interventions for women in the perinatal period.

Researchers at the University of Birmingham conducted a meta-analysis exploring the impact of delivering varying afterbirth interventions after a traumatic childbirth to reduce maternal psychological morbidity (post-traumatic stress symptoms, depression and anxiety). When comparing all interventions, the findings revealed that interventions only reduced the severity of post-traumatic stress in the short term up to 3 months, though did not sustain longer-

term recovery in the medium to long term. Debriefing interventions did not show advantageous findings, whilst self-directive expressive writing tasks based upon Pennebaker (1997) approach showed effectiveness in reducing post-traumatic stress and depressive symptoms. Due to small number of studies contributing to anxiety, reliable analysis could not be conducted. The review adds to the existing mixed to unclear evidence about the effectiveness of debriefing interventions in reducing maternal morbidity and does not support the routine use for women who experience their birth as traumatic. Interestingly, the review adds to the literature base in highlighting the potential utility of self-expressive writing tasks in reducing psychological morbidity within the maternity context.

Variability in the interventions and the way the studies were conducted impacted the scientific rigour and influences the accurate interpreting effect of the interventions.

The researchers make recommendations for future research, including, future studies reporting the intervention protocol and completing/providing an assessment of fidelity to enable clearer interpretation of the interventions, and future research into the utility of expressive writing tasks and self-help psychoeducation material in reducing maternal morbidity following a traumatic birth as the evidence is within its infancy for these interventions.

ENDS

For media enquiries please contact Anna Chattaway, School of Psychology, University of Birmingham, tel: [redacted] email: [redacted]

Notes to editor:

- The University of Birmingham is ranked amongst the world's top 100 institutions. Its work brings people from across the world to Birmingham, including researchers, teachers and more than 6,500 international students from over 150 countries.

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University of Birmingham News Release

British-Pakistani women experience ethnic inequalities in their support following baby loss: culturally safe care can improve women's experiences of support

It has long been recognised that Asian women continue to experience disproportionate racial inequities in maternity outcomes, including being more likely to have worse care, die and experience baby loss during pregnancy and childbirth, as compared to White women (Birthrights, 2022; Draper et al., 2021; Knight et al., 2021). Despite disproportionately high rates of perinatal loss amongst British-Pakistani women in Birmingham, there is a paucity of research exploring their experiences of receiving support.

To help understand how British-Pakistani women make sense of their experiences of support following baby loss and their subsequent support needs, researchers at the University of Birmingham interviewed six British-Pakistani about how healthcare professionals, their family, friends, and wider community supported them following the loss of their babies. Women felt that dominant medicalised and sociocultural narratives strengthened a cycle of silence surrounding perinatal loss and ultimately influenced their grief journeys and ability to access support. Women reflected on poor and on occasion clinically negligent support from healthcare professionals, despite their power and responsibility to advocate for their support needs, and the harmful implications of this upon seeking and receiving professional support in the future. The significance of compassionate support from healthcare professionals and their family, friends and community, alongside connecting through shared experiences of loss and to their religious and spiritual identity was also highlighted.

The researchers make several recommendations and call upon the National Health Service to take responsibility and commit to urgent action to ensure that British-Pakistani

women receive racial equality in maternity care, through the provision of high quality care that meet their diverse values, beliefs, social and cultural needs, irrespective of ethnicity (Horvat et al., 2014).

The researchers would like to thank the brave British-Pakistani women who lived and reshared their traumatic experiences of baby loss and their experiences of receiving support.

ENDS

For media enquiries please contact Anna Chattaway, School of Psychology, University of Birmingham, tel: [redacted] email: [redacted]

Notes to editor:

- The University of Birmingham is ranked amongst the world's top 100 institutions. Its work brings people from across the world to Birmingham, including researchers, teachers and more than 6,500 international students from over 150 countries.

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The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester.

Knight, M., Bunch, K., Tuffnell,. D, Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S., & Kurinczuk, J. J. (Eds.). (2021). *Saving lives, improving mothers' care: Lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2017-19.* MBRRACE-UK.

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Appendices

Appendix A: Glossary of terminology and definitions

Ethnicity

"*The social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry, and physical features traditionally associated with race (see race). Increasingly, the concept is being used synonymously with race but the trend is pragmatic rather than scientific"* (Bhopal, 2004, p. 443).

Ethnicity categories (based upon the Census)

Asian or Asian British

Including Indian, Pakistani, Bangladeshi, Chinese, and any other Asian background.

Black or Black British

Including African, Caribbean, and any other Black African or Caribbean background.

Mixed ethnicity

Including White and Black Caribbean, White and Black African, White and Asian and any other mixed or multiple background (e.g., Black and Asian).

British-Pakistani

A person born and raised in the UK, or Pakistani-born and migrated to the UK.

Western

"A person or populations with ancestry in a region conventionally known as the west, effectively European countries, as distinguished from Eastern or Oriental populations" (Bhopal, 2004, p. 444).

Racism/institutional racism

"A belief that some races are superior to others, used to devise and justify individual and collective actions that create and sustain inequality among racial and ethnic groups. Individual racism is usually manifested in decisions and behaviours that disadvantage small numbers of people. Institutional racism, whereby policies and traditions, sometimes unwittingly, favour a particular racial or ethnic group, may be less obvious but may disadvantage large populations." (Bhopal, 2004, p. 444).

Racial prejudice

"Negative beliefs, perceptions, or attitudes towards one or more ethnic or racial groups." (Bhopal, 2004, p. 444).

Islamophobia

An 'unfounded hostility towards Islam' and the consequential discrimination this hostility causes to individuals and communities that are associated with Islam (Conway, 1997).

