Using An Emotion-Focused Approach In Preventing Psychological Birth Trauma

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Abstract

Purpose

This discussion article considers how an emotion-focused approach can be adopted to prevent psychological birth trauma and to optimize perinatal wellbeing for women and their families.

Conclusions

Emotion-focused approaches have a different perspective when compared to other classic psychotherapy methods. This approach may help women to resolve the negative impacts of psychological birth trauma; to prevent post-traumatic stress disorder onset; to lead to better results for mother and baby well-being; and may be cost effective.

Practice Implications

Mental health nurses/midwives should receive education about emotion-focused approaches in addition to gaining competence in basic counseling skills so that they can utilize these approaches with women.

Key words. Emotion-focused approach, psychological birth trauma, perinatal well-being, midwifery, mental health nurses

1. Introduction

The perinatal period (a period that spans pregnancy to one year postnatal) is a very important and unique experience for the mother and the infant that can be affected by various environmental and social factors. The perinatal period involves not only physiological changes but also psychological/emotional rapid and profound changes in a woman's sense of identity and purpose (Wadephul, Glover & Jomeen, 2020). Furthermore, although change occurs during the whole perinatal period, it is most marked at the time of birth. The birth is often considered as summative from a clinical perspective; i.e. product/baby/outcome-oriented. In reality, it is a very critical and formative experience for the mother and the infant. Although the childbirth experience represents a separation of the mother-baby unity as the baby leaves its mother's body there is also a powerful reunion as the hormonal surges intensify bonding behaviours and the mother experiences her baby through her five senses for the first time (sight, sound, smell, touch and taste).

Childbirth is generally regarded as a positive experience during which women, who physically and mentally witness the birth of their babies, naturally have eustress (an optimal level of stress or arousal) (Dikmen-Yildiz, Ayers & Phillips, 2018; Ayers & Sawyer, 2019). However, for some women, birth can be a psychologically traumatic and distressing experience (Bastos et al., 2015) with pervasive and negative impacts for women, infants and their families (Fenech & Thomson, 2014). Psychological birth trauma, like other forms of trauma, can lead to post-traumatic stress disorder (PTSD) (Ayers & Sawyer, 2019). A key reason for PTSD onset is due to memories and emotions associated with the traumatic event not being processed (van der Kolk, 2014). While methods such as Eye Movement Stress Disorder and Cognitive Behavioural Therapy are recommended treatment options for PTSD, currently there is little evidence of their effectiveness in a perinatal population (Furuta et al., 2018). There are also alternative therapy methods used in the treatment of trauma such as emotion-focused approaches which could be valuable in helping women to come to terms with a distressing birth and to facilitate more positive memory processing (Dekel et al., 2017). Therefore, helping women to resolve the negative impacts of birth trauma and to prevent PTSD onset will result in better results for mother and baby well-being and will be cost effective. This discussion article considers how an emotion-focused approach can be adopted to prevent psychological birth trauma and to optimize perinatal wellbeing for women and their families.

2. Psychological birth trauma: Preventive and Therapeutic Approaches

Birth trauma is often used to refer to a physical injury to the mother and her baby (Collins & Popek, 2018; Dumpa & Kamity, 2020). However, it is also a term that involves not only physical injury but also negative psychological reactions related to the birth experience (Anderson, 2017; Greenfield, Jomeen & Glover, 2016). Birth-related trauma

relates to threats of injury or death to themselves and their baby and women define it as the moment of fear, hopelessness and terror (Beck & Casavant, 2019). In several studies, many women define childbirth as a traumatic experience and were found to have posttraumatic stress symptoms (PTSS) or even met the threshold of a clinical diagnosis of PTSD (Patterson, Hollins Martin & Karatzias, 2019; Dikmen-Yildiz, Ayers & Phillips, 2017). Although studies assessing the prevalence of psychological birth trauma have used different measurement tools and criteria, more than 45% of the women consider their birth experience as traumatic (Patterson, Hollins Martin & Karatzias, 2019). Systematic reviews and meta-analyses have reported that 3%-5% of the women with a healthy pregnancy and childbirth, and 15%-18% of the women classified as high-risk (due to mental health issues, history of PTSD, stillbirth, premature baby) have birth-related PTSD (Dekel, Stuebe, & Dishy, 2017; Dikmen-Yildiz et al., 2017).

There are many personal, environmental and social etiological factors creating birth-related trauma/PTSD (Ayers et al., 2016). Emotionally, following psychological birth trauma, women experience a loss of control where their humanity is threatened, have ambivalent emotions about birth and negative emotions such as panic, anger, nervousness, aggressiveness, irritability, guilt, suicidal thoughts, helplessness and hopelessness (Elmir et al., 2010). Women can experience: social isolation and disrupted relationships with their spouses and infants (Elmir et al., 2010; Fenech & Thomson, 2014). They can also experience classic PTSD symptoms of flashbacks and nightmares related to parts of the traumatic birth experience, avoid remembering their birth experience or consider it as a worthless memory (Beck & Casavant, 2019). Maternal PTSD not only effects on the health of women but also on breastfeeding rates, mother-infant interaction and child development (Cook et al., 2018). Infants of mothers who have PTSD following childbirth may have communication, interaction and bonding problems with their mothers, low weight gain, high cortisol levels in saliva and

eating/sleeping problems (Stuijfzand et al., 2020; Cook et al., 2018). Mothers who have experienced psychological birth trauma are also less likely to breastfeed due to avoidance issues (Cook et al, 2018).

Despite the presence of factors likely to be associated with psychological birth trauma such as obstetric complications and a lack of support, having positive perceptions about the birth decreases the risk of pathological changes in postpartum emotions (Jomeen and Martin, 2018; Ayers, 2017). It is important for women to have positive perceptions and emotions about their birth experience so that their mental health can be protected in the postpartum period. Some of the interventions identified to help protect against birth-related PTSD are structured psychological interventions (e.g. psychoeducation and exposure therapy), computer games (e.g. Tetris), writing about birth-related emotions, and skin to skin contact immediately post birth (de Graaff et al., 2018). It is known that trauma-focused psychological therapies such as exposition therapy, trauma-focused cognitive behavioral therapy, eye movement desensitization and reprocessing are effective in birth-related PTSD. While trauma-focused cognitive behavioral therapy, eye movement desensitization and reprocessing in particular reduce symptoms of PTSD (Furuta et al., 2018), there is no evidence of their effectiveness in a perinatal population. In a meta-analysis performed to evaluate the duration of effects of psychotherapy for birth-related PTSD, the study found that the therapy decreased PTSD symptoms in the short term (0-3 months) and the medium term (3-6 months), but no evidence was found about complete elimination of symptoms (Furuta et al., 2018).

While not all women who have experienced psychological birth trauma will go on to develop PTSD (Morina et all., 2014), it has been emphasized that midwives should follow women closely, particularly those with a history of mental illness, and to offer appropriate support. Women want to receive support from maternity care professionals (Thomson &

Garrett, 2019). Therefore healthcare professionals need to be trained to identify key signs of how psychological birth trauma can manifest through trauma-associated thoughts ("My baby is dying"), concurrent emotions (emotion very frightened, terrorized and threatened) and physical sensations (difficulty in breathing and increased heart beat). Following the birth, women often do not understand their trauma responses, and are concerned about how they will be perceived if they talk about their negative emotions (Seligowski et al., 2015). Although childbirth can often elicit a range of emotions it is often not possible for women to experience positive emotions (satisfaction and love etc.) when psychological birth trauma/PTSD develops (APA, 2013). Therefore, it is suggested that an emotion-focused approach can be effective in alleviation of symptoms in childbirth-related traumas.