Appendix B: Sponsorship from the University of Birmingham

UNIVERSITY OF BIRMINGHAM
FINANCE OFFICE

Miss Anna Chattaway
School of Psychology
University of Birmingham

Thursday, 22 July 2021

Dear Miss Chattaway

Project Title: **British Pakistani womens experiences of support following a perinatal loss during the Coronavirus pandemic within the United Kingdom.**
IRAS ID: **297126**
Sponsor Reference: **RG_20-195**
UoB Ethics Reference: **ERN_20-1861**

Under the requirements of UK Policy Framework for Health and Social Care Research, the University of Birmingham agrees to act as Sponsor for this project. Sponsorship is subject to you obtaining a favourable ethical opinion, HRA approval and NHS R&D management approval where appropriate.

As Chief Investigator, you must ensure that local study recruitment does not commence until all applicable approvals have been obtained. Where a study is or becomes multi-site you are responsible for ensuring that recruitment at external sites does not commence until local approvals have been obtained.

Following receipt of all relevant approvals, you should ensure that any subsequent amendments are notified to the Sponsor, REC, HRA and relevant NHS R&D Office(s), and that an annual progress report is submitted to the Sponsor, REC and NHS R&D departments where requested.

Please ensure you are familiar with the University of Birmingham Code of Practice for Research (http://www.birmingham.ac.uk/Documents/university/legal/research.pdf) and any appropriate College or School guidelines.

Finally please contact researchgovernance@contacts.bham.ac.uk should you have any queries.

You may show this letter to external organisations.

Yours sincerely

Dr Birgit Whitman
Head of Research Governance and Integrity

cc: Dr George Johnson

Appendix C: NHS Health Research Authority Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Anna Chattaway
Trainee Clinical Psychologist
Birmingham and Solihull Mental Health Foundation Trust
B1 Trust HQ
Unit 1, 50 Summer Hill Rd, Birmingham
West Midlands
B1 3RBN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

01 November 2021- Reissued 19 November 2021

Dear Miss Chattaway

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**British Pakistani women's experiences of support following a perinatal loss during the Coronavirus pandemic within the United Kingdom.**
IRAS project ID:	**297126**
Protocol number:	**RG_20-195**
REC reference:	**21/IEC08/0027**
Sponsor	**University of Birmingham**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **297126**. Please quote this on all correspondence.

Yours sincerely,
Barbara Cuddon

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Dr Birgit Whitman*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Please note: The date and version number on the Participant Information Sheet differs between the REC favourable opinion letter and the HRA Approval letter as changes had to be made for HRA Approval.

Document	*Version*	*Date*
Evidence of Sponsor Insurance or Indemnity (non NHS Sponsors only) [IRAS ID 297126 - Confirmation of Sponsor Insurance letter]	Version 1	22 July 2021
Interview schedules or topic guides for participants [IRAS ID 297126 - Interview topic guide]	Version 1.1	29 September 2021
IRAS Application Form [IRAS_Form_23072021]		23 July 2021
IRAS Application Form XML file [IRAS_Form_23072021]		23 July 2021
Letter from sponsor [IRAS ID 297126 - Confirmation of Sponsorship letter]	Version 1	22 July 2021
Letter from statistician [IRAS ID 297126 - Review of Proposal (Research Tutor CJ)]	Version 1	16 September 2020
Letters of invitation to participant [IRAS ID 297126 - Invitation letter to study]	Version 1	19 July 2021
Non-NHS/HSC Site Assessment Form [IRAS ID 297126 - Birth Trauma Association PIC Agreement]	Version 1	19 July 2021
Non-NHS/HSC Site Assessment Form [IRAS ID 297126 - Approachable Parenting PIC Agreement]	Version 1	19 July 2021
Non-NHS/HSC Site Assessment Form [IRAS ID 297126 - Acacia PIC Agreement]	Version 1	19 July 2021
Organisation Information Document [IRAS ID 297126 - Organisation Information Document NonCommercial - Version 1 March 2021]	Version 1	12 July 2021
Other [IRAS ID 297126 - Consent to Contact Form]	Version 1.1	29 September 2021
Participant consent form [IRAS ID 297126 - Participant Consent form]	Version 1.1	29 September 2021
Participant information sheet (PIS) [IRAS ID 297126 - Participant Information Sheet]	Version 1.1	29 September 2021
Participant information sheet (PIS) [IRAS ID 297126 - Participant Information Sheet]	Version 1.2	27 October 2021
Referee's report or other scientific critique report [IRAS ID 297126 - Review of Proposal (Research Tutor CJ)]	Version 1	16 September 2020
Research protocol or project proposal [IRAS ID 297126 - Qualitative Protocol]	Version 1	19 July 2021
Response to Additional Conditions Met [Response to Provisional Opinion]		01 October 2021
Schedule of Events or SoECAT [IRAS ID 297126 - Schedule of Events]	Version 1	29 March 2021
Summary CV for Chief Investigator (CI) [IRAS ID 297126 - Anna Chattaway CV]	Version 1	01 March 2021
Summary CV for student [IRAS ID 297126 - Anna Chattaway CV]	Version 1	29 March 2021
Summary CV for supervisor (student research) [IRAS ID 297126 - Supervisor CV]	Version 1	12 July 2021
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [IRAS ID 297126 - University of Birmingham employer's liability / public and products liability letter]	Version 1	01 August 2020
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [IRAS ID 297126 - University of Birmingham CT coverage letter]	Version 1	01 August 2020

IRAS project ID	297128

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All NHS organizations will be undertaking the same research activities, therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organization information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No funding will be provided to study sites, as per the Organization Information Document	A local collaborator is required at NHS study sites. The researcher has requested a Principal Investigator at NHS study sites, however it is the HRA's opinion that a local collaborator would suffice. The Chief Investigator will be undertaking any research activities beyond participant identification and recruitment.	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to seek inclusion on the NIHR LCRN Portfolio. The applicant has included Model Non-Commercial Participant Identification Centre Agreements for non-NHS PIC sites. HRA Approval covers NHS organizations only, therefore the Initial Assessment letter concerns the NHS sites only. That said, the mNC (PIC) agreement supplied is the most appropriate agreement for all sites undertaking PIC activity.

Appendix D: Participant Information Sheet



PARTICIPANT INFORMATION SHEET





BRITISH PAKISTANI WOMEN'S EXPERIENCES OF SUPPORT FOLLOWING A BABY LOSS.

Title of Project: What are British Pakistani women's experiences of support following a perinatal baby loss within the United Kingdom?

Researchers: Anna Chattaway, Dr George Johnson (Clinical Psychologist and Academic Lecturer), Dr Samantha Day (Consultant Clinical Psychologist and Clinical Lead of the Maternal Mental Health Service across Birmingham and Solihull) and Dr Rukhsana Arshad (Clinical Psychologist).

This study is being conducted as part of Anna Chattaway's Doctorate in Clinical Psychology at the University of Birmingham.

We would like to invite you to take part in a research study being Sponsored by the University of Birmingham. Before you decide if you want to take part, it is important that you understand why the research is being completed and what it would involve for you. Please read the below information carefully and if you have any more questions, please let us know. Joining the study is entirely up to you and you don't have to take part.

What is the purpose of this research?

The experience of pregnancy and giving birth can often be frightening, with many women experiencing complications throughout their maternity journey, including the loss of their baby through miscarriage, stillbirth or neonatal loss.

This research hopes to understand how British Pakistani women have been supported to cope with the experience of baby loss, through miscarriage, stillbirth or neonatal loss. There is very little research in this area and a lot that healthcare services do not know about how to best support women like you. This research hopes to understand how British Pakistani women have coped with these difficult experiences and explore things that services, communities, family members, friends or others have done that is helpful or things that you would like to have been provided.

It's hoped that the research will help to inform healthcare services about how to provide better trauma-informed care that supports women's needs throughout these traumatic experiences, particularly women from ethnic minority backgrounds.

Why have I been invited to take part?

You have been asked to take part as we are looking to speak with English speaking British Pakistani women, 18 years and above, who have experienced the loss of a baby (miscarriage, stillbirth, neonatal loss).

Someone at Approachable Parenting who knows you thought that you might be interested in sharing your experiences.





UNIVERSITY OF BIRMINGHAM









BRITISH PAKISTANI WOMEN'S EXPERIENCES OF SUPPORT FOLLOWING A BABY LOSS.

What would taking part involve?

Taking part in the study would involve you coming to an interview. This will be like a discussion and you will be asked questions about your experiences of support following the loss of your baby. The interview will be around 60 minutes, though this will be flexible on how you feel. There are no right or wrong answers to the questions and we are just interested in hearing about your experiences.

We know that experiencing baby loss is an incredibly traumatic experience and so we will ask you what you need to feel safe within the interview. You only have to share what you feel comfortable and safe to talk about, and if the interview needs to stop at any time, that is okay.

Due to Coronavirus social distancing restrictions, the interview will either be completed over a video-telephone call or face-to-face at a convenient location for you (e.g. your home, community buildings, NHS trust sites). With your consent, your interview will be audio-recorded with an encrypted and secure electronic recording device. You can stop the recording or the interview at any time. Your interview will be recorded so that we can transcribe (typed out on the computer) the interview and look if there are any similarities or differences between your experiences and the other women that we will be interviewing.

It is entirely up to you if you want to take part in the research. You can say no if you do not want to.

How will my information be used?

We will need to use information from you for this research project. This information will include your name, contact details and the information you provide during the interview. The research team will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead and we will provide you with a code name. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results.

We will write our research in a way that no one can work out that you took part in the study. For example, quotes from your interview will be used in the write-up, but these will be anonymised using a code name and no personally identifiable information will be written in the findings.

Yours and other women's answers to the interviews will be written up and submitted as part of Anna Chattaway's Doctorate in Clinical Psychology. The findings will hopefully be published in a research journal. If you would like to, it is your choice if you want to receive a summary of the research findings.



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BRITISH PAKISTANI WOMEN'S EXPERIENCES OF SUPPORT FOLLOWING A BABY LOSS.

What are my choices about how my information is used?

If you take part in the interview but change your mind about being involved you can withdraw from the research up until 2 weeks after your interview. If you withdraw from the study during this 2 week period, any information collected such as your name, telephone number, or interview recording will be securely destroyed. After this 2-week period, we will be unable to remove information about you that we already have, as it will likely have been included in the research analysis.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

If you decide not to take part in this study or you withdraw, you do not have to provide a reason for withdrawing and your decision will not affect the care you might receive now or in the future from any services.

Will my information be kept confidential?

Any information you share that identifies you will remain confidential and will not be made publicly available. All of your data will be kept in a secure location and only remembers of the research team will be able to access it. Your information will be kept for the duration of the study and will then be destroyed in line with the General Data Protection Regulation (GDPR, 2018).

The only time that we might have to share something you have said is if we have concerns about yours or others immediate safety as we have a duty of care to inform the relevant healthcare professionals to keep you and others safe. For example, if you talk about something that may put yourself or others in danger. If after the interview, we feel that you may need some further emotional support, we may talk to your care team (if you are under a professional service), or we may encourage you to contact your GP for support. We would discuss any decisions like this with you first.

Where can I find out more about how my information is used?

You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from www.hra.nhs.uk/patientdataandresearch
- by asking one of the research team (contact details below)
- by contacting the University of Birmingham's Data Protection Officer (Nicola Cárdenas Blanco) on 0121 414 3916 or dataprotection@contacts.bham.ac.uk



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BRITISH PAKISTANI WOMEN'S EXPERIENCES OF SUPPORT FOLLOWING A BABY LOSS.

What are the possible benefits of taking part?

Some people find it helpful to talk about their difficult experiences to researchers.