3. Traumas and Emotion-Focused Approach/Therapy

Emotion-focused therapy is a humanistic method based on integration of modern emotion therapies and dialectic metatheories into individual-focused approaches and Gestalt practice, and is empirically evaluated. Emotions affect what individuals perceive, how they perceive a thing, at what speed they process information, what they will think about a situation and how they respond to it. They offer information about the priority and importance of situations during life experiences in accordance with values, aims and goals of individuals. For this reason, emotion therapy provides fundamental mechanisms which regulate relationships with the self and others and to enable individuals to create new meanings of experiences (Greenberg, 2015).

Individuals have the capacity to access emotional information, utilize emotions as a guide in their experiences, recognize the sensations created by emotions in their bodies and symbolize and change them into words, and to constantly and alternately create the sensations of their experiences. Emotion schemes, which are the primary sources of experiences, are formed through synthesis of emotional experiences. The meaning of emotional inputs from

the internal and external environments in life experiences are interpreted and transformed and rapid and automatic sensations are produced by emotion schemes. They are the main targets of therapeutic interventions and changes. During the process of emotion-focused counseling, individuals who want to change their nonadaptive mood or an unwanted experience are provided with help in a safe and empathic environment (Greenberg, 2015).

Emotion-focused therapies for trauma are based on the attachment and trauma literature, as well as the general emotion-focused therapy model (Mlotek & Paivio, 2017; Greenberg, 2015). Individuals who experience trauma feel stressed due to difficulties they are consciously aware of, as well as repressed/unexpressed emotions and attachment needs. Therefore, in emotion-focused therapies for trauma, not only nonadaptive emotions (fear and embarrassment etc.) but also blocked adaptive emotions (anger and sadness etc.) are accessed and new meanings are formed from the emotional information (Greenberg, 2015). Individuals are enabled to recall their traumatic experience, express previous adaptive emotions, find meanings of their emotions and become aware of their emotional needs like unmet needs for protection and love (Mlotek & Paivio; 2017). The goal of these approaches is to help individuals focus on their memories, to decrease fear and avoidance, to have more adaptive emotions and perceptions about themselves and other people and to reinterpret their experiences (Mlotek & Paivio, 2017).

4. The Process of Emotion-Focused Therapy for Psychological Birth Trauma

Childbirth is a physiological event; however, it is experienced differently by each woman and it can change from one birth to another. Emotion schemes are of great importance for childbirth. They may be affected by the culture of the society, childbirth experiences told by other women, childbirth experiences witnessed by women, childbirth images shared on the media, clichés about childbirth used by health professionals and other individuals, and prior childbirth experiences. Women may therefore not only be traumatized by their own childbirth

experiences but also by childbirth experiences they witness and narrations of traumatic childbirth experiences by others. Emotion schemes may influence women's adaptive or maladaptive responses to their future childbirth experiences (Greenberg, 2015).

Emotion-focused approaches should be initiated as part of preconceptual care and maintained in the perinatal period to prevent childbirth-related trauma. The primary goal of emotion-focused approaches is to encourage women to identify, accept and tolerate their emotions by building emotional attention in a reliable, emphatic and sustainable relationship framework; to transform their emotional experiences and to create new emotion schemes for use in solving daily life problemsWhen compared with other life-threatening traumas (wars, natural disasters and abuse etc.), psychological birth trauma is advantageous in terms of transforming an emotion and experiencing the new emotion since the hormones oxytocin and endorphin, which can support emergence of positive emotions, are released naturally due to the physiology of the postpartum period. These hormones enable mother-baby bonding and support creation and maintenance of positive emotions. Identification of women at risk of psychological birth trauma earlier, utilization of appropriate approaches during counseling and provision of guidance in transformation of emotions by nurses and midwives play an important role in making use of these hormonal process and maintaining wellbeing of the women. An emotion-focused therapy, which involves accessing and adapting or replacing emotions, has three phases: (1) bonding and awareness, (2) evoking and exploring, (3) transformation and change (Greenberg, 2015). A description of these stages, as well as how this could be undertaken in a childbirth related context are outlined as follows (Figure).

4.1. Bonding and Awareness

First, a bonding process between the counselor (such as a nurse/midwife) and the individual should be initiated. To achieve this, midwife/nurse should utilize their empathizing skills and create a safe environment. Although, if the cause of psychological birth trauma is

the actions or omissions of health professionals, women may not wish to access due to intense distrust and maladaptive coping may persist. As trauma can create challenges in individuals being unable to symbolize and interpret their emotions, behaviours or bodily responses, this phase concentrates on woman's felt, emotional experiences via validation. The midwife/nurse counselor should provide guidance to help women identify and recognize their emotions, to access emotional information (such as why they feel these emotions), and to accept and validate their emotions (Greenberg, 2015).

4.2. Evocation and Exploration

The evocation and exploration phase focuses on identifying whether emotions are primary, secondary and instrumental (Greenberg, 2015).

Primary emotions are direct emotional responses which have a biological adaptative focus and which cannot be reduced to another emotion (Greenberg, 2015). There are seven inborn emotions: fear, anger, sadness, shame, disgust, joy and surprise (Özakkaş, 2018). All of which women can experience following a psychologically traumatic birth experience (Beck & Casavant, 2019). Primary emotions can be either adaptive or maladaptive. Accepting and establishing control of emotions demonstrates that these emotions are adaptive. Whereas primary maladaptive emotions are unhealthy, harmful and involve learned responses (often based on previous trauma) that stimulate poor coping, and prevent problem solving, forming social interactions and growth. In psychological birth trauma, fear, shame and disgust are primary maladaptive emotions (such as being associated with avoidance behaviours), while anger and sadness are primary adaptive emotions (due to individuals taking assertive actions or motivating the need for social connections).

Primary emotions stimulate secondary emotions, which are responses of individuals to their own emotions and thoughts rather than a specific or different situation. Secondary

emotions are created due to an inability to tolerate primary emotions and block the flow of functional emotions (Greenberg, 2015). For example, a woman who has become fearful following childbirth, may become angry about this sense of fear, even if feeling anger makes her feel more fearful. Secondary emotional responses are often problematic and not useful. The types of secondary emotions associated with psychological birth trauma include threat (death/injury of the woman or her infant and threat to her humanity etc.), hopelessness, guilt, terror, loss of control, panic, helplessness, loneliness, irritability, anxiety, insecurity and nervousness (Beck & Casavant, 2019; Elmir et al., 2010).

Individuals can also respond through instrumental emotions. These emotions are considered the most inauthentic and appear when individuals cannot express their real needs. Individuals display rather than express instrumental emotions, and these emotions are defined as manipulative as they are designed to trigger a response in others. While this type of emotions are learned through emotional experiences, individuals may not be consciously aware of them (Greenberg, 2015). Since cognitive processes are affected by psychological birth trauma, women may not organize their instrumental emotions. However, when the intensity of trauma symptoms decreases, and when cognitive functioning returns, instrumental emotions may appear. After psychological birth trauma, women may need affection, tenderness, and love, but may use instrumental emotions of fear, shame and disgust to try and unconsciously provoke the responses they need.

The evocation and exploration phase involves establishing support for emotional experiences, to evoke and arouse problematic feelings, to undo interruptions of emotion, and to help access primary emotions or core maladaptive schemes. During this phase of emotional therapy it is important for the nurse/midwife to work with the woman to help her identify whether the emotions are primary, secondary or instrumental as it is only when the emotions are identified, can an appropriate approach be adopted (Özakkaş, 2018). During this stage,