There is also no research exploring British Pakistani women's unique support needs following a baby loss and so sharing your experiences will help us to understand how women similar to yourself have coped with these difficult experiences. This research may lead to changes in the way services are run, by providing greater trauma-informed care and improving the type of support available to women from ethnic minority backgrounds, in particular British Pakistani women.

What are the possible disadvantages?

We understand that experiencing baby loss is an incredibly traumatic experience and recognise that some questions may cause you to feel upset. If you choose to take part in the interview, we will ask you what you need to feel safe and you only have to share what you feel comfortable and safe to talk about. If you become upset during the interview, we can either take a break or completely stop the interview. If you decide to stop the interview you won't need to provide a reason.

Expenses

If you decided to take part in the research and travel to a face to face interview, only your travel expenses to the interview will be reimbursed. Please provide a valid travel ticket (bus or train) and if you travel by car, you will be reimbursed 25 per mile you travel.

Who has reviewed the study?

This study has been reviewed by the School of Psychology at the University of Birmingham. All research which is conducted within the NHS is reviewed by an independent panel called a Research Ethics Committee to ensure that it meets important standards of ethical conduct. This study has been reviewed and given a favourable opinion by the Social Care REC.

How do I take part in this study?

If you are interested in taking part in the study or want to ask any more questions before making a decision, please contact the researcher on the below details or let Approachable Parenting know that you would like to be contacted.

There is no commitment to be involved in the research at this stage and a member of the research team will happily talk with you to answer any questions that you might have before you make your decision. If you decide to take part in the research, you will be asked to sign a consent form.



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BRITISH PAKISTANI WOMEN'S EXPERIENCES OF SUPPORT FOLLOWING A BABY LOSS.

Contacts for further information or any questions about the study

Researcher Name: Anna Chattaway

Contact e-mail: [redacted]

Please contact this number to talk about being involved in the research.

PALS (Patient Advice and Liaison Service):

PALS is a free and confidential service that can provide advice and support.

Contact number: 0800 953 0045

If you have a problem or a complaint regarding the research, please contact my Supervisor, Dr George Johnson (G.A.Johnson@bham.ac.uk).

Contact details for local organisations supporting parents and families impacted by the loss of a baby

SANDS (Stillbirth and Neonatal Death Charity):

A UK charity that works to support anyone affected by the death of a baby.

Contact details: 020 7436 5881 / www.sands.org.uk

The Lily Mae Foundation:

Supports parents and families after a stillbirth, neonatal death, miscarriage or medical termination.

Contact details: 01676 535716 / www.lilymaefoundation.org/

Edwards Trust:

Supporting children and families facing loss and surviving bereavement across the West Midlands.

Contact details: 0121 454 1705 / www.edwardstrust.org.uk/

I would like to thank you for taking the time to read this sheet and I hope that you consider taking part in this research study.



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Appendix E: Participant Consent Form



Consent Form (IRAS ID: 297126)
Version 1.1: Date: 29.09.21





CONSENT FORM

BRITISH PAKISTANI WOMEN'S EXPERIENCES OF SUPPORT FOLLOWING BABY LOSS.

Participant identification number for this study:

Name of Researcher: Anna Chattaway

Research Title: What are British Pakistani women's experiences of receiving support following baby loss in the United Kingdom?

Please read each statement. If you agree with the statement, please place your initials in the box. If you do not understand any of the statements or have any questions, please discuss this with the researcher.

Please initial the box to indicate agreement

Once you have completed the form, please sign and date it in the space provided below.

1. I confirm that I have read and understood the Participant Information Sheet dated 27.10.21 (Version 1.2) for the above study. ☐

2. I confirm that I have been given the opportunity to ask the researcher any questions that I have had about taking part in the research and that these questions were answered satisfactorily. ☐

3. I understand that taking part in the research is entirely voluntary. ☐

4. I understand that I can withdraw from the research at any time, before, during, or up to two weeks after the interview has taken place without needing to give a reason. I understand that after this two week period my interview will have been written up as part of the research and I won't be able to remove my data. ☐

5. I understand that the interview will be audio-recorded and then transcribed (typed out on the computer) by the researcher. ☐

6. I understand that the audio recording of the interview will be securely stored on the University of Birmingham's secure server. ☐

7. I understand that the researcher may include quotes (my actual words) from our interview in the write-up and that this research may be published. I understand that I will be given a code name so that nobody will know that the quote came from me. ☐



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Consent Form (IRAS ID: 297126)
Version 1.1: Date: 29.09.21





CONSENT FORM

BRITISH PAKISTANI WOMEN'S EXPERIENCES OF SUPPORT FOLLOWING BABY LOSS.

8. I understand that other members of the research team might see parts of my interview after it has been transcribed. However, they will never know my real name as only my code name will be used in discussions about the research. ☐

9. I understand that if the research team have concerns about mine or others immediate safety, that they have the duty of care to inform the relevant healthcare professionals to keep me and others safe. ☐

10. I understand that after the interview if the research feels that I might need further emotional support, that they may talk to my care team (if I am under a professional service), or they may encourage me to contact my GP for support. I understand that they will discuss anything like this with me before. ☐

11. I confirm that I have declared my involvement in any current or recent research studies. ☐

12. I agree to take part in the above study. ☐

Please print and sign your name in the below space:

Name of Participant	Date	Signature
_____	_____	_____

Name of Person taking consent	Date	Signature
_____	_____	_____

(For consent gained over video-call, if you do not have an electronic signature, consent can be provided verbally)

When completed: 1 to be given to the participant and 1 to be kept in the researchers file



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Appendix F: Research Poster



Research Poster (IRAS ID: 297126)
Version 1.1: Date: 29.09.21





RESEARCH PARTICIPANTS WANTED!

BRITISH PAKISTANI WOMEN'S EXPERIENCES OF SUPPORT FOLLOWING BABY LOSS.