relaxation, empty chair etc. methods may be used (Özakkaş, 2018) as the individual needs to be ready to recognize and face their emotions. In addition, the counselor should evaluate whether clients have sufficient internal and external support so that their primary maladaptive emotions can be recalled and revealed. The counselor works with the client to help them understand how he/she avoids emotion or that a cognitive, physical or behavioral activity interrupts his/her emotion. For example, a woman exposed to sexual abuse in her childhood could be extremely frightened of a vaginal birth, which is the source of her physical and emotional suffering. Cognitively she may have an expectation of a disaster, physically she may have tremors, flashing and failure to regulate her breathing, and behaviorally she may avoid talking and change the topic of the conversation. Midwives and nurses should be aware of these signs and help the woman to access her primary emotion or the core maladaptive schemes.

4.3. Change and Transformation

The main focus of emotional change and transformation is to reinterpret an emotional experience, to create new emotional responses and to experience the newly transformed emotion. The emotional change and transformation process is based on several principles. They include awareness, expression, organization, reflection and transformation of emotions and corrective emotional experience (Greenberg, 2015).

Awareness of emotions refers to working with clients to recognize their needs by perceiving signals from their emotions and satisfaction of these needs. It does not require thinking about the emotion but requires an awareness of what the emotion is (Greenberg, 2015). Clients may need help to express their emotional experiences by using symbols, to approach, feel and recognize their emotions and to find words to express them. This process involves working with clients to enable them to discover their distorted beliefs and thoughts and to avoid and stay away from unwanted emotions. Expression of emotions is not

performed to get rid of them but to prevent their avoidance and to reveal repressed emotions (Greenberg, 2015).. The social/cultural perception of expected birth-related and motherhood emotions may prevent women from sharing their emotions with partners, relatives and/or health professionals, and can cause them to isolate, avoid and suppress their emotions (Nilsson 2018). To overcome this, women need to be able to cognitively orient to their birth-related emotion and explain, reflect and feel their emotional experience (Greenberg, 2015).

Organizing emotions involves naming, defining, identifying, permitting and tolerating emotions, creating a distance to work on emotions, increasing positive emotions, and decreasing vulnerability due to negative maladaptive emotions. The regulation of emotions can be achieved by stimulating the parasympathetic system via psychological relaxation techniques (Greenberg, 2015). A functioning parasympathetic system during birth is a protective factor in psychological birth trauma (Gonzalez et al., 2019). The key techniques recommended for women with psychological birth trauma are breathing and emotional freedom techniques, awareness practices and meditative practices such as yoga (Irmak Vural &Aslan, 2019; Saxbe, 2017; O'Connell et al., 2019). After the emotions have been regulated, they should be reflected upon. During the reflective process, emotions, needs, thoughts, experiences, meanings and different parts of self are described, associated and integrated to create a new narration (Greenberg, 2015). Regulated emotions in women with psychological birth trauma allows reflecting on and reinterpreting their birth experiences and preventing and reducing symptoms (Phunyammalee et al., 2019).

Transformation of an emotion refers to changing that emotion into another one. Generally, primary maladaptive emotions require transformation, which occurs in stages. First, maladaptive negative emotions are transformed into adaptive negative emotions and then they are changed into adaptive positive emotions. When ambivalent emotions are activated, adaptive emotions are synthesized from the concurrently activated schemes and

new schemes are formed. It is highly important to access a maladaptive emotion not only for information and motivation about it but also for its transformation. If an emotion is maladaptive, it is necessary to transform it rather than try and reduce its impact, since transformation of that emotion allows a change in schemes. In addition, transformation of emotions improves the ability of individuals to develop adaptive responses (Greenberg, 2015). In psychological birth trauma, maladaptive emotions such as fear and hopelessness need to be transformed into adaptive negative emotions like anger and anxiety and then changed into adaptive positive emotions like self-efficacy and gaining control.