- Are you a British Pakistani woman aged 18 years or above?
- Are you able to speak English?
- Have you experienced a baby loss through miscarriage, stillbirth or neonatal loss?
- Will you talk to us about the support you received from healthcare services, your family, friends and your community?
- Will you share your story to help improve the support that can be offered to women like you after baby loss?

IF YES TO THE ABOVE, WILL YOU TAKE PART IN A 60 MINUTE INTERVIEW?

The research hopes to understand how British Pakistani women have coped with these difficult experiences by finding out what support was helpful, or what could be improved.

Interviews are confidential and can be arranged at a convenient time for you.



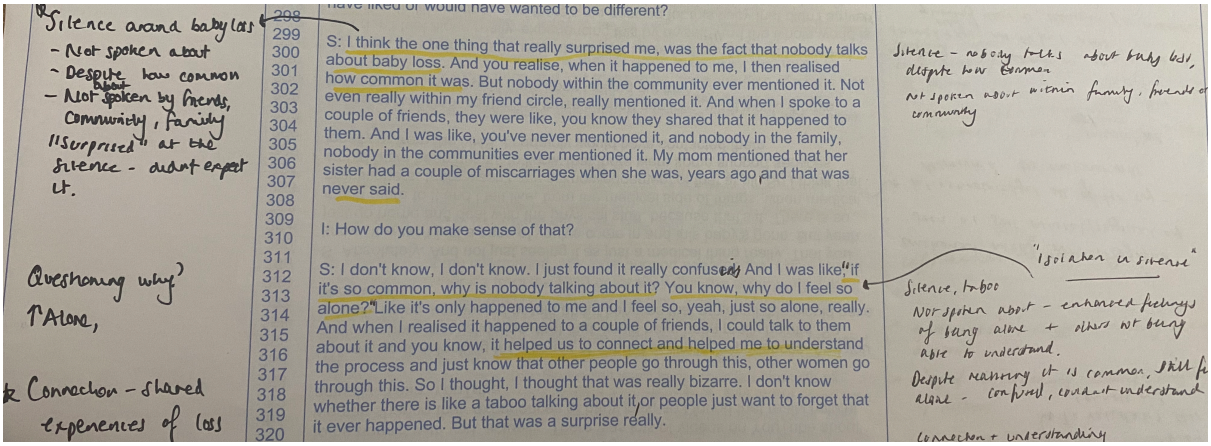
Please contact **Anna Chattaway** if you are interested and would like to find out more information.

[redacted]

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Appendix G: Initial coding of Sara's transcript



Appendix H: Emergent theme for Sara - Cycle of Silence around perinatal loss

Emergent theme	Subordinate Themes	Quotes
Cycle of Silence	**Cultural pressure and expectations:**	*So I think culturally, there's, there's that pressure as well. So it was like, so I was trying to pull myself together. So I wasn't seen to be all lazy, or she's trying to play this out or whatever. So that was that was another challenge. (Line 156 – 160)* *She was supportive and whatnot. But at the same time, there was this sense of like, oh I don't know, maybe it was imagined? I don't think it was, because again, I felt it the second time. That there was, Yeah, oh okay it's been a week now, shall we? Yeah, do you want to start cooking or whatever, you know. So yeah, there was, there was that pressure. (Line 172 – 177)* *I think within maybe, maybe it's a I don't know, maybe it's universal thing? or with certain communities you think. If you have a baby loss and you think, what will my in-laws say? Will they think that I can't have babies? And you know, I'm not, I'm not like, a full woman or whatever. You know? There's that aspect of it as well. Yeah, so, yeah, the pressure and maybe perceived pressure? (Line 337 – 324)*
	Nobody talks about *it*:	*I think the one thing that really surprised me, was the fact that nobody talks about baby loss. And you realise, when it happened to me, I then realised how common it was. But nobody within the community ever mentioned it. Not even really within my friend circle, really mentioned it. (Line 299 – 303)* *I don't know, I don't know. I just found it really confused. And I was like, if it's so common, why is nobody talking about it? You know, why do I feel so alone? Like it's only happened to me and I feel so, yeah, just so alone, really. (Line 311 – 313)* *So I thought, I thought that was really bizarre. I don't know whether there is like a taboo talking about it or people just want to forget that it ever happened. But that was a surprise really. (Line 317 – 320)* *I'd say generally people don't talk about baby loss, universally. And I think there's, there might be certain reasons, maybe, other reasons why we don't talk about it within the Pakistani community. I'm not entirely sure. I don't know. I don't know. I think universally, we just don't talk about it enough. (Line 325 – 328)* *I just feel like it's not talked about, it's not mentioned. It's like let's forget about it, it happens and just move on from it. And I feel like, so many women are going through this, and it's just a cycle. (Line 330 – 333)*
	Internalised blame:	*Because it happened a second time, I was like, why? Why has this gotta' happen to me a second time, and is it not meant to be. (Line 610 – 612)* *Oh it really, it was like I had to keep it a secret and not tell people, because they might think it's my fault. So, again, it created other barriers to seeking support. I think I did anyway eventually I did. But yeah, within your mind, it's just oh gosh I don't want people to know, are they gonna think it's my fault? And yeah, perhaps it is my fault. Perhaps I did work too much, or whatever, you start to question. So it certainly, I think there is certainly a bit of a blame culture towards women. (Line 828 – 834)* *But at the time, it still made me even think, oh gosh, what if it is my fault (Line 844)*