The last stage of emotional change and transformation is to experience the new emotion and to form strong reinforcements for the new emotion schemes. During this process, the individual is guided in recognizing and experiencing the new emotion, and as new meanings are created, he/she feels a stronger sense of self. In psychological birth trauma, after all emotion transformation processes, new emotions can be self-efficacy, control, adaptation, happiness, satisfaction, hope love, compassion. new emotions are reflected in the individual's expressions and behaviors. At this stage, midwives and nurses can collect data by observing very well and give feedback to the individual by using reflection. Approval of the new emotion by the midwife/nurse may also help to reinforce and validate the woman’s newly developed sense of self (Greenberg, 2015). Enabling women with psychological birth trauma to recognize and utilize adaptive emotions can help to improve and maintain postpartum wellbeing of the women, their babies and families (Phunyammalee et al., 2019).

6. Conclusion

Women’s perceptions of labor can be affected by cultural, social and individual factors. While labor often involves positive and negative emotions, women who have a traumatic birth

tend to experience these emotions differently and which may ultimately affect the severity of their trauma symptoms.

Women and their families should be informed about risk factors of psychological birth trauma from preconception till the end of the perinatal period. If the woman does experience psychological birth trauma, they should be offered professional guidance and counseling in accordance with their needs by midwives/nurses. Although emotion-focused approaches have a different perspective when compared to other classic psychotherapy methods, the techniques provide motivation for change. It uses methods to encourage and enable women to recognize their maladaptive and negative emotions, and to replace the dysfunctional emotions with adaptive or transformative ones; to maintain and enhance wellbeing in the perinatal period.

Implications for Mental Health Nursing /Midwifery Practice.

An emotion-focused approach can enable mental health nurses/midwives to understand the feelings of the woman, to accept emotions, to understand and accept the identity of the individual, and to strengthen the self with emotion-focused approaches. The empathic approach may enable the women to recognize basic emotions such as fear, shame, guilt, anger, sadness, disgust, enthusiasm, and joy. By determining the maladaptive emotions of the woman they can help them to regulate their emotions and guide these feelings into adaptive emotions. Mental health nurses/midwives took part in the team in the recovery processes of individuals with many mental problems such as emotion-oriented approaches such as depression, trauma and stress, couple relationships, eating disorders, borderline personality disorder and anxiety disorders. Similarly, mental health nurses/midwives use their emotion-focused approach skills to help individuals with psychological birth trauma to recognize their emotions, express their feelings appropriately and adequately, and establish healthy communication and relationships. The recovery potential in emotion- focused approaches is

within the individual, and the mental health nurses /midwife guides the individual/patient in all these processes.

Mental health nurses /midwives should receive education about emotion-focused approaches in addition to gaining competence in basic counseling skills so that they can utilize these approaches with women, as well as with colleagues. While emotional-focused approaches have an evidence base in areas such as trauma, anxiety and depression, further studies to determine their effectiveness with perinatal women following psychological birth trauma are needed.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, DC, American Psychiatric Association

Anderson C. A. (2017). The trauma of birth. *Health care for women international*, *38*(10), 999–1010. https://doi.org/10.1080/07399332.2017.1363208

Ayers, S., Sawyer, A., (2019). The impact of birth on women's health and wellbeing. In: Taubman-Ben-Ari, O. (Ed.), *Pathways and Barriers to Parenthood : Existential Concerns Regarding Fertility, Pregnancy, and Early Parenthood*. Springer International Publishing, New York, pp. 199–2018.

Ayers S. (2017). Birth trauma and post-traumatic stress disorder: the importance of risk and resilience. *Journal of reproductive and infant psychology*, *35*(5), 427–430. https://doi.org/10.1080/02646838.2017.1386874

Bastos, M. H., Furuta, M., Small, R., McKenzie-McHarg, K., & Bick, D. (2015). Debriefing interventions for the prevention of psychological trauma in women following childbirth. *The Cochrane database of systematic reviews*, (4), CD007194. https://doi.org/10.1002/14651858.CD007194.pub2