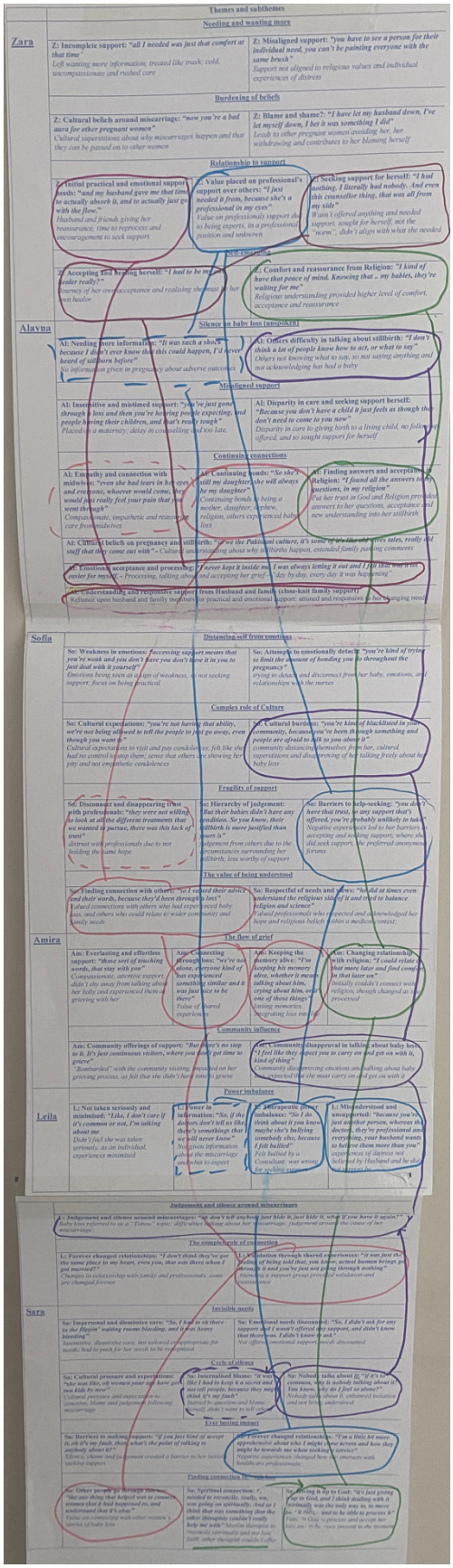
Appendix I: All participants emergent themes

	Themes and subthemes		
Zara	**Needing and wanting more**		
	Z: Incomplete support: ***"all I needed was just that comfort at that time"*** *Left wanting more information; treated like trash; cold, uncompassionate and rushed care*	**Z: Misaligned support:** ***"you have to see a person for their individual need, you can't be painting everyone with the same brush"*** *Support not aligned to religious values and individual experiences of distress*	
	Burdening of beliefs		
	Z: Cultural beliefs around miscarriage: ***"now you're a bad aura for other pregnant women"*** *Cultural superstitions about why miscarriages happen and that they can be passed on to other women*	**Z: Blame and ~~shame?:~~** ***"I have let my husband down, I've let myself down, I bet it was something I did"*** *Leads to other pregnant women avoiding her, her withdrawing and contributes to her blaming herself*	
	Relationship to support		
	Z: Initial practical and emotional support needs: "*and my husband gave me that time to actually absorb it, and to actually just go with the flow.*" *Husband and friends giving her reassurance, time to reprocess and encouragement to seek support*	**Z: Value placed on professional's support over others:** ***"I just needed it from, because she's a professional in my eyes"*** *Value on professionals support due to being experts, in a professional position and unknown*	**Z: Seeking support for herself:** ***"I had nothing. I literally had nobody. And even this counsellor thing, that was all from my side"*** *Wasn't offered anything and needed support, sought for herself, not the "norm", didn't align with what she needed*
	Self-emerging		
	Z: Accepting and healing herself: ***"I had to be my own healer really?"*** *Journey of her own acceptance and realising she must be her own healer*	**Z: Comfort and reassurance from Religion: ~~"~~*I kind of have that peace of mind. Knowing that my babies, they're waiting for me"*** *Religious understanding provided higher level of comfort, acceptance and reassurance*	
Alayna	**Silence on baby loss**		
	Al: Needing more information: ***"It was such a shock because I didn't ever know that this could happen, I'd never heard of stillborn before"*** *No information given in pregnancy about adverse outcomes*	**Al: Others difficulty in talking about stillbirth:** ***"I don't think a lot of people know how to act, or what to say"*** *Others not knowing what to say, so not saying anything and not acknowledging has had a baby*	
	Misaligned support		
	Al: Insensitive and mistimed support: "*you've just gone through a loss and then you're hearing people expecting, and people having their children, and that's really tough*" *Placed on a ~~maternity~~ delay in counselling and too late.*	**Al: Disparity in care and seeking support herself:** ***"Because you don't have a child it just feels as though they don't need to come to you now"*** *Disparity in care to giving birth to a living child, no follow-up offered, and so sought support for herself* ***wanting more, not offered****	
	Continuing connections		
	Al: Empathy and connection with midwives: ***"even she had tears in her eyes and everyone, whoever would come, they would just really feel your pain that you went through"*** *Compassionate, ~~empathetic~~ empathetic and reassuring care from midwives*	**Al: Continuing bonds: "*So she's still my daughter, she will always be my daughter*"** *Continuing bonds to being a mother, daughter, nephew, religion, others experienced baby loss*	**Al: Finding answers and acceptance in Religion:** ***"I found all the answers to my questions, in my religion"*** *Put her trust in God and Religion provided answers to her questions, ~~acceptance~~ acceptance and new understanding into her stillbirth*
	Al: Cultural beliefs on pregnancy and stillbirth: "*so we the Pakistani culture, it's some of it's like old ~~wives~~ tales, really old stuff that they come out with*" - *Cultural understanding about why stillbirths happen, extended family passing comments*		

	Al: Emotional acceptance and processing: ***"I never kept it inside me, I was always letting it out and I felt that was a lot easier for myself. -*** *Processing, talking about and accepting her grief – "day by day, every day it was happening"*			
	Al: Understanding and responsive support from Husband and family (close-knit family support) Reliance upon husband and family members for practical and emotional support: attuned and responsive to her changing needs			
Sofia	**Distancing self from emotions**			
	So: Weakness in emotions: ***"accessing support means that you're weak and you don't have you don't have it in you to just deal with it yourself"*** *Emotions being seen as a sign of weakness, so not seeking support; focus on being practical*	**So: Attempts to emotionally detach:** ***"~~you're~~ kind of trying to limit the amount of bonding you do throughout the pregnancy"*** *trying to detach and disconnect from her baby, emotions, and relationships with the nurses*		
	Complex role of Culture			
	So: Cultural expectations: ***"you're not having that ability, we're not being allowed to tell the people to just go away, even though you want to"*** *Cultural expectations to visit and pay condolences, felt like she had no control to stop them; sense that others are showing her pity and not empathetic condolences*	**So: Secrecy and superstitions (previous Cultural burdens):** ***"you're kind of blacklisted in your community, because you've been through something and people are afraid to talk to you about it"*** *community distancing themselves from her, cultural superstitions and disapproving of her talking freely about her baby loss*		
	Fragility of support			
	So: Disconnect and disappearing trust with professionals: ***"they were not willing to look at all the different treatments that we wanted to pursue, there was this lack of trust"*** *distrust with professionals due to not holding the same hope*	**So: Hierarchy of judgement:** ***"But their babies didn't have any condition. ~~So~~ you know, their stillbirth is more justified than yours is"*** *judgement from others due to the circumstances surrounding her stillbirth; less worthy of support*	**So: Barriers to help-seeking:** ***"you don't have that trust, so any support that's offered, you're probably unlikely to take"*** *Negative experiences led to her barriers in accepting and seeking support; where she did seek support, she preferred anonymous forums*	
	The value of being understood			
	So: Finding connection with others: ***"so I valued their advice and their words, because they'd been through a loss"*** *Valued connections with others who had experienced baby loss, and others who could relate to wider community and family needs*	**So: Respectful of needs and views:** ***"he did at times even understand the religious side of it and tried to balance religion and science"*** *Valued professionals who respected and acknowledged her hope and religious beliefs within a medical ~~context~~*		
Amira	**The flow of grief**			
	Am: Everlasting and effortless support: ***"~~those sort of touching words~~ that stay with you"*** *Compassionate, attentive support, didn't shy away from talking about her baby and experienced them as grieving with her*	**Am: Connecting through loss:** ***"we're not alone, everyone kind of has experienced something similar and it was just nice to be there"*** *Value of shared experiences*	**Am: Keeping the memory alive:** ***"I'm keeping his memory alive, whether it means talking about him, crying about him, or it's one of those things"*** *lasting memories, integrating loss into life*	**Am: Changing relationship with religion:** ***"I could relate to that more later and find comfort in that later on"*** *Initially couldn't connect with religion, though changed as she processed*
	Community influence			
	Am: Community offerings of support: ***"But there's no stop to it. It's just continuous visitors, where you don't get time to grieve"*** *"Bombarded" with the community visiting, impacted on her grieving process, as felt that she didn't have time to grieve*	**Am: Community disapproval in talking about baby loss:** ***"I feel like they expect you to carry on and get on with it, kind of thing"*** *Community disapproving emotions and talking about baby loss, expected that she must carry on and get on with it*		

<table>
<tr><td rowspan="6">Leila</td><td colspan="4">Power imbalance</td></tr>
<tr><td>L: Not taken seriously and minimised: “Like, I don't care if it's common or not, I'm talking about me
Didn’t feel she was taken seriously, as an individual, experiences minimised</td><td>L: Power in information: “So, if the doctors don't tell us like, there's somethings that we will never know”
Not given information about the miscarriage and what to expect</td><td>L: Therapeutic power imbalance: “So I do think about it you know, maybe she's bullying somebody else, because I felt bullied”
Felt bullied by a Consultant; was wrong for seeking support</td><td>L: Misunderstood and unsupported: “because you're just another person, whereas the doctors, they're professional and everything, your husband wants to believe them more than you”
experiences of distress not believed by Husband and he did not support he</td></tr>
<tr><td colspan="4">Judgement and silence around miscarriages</td></tr>
<tr><td colspan="4">L: Judgement and silence around miscarriages: “oh don't tell anybody just hide it, just hide it, what if you have it again?”
Baby loss referred to as a “Taboo” topic; difficulties talking about her miscarriage; judgement around the cause of her miscarriage</td></tr>
<tr><td colspan="4">The complexity of relationships</td></tr>
<tr><td colspan="2">L: Forever changed relationships: “I don't think they've got the same place in my heart, even you, that was there when I got married?”
Changes in relationship with family and professionals; some are changed forever</td><td colspan="2">L: Validation through shared experiences: “it was just the feeling of being told that, you know, actual human beings go through it and you're just not going through nothing”
Attending a support group provided validation and reassurance</td></tr>
<tr><td rowspan="6">Sara</td><td colspan="4">Invisible needs</td></tr>
<tr><td colspan="2">Sa: Impersonal and dismissive care: “So, I had to sit there in the flippin’ waiting rooms bleeding, and it was heavy bleeding”
Insensitive, dismissive care, not tailored or appropriate for needs; had to push for her needs to be recognised</td><td colspan="2">Sa: Emotional needs discounted: “So, I didn't ask for any support and I wasn't offered any support, and didn't know that there was. I didn't know to ask”
Not offered emotional support, needs discounted</td></tr>
<tr><td colspan="4">Cycle of silence</td></tr>
<tr><td>Sa: Cultural pressure and expectations: “she was like, oh women your age have got two kids by now”
Cultural pressure and expectation to conceive, blame and judgement following miscarriage</td><td>Sa: Internalised blame: “it was like I had to keep it a secret and not tell people, because they might think it's my fault”
Started to question and blame herself, didn’t want to tell others</td><td colspan="2">Sa: Nobody talks about it: “if it's so common, why is nobody talking about it? You know, why do I feel so alone?”
Nobody talks about it, enhanced isolation and not being understood</td></tr>
<tr><td colspan="4">Ever lasting impact</td></tr>
<tr><td colspan="2">Sa: Barriers to seeking support: “if you just kind of accept it, oh it's my fault, then, what's the point of talking to anybody about it?”
Silence, shame and judgement created a barrier to her initially seeking support</td><td colspan="2">Sa: Forever changed relationships: “I'm a little bit more apprehensive about who I might come across and how they might be towards me when seeking a service”
Negative experiences changed how she interacts with healthcare professionals;</td></tr>
<tr><td colspan="4">Finding connection through loss</td></tr>
<tr><td>Sa: Other people go through this too: “the one thing that helped was to connect women that it had happened to, and understand that it's okay”
Value on connecting with other women’s stories of baby loss</td><td>Sa: Spiritual connection: “I needed to reconcile, really, what was going on spiritually. And so I think that was something that the other therapists couldn't really help me with” Muslim therapist to reconcile spiritually and not lose faith; other therapist couldn’t offer (either valued professional support, or connection)</td><td colspan="2">Sa: Giving it up to God: “it's just giving it up to God, and I think dealing with it spiritually was the only way to, to move past it really, and to be able to process it”
Faith in God to process and accept her loss and to be more present in the moment</td></tr>
</table>