Beck, C. T., & Casavant, S. (2019). Synthesis of Mixed Research on Posttraumatic Stress Related to Traumatic Birth. *Journal of obstetric, gynecologic, and neonatal nursing : JOGNN*, *48*(4), 385–397. https://doi.org/10.1016/j.jogn.2019.02.004

Collins, K. A., & Popek, E. (2018). Birth Injury: Birth Asphyxia and Birth Trauma. *Academic forensic pathology*, *8*(4), 788–864. https://doi.org/10.1177/1925362118821468

Cook, N., Ayers, S., & Horsch, A. (2018). Maternal posttraumatic stress disorder during the perinatal period and child outcomes: A systematic review. *Journal of affective disorders*, *225*, 18–31. https://doi.org/10.1016/j.jad.2017.07.045

de Graaff, L. F., Honig, A., van Pampus, M. G., & Stramrood, C. (2018). Preventing post-traumatic stress disorder following childbirth and traumatic birth experiences: a systematic review. *Acta obstetricia et gynecologica Scandinavica*, *97*(6), 648–656. https://doi.org/10.1111/aogs.13291

Dekel, S., Stuebe, C., & Dishy, G. (2017). Childbirth Induced Posttraumatic Stress Syndrome: A Systematic Review of Prevalence and Risk Factors. *Frontiers in psychology*, *8*, 560. https://doi.org/10.3389/fpsyg.2017.00560

Dikmen-Yildiz, P., Ayers, S., & Phillips, L. (2017). Factors associated with post-traumatic stress symptoms (PTSS) 4-6 weeks and 6 months after birth: A longitudinal population-based study. *Journal of affective disorders*, *221*, 238–245. https://doi.org/10.1016/j.jad.2017.06.049

Dikmen-Yildiz, P., Ayers, S., & Phillips, L. (2018). Longitudinal trajectories of post-traumatic stress disorder (PTSD) after birth and associated risk factors. *Journal of affective disorders*, *229*, 377–385. https://doi.org/10.1016/j.jad.2017.12.074

Dumpa, V., & Kamity, R. (2020). *Birth Trauma*. In StatPearls. StatPearls Publishing.

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *Journal of advanced nursing*, *66*(10), 2142–2153. https://doi.org/10.1111/j.1365-2648.2010.05391.x

Fenech, G., & Thomson, G. (2014). Tormented by ghosts from their past': a meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery*, *30*(2), 185–193. https://doi.org/10.1016/j.midw.2013.12.004

Furuta, M., Horsch, A., Ng, E., Bick, D., Spain, D., & Sin, J. (2018). Effectiveness of Trauma-Focused Psychological Therapies for Treating Post-traumatic Stress Disorder Symptoms in Women Following Childbirth: A Systematic Review and Meta-Analysis. *Frontiers in psychiatry*, *9*, 591. https://doi.org/10.3389/fpsyt.2018.00591

Rodríguez-González, M., Schweer-Collins, M., Greenman, P. S., Lafontaine, M. F., Fatás, M. D., & Sandberg, J. G. (2020). Short-Term and Long-Term Effects of Training in EFT: A Multinational Study in Spanish-speaking Countries. *Journal of marital and family therapy*, *46*(2), 304–320. https://doi.org/10.1111/jmft.12416

Greenberg, L. S. (2010). *Emotion-focused therapy: An overview*. Turkish Psychological Counseling and Guidance Journal, 4(33), 1-12.

Greenberg, L.S. (2015). *Emotion-focused therapy: Coaching clients to work through their emotions.* Washington, DC: American Psychological Association.

Greenfield, M., Jomeen, J., & Glover, L. (2016). *What is traumatic birth? A concept analysis and literature review.* British Journal of Midwifery, 24(4), 254-267. https://doi.org/10.12968/bjom.2016.24.4.254

Irmak Vural, P., & Aslan, E. (2019). Emotional freedom techniques and breathing awareness to reduce childbirth fear: A randomized controlled study. *Complementary therapies in clinical practice*, *35*, 224–231. https://doi.org/10.1016/j.ctcp.2019.02.011

Jomeen, J. , Martin, C. , (2018). Well-being and quality of life in a maternal health context. In: Galvin, K. (Ed.), Routledge Handbook of Well-Being. Routledge, Abingdon.