Appendix J: Looking for connections across participants



Appendix K: Grouping of similar emergent themes and sub-themes

Participant	Sub/theme **Silence of baby loss**	Quotes
Sara	**Nobody talks about *it*:** *Nobody talks about it, enhanced isolation and not being understood*	*"If it's so common, why is nobody talking about it? You know, why do I feel so alone?" – Line 311 - 314* *"So I don't feel alone really, experiencing this by myself. And the whole world is carrying on like normal, and there's me grieving for this baby that didn't arrive" Line 272 - 275* *"...was the fact that nobody talks about baby loss" Line 299 - 230* *"But nobody within the community ever mentioned it. Not even really within my friend circle, really mentioned it" Line 301 - 302* *"I don't know whether there is like a taboo talking about it or people just want to forget that it ever happened" Line 317* *"Generally people don't talk about baby loss, universally" Line 325* *"I just feel like it's not talked about, it's not mentioned. It's like let's forget about it, it happens and just move on from it. And I feel like, so many women are going through this, and it's just a cycle" Line 330 332*
Alayna	**Others difficulty in talking about stillbirth** *Others not knowing what to say, so not saying anything and not acknowledging she has had a baby*	*"I don't think a lot of people know how to act, or what to say" Line 545* *"So I found it a bit weird, because imagine someone's come to your house, and they're not saying anything to you, not mentioning to you that you've had a child or anything, and I found it really odd at the time" Line 549 - 551* *"But I think people just didn't know what to say, or whether to ask about the baby or not, and I think just being silent on someone and not talking to them at all, I think that's really difficult as well" Line 557 - 560* *"They're just number one, dismissing the fact that what has happened, and then they just say that, they're trying to say that, you know, don't worry, you'll have another child" Line 1009 - 1012*
Leila	**Judgement and silence around miscarriages:** *Baby loss referred to as a "Taboo" topic; difficulties talking about her miscarriage; judgement around the cause of her miscarriage (superstitions)* *-leading to difficulties getting support from others*	*"…oh don't tell anybody just hide it, just hide it, what if you have it again" Line 375* *"it's still considered kind of taboo of losing a baby. So first one, I did tell them, but the second one, I was like, oh don't tell anybody just hide it, just hide it, what if you have it again?" Line 373 - 376* *"Yeah I could have told them you know, but like I said, it just feels like because I went through it, I feel like they won't understand" Line 593 - 594* *"And I just felt weird going to them, oh look I was pregnant, now I've lost the baby. So there wasn't much chance of getting support from people" Line 360 - 361.* *"...it was just weird because nobody was celebrating when I got pregnant again, they were just like, "Shhh don't tell anybody, don't tell anybody". (Line 398 – 400)* *"And for the third time, when I was carrying my son for the third time, they were like, don't tell anybody because maybe you had the evil eye, that's why you were getting miscarriages" Line 522 - 525*
Amira	**Community disapproval in talking about baby loss** *Community disapproving emotions and talking about baby loss, expected that she must carry on and get on with it*	*"I feel like in our community, they kind of brush the emotions of people under the carpet, like you're not able to express how you feel about loss, especially about baby loss or in pregnancy, miscarriaging, or anything like that. I feel like they expect you to carry on and get on with it, kind of thing." Line 250 - 254* *"But when he[son] mentions it [stillborn baby] in front of family, they kind of frown and they think, oh but how does he know?" Line 215 - 216*
Sofia	**Secrecy and superstitions:** *Community distancing themselves from her, cultural superstitions and disapproving of her talking freely about her baby loss*	*"...you're kind of blacklisted in your community, because you've been through something and people are afraid to talk to you about it. Which is another thing why I think community kind of stays away from you, because they don't want to be cursed with the same thing that you have, which is what you find." Line 987 – 991)* *"They always say that when you've had a miscarriage, this is kind of like a belief in our culture, when you've had a miscarriage you're not supposed to walk past a pregnant woman because your shadow, if it falls, if it passes her, then it curses her baby, so people keep their distance from you" Line 996 - 1000* *"I find that I'm quite talkative, and I'm quite open with everything that I've been through, people are uncomfortable with that" Line 1002 - 1003* *"So you get that vibe of people, that they're not comfortable with you speaking out about everything that you've been through, in their eyes it's supposed to be something that's really secretive" Line 1003 - 1006* *"I think, just the way the community is, we shouldn't air everything. We should believe in God and you know, that this happens for a reason, just accept it and move on. But things don't change, things don't work like that, and it's good to talk" Line 1030 - 1033*