Mlotek, A.E., & Paivio, S.C. (2017) Emotion-focused therapy for complex trauma. *Person-Centered & Experiential Psychotherapies*, 16, 3, 198-214, https://doi.org/10.1080/14779757.2017.1330704

Morina, N., Wicherts, J. M., Lobbrecht, J., & Priebe, S. (2014). Remission from post-traumatic stress disorder in adults: a systematic review and meta-analysis of long term outcome studies. *Clinical psychology review*, *34*(3), 249–255. https://doi.org/10.1016/j.cpr.2014.03.002

Nilsson, C., Hessman, E., Sjöblom, H., Dencker, A., Jangsten, E., Mollberg, M., Patel, H., Sparud-Lundin, C., Wigert, H., & Begley, C. (2018). Definitions, measurements and prevalence of fear of childbirth: a systematic review. *BMC pregnancy and childbirth*, *18*(1), 28. https://doi.org/10.1186/s12884-018-1659-7

O'Connell, M.A., O'Neill, S.M., Dempsey, E., Khashan, A.S., Leahy-Warren, P., Smyth, R.M.D., Kenny, L.C. (2019). Interventions for fear of childbirth (tocophobia). *Cochrane Database of Systematic Reviews*, Issue 5. Art. No.: CD013321. https://doi.org/10.1002/14651858.CD013321.

Özakkaş, T. (2018). *Duygu Odaklı Bireysel Terapi Eğitimi*. Psikoterapi Enstitüsü Eğitim Yayınları, İstanbul.

Patterson, J., Hollins Martin, C., & Karatzias, T. (2019). PTSD post-childbirth: a systematic review of women's and midwives' subjective experiences of care provider interaction. *Journal of reproductive and infant psychology*, *37*(1), 56–83. https://doi.org/10.1080/02646838.2018.1504285

Phunyammalee, M., Buayaem, T., & Boriboonhirunsarn, D. (2019). Fear of childbirth and associated factors among low-risk pregnant women. *Journal of obstetrics and gynaecology : the journal of the Institute of Obstetrics and Gynaecology*, *39*(6), 763–767. https://doi.org/10.1080/01443615.2019.1584885

Saxbe, D. E. (2017). Birth of a New Perspective? A Call for Biopsychosocial Research on Childbirth. *Current Directions in Psychological Science*, *26*(1), 81-86. https://doi.org/10.1177/0963721416677096

Seligowski, A. V., Lee, D. J., Bardeen, J. R., & Orcutt, H. K. (2015). Emotion regulation and posttraumatic stress symptoms: a meta-analysis. *Cognitive behaviour therapy*, *44*(2), 87–102. https://doi.org/10.1080/16506073.2014.980753

Stuijfzand, S., Garthus-Niegel, S., & Horsch, A. (2020). Parental Birth-Related PTSD Symptoms and Bonding in the Early Postpartum Period: A Prospective Population-Based Cohort Study. *Frontiers in psychiatry*, *11*, 570727. https://doi.org/10.3389/fpsyt.2020.570727

Thomson, G., & Garrett, C. (2019). Afterbirth support provision for women following a traumatic/distressing birth: Survey of NHS hospital trusts in England. *Midwifery*, *71*, 63–70. https://doi.org/10.1016/j.midw.2019.01.004

Van der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. New York: Viking.

Wadephul, F., Glover, L., & Jomeen, J. (2020). Conceptualising women's perinatal well-being: A systematic review of theoretical discussions. *Midwifery*, *81*, 102598. https://doi.org/10.1016/j.midw.2019.102598

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